



CULTURAL COMPETENCE PLAN & THREE-YEAR STRATEGIC PLAN

2021



COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

The County of San Diego has long had a commitment to cultural competence. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. Sharing a border with Mexico, San Diego has one of the highest rates of immigration of all of California's counties. It is ethnically diverse and will be increasingly so, where for county residents under age 18, 37% are Hispanic, with the Hispanic population expected to continue to grow at a rapid rate. Approximately 21.5% of the county's population is immigrants, including refugees, who come from other countries, speak 68 different languages, and have a variety of needs as they assimilate into their new environment. The senior and disabled populations are also growing disproportionately compared to the rest of the population.

The need to provide physical and mental health services to persons from many diverse cultures and different socioeconomic backgrounds has been acknowledged throughout all parts of the County of San Diego Health and Human Services Agency (HHSA), whether it is through Public Health, Behavioral Health, Aging and Independence Services, or County Medical Services for persons receiving Medi-Cal and low-income residents. HHSA previously launched a ten-year effort called "Building Better Health Program" to align County services to promote both physical and mental health in collaboration with community partners and businesses. The goals are to build a better system, support healthy choices, and pursue policy changes for a healthy environment. This service has evolved into a greater, long-term *Live Well San Diego* Vision to improve the health, safety, and quality of life of all County residents.

The County provides mental health and substance use services to roughly 120,000 children, youth, transition age youth, adults, and older adults each year. The services are largely contracted out, with few County programs. The County of San Diego Behavioral Health Services (SDCBHS) and its contractors provide services through approximately 300 programs, over 400 school-based mental health sites, and over 800 Fee-for-Service practitioners under contract to the BHS' Administrative Services Organization (ASO)

SDCBHS (composed of Mental Health Services and Substance Use Disorder Services) incorporates the recognition and value of racial, ethnic, and cultural diversity within its system, and included these values in its first Cultural Competence Plan in 1997. SDCBHS recognizes that there are measurable disparities in health care outcomes which indicate that bias exists within the health care system, both at the individual and systemic level. The department also has a long-term commitment to creating and maintaining a culturally relevant and culturally responsive system of care. Cultural competence is about recognizing that culture impacts our relationships and interactions in ways that most people don't even realize. It is a continual growth process which involves self-awareness, knowledge, skills, advocacy, and the examination of all those factors within a larger context. Recognizing the complex nature of personal identity, how each of us manages multiple identities, and how the intersection of our experience can be a powerful tool for healing and change, helps those providing services within SDCBHS to provide more culturally relevant and responsive care to the people being served.

In recent years, the term cultural humility has become more widespread. The term is based on the idea that we must be open to the identities and experiences of others as a primary way of being in the world.

There are three parts to this:

- A lifelong commitment to self-evaluation. We are never finished – we never arrive at a point where we are done learning. Therefore, we must be both humble and flexible;
- A desire to fix power imbalances. Each person brings something different to the table. Each person is the expert on their own life, symptoms, and strengths. Both people must collaborate and learn from each other for the best outcomes; and,
- A willingness to develop partnerships with people and groups who advocate for others. We cannot individually commit to self-evaluation and fixing power imbalances without advocating within the larger organizations in which we participate.

To determine whether all population groups in the County are getting access to needed mental health and/or substance use services, SDCBHS developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report to measure its service provision by age, gender, and racial/ethnic groups and to inform SDCBHS' strategies for addressing disparities. The data analysis began in FY 2001-02. Through the Mental Health Services Act (MHSA) funding, adult and children's mental health services have been expanded to begin reducing the disparities noted in these reports, but there is always area for growth.

The Cultural Competence Plan summarizes where SDCBHS is now and highlights future initiatives and next steps. It includes information on the eight criteria set by the State as indicators of cultural competence.

SDCBHS METHODOLOGY IN EVALUATING ITS SYSTEM

To understand the needs of the whole County mental health population for MHSA planning, SDCBHS and the University of California, San Diego (UCSD) Research Centers analyze service disparities on a triennial basis in a report titled *Progress Towards Reducing Disparities in Mental Health Services*. The most recent report covers three time points spanning across 8 years (Fiscal Years 2009-10, 2012-13, and 2015-16). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which is used to supplement the State required information. The report has since been reimagined as the *Community Experience Project*, a set of dashboards that will allow for flexible queries regarding health equity information that will provide timely, accessible, and actionable data for system policy development and decision making. With the County's renewed commitment to patient-centered care, these tools will provide support for initiatives that focus on the clients' specific long-term needs and community level services.

Although SDCBHS functions as a unified system, the focus of the services for children, youth, adolescents, families, adults, and older adults differs slightly, as is age appropriate. The Adult and Older Adult (AOA) System of Care focuses on psycho-social recovery, while the Children, Youth, and Families (CYF) System of Care focuses on family-centered treatment and resiliency. For the purposes of this report, much of the information on programs, initiatives, and future activities is divided into sections based on the population served.

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COMMITMENT TO CULTURAL COMPETENCE

I. The County of San Diego Behavioral Health Services' commitment to cultural competence

The County shall include the following in the CCP:

A. Policies, procedures, or practices that reflect steps taken to duly incorporate the recognition and value of racial, ethnic, and cultural diversity within SDCBHS.

BHS has the following policies, procedures, and practices in place that recognize and value cultural diversity:

The County of San Diego Department of Human Resources Policies

County of San Diego Department of Human Resources (DHR) has policies in place that reflect recognition of racial, ethnic, and cultural diversity in areas of training and recruitment. These include:

- Training and Development Program (*Policy Number 1002*) – “It is the policy of the Department of Human Resources to assist all departments and employees in the design, implementation and evaluation of professional and organizational development strategies through consultation, coaching, education and training.” One such training opportunity that addresses cultural competence is Embracing Diversity and Encouraging Respect, which the County strongly encourages each employee to take.
- Equal Employment Opportunity (*Policy Number 109*) – “It is County policy to provide the conditions which promote equal employment opportunity for all persons regardless of race, color, ancestry, national origin, religion, sex, marital status, age, sexual orientation, political affiliation, disability, or any other status protected by law.”
- Employee Organizations (*Policy Number 902*) – “It is County policy to maintain positive and productive relationships with all employee organizations; to foster activities, which are collaborative, cooperative and non-adversarial; and to assure that all County practices are free from discrimination based on employee organization membership or participation by County employees.”

SDCBHS Policies and Procedures

SDCBHS has several policies and procedures in place to ensure culturally and linguistically appropriate services are available. These include:

- Culturally and Linguistically Competent Services: Assuring Access and Availability (*Policy Number 5994*). The purpose of this policy is to assure improvements in the access and availability of culturally and linguistically competent services in County Behavioral Health Services. SDCBHS makes ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of San Diego residents. The policy is included in Appendix 1.
- Cultural Competence Resource Team (*Policy Number 5946*). The purpose of this policy is to establish a Behavioral Health Services Cultural Competence Resource Team (CCRT) to advise the SDCBHS Executive Team of Adult/Older Adult (AOA) and Children, Youth, and Families (CYF) Systems of Care (SOC) on issues of cultural competence. The policy promotes mental health, wellness and recovery, eliminates the

CRITERION 1

debilitating effects of psychiatric and alcohol and other drug conditions in a culturally centered manner, and promotes cultural competence. The policy is included in Appendix 2.

- Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services (*Policy Number 5977*). The purpose of this policy is to ensure that all individuals requesting services at Mental Health and Substance Use Disorder programs providing Specialty Mental Health Services have been evaluated for needing culturally/linguistically specialized services and linked with services or referred appropriately. The policy is included in Appendix 3.
- Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services (*Policy Number 6030*). The purpose of this policy is to ensure that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner to their special needs, to assist them in accessing Specialty Mental Health Services. The policy is included in Appendix 4.

SDCBHS Principles That Support Cultural Competence

The County of San Diego has two systems of care: the Adult and Older Adult System of Care and the Children, Youth, and Families System of Care. The systems work together to create the Behavioral Health System. Additionally, the Community Services and Support (CSS) component of the Mental Health Services Act (MHSA) and the Comprehensive Continuous System of Care for co-occurring mental health and substance use have guiding principles addressing cultural competence which further embed this value in SDCBHS.

Adult and Older Adult System of Care (AOA SOC) Guiding Principles

The AOA SOC is based on Biopsychosocial and Rehabilitation (BPSR) principles that have been shown to be effective in reducing psychiatric hospitalization and assisting behavioral health clients in becoming more productive community members. Biopsychosocial rehabilitation and recovery services are comprehensive, culturally competent, age appropriate, and are tailored to individual client's needs and choices within their cultural context. The AOA SOC Guiding Principles are in Appendix 5.

Children, Youth, and Families System of Care (CYF SOC) Guiding Principles

The mission of CYF is to advance a rich array of services delivered through an integrated, community-based behavioral health system of care that enables children and adolescents to achieve positive outcomes.

The CYF SOC Council's Vision is wellness for children, youth and families throughout their lifespan. The mission is to advance systems and services to ensure that children and youth are healthy, safe, lawful, and successful in school and in their transition to adulthood, while living in nurturing homes with families. There are 10 Guiding Principles of the CYF SOC, one of which is that services are culturally competent. The Principles are: four-sector collaboration; integrated care; child, youth and family driven; individualized; strength-based; community-based; outcome driven; culturally competent; trauma informed; and persistence. The CYF SOC incorporated Trauma Informed System in FY 2016-17 and Persistence in FY 2017-18. The CYF SOC Guiding Principles were approved in May 2018 and are in Appendix 6.

Clinical Director's Office (CDO)

The Clinical Director's Office provides quality management across the entire behavioral health system, in addition to developing and monitoring various workforce and integrated care programs. CDO also oversees hospital services, as well as long-term care coordination.

Prevention and Community Engagement Unit (PCE)

The Prevention and Community Engagement Unit is the public face in the community for SDCBHS and provides oversight, coordination, and leadership around prevention and early intervention activities and initiatives, including the integration of the *Live Well San Diego* Vision. SDCBHS has integrated community outreach; MHSA coordination; suicide prevention and stigma reduction planning; primary, secondary, and environmental prevention activities for Substance Use Disorder and Mental Health contracts and initiatives; and media campaigns under the PCE.

Community Services and Supports (CSS) Vision Statement and Guiding Principles

In addition to the Systems of Care described above, SDCBHS has implemented MHSA CSS programs and services. These include:

- Full implementation of an approach to services through which each client and her/his/their family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns, and motivations.
- Development and expansion of practices, policies, approaches, processes, and treatments which are sensitive and responsive to clients' cultures.
- The Guiding Principles of CSS include cultural competence items such as:
Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the racial and ethnic diversity within counties, as well as to eliminate disparities in accessibility and availability of behavioral health services.
- Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation, and religious/spiritual beliefs.

Comprehensive Continuous Integrated System of Care (CCISC): Co-Occurring Disorders

The CCISC initiative utilizes eight practice principles that directly impact the way services are planned and provided for the special cultural population of dually diagnosed (living with mental health and substance use disorders) individuals in SDCBHS. CCISC Training is available to County and contracted behavioral health staff to help ensure programs become "dually diagnosed capable or enhanced" and work collaboratively across systems to improve services. With support from the Behavioral Health Advisory Board (BHAB), SDCBHS adopted the CCISC model for designing system changes to improve outcomes for persons living with co-occurring disorders, within the context of existing resources, via a Consensus Document.

Trauma Informed Systems Integration

The San Diego County Health and Human Services Agency (HHSA) is dedicated to being a Trauma Informed System. Being trauma informed is a component of cultural competence, an approach to engage all people served, all staff, and those encountered whilst conducting business.

Trauma Informed Systems recognize and hold a universal awareness of trauma and/or complex stress as seen through social, ecological and cultural lenses. Trauma often results in individualistic coping strategies that may contribute to multiple strengths and challenges over their lifespan. To this end, HHSA seeks to:

1. Ensure systems and services are outcome driven, culturally competent, recovery focused, client-partner directed, and trauma informed.
2. Support activities designed to support wellness and complete health, reduce stigma, and raise awareness surrounding behavioral/medical health and wellness.
3. Uphold a policy that, on an annual basis, each region and division within HHSA will conduct a scan, as well as develop and implement an action plan addressing trauma informed systems integration across policies, language, environments, and client partner inclusion in decision making.

SDCBHS Organizational Provider Operations Handbook (OPOH) and Substance Use Disorder Organizational Provider Operations Handbook (SUDPOH): Cultural Competence

SDCBHS maintains the OPOH and SUDPOH, which are addenda to all mental health and substance use disorder provider contracts respectively. These handbooks are updated at a minimum annually and serve as a way for BHS to keep its contractors up to date on new or changing requirements for the provision of services. The OPOH and SUDPOH contain a “Cultural Competence” section which includes Culturally and Linguistically Appropriate Services (CLAS) Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards, originally developed by the Health and Human Services Office of Minority Health, are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The Standards are as follows:

Principal Standard:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The complete Cultural Competence section of the OPOH is included in Appendix 7. The full OPOH is linked in the [Technical Resource Library](#) and the [Optum San Diego MHP Provider Documents webpage](#).

The complete Cultural Competence section of the SUDPOH is included in Appendix 8. The full SUDPOH is also linked in the [Technical Resource Library](#) and in the [Optum San Diego DMC-ODS document library](#).

Uniform Clinical Records Manual (UCRM)

The UCRM includes a Behavioral Health Assessment which requires information on the client's race/ethnicity, language, support systems, alternative health practices, culture specific symptomatology/explanations for behavior, cultural issues, and any family history of immigration and acculturation issues.

Next Steps toward Increasing the Emphasis on Cultural Competence

As of December 2013, each legal entity, that includes both mental health and SUD providers, is required to have a Cultural Competence Plan that demonstrates the policies and practices of culturally competent services for both mental health and substance use disorder services.

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

- B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:*
- 1. Mission Statement;*
 - 2. Statement of Philosophy;*
 - 3. Strategic Plans;*
 - 4. Policy and Procedures Manual;*
 - 5. Human Resource Training and Recruitment Policies;*
 - 6. Contract Requirements*
 - 7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence)*

BHS shall have items 1-7 available on-site during the compliance review.

COMMITMENT TO CULTURAL COMPETENCE

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

The CCPR shall be completed by the County Behavioral Health Services Division. The County will hold contractors accountable for reporting the information to be inserted into the CCPR.

The County shall include the following in the CCPR:

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

SDCBHS has traditionally solicited stakeholder input on behavioral health programming through a variety of committees, councils, workgroups, and other groups ranging from client representatives participating in the SDCBHS Administration Core Planning Group to large stakeholder meetings. When MHSA funding became available, an even more extensive effort was made to include participants from identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities. Recognizing and valuing the diversity of County residents, a range of channels was used to ensure a wide scope of opportunities to provide input and ideas on needed improvements to behavioral health services were available. Community forums, regional meetings, focus groups, surveys, and the formation of age-focused ongoing Advisory Councils contributed to decisions to create programs which operationalize community outreach and engagement and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities. Those efforts from the PCE, as well as the CDO, are incorporated under programs targeted to both children and adults.

Programs Focused on Serving Children, Youth, and Families:

The following programs serve as examples of services offered to children and adolescents which demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities:

- **UPAC Multi-Cultural Counseling Center (MCC)** provides intensive cultural and language specific outpatient behavioral health services and case management for Seriously Emotionally Disturbed (SED) children and families utilizing a comprehensive approach that is community based, client and family driven, trauma informed, and culturally competent. The focus of this program is to provide services to underserved Asian Pacific Islander (API) and Latino SED clients with emphasis on API clients.
- **Community Research Foundation (CRF) – Crossroads** program provides outpatient behavioral health services to children, youth, and their families in the underserved rural 1,000 mile square “backcountry” of East San Diego County. Services are provided where they are most convenient and appropriate for the families, which include schools, homes, church, community meeting centers, or even under oak trees in an outdoor setting.
- The **Community Circle Central** program at Logan Heights Family Counseling Center primarily serves Spanish-speaking Latino clients age 5 to 18 and their families. Mental health services are provided in 10 different schools, in the home, and in the community.
- **CRF – Nueva Vista Family Services (NVFS)** is a Full Service Partnership (FSP) program which provides a range of behavioral health services to children and youth ages 5-21 years old. NVFS is a dual diagnosis enhanced program and is culturally sensitive to the community which it serves, with over 75% of staff being bilingual (Spanish) and bicultural (Latino).
- **Episcopal Community Services (ECS) – Para Las Familias** program provides a wide range of behavioral health services to children, ages 0 to 5 and their families in the South Bay region. Services are made available to high-risk children, including behavioral health assessments and family therapy. The program’s mission is to empower parents with increased knowledge and skills to meet the social-emotional and developmental needs of their children, as well as knowledge of where and how to secure educational, health and other supportive services. To meet the population needs, 100% of the clinical staff is Latino/Hispanic culturally competent.
- **Palomar Family Counseling Services Prevention and Early Intervention (PEI) School-Based Component** provides social-emotional mental health evidence-based PEI services for elementary school age children at public schools in Escondido, Oceanside, and Valley Center school districts. The program targets underserved clients living in high-risk communities with high ratios of Latino and socio-economically disadvantaged families, many of whom are unemployed or under-employed, illiterate or have limited education, and homeless. Many families are single parent households and monolingual, with Spanish being their primary language. The Services include three components: Positive Behavioral Support (PBS) implemented through the Building Effective Schools Together (BEST) model, Incredible Years Parent, Teacher and Child Training services, and screening with at-risk children.
- **Harmonium Family/Youth Partner FSP** program serves eligible children, youth and their families that mostly reside in the southeast County communities. Due to obesity, diabetes, and hypertension concerns, particularly in African American and Hispanic

youth, the integration of medical treatment and mental health treatment is always part of the treatment spectrum. The primary focus is to provide support services to help clients achieve their mental health treatment goals.

- **Peer-to-Peer Text and Chat Support and Referral Services for Youth** – Peer-to-Peer program provides bilingual (English and Spanish) non-crisis peer support to youth using Live Chat and Text messaging that is confidential, anonymous and mental health stigma-free.
- **The Urban Youth Center of the San Diego American Indian Health Center** serves at-risk and high-risk Urban American Indian and Alaska Native youth ages 10-24 and their families. They provide screenings, assessments, and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for urban Native American youth.
- **McAlister Institute for Education and Treatment (MITE) – New Hope Alcohol and Drug Treatment and Recovery** provides services to pregnant and parenting adolescent females, primarily of Latina descent, who are using or have used alcohol and drugs. This Perinatal Teen Recovery Center offers treatment and recovery services for hard-to-reach Latino teen girls.
- **The Juvenile Forensic Services’ (JFS) Stabilization, Treatment, Assessment and Transition (STAT)** team provides clinical services and crisis intervention to youth and their families in the Juvenile Justice System.
- **The Juvenile Forensic Assistance for Stabilization & Treatment (JFAST)** is a juvenile mental health court which began in July 2010, focused on diverting emotionally disturbed youth out of the Probation system, while setting up intensive mental health treatment and family support in the communities, thereby improving probation outcome, public safety, and reducing recidivism.
- **New Alternatives, Inc.** provides therapeutic services to adolescents who live on-site at a residential treatment center. The Day Rehabilitation program offers a variety of treatment modalities to the clients to meet their needs effectively, help stabilize their behaviors, and obtain lasting changes in various aspects of their life.
- **SchoolLink** is the result of a partnership between the County and the local school districts intended to provide County-funded behavioral health services at schools directly, for students who are Medi-Cal enrolled, low income, underinsured, or uninsured. Families and school staff can submit a student referral form to access a range of services (at no or low cost) including mental health & substance abuse services, individual/family & group therapy, medication support, case management, collateral services, and rehabilitative services. Services are offered in many languages and can be provided during or outside of school hours, and on-campus or in a community setting, in order to minimize barriers to access for the most vulnerable clients.

Programs Focused on Serving Adults and Older Adults:

The following programs that focus on adult and older adult clients demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities:

- **Project In-Reach** provides services primarily to at risk African American and Latino citizens who are incarcerated adults or Transition Age Youth (TAY) at designated detention facilities and will be released in San Diego County. Services include: in-

reach and engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant’s quality of life; diminish risk of recidivism; and diminish impact of untreated physical health, mental health and/or substance abuse issues.

- The **Breaking Down Barriers (BDB)** PEI program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups, participant and family member organizations, and other stakeholders to reduce mental health stigma and increase access to behavioral health services by unserved and underserved culturally diverse communities. The program provides prevention and early intervention services through the efforts of Cultural Brokers who are individuals known in the local community to provide outreach and engagement support. Some of the services/programs include but are not limited to: mental health outreach; engagement and education to persons in the Latino, Native American (rural and urban), Lesbian/Gay/Bisexual/Transgender/Questioning+ (LGBTQ+), African, and African American communities; the implementation and evaluation of strategies to reduce mental health stigma; and effective collaborations with other agencies, community groups, participants, and family member organizations. BDB is one of many programs implemented as a result of the MHPA.
- The **Fotonovela Project** published and distributed a bilingual Fotonovela that reached out to the Latino community as part of a “stigma busting” effort on mental health issues, including information on how and where to access mental health services. In June 2013, San Diego County won the Silver Anvil Award of Excellence for the Fotonovela.
- **Clubhouses** provide services that assist members in reducing social isolation, as well as increasing their social rehabilitation skills and independent functioning, and improving education and employment. The Friendship Clubhouse targets unserved TAY and adult African American and Latino clients. The Eastwind Clubhouse provides culturally competent services to Asian/Pacific Islanders in their preferred language. Casa del Sol has a special focus on the adult, older adult and TAY Latino populations. The Oasis Clubhouse provides support groups, independent living skills, job skills development, peer mentoring, and crisis intervention for TAY. The Deaf and Hard of Hearing Member-Operated Recovery and Skill Development Center Program provide social skill development, rehabilitative, recovery, vocational supports, peer support, and advocacy to the target population in Communication Accessible language.
- **Bio-Psychosocial Rehabilitation (BPSR)** Wellness Recovery Centers (WRC) provide outpatient mental health rehabilitation and recovery services, co-occurring substance use treatment, case management, and vocational services for clients living with serious mental illness ages 18 and over, including those who may have a co-occurring substance use disorder. The Southeast Mental Health Center, Maria Sardiñas BPSR WRC and South Bay Guidance WRC provide services to the underserved Latinos in the County’s Central and South Regions. The UPAC BPSR WRC exclusively serves Asian/Pacific Islanders in their preferred language. The Chaldean-Middle Eastern Social Services Behavioral Health Program serves the County’s East Region Middle Eastern refugees. Heartland WRC also provides services to the County’s East Region Middle Eastern refugees along with several other underserved communities.

- **Outpatient Services for Deaf and Hard of Hearing**, a program of Deaf Community Services, provides specialized, culturally, linguistically and developmentally appropriate outpatient BPSR and SUD services for Medi-Cal and unfunded deaf and hard of hearing persons of all ages with serious mental illness, as well as those who may also have a co-occurring substance use disorder. Providers are fluent in American Sign Language (ASL) and are members of the deaf community. As of July 1, 2010, services have been expanded to provide substance use disorder services and alcohol and drug counseling with the addition of experienced and certified Alcohol and Drug counselors who are ASL-fluent.
- In 2013, two **Behavioral Health Services (SDCBHS) and Faith Based Community Dialogue Planning Groups** were established to facilitate conversations in the Central and North Inland regions with particular emphasis in the African American and Latino communities. A Community Dialogue Breakfast was held in each of the regions and a compendium of recommendations was compiled. One key outcome was the formation of SDCBHS Faith-Based Councils to provide input and recommendations to the SDCBHS administrative team on community needs and solutions. Both Councils submitted ideas for faith-based programs which resulted in innovation funding set aside for the faith-based programs. The Faith-Based Initiative was established in 2016 and primarily focuses on African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. The programs include development of collaboration and partnerships, including outreach and engagement to faith-based congregations; community education utilizing Faith-Based Champions; crisis in-home response to individual/family crisis situations such as suicides, homicides, and domestic violence on a 24/7 on-call system; and a wellness and health ministry that focuses on adults diagnosed with a serious mental illness receiving mental health services while in jail. The Faith-Based Initiative is divided into four Task Orders that target specific needs identified within the faith-based community.
- **Courage to Call** is a veteran-staffed 24/7 helpline that provides free confidential information, self-screening tools and appropriate resources, guidance, and referrals to individuals who have served in the military and their families. The program also provides training to improve cultural awareness and understanding for community organizations and providers serving those with a military or military family background.
- **Survivors of Torture, International (SOTI)** provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength-based, client and family driven, and culturally competent.
- **Innovative Mobile Hoarding Intervention Program (IMHIP)** is funded through MHSA Innovations and focuses on diminishing long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior lived experience receiving treatment for hoarding behaviors to provide support and encouragement to

IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participants' overall quality of life. The program began providing services in April 2016 and was approved for an extension in October of 2017.

- **Roaming Outpatient Access Mobile (ROAM)** is funded through MHSA Innovations to provide and operate a mobile mental health clinic for Native American transition age youth, adults, and older adults residing on tribal reservations in the East and North Inland Regions. The project is designed to decrease behavioral health symptoms and improve the level of functioning of participants, as well as improve care coordination and access to physical health care. Additional MAT services are also now provided as part of the ROAM Innovation Project in both East and North Inland regions to serve rural, tribal communities. Additionally, Withdrawal Management services were expanded to additional residential SUD contracts as of May 2020.
- **Home Finder Program & Tenant Peer Support Services Program** provides outreach, housing navigation, housing location, and tenant support services to individuals experiencing homelessness and living with severe mental illness. The program works closely with two outpatient clinics (Areta Crowell Center and the North Central Mental Health Clinic) to provide clients with housing opportunities. Home Finder staff are co-located at the clinics for immediate engagement with clients and to facilitate housing options. In partnership with 211 San Diego, the Home Finder program developed the Housing Resource Hub (HRH) which is an online housing resource directory used by housing navigators, designated outpatient clinics and program clients. In its first year (FY 2016-17), 222 individuals were engaged and assessed for housing using the Coordinated Entry System assessment tool. Of these 222 individuals, 163 were engaged in services to locate housing or supported to maintain current housing. Of these 163, 74 were placed into permanent housing. Fifty-five percent of these clients were housed within the first three months of program enrollment. Through housing and education efforts, the program has engaged with 102 landlords to expand housing options for clients, resulting in 68 new units. Interested landlords are linked to the HRH where they are able to list their housing unit vacancies. Home Finder also implemented a centralized roommate matching program to connect interested roommates with the most suitable support clients whose income may limit their ability to sustain housing costs.

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

SDCBHS seeks to enhance client and family engagement and involvement of ethnically and linguistically diverse clients at all levels of the behavioral health planning process. The following describes these engagement and involvement efforts.

Behavioral Health Engagement and Involvement Efforts Focused on Services for Children, Youth and Families:

- **The CYF Behavioral Health System of Care Council (The Council)** was established to provide community oversight on the integrity of services and advancements of all aspects of the system of care. The Council is a strong four sector partnership between youth/families, public agencies, private organizations, and education. The Council embraces the following Guiding Principles:
 - Collaboration of four sectors: Coordination and shared responsibility between child/youth/family, public agencies, private organizations and education.
 - Integrated: Services and supports are coordinated, comprehensive, accessible, and efficient.
 - Child, Youth and Family Driven: Child, youth and family voice, choice, and lived experience are sought, valued and prioritized in service delivery, program design and policy development.
 - Individualized: Services and supports are customized to fit the unique strengths and needs of children, youth and families.
 - Strength-based: Services and supports identify and utilize knowledge, skills, and assets of children, youth and families and strengthen their connections to natural supports and local resources.
 - Community-based: Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.
 - Outcome driven: Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.
 - Culturally Competent: Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.
 - Trauma Informed: Services and supports recognize the impact of trauma and chronic stress, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care, resiliency, and safety.
 - Persistence: Goals are achieved through action, coordination and perseverance regardless of challenges and barriers.

The Council meets monthly and has member representation from the BHAB, Juvenile Probation and Juvenile Court, HHSA Regions, Special Education Local Plan Areas (SELPA), First 5 Commission, San Diego Non-Profit Association (SDNA), Regular Education-Pupil Personnel Services, Substance Use Disorder Services Contractors Association, Youth served by the Public Health System, Managed Health Care Plans, Behavioral Health Services, Child Welfare Services, School Board, Mental Health Contractors Association, fee-for-service and organizational providers, San Diego Regional Center for the Developmentally Disabled, Family Receiving Services, and Public Health.

- **The Children’s System of Care Academy** provides seven CSOC specific trainings, including an annual conference that increases the skills of the entire range of participants in order to provide better services to families and youth. In April 2018, the CSOC

Academy held a conference that focused on the resources that support self-efficacy for children, youth and families experiencing homelessness. The title of the conference was Unpacking Hope: Understanding the Unique Needs of Children, Youth and Families Experiencing Homelessness. Last year, the Academy held a conference titled: Honoring the Journey-Partnering with Refugee Families.

- **The Family/Youth Liaison (FYL)** program has the primary duty of coordinating and advancing family/youth professional partnerships in the CYF SOC. The FYL Director works closely with CYF SOC administrative staff to ensure that family and youth voice and values are incorporated into service development and implementation plans.
- **National Alliance on Mental Illness San Diego (NAMI) Children, Youth, and Family Liaison Team** works to build resiliency in and connections with the communities they serve, sharing information on best practices, programs and support. Additionally, the CYF Liaison offers free workshops, forums, webinars, training events, and focus groups on a regular basis.
- Through its CYF SOC, BHS has been working with **Project Save Our Children** to address disproportionality and disparities in serving youth and families in southeast San Diego, especially with African American youth. SDCBHS has joined efforts with the faith-based community and other stakeholders to help increase access and break down the stigma of individuals and families experiencing mental health conditions. This project includes collaboration with Probation and Child Welfare Services. In November 2016, BHS spoke at one of the Project Save Our Children stakeholder meetings and presented on the racial/ethnic breakdown of children and youth served by BHS in different regions. The focus of the presentation was on the African American population.

Behavioral Health Engagement and Involvement Efforts Focused on Services for Adults:

- In order to provide feedback and recommendations to the Behavioral Health Services Director on the design and implementation of the AOA SOC, the following stakeholder groups were assembled:
- **Adult Council, Older Adult Council, Behavioral Health Services Housing Council, and Transition Age Youth (TAY) Council.** These groups also have a voice in making recommendations for policy development. Members are appointed from constituencies including: community organizations, BHAB, Community College District, TAY, primary health care, advocacy, National Alliance on Mental Illness (NAMI), Mental Health Contractors Association, Employment Services, Probation, Sheriff, Police Departments, fee-for-service mental health providers, Cultural Competence Resource Team (CCRT), Co-Occurring Disorders/Change Agents Developing Recovery Excellence (CADRE), Mental Health Coalition, hospital partners, underserved communities, long-term care representatives, service providers for adults and older adults, veterans services, Case Management, and clients and family members. Diverse consumer and family cultural representation is also continually sought.
- **Program Advisory Groups (PAGs)**, composed of at least 51% of clients living with mental health issues and/or family members, are a required program component for outpatient programs. PAGs, which are ideally facilitated by peers/family members, provide feedback and ideas to mental health programs about improving recovery services. PAG meetings have a format, agenda, and record attendance and minutes. Through Recovery Innovations International, PAGs have established implementation guidelines

across the AOA SOC in an effort to standardize this important vehicle for soliciting feedback to improve programs.

- **The Behavioral Health Advisory Board (BHAB)** addresses the unique and common needs of both mental health and substance use communities, and meets the needs of clients who are diagnosed with co-occurring disorders. The BHAB advises the Board of Supervisors, the Chief Administrative Officer, the Director of Health and Human Services Agency, and the Director of Behavioral Health Services regarding prevention, early intervention, treatment, and recovery services. The BHAB’s efficiency and streamlined process meet the State mandate of Welfare and Institutions Code 5604 and also mirror the delivery of services offered by SDCBHS. In addition, the BHAB is a key communication and oversight link between the client and family community and the local SDCBHS system.
- **The Quality Review Council (QRC)** involves a culturally diverse and representative group of members, including community behavioral health organizations, clients and family members, service providers, client-run service providers, and educational organizations. Members participate in the review of ongoing program monitoring, program and client outcomes, and system problems to help ensure that clients continue to receive high quality, effective services in a trauma-informed and recovery-oriented system.
- Through **NAMI San Diego**, the Family-to-Family program for adults ages 18 and older reaches out to families that support relatives living with mental illness. This 12-week program provides an understanding about mental illnesses, as well as a wide array of coping skills. The program is offered in Spanish, Vietnamese, and Arabic. NAMI also provides a 10-week Peer-to-Peer education program that engages people living with mental illnesses and provides them information on the illnesses, treatment, relapse prevention, and living well. It is offered in English and Spanish.

Community-Based Organizations:

BHS has developed activities that involve community-based organizations (CBO). Funded by Prevention and Early Intervention (PEI), Community Health Promotion Specialists and Aging Specialists bring mental health awareness to the general public and to those populations not normally seen within SDCBHS and who may be at risk for developing a mental illness. Promotion and Aging Specialists have incorporated “Good Mental Health Is Ageless” training in presentations to provide to community groups, including the older adult population and Hispanic older adult population. Staff attend health fairs throughout the county to distribute information and talk about mental health with community members. Staff also coordinates special events, such as the discussion of the San Diego County Report Card on Children and Families, including mental health and substance use data, and the “Es Difícil Ser Mujer” workshop.

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

County Participation in State Initiative for Ethnically and Culturally Focused Community Based Organizations Providing Services to Children and Adults:

The Center for Multicultural Development (CMD) at the California Institute for Behavioral Health Solutions (CIBHS) and the California Department of Health Care Services (DHCS) formed a collaborative with the objectives of: 1) fostering successful partnerships between counties and ethnic and culturally focused CBOs in the implementation of MHSA activities; and 2) providing strategies, training, and tools for developing organizational capacity of ethnic and culturally focused CBOs. In 2010, the County of San Diego identified two agencies, Chaldean Middle Eastern Social Services (CMSS) and Survivors of Torture, International (SOTI) to participate in trainings.

- **CMSS’s Behavioral Health Program** is a community-based, comprehensive outpatient program that addresses the mental health needs of our Chaldean and Middle-Eastern communities in San Diego County with a host of services for individuals, couples, families, and refugees.
- **SOTI** provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill, and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery- and strength-based, client and family driven, and culturally competent.
- **Our Safe Place** is a behavioral health services program for Lesbian, Gay, Bisexual, Transgender, Questioning + (LGBTQ+) youth that began offering treatment services in September 2017. It offers support with health and wellness activities, educational and vocational training, support groups for youth and caregivers, a mentorship program, GED preparation, life skills training, and crisis support to LGBTQ+ youth. Additionally, the program has four drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers.
- As part of the Countywide effort to support a healthy, safe, and thriving region through the *Live Well San Diego* Vision, the County of San Diego focuses on the integration of a trauma-informed model in the philosophy, approach, and methods to become a fully trauma-informed organization and to more effectively engage the people served, staff, and all others with whom the County conducts business. The goal is to enhance how the County responds to the needs of those whose lives have been impacted by trauma and or complex stress and ensure stronger coordination of care to promote wellness. SDCBHS continues to lead efforts to assist the HHS in moving toward an integrated trauma-informed system. With the assistance of a consultant, SDCBHS conducted an assessment of the trauma-informed competencies and leveraged the recommendations to begin the countywide implementation and change. This continued evaluation of system change will: build a better service delivery system; support staff, partners, and families in making positive choices by providing appropriate training and resources; aid in the pursuit of policies and environmental changes that support healthy, safe, and thriving communities; and continue to enhance the County culture from within. During FY 2016-17, SDCBHS provided training to providers on the Neurobiology of Trauma, assisted in the development of an e-Learning that will be provided to County staff by The Knowledge Center (TKC), continued to support employee wellness and self-care by offering regular

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onsite activities for staff (e.g., weekly physical fitness group class), and continued to include participation of individuals with lived experience of behavioral health challenges in community engagement forums, Council meetings, workgroups, and trainings.

- **Pathways to Well-Being** is the County of San Diego's joint partnership between SDCBHS CYF and Child Welfare Services (CWS), dedicated to collaboration in order to ensure safety, the promotion of a permanent living situation known as permanency, and well-being for youth in, or at imminent risk of placement in, foster care. Under the initiative, all youth entering the Child Welfare System are screened for mental health needs to receive appropriate services and support. Aligning with the Core Practice Model, the purpose of Pathways to Well-Being is to enhance the delivery of children's services through a collaborative team of mental health providers, CWS social workers, parent and youth partners, other system partners, and the youth and family. SDCBHS, CWS, Probation, and family and youth partners work together to support a shared vision of the Pathways to Well-Being. As of July 2016, the state expanded Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to be available to all children and youth under the age of 21 who are eligible for full scope Medi-Cal services and who meet medical necessity for these services.
- **I CARE** is a new program in the CYF System of Care and began its services in September 2017. The program offers behavioral health treatment services to youth up to the age of 21 who are at risk for or are victims of commercial sexual exploitation (CSEC) through an outpatient clinic. The program also has a 7-day a week drop-in center that offers supportive services such as assistance with school and groups for youth and caregivers. The program is well connected with other systems and County wide efforts to support sexually exploited children.

Other County Efforts to Strengthen Community Based Organizations:

Primary Care and Mental Health Services Integration programs include efforts with multiple primary care health centers to develop collaboration, capacity, and infrastructure to transition clinically stable mental health clients to primary care for treatment of co-occurring disorders. Eleven community health centers are participating to enhance capacity and infrastructure and facilitate the transition of clinically stable mental health clients to the primary care centers.

- **Rural Health Initiative** developed extensive behavioral health prevention, education, and intervention services within the context of several rural family practice clinics.

NAMI San Diego has helped address 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, through the provision of the following culturally competent activities:

- **Elder Multicultural Access and Support Services (EMASS)** provides outreach to Latino Older Adults in the South, Central, and North Inland regions of the County with the goal of providing mental health prevention and early intervention services.
- **Family-to-Family** is a 12-week education program for families (offered in Spanish, Vietnamese, and Arabic), which provides exhaustive information about mental illnesses, on understanding and supporting the relative living with the illness, as well as a wide array of coping skills.

- **Peer-to-Peer** provides a 10-week education program (for English and Spanish) for people living with mental illnesses.
- **NAMI Support Groups**, which are offered in English and Spanish, are open to family members and to all who need the assistance.

Housing for Mental Health Clients:

The Corporation for Supportive Housing (CSH) is a contracted housing technical consultant to SDCBHS. CSH provides trainings and educational forums for housing developers and supportive service providers to foster an understanding of the cultural dimensions of housing people with mental health conditions. CSH’s Fair Housing Training for Developers, for example, stresses not only the legal aspects of fair housing law requirements, but also the understanding of the various needs of this population. CSH continues to be the conduit working between the housing developers and service providers to resolve complex issues regarding tenancy and the related supportive services.

HHSA’s Building Better Health Program:

In 2010, after two years of collaborative planning sessions among County staff and community stakeholders, the County of San Diego Board of Supervisors adopted a comprehensive, long-term initiative on health called Building Better Health: Health Strategy Agenda. The decision was sparked by the realization that San Diego County, like much of the nation, was facing a tidal wave of chronic disease and rising healthcare costs. Four major themes are identified that combined can affect the health of residents:

- Building a Better System
- Supporting Healthy Choices
- Pursuing Policy Changes for a Healthy Environment
- Improving the Culture from Within

The original Building Better Health: Health Strategy Agenda has since evolved into a greater, long-term *Live Well San Diego* vision to improve the health, safety and quality of life of all County residents.

The theme of improving the culture from within focuses on increasing employee knowledge about health, promoting employee wellness, and implementing internal policies and practices that support employee health. Healthy County employees play a vital role in a healthier San Diego community.

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

In the design and development of services for culturally diverse groups, the lessons learned include the following:

- Building and developing relationships is a continuous and constant process to engage stakeholders through addressing common issues and concerns in a meaningful way.

- Meetings need to include key community leaders and representatives who can act as culture brokers and mediators. The meetings should be conducted in their own community.
- When engaging the community, we need to consider adjunct and complementary interventions that are common to the cultural and diverse groups that make up the community and utilize trauma informed approaches.
- Outreach and engagement strategies for ethnically and culturally diverse communities take time. The process and investment of resources may require developing and accommodating to non-traditional ways to build relationships and think creatively while leveraging the countywide effort to integrate trauma-informed systems.

E. Identify county technical assistance needs.

The County will welcome technical assistance in the following area: the adaptation of evidence supported and/or promising practices for culturally diverse groups to improve understanding, engagement, access to care, and retention. For example, in San Diego, information on how to adapt evidence supported/best practices for Latinos, Asian/Pacific Islanders, and Middle Easterners would be helpful.

COMMITMENT TO CULTURAL COMPETENCE

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

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

The County shall include the following in the CCPR:

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

Dr. Piedad Garcia is the Ethnic Services Manager (ESM). As the ESM, Dr. Garcia oversees cultural competence monitoring and initiatives that promote the development of trauma-informed and social-ecological mental health and substance use disorder services that appropriately meet the diverse needs of the County's various racial, ethnic, cultural, and linguistic populations.

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

The ESM also serves as the Deputy Director for Behavioral Health Services (SDCBHS). Dr. Garcia advises and directs planning, recommends policy, compliance, and evaluation

components of the County system of care. In her role as ESM, she makes recommendations to the SDCBHS Director to assure access and quality services for linguistically, ethnically, and culturally diverse groups. The ESM is the current Chair of the Cultural Competence Resource Team.

In her capacity as the Deputy Director for SDCBHS, she oversees a very large system of care that serves over 43,000 mental health, and over 15,000 substance use disorder clients in an array of outpatient, inpatient, crisis residential, rehabilitation, and recovery services across San Diego County. Her support staff monitors, oversees, and ensures the provision of integrated behavioral health services and co-occurring disorder services that are culturally relevant and appropriate. Dr. Garcia takes lead responsibility for the development and implementation of cultural competence planning within SDCBHS. She provides direction and oversight in the AOA SOC for diversity-related contracted and directly-operated services. She also oversees and participates in the monitoring of organizational providers to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations.

As an Executive Team member of the SDCBHS Management and Leadership team, the ESM makes program and procedure policy recommendations to the SDCBHS Director and the Quality Improvement Unit. She also maintains close collaborative relationships with consumer and family organizations. An active advocate, she consults and maintains a supportive relationship with local planning boards, advisory groups and task forces, the State, and other behavioral health advocates. Dr. Garcia has also been selected to participate in the California Latino Mental Health Reducing Disparities Project, Latino Concilio, which develops the Latino Health Care Disparities Strategic Plan for the DHCS. Additionally, Dr. Garcia was invited to speak at an international forum *Prevención de la Conductas de Autolesión y Suicidio en Jóvenes* in Tijuana, Mexico in May 2017 on suicide and self-harm reduction as part of the collaborative cross-border effort.

In June 2020, Dr. Garcia participated in the California Institute for Behavioral Health Solutions' Health Equity Data Skills Disparities Data webinar. The webinar covered an overview of technical assistance and resources, how to access data to measure health equity, and analyzing, reporting, and interpreting data to measure health equity.

Dr. Garcia was also a featured speaker in the 4th Binational Mental Health Symposium organized by the Binational Mental Health Work Group. The symposium focused on COVID-19 and its impact on the mental health of California-Baja California Border Communities. An informational flyer shared for this event is provided in Appendix 9.

COMMITMENT TO CULTURAL COMPETENCE

IV. Identify budget resources targeted for culturally competent activities.

The County shall include the following in the CCPR:

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

**EXAMPLES: BUDGET RESOURCES TARGETED FOR
CULTURALLY COMPETENT ACTIVITIES**

WET Specialized Training Modules (Cultural Competency)	279,472
San Ysidro Health Center’s Chaldean Middle-Eastern Social Services	486,000
Survivors of Torture, Int.	390,352
MH Services for Deaf, Hard of Hearing	431,750
Client Operated Peer Support Services	748,400
Mental Health Systems, City Star FSP	2,352,000
Union of Pan Asian Communities	1,706,777
Maria Sardinias Outpatient	2,480,639
Indian Health Council, Southern Indian Health, and SD American Indian Health Center	1,766,750
Pathways Community Services for TAY	4,379,170
McAlister Institute for Treatment and Education (MITE) – New Hope	422,000
Breaking Down Barriers, Jewish Family Services (JFS)	437,800
Faith Based Task Orders – Community Health Improvement Partners, Neighborhood House Association, Total Deliverance Worship Center, and Urban League.	513,331
San Diego Youth Services Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ+) youth and young adults	1,500,000

In addition to its ongoing programming, SDCBHS has 146 contracts with programs through MHSA CSS funding and 35 contracts with programs through PEI to help address disparities and provide more culturally competent activities for persons with mental health problems. There are currently five active MHSA Innovations programs, with two completed programs from previous cycles that will be continued through other funding sources due to their positive impact.

