This Cultural Competence Plan is available separately and can be found in the Technical Resource Library at: www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html *(Section 4)*.

Progress Towards Reducing Disparities in Mental Health Services

County of San Diego Behavioral Health Services

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Fiscal Years: 2009-2010, 2012-2013, and 2015-2016

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

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PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Executive Summary

The purpose of the Progress Towards Reducing Disparities report is to describe progress towards the reduction of disparities across age and racial/ethnic groups in both the 1) Children, Youth, and Families (CYF) and 2) Adult and Older Adult (AOA) Systems of Care in the County of San Diego Behavioral Health Services (BHS). This triennial report covers three time-points spanning six fiscal years (FY): 2009-10, 2012-13, and 2015-16.

The Mental Health Services Act (MHSA), which passed in 2004, allowed San Diego County to begin a large-scale implementation of programs in FY 2007-08. This influx of funding allowed for: 1) the creation of new services, and 2) the enhancement of existing programs and services. These enhancements included the implementation of Full Service Partnership (FSP) services, with a "whatever it takes" approach to address the clients' path to recovery. FSP programs provide comprehensive services offered by a team of mental health professionals. Services under FSP may also include the availability of short-term housing for adult clients. Overall, the additional MHSA funding enhanced the level and quality of care for unserved and underserved populations in San Diego County.

This report assesses age and racial/ethnic group disparities in service utilization (penetration rates), engagement (retention rates), type of services used (i.e. outpatient versus inpatient/emergency services), and diagnosis.

Utilization and other client data for this report were obtained from Cerner Community Behavioral Health (CCBH), formally Anasazi. Analyses of service utilization (penetration rates) required the calculation of a ratio consisting of behavioral health care system clients divided by the population eligible for services (target population) for a specific age or racial/ethnic group. Eligible clients were defined as those individuals in San Diego County who were uninsured or Medi-Cal eligible, and were under 200% of the federal poverty level that could potentially have a serious mental illness.

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

For children and youth, comparisons across fiscal years demonstrated that service utilization decreased for White, African American, and Native American clients from FY 2009-10 to FY 2015-16. Service utilization for Asian/Pacific Islander clients decreased slightly in FY 2012-13 from FY 2009-10, but increased back to the same rate as FY 2009-10 by FY 2015-16. For Hispanic clients, service utilization increased from FY 2009-10 to FY 2012-13, and then decreased from FY 2012-13 to FY 2015-16. Prior to FY 2015-16, there was a decreasing trend in service utilization from FY 2009-10 to FY 2012-13 for all racial/ethnic groups, except for Hispanic clients. Hispanic clients showed increasing service utilization across all these time points, until the decrease noted in FY 2015-16.

Similar to findings from previous analyses of disparities accessing mental health services in San Diego County, Hispanic, Asian/Pacific Islander, and Native American children and youth utilized services less frequently in FY 2015-16 than would be expected based on their proportion in the target population. However, it should be noted that 63% of children and youth clients were Hispanic. Service utilization was lowest among Native American and Asian/Pacific Islander clients, across all three fiscal years, compared to other racial/ethnic groups. Engagement for extended services (13+ sessions) was lowest for the Asian/Pacific Islander and Hispanic groups (46% each).

When examining types of services used, it was found that while a majority of CYF clients used outpatient services (95%), there were some racial/ethnic groups that utilized a disproportionate amount of more restrictive levels of service. In FY 2009-10 and FY 2012-13, Asian/Pacific Islander clients used inpatient/emergency screening unit (ESU) services without receiving any outpatient services more than any other racial/ethnic group (5% versus

1-2%*). However, utilization of these services among Asian/Pacific Islander clients decreased in FY 2015-16 to a utilization rate similar to that observed among other racial/ethnic groups (2% versus 0-1%*). African American clients used more Juvenile Forensic Services (JFS) without receiving any outpatient services compared to other groups (8% versus 3-5%*).

Several disparities were also found when examining racial/ethnic differences in diagnoses. Native American clients had the lowest rates of bipolar disorders (4% versus 7-8%*), and Asian/Pacific Islander clients had the lowest rates of stressor and adjustment disorders (15% versus 23-24%*). Depressive disorders were most common for Asian/Pacific Islander clients (26% versus 18-22%*). Externalizing disorders (i.e. oppositional/ conduct disorders and ADHD) were most common among African American clients (15% versus 10-13%*), and 17% versus 10-15%*), respectively]. African American clients were diagnosed with anxiety disorders less often than those in the other racial/ethnic groups (6% versus 11-13%*).