- 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; school-based services and the Hispanic youth;*
 - 3. Outreach to racial and ethnic county-identified target populations;*
 - 4. Culturally appropriate mental health services; and*
 - 5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.*

1. Interpreter and translation services

SDCBHS has provided services to persons with Limited English Proficiency through the usage of interpreter services. Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client’s service needs.

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According to 42 CRF, clients shall be routinely asked, at the time of accessing services, about their needs for language assistance. According to Title 9 and BHS policy, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages. BHS policy prohibits the expectation that family members, including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated programs can contact Hanna Interpreting Services, LLC (for language interpreting) at (619) 741-0000 or Interpreters Unlimited (for hearing impairment) at (800) 726-9891 to arrange for language assistance. To request interpreter services, County operated programs shall create an online account with Hanna Interpreting Services, LLC through their Language Services Online Portal Registration.

In addition, County operated programs can request written translation services through Hanna Interpreting Services, LLC at (619) 741-0000. A drop-box must be set up for each program that utilizes the service. This is done by submitting a Computing Service Registration Form (CSRF). Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website. [Budget details pending from SME, to be added to final copy]. A breakdown of interpreter services utilization for the MH and SUD systems of care is provided in Criterion 7, section I of this document.

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

To increase access to children's services and reduce ethnic disparities, SDCBHS began its effort to bring services to the community through the school-based programs. It was believed that minority groups would be more likely to be engaged because non-threatening treatment sites were established in local schools, and parents could participate without having to find transportation. The EPSDT and MHSA CSS funding allowed the County to expand the program from seven schools in 1999 to roughly 400 schools throughout the County. In FY 2019-20, 29 out of 42 school districts in San Diego County obtained onsite school services.

The penetration rate among Hispanic youth clients rose from 2.8 percent in FY 2001-02 to 5.1 percent in FY 2015-16; it is expected that programs funded through MHSA and the recent increase in school-based programs will continue to result in an increasing penetration rate.

Among the cultural disparities the County addressed, age targeted services were started through MHSA to reach out to underserved and unserved populations of Transition Age Youth (TAY) and older adults. A full-service partnership (FSP) program focuses on TAY and provides housing, treatment services, and a dedicated clubhouse with more age-appropriate services.

SDCBHS is addressing the service disparities for the homeless population. Several Assertive Community Treatment (ACT) programs help the homeless and those being released from jail get an appropriate level of care in the community, so that they can avoid costly inpatient and jail services.

One of San Diego's most vulnerable populations, LGBTQ+ youth, often suffer as a result of non-supportive or even hostile environments in their homes, schools and communities. Research demonstrates that LGBTQ+ youth who do not have access to LGBTQ+-affirming community environments are at higher risk for negative outcomes, including early high-school dropout, homelessness, negative mental health symptoms, increased substance use, suicide and physical, emotional and/or sexual abuse (Center for American Progress, 2010). Our Safe Place, a behavioral health services program for LGBTQ+ youth, provides direct clinical services, and three drop-in centers which offer support with health and wellness activities, educational and vocational training, support groups for youth and caregivers, mentorship program, GED preparation, life skills training, and crisis support to LGBTQ+ youth.

3. Outreach to racial and ethnic County-identified target populations

Many of SDCBHS programs reach out to racial and ethnic specific populations. For example, the two following PEI programs target specific ethnic groups. The Elder Multicultural Access and Support Services (EMASS) PEI program is a peer-based outreach and engagement program targeted to Hispanic, African refugee, African American, and Asian Pacific Islander older adults to support prevention of mental illness and increase access to care. Breaking Down Barriers is another program that provides mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), LGBTQ+, African, and African American communities.

In addition to the PEI programs, several Innovations programs were developed to reach hard to engage populations such as Native American and East African communities.

4. Culturally appropriate mental health services

All County and Contracted outpatient programs are required to be moving along a continuum toward providing trauma-informed, social-ecological, and culturally appropriate services. Such services currently include having staff with language capabilities matching the community needs to the maximum degree possible, creating a welcoming atmosphere, authentically partnering with our clients to develop meaningful relationships, and providing free access to interpreter services. All providers have cultural competence plans in place, are moving toward proficiency testing of bilingual staff, and employing a self-examination test of their own agency cultural competence. All contracts have also been updated to include the implementation of CLAS Standards, as well as ensuring staff have received at least four hours of Cultural Competence Training each year. In 2014, SDCBHS updated the Cultural Competence Handbook and incorporated the CLAS Standards. The Handbook contains tools to assist Behavioral Health providers with making improvements throughout the System of Care. The Handbook was

recently updated with an addition of two new cultural competence assessment tools and additional resources.

Still, other programs are targeted toward specific ethnic, cultural, or age groups. In FY 2016-17, SDCBHS spent approximately \$100M of the total budget on outpatient programs located on this continuum of providing culturally appropriate behavioral health services. In FY 2017-18, the number increased to about \$105M of the total budget.

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

County clinical staff who speak any of the threshold languages (Spanish, Vietnamese, Tagalog, Farsi, and Arabic) receive an additional hourly stipend. SDCBHS strongly encourages its providers to consider a similar system to help in the attraction and retention of bilingual staff.

Three-Year Strategic Cultural Competence Plan Criterion 1 Goals (July 1, 2021 – June 30, 2024)

CCRT allocated time over several meetings to discuss short- and long-term strategies and recommendations for the SDCBHS' culturally and linguistically appropriate services. The initial discussion focused on the County's policies, procedures, and practices that reflect steps taken to incorporate the recognition and value of racial, ethnic, and cultural diversity within SDCBHS.

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 1:

- **Expand the Mobile Crisis Response Teams (MCRT) program countywide.**
- **Develop a new County Department of Homeless Solutions and Equitable Communities as noted in County of San Diego Board of Supervisors (BOS) Chair Nathan Fletcher's State of the County Address.**

UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The County shall include the following in the CCPR:

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

The latest estimates for San Diego County from 2019 show that the overall population estimate of the County increased by almost 0.5% compared to the 2018 estimate (Note: 2020 Census data will be released in the fall of 2021).

While the estimate for children under age 5 decreased by 2% between 2019 and 2018, the estimated number of youth and TAY (ages 5-24) as well as adults ages 25-59 increased by less than 1%. In contrast, the older adult age group (60+) saw an increase of almost 3%. Over the same period, the estimates for the Hispanic, Black, and Asian/Pacific Islander populations increased, while the White and Native American populations saw a slight decrease. Lastly, the region's median age shows an incremental increase to 35.6 years in 2019. A detailed breakdown of San Diego County's population and demographics from 2018 to 2019 is provided in the following tables.

San Diego County Estimated Population in 2019: 3,351,785					
Age Group		Race/Ethnicity		Gender	
Under 5 years	207,723	White	1,510,327	Male	1,690,083
5-14	433,506	Hispanic	1,093,384	Female	1,661,702
15-24	514,390	Black	168,488	Median Age	
25-59	1,536,764	Native American	21,753		
60-74	460,395	Asian/Pacific Islander	441,882	35.6	
75+	199,637	Other	115,951		

Data Source: SANDAG Demographic and Socio-Economic Estimates, 2019 Estimates, San Diego Region

San Diego County Estimated Population in 2018: 3,333,127					
Age Group		Race/Ethnicity		Gender	
Under 5 years	212,283	White	1,515,649	Male	1,681,000
5-14	426,787	Hispanic	1,084,188	Female	1,652,127
15-24	517,539	Black	166,532	Median Age	
25-59	1,534,605	Native American	20,928		
60-74	447,214	Asian/Pacific Islander	431,625	35.3	
75+	194,699	Other	114,205		

Data Source: SANDAG Demographic and Socio-Economic Estimates, 2018 Estimates, San Diego Region

UPDATED ASSESSMENT OF SERVICE NEEDS

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

The County shall include the following in the CCPR:

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

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

San Diego MHP Medi-Cal Enrollees and Beneficiaries Served in CY19 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	165,383	10,723
Hispanic	360,834	10,645
African-American	49,748	3,274
Asian/Pacific Islander	68,389	1,660
Native American	3,615	265
Other	193,719	8,928
Total	841,688	35,493

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

Data Source: EQRO Approved Claims Report, as of July, 2020.

San Diego DMC-ODS Medi-Cal Enrollees and Beneficiaries Served in FY 2019-20 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	131,073	4,281
Hispanic	241,203	2,675
African-American	36,365	828
Asian/Pacific Islander	55,889	184
Native American	2,745	114
Other	168,845	3,280
Total	636,120	11,362

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

Data Source: EQRO Approved Claims Report, FY 2019-20.

UPDATED ASSESSMENT OF SERVICE NEEDS

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

The County shall include the following in the CCPR:

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

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

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

Every three years, SDCBHS develops a report titled “Progress Towards Reducing Disparities in Mental Health Services”. The purpose of the report is to provide progress towards the reduction of disparities across racial/ethnic and age groups. The most recent report was published in 2017 for FY 2015-16, and notes the disparities that exist in San Diego County and how they compare to FYs 2009-10 and 2012-13. SDCBHS continuously monitors its progress toward reducing disparities and identifies gaps between the demand for and the availability of services. As mentioned in Criterion 1, this report has been reimagined as a set of interactive dashboards called the *Community Experience Project* which is currently being developed. The next round of reporting will be available later in the year.

The latest “Progress Towards Reducing Disparities in Mental Health Services” report is included in Appendix 10.

The table below shows the breakdown of uninsured individuals or individuals on Medi-Cal under 200% FPL compared to actual CYF and AOA BHS clients in FY 2015-16.

	San Diego County Uninsured or Medi-Cal under 200% FPL, 2016		BHS Clients		San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		BHS Clients	
	CYF Population				AOA Population			
	Number	%	Number	%	Number	%	Number	%
White	34,144	13%	3,463	22%	81,229	22%	18,227	51%
Hispanic	190,351	71%	9,777	63%	226,968	60%	9,671	27%
African American	23,588	9%	1,691	11%	28,845	8%	5,211	15%
Asian/Pacific Islander	15,198	6%	519	3%	32,872	9%	2,283	6%
Native American	5,476	2%	95	1%	7,454	2%	309	1%
Total Clients	268,757	100%	15,545	100%	377,368	100%	35,701	100%

County of San Diego Behavioral Health Combined Population and Service Needs

In planning for services, SDCBHS has found it more useful and reflective of the County's population to consider the combined needs of the Medi-Cal and Indigent populations. The Disparities Report is specifically developed to highlight the disparities that exist in our system and assist SDCBHS in developing strategies to address specific service, access, and retention needs. The full report provides more definitive information by age, race/ethnicity, language, service utilization, and diagnosis to build on the State information. The full report can be located at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html (Section 6.1).

The FY 2015-16 Disparities Report identified the following disparities in SDCBHS:

Latino Adults may be underserved and not as easily engaged.

- The second lowest rate of service utilization across three fiscal years (4.3%).
- The lowest engagement rate (one service visit), (12.1%).
- 24% of Hispanic adult clients identified Spanish as their preferred language.
- 23% of adult clients served were Hispanic, while the County population was 33%.
- 11.2% of adults had only one visit to an outpatient program.
- 49% of adults had fewer than nine visits.

Latino Children may be underserved and not as easily engaged.

- Decrease in service utilization from FY 2012-13 to FY 2015-16.
- Had the lowest engagement rates for extended services of 13+ sessions (46%).
- Almost 30% identified Spanish as their preferred language.
- More than half the children receiving MH services identified themselves as Hispanic.
- 32% had fewer than six visits to outpatient services, and 12% had only one visit.

African American Adults may be underserved and/or not as easily linked with less acute levels of care.

- The highest prevalence rates of schizophrenia and other psychotic disorders (53%), compared to other racial/ethnic groups.
- More likely to receive services only in jail than other racial/ethnic groups (19%).

African American Children may be underserved and/or not as easily linked with less acute levels of care.

- Steady decline in penetration rate from FY 2009-10 to FY 2015-16 (from 10.9% to 7.2%).
- Decrease in service utilization from FY 2009-10 to FY 2015-16 (from 20.5% to 18.1%).
- More frequent use of Juvenile Forensic Services (JFS) without receiving any outpatient services, compared to other groups (8%).
- Less likely to have more than one session than other racial/ethnic groups (10.4%).

Asian/Pacific Islander Children were underserved.

- The lowest engagement rates for extended services of 13+ sessions (45.5%).

- More likely to use inpatient/emergency screening unit (ESU) services without receiving any outpatient services than other racial/ethnic groups.
- Had low access rates compared to other racial/ethnic groups, and the rates have gone down slightly over time.
- Had the lowest engagement rate and were most likely to discontinue services after one visit.
- 13.8% had only one visit.

Native American Adults were underserved.

- The lowest rate of service utilization (4.1%).

Native American Children were underserved and not as easily linked with less acute levels of care.

- Decrease in penetration rates from FY 2009-10 to FY 2015-16 (2.5% to 1.7%).

Other Factors Affecting Children's Usage of Mental Health Services

- 12% of children receiving mental health services were also involved with Child Welfare Services (CWS).
- The proportion of clients who received crisis stabilization services has been increasing since FY 2011-12 (from 2.2% to 4.8%).
- 10% of all CMHS clients were also open to the Probation System.
- Penetration rate among Transition Age Youth (TAY) has declined since FY 2009-10.
- The proportion of TAY who only received one service has almost doubled from FY 2009-10 to FY 2015-16 (10.1% to 19.8%).

The Gap Analysis and Disparities Report provided the foundation for determining service priorities for the CSS, WET, and PEI Plans.

Following the COVID-19 global pandemic, and in alignment with the County's efforts to provide trauma informed and culturally competent services, the County's Public Health Officer, Dr. Wilma Wooten provided daily reports to the public as part of Board of Supervisors daily updates. Information such as the number of positive cases among different ethnic and age groups are reported to the public daily. This information provides insight on whether different age and/or ethnic groups within the County may be disproportionately affected by the pandemic, and further highlights potential disparities among different ethnic groups. As of June 2021, the Native Hawaiian/Pacific Islander population appears to be disproportionately affected by COVID-19 (at a rate of 17,000 total positives per 100,000 individuals), followed by the Hispanic and Latinx population (11,974 total positives per 100,000 individuals). As of June 2021, vaccination rates are highest among the Native Hawaiian/Pacific Islander population at a 954 per 1,000 rate, and lowest among the Black/African American population at 346 per 1,000. Samples of these reports can be found in Appendix 11 and 12.

As [studies](#) begin to reveal that those who'd had COVID-19 are found to be at higher risk of mental health and substance use disorders, it is important to continue tracking infection and vaccination rates to reveal possible disparities in service needs in the county population.

UPDATED ASSESSMENT OF SERVICE NEEDS

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

The County shall include the following in the CCPR:

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

From Original CSS Plan:

Section II, Part II: Analyzing Mental Health Needs in the Community

A detailed gap analysis was prepared to fully understand the scope of mental health needs among all four target population age groups. The Gap Analysis, which included estimates of unserved, underserved and inappropriately served individuals, was provided to, reviewed, and discussed by the MHSA Workgroups.

Unserved Populations in San Diego County

The formula used to determine the number of unserved individuals in San Diego County was based on the estimated prevalence of mental health needs among those in poverty, for all age groups, across each ethnic classification, contrasted to the numbers served in the current service system.

In addition, as suggested in the CSS Requirements, the number of individuals who received inpatient or emergency services (stated in DHCS requirements as crisis only) and no other mental health services were included in the estimate of the unserved. Another factor considered was the estimated numbers of homeless. These data were provided by the San Diego Task Force on the Homeless.

As can be seen in the figures below, significant ethnic/racial disparities exist among numbers of persons expected to need services, compared to those receiving services in today's system. In addition to the notable disparities demonstrated in the data, these findings were re-affirmed through the community input provided by family members, providers, and other interested community stakeholders.

Also seen in the analysis below are significant ethnic/racial disparities that exist among numbers of persons who are not being served. Additional needs of the unserved populations include language, sexual orientation, and other special needs. Two "special needs" groups identified by the MHSA Workgroups were Deaf and Hard of Hearing and Trauma Victims. These findings were reaffirmed in the community input provided by family members, providers, and other interested community stakeholders.

Estimates for Unserved Populations in San Diego County

1. 15,821 Children and Youth (0-17)
 - Many of the children who are currently unserved are without insurance – number is estimated to be 15,667 (represents a duplicate count across gender and age).
 - Of these, the ethnic/racial groups that appear to have the largest number of children and youth in need of mental health services are Hispanic (8,805) and Asian Pacific Islander (1,447).
 - Children/youth of all ethnic/racial populations are unserved in the Age ranges of 0-5 (3,697) and ages 6-11 (3,154).
 - Primary language needs of unserved children and youth include Spanish, Tagalog, Vietnamese, and Arabic.
 - Females are underrepresented in CMH, 40% females compared to 60% males.
 - An estimated 950 of unserved children and youth may be gay or lesbian.
 - A number of unserved children may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims.

2. 8,900 Transition Age Youth (TAY) (between 18 and 25)
 - In San Diego County, the unserved TAY were identified as between 18 and 25 years of age because, based on prevalence data there, is no apparent service gap for 16 and 17 year olds.
 - i. Of this group, 7773 received no mental health services and 1,127 TAY received only crisis or emergency services.
 - ii. The ethnic/racial groups with the largest number of unserved are Latino (2,506) and Asian Pacific Islanders (312). 14 County of San Diego, Health & Human Services Agency, Mental Health Services Community Services and Supports Plan Addendum.
 - iii. Primary language needs of unserved TAY include Spanish, Tagalog, Vietnamese, and Arabic.
 - iv. Based on the State Prevalence report estimates of gender differences, it is possible that up to 5,000 females in this age group may be unserved.
 - v. Approximately 6-8% of the unserved TAY population may be Gay, Lesbian, Bi-Sexual or Transgender.
 - vi. A number of TAY may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims this unserved group, the primary ethnic/racial disparity groups are Latinos (2,506) and Asian Pacific Islanders (312).

3. 16,007 Adults (25-59)
 - 11,392 received no mental health services and 4,615 utilized only emergency or inpatient mental health services.
 - Based on projections in the State Prevalence Report large numbers of the county’s Latino (9,422) and Asian Pacific Islander (1,970) population are not accessing mental health services at all.
 - Of these, it is assumed that a higher percent may be monolingual Spanish, Vietnamese, Tagalog, or other language.

- In addition, although Native Americans and African Americans are accessing mental health services at a rate closer to the number projected by the State Prevalence data, they were much more likely to be receiving only emergency, inpatient or jail mental health services.
- Approximately 6-8% of this population may be Gay, Lesbian, BiSexual or Transgender
- A number of adults may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims *f* In addition, to the other factors noted it is possible that an estimated 11,000 adults who are unserved are without insurance.
- There are a substantial number of veterans who are seriously mentally ill and are in need of comprehensive mental health services.
- As a result of community input, SDMHS will track service use by Transitional Age Adults ages 50-59 to better understand mental health needs among this population.

4. 4,613 Older Adults (60+)

- 4,035 received no mental health services and 578 Older Adults received only inpatient or emergency services but were not connected to other MH services. 15 County of San Diego, Health & Human Services Agency, Mental Health Services Community Services and Supports Plan Addendum
- A relatively high percent of African Americans and American Indians received only emergency or inpatient mental health services
- It is estimated that 650 Latinos and 250 Asian/Pacific Islanders were unserved
- Many Latino and Asian/Pacific Islander older adults may be monolingual
- Based on estimates of gender differences, it is possible that up to 1,600 females in this age group may be unserved.
- Approximately 6-8% of this population may be Gay, Lesbian, BiSexual or Transgender, indicating a need for training
- There are a substantial number of older adults who are veterans who are seriously mentally ill and are in need of comprehensive mental health services.
- A number of older adults may have special needs such as being deaf or hard of hearing or being recent immigrants who are trauma victims
- Prevalence estimates will be re-evaluated on an on-going basis because the MHSA Older Adult Workgroup felt the prevalence estimates were too low, as stigma and isolation contribute to more underreporting and lack of recognition of mental illness among older adults

Chart A. Service Utilization by Race/Ethnicity

The following tables provide estimates that guided the development of the CSS programs of the total number of persons needing MHSA-level mental health services who already are receiving services, including those fully served or underserved/inappropriately served, by age group, race ethnicity, and gender.

Transition Age Youth (TAY) 18-24	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	5	0	746	574	5,409	100%	130,559	100%	337,506	100%
RACE/ETHNICITY										
African American	2	0	102	52	626	11.6%	8,935	7%	20,623	6%
Asian Pacific Islander	0	0	35	26	259	4.8%	12,660	10%	35,965	11%
Latino	1	0	209	129	1,579	29.2%	53,620	41%	122,665	36%
Native American	0	0	9	3	32	.6%	1,611	1%	2,147	1%
White	1	0	349	239	2,567	47.5%	48,699	37%	143,093	42%
Other*	1		42	125	346	6.4%	5,034	4%	13,013	4%

Adults 25-59	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	261	184	4,004	3,949	30,776	100%	347,997	100%	1,917,017	100%
RACE/ETHNICITY										
African American	46	39	583	558	3,656	11.9%	19,618	6%	78,404	4%
Asian Pacific Islander	10	11	174	190	1,626	5.3%	26,296	8%	164,799	9%
Latino	30	25	748	793	5,993	19.5%	127,502	37%	390,659	20%
Native American	0	3	22	33	189	0.6%	1,432	0%	7,896	0%
White	166	103	2,300	2,211	16,549	53.8%	87,216	25%	803,549	42%
Other*	9	3	177	164	2,763	9.0%	85,531	25%	471,710	25%

Older Adults 60+	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	14	15	175	373	577	100%	96,530	100%	434,147	100%
RACE/ETHNICITY										
African American	2	2	17	40	186	6.7%	4,676	5%	14,248	3%
Asian Pacific Islander	0	0	7	16	197	7.1%	9,482	10%	40,446	9%
Latino	0	2	29	74	420	15.1%	21,908	23%	56,392	13%
Native American	0	0	1	0	7	0.3%	414	0%	1,856	0%
White	12	10	107	226	1,571	56.6%	58,922	61%	314,353	72%
Other*	1	1	14	17	393	14.2%	1,530	2%	6,852	2%

* Other includes other, unknown and 2 or more races

** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+

*** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines

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

Analysis of Ethnic Disparities in Fully Served, Underserved or Inappropriately Served Populations in San Diego County

The populations continue to have disparities in mental health services in San Diego County. The disparities and variations in penetration rates and retention rates continue to be addressed through training, staffing, evidence-based practices, program evaluation, etc. Specific programs have been developed through MHSA to increase services to these populations based on the original gap analysis.

Children and Youth (CYF)

Hispanic

- Almost two-thirds (63%) of children and youth clients served in FY 2015-16 were Hispanic.
- The proportion of clients who received JFS services in FY 2015-16 increased by 3.8% compared to FY 2012-13 (1.0% to 4.8%).

African American

- Penetration rates for African American clients have steadily declined since FY 2009-10 (10.9% to 7.2%).
- Compared to other racial/ethnic groups, African American clients were slightly more likely to receive 13 or more sessions (52.9% versus 45.5-52.2%*).
- Compared to other racial/ethnic groups, African American clients had lower utilization of outpatient services (90.9% versus 94.0-96.1%*) and higher utilization of only JFS (8.0% versus 2.8-4.8%*).
- A smaller proportion of African American clients were diagnosed with anxiety disorders (6.3%), compared to clients from other racial/ethnic groups (11.2-13.1%*).

Asian/Pacific Islander

- Asian/Pacific Islander clients were least likely to receive 13 or more sessions (45.5%), compared to other racial/ethnic groups (46.1-52.9%*).
- Compared to the other racial/ethnic groups, a greater proportion of Asian/Pacific Islander clients were diagnosed with depressive disorders (26.0% versus 17.7-22.4%*).

Native American

- Penetration rates for Native American clients declined since FY 2009-10 (2.5% to 1.7%).
- The proportion of Native American clients who received only JFS increased from 0.0% in FY 2012-13 to 4.2% in FY 2015-16.
- Fewer Native American clients were diagnosed with bipolar disorders (4.2%), compared to other racial/ethnic groups (6.8-7.7%*).

Adults and Older Adults (AOA)

Hispanic

- The proportion of Hispanic clients receiving outpatient services has increased since FY 2009-10 (69.1% from 59.1%).
- Penetration rates for Hispanic clients were relatively stable from FY 2009-10 to FY 2015-16.
- Hispanic clients had among the lowest penetration rates for all three categories of services across all three fiscal years (2.7-4.4%*).
- A greater proportion of Hispanic clients only received one service visit (12.1%), compared to clients in other racial/ethnic groups (6.7-11.6%*).

African American

- African American clients were less likely than those in other racial/ethnic groups to receive outpatient services (63.0% versus 66.4-78.2%*).
- African American clients were more likely to receive services only provided in jail than other racial/ethnic groups (18.5% versus 6.4-13.9%), but this proportion has decreased since FY 2009-10 (29.3% to 18.5%).
- A greater proportion of African American clients (52.5%) were diagnosed with schizophrenic disorders compared to other racial/ethnic groups (33.6-49.5%*).

Asian/Pacific Islander

- Asian/Pacific Islander clients were more likely to receive outpatient services (78.2%), and less likely to receive only services provided in jail (6.4%) than clients in the other racial/ethnic groups.
- A greater proportion of Asian/Pacific Islander clients were diagnosed with depressive disorders (27.4%) compared to clients in the other racial/ethnic groups (15.2-22.9%*).

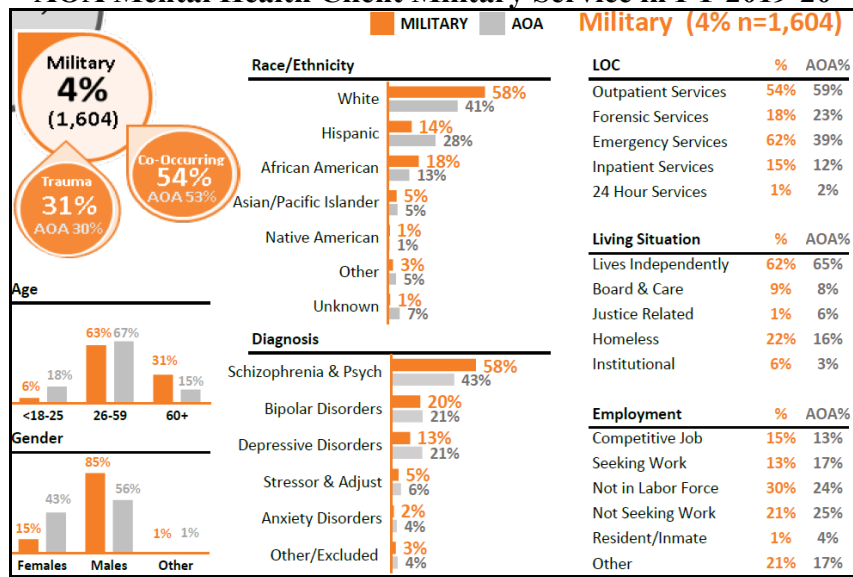
Native American

- Native American clients had among the lowest penetration rates for all three categories of services across all three fiscal years (2.9-4.7%*).
- Utilization of inpatient/emergency services has decreased among Native American AOA clients since FY 2009-10 (20.1% to 15.9%).

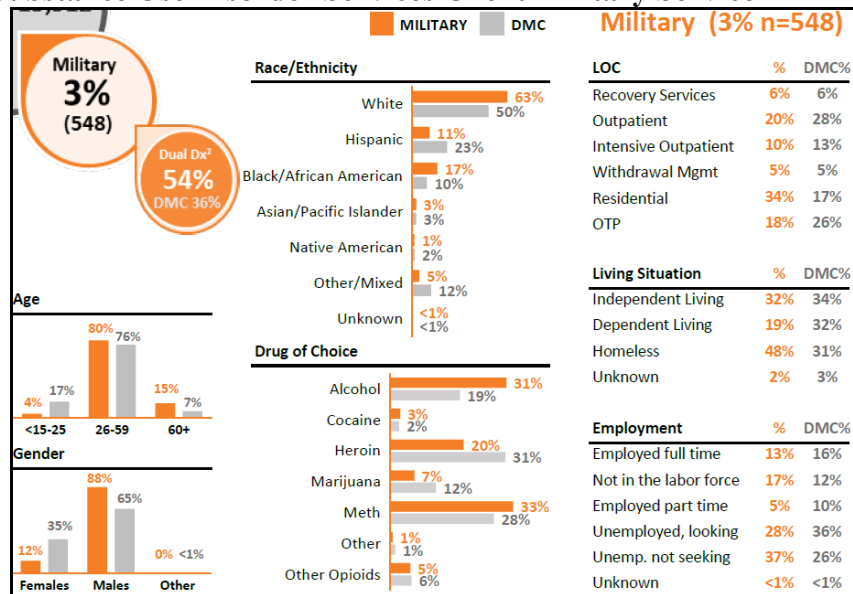
Veterans/Military Service

In order to measure disparities in behavioral health services among veterans in San Diego County, the number of AOA veterans is being continuously monitored. Of the 43,808 mental health clients served in FY 2019-20, 4% reported military service, which is consistent with the proportion of military service reported by 3% of the 15,912 substance use disorder clients served. There appears to be a higher rate of Emergency Services utilized by this population in mental health (62% compared to the rest of the AOA population’s utilization at 39%), and a higher rate of residential services in SUD (34% compared to the rest of the AOA population’s utilization at 17%). Higher rates of homelessness are also seen among this population in MH and SUD compared to the rest of the AOA population.

AOA Mental Health Client Military Service in FY 2019-20



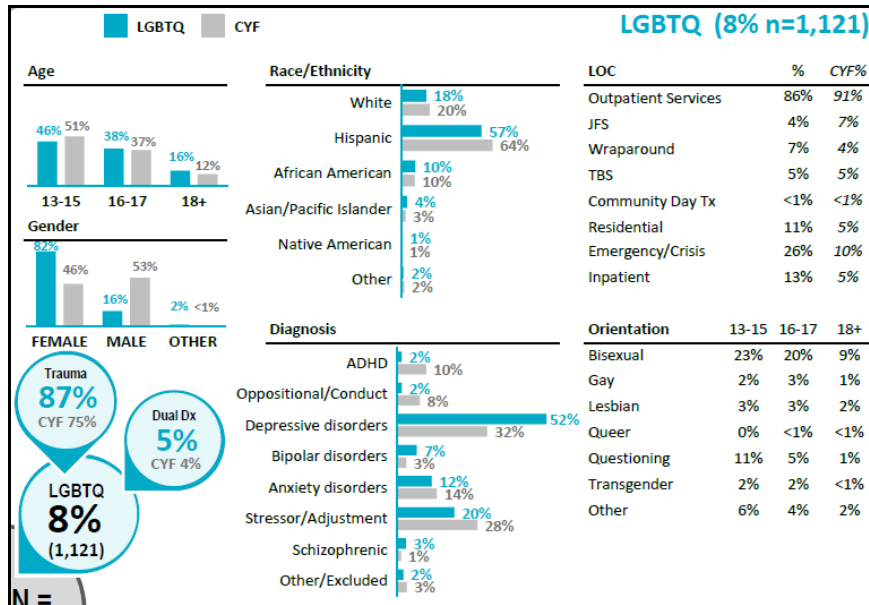
AOA Substance Use Disorder Services Client Military Service in FY 2019-20



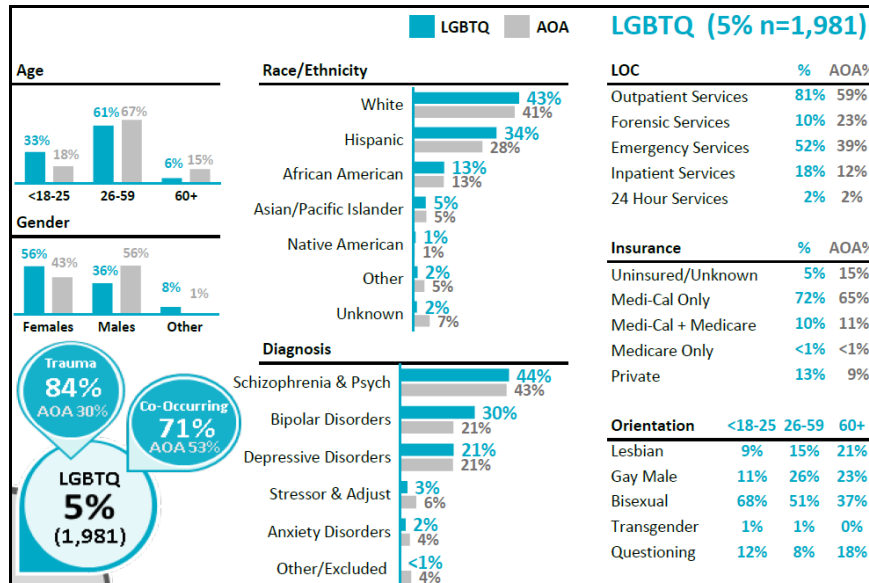
LGBTQ+

To ensure that clients who identify as LGBTQ+ are appropriately served, SDCBHS has been monitoring client sexual orientation among all population groups. Of the 13,758 CYF mental health clients served in FY 2019-20, 8% reported LGBTQ+ identification, a slightly higher rate compared to the 5% that reported LGBTQ+ identification among the 43,808 AOA mental health clients. In contrast, only 1% of the 15,912 AOA SUD population identified as LGBTQ+. The data shows that LGBTQ+ youth experience an increased risk of diagnosis with depressive disorders (52%) compared to the rest of the CYF population (32%). LGBTQ+ clients also appear to be overrepresented in the SUD levels of care across the board except for Residential and OTP.

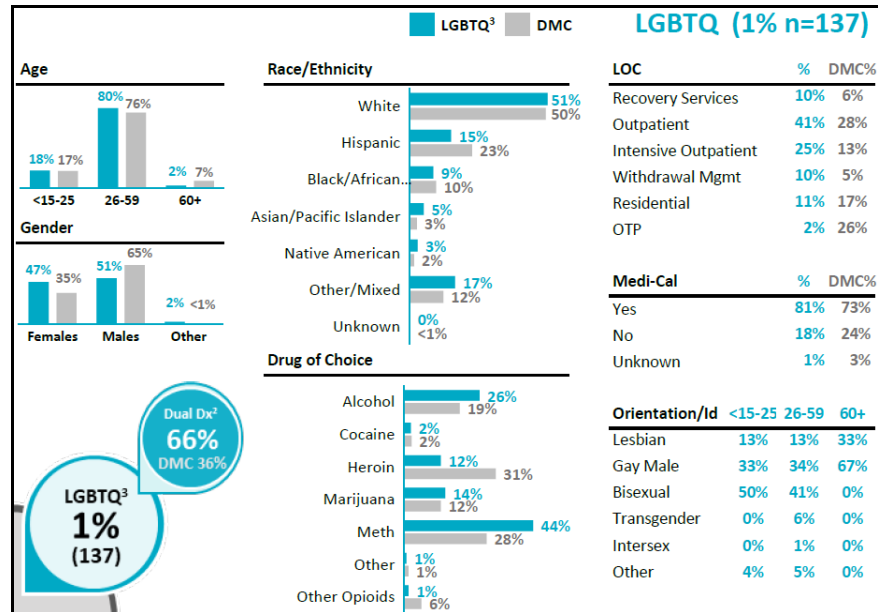
CYF Mental Health Client Sexual Orientation in FY 2019-20



AOA Mental Health Client Sexual Orientation in FY 2019-20



AOA SUD Client Sexual Orientation in FY 2019-20



Justice Involved Population

Over the past years, San Diego County has implemented programs and conducted analysis on disparities in mental health services among the jail population. In FY 2019-20, 16,512 justice involved adults ages 18 and older received mental health services (almost 38% of all AOA MH clients). On the SUD side, 7,514 justice involved adults received services (47% of all AOA SUD clients). For children and youth, 918 justice involved youth ages 0-17 received mental health services (almost 7% of all CYF clients). Across the system, more male justice involved clients are being served, and African American clients are overrepresented among the justice involved population.

**Demographics of Justice Involved Clients Compared to Overall BHS Population
FY 2019-20**

	JFS (Ages 0-17)	Jail (Ages 18+)	
		MH	SUD
Total Clients Receiving JFS/Jail MH Services	918	16,512	7,514
Total Clients Receiving All MH/SUD Services	13,758	43,808	15,912

	JFS (Ages 0-17)	All CYF	AOA MH		AOA SUD	
			Jail (Ages 18+)	All MH	Jail (Ages 18+)	All SUD
Female	26%	46%	28%	43%	27%	35%
Male	74%	53%	71%	56%	73%	65%
Other	0%	<1%	1%	1%	<1%	<1%

Table 3. By Race/Ethnicity FY 2019-20	JFS (Ages 0-17)	All CYF	AOA MH		AOA SUD	
			Jail (Ages 18+)	All MH	Jail (Ages 18+)	All SUD
White	18%	20%	42%	41%	44%	50%
Hispanic	55%	64%	32%	28%	24%	23%
African/American	20%	10%	18%	13%	11%	10%
Asian/Pacific Islander	3%	3%	3%	5%	4%	3%
Native American	1%	1%	1%	1%	2%	2%
Other	2%	2%	2%	5%	15%	12%
Unknown	-	-	2%	7%	<1%	<1%

Homeless Population

In 2020, the annual Point-In-Time-Count (PITC) identified 7,619 homeless individuals living on the streets or in shelters throughout San Diego County. The total number of homeless individuals represents a decrease of 6% compared to the PITC conducted in 2019. The County of San Diego continues to work toward improving coordination of services to help end homelessness. In FY 2015-16, the San Diego County Board of Supervisors approved to add 10 million dollars in one-time MHSA funding to leverage the development of permanent supportive housing for homeless persons with serious mental illness who are enrolled in Full Service Partnerships/Assertive Community Treatment (FSP/ACT) programs. The MHSA funding is in addition to 33 million dollars the County has leveraged to create 249 supportive housing units for the homeless. These funds have been focused on enhancing the County’s efforts to increase housing stock in the County of San Diego and help create approximately 69 new permanent supportive housing units.

In 2015, BHS released the 100 Homeless Person Request for Proposal (RFP) to provide mental health and addiction services and subsidies from the San Diego Housing Commission (SDHC) for up to 100 clients who will have access to an array of housing options. A second RFP was released to provide home finding services to adults who are enrolled in designated SDCBHS contracted and county outpatient mental health clinics, have a desire to upgrade current housing, have housing instability, and who may be homeless or at-risk of homelessness.

Additionally, former San Diego County Supervisor Greg Cox announced the approval of the recommendation to launch “Project One for All” (POFA) which will support the seriously mentally ill homeless population. POFA is an effort to provide intensive wraparound services to homeless individuals with serious mental illness (SMI) who are eligible for supportive housing. The four components of the POFA implementation plan include outreach and engagement; treatment services; housing resources; and performance measurement. Behavioral health contracts were expanded in February 2016 to provide 300 outreach and engagement slots through a variety of mechanisms to assist people in accessing housing and services. Implementation of POFA relies on a coordinated approach that braids treatment and housing. Furthermore, in response to the growing need among the homeless individuals to have a better service delivery system and to facilitate implementation of POFA, the County integrated the Department of Housing and Community Development into the HHS in July 2016. The significant organizational change supports the County’s efforts to address the needs of vulnerable residents, particularly homeless people with SMI. The realignment of services has better enabled the County to take a more comprehensive, “whole person” approach to delivering

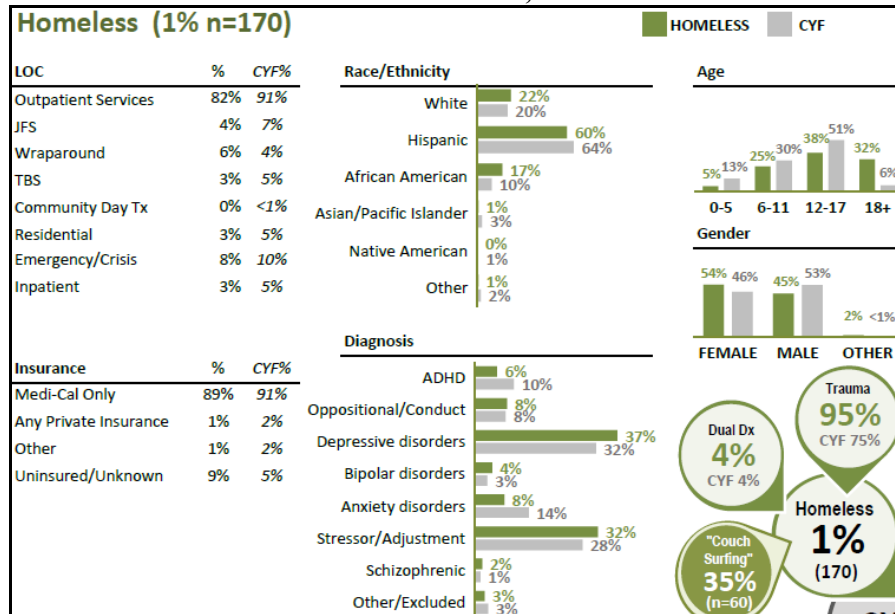
services, one of the goals of the County's *Live Well San Diego* Vision for healthy, safe and thriving communities. The program was implemented in the City of San Diego and the unincorporated areas of the County. The goal of POFA was to reach 1,250 homeless individuals. As of January 2020, 1,387 individuals had been housed with treatment.

In FY 2016-17, SDCBHS-contracted ACT programs spent more than 5.6 million dollars on client housing and housing-related supports. This included dedicated housing staff, client rental assistance, and non-rental assistance (such as deposits, utilities, application fees, and furniture). Two MHSA-funded permanent supporting housing developments opened in 2017. Atmosphere, which is located in downtown San Diego, is a 205-unit development that houses 31 adult clients who receive ACT services through the Community Research Foundation (CRF) IMPACT program. Mission Cove, which is located in Oceanside, is a 90-unit development that houses nine TAY clients who receive ACT services through Pathways Catalyst or Strengths-Based Case Management (SBCM) services through Mental Health Systems (MHS) Vista TAY. This is the first MHSA-funded development in San Diego to house SBCM clients. With the addition of these two developments, the number of MHSA-funded units in San Diego rose to 241. Additionally, in June of 2017, HCDS requested the Board of Supervisors to authorize the allocation of rehabilitation funds to a North County housing project and to adopt a resolution authorizing application for and receipt of No Place Like Home (NPLH) funding from the State. The request was presented to the BHAB for their review and support.

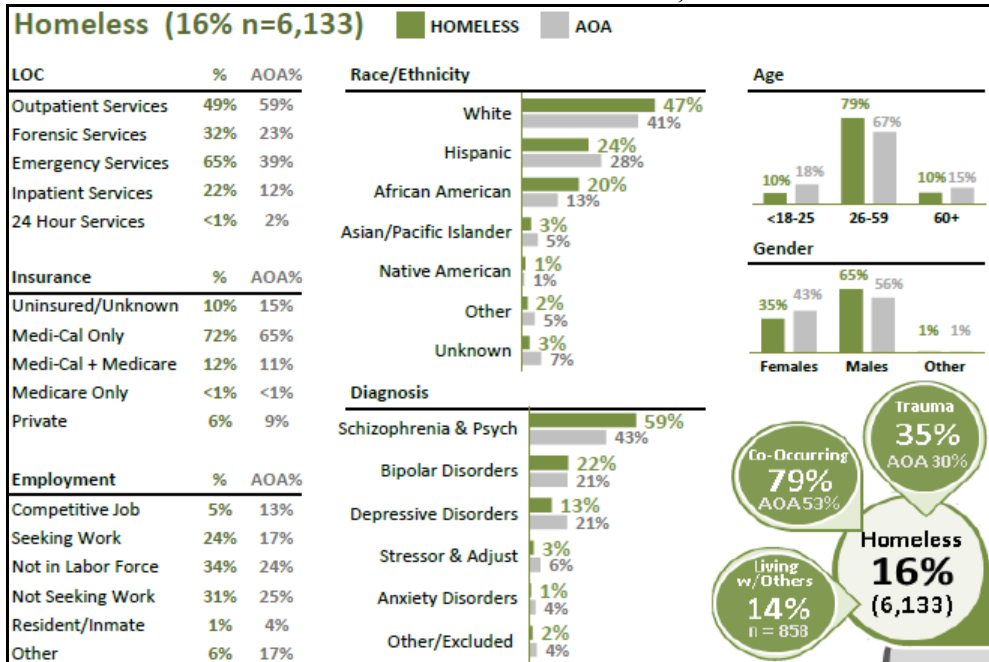
The Local Government Special Needs Housing Program (SNHP) provides capital funding for the development of permanent supportive housing units for individuals with serious mental illness (SMI) who are experiencing homelessness or are at-risk of homelessness. Benson Place, an 82-unit rehabilitation development located in Otay Mesa/Nestor (South Region) opened on August 12, 2020. It includes 25 SNHP units serving clients receiving Assertive Community Treatment (ACT), Strength Based Case Management (SBCM), outpatient mental health clinic, and tenancy support services.

In FY 2019-20, the largest proportion of CYF clients that identified as homeless were Hispanic (60%), between the ages of 12-17, and female (54%). For AOA Mental Health clients, the largest proportion that identified as homeless were White (47%), between the ages of 26-59 (79%), and male (65%). Meanwhile for AOA SUD clients, the largest proportion that identified as homeless were White (52%), between the ages of 26-59 (84%), male (68%), and reported Meth as their drug of choice (40%)

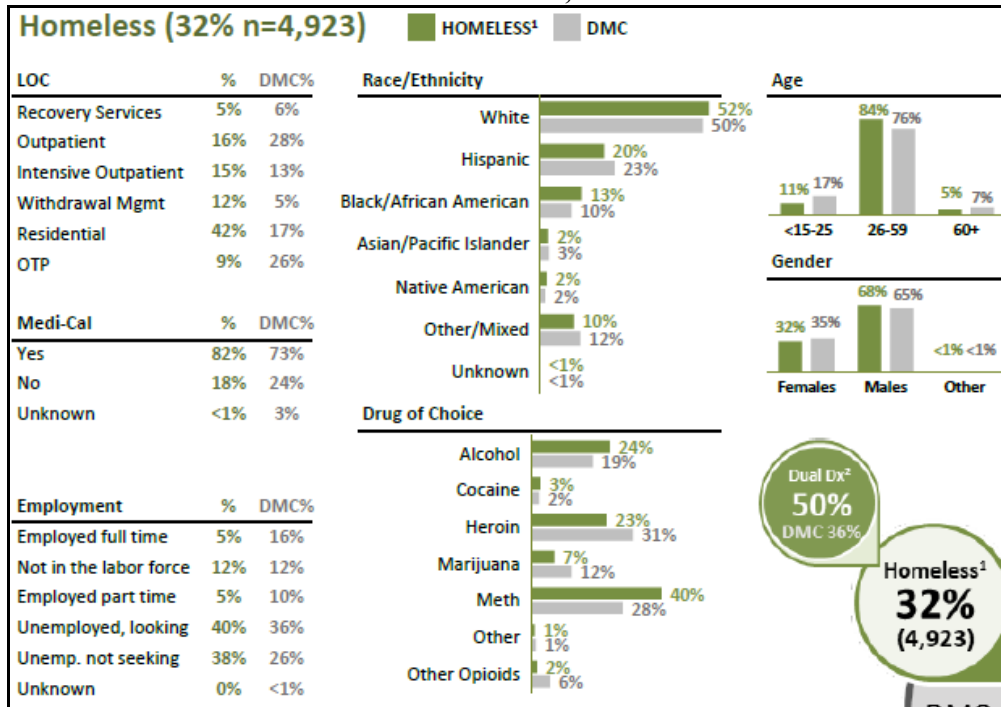
CYF Homeless Clients, FY 2019-20



AOA Mental Health Homeless Clients, FY 2019-20



AOA SUD Homeless, FY 2019-20



UPDATED ASSESSMENT OF SERVICE NEEDS

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

The County shall include the following in the CCPR:

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

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

All six of the priority populations were identified in San Diego County’s PEI Plan. Twenty PEI Project Work Plans were submitted, each one identified at least one of the Priority Populations, and most addressed at least two or three. San Diego County identified 10 priority populations based on community member input; most of these are contained within the broader six listed above. These are as follows: Older Adult Issues; Community and Domestic Violence; School Age; Early Childhood Services; Veterans and their Families; Native American Communities; Rural Community Issues; Co-occurring Disorders; First Break of Psychosis/Transition Age Youth; Primary and Secondary Prevention through outreach, education, and media campaigns.

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

The County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through our sustained Stakeholder-led Councils (Children’s System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council, and Behavioral Health Advisory Board). From this community-based input, San Diego County developed eight focus areas: Native American Communities, Veterans and their Families, Co-Occurring Disorders, School Age and Early Childhood, Community and Domestic Violence, First Break of Psychosis, Rural Community Issues (East County, North Inland, Mountain Regions), and Older Adult Issues. A September 2007 “Kickoff Forum,” co-facilitated by the Director of Behavioral Health Services and the Mental Health Services Deputy Director, introduced these eight PEI areas of focus and the PEI planning process to the larger community.

The MHSA Planning Team and MHS staff then organized eight community-based forums throughout the county for the purpose of soliciting stakeholder input within each of the focus areas. These community forums, each of which was facilitated by a lead member from the PEI Planning Team or staff support team, took place from November 2007 through March 2008.

During the same time the “Kickoff Forum” and the community forums were taking place, Dr. Hanger, ADD in charge of the MHSA Plan, and members of the PEI Planning Team attended numerous existing community-based stakeholder meetings as part of the outreach campaign to present and outline the PEI planning process, guidelines and timeline and engage community members in the planning process. Between July 2007 and April 2008, the MHSA Planning Team members and support staff participated in over 60 stakeholder meetings across six regions within San Diego County covering a variety of cultural and ethnic communities and age-ranges.

These stakeholder meetings included our ongoing Mental Health Councils, the constituency of which includes consumers, family/caregivers, providers, community experts, public agencies (City and County), education representatives, as well as open membership from local stakeholders. These Councils are chaired by members of the stakeholder community – not by mental health staff. Additional ongoing community meetings included community commissions (e.g., Children Youth and Family Commission, Domestic Violence Commission), which are similarly comprised of consumers, professionals, providers (public and private), interested community members, and designees from political offices.

Finally, 30 focus groups were convened specifically to obtain further stakeholder input from the immigrant, African Refugee, African American, Asian/Pacific Islander and LGBTQ+ communities, as well as other unserved and underserved populations. To ensure stakeholder input was also received from those with serious mental illness and serious emotional disturbances, focus groups were also facilitated in client clubhouses and an adult day health

center. Separate from these public meetings, community and stakeholder input was solicited and received in a variety of formats including phone messages, website submissions (the County maintains an ongoing website, <https://www.sandiegocounty.gov/hhsa/programs/bhs/>, which includes a section dedicated to disseminating information related to our MHSA planning process), e-mail and mail (PEI Community Input Forms, memos, letters, and full proposals). The information received was compiled for public review in a more “consumable” PEI Community Input Summary document.

All summary documents incorporating community input were posted on the County of San Diego’s Behavioral Health Network of Care website for public information and review. In addition, these summary documents were sent to all members in our continually expanding e-mail distribution list of consumers, professionals, agencies, and other interested parties. All community/stakeholder input received to date, as well as summary documents prepared by the PEI Planning Staff, were also presented in an open, public session of our April 2008 Mental Health Board. The Mental Health Board serves as the initial cross-threading work group, as they are a non-conflict body of existing consumers and other stakeholders. Given the “contracting” nature of our County’s mental health services, the issue of “conflict” had been previously resolved during the CSS planning process by our County requiring the absence of fiscal conflict as a condition of cross-threading membership.

Following additional community input received during the public comment period, the April 2008 Mental Health Board provided a ranking of key community needs and priority populations. These rankings were taken up further by 10 workgroups consisting of a County Mental Health Chief, Regional Program Coordinator, or Assistant Deputy Director as lead, pertinent inter-Agency County staff, non-conflict community experts, and non-conflict consumers and stakeholders. During the stakeholder input process, community members had recommended separating School Age and Early Childhood Services into two separate focus tracts for further detailed planning.

In the majority of the forum and focus groups, input was received recommending that the County address universal (“primary”) prevention needs of suicide risk and stigma and discrimination, as well as targeted (“secondary”) prevention for focus populations, within a separate work group. These workgroups scrutinized community input, relative data, and Mental Health Board rankings, as well as holding intensive meetings to develop PEI plans.

In FY 2019-20, the estimated total MHSA budget for PEI programs is \$26,761,835, representing a total decrease of \$5,161,950 from the MHSA Three-Year Plan funding priorities for FY 2019-20. The reduction is due to services being funded through other revenue sources in association with the implementation of the Drug Medi-Cal – Organized Delivery System (DMC-ODS). PEI programs were not enhanced due to component funding being maximized in previous fiscal years. Additionally, the State Department of Health Care Services (DHCS) issued new guidance for the distribution of MHSA revenue which will require the County of San Diego to reduce the amount of revenue allocated to the PEI component. This will result in a reduction in the PEI budget. As required by MHSA, a majority of funding for PEI programs must be directed to persons less than 25 years of age. In FY 2019-20, this requirement will be met with

nearly 59 percent of the budget for PEI programs allocated for programs serving persons under 25.

Enhancements and Changes for FYs 2018-19 and 2019-20:

Justice Involved Population

The California Mental Health Services Authority (CalMHSA) is a Joint Powers Authority (JPA) created by counties to administer statewide PEI projects. CalMHSA supports efforts such as maintaining and expanding social marketing campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to counties, schools, and local community-based organizations, providing stigma reduction trainings to diverse audiences, and building the capacity of higher education institutions to reduce stigma and prevent suicide. Programs include Each Mind Matters, Walk in Our Shoes, Directing Change, and Know the Signs. In FY 2019-20, SDCBHS will contribute \$400,000 of MHSA or other funds to CalMHSA for statewide PEI programs.

Integrated Peer and Family Engagement (CO-03)

The Integrated Peer and Family Engagement program provides comprehensive, peer-based care coordination, mental health screening, brief treatment, and system navigation, to adults with SMI and SUD. In FY 2018-19, the budget was increased by \$9,315 for one-time costs associated with upgrading computer equipment.

Supported Employment Technical Consultant Services (PS-01)

The Supported Employment Technical Consultant services program provides technical expertise and consultation on countywide employment development, partnership, engagement, and funding opportunities for adults with SMI. Services are coordinated and integrated through SDCBHS to develop new employment resources. In FY 2019-20, the budget was increased by \$50,258 for one-time costs and increased operating costs related to the execution of a new contract.

Veterans and Family Outreach Education – Courage to Call (VF-01)

The Courage to Call program provides confidential outreach, education, peer counseling, referrals, and support services to Veterans and their families to increase awareness of mental illness and reduce mental health risk factors. In FY 2019-20, the budget was increased by \$280,000 to add case managers.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 2:

- Develop a new disparities dashboard to assess community need and gaps in services.
- Launch the new Community Experience Project to gather feedback from the underserved communities with a goal to address inequities in services.

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

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

The County shall include the following in the CCPR:

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

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

Progress Towards Reducing Disparities

Efforts to decrease barriers to behavioral health care among racial/ethnic minorities and clients in different age groups have been a focus for the SDCBHS for many years. The process is complicated by the fact that the demographic breakdown of those eligible for services in the SDCBHS differs markedly from the demographic makeup of the county as a whole. For example, although persons of Hispanic origin make up 30% of the adults in the population of San Diego County, this segment accounts for 60% of the target (eligible client) population.

Children and Youth

Race/Ethnicity	Estimates of San Diego County Population (age 0 – 17)*	Target Population**	Actual Clients CYF SOC (FY 2015-16)
White (non-Hispanic)	26%	13%	22%
Hispanic	57%	71%	63%
African American	6%	9%	11%
Asian/Pacific Islander	9%	6%	3%
Native American	<1%	2%	1%

Adults and Older Adults

Race/Ethnicity	Estimates of San Diego County Population (age 18+)*	Target Population**	Actual Clients AOA SOC (FY 2015-16)
White (non-Hispanic)	51%	22%	51%
Hispanic	30%	60%	27%
African American	4%	8%	15%
Asian/Pacific Islander	14%	9%	6%
Native American	<1%	2%	1%

* Source: 2016 California Health Interview Survey (CHIS) data.

** Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

Therefore, efforts to increase service utilization often need to focus on specific groups disproportionately to their presence in the overall county population. In order to evaluate the disparities that exist in San Diego County and to report on the progress towards the reduction of disparities across racial/ethnic groups and age groups, the SDCBHS developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report. The latest report covers three time points (Fiscal Years 2009-10, 2012-13, and 2015-16).

SDCBHS uses this report to assess the disparities and to prioritize focus on target populations based on the data on the overall service utilization, types of services used, engagement and retention, client diagnosis, and racial/ethnic distribution rates. As mentioned previously in this document, the report is undergoing a revamp as the *Community Experience Project*, a set of dashboards that will allow for flexible queries regarding health equity information that will provide timely, accessible, and actionable data for system policy development and decision making. With the County's renewed commitment to patient-centered care, these tools will provide support for initiatives that focus on the clients' specific long-term needs and community level services. The findings will be used to update the priorities outlined in this section in future updates of the SDCBHS Cultural Competence Plan.

Furthermore, the Statements of Work for CSS, WET and PEI contracts include specific language on priority populations and target areas that are continuously monitored by the SDCBHS.

The PEI Target Populations selected by San Diego County include all of the following on the State list:

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 of experiencing juvenile justice involvement

Through the County PEI Planning Process, the following target populations were also identified:

- Children ages 0-5
- Adults, older adults, transition age youth
- Children 0-17, families and clients in target regions with the highest risk of child abuse and neglect
- Clients of all ages with co-occurring disorders
- Senior population ages 60 and over
- LGBTQ+
- Veterans, active duty military, reservists, National Guard, and family members
- Asian and Pacific Islander adults
- Latino population
- African American population
- Native Americans and Alaska Natives
- Refugees and asylees

A1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the County used to identify and target the population(s) (with disparities)

The detailed history on the planning process and rationale in identifying target populations can be found in Criterion 2 of the Cultural Competence Plan.

The County of San Diego continuously receives stakeholder input for community program planning and the focus areas. The feedback is often received through the monthly Behavioral Health Advisory Board, System of Care stakeholder-led councils, and workgroup meetings. The stakeholder-led councils provide a forum for Council representatives and the public to stay informed and involved. Council members, in turn, share the information with their constituents and other groups involved in behavioral health services and issues. Membership includes consumers and family members, as well as other key stakeholders in the community such as providers, Probation, First 5, Health Plans, program managers, representatives of consumer and family organizations, advocacy groups, law enforcement agencies, education representatives, and County partners.

In addition to ongoing communication with stakeholders, SDCBHS conducts an annual Community Planning Process (CPP). For 2020, the events were conducted virtually in compliance with local COVID-19 social distancing guidance. Participants in this engagement process were asked to describe what behavioral health problems they were observing in the community, with a specific focus on how the pandemic and other factors impacted behavioral health. They also shared their ideas about what SDCBHS should address moving forward and what could be done to ensure the strength and resiliency of the community. Two virtual community listening sessions were held – one designed for behavioral health care providers and the other for youth and families. In addition, 11 focus groups were hosted that prioritized communities of identity and/or geography. Finally, 10 one-on-one phone interviews were conducted.

Recruitment efforts for the engagement were expanded from previous years due to pandemic - related challenges, such as illness and death in the community and high levels of stress due to unemployment, food insecurity, and homelessness. Community engagement events were held during the surge in COVID-19 infection rates that occurred November 2020 through January 2021. Event attendance totaled 201, including 158 participants in the community listening sessions, 33 participants in the focus groups, and interviews with 10 individuals. Registration for forums was handled through www.listentosandiego.org, including full translations in all threshold languages.

As in previous years, the results of the input will be collected in an annual Community Engagement report, which will be released publicly as part of the public review of the MHSA Annual Update Fiscal Year 2021-22. For planning continuity, the report will include a look-back analysis, comparing engagement results over the past several years. Public review of the documents is expected during summer 2021.

The MHSA Three-Year Program and Expenditure Plan, Fiscal Years 2020-21 through 2022-23, was approved by the San Diego County Board of Supervisors in September 2020 following a 30-day public comment period and BHAB approval. The update included the Community Engagement Report, 2019.

The schedules for the 2020 general forums and focus groups were as follows:

Event	Date
Interviews	December 2020 - February 2021
Trauma Informed Guide Team Focus Group	November 12, 2020
LatinX Individuals Focus Group 1	November 18, 2020
API Individuals Focus Group	November 21, 2020
MH and SUD Service Provider Listening Session	December 1, 2020
LatinX Individuals Focus Group 2	December 2, 2020
Essential Workers Focus Group	December 3, 2020
Loved Ones of Those with SMI Focus Group	December 5, 2020
African American Individuals Focus Group	December 8, 2020
Individuals with SMI Focus Group	December 8, 2020
Family and Youth Listening Session	December 12, 2020
Loved Ones of Those with SUD Focus Group	December 15, 2020
Individuals with SUD Focus Group	December 17, 2020
Rural San Diego/Mtn Empire Focus Group	December 29, 2020

The CPP provides a structured process that the County uses in partnership with stakeholders in determining how best to utilize funds that become available for the MHSA components. Due to the success of the model, SDCBHS also utilizes input to assist with planning for all BHS related funds. The CPP includes participation from BHAB and System of Care Councils, as well as individuals, stakeholders, and community organizations. Comments are submitted at Council meetings or through the MHSA comments/question line. The CPP is ongoing, and the County encourages open dialogue to provide everyone with opportunities to have input of future planning. Stakeholders are encouraged to participate in BHAB and Council meetings and to contact SDCBHS.

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

II. Identified disparities (within target populations):

The County shall include the following in the CCPR:

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

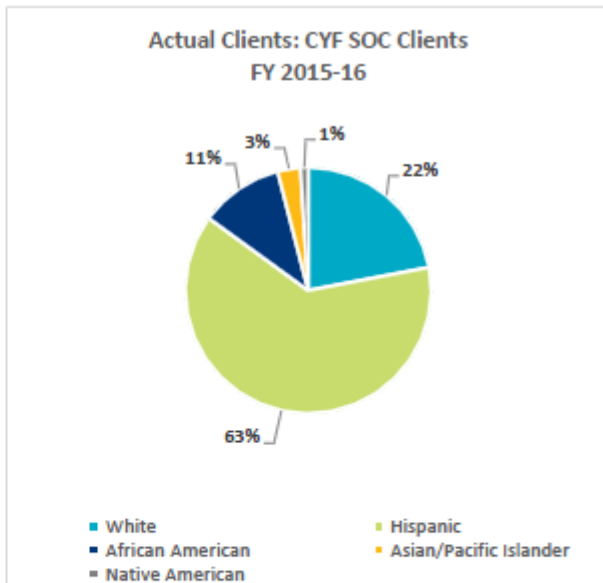
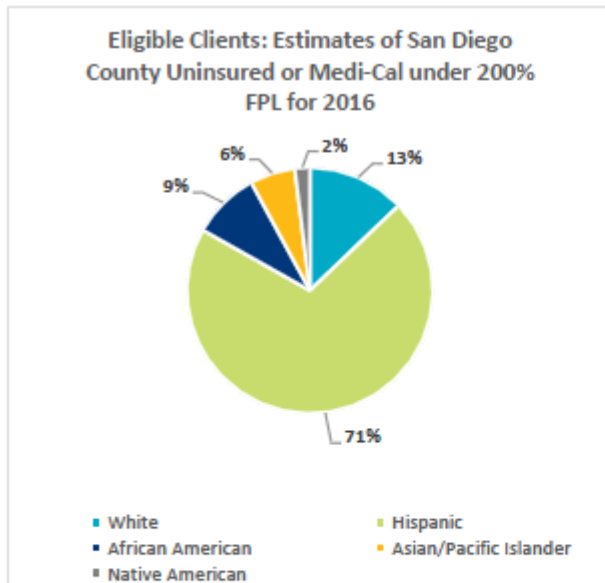
Client Disparities

As mentioned earlier, the SDCBHS uses the triennial *Progress Towards Reducing Disparities in Mental Health Services* report as a guide on the current disparities that exist in the County and progress towards the reduction of the disparities over the years.

A comparison of the San Diego County target population to those who received behavioral health services demonstrated that the most notable disparities continue among Hispanic adults, as mentioned in Section I of this Criterion. Additionally, although Hispanic, Asian/Pacific Islander, and Native American individuals were less likely to utilize services than expected given the number of potential clients, their service utilization rates have varied across the three time periods examined. The service engagement from FY 2009-10 to FY 2015-16 has increased for all racial/ethnic groups for 10 or more visits. Service utilization has decreased among children, youth, and adults across the fiscal years, with the exception of Hispanic clients.

Target population (eligible clients*) versus CYF SOC clients FY 2015-16

Race/Ethnicity**	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		CYF SOC Clients	
	Number	%	Number	%
White (non-Hispanic)	34,144	13%	3,463	22%
Hispanic	190,351	71%	9,777	63%
African American	23,588	9%	1,691	11%
Asian/Pacific Islander	15,198	6%	519	3%
Native American	5,476	2%	95	1%
Total Clients	268,757	100%	15,545	100%

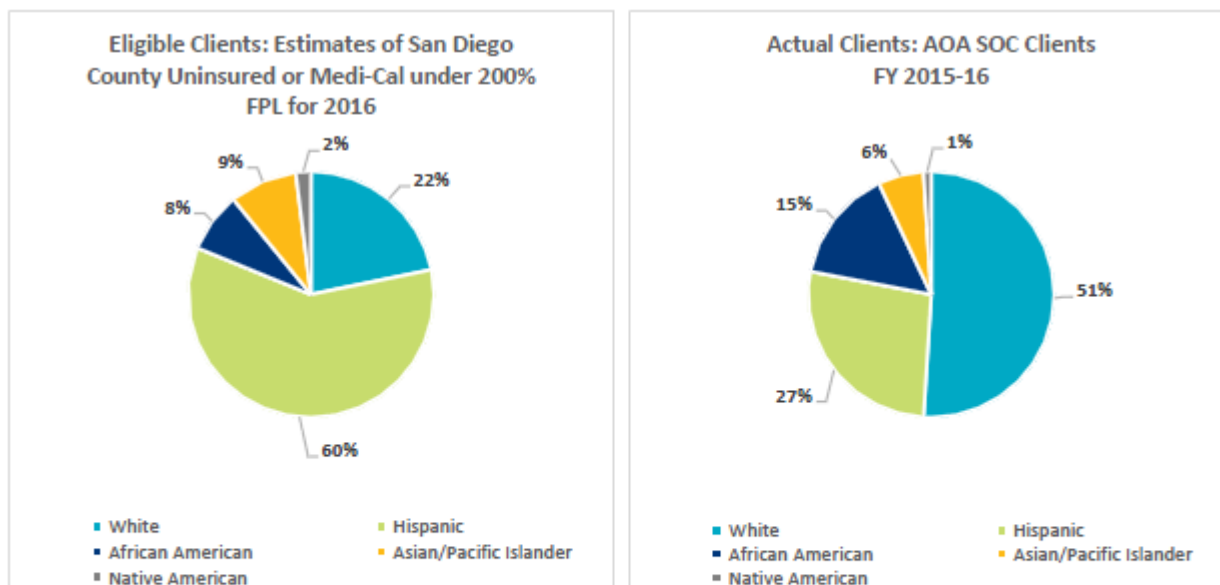


* Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (15,545 clients). An additional 1,756 (10%) were of Other or Unknown race/ethnicity.

Target population (eligible clients*) versus AOA SOC clients FY 2015-16

Race/Ethnicity**	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		AOA SOC Clients	
	Number	%	Number	%
White (non-Hispanic)	81,229	22%	18,227	51%
Hispanic	226,968	60%	9,671	27%
African American	28,845	8%	5,211	15%
Asian/Pacific Islander	32,872	9%	2,283	6%
Native American	7,454	2%	309	1%
Total Clients	377,368	100%	35,701	100%



* Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (35,701 clients). An additional 7,104 (17%) were of Other or Unknown race/ethnicity.

Children 5 Years of Age and Younger:

- Were less likely than other age groups to receive 13 or more sessions.
- Were more likely to receive only one session, compared to clients ages 6-11, ages 12-17, and 18 and older.
- Had the lowest penetration rates across all three fiscal years, compared to other age groups.

Transition Age Youth ages 18-25:

- Had the lowest long-term engagement rates among AOA age groups.
- Were more likely than other age groups to use inpatient/emergency services or only use jail services.

Older Adults:

- Were more likely to receive outpatient services than inpatient or jail services.
- Had an increase in service utilization in FY 2015-16, compared to FY 2012-13.

African American Children and Youth:

- Had a steady decline in penetration rate from FY 2009-10 to FY 2015-16.
- Had a decrease in service utilization from FY 2009-10 to FY 2015-16.
- Had more frequent use of Juvenile Forensic Services (JFS) without receiving any outpatient services, compared to other groups.

African American Adults and Older Adults:

- Had the highest prevalence rates of schizophrenia and other psychotic disorders, compared to other racial/ethnic groups.
- Were more likely to receive services only in jail than other racial/ethnic groups.

The complete report is available in Appendix 10.

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

III. Identified strategies/objectives/actions/timelines

The County shall include the following in the CCPR:

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

SDCBHS adopted the following strategies as the basis of planning for services and program expansion as each phase of the MHSA was rolled out:

CSS Plan Strategies/Actions/Objectives/Timelines

The CSS Plan identified the following Strategies/Objectives for the Provision of Culturally and Linguistically Competent Services to Address Disparities in Access to Care:

Based on the evident disparities in access to care for the ethnically diverse groups noted and listed in the previous question, SDCBHS committed to continuing expansion of its capacity to provide culturally competent services in the MHSA-funded programs described in the CSS Plan. The initial plan included the following specific strategies and interventions to address access-to-care disparities countywide:

- Conduct outreach to engage and increase access to care for Latinos and Asian/Pacific Islanders, African Americans, and Native Americans in the mental health system.
- Increase penetration and rates of client retention for underserved and unserved clients in age groups and racial/ethnic groups, and for females.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Provide culturally competent mental health services in all MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions, and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.
- Include training on working with interpreters, the deaf and hard of hearing, victims of trauma, and gender and sexual orientations in cultural competence training.
- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining, and retraining culturally competent staff.
- Address disparities in services for females in all age groups by requiring MHSA programs to ensure females are assessed for mental illness.
- Increase access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental services in community clinics.

- Establish relationships with tribal communities for as many of the 17 Native American tribes as possible who have reservations in San Diego County.
- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities.

WET Plan Strategies/Actions/Objectives/Timelines

The intent of the Workforce Education and Training (WET) component is to remedy the shortage of qualified individuals within the public mental health workforce that provides services to address severe mental illnesses. WET strategies include recruitment of high school and community college students for mental health occupations, development of curriculum to increase knowledge and skills of the existing workforce, promotion of the meaningful employment of consumers and their family members in the mental health system, and financial incentives that promote cultural and linguistic diversity in the public mental health workforce. The initial strategies identified in the Work Plan included:

- Addressing shortages in bilingual staff – Spanish, Vietnamese, Arabic, Tagalog, Russian, Cambodian, ASL, Lao, Somali, and Swahili.
- Implementing trainings/educational opportunities to build staff to fill unique qualifications for hard to fill jobs and for clinical supervision.
- Creating incentives to encourage nurses, child psychiatrists, and others to enter public mental health employment and take hard-to-fill positions.
- Increasing the numbers of Latino and African American staff.
- Creating positions and a career ladder for mental health consumers and/or family members.

PEI Strategies/Actions/Objectives/Timelines

The initial PEI Work Plan identified the following strategies towards reducing disparities:

- Provide education and outreach campaigns to reduce stigma and discrimination and to aid in suicide prevention for all age groups, race/ethnicities, persons with co-occurring substance abuse disorders, and caregivers.
- Assist in maintaining a safe home and a community safety net for children and in reducing the effects of trauma exposure (including gang experience).
- Promote healthy, effective parenting styles, connecting children with necessary health and other related service, to prevent re-traumatization of children and families already exposed to domestic and/or community violence.
- Increase Native American community involvement and education through services designed and delivered by Native American community members.
- Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children and help reduce their behavioral/emotional problems.
- Reduce the potential negative outcomes associated with mental health issues in the early stages of mental illness.
- Increase access to care for older adults from minority populations.
- Educate caregivers and primary care service providers in effort to increase awareness and understanding of the older adult concerns, and create a wellness focus.
- Support caregivers of clients with Alzheimer’s, to reduce incidence of caregiver mental health problems.

- Provide outreach and outreach services to the Veterans community to improve their knowledge of, and access to, mental health services.
- Provide prevention services for clients in rural community clinics to help them address behavioral health issues, addiction, and severe mental illness at an early stage.
- Support persons being treated for substance abuse in dealing with mental health issues through providing integrated services.

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

II. Medi-Cal population  *combined for San Diego*
III. 200% Poverty combined for SDCMHS 

SDCBHS has historically conducted its planning for the combined populations of Medi-Cal and 200% Poverty, as explained in Criterion 1. Prior to receiving MHSA funding, SDCBHS had already adopted a number of strategies to increase access to care and reduce disparities for ethnic, racial, and cultural groups. Changes in services over the years have occurred in both the CYF and the A/OA Systems of Care.

In light of a rapidly expanding County population and in response to the national effort to advance health equity, improve quality, and help eliminate health care disparities, SDCBHS has replaced Culturally Competent Clinical Practice Standards with the Culturally and Linguistically Appropriate Services (CLAS) Standards. The requirement to adhere to CLAS Standards is part of each contractor’s Statement of Work. The CLAS Standards are also available in the Organization Provider Operations Handbook—a part of all service provider contracts. Additionally, SDCBHS has been requiring its County and contracted agencies to complete regularly scheduled self-assessments to evaluate cultural and linguistic competence of the programs’ services and staff in effort to enhance the quality of services provided to the County population. More information on the surveys can be found in Criterion 5 of the Cultural Competence Plan.

The CLAS Standards and the survey protocols are part of the newly enhanced Cultural Competence Handbook available in Appendix 14. The Handbook is a tool to help guide the providers in making improvements in the delivery of culturally and linguistically appropriate services throughout the system of care. The Handbook also encourages providers to assess local community needs; develop, implement, and sustain a Cultural Competence Plan; and to develop a process to assess staff cultural competence.

Additionally, the County administration has been working hand in hand with seven Medi-Cal approved health plans (Aetna Better Health, Care 1st Health Plan, Community Health Group, Health Net, Kaiser Permanente, Molina Healthcare, and United Healthcare), to develop communication around the ACA and Cal MediConnect, and access to services under coverage expansion and to continuously address barriers to client care. SDCBHS, the health plans, and other community partners meet on a monthly basis. As the result of a Medi-Cal Managed Care

Geographic Expansion process, two Medi-Cal Managed Care Health Plans recently joined San Diego County.

The report on disparities outlined earlier has served as a guide for planning the effective use of MHSA CSS, PEI and WET funding.

Additionally, over the course of FY 2013-14, the leads for the CCRT California Reducing Disparities Project (CRDP) Work Groups volunteered to address the recommendations put forth by the CCRT Chair (who also serves as the designated Cultural Competence/Ethnic Services Manager) per their request to move forward and enhance the BHS System of Care as it addresses equity and disparities in the prevention and early intervention arena, access to care and in the treatment delivery system for diverse communities of San Diego County. The document is available in Appendix 15. Furthermore, in April 2018, County representatives attended the California Reducing Disparities Project to Advance Mental Health Equity Conference hosted by California Pan-Ethnic Health Network. The conference provided an opportunity for advocates, providers, consumers, and other community partners to collaborate and develop strategies for change.

The elimination of the health disparities is always a priority for the County, and SDCBHS continuously and systematically evaluates disparities on a regular basis and collaborates internally and externally to develop and implement strategies to eliminate health disparities.

IV. MHSA/CSS population -- Objectives/Actions/Timelines

The majority of MHSA programs and strategies are implemented through the CSS component, and approximately 78% of the total MHSA funding is allocated to these services. These programs ensure that individualized services are provided to children and adults who have a severe emotional/mental illness. There are currently 179 CSS contracts that offer integrated, recovery-oriented mental health treatment, case management and linkage to essential services, housing and vocational support, and self-help. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 16.

*V. PEI priority populations (s) selected by the County, from the six PEI priority populations—
Objectives/Actions/Timelines*

PEI programs are designed to prevent mental illness from becoming severe and disabling, and approximately 17% of the total MHSA funding is allocated to the PEI component. Programs utilize strategies to reduce negative outcomes that may result from untreated mental illness, such as: suicides, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes. There were 36 PEI contracts that provide services to hard-to-reach populations in an effort to reduce stigma associated with mental illness, make people aware of mental health resources in their communities, and connect

underserved and unserved populations with resources at an early stage of their mental illness. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 16.

VI. WET Plan—Objectives/Actions/Timelines

The intent of the WET component is to remedy the shortage of qualified individuals within the public mental health workforce which provides services to address severe mental illnesses. WET strategies include recruitment of high school students for mental health occupations, development of curriculum to train and retain staff, promotion of the meaningful employment of consumers and their families in the mental health system, stipend programs, and promote the inclusion of cultural competency in training and education programs. There are currently six (6) WET programs that address disparities in the workforce to ensure that the County can more effectively provide services for ethnic/racial and cultural populations. These programs focus on expanding the workforce and making skills development training available to existing staff. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 16.

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

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

The County shall include the following in the CCPR:

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

Note: *New strategies must be related to the analysis completed in Criterion 2.*

SDCBHS is continuously involved in strategy development and implementation in an effort to remediate disparities in access and treatment. Examples include:

- **Chaldean Middle Eastern Social Services** focus on members of the Middle Eastern community who have not traditionally accessed mental health services due to cultural or language barriers. The goal of the program is to decrease stigma around mental health issues through the provision of culturally competent services that increase wellbeing and symptom management. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals for Middle Eastern population and the manifestations of mental disorders in this population. The program collaborates with mental health providers, CWS, Chaldean Catholic Church in El Cajon, Survivors of Torture & Trauma, law enforcement, and Middle Eastern private practice providers of physical and mental health services.
- **Courage to Call** is a veteran-staffed 24/7 Helpline that provides free confidential information, self-screening tools and appropriate resources, guidance, and referrals to individuals who have served in the military and their families. The program also

provides training to improve cultural awareness and understanding for community organizations and providers serving those with a military or military family background.

- CWS and SDCBHS made operational the Core Practice Model (CPM) Guide with the creation of Pathways to Well-Being. Pathways to Well-Being seeks to positively impact all CWS children and youth by providing mental health screening, mental health assessment as warranted, and thoughtful and timely linkage to mental health and supportive services for our most impacted children and youth.
- **Project Enable/In-Reach** is an outreach and engagement program for incarcerated individuals ages 18 and over who have or are at risk of substance use and/or psychological disorders as they prepare to exit the detention facility. One of the goals of this program is to provide services primarily to at-risk African American and Latino adults incarcerated in San Diego County. The program is focused on preventing the onset of mental illness and providing early intervention to help decrease severity. Services include: in-reach and engagement; education; peer support; and follow up after release from detention facilities and linkages to services that improve participant's quality of life, diminish risk of recidivism, and diminish impact of untreated health, mental health and/or substance abuse issues.
- In response to the national initiative, the SDCBHS has developed several adult and older adult programs that aim to reduce the number of people with a mental illness in jails. As part of the effort, the County has recently enhanced the Public Defender's Office with two clinicians to screen and refer individuals to the appropriate Behavioral Health programs and levels of care. Additionally, a Faith Based Innovations program was established in July 2016 in North County and Central regions. It aims to provide in-reach services in jails to clients in acute care or outpatient services in an effort to coordinate transitions and connection to Behavioral Health programs and social services. Furthermore, Project In-Reach was enhanced in October 2016 to address individuals in the psychiatric and step-down units within the jail.
- In 2013, two SDCBHS and Faith-Based Community Dialogue Planning Groups were established to facilitate conversations in the Central and North Inland regions with particular emphasis in the African American and Latino communities. A Community Dialogue Breakfast was held in each of the regions and a compendium of recommendations was compiled. One key outcome was the formation of SDCBHS Faith-Based Councils to provide input and recommendations to the SDCBHS administrative team on community needs and solutions. Both Councils submitted ideas for faith-based programs which resulted in innovation funding set aside for faith-based programs. The Faith-Based Initiative was established in 2016 and primarily focuses on African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. The programs include development of collaboration and partnerships including outreach and engagement to faith-based congregations; community education utilizing Faith-Based Champions; crisis in-home response to individual/family crisis situations such as suicides, homicides, domestic violence on a 24/7 on-call system; and a wellness and health ministry that focuses on adults diagnosed with a serious mental illness receiving mental health services while in jail. The Faith-Based Initiative is divided into four Task Orders that target specific needs identified within the faith-based community.

- **Union of Pan Asian Communities (UPAC)** Multi-Cultural Counseling (MCC) program provides cultural/language specific outpatient mental health services to the target population of underserved Asian/Pacific Islander and Latino children and families.
- The **Urban Youth Center of the San Diego American Indian Health Center** serves at-risk and high-risk Urban American Indian and Alaska Native children and youth ages 10-24 and their families providing screening and assessment and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for urban Native American youth.
- The **KidSTART** program was developed as a response to the need of integrated services for foster children ages 0-5. This program was developed in collaboration with the First 5 Commission and Child Welfare Services. KidSTART provides a focused, comprehensive system to identify, assess and treat children with developmental delays, behavioral and/or mental health issues at the earliest age possible, when that treatment can be most effective and cost-efficient. The core principles of KidSTART service delivery are: developmental knowledge, relationship/attachment focus, family support, links to existing children’s services, responsiveness to community, and culture and outcomes.
- **Elder Multicultural Access and Support Services (EMASS)** program provides outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees, African-Americans, and Filipinos by Promotoras, a Latin American approach that uses community peer workers and community health workers.
- **Survivors of Torture, International (SOTI)** provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength-based, client and family driven, and culturally competent.
- **Innovative Mobile Hoarding Intervention Program (IMHIP)** is funded through MHSAs Innovations and focuses on diminishing long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior lived experience receiving treatment for hoarding behaviors to provide support and encouragement to IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participants’ overall quality of life. The program began providing services in April 2016 and was expanded to other regions in the Fall of 2017.

A1. 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.

MHSA funding has enhanced the SDCBHS' efforts to increase the selection of services provided in San Diego County, thus ensuring care for greater numbers of County residents. MHSA has also done much to promote prevention and early intervention for mental wellness, as well as addiction-free lifestyles. Integrating behavioral health and primary care has been an essential element of the service transformation. The intent was to improve health care delivery and health outcomes and reduce disparities in access to and engagement in services. Services that have been implemented include, but aren't limited to: behavioral health consultation and telepsychiatry in rural community health centers; treatment of depression within the primary care setting; and supported transition of individuals with stable yet serious mental illness from specialty mental health to primary care. Integration services have also included provider education, training, and psychiatric consultation to help providers meet the unique needs and challenges of individuals who often have mental health or substance abuse, as well as physical health issues.

Prior to the implementation of MHSA, there were no culturally specific prevention services for Native Americans; however, SDCBHS has developed "Dreamweaver Consortium," consisting of four Indian Health Clinics serving 18 reservations in San Diego County to provide preventive mental health and alcohol and drug services.

PEI programs like Positive Parenting Program (Triple P), Breaking Down Barriers, Courage to Call, Bridge to Recovery, Kickstart, Older-Adult programs, and school-based interventions have not only made a difference in the lives of San Diego families and communities, but have played an integral role in reducing health disparities in our county, as well.

The community stated that they felt the same strategies noted above in Section III of this Criterion can be applied to all programs, not limited to the MHSA funded programs. For annual achievements, refer to Section III of this Criterion.

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

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

(Criterion 3, Sections I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

The County shall include the following in the CCPR:

A. List the strategies/objectives/actions/timelines provided in Sections III and IV above, and provide the status of the County's implementation efforts (i.e., timelines, milestones, etc.).

All programs are currently active and can be noted in the MHSA program summaries for CSS, PEI, WET, and Innovations (Appendix 16).

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.

Note: County shall be ready in 2011 to capture and establish current baseline data to be used for ongoing quality improvement and qualitative analysis of the County's efforts to reduce identified disparities. Baseline data information and updates of the County's ongoing progression in the reduction of mental health disparities will be required in 2011 and in subsequent CCPR Annual Updates.

Additionally, in subsequent CCPR Annual Updates, counties will share what has been working well and lessons learned, through the process of the County's planning and monitoring of identified strategies, objectives, actions, and timelines to reduce mental health disparities.

Between 2008 and 2010 the SDCBHS undertook an initial review of the tools and reports it was using to monitor program and client outcomes. The goal was to be better able to measure the success of efforts to increase access to services for the underserved and unserved populations, as well as to build the recovery orientation of its mental health system. The following tools continue to be used today:

- As mentioned earlier, the SDCBHS developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report. The latest report covers three time points (Fiscal Years 2009-10, 2012-13, and 2015-16), and is used as a guide on the current disparities that exist in the County and progress towards the reduction of the disparities over the years. The full report is available in Appendix 10. As mentioned previously, SDCBHS has reimagined this report as a set of dynamic dashboards called the *Community Experience Project*. The project is ongoing and is currently being produced to replace the static *Progress Towards Reducing Disparities in Mental Health Services Report*.
- SDCBHS has contracts with the University of California San Diego (UCSD) Health Services Research Center (HSRC), and Child and Adolescent Services Research Center (CASRC) to track client and system outcome measures, evaluate programs, and provide service utilization data. The reports developed by the Research Centers assist the SDCBHS in making the relevant decisions in regard to the reduction of health disparities.
- The QI Unit, in conjunction with its UCSD Research Centers, develops annual systemwide and program-level databooks that contain information on the age, gender, diagnosis, and race/ethnicity, preferred language, living arrangement, substance use, insurance status, and history of trauma among clients served, as well as the services provided. The reports have been enhanced over the years to include focus on diverse cultural groups being served. The reports are distributed to the Executive team and the Contract Monitors who use the results to track the populations served and the services received and use the information to have discussions with individual program managers on a regular basis.

- SDCBHS continues to monitor CYF and AOA client satisfaction with services through the use of semiannual State-developed survey tools (Youth Services Survey or YSS for CYF clients and Mental Health Statistics Improvement Program or MHSIP for AOA clients), and the Treatment Perceptions Survey (TPS) for SUD clients. Survey tools are provided in multiple threshold languages, and the County feels that the survey is an important way to hear the client voice on the program level. Many of the County's providers have a requirement in their contracts to participate in this survey. Additionally, the SDCBHS often includes a supplemental questionnaire on a regular basis that focuses on such areas like Peer and Family Support Specialists, substance use, foster care, physical health, trauma-informed systems, housing, and spirituality.
- The behavioral health entities are required to have a Cultural Competence Plan in place, and individual programs are encouraged to enhance the Plan to better match the clients they serve and their communities' needs.
- The QI Unit uses the annual and biennial surveys to evaluate the programs' progress in becoming culturally and linguistically competent. More information on the surveys is available in the Criterion 5.
- The QI Unit has been working with the software vendor (Cerner) to develop the Access to Services Journal Design document for Cerner Community Behavioral Health (CCBH) in an effort to better assess the timeliness of access to services across San Diego County. The Access to Services Journal was implemented in October 2017 allowing for a more efficient workflow for the clinicians and a more meaningful way of data interpretation.
- Additionally, SDCBHS:
 - Reviews Quarterly Status Reports (QSRs) and Monthly Status Reports (MSRs) from providers as a tool for data and outcomes.
 - Hosts monthly meetings with regional program managers to ensure that all programs receive timely System of Care updates.
 - Monitors access times to services on a regular basis.
 - Conducts program site visits annually or more often, if necessary.
 - Reviews the Cultural Competence Staffing and Training reports on a regular basis.
 - Updates contractual Statements of Work on a regular basis and as necessary.