Regarding age, penetration rates increased for all age groups from FY 2009-10 to FY 2012-13, and then decreased for all age groups from FY 2012-13 to FY 2015-16. This pattern was most noticeable among children between the ages of six and eleven years. Children ages five years and younger were less likely than the other age groups to receive 13 or more service sessions, and more likely to only receive one service session. Lastly, the type of service used also varied notably by age group, as almost all younger children used only outpatient services.

Adult and Older Adult System of Care (AOA SOC) Findings

For adults and older adults, there was also an overall decrease in service utilization for most racial/ethnic groups from FY 2009-10 to FY 2015-16, with the exception of Hispanic clients, whose service utilization remained stable across the time period. Similar to disparities noted in the CYF system, the number of Hispanic, Asian/Pacific Islander, and Native American clients who utilized services in FY 2015-16 was less than would be expected based on their proportion in the target population.

There was a substantial increase in service engagement (retention rates) from FY 2009-10 to FY 2012-13 among the proportion of clients engaged in services for ten or more visits, for all racial/ethnic groups. These levels of engagement for ten or more sessions decreased slightly across all racial/ethnic groups in FY 2015-16, but proportions remained higher than they were in FY 2009-10 for all racial/ethnic groups (51-52%† versus 37-47%‡). More noticeable disparities were observed among the proportions of clients who only received one service session in FY 2015-16. For example, 12% of Hispanic clients served in FY 2015-16 only received one service visit, compared with 9% in FY 2012-13. Similarly, 10% of Native American clients only received one service visit in FY 2015-16, an increase from 7% in FY 2012-13. Asian/Pacific Islander clients had the lowest proportion of clients who only received one service visit in FY 2015-16 (7% versus 10-12%*), up from 6% in FY 2012-13.

Similar to observations noted among children, disparities were observed when examining racial/ethnic differences in diagnoses among adult clients in FY 2015-16. African American clients had the highest prevalence rates of schizophrenia and other psychotic disorders (53%), followed by Native American clients (50%) and Asian/Pacific Islander clients (45%), compared to the other racial/ethnic groups (34-38%*). Asian/Pacific Islander (27%) and Hispanic (23%) clients had higher rates of depressive disorders, compared to other racial/ethnic groups (15-19%*). The highest prevalence rates of bipolar disorders were seen in White (25%) and Native American (22%) clients. Native American clients had the lowest prevalence rates of stressor and adjustment disorders (2%), compared to all other racial/ethnic groups (3-5%*).

* *Range refers to the percentage of clients in the other racial/ethnic groups.*
† *Range refers to percentage of clients in all racial/ethnic groups in FY 2015-16.*
‡ *Range refers to percentage of clients in all racial/ethnic groups in FY 2009-10.*
Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

There were also some notable trends evident in the age group analysis. First, service utilization for all services decreased from FY 2009-10 to FY 2015-16 for clients ages <18 to 25 years, and for clients ages 26 to 59 years, but increased for clients ages 60 years and older. However, utilization of outpatient services among clients ages <18 to 25 years increased across this time period, while a decrease of outpatient service utilization was observed for clients between the ages of 26 and 59 years. Also notable was the continued increase in service utilization among clients ages 60+ years across the three fiscal years examined in this report.

As for engagement in services, there was an increase in retention rates across all age groups from FY 2009-10 to FY 2012-13 for 10 or more visits, but these retention rates decreased in FY 2015-16 for all age groups. Clients ages <18 to 25 years were least likely to engage in services for ten or more visits, as more than 60% of clients in this age range served in FY 2015-16 received fewer than ten service visits. Clients age <18 to 25 years were also more likely than clients in the other age groups to only receive one service visit in FY 2015-16 (20% versus 14%); a proportion that has increased from 13% in FY 2012-13, and from 10% in FY 2009-10.

A goal of AOA SOC has been to encourage appropriate use of services to help stabilize symptoms and progress towards recovery. Progress towards meeting this goal was observed in all three age groups. The proportion of clients ages <18 to 25 years who used outpatient services increased from 44% in FY 2009-10 to 61% in FY 2015-16, while a simultaneous reduction in utilization of inpatient/ emergency services (30% to 24%) and jail only services (27% to 15%) was also noted among clients in this age group. Utilization of outpatient services was already relatively high in FY 2009-10 for clients ages 26-59 years (62%) and clients 60+ years (72%), but similar trends regarding increased utilization of outpatient services and decreased utilization of inpatient/ emergency and jail only services since FY 2009-10 was observed in FY 2015-16.