C. Identify county technical assistance needs.

SDCBHS would like technical assistance with a recommendation of evidence-informed strategies that are used by other counties and nationwide to help reduce health disparities and improve access to care.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 3:

- Continue to enhance collaboration with the Indian Health Council for DMC-ODS to increase services in rural communities.
- Enhancement of the San Diego County Perinatal Equity Initiative focused on the Black community, providing education resources and support for soon to be fathers.
- Establish a new framework for healthcare in County Jails, specifically minimizing the expansion of outsourcing healthcare and increasing the number of county health nurses, mental health professionals, and drug treatment providers as noted in Chair Fletcher's County Address.
- Ensure a bottom-up, community-based approach in engaging BIPOC communities.

Client/Family Member/Community Committee:
INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY
MENTAL HEALTH SYSTEM

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

The County shall include the following in the CCPR:

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

Policy #5946 (Cultural Competence Resource Team, see Appendix 2) establishes the SDCBHS Cultural Competence Resource Team (CCRT) to advise the Deputy Directors of CYF and AOA Systems of Care on issues of cultural competence. The policy promotes mental health, wellness, and recovery, and eliminates the debilitating effects of psychiatric, alcohol, and substance use conditions in a culturally centered manner, as well as promotes cultural competence throughout services provided by San Diego County Behavioral Health Services.

The CCRT is an advisory board operating at the behest of the San Diego County Behavioral Health Services (SDCBHS) Director. The team establishes annual goals in support of San Diego's Behavioral Health Cultural Competence Plan submitted, approved, and monitored by the State. The Committee consists of a Chairperson (also the Ethnic Services Coordinator), twenty (20) voting members, and two (2) Subcommittees. The Executive Committee consists of the Subcommittee Chairpersons and the CCRT Chair. The CCRT meets for one and a half hours on the first Friday of each month. The standing monthly agenda items include: CCRT Chair's report, Mental Health Services Act (MHSA) update, Quality Improvement Updates, and Committee Updates: Education and Training, and Children, Youth, and Families (CYF).

Membership is chosen in such a way as to be as representative as possible of the Behavioral Health community. The recruitment procedure is as follows:

1. CRITERIA FOR SELECTION

- A. Candidates will be recruited from San Diego, a thriving, culturally diverse community, which is not limited to, but will include:
 - i. County Regions
 - ii. County Contractors
 - iii. Community Hospitals
 - iv. Optum Programs
 - v. Community Services Programs
 - vi. Consumer/Community Organization (adult & youth)

- B. Candidates will have demonstrated a sincere interest in cultural diversity (resumé, if applicable) and an expressed interest in promoting the CCRT's agenda (written letter, with paragraph on why candidate desired to become a member).

The CCRT shall consist of no more than 20 active voting members and an unspecified

number of inactive and honorary members. Active members are appointed by the SDCBHS Director. Inactive membership and honorary members can be designated by the CCRT Chairperson and the SDCBHS Director.

- C. Candidates can become active members in one of three ways:
 - i. Direct appointment by the SDCBHS Director;
 - ii. Active participation on a Subcommittee task force project, followed by a recommendation by Subcommittee Chairperson; or
 - iii. Recommendation by CCRT Chairperson.

2. ACTIVE MEMBERSHIP

Active membership shall be reserved for those members who are committed to:

- A. Thorough review of the Cultural Competence Plan for the SDCBHS and a commitment to read all materials pertinent to CCRT.
- B. Attend CCRT monthly meeting (notify CCRT of any absences).
- C. Accept assignments to one or both subcommittees and assume role in the subcommittee's task force projects.
- D. Willingness to take advantage of every opportunity to actively promote and support the goals of the CCRT.

3. INACTIVE MEMBERSHIP

Inactive membership shall be reserved for those persons who have served as an active member for two or more years and for personal or professional reasons are unable to attend the CCRT meetings on a regular basis.

Inactive members agree to act as a consultant, as well as to promote and support the goals of the CCRT in the workplace and the community. Membership can be activated by written request to the Chair.

4. HONORARY MEMBERSHIP

Honorary membership shall be reserved for those persons in the community who have outstanding achievement in the Cultural Competence arena, and who support and promote the goals of the CCRT.

All levels of membership entitle the holder to receive CCRT minutes, announcements, and newsletters.

Inactive and Honorary members have an open invitation to attend all CCRT meetings, at their convenience.

The community provided feedback on the organizational structure, functions, and role of the Cultural Competence Committee known as the Cultural Competence Resource Team (CCRT). It was recommended that representation of the CCRT be present at other System of Care Council meetings, as well as have program managers attend CCRT meetings. Members from the CCRT group have actively shared announcements at various council meetings to share resources and create a more fluid system of care. These changes have demonstrated that the guiding principles

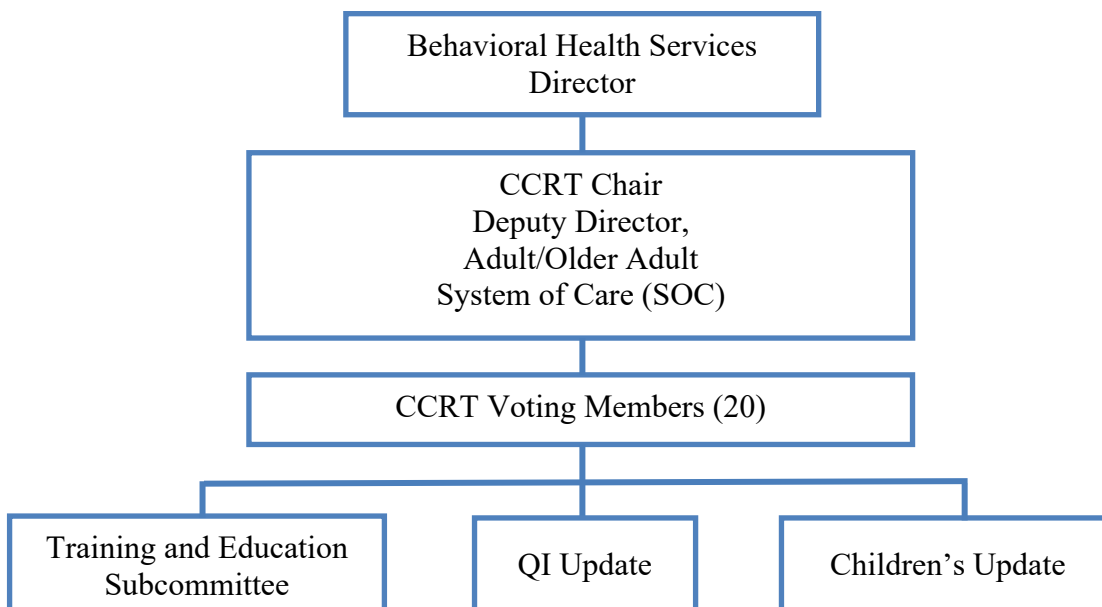
of the CCRT can aid in executive decision-making. With the community input received, SDCBHS will ensure continued diversity on the CCRT to accurately represent the community served. In addition, efforts will be made to ensure CCRT members who sit in other councils, community meetings and stakeholder events relay information from the CCRT in their capacity.

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including County management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

Policy #5946 assures that members of the CCRT are 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 policy states that members of the resource team shall be appointed by the Deputy Directors of SDCBHS and that appointees be from various organizational units and disciplines within SDCBHS, as well as member-at-large appointees from the community including consumers and family representatives. Representation from key groups such as, SDCBHS Quality Improvement Unit, the Clinical Staff Association, the Mental Health Contractors Association (ADSPA), and the BHAB will be requested to be appointees.

C. Organizational chart

Cultural Competence Resource Team (CCRT)



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

The list below consists of voting members, alternates, and County administrative support.

Member	Organization
Abdi, Sahra	United Women of East Africa
Alami, Mahvash	Survivors of Torture, International
Barnett, Elisa	The Center San Diego
Camarena, Juan	San Diego State University (SDSU)
Cooper, Fran	BHS – CYF SOC
Dare, Martin	BHS – PPU
Dauz, Elizabeth	Juvenile Forensic Services
Dones, Luisa	BHS – AOA SOC
Duron, Andrea	BHS – AOA SOC
Eguiza, Danielle	BHS – AOA SOC
Garcia, Piedad	BHS – AOA SOC, Chair BHS Deputy Director
Haddad, Shadi	San Ysidro Health Clinic - Chaldean Middle Eastern Social Services (CMSS)
Harris, Karen	The Knowledge Center (HHSA)
Heller, Rick	HSRC
Hunter, Celeste	CASRC
Jaimes, Shiva	Responsive Integrated Health Solutions (RIHS)
Katsanis-Semel, Kat	Mental Health America
Le Fol, Nicole	BHS – AOA SOC
Lozada, Rosa Ana	Harmonium, CYF Council Representative
Ly, Michelle	Union of Pan Asian Communities (UPAC)
Miles, Liz	BHS – QI
Mohler, Edith	BHS – CYF SOC
Paida, Rebecca	Nile Sisters Development
Pettiford, Kimberly	BHS – PPU
Pino, Luz	NAMI – CYFL
Ramos, Nilanie	BHS – CDO
Riley, Claire	BHS – AOA SOC
Rodriguez, Nancy	County Case Management
Rusit, Jennifer	BHS – CDO
Vilmenay, Ann	BHS – AOA SOC
Webber, Mercedes	RI International
White-Voth, Charity	BHS – AOA SOC
Young, Jessica	Neighborhood House Association - Project Enable (TAY)
Zare, Sara	The Knowledge Center (HHSA)

Client/Family Member/Community Committee:
INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL
HEALTH SYSTEM

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

The County shall include the following in the CCPR:

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

- 1. Reviews of all services/programs/cultural competence plans with respect to cultural competence at the County.*

Policy #5946 (Cultural Competence Resource Team) and Policy #5994 (Culturally and Linguistically Competent Services: Assuring Access and Availability) demonstrate that the CCRT is integrated within the Behavioral Health System through the charges and activities outlined in Appendix 1 and 2.

The charge of the CCRT is to serve as the “eyes, ears and conscience” of the SDCBHS system regarding the development of cultural competence in the delivery of behavioral health services to culturally diverse populations and systemwide adherence to the local Cultural Competence Plan. The CCRT is a formal mechanism for providing to both organizational and contracted individual providers input and feedback on cultural competence (#5946). Members provide such input collectively and bring the message of the CCRT to the community organizations, committees, councils, and advisory boards to which they belong.

A practice has been implemented of briefing the CCRT at the beginning of most meetings about the economic and regulatory realities at the State level and their expected influence on the County in effort to provide context on proposed changes and issues facing the SDCBHS for CCRT members.

The CCRT meets monthly and includes discussion with respect to cultural competence issues at the County, such as: Adult and Older Adult Services; Children's Services; Education and Training; Policy and Program Development; Health Care Disparities; California Mental Health Planning; and other pertinent topics.

In recent years, the following procedures and practices have been implemented to enhance the CCRT activities including:

- Reviewing data for the last two to three years on penetration, retention, and number of visits the Black/African-American community and other ethnicities comprise of, as well as looking at what the need in the community is.
- Identifying gaps in representation within CCRT and develop targeted outreach for those agencies/community groups for participation.
- Providing quarterly CCRT updates, using a standardized tool for presentation, at various meetings and Councils to provide consistent messaging.

- Providing dedicated support to programs, contractors, and community agencies who request technical assistance and guidance around cultural competence efforts within their organization.
- Presenting an annual services review through presentation of data from the QI Work Plan Evaluation, including staff linguistic and cultural proficiency, participation in cultural competence trainings, and consumer satisfaction survey results.
- CCRT has been participating in the development of the three-year strategic plan for the Cultural Competence Plan.
- In previous years, an annual retreat has afforded CCRT members the opportunity to learn, in greater depth, about new initiatives that the SDCBHS is considering and to hear reports on the successes or failure of initiatives undertaken, and system and client outcomes. The CCRT would then chart its course for the next year as well as draft and organize recommendations on impending service changes with an emphasis on cultural competence and improving services for cultural and linguistic minorities. The CCRT has also used the retreat to review its most recent ethnic/racial and cultural composition and considers strategies to reflect the changing demographics and needs of San Diego.

The CCRT also contributed to the development of practices which are increasing the emphasis on culturally competent programming being a priority.

- The CCRT Chair shared an article called “Why the Term BIPOC (Black Indigenous and People of Color) Is So Complicated, explained by Linguists” with members of the group.
- The CCRT reviewed LGBT recommendations, which are aligned with the County of San Diego’s 10-Year Roadmap.
- The CCRT reviewed and discussed the Strategic Plan for Diversity & Inclusion (2015-2020).
- The County Executive Leadership Academy Training based on anti-racism and social equity is under development in partnership with RIHS.
- The CCRT Chair presented at the graduation for the Cultural Competency Academy Capstone, which included 40 hours of training on cultural competency.
- The CCRT members participated in the Birth of Brilliance Conference, which is a collaborative effort of the Early Childhood Committee, CYF Behavioral Health System of Care Council (CYFBHSOC).
- The CCRT reviewed and provided input on the 2017, 2018, 2019, 2020 and 2021 versions of the Cultural Competence Plan and a Three-Year Strategic Plan and goals.
- The CCRT played a vital role in providing input, reviewing, and approving the new Cultural Competence assessment tools.
- The CCRT reviewed and provided input on the Cultural Competence Handbook, including a recommendation to make the Survey for Clients to Assess Program’s Cultural Competence more client-friendly and comprehensive.
- Updated the Cultural Competence Handbook to reflect changes in the existing tools. The CCRT also provided feedback to the CYF SOC Council on the Guiding Principles.
- The CCRT participated in the 2018, 2019, 2020, and 2021 External Quality Review (EQR) by attending the Cultural Competence related sessions, providing information on CCRT local activities, and responding to questions related to the CCRT.

- The CCRT Chair and other County representatives met with the East African and Refugee communities to gather input on service needs and gaps.
- The CCRT Chair and other County representatives have been actively involved in the implementation and advancement of cultural competence in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- The CCRT Chair and other County representatives have been actively involved in a series of presentations on trauma-informed care for asylees at the migrant shelters in March 2019. The presentations were a part of the San Diego Rapid Response Network (SDRRN) and included participants such as public health nurses and other volunteers helping to respond to the overwhelming need at the border.
- The CCRT identified a need for a comprehensive list of resources for the providers to learn about various cultural groups and worked to update the list.
- The CCRT identified goals for FY 2021-21 which includes addressing Equity and Social Justice, identifying training as a strategy.

2. Provides reports to Quality Assurance/Quality Improvement Program in the County;

SDCBHS, with the guidance of the CCRT, will ensure ongoing progress toward meeting service availability based on the cultural and linguistic needs of the population of San Diego County requiring behavioral health services.

There is a close linkage between the CCRT and the Quality Improvement Unit of SDCBHS. The QI Unit Administrator is a lead member of the CCRT, and other QI Performance Improvement Team staff also participate on the Committee to be sure that the two-way exchange of information is maintained. Additionally, Quality Improvement is a standing item on the monthly CCRT agenda, and the following topics are discussed: organizational and individual cultural competence evaluation tools; SDCBHS Annual Databook; outcomes reports; Annual EQR; Cerner Community Behavioral Health (CCBH) EHR System training; the implementation of the Medicaid Managed Care Final Rule (Mega Regs); the collective review and feedback on Mental Health (MH) and Substance Use Disorder (SUD) Provider Cultural Competence Plans; and other additional reports and data that relates to the cultural/ethnic diversity of the individuals served.

CCRT members informally report on updates and pertinent information gathered at various Councils, meetings, and conferences they attend, thus enhancing the CCRT's and QI Unit's knowledge of the community. CCRT members are given an opportunity to share handouts from other meetings as well, to relay community concerns and needs.

3. Participates in overall planning and implementation of services at the County;

The CCRT participates in overall planning and implementation of services at the County through analysis of demographic information to determine or identify gaps in service provision and assurance that cultural and linguistic needs are considered in strategic plans, human resource training and recruitment, and contracting requirements (Policy Reference #5994).

Overall planning and implementation of services in San Diego County continues to be regularly discussed at CCRT meetings, covering target areas such as:

- Access to Care – the need to continue with multiple efforts to engage culturally and ethnically diverse individuals who are unserved or underserved.
- Evidence-Based Practices – the need to continue to measure success of evidence-based practices (EBP) put into place on integrated physical health and mental health services and dual diagnosis services in areas of diverse populations.
- Workforce Development – the need to evaluate expansion of cultural competence education to include establishing community liaisons or culture brokers to enhance its outreach to diverse underserved populations.
- Evaluation and Outcomes – the need to identify a set of standards or elements that would encompass defining criteria that would go beyond what is being currently required, possibly using EBPs as interventions with specific outcomes.
- Quality of Care – the need to identify and evaluate a set of specific quality of care standards that would inform the administration on how well the needs of ethnically diverse clients are met by the SDCBHS system.

The CCRT has also provided ongoing input and review of the development and implementation of all phases of the MHSA Plans, and MHSA is a standing item on the agenda. The CCRT also continues to maintain its interest in reports on the outcomes of services implemented to benefit ethnically, racially, and culturally diverse populations. The CCRT has provided feedback on suggested uses of Enhancement funding for the CSS Plan. The Ethnic Services Coordinator continues to carry CCRT's concerns to SDCBHS Executive Core meetings. CCRT input was carried into multiple phases of the MHSA process, through member participation on the CYF, A/OA, Older Adult, and Housing Councils, TAY Council, and other stakeholder and work groups. In 2014, the CCRT, through its members and its Ethnic Services Coordinator, participated in the review of the State's CRDP recommendations for the five target populations and proceeded to make recommendations of which programs would align with the local culture and community needs. Furthermore, they have worked to engage community leaders, mental health providers, and clients to provide feedback and recommendations for culturally and linguistically specific programs to address underserved populations. There have been multiple programs developed to include culturally and linguistically specific services, specifically addressing the five target populations, which align with the local culture and community needs. The following programs address adult and older adult clients demonstrating community outreach, engagement, and involvement efforts with the five identified racial, ethnic, cultural, and linguistic communities (Latino, African American, API, LGBTQ+, and Native American). While there was a focus on the five target populations, SDCBHS is mindful of San Diego's diversity, specifically with immigrant and refugee communities, and have included programming outside of the five target populations: Project In-Reach, Breaking Down Barriers, the Fotonovela Project, clubhouses, Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Centers (WRC), Outpatient Services for Deaf and Hard of Hearing, Survivors of Torture, International (SOTI), Innovative Mobile Hoarding Intervention Program (IMHIP), Our Safe Place, Roaming Outpatient Access Mobile (ROAM), and two San Diego County Behavioral Health Services (SDCBHS) and Faith Based Community Dialogue Planning Groups. In addition to the programs mentioned above focusing on the five target populations, SDCBHS has also been responsive to

the needs of the East African refugee community, which has increased in population within San Diego County. SDCBHS has augmented the contract with the United Women of East Africa to provide greater support and access for the community regarding mental health treatment and prevention services.

Stakeholders provided feedback on the policies, procedures, and practices of the Cultural Competence Resource Team. They recommended as part of the new hire orientation, new SDCBHS employees attend, at minimum, one CCRT meeting. Additionally, it was suggested to have a connection with Contracting Officer's Representatives (CORs) on an ongoing basis to continually monitor contracted programs' cultural competence as well as to receive feedback and updates from CORs regularly. Also, cultural competence was recommended to be one standing agenda item at all System of Care Council meetings. Lastly, recommended practices included COR presentations of programs and how cultural competence is implemented, reviewing training contracts and monitoring cultural competence outcomes.

With the community input received, SDCBHS will also focus on enhancing COR training in monitoring for cultural competency. Within the Cultural Competence Strategic Plan, efforts will be made to identify training opportunities for all CORs to assist them with the monitoring of cultural competence. In addition, Quality Improvement will continue to review the cultural competence policies to ensure the alignment with the program cultural competency requirements.

4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;

San Diego County's commitment to cultural competence in policies and practices is documented in the CCRT meeting minutes which have been included in Appendix 17.

The CCRT transmits recommendations to the executive level by providing recommendations to the Ethnic Services Coordinator and QI Unit Administrator who can directly relay recommendations from the CCRT to the SDCBHS Director.

The CCRT works with the QI Unit on performance outcomes and standards for assessing the behavioral health system's cultural competence in servicing culturally diverse populations and recommending data collection strategies. The CCRT is able to recommend corrective action when the system's performance does not meet expected standards of cultural competence (Policy Reference #5946).

5. Participates in and reviews County MHSa planning process.

The CCRT provided input during the development of the MHSa planning process. Presentations were made directly to the CCRT by the MHSa staff. The CCRT has contributed to and reviewed

the ongoing County MHSA planning process through participation in stakeholder groups, the CYF, AOA, and Older Adult Councils. Additionally, the views of the CCRT are also reflected by the Ethnic Services Coordinator, AMSAs and the QI Unit in all Executive planning committees.

6. Participates in and reviews County MHSA stakeholder process;

As discussed above, the CCRT has participated in the SDCBHS MHSA stakeholder input process both as a group and as individual members. The CCRT members serve on a variety of different stakeholder groups including the CYF, AOA, Older Adult, and Housing Councils, the TAY Council, and other meetings.

On the Committee level, the CCRT Education and Training Sub-Committee provided input on education and training needs for culturally and linguistically diverse populations.

7. Participates in and reviews County MHSA plans for all MHSA components;

For evidence of CCRT participation in and review of County MHSA programs, community feedback, and the annual updates for MHSA components, see the attached CCRT meeting minutes located in Appendix 17. MHSA is a standing item on the agenda and there is always an MHSA representative in attendance at the monthly meetings.

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

The CCRT provided input for the MHSA Forum. Members of two leading client/family operated agencies—Recovery Innovations International and NAMI serve on the CCRT, bringing their unique expertise to all discussions. Peer and family representatives participate in review of client developed and run programs. Additionally, representatives from UPAC, Southern Indian Health Council, Mental Health America, Deaf Community Services, the Research Centers, Optum, RIHS, The Knowledge Center, Harmonium, Courage to Call, MHS Inc., and Exodus Recovery assist with the review of the client developed programs.

The CCRT Chair presented at the graduation for the Cultural Competence Academy Capstone (which included 40 hours of training on cultural competency), and participation in the Birth of Brilliance Conference to raise the collective awareness around the effects of racial disparities and implicit bias in mental health, social services, developmental services, early childhood education, and medical care (a collaborative effort of the Early Childhood Committee and the CYF System of Care).

9. *Participate in revised CCPR (2010) development.*

The purpose and structure of the CCRT supports the local Cultural Competence Plan as mandated by the DHCS, as can be seen in Policy #5946, included in Appendix 2.

In 2015, the CCRT participated in the revision of the CCPR (2015), devoting time in each meeting to give input, feedback, and final review of portions of the CCPR, as they became available.

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

As discussed, and documented above in Sections 1-8, San Diego County’s CCRT participates in the review process for County MHSA planning process, including but not limited to:

- County MHSA stakeholder process
- County MHSA annual updates for all MHSA components
- Client developed programs (wellness, recovery, and peer support programs)

This is evidenced in the attached meeting minutes in Appendix 17.

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*

- The CCRT meets monthly and makes it a priority to discuss goals and objectives of the committee and the sub-committees. The attached meeting minutes detail the discussion, decisions made, and the priorities and goals of the committee. In April 2021, the CCRT provided input, highlights, and updates from their meetings. Discussions included, but were not limited to, equity and racial training needs for service providers, primary care and behavioral health integration, as well as COVID-19 discussions on addressing racial and ethnic disparities, telehealth services, and client engagement. Other discussions included increasing CCRT Substance Use Disorder provider and consumer membership, inviting programs to present their respective Cultural Competence Plan which would include the program’s approach, implementation, challenges, and goals, as well as

- advancing culturally responsive community-based organizations to evidence-based standard. Additionally, it is the proposed goal that the policy of the CCRT includes identifying and implementing strategies to strengthen system wide advancement of cultural competence standards consistent with the State Plan and CLAS standards.
- ii. The CCRT continues to set new goals and objectives as they relate to enhancing services to be culturally and linguistically appropriate, and trauma informed. The CCRT met a large number of goals that were discussed at the beginning of the year, some of which included, but were not limited to: HHSA/SDCBHS reviving the Diversity and Inclusion Executive Council at the Agency level and the County Executive Leadership Academy Training based on anti-racism and social equity is under development. Other goals met include BHS' role with the Asylee Shelter, which involved integrating services to include behavioral health services within a public health emergency context; and the implementation of the Roaming Outpatient Access Mobile (ROAM) via two (2) contracts with Southern Indian Health Council, Inc. and Indian Health Council, Inc. to serve Native Americans in East and North Inland regions. The CCRT also provides input to the QI team on the Three-Year Strategic Cultural Competence Plan; reviews and implements new cultural competence assessment tools in the SDCBHS system; and updates the Cultural Competence Handbook.
 - iii. SDCBHS considers the goals successful because throughout the year the sub-committees and leads from various internal teams updated CCRT at monthly meetings and continuously worked to obtain input from the committee members in order to meet the goals. Recommendations include integration of the Children, Youth, and Families (CYF) System of Care guiding principles, cultural competence and trauma informed practice looking into cultural disparities and the impact of trauma across a lifespan, and trainings on cultural bias. Other criteria in this Cultural Competence Plan further detail the activities, initiatives, and goals that were achieved as the result of the effort at the CCRT.
 - iv. The Training and Education Sub-Committee met monthly throughout FY 2020-21 to identify, review, and implement new cultural competence assessment tools, in effort to align with the SDCBHS system, its priorities, and populations served.
 - v. Over the course of FY2020-21, the leads for the CCRT Work Groups volunteered to address the recommendations put forth by the CCRT Chair per their request to move forward and enhance the SDCBHS System of Care as it addresses equity and disparities in the prevention and early intervention arena, access to care and in the treatment delivery system for diverse communities of San Diego County. The recommendations are available in Appendix 18.
 - vi. As of December 2013, Cultural Competence Plans are required for all legal entities. To support the entities in their efforts to update or develop the respective Cultural Competence Plans, CCRT assisted the QI Unit in enhancing a Cultural Competence Handbook as a tool to guide the providers. The QI Unit collaborated with CCRT again this past fiscal year to request Cultural Competence Plans from all mental health and substance use programs to review and provide feedback. CCRT members used a standardized tool to review provider organizational Cultural Competence Plans by legal entity and provide recommendations for continuous improvement. All legal entities received a letter with specific feedback on their plan.
 - vii. A representative from the QI Unit presented the results from the 2016 SDCBHS workforce assessment, specifically highlighting the diversity among the racial/ethnic

- groups, language proficiency among staff, and utilization of interpreter services across the system. The Clinical Director’s Office (CDO) is now responsible for the workforce assessment and QI works collaboratively with them to interpret the results in relation to the client diversity.
- viii. The CCRT has reached out to Child Welfare Services to support their efforts to address race and equity by sharing tools currently used in the Behavioral Health System and mutually learning about potential additional new tools that support advancement of equity, cultural, and linguistic appropriate services throughout the Health and Human Services Agency. Additionally, SDCBHS developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report that covered three time points (Fiscal Years 2009-10, 2012-13, and 2015-16). CCRT used this report to assess the disparities and to prioritize focus on target populations based on the data on the overall service utilization, types of services used, engagement and retention, client diagnosis, and racial/ethnic distribution rates. In FY 2017-18, representatives from the Research Centers presented key findings from the report at one of the CCRT meetings. Additionally, CCRT leveraged the 2016 Workforce Assessment to assist the committee with developing specific strategies that focus on developing a culturally competent workforce. The Disparities Report is continuously referenced as new goals and strategies are discussed and developed at monthly CCRT meetings.
 - ix. The Behavioral Health Services Training and Education Committee (BHSTEC) meets quarterly and develops training topics that include recommendations from RIHS and suggestions from other members in attendance. The Committee’s focus areas for FY 2017-18 included topics such as: cultural competence, integrating faith-based communities, and working with hard-to-engage populations, especially the criminal justice involved population.
 - x. For other activities discussed at CCRT, please see the meeting minutes in Appendix 17.

As mentioned above, the CCRT leads program and organizational related efforts throughout the fiscal year. SDCBHS continues to work with providers to rate their own agency’s cultural competence through the Cultural and Linguistic Competence Policy Assessment (CLCPA). The assessment was implemented in October of 2017 as a replacement to the Cultural Competence Program Annual Self-Evaluation (CC-PAS). The assessment’s goals are to: enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. It is expected that improvement will be seen as staff advance in their cultural competence skills. Staff competence can also be measured by a biennial administration of the Promoting Cultural Diversity Self-Assessment (PCDSA), a replacement to the California Brief Multicultural Competence Scale (CBMCS). PCDSA was first implemented in 2018, and its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The CLCPA is completed by the program managers, and the PCDSA is completed by all staff. Additionally, SDCBHS continues to encourage new SDCBHS employees to attend, at minimum, one CCRT meeting.

The CCRT membership listing is regularly reviewed, including the membership of the subcommittee Education and Learning Workgroup. The membership will continue to be updated annually to ensure adequate representation of stakeholders throughout the system of care.

The CCRT continues to provide uniform quarterly updates and highlights to various meetings and Councils in an effort to provide consistent messaging across the system of care. The CCRT has continued to create and strengthen the approach of having a common voice and common message throughout the system of care within SDCBHS. Members from CCRT actively attend and participate in various council meetings, such as the CYF council meeting, and provide announcements of highlights, achievements, goals, and plans. The delivered message is consistent across each council meeting, so each group is provided with the same information.

The CCRT Accomplishments for FY 2020-21 and Goals for FY 2021-22 are available in Appendix 19. In addition to having a CCRT representative at the Council meetings, Cultural Competence/Diversity & Inclusion (D&I) is also proposed as a standing agenda item in Council Meetings.

The Knowledge Center (TKC) offered the following trainings to HHSA staff and licensed professionals to align with the needs and goals identified by the CCRT Education and Learning Workgroup: Trauma-informed Approaches in Working with Individuals Experiencing Homelessness; Talking about Racial Equality; Implicit Bias I & II; Understanding Racial and historical trauma; Working with Hispanic/Latino Older Adults; Gender Identity and Gender Variance; Cultural perspectives on Family Driven Care; Racial / Ethnic Difference in Mental Health Service; Resilience in African American Children and Adolescents; Racial and Ethnic Disparities in Healthcare: COVID-19 and the African American Community; Human Diversity: Current Multicultural Issues in Research and Therapy. Previous trainings include: Understanding Diversity in Homelessness; Understanding Trauma and its Impacts on the Families We Serve; and Stigma and Opioid Use Disorder. These classes support Live Well San Diego by promoting a better delivery system that is culturally competent and trauma-informed guiding the County's ongoing effort to support a community that is building better health, living safely, and thriving.

Other trainings and conferences offered to programs included Racial Inequity in San Diego County presented by San Diego Workforce Partnership; Working Together held by the National Alliance on Mental Illness (NAMI); Crime Victim & Survivor Summit: Mapping Intersections Across Service Systems for Prevention, Protection and Healing hosted by County of San Diego District Attorney's office; a virtual live event in Spanish during Binational Health week held on October 14, 2020; and Suicide Awareness & the BIPOC (Black, Indigenous, People of Color) Community Real Talk series held in September 2020. Previous conferences include: Warrior Spirit: "Calling Upon the Warrior Spirit to Heal Historical Trauma" hosted by the Viejas Band of Kumeyaay Indians; the 2018 Cultural Competence Summit: "Honoring California's Diversity: A Call to Action" held in October 2018; and the Binational Mental Health Symposium held in Tijuana, Mexico at the Universidad Autonoma de Baja California, which reflects the strong behavioral health partnership between San Diego and Tijuana, Mexico.

Additionally, the first meeting of the Cultural Competency Academy (CCA) Foundational Training series was held on March 15, 2019. In collaboration with Responsive Integrated Health

Solutions (RIHS), they developed a list of needed topics for the CCA training series and made recommendations to recruit members to serve on a CCA monthly curriculum subcommittee.

In April 2019, the CCRT workgroup members and other members of CCRT participated in a focus group conducted by Dr. Jonathan Martinez of California State University (CSU), Northridge. The goal of the focus group was to understand SDCBHS' strengths, challenges, and areas of need in providing culturally competent care through the perspective of CCRT members. The information obtained from the focus group which was comprised of County representatives, providers, and contractors, will be used in planning future cultural competence initiatives, and a list of recommendations will be provided to CCRT.

Collectively, the CCRT reviewed and provided feedback on Mental Health (MH) and Substance Use Disorder (SUD) legal entities' Cultural Competence Plans (CCP) during FY 2019-20. Members of the CCRT reviewed the CCPs thoroughly and provided culturally focused and CLAS standard specific feedback. Each legal entity received a formal letter highlighting the specific feedback and were offered suggestions to incorporate into their CCP.

Additional efforts of the CCRT include the implementation of the Roaming Outpatient Access Mobile (ROAM) to serve Native Americans in the East Region and North Region through coordination with the Southern Indian Health Council, Inc. and the Indian Health Council, Inc. as well as Community Program Planning forums by San Diego State University (SDSU) Research Foundation Consultants to encourage broad outreach with under-represented community members.

As mentioned in Criterion 2, SDCBHS has implemented the use of the annual CLCPA (program-level survey) and the biennial PCDSA (program staff survey) as new cultural competence assessment tools that are aligned with the National CLAS Standards. The systemwide reports for both assessments are completed and then distributed to the programs, with the program-level results distributed through the County's contract monitors to facilitate the discussion of individual results with the programs. These surveys are henceforth incorporated into the annual program evaluations as stipulated in the Organizational Provider Operations Handbook (OPOH) and Substance Use Disorder Provider Operations Handbook (SUDPOH).

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 4:

- Enhance the reach of the CCRT by ensuring representatives are sharing information and promoting collaboration at community meetings, stakeholder meetings, and councils.
- Enhance the representation from substance use providers on the CCRT.

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The County shall include the following in the CCPR:

- A. *The County shall develop a three-year training plan for required cultural competence training that includes the following:*
 - 1. *The projected number of staff who need the required competence training. This number shall be unduplicated.*

All SDCBHS staff and contracted staff are required to complete a minimum of four (4) hours of cultural competence training annually. This consists of roughly 2,003 mental health staff and 1,357 substance use disorder staff. The staff includes: County and contracted unlicensed direct service staff; licensed staff; psychiatrists; nurses; volunteers; managers; and support staff. This is mandated for each SDCBHS contract and for County operated facilities, including both mental health and substance use disorder programs.

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

SDCBHS has shown growth in reaching the target of 100% of staff trained in cultural competence by requiring and reminding County and contracted staff, including support staff working with clients, to receive four (4) hours of cultural competence training each year. This requirement is contained in the Organizational Provider Operations Handbook (OPOH), which is a part of each contract. SDCBHS has contracted out the vast majority of its services, ranging from hospitalization to outpatient services for all age groups, in which County and contracted providers are responsible for obtaining and providing the required four hours of cultural competence trainings for their staff. County program monitors and the Clinical Directors Office track completion of the required four hours of training on a regular basis.

To ensure continued compliance, a three-prong approach to expanded training has been implemented, which takes into consideration the changing economic and environmental climates.

First Prong: County and Contractor Self-Provided Trainings

Trainings are provided for County employees at no cost and for a small number of contracted providers' staff on a fee basis through the County of San Diego HHSA's training unit, The Knowledge Center (TKC).

Cultural Competence Trainings Offered by The Knowledge Center:

FY 2014-15

- Middle East and East African Populations
- Working Effectively with Healthcare Interpreters
- Role of Spirituality in Healthcare
- Setting the Triadic Stage for Success: Working Effectively with Health Care Interpreters

FY 2015-16

- LGBTQ+ Population
- Filipino American Population
- Disability Etiquette
- Deaf and Hard of Hearing Culture

FY 2016-17

- Diversity & Inclusion
- Middle Eastern & East African Cultures
- African American Culture
- Native American Culture
- The Role of Migration on the Identity of Latina Women
- Self-Awareness and Implicit Bias
- Poverty
- Gender Identity and Sexual Behavior
- Disability Awareness and Etiquette

FY 2017-18

- Diversity & Inclusion
- Cultural Competency Overview
- Middle Eastern & East African Cultures
- African American Culture
- Native American Culture
- Middle Eastern Culture
- Filipino-Americans and Mental Health
- Gender Differences in the Workplace
- Understanding Diversity in Homelessness
- Engaging Multiple Generations in the Workplace
- Working with Hispanic/Latino Older Adults
- Disability Awareness Training
- Cross Cultural Encounters Bridging Worlds of Difference
- Microaggressions

FY 2018-19

- Cultural Competency Overview
- Cross-Cultural Issues
- Cultural Perspectives on Family Driven Care
- Cross Cultural Encounters Bridging Worlds of Difference
- Self-Awareness, Implicit Bias, and Cultural Responsivity
- Intro to Diversity and Inclusion
- Serving Diverse Customers
- Generations in the Workforce
- Diversity and Domestic Violence
- Promoting an Inclusive Workplace
- Exploring Linguistic Diversity

FY 2019-20

- Introduction to African American Culture
- Gender Differences in the Workplace
- Disability Awareness
- Understanding Diversity in Homelessness
- Filipino-American Mental Health
- Self-Awareness, Implicit Bias, and Cultural Responsivity
- A Look at Poverty
- Gender Dysphoria: Beyond the Diagnosis Aydin Olson Kennedy
- Middle Eastern and East African Culture
- Disability Awareness and Etiquette

FY 2020-21

- Trauma-informed Approaches in Working with Individuals Experiencing Homelessness
- Racial and Ethnic Disparities in Healthcare: COVID-19 and the African American Community
- Talking about Racial Equality
- Implicit Bias I
- Implicit Bias II
- Understanding Racial and historical trauma
- Understanding and Addressing Trauma in the Families we Serve
- Working with Hispanic/Latino Older Adults
- Gender Identity and Gender Variance
- Cultural perspectives on Family Driven Care
- Racial / Ethnic Difference in Mental Health Service
- Resilience in African American Children and Adolescents
- Human Diversity: Current Multicultural Issues in Research and Therapy

Several of San Diego County’s larger contractors, including Community Research Foundation (CRF), New Alternatives, Inc., and Mental Health Systems, Inc. (MHS) offer their own cultural competence trainings to their individual programs to meet the four-hour requirement. Their courses are also offered free of charge to agency staff, and to the public on a fee basis. CRF offers both live trainings and online courses for their staff. Course examples include “A Culture-Centered Approach to Recovery” and “Valuing Diversity in the Workplace.” An additional example of training is the MHS training titled “Cultural Competency 101 – Awareness and Understanding.” This class is a four-hour introduction to concepts and theories of culture.

Participants are presented with demographics and information that demonstrate MHS’ commitment to cultural sensitivity, raising cultural awareness and interactive opportunities for participants to become aware of their own cultural values, beliefs, and assumptions. This content is presented to include organizational and individual elements of cultural competence and activities which facilitate integration and application.

Additionally, various divisions and county operated programs within SDCBHS complete their own internal cultural competence activities and have meaningful discussions. For example, the Children, Youth and Families (CYF) division developed a presentation for their staff focusing on general cultural competency. This presentation highlighted many aspects of cultural competency which includes the “Iceberg Concept of Culture,” the “Many ‘Cultures’ That Individuals Are Part Of,” Types of Cultures, and Culture Related Influences. CYF includes a diversity and inclusion/cultural component into their monthly team meetings. The Adult/Older Adult (AOA) division dedicates a minimum of one meeting per month with a focus on diversity and inclusion. Topics range from discussing the disparities report, discussing CLCPA and PCSDA results, how to manage results with contractors, upcoming cultural trainings and conferences around diversity and responsiveness, racial bias and discrimination in San Diego County, as well as new initiatives and developments (i.e., Office of Racial Justice and Equality). AOA staff are also provided with a quarterly Diversity and Inclusion Digest which connects them to curated educational videos, podcasts, articles, and links to educational opportunities. The SDCBHS QI unit also allocates time within their monthly unit meetings to feature speakers and presentations on programs, community resources and relevant issues as they relate to Diversity and Inclusion. A list of these presenters and topics for FY 2020-21 is provided below:

SDCBHS QI Unit Diversity and Inclusion Presentations FY 20-21		
Presenter	Presentation Topic	Subtopic
Dr. Keisha Clark , President of AAACE ERG	Black Lives Matter	Racial disparities, taking action, listening groups, resources
Vanessa Pineda , Lead Outreach Coordinator, Breaking Down Barriers, Jewish Family Services (JFS)	Suicide Awareness: Cultural Issues and Disparities Among Minorities	Demographic Data, points of assessment/conversation/action. process questions, resources
Kathi Anderson , Executive Director, Survivors of Torture International	Border Issues and Needs of Newcomers	San Diego/Mexico border, awareness, needs of newcomers (immigrants), resources
Antonio Page-Kahn , Staff Attorney, CCHEA, Legal Aid Society of San Diego	Legal Needs of LGBTQ+	Common issues, creating an affirming space, call to action, resources
Amanda Lee , LCSW, Division Dir. of Adult/Older Adult Mental Health, Union of Pan Asian Communities (UPAC)	Violence toward AAPI community	UPAC community resources

Second Prong: SDCBHS Contracted Trainings through RIHS

SDCBHS contracts with San Diego State University Foundation, Academy of Professional Excellence Responsive Integrated Health Solutions (RIHS) to offer free clinical, administrative, and cultural competence trainings to County and contracted SDCBHS staff. RIHS offers instructor-led classroom trainings and e-learning courses. RIHS has previously hosted an hour-long webinar on CLAS to all County-contracted agencies that was conducted by SDCBHS in collaboration with the Union of Pan Asian Communities (UPAC), a County-contracted agency. The webinar met one hour of the required four hours in cultural competence training that each County-operated and County-contracted employee must meet annually. More specifically, the trainers addressed each of the 15 components, discussed the applicability of the standards to the organizational policies and procedures, operations, and client care, and shared strategies for implementing the standards in the organization. In FY 2016-17, RIHS collaborated with subject matter experts from SDCBHS and San Diego State University (SDSU) to develop an e-learning on CLAS Standards. In May 2018, RIHS updated its three-hour e-learning on cultural competence. The “Cultural Competence as a Process” e-learning meets two-and-a-half hours of the annual requirement. This e-learning provides an introduction to cultural competence and resiliency in behavioral health, an overview of culture, introduces a method of self-assessment, including the use of cultural assessment in treatment.

RIHS has also hosted a half-day informational and interactive training, “Engaging the Refugee Community,” which provided participants with an orientation to the term refugee and a deeper understanding into the journey of those currently coming to the U.S. and why they are making the journey. The presenters shared examples of challenges and successes they’ve experienced while working with and engaging the refugee community in the City Heights area of San Diego. Additionally, refugee parents and youth shared their personal stories of leaving one’s homeland and coming to San Diego. The training offered lessons learned, key insights, and responsive strategies for participants to utilize in their own work with the refugee community.

RIHS launched the East-African eLearning in January 2019 and Advanced Geriatric Mental Health series in March 2019. The Geriatric Mental Health series ended in May 2019. Additionally, the CCA was in the planning stages for the curriculum for a 5-day training. The plan was to begin the rollout of the CCA 5-day training cohort in August 2019, the second cohort in October 2019, and the third cohort in January 2020. The Capstone for all 3 cohorts was set for June 2020. The curriculum planning included a proposal for the launch of new and booster trainings. The African American and API boosters were planned for December 2019 and May 2020, respectively. The CCA also planned for the inclusion of an Administrative Support webinar, a Management booster, and a Clinician booster, all of which was planned for May 2020. During this year, a new undetermined cultural eLearning was also in the planning stages and set to be completed by June 2020.

Two Administrative Support webinar sessions were offered on April 2 and May 21, 2020. As part of its continuous efforts to provide the SDCBHS workforce with tools to provide culturally and linguistically competent services, CCA offered both the Management booster and the Direct Service booster virtually to mitigate COVID-19 restrictions. The Management booster was developed into a 2-hour virtual training and offered on May 5 and May 19, 2020. The Direct

Service booster was also developed into a 2-hour virtual training and was offered on May 8 and May 20, 2020. SDCBHS will continue to work with RIHS to identify additional eLearning opportunities.

Third Prong: WET Workforce Building Activities

The goal of the WET Plan has been to build an education and training framework or infrastructure that supports growing and maintaining a public behavioral health workforce consistent with the MHSA and WET fundamental concepts. A second goal is to ensure a culturally and linguistically competent workforce, including staff and family members capable of offering client- and family-driven wellness, recovery, and resilience-oriented services within an integrated service experience. To achieve these goals, the following programs have been implemented:

Specialized Training Modules: This action was designed to increase the number and diversity of trainings offered to the County of San Diego’s public behavioral health workforce. The training modules outlined support the core competencies for the public behavioral health workforce: the philosophy of client and family-driven services that promote wellness, resilience, and recovery-oriented services that lead to evidenced-based, value-driven outcomes. Cultural diversity must be incorporated into staffing, environment, and service delivery models. In accordance with this consideration, training has been aligned with targeted population groups to include Early Childhood, Youth, Transition Age Youth, Adults, and Older Adults, as well as culturally, linguistically, and ethnically diverse communities.

Public Behavioral Health Training: This action uses multiple strategies to reduce barriers to employment and to create opportunities for individuals, including consumer and family members, to become part of San Diego County’s public behavioral health workforce. The training programs are intended to be collaborative and community based. It focuses on two distinct, but related, pathway tracks that lead to certification, skill development, and employment in the public behavioral health workforce.

- 1) Public Mental Health Academy for potential future and incumbent mental health employees in a variety of direct services occupations, both licensed and unlicensed direct positions. The Public Mental Health Worker Certificate of Achievement is a 19-unit program which prepares individuals for entry-level positions in the public mental health system and serves as a springboard for those who wish to pursue further study in the field. In addition, the certificate program has been instrumental in enhancing the knowledge and skills of entry-level personnel already working in the field. For the 2019-20 academic year 62 students were enrolled in the PMHA/Mental Health Work Certificate program with 42 students completing the certificate, contributing to the 312 total graduates since the program’s inception.
- 2) Peer Specialist Training programs have been implemented to assist consumers and family members to become members of the public behavioral health workforce. These programs include: Peer to Peer Recovery Education; Peer Specialist Training; and Peer Advocacy Training. A local university partners with various organizations that provide these trainings, which has facilitated the translation of six existing certificate programs into academic credits. In addition, this partnership provides mentoring and other support to assist individuals in achieving their educational and employment goals.

Both pathways have been designed to create an avenue for professionals with lived experience to deliver services based on the principles of recovery, wellness, and consumer and family involvement.

Community Psychiatry Training Tracks: SDCBHS has partnered with a local School of Medicine/Department of Psychiatry to include training programs for general community psychiatry residents and psychiatric and mental health nurse practitioners for child and adolescent psychiatry. The program fosters the development of leaders in Community Psychiatry and provided medical and nursing students and psychiatry residents with instruction on principles of Community Psychiatry and exposure to the unique challenges and opportunities within this context. Community Psychiatry fellows, residents and nurse practitioners work with the County of San Diego’s public behavioral health system to gain clinical, administrative, managerial, leadership and policy exposure.

Psychiatric Nursing Training: SDCBHS has partnered with local clinical psychologists to support the psychiatric nurses staffed at San Diego County Psychiatric Hospital (SDCPH). The purpose of these training tracks is to enhance knowledge of psychiatric treatments and diagnoses for nursing staff at SDCPH with the following:

1. This training program focuses on psychological disorders. The goal of the program is to train up to 100 nursing staff by providing four separate training cohorts, each over a seven-week period. Each class addresses up to two topics, including diagnostic criteria, facts, formal treatment modalities, nursing staff intervention and practice vignettes. This program was provided from July 2017 through June 2018.
2. The goal of this program is to train up to 120 nursing staff addressing treatment of forensic patients separated into two teams. The training topics include criminal behavior; connections and conclusions of mental illness; substance abuse violent offenders- violence risk and threat factors; why Forensic patients are in the hospitals, security/safety issues; acknowledging fear and how to use it within the hospital and community. This program was provided from March 2018 through June 2018.

Training and Development Forums; Commitment to Growing a Multicultural Workforce: SDCBHS is committed to assist all behavioral health providers and professionals who serve San Diego communities and their members through educational and training forums from trained and qualified presenters/providers. These include the following:

1. *SDCBHS Workforce Collaborative:* Through the SDCBHS Workforce Collaborative, a presentation on community inclusion and integration within the public behavioral health workforce was delivered to County of San Diego’s behavioral health stakeholders. The presenter spoke about community integration and how it closely ties with the workforce collaborative’s mission. The mission of Behavioral Health Workforce Collaborative is to build, enhance and sustain a strong, culturally competent client/family member unit.
2. *Justice Involved Services Training Academy (JISTA)* was developed in partnership with the Public Safety Group to provide trainings to SUD and mental health treatment providers to address the criminogenic needs and treatment for the SDCBHS justice involved population. The 6 full-day series began in September 2018, with 32 participants engaged in the Academy. Participants included mental health and substance use disorder community treatment providers, as well as some providers from within the justice system (Sheriff,

Public Defender). The first JISTA cohort graduated on November 15, 2018. Second and third cohort sessions were completed in 2019. A fourth cohort was planned for Spring 2020, however, there were delays due to the COVID-19 pandemic. The total number of participants trained in JISTA include 85 participants from 40 SUD and Mental Health programs.

Cultural Competence Academy (CCA)

Through 2016, the CCA has successfully completed three cohorts and offered trainings focused on Native American, Black/African American, Latino and LGBTQ+ populations to 262 staff. Of these participants, 112 have graduated and completed the year-long training and practicum. Although the contract terminated on October 31, 2016, the Cultural Competency Academy (CCA) contract was awarded again on September 27, 2018. Through this contract, SDCBHS has continued to provide County SDCBHS staff and contracted staff with further trainings focused on clinical and recovery interventions for multicultural populations. The goal for CCA is to provide awareness, knowledge, and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications. The CCA general training series for providers will continue to be offered in fiscal year 2021-22.

Beginning in March 2021, a CCA Executive Series was offered to the executives of County of San Diego Behavioral Health Services (SDCBHS). There were two offerings of the executive series and the capacity for each training series is 10 participants. Each series will include three 90-minute virtual training sessions, a one-hour coaching call, an executive project, networking time, offline work via an online workgroup, as well as a final one-hour graduation project with discussion.

3. How cultural competence has been embedded into all trainings.

All trainings provided through the SDCBHS are required to have a cultural competence component. These trainings are conducted by RIHS, the SDCBHS QI Unit, HHS, TKC, and contracted training organizations. Policies have been developed and implemented to ensure that all trainings for mental health and SUD services are consistent with mental health and SUD philosophy and principles. Training standards that have been developed have a cultural competency component embedded, as appropriate.

Guidelines for RIHS (the largest provider of trainings for SDCBHS) are provided below:

Guidelines for RIHS Topics

The Behavioral Health Services Training and Education Committee (BHSTEC) is the hub for training planning in the SDCBHS system and it drives the training topics that Responsive Integrated Health Solutions (RIHS) implements each fiscal year. BHSTEC's role is to provide direction to RIHS to address education and training needs across the entire behavioral health system:

- To ensure that education and training consistently meet the objectives of the system at the program and direct service levels.
- To consider workforce development training needs.

- To analyze and evaluate current trainings and redundancies.

At an organizational level, RIHS will continue to support SDCBHS system’s growth and focus on diversity, equity, and inclusion by shifting deliverables and trainings as needed.

The Guidelines for RIHS Trainers are included in Appendix 20.

CULTURALLY COMPETENT TRAINING ACTIVITIES

II. The Annual cultural competence trainings

The County shall include the following in the CCPR:

- A. *Please report on the cultural competence training for staff. Please list training, staff, and stakeholder attendance by function (if available, include if they are clients and/or family members).*
 1. *Administration/Management;*
 2. *Direct Services, Counties;*
 3. *Direct Services, Contractors;*
 4. *Support Services;*
 5. *Community Members/General Public;*
 6. *Community Event;*
 7. *Interpreters; and*
 8. *Mental Health Board and Commissions; and*
 9. *Community-based Organizations/Agency Board of Directors.*

Contractors are required to report on trainings attended by staff on their Quarterly Status Reports (QSRs). The County compiles summary statistics on the training attendance by extracting these data from over 200 QSRs for each of 12 months. The FY 2019-20 summary report is available below. The topic of individual trainings is created by each provider since providers are responsible for their individual cultural competence trainings. Some trainings may be provided by a legal entity and are reported separately by individual attending programs. SDCBHS collects the following information: the topic or description of the training (as self-reported); course length; attendance by function; total attendees/provider/training; the course date; and the program reporting. It should be noted that in smaller programs the program manager may function both as an administrator and a direct service provider, which creates potential for duplication. Due to the time consumption and labor involved with the data collection process, the names of presenters have not been captured, nor is it possible to categorize trainings by the topic types requested in item B. Starting in October 2018, SDCBHS has required contractors to report on trainings attended by staff through a report template as an attachment to the annual CLCPA. The following charts detail the number/percentage of MH and SUD contracted provider staff that have completed the 4 hours of cultural competence training for FY 2019-20.

FY 2019-20 MH Provider Staff Cultural Competence Training

	Category	Total FTE	Total Unduplicated Individuals	# Completed CC Training	% Completed CC Training
2019-20	Unlicensed Mental Health Direct Services Staff	1,053.52	1,233	993.00	80.54%
	Licensed Mental Health Direct Services Staff	254.66	379	314.00	82.85%
	Other Health Care Staff	222.63	276	193.00	69.93%
	Managerial/Supervisory Staff	194.43	286	230.00	80.42%
	Support Staff	247.14	413	288.00	69.73%
Total		1,972.38	2,587	2,018.00	78.01%

FY 2019-20 SUD Provider Staff Cultural Competence Training

	Category	Total FTE	Total Unduplicated Individuals	# Complete CC Training	% Completed CC Training
2019-20	Unlicensed Direct Services Staff	976.34	1,139	755	66.29%
	Licensed Direct Services Staff	260.27	396	258	65.15%
	Other Health Care Staff	57.00	76	47	61.84%
	Managerial/Supervisory Staff	145.76	188	113	60.11%
	Support Staff	189.09	252	140	55.56%
Total		1,628.46	2,051	1,313	64.02%

- B. Annual cultural competence trainings topics shall include, but not be limited to the following:*
- 1. Cultural Formulation;*
 - 2. Multicultural Knowledge;*
 - 3. Cultural Sensitivity;*
 - 4. Cultural Awareness; and*
 - 5. Social/Cultural Diversity (Diverse Groups, LGBTQI, SES, Elderly, Disabilities, etc.);*
 - 6. Mental Health Interpreter Training;*
 - 7. Training staff in the use of mental health interpreters;*
 - 8. Training in the use of interpreters in the Mental Health Setting.*

Responsive Integrated Health Solutions (RIHS)

Instructor-led and E-Learning Training Topics Provided by RIHS in FY 2018-19	Number of Participants/Trainees
Introduction to Geriatric Mental Health Series	22
Advanced Geriatric Mental Health Series	10
CCA Dealing with Difficult Situations	26
Effectively working with LGBTQ+ Youth	68
Relapse Prevention	26
Engaging Teens in SUD Treatment	23

CLAS Standards eLearning	278
Cultural Competence as a Process eLearning	486
Introduction of African American Populations eLearning	213
Introduction to Latino Populations eLearning	250
Introduction to LGBTQ+ Populations eLearning	92
Introduction to Native American Populations eLearning	139
Senior Veterans eLearning	11

Instructor-led and E-Learning Training Topics Provided by RIHS in FY 2019-20	Number of Participants/Trainees
Cultural Competency Academy Foundational Series Cohort 1*	20
Cultural Competency Academy Foundational Series Cohort 2*	12
Cultural Competency Academy Foundational Series Cohort 3*	TBD
Geriatric Behavioral Health Certificate Training	12
Geriatric Behavioral Health Training Booster-Trauma Informed Care	26
TERM-- CSEC	15
Implicit Bias	30

Instructor-led and E-Learning Training Topics Provided by RIHS in FY 2020-21	Number of Participants/Trainees
Bridges Out of Poverty	19
Cultural Competency Academy Foundational Series Cohort 3*	13
CCA Management Booster	1
CCA Direct Service Booster	9
African-American Booster	19
Asian-American and Pacific Islander Booster	15
CCA Capstone + Graduation	35

Cultural Competence Academy (CCA)

Since its inception, the CCA successfully completed three cohorts and offered the training to 262 staff. Of these participants, 112 have graduated and completed the year-long training and practicum. In FY 2015-16, CCA offered the Native American and Black/African American tracks with 35 staff in attendance. Although, the program terminated in October 2016, SDCBHS re-procured the contract on September 27, 2018. Through this contract, SDCBHS provides County SDCBHS staff and contracted staff with further trainings focused on clinical and recovery interventions for multicultural populations. The goal for CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications. Since its re-procurement, the CCA has successfully completed three cohorts; a total of 45 individuals have completed this training series. Additionally, it has provided audience-specific trainings such as: Geriatric Behavioral Health Certificate; GCT Booster: Trauma-Informed Practice for Older Adults; and Implicit Bias for CYF. The objective of this 5-day training series is to enable participants to create a measurable change within their organization which they will then present at their graduation. Participants from the same organization are given the opportunity to work together toward this objective. An informational flyer from the January 2020 CCA Foundational Series can be found in Appendix 21.

The CCA Foundational Series consist of the following 5 days:

- Day 1: Self-assessment “What does this have to do with me?”
- Day 2: Have things changed? (What is culture?)
- Day 3: Culture in the workplace
- Day 4: Culture and Behavioral Health Services
- Day 5: Implementation and Next Steps

CCA Core Curriculum Outline

<p>Day 1: Self-assessment “What does this have to do with me?”</p> <ul style="list-style-type: none"> Self-assessment Person-first/recovery language Implicit bias Normalize biases Intersectionality Cultural curiosity Cultural competence vs. cultural humility vs. cultural responsiveness Cultural competency is fluid vs. terminal Introduction and expectations for participant Capstone Projects Begin the conversation next class: What is culture? Have things changed? (Next class will deep dive into it)
<p>Day 2: Have things changed? (What is culture?)</p> <ul style="list-style-type: none"> Historical trauma (general, epigenetics, etc.) Privilege, guilt and identity development Provider stigmas; culture of SDCBHS, SUD, etc. Cultural responsiveness in different settings (as it relates to employee relations and different clinical settings) Education surrounding culture vs. race Cultural competence vs. cultural humility and how to navigate it What does culture look like today?
<p>Day 3: Culture in the workplace</p> <ul style="list-style-type: none"> Equity Microaggressions/difficult conversations How one’s culture forms their perspective on how they do their work Issues surrounding one person representing a whole population Subcultures within a culture (ex: disabilities, different areas: east, west, Urban, City) Having the same cultural background but different upbringings (language, socio-economics, gender) Implementation: What does cultural competence/humility/responsiveness look like in practice? Institutional bias Capstone check-in
<p>Day 4: Culture and Behavioral Health Services</p> <ul style="list-style-type: none"> Cultural responsiveness in SDCBHS settings Identifying and managing your biases How guilt, privilege and shame affect service provision in SDCBHS Assumptions that are rooted in bias Implementation: What does cultural competence look like in practice? Institutional bias
<p>Day 5: Implementation and Next Steps</p> <ul style="list-style-type: none"> Self-assessments, discourse and closing the loop Capstone Implementation: What does cultural competence look like in practice?

The Knowledge Center

The Knowledge Center has offered the following cultural competence classes over a span of eight fiscal years:

FY 2013-14				
Title	Hours	CEUs	Enrolled	Completed
African-American Population: A Journey to Good Health	8	8	22	19
Encouraging Healthy Nutrition in a Culturally Competent Way	9	8	29	29
Cultural Awareness for Suicide Prevention	4.15	4	32	23
LGBTQ+ Services for Older Adults	4	4	<i>Not available</i>	16
Disability Etiquette	4	4	25	22
African-American Populations	4	4	34	28
FY 2014-15				
Title	Hours	CEUs	Enrolled	Completed
Sexual Orientation Assessment	4	4	34	27
The Role of Spirituality in Healthcare	8	8	37	35
Middle Eastern and African Cultures	4	4	45	38
Helping Native American Families	4	4	13	11
Principles of Disability Etiquette	4	4	44	40
Engaging Multiple Generations in the Workplace (offered twice, 4 hours each)	8	8	24	22
FY 2015-16				
Title	Hours	CEUs	Enrolled	Completed
Cross-Cultural Encounters	6	6	46	42
Principles of Disability Etiquette	4	4	24	21
Cultural Competency Overview	4	4	12	12
Disability Awareness and Professionalism: An Interactional Perspective	4	4	31	30

Understanding Deafness & Deaf Culture	4	4	41	36
Filipino Americans and Mental Health Training	4	4	<i>Not available</i>	<i>Not available</i>
Sexual Orientation and Gender Assessment	4	4	<i>Not available</i>	<i>Not available</i>
FY 2016-17				
Title	Hours	CEUs	Enrolled	Completed
Diversity & Inclusion Training	2	2	17	17
Middle Eastern & East African Cultures	4	4	31	31
Diversity and Inclusion at the County of San Diego	2.5	2.5	18	18
An Overview of Middle Eastern Culture (offered twice, 4 hours each)	4	4	29	29
Multiple Generations in the Work Place (offered twice, 4 hours each)	4	0	34	34
Microaggressions	4	4	34	34
Gender Differences in the Workplace	4	4	32	32
Introduction to African American Culture	4	4	34	34
Person Centered Care Planning and Case Management	4	4	21	21
Cultural Competency Overview	4	0	24	24
Introduction to Native American Culture	4	4	28	28
The Role of Migration on the Identity of Latina Women	4	4	24	24
Healing the Healer	6	6	39	39
Self Awareness and Implicit Bias	7	7	<i>Not available</i>	<i>Not available</i>
Gender Identity and Sexual Behavior Assessment: Best Practices for all Orientations	4	4	<i>Not available</i>	<i>Not available</i>
Disability Awareness and Etiquette	4	0	<i>Not available</i>	<i>Not available</i>
A Look at Poverty	4	4	<i>Not available</i>	<i>Not available</i>
FY 2017-18				
Title	Hours	CEUs	Enrolled	Completed
Introduction to Diversity and Inclusion	2	0	30	30
Cultural Competency Overview	4	0	18	18
African American Culture	4	4	21	21

Middle Eastern & East African Cultures	4	4	23	23
Native American Culture	4	4	32	32
An Overview of Middle Eastern Culture	4	4	36	36
Filipino-Americans and Mental Health	4	4	30	30
Gender Differences in the Workplace	4	0	26	26
Understanding Diversity in Homelessness	4	0	37	37
Disability Awareness Training	3	0	21	21
Engaging Multiple Generations in the Workplace	4	0	27	27
Working with Hispanic/Latino Older Adults	5	5	17	17
Cross Cultural Encounters Bridging Worlds of Difference	7	6	21	21
Microaggressions	4	4	30	30
FY 2018-19				
Title	Hours	CEUs	Enrolled	Completed
Understanding Diversity in Homelessness	4	4	29	29
Gender Identity and Sexual Orientation Assessment: Best Practices for All Orientations	4	4	26	26
Engaging Multiple Generations in the Workplace	4	4	16	16
The Role of Migration on the Identity of Latina Women	4	4	27	27
Understanding Diversity in Homelessness	4	4	20	20
Gender Dysphoria: Beyond the Diagnosis	4	4	35	35
Introduction to African American Culture	4	4	34	34
Cultural Competency Overview	4	4	16	16
Gender Differences in the Workplace	4	4	21	21
Cultural Competency Overview	4	4	13	13
Principles of Disability Etiquette	4	4	19	19

Understanding Diversity in Homelessness	4	4	26	26
Filipino-Americans and Mental Health	4	4	26	26
A Look at Poverty	3.5	0	20	20
Intro to Diversity and Inclusion	2	0	29	29
FY 2019-20				
Title	Hours	CEUs	Enrolled	Completed
Introduction to African American Culture	4	4	68	67
Gender Differences in the Workplace	4	4	66	48
Disability Awareness and Etiquette	4	4	59	46
Understanding Diversity in Homelessness	4	4	35	28
Filipino-Americans and Mental Health	4	4	26	26
Self-Awareness, Implicit Bias, and Cultural Responsivity	8	7	26	26
A Look at Poverty	3	3	29	20
Gender Dysphoria: Beyond the Diagnosis	4	4	33	24
Middle Eastern and East African Culture	4	4	32	30
FY 2020-21				
Title	Hours	CEUs	Enrolled	Completed
Trauma-informed Approaches in Working with Individuals Experiencing Homelessness	2	2	10	7
Racial and Ethnic Disparities in Healthcare: COVID-19 and the African American Community	2	2	22	19
Talking about Racial Equality	2	2	12	9
Implicit Bias I	4	4	10	7
Implicit Bias II	4	4	15	11
Understanding Racial and historical trauma	4	4	6	4

Understanding and Addressing Trauma in the Families we Serve	4	4	15	12
Working with Hispanic/Latino Older Adults	5	5	3	3
Gender Identity and Gender Variance	4	4	4	4
Cultural perspectives on Family Driven Care	3	3	6	6
Racial / Ethnic Difference in Mental Health Service	2	2	7	7
Resilience in African American Children and Adolescents	8	8	3	3
Human Diversity: Current Multicultural Issues in Research and Therapy	3	3	4	4

CULTURALLY COMPETENT TRAINING ACTIVITIES

III. Relevance and effectiveness of all cultural competence trainings.

The County shall include the following in the CCPR:

- A. *Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:*
 - 1. *Rationale and need for the trainings: Describe how the training is relevant in the addressing identified disparities.*

Rationale: “The Institute of Medicine (IOM) report, *Unequal Treatment*¹, recommended that all health care professionals should receive training in cross-cultural communication—or cultural competence—as one of multiple strategies for addressing racial/ethnic disparities in health care. This recommendation emerged from robust evidence highlighting the fact of health care providers failing to acknowledge, understand, and manage socio-cultural variations in the health beliefs and behaviors of their patients that may impede effective communication, affect trust, and lead to patient dissatisfaction, non-adherence, and poor health outcomes, particularly among minority populations. Similarly, another IOM report, *Crossing the Quality Chasm*², noted that patient-centered care—particularly its attributes of being respectful of patients' values, beliefs, and

behaviors—is an essential pillar of quality.” (Excerpt retrieved from: http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Commentary__Linking_Cultural_Competence_Training.14.aspx.)

Formulating a training curriculum has been a developmental process for SDCBHS. It is understood that Cultural Competence trainings improve the attitudes, knowledge, and skills of providers. Culturally competent interventions that are embedded in best practices or promising practices, such as IMPACT and Salud, also improve patients' ratings of care. Through the Disparities Report, discussed previously, SDCBHS has been able to pinpoint some of the inequalities which need to be addressed. This report has been brought to the planning groups in the CCRT, and efforts have been made to start addressing the disparities. RIHS, the CCRT Education and Training Committee, and SDCBHS Training and Education Committee (SDCBHSTEC) have been working together to create coursework curricula to address disparities as outlined in the Cultural Competence Training Plan.

Need: In FY 2015-16, approximately 65% of the SDCBHS population was ethnically diverse, compared to 54% of the SDCBHS workforce. The profiles of the provider staff and the SDCBHS client profiles are dissimilar, as can be seen from the following chart reproduced from the WET Needs Assessment conducted in 2008, 2013, and 2016. The need for staff to receive cultural competence training is apparent in order to have clinicians/direct service staff to work as effectively as possible with their clients. The following chart is a comparison of the workforce and the clients served in 2013 and a recent assessment conducted in 2016.

MH Workforce/Client Comparison

Race/ Ethnicity	2013 Workforce	FY 2012- 13 Mental Health Clients	2016 Workforce	FY 2015-16 Mental Health Clients	2016 Comparison*	Change from 2013 to 2016	FY 2018-19 Mental Health Clients
<i>White</i>	41%	39%	37%	36%	+ 1%	- 4%	41%
<i>Hispanic</i>	25%	33%	28%	32%	- 4%	+ 3%	27%
<i>African American</i>	11%	12%	8%	11%	- 3%	- 3%	12%
<i>Asian/ Pacific Islander</i>	10%	4%	10%	5%	+ 5%	0%	5%
<i>Native American</i>	0.9%	0.6%	0.5%	0.6%	- 0.1%	- 0.4%	0.7%
<i>Other/ Unknown</i>	12%	10%	16%	15%	+ 1%	+ 4%	14%

* +/- indicates that a race/ethnicity is more/less represented in the workforce than the proportion of clients in the mental health system.

Starting FY 2019-20, SDCBHS began tracking race/ethnicity of its MHS workforce using the data entered into CCBH by providers. Additionally, in collaboration with Optum, SDCBHS is working on developing a System of Care database which would enable tracking of workforce and client

race/ethnicity information more efficiently in the coming years for both mental health and substance use programs.

2. Results of pre/post-tests (counties are encouraged to have a pre/post-test for all trainings);

SDCBHS contractors are encouraged to have pre/post tests for their trainings. TKC and RIHS utilize pre/post-tests routinely for cultural competency courses. CRF, MHS, Inc., and New Alternatives provide their own cultural competence trainings for their staff.

3. Summary report of evaluations; and

Since almost 1,000 trainings (both web- and classroom-based) took place throughout San Diego County and were provided by a variety of providers, there has not been a summary report of evaluations created. However, all trainings conducted through RIHS and TKC have surveys to allow for participant feedback. RIHS also evaluates the transfer of learning as part of the evaluation process.

**NOTE: RIHS, along with other training departments of service provider agencies, has the capability to provide summary of trainings they offer.*

**NOTE: TKC retains the evaluation data on all cultural competence classes, which are reviewed to influence the selection of future instructors and topics. These data are utilized for the annual report that is submitted to the State.*

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

The County works with providers to rate their own agency's cultural competence through the Cultural and Linguistic Competence Policy Assessment (CLCPA). The assessment was first implemented in October 2017 as a replacement to the Cultural Competence Program Annual Self-Evaluation (CC-PAS). The assessment's goals are to: enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. It is expected that improvement will be seen as staff advances in their cultural competence skills. Staff competence can also be measured by a biennial administration of the Promoting Cultural Diversity Self-Assessment (PCDSA), a replacement to the California Brief Multicultural Competence Scale (CBMCS). PCDSA was first implemented in 2018, and its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The CLCPA is completed by the program managers, and the PCDSA is completed by all staff.

2020 CLCPA Report

In February 2020, the SDCBHS QI unit administered the CLCPA among contracted MHS and SUD programs, and distributed program-level results to CORs. SDCBHS CORs will continue to incorporate this tool in monitoring their respective programs. A total of 228 programs responded to the survey, with 161 (70.6%) from MHS, and 67 (29.4%) from SUD Services.

Results show that:

- The majority of respondents were in a Program Manager or Program Director role (49.8% and 40.8%, respectively). Almost 10% of respondents indicated that they held another position at the program. The same breakdown of respondents was recorded for the 2019 CLCPA.
- Respondents reported that they were fairly or very familiar with the diverse communities and the demographic makeup of their service areas. These results are almost identical to those from 2019.
- Majority of respondents indicated some form of personal and program staff involvement in the communities’ culturally diverse activities.
 - The majority of respondents indicated support for cultural competence in the overall organizational philosophy most of the time or all the time.
- About four-out-of-five respondents reported collaborating with community-based organizations to address the health and mental health needs of culturally diverse groups in their service area.
 - More than three quarters of the respondents (77.6%) indicated that their organizations identified opportunities for staff to share their experiences and knowledge about diverse communities with colleagues most of the time or all the time. This proportion has fell by about 3% compared to those reported in the 2019 CLCPA.
- Responses indicated that the organizations’ staff were relatively diverse culturally and linguistically, with Peer Support Specialists and support staff as the most diverse classifications, and the board members and executive management as the least diverse. These results were similar to those reported on the 2019 CLCPA.
 - Upon review of the 2020 CLCPA at a SDCBHS CCRT meeting, the attendees discussed methods by which the low level of diversity among leadership and executive management positions could be addressed.
- According to the respondents, the programs use trained medical interpreters more regularly than certified medical interpreters or sign language interpreters. While nearly half of the respondents indicated that their organizations regularly evaluate the quality and effectiveness of these services, about a fifth reported that their organizations never or seldom did so; this proportion is identical to those reported on the 2019 CLCPA.
- Most of the technical assistance (TA) requests from the participating providers were related to community engagement, the CLAS Standards, interpretation services, beneficiary materials, assessment tools, and whole person wellness.
- Nearly all respondents (98.7%) indicated that their organizations’ Cultural Competence Plans identified and supported the CLAS Standards.

The 2020 CLCPA Report is available in Appendix 22.

2018 PCDSA Report

In February 2018, the SDCBHS Quality Improvement unit requested each contracted Mental Health Services (MHS) and Substance Use Disorder (SUD) program manager to distribute the PCDSA to their organization for completion. A total of 2,672 respondents completed the survey: 2,195 for MHS and 477 for SUD. The program level data was distributed to the Programs/CORs in October 2018. The survey data shows that the provider’s self reported Values and Attitudes are overall aligned with the diverse populations they serve. The PCDSA supports SDCBHS’ commitment to a culturally competent workforce and upholds the guidelines described in the Cultural Competence Plan and Handbook. These documents are located in the SDCBHS Technical Resource Library in Cultural Competence [section 4.4](#). The next round of PCDSA was conducted in October 2020.

The table below presents the PCDSA respondents in 2018 compared to clients served for FY 2016-17.

Race (MHS & SUD)	2018 Staff Survey Respondents		FY 2016-17 Clients	
	Count	%	Count	%
White	1,119	41.9%	26,435	38%
Hispanic	792	29.6%	23,345	33%
African-American	229	8.6%	8,147	11.7%
Multirace/Mixed	227	8.5%	2,735	4%
Asian/Pacific Islander	212	7.9%	3,084	4%
Unknown	33	1.2%	5,579	8%
Other	25	0.9%	N/A	N/A
Native American	24	0.9%	588	0.8%
African	4	0.1%	N/A	N/A
Latino	3	0.1%	N/A	N/A
Caucasian	2	0.1%	N/A	N/A
Latino non-Hispanic	1	0.0%	N/A	N/A
Mexican-American	1	0.0%	N/A	N/A

Primary Language	Count	%
Only English	1,382	52%
Spanish*	979	37%
All Other Languages	133	5%
Tagalog*	59	2%
Arabic*	41	2%
Farsi*	29	1.1%
Vietnamese*	25	0.9%
American Sign Language	24	0.9%

Second Language	Count	%
No Second Language	2,532	95%
All Other Languages	99	4%
Spanish*	17	1%
American Sign Language	11	0.4%
Tagalog*	11	0.4%
Farsi*	2	0.1%

*Threshold languages

Staff Position	Staff Survey Respondents					
	MHS		SUD		Combined (MHS & SUD)	
	Count	%	Count	%	Count	%
Direct Service Provider	1,220	56%	256	54%	1,476	55%
Indirect/Support Services	258	12%	89	19%	347	13%
Manager/Supervisor	269	12%	75	16%	344	13%
Peer Support Specialist/Youth Support Partner/Family Support Partner	323	15%	28	6%	351	13%
Program Director or Other Senior/Executive Level Staff	125	6%	29	6%	154	6%

Key Findings:

- The majority of staff survey respondents answered "Things I do occasionally" or "Things I do frequently".
- Section 1 pertaining to Physical Environment, Materials, and Resources reflect the greatest need overall.
- Question 4, pertaining to offering food that is unique to the community's ethnic group, shows the most need - 12% of respondents answered "Did not occur to me".
- The greatest disparity between MHS and SUD staff responses is reflected in the results for Question 37, pertaining to awareness of cultural-specific healing methods). A total of 3% of MHS respondents answered "Did not occur to me" compared to 29% of SUD respondents. The same proportion of MHS respondents (30%) answered "Things I do occasionally" to this question.

The 2018 PCDSA Report is available in Appendix 23.

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

SDCBHS leverages the CLCPA, the PCDSA, the CLAS Standards, and entity-specific Cultural Competence Plans to measure change in the levels of cultural competence on provider and staff levels. To measure the effectiveness of cultural competence training over time, the Disparities Report, as discussed previously, is conducted every three years, anticipating positive changes in retention and penetration rates. The contractors are required to have a Cultural Competence Plan in place, the program managers are required to complete the CLCPA annually, and all program staff are required to complete the PCDSA every two years. These requirements are outlined in each program’s contract.

SDCBHS also collects consumer satisfaction data from youth and adult clients in the Substance Use Disorder (SUD) system of care. The method used to obtain this data is the Treatment Perceptions Survey (TPS). Many questions on the TPS focus on client access and satisfaction with services provided by the SUD system of care. The TPS gives a snapshot of how clients are feeling about the substance use disorder services they are receiving within San Diego County. This consumer satisfaction survey helps ensure staff are currently, as well as over time, utilizing skills learned from various trainings, meetings, and guidelines.

Key findings from the **2018 Youth TPS:**

- ❖ **Perception of Access**
 - Convenience of the location of treatment services had the highest dissatisfaction compared to any other item in the TPS (7%).
- ❖ **Perception of Quality and Appropriateness**
 - 91% of youth clients agreed or strongly agreed the staff treated them with respect.
- ❖ **Perception of the Therapeutic Alliance**
 - 81% of the youth clients agreed or strongly agreed with having a positive therapeutic alliance with the staff members who provided them services.
- ❖ **Perception of Care Coordination**
 - Overall, 76% of youth clients reported satisfaction within the *Perception of Care Coordination* domain.
- ❖ **Perception of Outcome Services**
 - The *Perception of Outcome* domain had the overall lowest satisfaction rating among youth clients compared to the other six domains.
- ❖ **General Satisfaction**
 - Only 71% of youth clients agreed or strongly agreed that they would recommend the services to a friend who is in need of similar help.

Key findings from the **2018 Adult TPS:**

- ❖ **Perception of Access**
 - Convenience of the location of treatment services had the highest dissatisfaction compared to any other item in the TPS (5%).
- ❖ **Perception of Quality and Appropriateness**
 - 91% of adult clients agreed or strongly agreed the staff spoke to them in a way they could understand.
- ❖ **Perception of Care Coordination**
 - The *Perception of Care Coordination* domain had the overall lowest satisfaction rating among adult clients compared to the other four domains (80%).
- ❖ **Perception of Outcome Services**
 - 88% of adult clients agreed or strongly agreed as a direct result of the services they are receiving, they are able to do things that they want to do.
- ❖ **General Satisfaction**
 - 91% of adult clients agreed or strongly agreed they felt welcomed at the place where they received services.

Key Findings from **2019 Youth TPS:**

- ❖ **Perception of Access**

- Systemwide, 91.1% (0.8% increase compared to 2018) of Parent/Caregivers reported satisfaction with *access to services*; 81.9% (2.9% increase compared to 2018) of youth reported satisfaction with this domain.
- While reported dissatisfaction with convenience of the location of treatment showed a 3% improvement, this item remained the one with highest dissatisfaction compared to any other item in the TPS.
- 100% of Native American respondents reported satisfaction with *access*, followed by 90% of Hispanic respondents.
- ❖ **Perception of Cultural Sensitivity**
 - Systemwide, 97.8% of Parent/Caregivers reported satisfaction with *cultural sensitivity of services* (0.4% increase compared to 2018); 93.5% of youth services reported satisfaction with this domain (1.1% increase compared to 2018).
 - 97.8% (0.4% increase compared to 2018) of parents/caregivers reported to have been treated with respect; 92.1% (1.1% decrease compared to 2018) of youth who received outpatient services reported satisfaction with this item.
 - 96.1% of Asian/Pacific Islander respondents reported satisfaction with the *cultural sensitivity* domain.
- ❖ **Perception of Participation in Treatment Planning**
 - Systemwide, 94.4% (2.8% increase compared to 2018) of parents/caregivers reported satisfaction with *participation in treatment planning*; 82.3% (2.2% increase compared to 2018) of youth reported satisfaction with this domain.
 - Over 90% of parents/caregivers reported to have chosen their child’s treatment plans and goals; both items presented improvements compared to 2019 data.
 - 100% of Native American respondents reported satisfaction with *participation in treatment planning*; 85.2% of African American respondents reported satisfaction with this domain.
- ❖ **Perception of Outcomes of Services**
 - Systemwide, 68.6% (1.1% increase compared to 2018) of parents/caregivers reported satisfaction with *outcomes of services*; 65.6% (0.4% decrease compared to 2018) of youth reported satisfaction with this domain.
 - 73.4% (1.8% increase compared to 2018) of parents/caregivers reported their child to have improved in handling daily life as a result of services received.
 - 60.2% (3.5% decrease compared to 2018) of White respondents reported satisfaction with *outcomes of services*; this group reported the lowest satisfaction with this domain.
- ❖ **Perception of Functioning**
 - Systemwide, 71.9% (0.9% increase compared to 2018) of parents/caregivers reported satisfaction with *functioning* domain; 71.6% (1.7% increase compared to 2018) of youth reported satisfaction with this domain.
 - While results collected from youth are consistently lower than those of parents/caregivers for all domains, they reported the most similar satisfaction level for this domain.
 - 61.8% (3.6% decrease compared to 2018) of youth reported to better get along with family members as a result of services received.
 - 74.8% (1.5% increase compared to 2018) of Hispanic respondents reported satisfaction with this domain.
- ❖ **Perception of Social Connectedness**

- Systemwide, 91.7% (2.2% increase compared to 2018) of parent/caregivers reported satisfaction with the *social connectedness* domain; 83.0% (0.9% increase compared to 2018) of youth reported satisfaction with this domain.
- 84.1% (2.2% increase compared to 2018) of youth reported to have people with whom they are comfortable talking about their problems.
- 90.7% (0.8% increase compared to 2018) of Asian/Pacific Islander respondents reported satisfaction with this domain.
- ❖ **General Satisfaction**
 - 85.3% of youth reported an overall satisfaction with the services they received; 92.1% of parents/youth reported an overall satisfaction.

Key findings from the **2019 Adult TPS**:

- ❖ **Perception of Access**
 - 86% (1% increase compared to 2018) reported satisfaction with *access* to services.
 - Convenience of the location of treatment services had the highest dissatisfaction compared to any other item in the TPS (5%), but feedback in this area was overall positive.
 - Among the different ethnic groups, Latinx respondents reported the highest satisfaction with *access*.
- ❖ **Perception of Quality and Appropriateness**
 - 90% (2% increase compared to 2018) reported satisfaction with *quality and appropriateness* of services.
 - 93% of adult clients agreed or strongly agreed the staff spoke to them in a way they could understand.
 - Among different ethnic groups, American Indian/Alaskan Native respondents reported highest satisfaction with *quality and appropriateness*.
- ❖ **Perception of Care Coordination**
 - 82% (2% increase compared to 2018) reported satisfaction with *care coordination*.
 - The *Perception of Care Coordination* domain had the overall lowest satisfaction rating among adult clients compared to the other four domains (82%).
 - Among different ethnic groups, Latinx respondents reported the highest satisfaction with *care coordination*.
- ❖ **Perception of Outcome Services**
 - 85% (3% increase compared to 2018) reported satisfaction with *outcome services*.
 - 85% of adult clients agreed or strongly agreed as a direct result of the services they are receiving, they are able to do things that they want to do.
 - Among ethnic groups, American Indian/Alaska Native respondents reported highest satisfaction with this domain.
- ❖ **General Satisfaction**
 - 90% (3% increase compared to 2018) reported an overall satisfaction with services.
 - 92% of adult clients agreed or strongly agreed they felt welcomed at the place where they received services.
 - Among ethnic groups, Native Hawaiian/Pacific Islander respondents reported the lowest general satisfaction, while American Indian/Alaska Native reported highest satisfaction.

In 2020, the Treatment Perceptions Survey (TPS) was offered between November 9, 2020 and November 13, 2020, to all clients who were receiving substance use disorder services from a

provider. As a result of the COVID-19 pandemic, the TPS was newly administered in an electronic web-based format. However, for many clients who continued to receive in-person services, specifically in SUD Withdrawal Management and Residential Care, paper copies of the survey were available upon request.

Key Findings from the **2020 Youth TPS** (available in Appendix 24):

- ❖ **Perception of Access**
 - 85% of youth clients agreed or strongly agreed that services were available at convenient times.
- ❖ **Perception of Quality and Appropriateness**
 - 99% (15% increase from 2019) of youth clients agreed or strongly agrees the staff treated them with respect.
- ❖ **Perception of the Therapeutic Alliance**
 - 95% (10% increase from 2019) of youth clients agreed or strongly agreed the staff members who provided them services took the time to listen to what they had to say.
- ❖ **Perception of Care Coordination**
 - Overall, 95% of youth clients agreed or strongly agreed the staff members who provided them services made sure that their health and emotional health needs were being met.
- ❖ **Perception of Outcome Services**
 - About three quarters (77%) of youth clients agreed or strongly agreed that they are better able to do things they want to do as a result of the services they received.
- ❖ **General Satisfaction**
 - 93% of youth clients agreed or strong agreed to be overall satisfied with the services they have received.
- ❖ **Satisfaction by Race/Ethnicity**
 - Satisfaction and perception of outcome within all six domains varied widely among different racial/ethnic groups. Overall, youth with Unknown/Missing Race information reported the greatest satisfactions averaged across all six domains.
 - Multiracial youth reported the lowest satisfaction averaged across all six of the domains.
 - Across all racial/ethnic group youth reported the greatest satisfaction averages in the *Perception of Therapeutic Alliance* domain compared to the other domains.

Key findings from the **2020 Adult TPS** (available in Appendix 25):

- ❖ **Perception of Access**
 - Convenience of the location of treatment services had the highest dissatisfaction compared to any other item in the TPS (5.4%), but overall feedback in this area was positive.
- ❖ **Perception of Quality and Appropriateness**
 - 93.5% (0.5% increase from 2019) of adult clients agreed or strongly agreed the staff spoke to them in a way they could understand.
- ❖ **Perception of Care Coordination**
 - The *Perception of Care Coordination* domain had the overall lowest satisfaction rating among adult clients compared to the other four domains (84.8%).
- ❖ **Perception of Outcome Services**
 - 86.7% (1.7% increase from 2019) of adult clients agreed or strongly agreed as a direct result of the services they are receiving, they are able to do things that they want to do.
- ❖ **General Satisfaction**

- 93.6% (1.6% increase from 2019) of adult clients agreed or strongly agreed they felt welcomed at the place where they received services.
- ❖ **Satisfaction by Race/Ethnicity**
 - Asian adults reported the lowest satisfaction averaged across all five of the domains.
 - American Indian/Alaskan Native adults were among the highest reported overall satisfaction across all five domains in the services they received.

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR:

A. *Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:*

- *Cultural-specific expressions of distress (e.g., nervous);*
- *Explanatory models and treatment pathways (e.g., indigenous healers);*
- *Relationship between client and mental health provider from a cultural perspective;*
- *Trauma;*
- *Economic impact;*
- *Housing;*
- *Diagnosis/labeling;*
- *Medication;*
- *Hospitalization;*
- *Societal/familial/personal;*
- *Discrimination/stigma;*
- *Effects on culturally and linguistically incompetent services;*
- *Involuntary treatment;*
- *Wellness;*
- *Recovery; and*
- *Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.*

SDCBHS contracts with RIHS, which, in turn, has a contract with National Alliance on Mental Illness (NAMI) to provide trainings on adult client culture. The NAMI contract has the following objectives:

- A minimum of 90 clients will participate in peer education training to encourage client awareness of mental illness, coping skills, resources available, and mutual support possibilities (10 two-hour classes).
- A minimum of 10 people will complete the peer education “Train the Trainer” course.
- Family education materials are available in English, Spanish, Farsi, Vietnamese, and Arabic. Peer education materials are available in English and Spanish.

Furthermore, The Consumer Family Pathways Program includes: Provider Education Training conducted by consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and family members trained as Family-to-Family Education Program teachers who have been

certified through the NAMI Provider Education Training. These series of trainings focus on current providers in the public mental health system. A penetrating, subjective view of family and consumer experiences with serious mental illness, this training helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness. The training focuses on family culture, client culture, and provider culture, and will also play an important role in educating contract agencies and County-operated programs on the benefits of hiring and advancing consumers.

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

1. Family focused treatment;

NAMI San Diego's Family Education Services program provides countywide family education focused on the challenges experienced by family members who have a loved one living with mental illness. This free program for adults (18 and older) is comprised of a series of 12 classes for the families of persons with serious and persistent brain disorders (mental illnesses). These classes are small and represent a new concept and curriculum. In this model, the course co-teachers are family members themselves and the course has been designed and written by an experienced family member-mental health professional. The course balances education and skill-training with self-care, emotional support and empowerment. These Family-to-Family classes were conducted in English, Spanish, Vietnamese, and Arabic in the six regions designated by the County of San Diego (East, North Inland, North Coastal, South, Central and North Central).

2. Navigating multiple agency services; and

Training on navigating resources and services is part of the trainings and outreach efforts at RI International, NAMI, and through RIHS.

3. Resiliency

Training on resiliency is embedded throughout many of the offered trainings. One example is the web-based Cultural Competence course, a three-hour class providing an introduction to cultural competence, discussed earlier in the Plan.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 5:

- To develop new trainings and enhance current trainings with focus on equity, diversity, and inclusivity.
- To enhance the client culture, RI and NAMI will promote additional trainings and venues for peer and family discussions.

County's Commitment to Growing A Multi-Cultural Workforce:
HIRING AND RETAINING CULTURALLY AND
LINGUISTICALLY COMPETENT STAFF

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

The County shall include the following in the CCPR:

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

The initial assessment of the County of San Diego's behavioral health workforce was conducted in 2008, and the findings were submitted as part of the Exhibit 3: Workforce Needs Assessment. A follow-up assessment was conducted in 2013 and in 2016. The results of the 2016 assessment are summarized below and continues to be the most current needs assessment available. The diversity of the behavioral health workforce was reassessed in 2020. Historically, the workforce assessment was required for the mental health system. SDCBHS will also be examining the workforce of the substance use programs in the future.

Shortages by Occupational Category

Approximately 82% of the County of San Diego's behavioral health workforce is contracted staff employed by community-based organizations (CBO) or network providers. The County itself employs most of the remainder of the workforce. From 2013 to 2016, the workforce of the County-operated programs grew by 29%.

Current workforce distribution figures indicate that the highest percentage of positions are in Unlicensed Mental Health Direct Staff (30.9%), followed by Licensed Direct Staff (24.8%) and Support Staff (22.1%). A comparison with the initial assessment shows an increase in the proportion of the non-psychiatric health care workforce (such as physicians, nurses, medical assistants, etc.) from 80.1 authorized full-time equivalent staff (FTEs) in 2008 and 186.23 authorized FTEs in 2016.

Comparability of Workforce, by Race/Ethnicity, to Target Population Receiving Public Behavioral Health Services

Both San Diego County's public behavioral health workforce and its target population receiving public behavioral health services are diverse. Examining the workforce by diversity in 2020, the current public behavioral health workforce in San Diego County is 38% Caucasian, 29% Latino/Hispanic, 12% African American, 8% Asian/Pacific Islander, and less than 1% Native American. Similarly, the client diversity is as follows: 41% Caucasian, 29% Latino/Hispanic, 12% African American, 8% Asian/Pacific Islander, and 1% Native American.

In comparison with 2013, the current public mental health workforce is generally more ethnically and culturally diverse. The 2020 workforce assessment demonstrated a smaller gap between the workforce and the mental health population served. The largest shift in the workforce was a 4 percent increase in the Black/African American workforce.

Race/ Ethnicity	2013 Workforce	FY 2012-13 Mental Health Clients	2016 Workforce	FY 2016-17 Mental Health Clients	2020 Workforce	FY 2019-20 Mental Health Clients
<i>White</i>	41%	39%	37%	38%	38%	41%
<i>Hispanic</i>	25%	33%	28%	35%	29%	28%
<i>Black/ African American</i>	11%	12%	8%	12%	12%	13%
<i>Asian/ Pacific Islander</i>	10%	4%	10%	5%	8%	5%
<i>Native American</i>	0.9%	0.6%	0.5%	0.6%	0.4%	1%
<i>Other/ Unknown</i>	12%	10%	16%	13%	7%	11%

SDCBHS also exercises inclusive contracting strategies in procurement and contract administration activities that can demonstrate the commitment in increasing contractor and supplier diversity. Medi-Cal eligible residents are low-income by definition and as such are disproportionately more likely to struggle with social and economic factors that can negatively impact behavioral health. These factors, referred to as the social determinants of health (SDOH), are rooted in unequal distribution of resources. SDCBHS has a responsibility to ensure that its contracted programs address the social determinants of health and that the contracted service providers within the network of care provide accessible, equitably-distributed services to the local populations most in need. To this end, data analytics of diverse populations are evaluated to meet specific needs within the community, and outreach to diverse providers include a variety of opportunities that involve shared and collected information for incorporation in the planned procurement and contract design process.

- Focus areas for procurement equity in awarding and extending provider contracts include:
- Integrated services to reduce health-system silos and improve access to care.
- Behavioral health services provided in primary care settings to engage the most underserved and hard to reach individuals in the rural communities in the East and North Inland HHSR Regions of the county.
- Specialty outpatient services to address population-specific needs and enhanced with service components or elements to address and mitigate social determinants of health.
 - Outpatient services to address the needs of youth, adolescents and young adults who live in San Diego County and are at risk, or currently involved in commercial sexual exploitation and their families.
 - Outpatient behavioral health services for LGBTQ+ youth which includes components to address the additional vulnerabilities of LGBTQ+ youth who may not have access to affirming communities and are at higher risk for negative health outcomes.

- Youth with high needs who are involved with the foster care system to maintain placement in the home or home-like environment
- Gender-Specific SUD outpatient services and supports for clients who are pregnant and parenting.
- Positive Parenting Program to reduce the risk of behavioral/emotional problems in young children of families living in under-resourced and underserved communities of color, including Asian, Black, Latino and Pacific-Islander.

Positions Designated for Individuals with Consumer and/or Family Member Experience

Consumers and family members offer a wealth of life experiences, cultural competencies, compassion, understanding of the behavioral health system, and related resources. They assist in linking consumers to services, provide useful information on navigating the behavioral health system, and give much-needed encouragement and moral support to their peers.

The number of specifically designated consumer/family positions in the public behavioral health workforce tripled from 54.2 FTEs in 2008 to 163.8 FTEs in 2013. It decreased slightly in 2016, but the number of the Peer Support Specialists increased by 16%.

Position with Lived Experience	2013 # of FTEs	2016 # of FTEs
<i>Peer Support Specialists</i>	18.7%	23.4%
<i>Family Support Specialists</i>	34.6%	17.8%
<i>Managerial/Supervisory</i>	9.6%	3.4%

In a 2020 assessment for the adult/older adult programs it was noted that there were 115.8 FTE peer positions among a total of 162 peer staff.

Language Proficiency

The threshold languages for San Diego County are English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic. In addition to these threshold languages, multiple other linguistic needs were previously identified, including Chaldean, Hmong, Cambodian, Laotian, Somali, Russian, and Swahili. According to the 2016 workforce assessment, 27% of the workforce speaks Spanish. Additionally, contracted programs employ staff fluent in over 20 unique languages.

The table below shows the breakdown of languages spoken by staff from the 2016 workforce assessment.

Language Spoken by Staff	Level of Staff	2016 # of FTEs
Spanish*	Direct Service Staff	322
	Others	133
Tagalog*	Direct Service Staff	20
	Others	5
Vietnamese*	Direct Service Staff	12
	Others	3

Arabic*	Direct Service Staff	9
	Others	2
Russian	Direct Service Staff	8
	Others	1
Cambodian	Direct Service Staff	3
	Others	3
Sign Language	Direct Service Staff	3
	Others	2

**Indicates a threshold language*

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

As outlined above, in comparison with 2013, the public behavioral health workforce is generally more ethnically and culturally diverse; however, some cultural and ethnic groups remain under-represented. For example, in 2016 35% of the behavioral health client population was Hispanic/Latino which was 7% higher than the total Hispanic/Latino workforce. In 2020, this gap was much closer, with only 1% difference.

The WET Plan also notes that Unlicensed Direct Staff and Support Staff are the closest in proportions to the diversity of those being served, while licensed, management/supervisory, and other healthcare position classifications are significantly less representative of the diversity of those being served. This indicates a shortage of therapists, psychologists, and psychiatrists with bilingual skills that are needed by the behavioral health population.

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

The County of San Diego Behavioral Health Services (SDCBHS) did not receive cultural consultant technical assistance recommendations.

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

Target Reached:

Obtained a broad spectrum of stakeholder input on education and training needs

The target was built upon Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) planning processes which included over 950 adult and older adult client surveys in the threshold languages at the time of distribution (English, Spanish, Vietnamese, Tagalog, and Arabic) and 700 family member surveys, 60 stakeholder meetings, and ongoing input from CYF, Adult, and Older Adult Care Councils.

Target Reached:

Developed a workforce needs assessment:

- Contracted with SDSU Research Foundation Academy for Professional Excellence (APE) to lead the effort and provide expert advice.
- *Phase 1:* Collected baseline information from a broad range of stakeholder and community members involved with the public behavioral health system. The efforts included 25 semi-structured focus groups, and members of hard-to-reach communities were especially sought out for participation. Over 50 Key Informant Interviews were conducted with individuals who had in-depth experience with targeted key populations. Additional focused surveys were administered to a target group of 290 clients/family members, program managers, and direct behavioral health service providers. Finally, existing County data was aggregated.
- *Phase 2:* Completed data analysis comparing the ethnic and age composition of the San Diego population, SDCBHS behavioral health population, and the workforce. Compiled baseline information about educational institutions in San Diego with programs geared toward behavioral health occupations from high schools to post-doctorate degrees. Conducted an in-depth training assessment survey of 721 BHS staff regarding specific training needs. Also conducted additional Key Informant Interviews with community partners with workforce development expertise.

Target Reached:

Developed WET Needs Plan:

- Community and stakeholder input on WET Needs Assessment gathered through System of Care Councils, and contractor and County staff meetings.
- WET Work Group, which included subject matter experts from Key Informants, SDCBHS staff, and stakeholder representatives.
- A Cross Threading Group, composed of stakeholders from all groups, but who would not financially benefit from any contracts, reviewed the recommendations and set priorities for funding. The recommendations were brought to three planning presentations around the County open to the behavioral health community and the public.

Target Reached:

Behavioral Health Board Approval and Submission to the State:

- Final input from community meetings was incorporated into the WET Plan.
- The WET Plan was submitted to the Mental Health Board and approved in April 2009.

Target Reached:

Program Procurement and Implementation:

- Currently, the target populations reached include the current public behavioral health workforce through the behavioral health training component under Training and Technical Assistance. San Diego State University Foundation, Academy of Professional Excellence is the County's current contractor through Responsive Integrated Health Solutions (RIHS) to provide behavioral health training to SDCBHS staff and County-contracted behavioral health providers. Training topics are numerous, but always include cultural competency components, including a Cultural Competency Academy that was implemented in 2012 and subsequently re-procured in 2018. The curriculum development committees include persons with lived experience.

- SDCBHS implemented the Consumer/Family Academy with Early Implementation Activities funding under Training and Technical Assistance. The Consumer Family Pathway had been incorporated into the Public Behavioral Health Pathways. The County contracts with NAMI and Recovery Innovations to provide targeted training and support to consumers and family members.
- During the program development process, each WET program was required to address the following components in their Statements of Work:

Target Population

- 1.1. **The contractor shall create culturally and linguistically appropriate, targeted approaches to ethnically and linguistically diverse populations based on community and public behavioral health workforce need. Potential populations may include, but are not limited to:**
 - 1.1.1. **Latino population.**
 - 1.1.2. **Asian/Pacific Islander population.**
 - 1.1.3. **Lesbian, gay, bisexual, and transgender (LGBTQ+) population.**
 - 1.1.4. **Individuals in or recently out of the foster care system.**
 - 1.1.5. **Other populations as defined by County staff, community and public behavioral health workforce need.**

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

During the planning and implementation process, the County of San Diego has learned how valuable it is to expand beyond our traditional behavioral health partners. To ensure the success of the development and implementation of WET programs, outreach included local schools, universities, and workforce developers such as the San Diego Workforce Partnership and the Department of Rehabilitation. SDCBHS worked closely with our community partners to ensure any prospective partners were aware of WET and their potential role along the educational/workforce pathway.

WET programs have successfully engaged culturally and ethnically diverse participants. Some programs have similar state level investments being made, such as stipends for those in training for licensed positions. Programs that have received WET support for curriculum development include the Public Mental Health Academy to facilitate workforce development and career pathways in public behavioral health by offering coursework that leads to a Mental Health Work Certificate. Other activities will require ongoing support from other MHSA funding sources. These include programs focused on enhancing knowledge, skills, and cultural competence of the existing workforce, and those providing training to prepare consumers and family members for employment in the public behavioral health workforce.

F. Identify County technical assistance needs.

SDCBHS would like technical assistance with information on the success of the programs in other counties, and the techniques/processes used to recruit, train, and maintain a culturally diverse and bilingual workforce. It would be helpful to learn of particular strategies that have been successful for specific ethnic populations such as Latino, Vietnamese, Filipino, Arabic, African refugees, and others. SDCBHS would be interested in strategies that have been successful in increasing the cultural and ethnic diversity of licensed clinical staff.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 6:

- SDCBHS will have a BHS Race/Equity Workgroup with newly hired BHS Consultant, Reggie Caldwell, aimed at addressing racial equity in policy development, guidelines and trainings implemented throughout BHS.
- The County will develop and continue to enhance a New Office of Equity and Racial Justice.
- To develop a Contractor Diversity Plan to be included in the RFP process, which would ask contractors to outline linguistic/cultural diversity of staff, workforce efforts/cultural diversity strategies in staffing, outreach plans.

LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The County shall include the following in the CCPR:

- A. *Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:*
 - 1. *Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.*

SDCBHS had been seeking ways to develop the diversity of the systemwide workforce for a number of years, but the lack of available funding for incentives and training was a serious limitation. The inclusion of WET funding in the MHSAs has enabled the County to grow the bilingual staff capacity of its workforce. The WET Plan can be located at: http://sandiego.camhsa.org/files/MHSACERTIFIED3YearPlanFY17_20.pdf.

To specifically address building bilingual staff capacity, the following programs have been developed and implemented. While the programs below were funded through WET, there are several programs that will continue through CSS funding: The San Diego Community College District Public Mental Health Academy, and the Community Psychiatry Fellowship and Child Psychiatry Fellowship, which also include the Nursing Partnership for Public Mental Health Professionals. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually. In FY 2018-19, a portion of CSS funds were transferred to the WET component to continue funding programs.

Action #3: Public Mental Health Credential/Certificate Pathway

This credential/certificate will be part of an accredited institution, such as a community college, and will assist individuals with educational qualifications for current and future employment opportunities. Recruitment would focus on specific shortages in the public mental health direct service areas, as well as on the delivery of services to targeted population groups such as early childhood, youth, transition age youth, adult older adults, and linguistically and culturally diverse communities. Partnering with a community college has a decided advantage in that it will create options for the credential/certificate to be matriculated into AA and/or BA programs to assist those with lower levels of education to move into a career pathway continuum. In addition, when coupled with practicum and mentorship opportunities and/or scholarships or stipends, the credential/certificate pathway could serve to encourage participation from culturally diverse populations, e.g., age, income, ethnicity and/or traditional healers.

The program was selected through a competitive procurement process called Request for Proposal (RFP), and the successful bidders were San Diego Community College District and Alliant International University.

San Diego City College's Public Mental Health Academy is embedded within the Institute for Human Development. The Academy initiates a career pathway for a diverse population of students through a 19-unit Mental Health Work Certificate of Achievement. The certificate

program serves as both workforce development for entry-level positions in the mental health and human services field and as an academic steppingstone toward higher academic degrees in the field of mental health. The Academy has also established a pre-certificate preparation course for potential students who are non-native English speakers. The Public Mental Health Work Certificate of Achievement program started in October 2010. While the initial funding ended in September 2015, an extension of funding was secured for the 2015-2016 academic year specifically to provide continued academic counseling support and administration of the program. The County of San Diego then approved a 5-year grant beginning with the 2017-2018 academic year to again continue on-going academic counseling support to PMHA students and oversight of the program. For the 2019-2020 academic year, 62 students were enrolled in the PMHA/Mental Health Work Certificate program with 42 students completing the certificate, contributing to the 312 total graduates since the program's inception. Many of the most recent graduates of this program are currently in the workforce, serving roles in various organizations such as NAMI San Diego, Rady Children's Hospital, Pathfinders San Diego, and Crestwood Behavioral Health Center. Appendix 26 presents a complete report of this program from FY 2019-2020.

Alliant International University's Community Academy was a partnership between NAMI San Diego, Recovery Innovations (RI) International, the Family Youth Round Table, and the California School of Professional Psychology (CSPP) at Alliant International University. It provided training and employment assistance for individuals with lived experience of mental illness and/or family members, including support provided through pairings with academic and peer mentors. The Community Academy supported the partners' six existing certificates and had facilitated translation of these certificates into academic credit. In addition, the program linked students, partnering agencies, and the community with community trainings and evidence-based literature that address stigma, recovery into practice, and barriers to accessing a career pathway through stipends and support. Additionally, it provided community training addressing stigma about mental illness and recovery. As of March 2016, 59 participants completed the program. Among those who have completed this program, 21 (36%) have a primary language other than English, and 26 (44%) are bilingual. This contract has since ended.

Action #4: School-Based Pathways/Academy

In order to promote mental health careers to students, this action will create a partnership between the County of San Diego and San Diego County schools to implement a mental health component/track to existing established Health Care Pathways programs. The intended result is an increase in the number of high school students who choose to pursue mental health careers. The schools that will be targeted will include those whose enrollments include a high number of students who are linguistically, culturally, and economically diverse. This partnership with the schools affords San Diego County the opportunity to increase the diversity of the mental health workforce, while also reducing the stigma associated with mental illness. Exposure to occupations will include those indicated as priority areas, including both clinical and non-clinical direct positions, as well as a focus on occupations that serve particular areas of need, e.g., early childhood, transition age youth, adult, and older adult, as well as cultural and linguistic diversity.

The Program was selected through the RFP process, and the successful bidder was Health Sciences High and Middle College (HSHMC). HSHMC is a public charter high school that

provides students an opportunity to explore opportunities in healthcare through its college preparatory curriculum, specialized electives and four-year, work-based internship program. With WET funding, HSHMC had created a specialized mental health worker career track for juniors and seniors. Up to 50 students per year participated in the two-year certificate program. Curriculum and specialized activities were offered school-wide to encourage all campus students to take steps toward ending the stigma associated with mental health challenges, to have greater awareness and know more about seeking services for their own needs, and to consider this area of development as part of their own career exploration.

As of August 2015, a total of 103 students had completed the mental health career Pathways program. Among those enrolled in the last contract year 2014-15, 26 (52%) have a primary language other than English, and 44 (88%) are bilingual. The contract ended August 2015.

Action #5: Nursing Partnership for Public Mental Health Professionals

This program is targeted to expand the capacity for developing additional public mental health professionals in nursing occupations that are most needed. Programming would be in coordination with existing nursing pathways at local institutions of higher education. The areas of nursing need are: Clinical Specialists, licensed Vocational Nurses, Registered Nurses, and Psychiatric Nurse Practitioners. Schools that will be targeted will include those whose enrollments include a high number of students that are linguistically, culturally, and economically diverse. Academic instruction will be coupled with practicum and mentorship opportunities with public mental health contractors or with the County of San Diego. The objectives include increasing the skill levels and educational attainment of diverse culturally and linguistically diverse/representative groups and increasing the number of culturally and linguistically diverse individuals working in public mental health occupations.

The Program completed its RFP process, and the successful bidder was California State University San Marcos School of Nursing. WET funding had supported the development of curriculum and teaching modalities for an integrated Psychiatric/Mental Health Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) program. This Advance Practice Nurse received a Master of Science in Nursing, was eligible for national certification, and could practice in inpatient, outpatient or community settings with prescriptive authority and skills in psychotherapy and other treatment modalities. A total of 20 students completed the program. Students represent various ethnic groups such as Caucasian, African American, Asian, Pacific Islander and Middle Eastern. All are fluent in English, one is bilingual in Tagalog and one is bilingual in Arabic. Students ranged in age from 25 to 59 years, with two individuals being veterans. The contract ended August 2015.

Action #6: Community Psychiatry Fellowship

This program is directed toward remedying the shortage of psychiatrists through partnering with a medical school to fund a position(s) with the intent of increasing family medicine/psychiatry fellows with a community psychiatry specialization. The program encourages culturally and economically diverse populations.

Action #7: Child Psychiatry Fellowship

This program is directed toward remedying the shortage of child psychiatrists through partnering with a medical school to fund a position(s) with the intent of increasing family medicine/psychiatry fellows with a community child psychiatry specialization. The program encourages culturally and linguistically diverse populations.

The Community Psychiatry Fellowship program (actions 6 & 7 combined) at UCSD began in fall of 2011. Since Spring 2012, fifteen participants have completed the general community psychiatry fellowship, five participants have completed the child community psychiatry fellowship and twenty participants have completed the psychiatric nurse practitioner program. Additionally, eight participants are currently enrolled in the general community psychiatry fellowship, two enrolled in the child community psychiatry fellowship and eleven enrolled in the psychiatric nurse practitioner program, with two general community psychiatry fellows and one child community psychiatry fellow graduating in June 2020. Among these individuals, four are fluent in Spanish and two in Vietnamese.

Action #8: LCSW/MFT Residency/Intern

This program is directed at increasing the presence of licensed students in San Diego. The County of San Diego will explore developing a partnership with established LCSW and MFT training programs to fund residency/internship slot(s) to offer students compensation in exchange for a commitment to practice in San Diego County's public mental health workforce. The program objectives include having students be fluent in threshold and critically needed languages and be affiliated with under-served or unserved communities including Latino, African American, Vietnamese, Cambodian, Hmong, Lao, and Samoan, and/or experiences or providing services to such communities.

The Program was RFP'd and the two bidders below were successful. The programs started in September 2010.

San Diego State University-LEAD (MFT) – The LEAD Project sought to increase the presence of ethnically and linguistically diverse licensed clinicians in San Diego County by funding stipends for bilingual/bicultural MFT interns in exchange for a commitment to practice in San Diego County's public behavioral health workforce. In addition, this program also provided supervision hours and classes to prepare interns for licensure. As of August 2015, a total of 15 participants had completed the program. Each of these participants were bilingual and bicultural, with a wide range of races/ethnicities and languages represented, including the following:

- Mexican-American female fluent in Spanish
- Italian-American fluent in Spanish
- Latina fluent in Spanish
- Asian-American male fluent in Vietnamese and English
- Hispanic female fluent in both Spanish and English
- Pacific Islander female fluent in Chamorro and English
- Asian female fluent in Spanish and English and able to speak Chinese (more specifically Cantonese)
- Asian female fluent in Chinese (more specifically Mandarin) and English

- Hispanic female fluent in both Spanish and English.
- Iranian male fluent in Farsi and English
- Mexican-American female fluent in Spanish and English
- Cuban female fluent in English and Spanish
- Hispanic female fluent in English and speaks conversational Spanish
- Mexican male fluent in Spanish and English
- German male fluent in German, Spanish and English

The contract ended August 2015.

Alliant International University – Alliant International University, on behalf of San Diego MFT Educators’ Consortium that represents all the MFT programs in San Diego County, is the host of the San Diego County MFT Residency/Internship Program. The program provides three educational stipends each year in exchange for a commitment to work in the County’s public behavioral health system for at least two years.

Action #9: Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff

This program is designed to aid in the recruitment and retention of licensed eligible and culturally, linguistically and/or ethnically diverse public mental health staff to work in both the County and contracting community-based organizations (CBOs). The WET Needs Assessment also revealed a number of positions in licensed and unlicensed direct services were deemed hard to fill, including bilingual clinical positions. The objectives of this program include increasing the ethnic diversity of licensed professionals, increasing the number of employees from underserved backgrounds, and increasing the number of employees with critical linguistic proficiencies.

Financial incentives were awarded on a competitive basis. Criteria included:

- Fluency in threshold and critically needed languages, e.g., Spanish, Vietnamese, Tagalog, Arabic, Chaldean, Hmong, Cambodian, Laotian, Somali and Swahili.
- Culturally underserved, unserved or underrepresented community affiliation e.g., Latino, African American, Vietnamese, Cambodian, Hmong, Lao and Samoan and/or experience providing services to such community members.
- Focus on specific regions or particular cultural/language diversity-focused positions (e.g., rural, non-English speaking, Native Americans, refugees/immigrant populations).

Candidates were selected from a pool of candidates who had submitted a complete application. In addition, the application process included an interview that was used to assess the candidate’s capacity to complete any educational programming required by the designated position and/or their commitment to continuing employment in the public mental health field in San Diego County (i.e., a demonstrable, longstanding family or community ties in San Diego and/or an interest in working within the County for the foreseeable future).

Application pools were opened and reviewed on a semi-annual basis. In years in which no funding was awarded, funding will “roll over” for allocation in future years. Opportunities were explored to leverage financial incentives and assistance funding through coordination and/or

integration with federal, state, regional, and educational financial incentive programs. Candidates were eligible for the following financial incentives, depending on merit and/or need.

Recipients of the larger stipends, scholarships and/or loan assumptions will be contractually obligated to work for Mental Health Services or contracting CBLs after completing studies for a period of time equal to the period in which they received support, with a minimum commitment of two years. Those who do not meet their obligations will be required to reimburse the County for the full amount of assistance.

2. Updates from Mental Health Services Act (MHSA), Community Service and Support (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

WET Plan – Exhibit 3: Workforce Needs Assessment

2016 WORKFORCE NEEDS ASSESSMENT		
III. Language Proficiency		
<i>Language, other than English</i>		<i>Number who are proficient</i>
1. Spanish	Direct Service Staff	322
	Others	133
2. Tagalog	Direct Service Staff	20
	Others	5
3. Vietnamese	Direct Service Staff	12
	Others	3
4. Arabic	Direct Service Staff	9
	Others	2
5. Russian	Direct Service Staff	8
	Others	1
6. Cambodian	Direct Service Staff	3
	Others	3
7. Sign Language	Direct Service Staff	3
	Others	2
8. Lao	Direct Service Staff	N/A
	Others	N/A
TOTAL <i>(All languages other than English)</i>	Direct Service Staff	377
	Others	149

In addition to WET Plan activities to grow bilingual staff, all CSS programs contain a requirement for staff to be able to provide services in languages appropriate for their target populations, and have accordingly made efforts to hire bilingual staff to the maximum degree available. In FY 2018-19, a total of 34,514 CSS clients were served. In FY, 19-20, there was a slight increase to 35,901. (See Appendix 27 for the FY 2019-20 Community Services and Supports report.)

Several CSS Plans focus specifically on providing bilingual services to clients:

- **Health Center Partners (previously Council of Community Clinics)** focuses on primary health and mental health integration for Latinos in their communities through

care provision in 11 community-based, primary-care clinics. Five of the clinics utilize Promotoras to engage Latinos with diabetes and depression through interventions provided in Spanish.

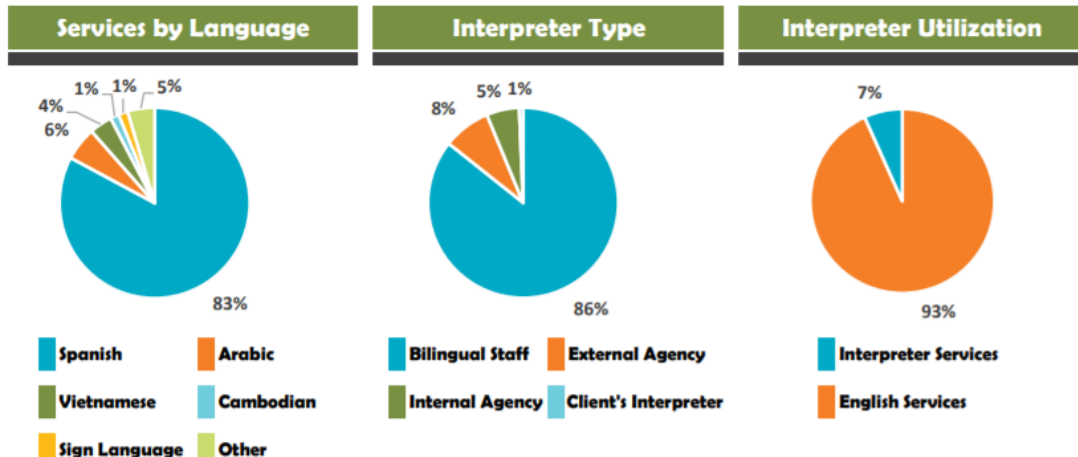
- **Chaldean Middle-Eastern Outpatient Services** provides services to the recently immigrated Middle Eastern community in San Diego who have previously been unable to access mental health programs due to cultural and language barriers. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals.
- **Cultural Language Specific Outpatient Services for Children and Youth** include a Full Service Partnership (FSP) designed to address disparities and reduce stigma associated with mental health services and treatment for Latino and Asian/Pacific Islander (API) populations. This program, with its cultural and language specific services, provides mental health services to seriously emotionally disturbed (SED) Latino and API children and their families, utilizing a comprehensive approach that is community based, client and family focused, and culturally competent. Expanded services include case management, treatment plans that address obesity and diabetes, co-occurring services, and additional outreach and education to targeted populations in the Southeast area. In FY 2018-19, a total of 8,757 clients were served by the Children and Youth Full Service Partnership programs.

3. Total annual dedicated resources for interpreter services.

SDCBHS has provided services to persons with Limited English Proficiency (LEP) through the usage of interpreter services in the entire system of care. In FY 2019-20, a total of 74,981 interpreter services were provided to 7,310 unique clients receiving Mental Health Services. The largest proportion of interpreter services was provided in Spanish (83%), followed by Arabic (6%). Additionally, 11,806 interpreter services were provided to 605 unique clients receiving Substance Use Disorder services. The largest proportion of interpreter services provided to these individuals was in Spanish (68%) followed by American Sign Language (22%).

MH Interpreter Services Report, FY 2019-20

(Please note: Data may be impacted starting March 2020 due to COVID-19)



* Both Tagalog and Farsi (threshold languages) were .5% of interpreter services.

MH Interpreter Services Report, FY 2019-20 (Continued)

Services by Month

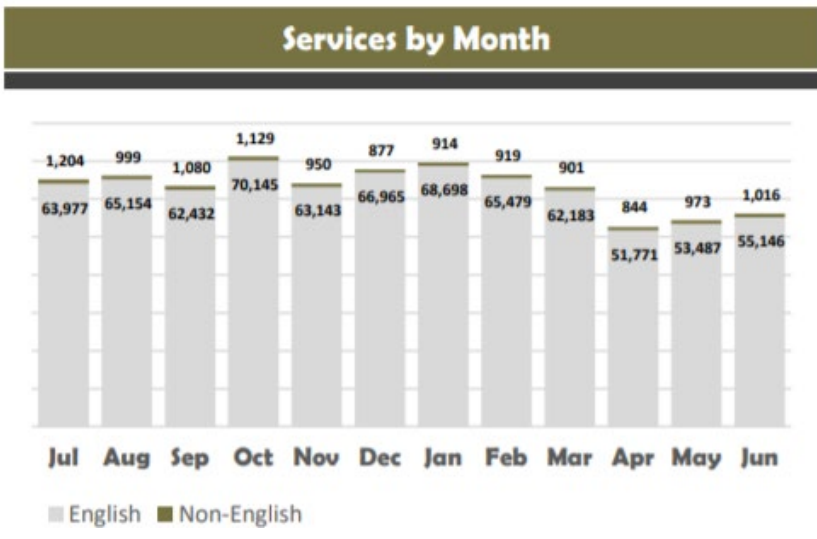
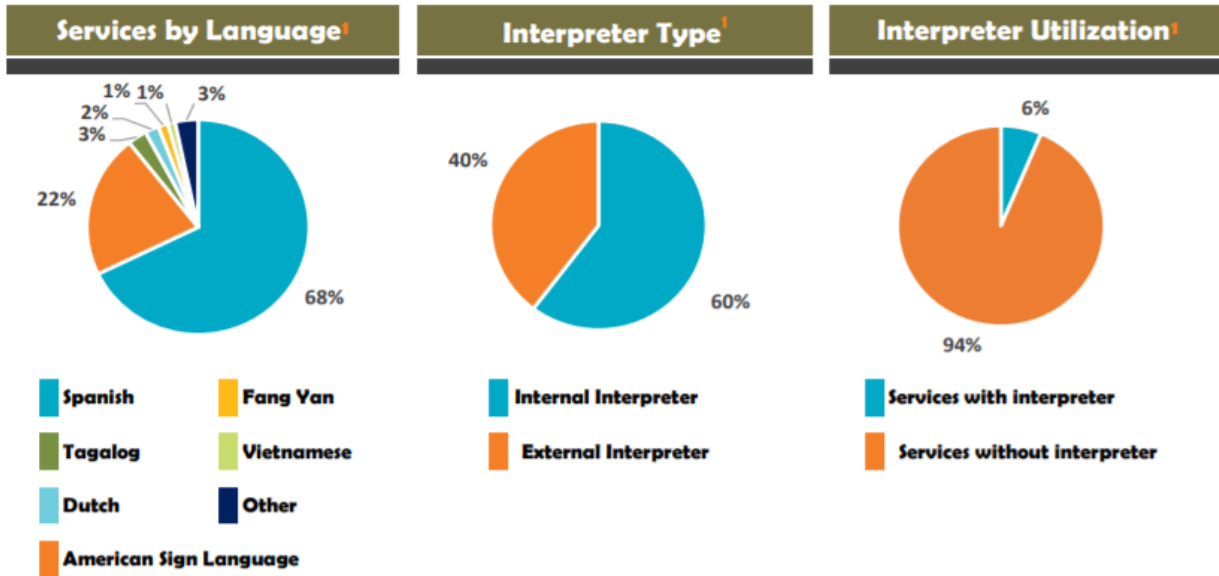


1,111,063 Total Services
74,981 Interpreter Services

7,310 Unique Clients
4,150 Youth (57%)
3,160 Adults (43%)

Services	Language	Clients
62,098	Spanish	5,678
4,262	Arabic	490
2,881	Vietnamese	289
1,187	American Sign Language	92
1,112	Cambodian	234
1,054	Other Non-English	224
323	All Filipino Dialects	102
318	Laotian	36
345	Farsi	69
297	All Chinese Langs & Dialects	44
351	Hmong	147
178	Korean	42
51	French	13
204	Russian	54
116	Japanese	8
25	Thai	8
79	Samoan	78
32	Armenian	29
36	Other Sign Language	25
4	German	4
5	Turkish	4
7	Polish	4
2	Italian	2
14	Portuguese	5
0	Hebrew	0

SUD Interpreter Services Report, FY 2019-20
(Please note: Data may be impacted starting March 2020 due to COVID-19)



748,580 Total Services
11,806 (1.6%) Non-English Services

605 Unique Clients¹
115 Youth
490 Adults

Footnote:
 1. Includes only Non-English services.
 2. Clients may be duplicated among different languages.

SUD Interpreter Services Report, FY 2019-20 (Continued)

Services ¹	Language	Clients ²
8,008	Spanish	478
2,544	American Sign Language	76
329	Tagalog	6
238	Dutch	6
169	Fang Yan	8
126	Vietnamese	3
91	Arabic	2
88	Large Print Eng	9
58	German	3
56	Armenian	3
43	Farsi	1
27	Hmong	1
17	Other Non-English Language	6
6	Laotian	1
3	Norwegian	3
2	French	2
1	Amharic	1
0	Tigrigna	0
0	Unknown Language	0
0	Finnish	0
0	Indian(General)	0
0	Chinese	0

Footnote:

1. Includes only Non-English services.
2. Clients may be duplicated among different languages.

LANGUAGE CAPACITY

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

The County shall include the following in the CCPR:

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

County Behavioral Health Services Cultural Competence Standards require that provider programs develop staff's language competency for threshold languages. However, if program staff cannot meet the need for language assistance, then the program shall provide interpreter services. The Organizational Provider Operations Handbook (OPOH) establishes a process to provide free interpreter service for mental health clients with Limited English Proficiency (LEP). Selected interpreter services include:

- Hanna Interpreting Services, LLC (for language interpreting)
- Interpreters Unlimited (deaf and hearing impaired)

In FY 2016-17, interpreter funding was decentralized and since, programs have had the freedom to choose an interpreter agency that fits their program needs.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Culturally and Linguistically Appropriate Services (CLAS) Standards:

The Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 standards.

The standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

SDCBHS and the Cultural Competence Resource Team (CCRT) have identified the following methods that providers are encouraged to implement for evaluating cultural competence:

- 1) Use of the PCDSA;
- 2) Administration of a survey amongst their clients to determine if the program's clinical and administrative services are perceived as culturally competent; and
- 3) Conducting a survey amongst their clients to determine if the program's clinical and administrative services are perceived as culturally and linguistically competent. The PCDSA is available online and is administered to all staff every two years. Surveys that aren't required can be developed independently. If providers prefer samples of surveys, they are available in the Cultural Competence Handbook (Appendix 14).

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.

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

The SDCBHS contracts with the Administrative Services Organization (ASO) to provide a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD.

In FY 2019-20, the Access and Crisis Line (ACL) received 74,753 calls (10,021 more than that in FY 2018-19), with monthly call volume ranging from 5,909 to 6,519 calls. Of those, 1,171 were calls conducted in a language other than English and 21 were hearing impaired calls. Of all the calls that were conducted in a language other than English, 96.4% of them were in Spanish.

The ACL is staffed by highly trained individuals, two-thirds of whom have an independent license and more than a quarter of them are license-eligible, registered interns. During the regular workday, there is at least one Spanish-speaking staff member available to immediately handle problems and inquiries from Spanish callers. To the maximum degree possible, management seeks out bilingual speakers with mental health knowledge to staff the ACL, finding themselves in competition with other County contractors for a comparatively small pool of persons with both mental health experience and bilingual in Vietnamese or Arabic. The ACL also contracts with the Language Line to provide immediate interpreter services as needed in threshold and non-threshold languages.

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

Telehealth services is outlined in the Organizational Provider Operations Handbook (OPOH) and the purpose of this program is to assure timely access of urgent psychiatric services to reduce emergency and acute clients' hospital inpatient services. Psychiatrists or Nurse Practitioners (NP) are to perform various psychiatric services via tele-video linkage when an on-site Psychiatrist or NP is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged. This practice also extends psychiatric services to clients in remote areas of the County. In FY 2019-20, a total of 49,556 telehealth services were provided to 8,633 unique clients. Adult individuals served was 3,739, while the remaining 4,894 individuals served were children/youth. SDCBHS Substance Use Disorder providers served 2,740 unique clients with 19,257 telehealth services (encounters).

Additionally, provider staff encountering clients whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs. If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated program staff can contact Hanna Interpreting Services, LLC (for language interpreting) or Interpreters Unlimited (for hearing impairment) to arrange for language assistance. In addition, written translation services are also available through Hanna Interpreting Services, LLC.

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

The OPOH sets forth the protocol for implementing language access through the ACL. Providers must inform clients of their right to receive help from an interpreter and document the response of the offer. Upon request of the client, providers must arrange for language assistance. Providers can get linked with the Language Line provided by the ASO, if they do not have an in-house link to other interpreter services.

The process used at the ACL to link a caller with its Language Line is as follows:

1. Ask the caller to hold while you get an interpreter.
2. On the Avaya IP Agent Software, press Conference Hold to place the caller on hold.
3. Dial 1-888-724-7240. Press 1 for Spanish interpreters. Press 2 for all other languages.
4. *Client ID: 795254*
Organizational Name: Optum, Crisis Line
People Soft Code: 41270 1540 1815
5. Advise the interpreter:
“Interpreter, this is the San Diego County Access and Crisis Line. I have a monolingual (language) caller on the line. I would like you to interpret directly. I will speak directly to the client and will start with our standard greeting. If you are ready, I will add the caller.”
6. Add the Limited English speaker to the line and use the standard greeting.
7. At the closing ask the caller: “Is there anything else I can assist you with today?”
If no, state: “Please release the interpreter when you are ready.”

4. *Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.*

ACL staff go through four phases of training to learn how to maintain contact with a caller and establish rapport, provide support, intervention and referrals, and handle the documentation required. One-to-one coaching is provided to learn these skills and tasks. Trainees initially monitor calls and observe the process and then go on to progressively participate in the calls and eventually to handle calls independently while being monitored. The goal for mastery of the Language Line and TDD is to:

- 1) Successfully determine that the caller required an interpreter;
- 2) Connect the caller to the Language Line;
- 3) Conference in the caller; and
- 4) Successfully complete the call.

Trainees are required to have five successes before being allowed to handle such calls alone. However, at all times, clinical supervision is readily available should staff experience a problem. Individual providers are expected to train their staff on connecting with the ACL to receive quick language assistance for a caller or drop-in visitor with limited English proficiency.

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

In the Quick Guide to Mental Health Services for Adults, Older Adults, and Children, distributed to all new consumers, there is a section that states:

San Diego's Mental Health Plan Provides:

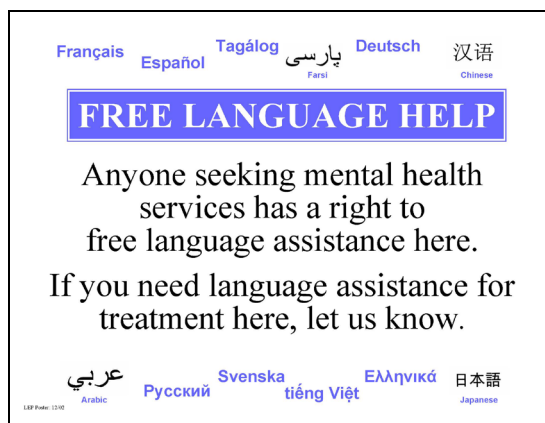
- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, Farsi, and Arabic, as well as in an audio format in all threshold languages. It is available at all organizational provider locations and, upon request, through Behavioral Health Services Administration. Providers can request the Quick Guides and all other Medi-Cal beneficiary materials using a PDF form-fill available online. A copy of the request form is available in Appendix 28 for MHS and Appendix 29 for SUD.

Additionally, the County provides a Guide to Medi-Cal Mental Health Services in San Diego: a booklet about the mental health services that San Diego County offers and about the Medi-Cal Service Plan. The booklet is available in English, Spanish, Tagalog, Vietnamese, Farsi, and Arabic. There is a section in the beginning of the booklet that states:

“If you feel you have a mental health problem, you may contact the San Diego Mental Health Plan Access and Crisis Line directly at (888) 724-7240. This is a toll-free number that is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. You do not need to see your regular doctor first or get permission or a referral before you call.”

Furthermore, all County Behavioral Health programs are required to have a copy of the sign below posted in their waiting rooms in threshold languages:



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

Appendix 30 has examples of client records and services provided by County contractors in Spanish, Arabic, Tagalog, Farsi, and Vietnamese.

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

The following lessons learned were shared in discussions with stakeholders:

- More bilingual staff are needed on site. Higher salaries for bilingual staff are needed for higher retention.
- When using Interpreters Unlimited services, it would be easier to have a way of scheduling electronically, rather than through phone calls and faxing.
- Therapists need to be patient – the process of recovery tends to be slower for non-English speaking clients than with English-speaking clients. Similarly, there is an impact on the therapy process (i.e., with an interpreter, 60 minutes is spent with the client, but 30 minutes is spent for interpretation).
- It is helpful to have pre- and post-session meetings with the interpreter.
- It would also be helpful to have a system in place to provide an evaluation of each interpreter service session.
- It’s important to train clinicians how to utilize interpreters – and likewise train interpreters about mental health services.
- It’s better to use a professional interpreter, rather than a family member to translate. Translators should be neutral and someone the client does not know personally.
- Clear instructions should be given to LEP clients so they know what to discuss with the clinician before a session.

- Families with LEP may not initially understand what psychotherapy is, so it needs to be explained to help them be more receptive to services.

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

SDCBHS had identified the following historical challenges and lessons learned for:

- Dedicating adequate funds to provide needed level of interpreter services at a time when there are many conflicting priorities.
- Staff needs to reflect the target population, but the scarcity of qualified personnel has limited access to language appropriate services.
- Staff retention is influenced by lack of resources to compensate at market rate for bilingual staff.
- Direct service programs need continuous monitoring to ensure that they are not overly relying on interpreter services, rather than directly hiring bilingual staff.

E. Identify County technical assistance needs.

- SDCBHS would find it helpful to have technical assistance on County programs which are successfully reaching out to clients with limited English proficiency. It would be useful to know strategies to engage clients, the amount of time it took for engagement to occur, and lessons their staff learned in putting together a successful program.
- San Diego is among the counties with the highest immigrant influx each year and is interested in learning how other counties nimbly respond to the changing needs of new immigrant groups.

LANGUAGE CAPACITY

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

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

The County shall include the following in the CCPR:

- A. Evidence of availability of interpreter (e.g., poster/bulletins) and/or bilingual staff for the languages spoken by community.*
- B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.*

SDCBHS has provided services to persons with Limited English Proficiency (LEP) through the usage of interpreter services in the entire system of care. In FY 2019-20, a total of 74,981 interpreter services were provided to 7,310 unique clients receiving Mental Health Services. The largest proportion of interpreter services was provided in Spanish (83%), followed by Arabic (6%). Additionally, 11,806 interpreter services were provided to 605 unique clients receiving Substance Use Disorder services. The largest proportion of interpreter services provided to these individuals was in Spanish (68%) followed by American Sign Language (22%).

Client use of interpreter services is also documented in each client’s clinical record.

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

The 24-hour ACL has Spanish coverage (the County’s second most used language) during regular day operating hours. See a sample of their weekly schedule on the next page. Clinicians who speak Spanish are highlighted in Red.

■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance													
SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
5:30am - 4pm	VACANT	5:30a-4pm	Ray (10)	5:30a-4pm	Ray (10)	5:30a-4pm	Ray (10)	5:30a-4pm	Ray (10)	5:30a-4pm	Sheila (10)	5:30am-4pm	Brett (10)
6:30am - 5pm	Hilda (10)	6am-4:30pm	Kaitlyn (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	6:30am - 5pm	IC Vacancy (8) Ruth # 835522
6:30am - 5pm 7:30am- 6pm	Mary (10)			6am-4:30pm	Sheila (10)	6am-4:30pm	Sheila (10)	6am-4:30pm	Sheila (10)			6:30am - 5pm 7:30am- 6pm	Mary (10)
9a-7:30p		6:30am-5pm	Hilda (10)	6:30am-5pm	Hilda (10)	7am-5:30pm	Kaitlyn (10)	7am-5:30pm	Kaitlyn (10)	7am-5:30pm	Kaitlyn (10)	9a-7:30p	
		7:30am-4pm	Rebecca (8)	7:30am-4pm	Rebecca (8)	7:30am-4pm	Rebecca (8)	7:30am-4pm	Rebecca (8)	7:30am-4pm	Rebecca (8)		
		8:30AM - 4PM	Laura (8)	8:30AM - 4PM	Laura (8)	8:30AM - 4PM	Laura (8)	8:30AM - 4PM	Laura (8)	8:30AM - 4PM	Laura (8)		
		9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)		
9am - 7:30pm	Mariana (10)					9:30AM - 8Pm	Brett (10)	9:30AM - 8Pm	Brett (10)	9:30AM - 8Pm	Brett (10)	9am - 7:30pm	Mariana (10)
10:30 AM -9 PM	Johanna (10)	10:30 AM-9 PM	Johanna (10)							10:30 AM -9 PM	Johanna (10)	10:30 AM -9 PM	Johanna (10)
		10:30PM - 9 PM	Mary (10)	11 AM -9:30 PM	Mary (10)							11 AM - 11:30 PM	Katie (12)
12:30PM-11PM	Tiffany (10)	12 PM -10:30 PM	Tiffany (10)	12 PM -10:30 PM	Tiffany (10)	12 PM -10:30 PM	Tiffany (10)						
				2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	1 - 9:30 PM	Joanne (8)
3 PM -1:30 AM		2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)		
3 PM - 1:30 AM		4:30-12 AM	Gracie (7)	4:30-12 AM	Gracie (7)	4:30-12 AM	Gracie (7)	4:30-12 AM	Gracie (7)	4:30-12 AM	Gracie (7)		
	Sharon (10)	5 PM - 1:30 AM	IC Vacancy (8) Ruth # 860410	5 PM - 1:30 AM	IC Vacancy (8) Ruth # 860410	5 PM - 1:30 AM	IC Vacancy (8) Ruth # 860410			7 PM - 1:30 AM	IC Vacancy (8) Ruth # 860410		Sharon (10)
3 PM - 1:30 AM	Daniel (10)							3 PM - 1:30 AM	Daniel (10)	3 PM - 1:30 AM	Daniel (10)	3 PM - 1:30 AM	Daniel (10)
		5:30PM-2AM	AC Vacancy (8) Req Transferred from UM - START #848806	7:30PM-2AM	AC Vacancy (8) Req Transferred from UM - START #848806	5:30PM-2AM	AC Vacancy (8) Req Transferred from UM - START #848806	5:30PM-2AM	AC Vacancy (8) Req Transferred from UM - START #848806	5:30PM-2AM	AC Vacancy (8) Req Transferred from UM - START #848806		

6PM-2:30 AM	Req #853567 (8)	6PM-2:30AM	Req # (8)					6PM-2:30AM	Req #853567 (8)	6PM-2:30AM	Req #853567 (8)	6PM-2:30AM	Req #853567 (8)
5:30 PM - 5 AM	Rose (12)												
6:30 PM-7 AM	Kim (12)	6:30 PM-7 AM	Jody (12)	6:30 PM - 7 AM	Jody (12)	6:30 PM - 7 AM	Jody (12)	6:30 PM - 7 AM	Maria (12)	5:30 PM- 5 AM	Rose (12)	5:30 PM- 5 AM	Rose (12)
6:30 PM - 7 AM	Katie (12)	6:30 PM - 7 AM	Katie (12)	6:30 PM - 7 AM	Nicole (12) R	6:30 PM - 7 AM	Nicole (12) R	6:30 PM - 7 AM	Nicole (12) R	6:30 PM - 7 AM	Maria (12)	6:30 PM - 7 AM	Maria (12)
12 AM - 6AM	Jim (6)	12 AM - 6AM	Jim (6)	12 AM - 6AM	VACANT	12 AM - 6AM	VACANT	12 AM - 6AM	VACANT	6:30 PM - 7 AM	Kim (12)	6:30 PM - 7 AM	Kim (12)
ACL-L 4.0													
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY						
	off	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather		Off
	Off	9AM- 5:30 PM	Pete	9AM- 5:30 PM	Pete	9AM- 5:30 PM	Pete	9AM- 5:30 PM	Pete	9AM- 5:30 PM	Pete		Off
3 PM - 11:30 PM	Jim	12:30 PM - 9PM	Jim	12:30 PM - 9 PM	Jim	12:30 PM - 9 PM	Jim		off		off	3 PM - 11:30 PM	Jim- current
	off		off	2:30 PM - 11PM	Joanne	2:30 PM - 11PM	Joanne	2:30 PM - 11PM	Joanne	2:30 PM - 11PM	Joanne	1 PM - 9:30PM	Joanne - current
CACs 3.25													
11am-8:30pm	Jerry	6:30am-3pm	Emma (8)	6:30am-3pm	Emma (8)	6:30am-3pm	Emma (8)	6:30am-3pm	Emma (8)	6:30am-3pm	Emma (8)	11am-8:30pm	Jerry
		8:30am-5pm	Tessa (8)	8:30am-5pm	Tessa (8)	8:30am-5pm	Tessa (8)	8:30am-5pm	Tessa (8)	8:30am-5pm	Tessa (8)		
		5pm-11pm	Huey (6)	5pm-11pm	Huey (6)	5pm-11pm	Huey (6)	5pm-11pm	Huey (6)	5pm-11pm	Huey (6)		

In view of the shortage, and in some cases scarcity, of clinicians and other direct service staff who are bilingual in threshold languages, especially Vietnamese and Arabic, the SDCBHS does not currently require providers to submit evidence of in-house staff linguistic proficiency during regular day operating hours. However, an overall picture of staff language proficiency has been included in Criterion 6. The majority of services are conducted during business hours, so it is possible to use the report as a gross indicator of bilingual availability.

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

While providers have the freedom to work with the interpreter agency of their choice, SDCBHS has a contract in place with Interpreter’s Unlimited to provide interpreter services. Their contract Statement of Work includes the following statements about ensuring interpreters are trained and monitored for language competence:

- “Contractor shall ensure all personnel assigned to provide language interpretive services meet all applicable licensing, applicable certification, training and/or professional criteria during all periods of services provision. Interpreters shall demonstrate proficiency in English and non-English languages, possess knowledge of specialized terms used in the mental health field, and have clear understanding of interpreting ethics and practice.”
- “Contractor shall maintain files of language interpretation professional criteria of all assigned personnel, including contracted and subcontracted personnel. Contractor will maintain and make available personnel files of aforementioned professional criteria upon request of the County.”

Evidence of Interpreter Services Training by the Language Line (used by the SDCBHS 24/7 ACL):

“Recruiting, Training & Quality Processes at Language Line Services” (LLS)

Language Line Services has implemented the highest standards for its interpreters in recruiting, training, and interpreter certification in the country. It has also specifically trained its interpreters on the Standards for Practice from the National Council on Interpreting in Health Care. The details of Language Line Services’ recruiting assessment, training, and certification program are described below.

1. Interpreter Recruiting Process

To ensure and maintain premium language interpretation services, Language Line Services (LLS) deploys a comprehensive testing and evaluation process to retain the best interpreters. All interpreters are tested and accredited by Language Line Services' highly qualified and experienced raters to provide our customers with the most accurate and professional telephonic interpreting services in the industry.

Resumes are received from a wide variety of sources from all over the country. Language Line Services is represented at every major professional interpretation conference in the country, including the annual conferences of National Association of Judiciary Interpreters and Translators (NAJIT), American Translators’ Association (ATA), and other interpreters’ associations.

LLS closely monitors all interpreter training developments nationwide and keeps a database of schools, organizations, websites, and agencies for recruiting purposes. LLS recruiting department initiates and maintains relationships with those recruiting sources that have proven to be most productive. It also conducts extensive Internet research on language-related sites and frequently identifies candidates over the Internet. Furthermore, LLS gives presentations and workshops on the unique nature of telephonic interpreting at different interpretation training programs to attract the best candidates with related training background.

LLS also has an extensive referral program through its staff interpreters and advertises in major newspapers and publications targeted towards certain ethnic groups and language professionals.

Once candidates are identified, they are screened, tested, and accredited through the following multi-step process:

- 1) Preliminary screening through an over-the-phone interview to verify skills indicated on the candidate’s resume.
- 2) An oral proficiency test for both English and the target language. The proficiency test evaluates key areas, such as the speaker’s comprehension ability, grammar, breadth of vocabulary, pronunciation and enunciation, and overall presentation. If proficiency is at the Advanced or Superior level, the candidate is scheduled for the next requisite test.
- 3) Interpreter Skills Assessment (ISA) is a Language Line Services proprietary test, developed with over 20 years’ experience as the leader of the industry. The ISA is a rigorous, criterion-referenced integrative test designed to specifically evaluate

a candidate’s interpretation skills. It is bi-directional from English into a target language and from the target language into English. It is conducted in the consecutive mode, mirroring in content, as well as format, the interpretation scenarios LLS interpreters handle, including calls from the medical settings. The ISA is evaluated by both an objective scoring method and a subjective assessment, with an emphasis on the objective scores.

2. Interpreter Training and Certification:

A. Orientation Processes

Language Line Services has a two-week new hire orientation process for its interpreters. During the orientation, new hires undergo basic training, job shadowing with senior interpreters, service observation and feedback, and question-and-answer sessions. Specifically, the following will be covered:

- The basics of interpretation
- The roles of an interpreter and the Interpreter Code of Ethics. Confidentiality is emphasized and each interpreter is required to sign a Non-Disclosure Agreement, which is witnessed and kept on file; interpreters are also trained on HIPAA and GLB Act requirements on confidentiality.
- Methods and Procedures of call handling, Personnel Guide, and other administrative matters.
- Interpreting skills and customer service skills. In addition to training on fundamental interpreting skills, such as note taking and memory retention, the trainer also teaches new hires the required skills for providing exceptional customer service and the highest degree of professionalism.
- Review of industry standards; interpreters listen to scenarios of simulated typical interpretation calls. LLS has developed standards for each industry based on formal feedback gathered from customer surveys and Voice of the Customer programs, as well as from participation in professional organizations such as the American Translators Association, National Council on Interpreting in Health Care, and ASTM.

New hires also job shadow senior interpreters and discuss their learning with the Orientation Trainer. In addition to learning and practicing typical industry scenarios and terminology, new-hires are provided an internally developed, 575-page At-A-Glance Industry-Specific Glossaries as a job aid to assist them on calls.

The new-hire orientation also contains an evaluation component. Only those who meet the predetermined criteria, as demonstrated through role playing and other exercises, will be deemed qualified to take calls as active interpreters.

Every new hire is assigned to a Senior Language Specialist (SLS) who will then provide hands-on, one-on-one training. The SLSs are senior interpreters with extensive education and experience in the interpretation field. Each SLS works with a group of 15-30 interpreters. The SLS will not only share his or her skills

and experience with the new hire but will also observe the new hire during calls and provide immediate feedback and coaching. Usually, feedback is given to new hires within the same day of the observation, no later than the next business day, to help new hires build up skills and confidence, identify improvement areas, and offer guidance.

B. Training, Continuing Education and Development for the Interpreters:

The Interpreter Training Department at LLS provides on-going training in the following areas: Finance, Insurance, Court, Medical, Technical Terminology, 911, Stress Reduction, and Customer Service Skills.

Many of the training curricula are developed in collaboration with external training/teaching experts and with input from customers. The Advanced Medical Training for healthcare interpreters was developed internally by medical professionals who are also interpreters for LLS, as well as interpreters with experience as trainers and healthcare interpreters; this training is used to supplement the more basic Medical Interpreter Training that LLS co-developed with the Cross-Cultural Health Care Program, a leading medical interpreting training organization, located in Seattle, Washington (www.xculture.org).

All of LLS's training programs provide both training material and instructed training sessions. The training contents are pertinent to real call scenarios that the interpreters deal with on the job. During the training sessions, the interpreters actively participate in role playing and discuss terminology in their working languages. Training sessions are taught by the instructors who have been involved in the training development because of their expertise in the industry; they are also senior interpreters.

LLS also trains the interpreters on healthcare interpreting requirement based on the document of Standards of Practice issued by the National Council on Interpreting in Health Care.

C. Interpreter Certification:

Because of a lack of standard certifications at the national level, and in response to clients' needs and the demand for interpreters with proven competence in interpreting for specific industries, LLS has become a pioneer in the certification field. In the late 1990's, LLS developed its own internal certification program with the collaboration and validation of external experts. All certification tests have been validated by a psychometrician and external experts, including LLS clients from the industry. The tests have been designed to represent the breadth of calls that LLS interpreters encounter during their work, as well as the wealth of terminology that exists within each industry and the industry-specific protocols. Each test is an oral over-the-phone exam that is administered on a one-to-one basis, and in the consecutive mode. In addition to their work experience, test candidates are provided with test preparation materials prior to each testing round.

To be deemed Certified in any given industry, an interpreter must have met the following criteria:

- Passed the initial Interpreter Skills Assessment Test
- Undergone the New Hire Orientation
- Completed Industry-specific Training
- Passed the Industry-specific Certification Test
- Maintained satisfactory service observation ratings
- Received positive customer feedback based on data from the Voice of the Customer Program.

All six criteria are carefully reviewed once an interpreter has passed the Certification Test, and industry-specific certifications are issued only to those interpreters who have demonstrated a consistent quality of performance and level of expertise worthy of certification, as measured by the aforementioned standards.

This multifaceted model is based on the Company's belief that no single form of evaluation can provide a complete assessment of an interpreter's proficiency. Our model examines diverse domains to measure interpreter competency and utilizes both skills assessments and performance-based evaluation criteria for certification. The aforementioned six components include evaluations of interpreters' job performance through service observation and customer feedback, training participation, as well as skills assessment through testing. This makes Language Line Services' certification distinctly different from any other certification program. LLS has filed for a patent for this comprehensive certification program and the patent is pending.

Currently, LLS' Medical Certification Test, Language Proficiency Test, and Interpreter Skills Assessment, along with several LLS training programs, are all available to LLS customers through Language Line University.

3. Quality Monitoring

LLS has a department dedicated to managing the quality monitoring process, the Quality Assurance Department. A group of Senior Language Specialists (SLS) are trained to not only conduct quality monitoring, but also to provide constructive feedback. A Senior Language Specialist usually works with 15-30 interpreters and all SLSs are selected for their top-notch language and interpretation skills and are trained to provide in-language observation and feedback.

Additionally, the Interpreter Training Department works closely with the Quality Assurance Department in identifying training needs and developing training programs at a higher level. Many Senior Language Specialists are also trainers who can train the interpreters on their teams. Observation information is also frequently taken into consideration in interpreter communications, e.g., the monthly interpreter newsletter covers issues and challenges identified through monitoring, without using real client or interpreter names to maintain confidentiality.

Interpreters are evaluated according to their performance level, which is determined by both service observation data as well as customer feedback. Performance is reviewed and measured according to the identified needs of the individual interpreter. The interpreter manager will evaluate the performance of an interpreter at any time if there is a concern raised by either external or internal customers. A formal written appraisal is conducted once a year.

LANGUAGE CAPACITY

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

The County shall include the following in the CCPR:

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

Policy #5977 – Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services (Appendix 3) includes practices and procedures for referring and otherwise linking clients who do not meet the threshold language criteria (e.g., LEP clients) to culturally and linguistically appropriate services.

See also the SDCBHS OPOH section on Cultural Competence (Appendix 7) for procedures in place to serve, link and refer, as necessary, clients to culturally and linguistically appropriate services.

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

See answer above in Section IV. A.

- C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:*
- 1. Prohibiting the expectation that family members provide interpreter services;*
 - 4. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services;*
 - 5. Minor children should not be used as interpreters.*

Based on the Civil Rights Act of 1964 (42 U.S.C., Section 2000(d), 45 C.F.R., Part 80), when a need is determined, the County of San Diego Health and Human Services Agency (HHSA) – Behavioral Health Services (SDCBHS), shall ensure that a process is in place for accommodating and referring clients to available culturally and/or linguistically appropriate services. This process is established through Policy #5977 (Appendix 3). This policy also requires that all providers provide language assistance to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

The policy states that all LEP persons speaking threshold or non-threshold languages shall be informed in a language they understand that they have a right to free oral interpretation assistance. It also states that:

- There is no expectation that family members provide interpreter services.
- A consumer/client may choose to use a family member or friend as an interpreter, after being informed of the availability of free interpreter services.
- Other than in extenuating circumstances, minors (under the age of 18) may not be used as interpreters even if the applicant/beneficiary requests to do so; although at the applicant’s/beneficiary’s request, the minor may be present in addition to the County-provided interpreter. Temporary extenuating circumstances may include using a minor child to determine the appropriate language needs of the adult so that an appropriate interpreter or bilingual staff person could be called or in order for the County to ask the client to wait while the County obtains the interpreter service.

LANGUAGE CAPACITY

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

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

- A. *Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:*
 1. *Member service handbook or brochure;*
 2. *General correspondence;*
 3. *Beneficiary problem, resolution, grievance, and fair hearing materials;*
 4. *Beneficiary satisfaction surveys;*
 5. *Informed Consent for Medication form;*
 6. *Confidentiality and Release of Information form;*
 7. *Service orientation for clients;*
 8. *Mental health education materials; and*
 9. *Evidence of appropriately distributed and utilized translated materials.*

Samples of the materials listed in items 1-8 above are made available at the tri-annual DHCS compliance visit. The availability of materials at provider locations is monitored by the QI Unit through Site Reviews and other reports.

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

SDCBHS provides documented evidence in the clinical chart at each DHCS tri-annual compliance review. Please see Appendix 30 for a sample of such case notes.

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

SDCBHS uses the mandated State satisfaction survey for all of its outpatient providers. Surveys are made available in threshold languages when requested by programs.

Summary reports of results of the Youth and Adult Satisfaction Surveys are in Appendices 24-25.

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

Currently the SDCBHS uses a translation service to provide needed translations and updates of translated documents. Materials received from the translation service are reviewed by SDCBHS clinicians and native speakers for accuracy prior to distribution.

*E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).
Source: Department of Health Services and Managed Risk Medical Insurance Boards.*

The text difficulty of all documents is tested through the Microsoft Office grading system, and wording is modified to the maximum degree possible to keep materials at a sixth-grade reading level.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 7:

- BHS will examine access times by client language to determine if there are barriers to access to services.
- 100% of mental health clients and families indicating in the Consumer Perception Survey report that they had access to written information in their primary language and/or received services in the language they prefer.
- 100% of SUD clients and families in the Treatment Perception Survey report that they had access to written information in their primary language and/or received services in the language they prefer.

ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs.

The County shall include the following in the CCPR:

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

SDCBHS has the following client driven recovery and wellness programs:

Recovery Innovations (RI) International

RI International offers a number of services that create opportunities to empower people and organizations to recover. Recovery education classes such as WRAP, WELL, and Medication for Success enable people to develop self-help skills. One-to-one Peer Support and recovery classes in the San Diego County Short Term Acute Residential Treatment (START) crisis facilities provide people an introduction to recovery and community recovery links. Peer Employment Training (PET) and other recovery trainings for individuals and unique trainings for professional staff equip people and organizations with the tools to transform their operations to a recovery-based model. The Peer Liaison Services program assists people to advocate for their needs and rights by acting as a two-way conduit to gather and disseminate information between the Mental Health System of Care and people receiving services and their families.

RI International, who provides training support to individuals with lived experience who work or plan to work in the public behavioral health system, provided five (5) peer specialist training series in FY 2018-19 with 91 participants who graduated from the program. Thirty-one of the graduates were already employed within the public behavioral health system at the start of the series. Also, aligned with SDCBHS' goal to continue to serve behavioral health clients during the COVID-19 pandemic, programs such as RI International shifted their diverse workforce resources and continued providing services such as Peer and Family Support over the phone. To further support this effort, RI Peer Run Services announced the addition of 5 new/updated virtual classes and meetings to support the peer and recovery community starting in February 2021. An information flyer with descriptions of the offered classes can be found in Appendix 31. SDCBHS continues its commitment to enhancing peer training and opportunities throughout the mental health and substance use systems of care.

Most recently, RI integrated a Client Liaison Services program that led tool kit efforts for COVID-19 related matters. A desk review conducted in December 2020, indicated that the tool kits included a tip sheet, laminated info cards with CDC guidance info, multiple face coverings, hand sanitizer, and a water bottle. The Access and Crisis Line contact information will be included on info cards. The tool kits were disseminated to at least 250 clients in need through an initiative called Boots on the Ground. RI held virtual workshops in November 2020 to provide information on how the Boots on the Ground initiative is serving the community (See Appendix 32). Additionally, RI presented at five public BHS system of care meetings reaching approximately 169 stakeholders and programs. These meetings included the Housing Council

Meeting, Workwell Meeting, TAY Council Meeting, Adult/Older Adult Council Meeting, and the ACT Providers Meeting.

RI International Peer Employment Training Program and Employment Search Assistance

The Peer Employment Training (PET) program is a 75-hour training provided for people with lived experience of recovery from mental health or co-occurring mental health and substance use challenges to work in the service system as a Peer Support Specialist. The training focuses on ways to use personal experience and skills to inspire hope in the lives of other individuals receiving services. Prerequisites include: High School Diploma or GED, Completion of WRAP (Wellness Recovery Action Plan), and attending the PET orientation. Program graduates are eligible to receive job search assistance in various positions in the mental health or substance use disorder fields including peer support specialists, recovery educators, peer counselors, recovery coaches, and peer liaisons to peer employment specialists. RI International partners with other community mental health agencies through an Employment Coordinator who serves as a link to community mental health and substance use disorder agencies and assists applicants with employment preparation such as resume building, review, and consultation.

SDCBHS continues to work closely with RI International, providing trainings and consultation to organizations to further develop recovery culture and provide Peer Support Specialists with the tools they need to succeed. Through PET, persons with lived experience of recovery from mental health or co-occurring substance use disorders are provided with tools to help with using their personal experience to inspire hope in others.

RI also hosted the 2nd Annual Peer Employment Training Alumni Symposium, held on June 12, 2019 at the Marina Conference Center in the Sunset Room. The informational networking event focused on providing employment related information for graduates of the Peer Employment Training Program.

In March 2021, RI International hosted a virtual San Diego Peer Liaison County Wide special employment presentation including topics on “Tapping into the Hidden Job Market” from the Department of Rehabilitation and the “State of Employment in San Diego County” from Employment Solutions. See Appendix 33 for an informational flyer shared for this event.

National Alliance on Mental Illness (NAMI) Programs

Trained NAMI volunteers bring peer and family-led programs to a wide variety of community settings, from churches to schools to NAMI Affiliates. SDCBHS works with NAMI San Diego to provide skill-based training on prevention to the community. With the unique understanding of people with lived experience, the following programs and support groups provide free education, skills training and support:

- **Family-to-Family (F2F)** is a class for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members. This program was designated as an evidence-based program by SAMHSA. The course is also available in Spanish, De Familia a Familia de NAMI. Their first English language Family to Family class for FY 2019-20 was hosted at La Jolla Presbyterian Church, a newly developed venue, and 22 (88%) individuals

graduated. They also opened the following four English F2F classes: two in North Coastal, one in North Inland and one in East County. Three English F2F classes, scheduled in January 2020, were hosted by churches. Additionally, they scheduled two Spanish classes in North Inland and South County and one English class in the Central region to start in February 2020. They also secured locations in East County for one Arabic class and two English classes in the Central and North Inland regions.

- **Peer-To-Peer** is a recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants. This program is also available in Spanish, De Persona a Persona de NAMI.
- **In Our Own Voice** is a presentation about living with mental illness by intensively trained individuals who tell their stories to educate the community, providers, and others living with mental illness.
- **Ending the Silence** is an in-school presentation designed to teach middle and high school students about the signs and symptoms of mental illness, how to recognize the early warning signs and the importance of acknowledging those warning signs.
- **Parents & Teachers as Allies** is a presentation for teachers and other school personnel to raise awareness about mental illness, early warning signs, and the importance of early intervention.
- **San Diego Helpline** is a telephone service for families, friends and those affected by serious mental illness. NAMI provides information about available classes and support groups, as well as assist with other mental health related resources.
- **Family and Adult Peer Support Line** provides specialized culturally and developmentally appropriate behavioral health service for adults, older adults, and their families who live in communities with a high concentration of ethnic minorities in order to promote their social and emotional wellness. This non-crisis, confidential, anonymous, stigma-free, toll-free, peer support line provides countywide telephone counseling services, support and referrals to adults and older adults, including those who may struggle with alcohol or drugs.
- **Next Steps** comprises of peer specialists and family support specialists, including those who speak Spanish and API languages.
- **Friends in the Lobby** partners with Sharp Mesa Vista Hospital, UCSD Medical Center, Scripps Mercy Hospital, Bayview Behavioral Health Campus, Alvarado Parkway Institute, Palomar Medical Center, Tri-City Hospital, Crestwood Behavioral Health, and the VA Medical Center La Jolla to provide outreach and engage individuals visiting their loved ones in local hospitals. This innovative program that began January 2016 is part of NAMI San Diego.
- **CYF Liaison** serves as the MHSA Resolution Point-of-Contact for issues with the CYF System of Care. The program facilitates dialogue between families, Family Youth Partners, and providers. Families can attend Family Voice Meetings to talk about what is working well for them and where they need additional support within the CYF System of Care. In February 2021 the CYF Liaison program hosted a virtual “Working Together” training providing a learning experience to build the foundation for collaboration between clinicians, mental health workers, therapists, program staff and Youth/Family Support Partners, Children, Youth and Families System of Care Peer Staff with lived experience. An informational flyer shared for this event is provided in Appendix 34.

- **Side-by-Side** is a program that aims to inspire hope and connect participants who identify as having a mental health challenge, with Companions who provide support to those seeking recovery. Companions are either peers living in recovery, a family member of an individual living with mental health challenges, or a Mental Health Champion. Participants and Companions have the opportunity to meet up in the community and enjoy activities such as exploring a museum, going on a hike, visiting a park, attending a community event, and more, at no cost to the participant. Through these activities the program's intention is to foster hope, socialization, motivation, support, friendship, inspiration, and the sharing of information on Mental Health resources.
- **NAMI San Diego Tech Café** is a consumer and family empowerment project funded through the MHSA Capital Facilities and Technological Needs plan that is centered on the creation and expansion of opportunities to support culturally competent recovery and resilience through the use of technology. The services are provided to existing consumers and family members of consumers within the SDCBHS system of care.
- **oscER San Diego (Organized Support Companion in an Emergency Situation)** is a mobile application that guides users in navigating psychiatric crisis situations. It provides clear content on what to do before, during, and after a psychiatric crisis, and provides helpful resources such as psychiatric clinic phone numbers and hours. Users also can use the app to find assistance with housing and legal aid, get education, and find walk-in centers, emergency departments, and psychiatric hospitals in San Diego. In addition to these practical resources, oscER is also a navigational guide that serves a support companion to users in a mental health crisis. It is free for download in Android, Apple, and Windows app stores.
- **NAMI Connection** is a 90-minute support group run by persons who live with mental illness for other persons who live with mental illness (all psychiatric diagnoses). The program focuses on allowing all participants to share their experiences and learn from each other in a safe and confidential environment. It includes NAMI-trained peer facilitators and employs principles of support designed to empower its members.
- **NAMI Connection to Community Clubhouse** is a program that also provided care packages to include multiple face coverings, hand sanitizer, a water bottle, a flashlight, six pairs of socks, a power bank, facial tissues, sunscreen, soap, deodorant, a toothbrush, toothpaste, a notepad, pen, bandages, and two doses of Naloxone. The tool kits also included laminated info cards with CDC guidance info, COVID-19 best practices, and Access and Crisis Line contact information, as well as tips for health and wellness with regards to mental health, substance use disorders, telehealth, safe socialization, diet, and exercise. The tool kits were disseminated to at least 346 clients in need. Additionally, NAMI presented at 10 public/program venues. These venues included the Santee Community Collaborative, Connection to Community Clubhouse staff huddle, North County Prevention Coalition, Homeless Services Providers, San Diego Mesa College Basic Needs Center staff, La Mesa Collaborative (housing and behavioral health providers), Central/North Central Collaborative (Central/North Central housing and behavioral health providers), and the Operators Meeting (CHIP/ILA an RRA operators). (See Appendix 35)
- **NAMI Family Support Groups** focus on relatives, caregivers, and others involved with individuals with mental illness. The support groups provide a caring atmosphere for individuals to share their common experiences and assist individuals in developing the

skills for understanding, and the strengths needed to cope. The group is run by local affiliates and have NAMI-trained facilitators that provide a structure which encourages full participation.

- **PeerLINKS** is a program that supports clients who are 18 years or older and have been admitted to UC San Diego or Scripps Mercy's psychiatric inpatient units or CRF's Vista Balboa and New Vistas crisis homes, who are in need of resources or support. The program's goal is to link clients to needed services while increasing their knowledge and providing support. Services provided include peer support, coaching and mentoring, messages of hope and modeling recovery, assistance with healthcare navigation, information and assistance in navigating resources and obtaining benefits, psychoeducation, and family support and education. The PeerLINKS team is comprised of Peer/Family Support Specialists, a Registered Nurse, a Licensed Clinician, an Administrative Support Associate, and a Program Manager. It is funded through the MHSAs Innovations funding.

Program Advisory Groups

Program Advisory Groups (PAGs) are composed of at least 51% mental health consumers and/or family members who are integrated in outpatient programs as a required program component that provides feedback and ideas to mental health programs about recovery services in the program. PAG meetings follow an agenda, attendance is recorded, and minutes are taken. Guidelines for implementing PAGs across the Adult/Older Adult Mental Health System of Care have been instituted in an effort to standardize this important vehicle for soliciting feedback to improve programs.

Clubhouse Programs

The Adult/Older Adult System of Care currently supports the operation of 16 Clubhouse programs located throughout the different geographic regions of San Diego County. The Clubhouse programs provide social and vocational rehabilitation, as well as recovery and vocational services that assist members to increase their social rehabilitation skills, reduce social isolation, increase independent functioning, and increase and improve education and employment. Additional services include employment activities. Many different tools and techniques are employed to help clients learn living and interpersonal skills and to provide opportunities for advancement. In six of the Clubhouses, a Supplemental Security Income (SSI) Advocate is also available to provide assistance and support to non-General Relief mental health consumers seeking to apply for and secure SSA/SSI benefits.

In FY 2018-19, the ClubHOMS system was developed and piloted. The system collects the following data for Clubhouse members: demographic information including primary language, race and ethnicity, and gender identity; key outcomes related to employment, education, and housing; program satisfaction data; attendance and service utilization patterns. This tool will be used to assist Clubhouses in providing services that are culturally appropriate and meet the needs of the community where they are based. ClubHOMS was implemented in all SDCBHS contracted Clubhouses in July 2019. During FY 2019-20, there was frequent collaboration between Clubhouses and the ClubHOMS development team to ensure access for all members. This includes regular feedback on accessibility and member satisfaction.

Warm Line, Mental Health Systems, Inc.

The “Warm Line” is an essential non-crisis peer telephone support service for persons recovering from mental illness who are living in the San Diego County community. This peer-run service assists callers by providing support, understanding, information, and referrals. The “Warm Line” is operated seven hours a day in the late afternoons/evenings each week by persons who have been successful in managing their mental health symptoms and who are supporting others in their recovery efforts. The goals of the Warm Line program include promoting stability and reducing problematic situations that may lead to a crisis. Callers are provided information and referrals to appropriate community resources and non-crisis intervention services including offering coping techniques in order to assist callers to improve their self-care skills.

Older Adult Elder Multicultural Access and Support Services (EMASS) Program

The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County. EMASS is an age and culturally/linguistically appropriate, peer-based, outreach and engagement model to support prevention activities and increase access to care. It utilizes “Promotoras” or Community Health Workers (CHW) as liaisons between their communities and health, human service and, social organizations to bring information to their communities. The CHW and/or peer community liaison functions as an advocate, educator, mentor, outreach worker, role model, cultural broker, and translator.

Roadmap to Recovery

Roadmap-to-Recovery (R2R) groups provide a non-threatening and non-judgmental learning environment led by trained Peer Facilitators who discuss how clients can best interact and learn to advocate for themselves with their treatment team. Through discussion, the R2R groups aim to educate about self-management and treatment of their illnesses from the experiences of others. The R2R program utilizes collections of drawings made by clients to facilitate discussion that provides reassurance and support by the sharing of participants’ own stories.

Next Steps Program

A project under development with NAMI San Diego, the Next Steps Program provides comprehensive, peer-based care coordination, brief treatment, and health system navigation to adults with mental health and/or substance abuse issues who present at the San Diego County Psychiatric Hospital (SDCPH) and other participating sites throughout the County. The program goal is to reduce problems associated with substance abuse, improve participants’ mental and physical well-being, and reduce unnecessary use of psychiatric hospitalizations. Support, education, and advocacy will also be provided for families as a key part of the program in which five outreach teams consisting of one Alcohol and Other Drugs (AOD) counselor and one Peer or Family Support Specialist each, as well as other clinical and peer support staff, are integrated into the new model.

Courage to Call

Courage to Call is a peer-to-peer support program staffed by veteran peers providing countywide outreach and education to address the mental health conditions that are impacting Veterans, Active-Duty Military, Reservists, National Guard and their families (VMRGF), and provide training to service providers of the VMRGF community. Mental Health Systems, Inc. provides services in collaboration with 2-1-1 San Diego and Veterans Village of San Diego.

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.*

SDCBHS offers the following alternatives to accommodate individual preferences:

The Language Line provides interpreter services designed to help individuals understand a program/service delivery without altering, modifying, or changing the intent of a message. This free service is available to clients with Limited English Proficiency (LEP) in threshold and non-threshold languages as needed for the delivery of specialty mental health services as well as substance use disorder services. American Sign Language (ASL) interpretation is also available.

The Warm Line service has two Spanish-speaking staff for some shifts and utilizes the Language Line for clients who request to speak with peers in their preferred language.

The Adult Peer Support line has Spanish-speaking staff for Spanish-language callers and plans the use of the Language Line for most non-English speakers. This program is also working collaboratively with providers to remotely utilize an Asian American peer for a more culturally attuned response to Asian/Pacific Islanders who use this service.

PAGs in the South region are conducted in English and Spanish to accommodate the high Spanish-speaking population.

Roadmap-to-Recovery (R2R) groups are facilitated in languages that reflect the population it serves. Clients can choose which R2R group they wish to attend.

Staff in SDCBHS programs/facilities reflects the diversity and closely matches the demographics within the community.

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

The following programs are client-driven/client operated:

Friendship Clubhouse

The data analysis indicated that in the Central region, Adult and TAY African Americans and Latinos may be groups that are underserved. Friendship Clubhouse improves both access and services by providing culturally appropriate services for these unserved populations.

Eastwind Clubhouse

The Eastwind Clubhouse located in San Diego County's Central region provides culturally competent services to Asian/Pacific Islanders in three Asian languages: Vietnamese, Hmong, and Cambodian.

Older Adult Elder Multicultural Access and Support Services (EMASS) Program

The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County.

Casa del Sol Clubhouse

This client-operated clubhouse program creates an environment that is welcoming to the culturally and ethnically diverse population of the region, with a special focus on Adult, Older Adult, and TAY Latino population in that area. All program staff are bilingual Spanish, so monolingual Spanish-speaking members can be accommodated.

Roadmap-to-Recovery (R2R)

Where appropriate and facilitator availability permits, a minimum of one R2R group in each clinic is conducted in a threshold language (other than English) that serves the majority of clients in that clinic or HHSA region.

Warm Line Service

The Warm Line service has bilingual Spanish peer specialists for some shifts.

Family and Adult Peer Support Line

This program utilizes a bilingual Spanish family member staff. This program will also offer family support in selected Asian/Pacific Islander languages.

Deaf Community Services (DCS) Clubhouse

The DCS Clubhouse is a safe environment for Deaf, Hard-of-Hearing, Deaf-Blind, and Late-Deafened persons at risk for or living with behavioral health disorders to improve their quality of life and work towards achieving their personal goals. The Clubhouse is a learning environment where members explore their own interests and become confident learners through a variety of activities. The mission is to promote healthy living, reduce the risk for behavioral health issues, and help members of the deaf community to achieve their personal goals. This is done through a variety of activities including: peer support advocacy, self-help groups, social activities, vocational activities, educational activities, and workshops.

Breaking Down Barriers

The Breaking Down Barriers program provides prevention and early intervention services through the efforts of Cultural Brokers to:

- Provide mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQI+), African, and African American communities;
- Implement and evaluate strategies to reduce mental health stigma; and
- Create effective collaborations with other agencies, community groups, participants, and family member organizations.

ADAPTATION OF SERVICES

II. Responsiveness of Mental Health Services

The County shall include the following in the CCPR:

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

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

Over the last decade, SDCBHS has been building up the spectrum of services available to foster recovery, while seeking to meet the age-specific and geographical needs of mental health consumers. A Provider Directory listing linguistic and specialty services are available to the public. This list is provided to clients upon request. The Provider Directory lists the cultural specialties of San Diego's organizational providers and is available on the Network of Care in multiple languages. SDCBHS has been working to enhance the Provider Directory in response to the Medicaid Managed Care Final Rule Regulations. The Organizational Providers Operations Handbook (OPOH) requires contractors and the County to meet the language preferences of clients to the maximum degree possible.

Because the penetration rate for Asians and Pacific Islanders has traditionally been low, SDCBHS has increased efforts to decrease this disparity. The CYF System of Care has implemented the CARE outpatient program using MHSA funding which targets Asians and Pacific Islanders. WET initiatives have contributed to building a workforce that is bilingual and bicultural in order to meet the needs of San Diego's threshold populations and other ethnic groups. Additionally, SDCBHS has contracted with the Union of Pan Asian Communities (UPAC) for over 20 years to provide services to the Asian and Pacific Islander populations.

As mentioned in Criterion 3 of the Cultural Competence Plan, SDCBHS has set up over 30 programs through Community Services and Support funding to address gaps in services for underserved and unserved populations. Please see the CSS program listing, with target populations served in the Appendix 16.

SDCBHS has engaged in Faith-Based Community Dialogue Planning in the Central and the North Inland regions. Recommendations were compiled and made available in a Compendium of Proceedings and from these recommendations Faith-Based Councils were established. Language was also added to contracts to address outreach and engagement of Faith-Based congregations in these two identified regions to address access to care, wellness and education, and health equity. The Faith-Based Initiative was established in 2016 and primarily focuses on

African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant SDCBHS services.

The Access and Crisis Line (ACL) can also connect clients who wish to see a Fee-For-Service (FFS) provider with a number of specific language capabilities; however, there continues to be a shortage of staff with capabilities in Asian and African languages.

As discussed previously, contractors are bound by the requirements in the Organizational Providers Operations Handbook (OPOH) and Substance Use Disorder Provider Operations Handbook (SUDPOH) to provide clients with language appropriate services. The County has provided services to persons with Limited English Proficiency (LEP) through the use of interpreter services. As of Quarter 3 of FY 2017-18, there were 81,774 interpreter services provided to 8,346 unique clients. The largest proportion of services was provided in Spanish (78.9%), followed by Arabic (7.8%).

In FY 2016-17, interpreter funding was decentralized.

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.

In the Quick Guide to Mental Health Services for Adult, Older Adults, and Children there is a section that states:

“San Diego’s Mental Health Plan Provides:

- A system to meet the needs of persons of diverse values, beliefs, orientations, races, and religions
- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired”

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, Farsi, and Arabic, as well as in an audio format in all threshold languages. It is available at all organizational provider locations and through Behavioral Health Services administration. Providers can request the Quick Guides and all other Medi-Cal beneficiary materials using a fillable PDF form available online. A copy of the request form is available in the Appendix 28.

Additionally, the County provides a Guide to Medi-Cal Mental Health Services, a booklet that includes information about the mental health services that San Diego County offers and how to get the services. The booklet is available in English, Spanish, Tagalog, Vietnamese, Farsi, and Arabic. There is a section in the very beginning of the booklet that states:

“If you feel you have a mental health problem, you may contact the San Diego County MHP Access and Crisis Line directly at (888) 724-7240. This is a toll-free telephone number that is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. You do not need to see your regular doctor first or get permission or a referral before you call.”

Furthermore, in the section “How Do I Get These Services?” the booklet refers to the ACL and states:

“You can request a list of providers in the region where you live including their language and cultural specialties. There are County-contracted clinics and many individual outpatient therapists providing services in all of San Diego to meet many language and cultural needs. Free language assistance is available for mental health services. You have a right to mental health services in a language you understand. Free interpreting is available.”

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

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

SDCBHS has the following policies, procedures and, practices in place for informing Medi-Cal beneficiaries of available services under consolidation of specialty mental health services:

In order to inform all Medi-Cal beneficiaries of available services under consideration of specialty mental health services, the County of San Diego Mental Health Services has in place Policy #6030 (Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services) that ensures that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner to their special need to assist them to access Specialty Mental Health Services.

The SDCBHS widely distributes its “Quick Guide to Mental Health Services” in English and four other threshold languages to inform clients of what mental health services are and how they can be accessed. The Quick Guides are also available in an audio format on a CD upon request. Additionally, the County has made an effort to provide community information and education through a number of types of media. The Ethnic Services Coordinator provided a series of radio broadcast interviews in Spanish over the last few years.

As part of the process of setting priorities for the uses of MHSA funding, SDCBHS conducted extensive outreach activities to all cultural and linguistic groups through focus groups,

community forums, regional meetings, over 60 stakeholders meetings, surveys, meetings with community commissions, client and family liaison agencies, etc., to try to ensure that the needs of all were heard and recorded.

Most recently, two SDCBHS Community Forums, one community tele-town hall, three population-specific focus groups, one innovative population-specific teleconference focus group, and one frontline tele-town hall were held to gather community feedback. In addition, below are examples of evidence of outreach for informing underserved populations of the availability of cultural and linguistic services and programs from the Quarterly Status Reports (QSRs) that contracted programs submit to SDCBHS:

Children’s Mental Health Services

The **Fred Finch Youth Center** Residential Outpatient Mental Health Services program for adolescents with a dual diagnosis of severe emotional disturbance and developmental disability strives to help program participants return to lower levels of care and function successfully in a community setting. Cultural competence related activities and outreach conducted in FY 2018-19, include the following, but are not limited to: visits to Lake Murray and Lake Jennings for instruction on local history, wildlife, and ecology; visits to colleges to learn about future education opportunities; shopping to local Asian markets; preparing Asian foods; working for ‘Toys for tots’ give away, practicing yoga and mindfulness.

Palomar Family Counseling Services Inc. collaborates with external and internal school-based programs in Escondido, Vista, Oceanside and Valley Center school districts to ensure all students having difficulty in essential life areas are being served. Some of the cultural competence related activities and outreach conducted in FY 2019-20 include, but are not limited to:

- Summer programing included the Dina Camp Event, where families from Oceanside and Vista school districts were invited to attend. Palomar Family Counseling Services Inc. partnered with the City of Oceanside for use of two centers. A total of 42 children participated in Dina Camp. Children from preschool to third grade received an “Incredible Years” lesson and related activity. Parents were also engaged and provided with topic driven presentations such as Library Resources, Stress Relief techniques from a program staff bilingual LMFT, and Banking Basics with Mission Federal Credit Union.
- The program will be implementing Incredible Years (IY) Parent series at each of their sites. Thus far, the program has served 48 parents of at-risk children. Graduation ceremonies are held to recognize successful completion. There were 36 parents who graduated with their children present.
- The program used special funds, provided by San Diego County, to improve the program’s appearance and provide additional Trauma-informed service and treatment to all program employees, all in attempts to provide the best services to the community.

Pathways Community Services - Cornerstone is a Full-Service Partnership (FSP) program that provides school-based and outpatient behavioral health services. Cornerstone is currently partnered with twelve area schools within the San Diego Unified School District. It provides services at these partner school sites, in addition to home, community, and clinic-based services.

Their clients are primarily elementary school aged, with most clients being 8 to 14 years of age. Though, Cornerstone also serves a moderate number of middle school aged clients and TAY. Three of the Cornerstone clinicians are bicultural Hispanic/Latino and are bilingual in English and Spanish. Additionally, Cornerstone has one clinician who is African-American, one clinician who is Filipino and bilingual in English and Tagalog, and their psychiatrist is bilingual/bicultural in Vietnamese. Their QI Coordinator and Family Support Partner are both bicultural Hispanic/Latino and are bilingual in English and Spanish.

Kickstart's (First Break). Kickstart staff continues to attend Suicide Prevention Council held on the 4th Tuesday of every month. Kickstart directors also attend TAY Council on the 4th Wednesday of every month, with APD Joseph Edwards holding a council seat, representing Prevention and Early Intervention. A cultural competency training titled "Working with youth on Probation" was attended by all staff at Kickstart as part of their 4-hour cultural competency training. Additionally, Kickstart staff participated in a 3-day on-site training for CBT for Psychosis (an evidence-based practice) from Dr. Kate Hardy (from Stanford University) on 9/18/19-9/20/19.

San Ysidro Health Center's Chaldean Middle-Eastern Social Services is an outpatient mental health program serving Arab-American and Chaldean children/youth, including the new Iraqi and Middle-Eastern refugee children who have recently resettled in San Diego County, predominately in El Cajon. Services include the following: mental health counseling (individual and family); groups (process and didactic); school-based services (eight-week acculturation groups for newcomers); intake and screening; case management; community outreach; and crisis intervention.

Some of the cultural competence related activities and outreach completed in FY 2018-19 include: Annual Health Fair targeting refugee population in the East region and the staff provided depression screening and appropriate referrals to clients; provided a resource table for Live Well San Diego Initiative; attended the Annual Summit on Student Engagement and Attendance on October 12, 2018 hosted by San Diego County Office of Education (SDCOE), 9th Annual Primary Care and Behavioral Health Integration Summit on December 6, 2018 held at the Jacobs Center.

In FY 2019-20, the program served 188 clients through March 2020 with an active caseload of 151 cases. Additionally, this provider provides a 4-hour training workshop or presentation in the assessment and treatment of refugees from Iraq who have PTSD or are seriously mentally ill. This will be presented twice a year to behavioral health service providers of San Diego County.

San Ysidro Health Center's Youth Enhancement Services (YES) provides culturally competent community and school-based outpatient mental health services to children, adolescents, and their families that reside in the Southbay area, including the communities of San Ysidro, Imperial Beach and South San Diego. Clients range from ages 5-18 years old. Additionally, 100% of the YES staff is bilingual (English/Spanish) and bicultural. Some of the cultural competence related activities, including outreach, completed in FY 2019-20:

- The Program Manager, Case Manager, and Clinicians participated in Annual SchoolLink meetings at each of designated five school sites in the San Ysidro School District.

- At the invitation of San Ysidro School District, Roberto Suarez, LMFT (Program Manager) participated in a San Ysidro School Based Services Panel discussion. The panel provided information regarding school-based services that are currently being provided to students and families in the San Ysidro School District.
- Roberto Suarez, LMFT (Program Manager), Sergio Ibanez (Family Therapist), and Aide Arredondo attended the 10th Annual Primary Care & Behavioral Health Integration Summit on December 4, 2019 and provided highlights to YES staff at their weekly treatment team meeting.
- Collaborated/participated with McAlister and San Ysidro School District for Red Ribbon week. SYH's Substance Abuse Counselor provided educational materials and presentations for more than 600 students.
- All staff required to attend at least one Substance Abuse training during the fiscal year in an effort to continue striving to increase knowledge and strengthen skills in working with clients and families with co-occurring disorders.

Catalyst Program provided a lot of outreach programs at Logan Health Youth Center and Marina Village Conference Center targeting homeless TAY. Outreach programs were also held at Urban Angels and Girls Rehab.

Innovations Programs provide novel, creative, and/or ingenious mental health practices/approaches that contribute to learning within communities through a process that is inclusive and representative of underserved individuals. The following innovations programs will continue to be active in FY 2019-20:

- **Caregiver Wellness Program** is a countywide program serving ages 0-5 with clinician and care coordinators that focuses on addressing the behavioral health needs of caregivers through direct care and comprehensive referrals.
- **Family Therapy Participation Engagement** utilizes parent partners to focus on increasing caregiver participation in family therapy.
- **Faith-Based Initiative** has four components: Faith-Based Academy; Community Education; Crisis Response; and Jail-Based In-Reach.
- **Ramp Up 2 Work (Noble Works)** aims to provide job readiness training, and on-the-job paid apprenticeship, leading ultimately to paid competitive employment.
- **Peer Assisted Transition (PeerLINKS)** is a person-directed, mobile program that works in partnership with designated acute inpatient hospitals and provides alternatives to hospitalization through programs to engage and provide transition and support services to clients discharged back to the community.
- **Urban Beats** is intended to engage at-risk youth in wellness activities by providing a youth-focused message created and developed by youth. As of December 15, 2017, Urban Beats includes an East African subcomponent and as of January 31, 2020, 28 TAY have been enrolled in the East African cohort. A total of 145 TAY and 116 non-TAY were exposed to, or participated via in-person, artistic showings or performances in the various artistic expressions.
- **Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST)** aims to diminish long-term hoarding behaviors among older adults through a unique treatment approach that integrates cognitive training and exposure therapy combined with care

management, peer support, linkages to community services, and periodic in-depth assessments and evaluations to track progress.

New Innovation Programs:

- Short Term and Bridge Housing for TAY
- Just Be U
- Roaming Outpatient Access Mobile (ROAM) in North Inland Region
- Medication Clinic
- Accessible Depression and Anxiety Peripartum Treatment (ADAPT)

UPAC Multicultural Community Counseling (MCC) provides intensive cultural and specific outpatient behavioral health services and case management for seriously emotionally disturbed (SED) children (ages 5-20) and families from Asian Pacific Islander (API) and Latino communities with an emphasis on API. UPAC MCC is a Full-Service Partnership (FSP) program which utilizes case management to provide intensive services and supports as needed. Each client is assigned a therapist that provides culturally and developmentally appropriate clinical services. A Family Support Partner is available to provide intensive case management and rehabilitative services. As a function of the Full-Service Partnership program, the Family Support Partners link the client to a primary care physician and completes a Wellness Notebook. MCC facility hours are Monday through Friday from 9am-6pm, with an after-hours line available to MCC clients outside of facility hours. In addition, MCC provides outreach engagements providing education on services and mental health. Multiple language abilities include Vietnamese, Spanish, Cantonese, and Mandarin. Referrals are from medical facilities, schools, Child Welfare Services (CWS), hospitals, other providers, word-of-mouth, drop-in, and other UPAC programs. Full-scope mental health services are provided at clients' homes, community sites and clinic. In FY 2019-20, UPAC had collaborations with CCRT - Education and Training Workgroup - Focus Group, Cultural Competence Resource Team, MHCA Executive Meetings - Representative as Children at Large, CYF Behavioral Health System of Care, San Diego Refugee Forum, Outcomes Committee, QI Leadership, QIP, Community Engagement for Child and Family Strengthening, Nathan Fletcher Behavioral Health Forum, API Legislature Caucus, and CA Commission on APIA affairs.

Adult/Older Adult Mental Health Services

The Union for Pan Asian Communities (UPAC) Positive Solutions is a home-based program utilizing gatekeeper model to identify older adults experiencing and or are at risk of depression and suicide. The Overall goal of the program is to provide outreach, and mental health prevention and early intervention to homebound/socially isolated seniors residing in North County, North Central, and Central Region of San Diego. UPAC Senior Community Workers are diligently delivering their services toward stigma reduction among Latino, Vietnamese and other community; they achieve this goal by doing various presentations at the places where seniors congregate or at their place of living such as SRO, Mobile Homes, ILF, Assisted Living places, Churches, Food Banks, Senior Center, community events participation and other faith based organization such as churches, temples, mosques, etc. Trainings and outreach were completed by program staff and include the TET festival at the Mira Mesa community park on January 26, 2020, Suicide Prevention Training (ASIST) on January 9 and 10, 2020 , as well as the North County Action Network for Older Adults on February 25, 2020.

UPAC Elder Multicultural Access and Support Services (EMASS) program provides outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees, African-Americans, and Filipinos by Promotoras, a Latin American approach that uses community peer workers and community health workers. They participated in the County wide Healthy Heart Day on February 14, 2019 in their EMASS Community Center and Summercrest Senior Apartment in National City and its sites served a total of 58 participants. EMASS was also represented in HHSA's Age Well Health and Community Support and Social Participation committee; Multicultural Foundation Prevention Alliance; Older Adult Mental Health Providers Collaboratives; San Diego County Promotores Coalition; Be There San Diego Accountable Communities for Health, and Behavioral Health Services Older Adult Council. Latina CHW continue to maintain the social and recreational activities at Cultivando Sabiduria Community Senior Center in Vista. Arabic CHWs had a community meeting with the 16 community garden participants and resolved issues on funding, lot/space, and maintenance supplies.

UPAC Alliance for Community Empowerment (ACE Program) is a partnership of community organizations working together to address the effects of community violence. By strengthening families and empowering San Diego's Central Region youth, adults and families, we work together to make the community a safe place to live. Services include: The Mobile Response Team, Teen Empowerment (ages 12-17), Parent Empowerment, Strengthening Families (ages 10-14), and Grief Support Services.

Visions Clubhouse regularly attends meetings and provides outreach events to inform providers and the public of their enhanced services. Additionally, the staff participated in the Recovery through Creativity event and took participants to a number of parks and spots around San Diego.

Neighborhood House Association continues to participate in community fairs and speak to senior groups to expand its recognizability as a viable resource for community partners, individual families and clients to utilize when addressing geriatric mental health issues and concerns. Additionally, clinicians and staff have attended community fairs in order to provide counseling and outreach to older adults with mental health needs in the community, as well as to expand its visibility in the community as a viable resource.

Maria Sardiñas Center continues to collaborate with faith-based organizations on educating the community members to engage with Geriatric Outreach Specialists. Additionally, clinicians continue to collaborate with certified American Association of Diabetes Educators (AADE) to develop monthly groups for clients in support of their mental health and diabetes management.

Mental Health Systems, Inc is a bio-psychosocial recovery-based, voluntary recovery-oriented program for adults with a psychiatric diagnosis. Mental Health Systems has provided stigma workshops in various parts of San Diego including First United Methodist Church, North County Providers, Crestwood Behavioral Health and Integration Summit in order to increase awareness of mental illness in the community and to educate community members on program's enhanced services.

Alianza (Alliance in English) Wellness Center is currently funded to have a primary focus on the Latino population and is staffed to provide services for individuals who use Spanish as the primary language. This program has been in operation since August 2019, when it received Short-Doyle Medi-Cal Certification. They started with a census of zero and continue to have available capacity to serve the community. Over the past year, to increase their census, the program partnered with a Residential Treatment provider included in BHS DMC-ODS. Alianza utilized their mobile outreach services for engagement of individuals to link to their outpatient services. This additional and unplanned support helped to engage the LGBTQI+ community and created an effective support for individuals who require assistance for services in both mental health and substance use at the same time.

Targeting All Populations

Survivors of Torture, International (SURVIVORS) provides bio-psychosocial rehabilitation services in the community that are recovery and strength-based client and family driven, and culturally competent. Program administration regularly attends meetings and provides outreach events to inform providers and the public of their enhanced services. As of March 2020, they have served 85 unduplicated clients comprised of children, asylum seekers, refugees, legal permanent residents or naturalized citizens, which exceeds their Statement of Work expectation of 71 clients annually and communicated in more than 50 different languages through their professional interpreters.

Deaf Community Services of San Diego, Inc. (DCS) continues to work closely with DeafHope, McAlister Institute, Child Welfare Services (Deaf Unit), Minnesota Chemical Dependency Program, and the Bridgman Group Home to coordinate efforts and ensure a seamless system of care within the deaf community. Additionally, DCS is involved with the San Diego Sober Living Coalition and the National AA program to improve sober living options and self-help groups for the deaf community.

Indian Health Council, Inc. has facilitated and participated in a significant number of community activities and events. Specific examples of community outreach are participation/presentations: Star Gathering at Campo and Barona Cultural Gathering to distribute materials on suicide prevention and awareness; Bike Rodeo at Campo Educational Center; “We R Native proud” Youth Meetings and events; Viejas Kumeyaay Family Gathering on Bullying and Parenting Teenagers; and National Council on Aging, Suicide Prevention and Older Adults Webinar. In April 2021, Indian Health Council, Inc. became a DMC-ODS SUD contracted provider offering outpatient services to clients.

La Maestra provides culturally and linguistically competent primary care, specialty services including behavioral and mental health, chronic disease management and essential support services to men, women and children in San Diego’s most culturally diverse and lowest income communities. Services are provided at four medical clinics, seven dental sites, three school-based health centers, and a mobile medical unit. Its main health center is located in City Heights, a community that is home to more than 90,000 residents, many of whom are recently settled refugees and immigrants from more than 60 countries with unique health and well-being needs.

It’s Up to Us campaign is designed to empower San Diegans to talk openly about mental illness, recognize symptoms, utilize local resources, and seek help. People do not seek professional care

and seek support, nor give support, because of the stigma that is associated with having a mental illness. To combat stigma, It's Up to Us educates the community and provides easy access to local organizations and services. The goal of the campaign is to initiate change in perception, inspire wellness, and reduce the stigma surrounding mental health challenges. In FY 2018-19, new Up2Us materials and media spots that reflect a more culturally diverse audience were produced. The existing outreach materials were adapted to be more culturally appropriate and reflective of the client base of the San Diego County Sheriff's Department to engage their Justice-involved clients and family members with suicide prevention and stigma reduction messaging. The Don't Delay campaign which is an update on outreach materials is projected to reach the black community, men, and older white men.

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:

a. Location, transportation, hours of operation, or other relevant areas;

As stated in the contracted Statements of Work, the following standards are required:

1. Sites shall be located within four blocks of a public transportation stop and shall meet all related state and local requirements.
2. Program hours of operation must be convenient to accommodate the special needs of the service's diverse population. In most cases, evening or weekend appointment hours for treatment services shall be available and scheduled as needed for a minimum of four hours per week.
3. The program site shall be welcoming to the various cultural populations in the community and to individuals with co-occurring disorders (COD) by providing materials, brochures, posters and other information regarding cultural competence and COD.
4. Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities.
5. Outpatient mental health services shall be provided in accordance with the County of San Diego's Cultural Competence Plan, Culturally and Linguistically Appropriate Services (CLAS) Standards, and the MHSA Gap Analysis.
6. Cultural Competence: Contractor shall comply with cultural competence requirements as referenced in the OPOH and the SDCBHS Cultural Competence Handbook, located on the Technical Resource Library (TRL), and shall demonstrate integration of cultural competence standards described in the San Diego County Behavioral Health Services (SDCBHS) Cultural Competence Plan located on the TRL.
 - Contractor shall provide a Human Resource Plan that includes how contractor will recruit, hire, and retain bilingual and culturally diverse staff.
 - Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County.

- 100% of staff shall participate in at least four (4) hours of cultural competence training per fiscal year.
 - Contractors shall provide a Cultural Competence Plan that is consistent with the SDCBHS Cultural Competence Plan. This may be the Legal Entity's Cultural Competence Plan.
 - Contractor shall use the Cultural and Linguistic Competence Policy Assessment (CLCPA) and the Promoting Cultural Diversity Self-Assessment (PCDSA) as tools to determine the levels of cultural competence at an organizational and staff levels, respectively. These tools are referenced in the OPOH and can be found in the SDCBHS Cultural Competence Handbook (Appendix 14). COR shall advise the Contractor when there is a need to use other evaluation tools.
 - Culturally and Linguistically Appropriate Services (CLAS) Standards: To ensure equal access to quality care by diverse populations, each service provider receiving funds from this contract shall adopt the federal Office of Minority Health CLAS Standards.
7. Mental health services are based on Biopsychosocial and Rehabilitation (BPSR) principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. BPSR guiding principles specify that services shall be client centered, culture centered, and built upon client's strengths.
8. Contractor's program and services shall be trauma-informed and shall accommodate the vulnerabilities of trauma survivors. Services shall be delivered in a way that will avoid inadvertently re-traumatizing clients and facilitate client participation in treatment. Contractor's trauma-informed program and services shall include: Screening of Trauma; Consumer Driven Care and Services; Trauma-Informed, Educated, and Responsive Workforce; Provision of Trauma-Informed, Evidence-Based and Emerging Best Practices; Safe and Secure Environments; Community Outreach and Partnership Building; and Ongoing Performance Improvement and Evaluation.
- All clients shall use current screening and assessment tools that include questions regarding trauma upon admission.
9. Contractor shall perform linkage and referrals to community-based organizations including, but not limited to, primary care clinics and complementary healing centers and faith-based congregations, ethnic organizations and peer-directed programs such as Clubhouses.
- 100% of clients requesting to be linked to any faith-based congregation shall be connected to the client's organization of choice.

SDCBHS in collaboration with the UCSD Health Services Research Center (HSRC), began the development of ClubHOMS in 2018, a highly secure, integrated web-based system for data collection and reporting for San Diego County Clubhouses. The goal is to improve the ability to track the usage and effectiveness of the County's Clubhouse programs. Clubhouses transitioned to and piloted the new ClubHOMS system in March 2019, and the system was fully launched by July 1, 2019. HSRC led the Clubhouse Director's Meeting discussions to gather feedback on the design of the new data system. The monthly meetings (which began in July 2018) focused on the development of ClubHOMS and several more meetings were planned in early 2019. In addition, HSRC organized a series of four focus groups at Clubhouses with staff and members in January

and February 2018. The purpose of these focus groups was to understand attendees’ perspectives on the outcomes that should be measured and validated self-report instruments that would be most useful for assisting members with tracking their recovery. HSRC has also conducted site visits to four Clubhouses during which staff detailed their current data tracking processes. More recent site visits have focused on collaborating with Clubhouse staff to create a plan for merging data from the current data system into ClubHOMS.

QI has worked extensively with new DMC-ODS providers to provide further training and support and to minimize requirements to facilitate the programs’ assimilation of the San Diego Web Infrastructure for Treatment Services (SanWITS). QI continues to respond to the entire DMC-ODS system of care’s need for enhanced monitoring and extra support particularly within the QI, billing, and fiscal infrastructures. Multidisciplinary teams were deployed starting May 2019 to provide support to providers by identifying thresholds in these domains, and helping providers work towards compliance. Further support on SanWITS data entry and reports are also being rolled out in 2020.

SDCBHS also conducted a review of requirements and priorities related to core operations and compliance with the Intergovernmental Agreement with the Department of Health Care Services (DHCS). As a result, the Medical Director's training requirements were re-evaluated and streamlined during the past year. Additionally, the training website was reconfigured to demonstrate what was a "one-time only" training versus what was an annual training requirement, thus minimizing provider confusion on training requirements and allowing them to prioritize as needed. Webinars were developed, as well, to create “on demand” availability to ensure provider schedule flexibility. The webinars are located on the “[DMC-ODS Required Trainings](#)” webpage hosted on the BHS website. There is no restriction to access, as it is available to all with internet access.

Other trainings are also available through BHS’ workforce training contractor, Responsive Integrated Health Solutions (RIHS), at no cost to SUD and mental health providers. This is a resource provided to reduce the administrative burden of providers having to locate and purchase trainings that are either required or of benefit to service delivery and operational success. Notable examples of RIHS SUD trainings include the *ASAM Overview*, *DMC Certification*, *Enhanced Case Management*, and *Overview of the ‘Risk Assessment and Safety Management Plan’ for Substance Use Providers*.

b. 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).

SDCBHS requires its service providers to comply with the facility standards as required in Statements of Work. Contractors’ facilities must meet all related state and local requirements, including the requirements of the American with Disabilities Act (ADA) and California Title 24.

In addition, contractors shall comply with all applicable provisions of the OPOH. The specific requirement for facilities: *In order to present a welcoming appearance to unique communities,*

providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations.

E. 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.)

Through MHSA, SDCBHS has funded programs that include co-location of services and/or partnerships with primary care services in non-threatening community settings, as well as non-traditional behavioral health settings in an effort to better connect with ethnic/racial groups who are often more comfortable seeing their family doctor. These efforts include:

Health Center Partners (previously Council of Community Clinics) is comprised of 16 health centers and other safety-net providers operating more than 140 sites throughout San Diego, Imperial, San Bernardino, Orange, and Riverside Counties, including 13 Federally Qualified Health Centers and three Indian Health Centers. In FY 2018-2019, the Primary Care and Behavioral Health Integration Project managed by Health Center Partners served 972 unique SDCBHS clients in San Diego. During that time the clients served by that project can be described as follows:

- Clients were treated for the following behavioral health conditions: Depression Disorders (50%), Anxiety Disorders including generalized anxiety, phobias, PTSD and adjustment disorders (38%), Bipolar Disorders (5%), Substance Use Disorders and Other Addictive Disorders (3%), Psychotic Disorders (2%), and Other Disorders (2%).
- The African American client population comprised of 2.6% of those served, and the majority (66.5%) of the clients served were Hispanic.
- 24% of the 972 clients served were between the ages of 18-29; 23% between 30-39; 23% between 40-49; 19% between 50-59 and 11% were 60+.
- Clients received a total of 3659 visits for therapy and medication management at participating health centers.
- The Peer Promotoras visited 3,170 sites and had 23,137 contacts with potential clients.

San Diego Youth Services encompasses a family-focused approach that engages families in their child's school success. School-based interventions are coordinated and designed to improve school climate, educational success, and child/parent social and emotional skills. The program focuses on school-age children and their families, as well as underserved Asian/Pacific Islanders and Latinos in order to reduce family isolation and stigma associated with seeking behavioral health services, increase resiliency and protective factors for children, reduce parental stress, and improve school climate for children to thrive at school. Services include: Positive Behavioral Support (PBS), screening and early identification of at-risk children, community outreach to families, and education and support.

SmartCare (Vista Hill) prevents patients in rural community clinics from developing an increased level of behavioral health issues, severe mental illness, or addiction. SmartCare specifically focuses on children, adolescents, transition age youth, adults, and older adults in community clinics located in the rural areas of San Diego and provides assessment and short-term interventions in rural community clinics for individuals who may be at risk for or in the early stages of mental illness. Services include assessment, brief intervention, education, and mobile outreach.

Project In-Reach primarily focuses on at risk African American and Latino citizens who are incarcerated adults or Transition Age Youth (TAY) at designated detention facilities and will be released in San Diego County. Project In-Reach program is designed to help incarcerated individuals with substance abuse and/or mental health disorders as they prepare for re-entry into the community by becoming educated about addiction and learning new coping mechanisms. Project In-Reach can also assist in the successful linkage to community resources and services pre and post release, guiding in the transition process and assisting in a positive new beginning.

Native American Integrated Services in San Diego County has integrated mental health services into primary care settings targeting Native Americans. Examples of programs that target prevention and early intervention to Native Americans are:

- The **Southern Indian Health Council, Indian Health Council, and San Diego American Indian Health Center** provide primary health, dental, specialty and specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the American Indian/Alaska Native (AI/AN) community in East San Diego County. They all focus on at-risk and high-risk children, TAY, adults and older adults and aims to increase community involvement and education through services designed and delivered by Native American community members.
- **San Diego American Indian Health Center** provides specialized culturally appropriate PEI services to Native American Indian/Alaska Native (AI/AN) Urban youth and their families who are participants at the Youth Center. The goal of San Diego American Indian Health center is to reduce the significant health disparities of San Diego’s urban American Indian population by increasing access to care and improving the quality of that care, resulting in increased life expectancy and improved quality of life.

SDCBHS continues to work with NAMI in their outreach to the community on reducing mental health stigma. In May of 2018, NAMI San Diego delivered a training at the County of San Diego’s Knowledge Center that met both continuing education and cultural competency requirements. The training, Mental Health Awareness and Available Resources, provided an interactive, comprehensive overview of mental health incorporating the lived and professional experience of the 3 presenters: Peer, Family Member, and the Clinician. Furthermore, NAMI San Diego has continued their outreach work within the community regarding mental health stigma through events such as the NAMI 5K walk, an event aimed to raise awareness about mental illness, and the Children’s Mental Health Well-Being Celebration at the ARTS Center in National City. The free event featured food, art, giveaways, and fun activities focused around the year’s theme, *Suicide Prevention: Strategies That Work*. Additionally, their program, In Our Own Voice, also allows community members and those with lived experience to share their stories of recovery with others. NAMI has several programs that support clients and provide

mental health resources, with new notable additions such as PeerLINKS, Side-by-Side, and the NAMI San Diego Tech Café.

ADAPTATION OF SERVICES
<p>III. Quality of Care: Contract Providers</p> <p>A. The County shall include the following in the CCPR:</p> <p><i>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.</i></p>

As discussed in Section II.D. above, provider contract language contains the Standard Service Delivery Requirements which include:

“Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities.”

The Cultural Competence Handbook states:

- **Cultural Competence Plan**
 To address these issues in the 2020 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

As stated in the contracted Statements of Work, the following standards are required:

1. Continue to conduct an ongoing evaluation of the level of cultural competence of the mental health system, based on an analysis of gaps in services that are identified by comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.
 2. Continue to compare the percentage of each target population with provider staffing levels.
 3. Investigate possible methods to mitigate identified service gaps. Enhance cultural competence training systemwide.
 4. Evaluate the need for linguistically competent services through monitoring usage of interpreter services.
 5. Evaluate system capability for providing linguistically competent services through monitoring organizational providers and Fee-for-Service (FFS) capacities, compared to both threshold and non-threshold language needs.
 6. Study and address access to care issues for underserved populations.
- **Current Standards and Requirements**
 To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is

representative of, and knowledgeable about, the clients’ culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

As discussed previously, the National CLAS Standards have replaced the Culturally Competent Clinical Practice Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competence across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 standards.

The standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an on-going basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals, and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct on-going assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Diversity is sought in the Source Selection Committee (SSC) reviewing all proposals received. Input and feedback is also sought in Industry Days for draft SOWs, as well as in stakeholder and community forums. Client and family focus groups provide input and feedback as well.

SDCBHS expects proposers to demonstrate a high level of achievement as an agency in providing culturally competent and culturally relevant services through the submittal requirement in the Requests for Proposals (RFPs) process. Proposers are also required to describe how the work specified in the Statement of Work, including meeting cultural competence requirements, will be accomplished.

SDCBHS focused on minimizing the bureaucratic impact on providers. The executives regularly met with MHS and SUD providers through the Mental Contractors Association of San Diego (MHCA) and the Alcohol & Drug Services Provider Association (ADSPA). MHCA represents the interest of San Diego County mental health contractors, while ADSPA is comprised of SUD providers – both groups are focused on increasing and maintaining the quality of services by meeting the service needs of San Diego County residents. The SDCBHS executives meet with both groups to strategize the reduction of administrative burden on clinical staff. One example of these strategies' fruition is the redesign of the client Discharge Summary Form, which includes questions that capture the clients' goals, discharge reason, and level of care destination.

During a CCRT meeting, stakeholders discussed how a contractor's ability to provide culturally competent behavioral health services is taken into account in the County's selection of contract providers. It was suggested that SDCBHS conduct contractor forums to seek out providers that do not usually contract with the County. In addition, there should be more flexibility with the background investigation during the hiring process, specifically for those with lived experiences. For example, in peer-to-peer programs, the lived experience is what makes the individual more qualified for the position, but the lived experience can hinder them from being hired due to the background investigation requirements. Continuing with the example of Peer Support Specialist positions, it was recommended to adjust the culture of productivity in the workplace for such employees. The amount of required paperwork at time of hire can also be overwhelming for the Peer Support Specialist. However, in discussions it was also realized that there is a balance required since peer employees should not be treated differently than other employees and should not have special accommodations based on their role. It was also recommended that supervisory training courses on how to supervise Peer Support Specialists be required for all programs that employ peers. The training should focus on those who supervise and/or are looking to hire Peer Support Specialists and would cover the essence of Peer Support, provide insight into Peer Employment Training, and assist employers in recruiting and retaining Peer Support Specialists.

Another suggestion was regarding the age group after TAY. It was suggested to develop programs that specifically target the age group 26 to 35 years. Such programs will allow individuals who age out of the TAY services a place to go and serve as a seamless transition from TAY services. A specific need was identified for clubhouse services for clients 26 to 35-

year old, as the non-TAY clubhouses tend to attract an older population. The community also suggested enhancing interpreter-led educational groups, which would focus on addressing mental health stigma and the communication of mental health issues in different cultures. Additionally, the importance of focusing on outreach to individuals who have not yet connected with SDCBHS programs was also discussed.

Stakeholders also had a discussion regarding the County’s policies, procedures, and practices to assess the quality of care provided for all consumers. One suggestion was to examine how the County can minimize the bureaucratic impact on providers, such as required paperwork. A second recommendation was regarding quality assurance for SDCBHS. The community discussed that there should be an evaluation process for SDCBHS to ensure that its policies are culturally competent. It was also suggested that in Requests for Proposals (RFPs), there should be specific line items for compensation for speaking additional languages versus allowing Offerors to include bilingual incentives but not requiring it. Lastly, there was concern expressed over the utilization management processes needing to occur after every thirteen individual treatment sessions for children and youth (the short-term treatment model) and suggested reevaluating the model.

With the community input received, the SDCBHS will focus on the implementation of Collaborative Documentation to assist with reduction of paperwork by incorporating the documentation of required information into each session. Collaborative Documentation is a model that supports recording services on appropriate forms in cooperation with the person served, such as during the service for service planning and diagnostic assessments, and at the end of the service for Progress Notes. With this model, it is suggested that there are higher levels of client engagement with treatment, as client involvement with the full process can expand the clinical discussion and the treatment is more individualized and person centered. In addition, this model ensures accuracy of documentation and reduces documentation load.

With the community input received, SDCBHS will focus on collaborating with CORs to encourage participation in supervisory training.

ADAPTATION OF SERVICES

IV. Quality Assurance

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

The County shall include the following in the CCPR:

A. List if applicable, any outcome measures, identification, and description of any culturally relevant consumer outcome measures used by the County.

One way to ensure that services are responsive to consumer needs is to collect information from the clients about their satisfaction with services and their perspectives on the quality of services.

Data on consumer satisfaction is collected through the semi-annual Youth Services Survey (YSS) which is completed by all youth (ages 13+) and parents/caregivers, and the Mental Health Statistics Improvement Program (MHSIP) Survey, which is completed by adults and older adults (ages 18 and older). In May 2019, the survey yielded the following results on the cultural and linguistic competence of the programs and services:

MHS State Survey Question	YSS “Agree/Strongly Agree” Responses		MHSIP “Agree/Strongly Agree Responses” Adult/Older Adult Clients (N=2,365)
	Youth Clients (N=1,181)	Family Members (N=2,155)	
Staff were sensitive to my cultural/ethnic background.	83.1%	96.2%	87.1%

During the most recent survey period for which the results are available (May 2019), the survey yielded the following results on the cultural and linguistic competence of the programs and services:

MHS State Survey Question	YSS “Agree/Strongly Agree” Responses		MHSIP “Agree/Strongly Agree Responses” Adult/Older Adult Clients (N=2,406)
	Youth Clients (N=1,114)	Family Members (N=1,996)	
Staff were sensitive to my cultural/ethnic background.	86.2%	96.4%	86.0%

Data on consumer satisfaction continues to be collected for youth and adult clients through the Youth Treatment Perceptions Survey (TPS) and the Adult Treatment Perceptions Survey (TPS) respectively during the October 2019 survey period. The Youth TPS was completed by any client 18 years old or younger served by a substance use disorder program in the youth system of care contracted by SDCBHS during the survey period. Meanwhile, the Adult TPS was completed by clients over 18 years of age.

SUD State Survey Question	Youth TPS “Agree/Strongly Agree” Responses Youth Clients (N=126)	Adult TPS “Agree/Strongly Agree Responses” Adult/Older Adult Clients (N=2,361)
Staff were sensitive to my cultural/ethnic background.	68%	88%

Additionally, these surveys evaluated the clients’ and the family members’ perception of the availability of materials in their preferred language, and the results below are for the three most recent survey periods:

Youth Clients (“yes” answers)			
YSS State Survey Questions	May 2017	May 2018	May 2019
Services received were provided in the preferred language.	96.4%(N=1,086)	96.1%(N=1,085)	95.6% (N=1,026)
Written information was available in the preferred language.	93.2%(N=1,049)	93.8%(N=1,056)	93.4% (N=998)
Parents/Caregivers (“yes” answers)			
YSS State Survey Questions	May 2017	May 2018	May 2019
Services received were provided in the preferred language.	98.4% (N=2,023)	98.5% (N=2,031)	98.9% (N=1,862)
Written information was available in the preferred language.	97.5% (N=2,023)	97.4% (N=2,019)	98.3% (N=1,848)

Adult/Older Adult Clients (“yes” answers)			
MHSIP State Survey Question	May 2017	May 2018	May 2019
Were the services you received provided in the language you prefer?	97.0%	98.0%	98.0%

The 2019 MHSIP and YSS reports can be found in Appendices 36 and 37.

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

Cultural and Linguistic Competence Policy Assessment (CLCPA)

One of SDCBHS’ quality improvement strategies is to survey all programs to assess for culturally competent service provisions. Accordingly, all County and County-contracted programs are required to complete the CLCPA on an annual basis. The CLCPA was

implemented in October of 2017. It was developed by Georgetown University’s National Center for Cultural Competence and was adapted by SDCBHS to be used by programs to evaluate their perception of their programs’ cultural and linguistic competence. The CLCPA is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and aligned with the CLAS Standards.

In February 2020, the SDCBHS QI unit administered the CLCPA among contracted MHS and SUD programs, and distributed program-level results to CORs. SDCBHS CORs will continue to incorporate this tool in monitoring their respective programs. A total of 228 programs responded to the survey, with 161 (70.6%) from MHS, and 67 (29.4%) from SUD Services.

Results show that:

- The majority of respondents were in a Program Manager or Program Director role (49.8% and 40.8%, respectively). Almost 10% of respondents indicated that they held another position at the program. The same breakdown of respondents was recorded for the 2019 CLCPA.
- Respondents reported that they were fairly or very familiar with the diverse communities and the demographic makeup of their service areas. These results are almost identical to those from 2019.
- Majority of respondents indicated some form of personal and program staff involvement in the communities’ culturally diverse activities.
 - The majority of respondents indicated support for cultural competence in the overall organizational philosophy most of the time or all the time.
- About four-out-of-five respondents reported collaborating with community-based organizations to address the health and mental health needs of culturally diverse groups in their service area.
 - More than three quarters of the respondents (77.6%) indicated that their organizations identified opportunities for staff to share their experiences and knowledge about diverse communities with colleagues most of the time or all the time. This proportion has fell by about 3% compared to those reported in the 2019 CLCPA.
- Responses indicated that the organizations’ staff were relatively diverse culturally and linguistically, with Peer Support Specialists and support staff as the most diverse classifications, and the board members and executive management as the least diverse. These results were similar to those reported on the 2019 CLCPA.
 - Upon review of the 2020 CLCPA at a SDCBHS CCRT meeting, the attendees discussed methods by which the low level of diversity among leadership and executive management positions could be addressed.
- According to the respondents, the programs use trained medical interpreters more regularly than certified medical interpreters or sign language interpreters. While nearly half of the respondents indicated that their organizations regularly evaluate the quality and effectiveness of these services, about a fifth reported that their organizations never or seldom did so; this proportion is identical to those reported on the 2019 CLCPA.
- Most of the technical assistance (TA) requests from the participating providers were related to community engagement, the CLAS Standards, interpretation services, beneficiary materials, assessment tools, and whole person wellness.
- Nearly all respondents (98.7%) indicated that their organizations’ Cultural Competence Plans identified and supported the CLAS Standards.

The 2020 CLCPA Report is available in Appendix 22.

The Promoting Cultural Diversity Self-Assessment (PCDSA)

The self-assessment is administered every two years to all County-contracted and County-operated staff with a goal to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The PCDSA was implemented in SDCBHS in 2018, and the results were not available.

In February 2018, the SDCBHS QI unit administered the PCDSA among contracted MHS and SUD programs. A total of 2,672 program staff responded to the survey, with 2,195 (82.1%) from MHS, and 477 (17.9%) from SUD Services. The results show that:

- Female staff survey respondents outnumber males 3 to 1, compared to the FY 2016-17 Systemwide client population which shows males (57%) outnumbering females (43%).
- The providers' self-reported race distribution closely reflects the self-reported race distribution of clients served in FY 2016-17. Majority of staff survey respondents (52%) speak English only, and Spanish is the second most prevalent primary language among staff survey respondents (37%). Less than 1% of staff survey respondents speak Vietnamese as a primary language, and the same is true for primary speakers of American Sign Language.
- Peer Support Specialists/Youth Support or Family Support Partners make up 15% of MHS staff survey respondents, compared to 6% in the same category for SUD.
- The programs' Physical Environment, Materials, and Resources reflect the greatest need overall. For example, offering food that is unique to the community's ethnic group did not occur to 12% of the respondents. The greatest disparity between MHS and SUD staff responses is reflected in the results for Question 37 (pertaining to awareness of cultural-specific healing methods). A total of 3% of MHS respondents answered "Did not occur to me" compared to 29% of SUD respondents. The same proportion of MHS respondents (30%) answered "Things I do occasionally" to this question.

The 2018 PCDSA Report is available in Appendix 23.

Mental Health and SUD Entity Cultural Competence Plans

In August 2019, MH and SUD legal entities were required to submit Cultural Competence Plans to outline current status and future goals for cultural competence within their organizations. The QI Unit formed a committee to evaluate the plans, note any innovative practices, and provide feedback on any areas which might benefit from enhancement. The committee focused on how the entities tailor services to reflect ethnic, racial, cultural, and linguistic profile of their unique service areas, as well as plans for addressing and reducing any service disparities affecting the programs (see the Review Guidelines in Appendix 38).

C. Grievance 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 Organizational Provider Operations Handbook (OPOH) and Substance Use Disorder Provider Operations Handbook (SUDPOF) outlines the Beneficiary and Client Problem Resolution Policy and Process to establish procedures for the monitoring of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) plan and Beneficiary and Client Problem Resolution Process; to ensure that client rights are maintained to their fullest extent; and to ensure MHP and DMC-ODS plans are in compliance with federal, state, and contract regulations.

The SDCBHS QI Unit is responsible for monitoring grievances, appeals, expedited appeals, and State Fair Hearings emanating from usage of the Beneficiary and Client Problem Resolution Process in order to identify trends and issues and make recommendations for needed system improvements. The QI Unit submits any required reports on grievances, appeals, expedited appeals, and State Fair Hearings to the DHCS on an annual basis and as required.

In order to ensure all client needs are met, unbiased contractor programs are available for clients to receive information about their inpatient and/or outpatient mental health services. Examples of contractor programs are below:

- **Jewish Family Service (JFS) Patient Advocacy** provides support for all inpatient mental health services. JFS Patient Advocacy represents patients in inpatient psychiatric hospitals, responds to inpatient psychiatric grievances and complaints, provides residential advocacy, responds to inmate mental health concerns, advocates for minors' rights, and provides trainings. The Patient Advocacy Program works to improve the mental health system by monitoring San Diego County hospitals, reviewing and commenting on policies and practices which affect recipients of mental health services, providing consultation and generating policy questions for the State Office of Patients' Rights, coordinating with other advocates for system reform, analyzing state and federal legislation and regulatory developments, and representing clients' interests in public forums.
- **Consumer Center for Health Education and Advocacy (CCHEA)** provides clients with information about their health plans and educates them about their rights, including information on the Affordable Care Act (healthcare reform) and how it affects them. The program also helps to advocate for those who have had their health services denied, reduced, or terminated, or who are unhappy with their health services and provides investigation of mental health patients' complaints. CCHEA is designated by SDCBHS as patients' rights advocate for outpatient mental health services.

SDCBHS contracts with these advocacy programs to provide services to consumers in MHP/DMC-ODS plans at inpatient, outpatient, and residential facilities, as well as other types of mental health and substance use disorder programs.

Quality Management Teams within the SDCBHS QI Unit prepare a summary of grievances, appeals, expedited appeals, and State Fair Hearings on a semi-annual basis. Additionally, the SDCBHS QI Unit compiles grievances and appeals received by JFS and CCHEA and developed a quarterly dashboard for review at the Quality Review Council (QRC) meetings. The

Grievances and Appeals dashboard summarizes the total grievances received, grievances resolved, appeals received, and appeals resolved. The quarterly dashboard also provides the count per quarter number of grievances received in the following categories for MH system of care: Access to Care, Quality of Care, Change of Provider, Confidentiality, and Other, as well as the following categories for SUD system of care: Access to Care, Quality of Care, Program Requirements, Enrollee's Rights, Relationship Issues, and Other. For an example of the quarterly Grievances and Appeals dashboard report, see Appendix 39.

Three-Year Strategic Cultural Competence Plan (July 1, 2021 – June 30, 2024)

As SDCBHS starts a new cycle of three-year strategic goals for the annual Cultural Competence Plan, the following goals were developed for Criterion 8:

- Enhance behavioral health services care coordination by developing regional hubs.
- Enhance the role of peer and family partners within recovery and wellness programs.
- Review and enhance language utilized with individuals served throughout the system of care to ensure sensitivity and inclusivity.