Progress Towards Reducing Disparities

Efforts to reduce barriers to behavioral health care across clients in different age groups and racial/ethnic minorities has been a priority for BHS for several years. However, the demographic breakdown of individuals eligible for BHS services differs markedly from the demographic make-up of the county as a whole. For example, although individuals 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. Therefore, efforts to increase service utilization often requires a focus on specific groups that is disproportionate to their presence in the overall county population.

The key findings highlighted in this report indicate that while improvements towards reducing barriers to behavioral health care across these groups have been made, disparities still exist. A comparison of the San Diego County target population to those who received behavioral health services (pages 9 through 11) demonstrated that these disparities continued; most notably for Hispanic adults. Hispanics comprised 60% of the adult target population, but only 27% of the adult clients who received behavioral health services. While the numbers were more favorable for children, with Hispanic children and youth representing 71% of the population and 63% of the clients who received behavioral health services, there is still room to further reduce these disparities.

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Key Findings by Age

Children and Youth (CYF)

Ages 0-5

- Clients ages five years and younger had the lowest penetration rates across all three fiscal years (2.2-2.6%*).
- Children age five and younger were much more likely to receive only one session (40.7%) compared to clients ages six to eleven years (9.7%), 12 to 17 years (8.6%), and 18 years of age or older (8.7%).
- Clients age five and younger were less likely to receive 13 or more sessions compared to other CYF age groups (30.6% versus 45.9-47.9%†).
- Almost all clients age five years or younger used only outpatient services across all fiscal years (99.8-99.9%*).

Ages 6-11

- Clients between the ages of six and 11 were more likely to use outpatient services (99.6%) compared to clients ages 12 and older [91.7% (clients ages 12 to 17 years) and 78.1% (clients ages 18+ years)].
- The proportion of clients age six to eleven years that received 13 or more sessions has decreased since FY 2009-10 (52.9% to 45.9%).

Ages 12-17

- The proportion of clients who used only JFS in FY 2015-16 was 6.4% compared to 1.5% in FY 2012-13.
- There was slight reduction in the proportion of clients age 12 to 17 who only used outpatient services in FY 2015-16, compared to FY 2012-13 (96.5% to 91.7%).
- Clients ages 12 to 17 years had the highest penetration rates across all three fiscal years (10.9-12.7%*) compared to the other CYF age groups.

Adults and Older Adults (AOA)

Ages 18-25 (TAY)

- TAY clients had the lowest long-term engagement rates among AOA age groups, with 60.4% receiving fewer than ten visits.
- TAY clients were more likely than other age groups to use inpatient/emergency services (24.2% versus 14.5-20.0%‡) or only jail services (14.9% versus 3.8-12.3%‡).
- While penetration rates for TAY clients decreased in FY 2015-16 from FY 2009-10 when considering all services (8.1% to 7.3%) penetration rates showed an increasing trend across the same time period when considering only TAY who received outpatient services (3.8% to 4.5%).

Ages 26-59

- Clients ages 26 to 59 had higher retention rates than both TAY and OA clients. However, retention rates for 10 or more sessions decreased in FY 2015-16 from FY 2012-13 (45.5% from 52.9%).
- Penetration rates for outpatient services decreased for clients ages 26 to 59 years from FY 2009-10 to FY 2015-16 (8.0% to 7.8%), but increased for TAY and OA clients (3.8% to 4.5% and 5.0% to 5.9%, respectively) across the same time period.
- A smaller proportion of clients ages 26-59 (14.5%) used inpatient/emergency services compared to TAY (24.2%) or OA (20.0%) clients, and utilization of these types of services among clients ages 26-59 decreased since FY 2009-10 (from 19.2%).

Ages 60+ (OA)

- The proportion of OA clients utilizing outpatient services increased in FY 2015-16 (76.2%) from FY 2012-13 (72.8%).
- Compared to previous fiscal years, penetration rates for all OA clients increased in FY 2015-16 (6.8% to 7.8%).
- 15.2% of OA clients were uninsured in FY 2015-16.

* *Range refers to the percentage of clients in the three fiscal years.*
† *Range refers to the percentage of clients in the other CYF age groups.*
‡ *Range refers to the percentage of clients in the other AOA age groups.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Key Findings by Race/Ethnicity

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%).

* *Range refers to the percentage of clients in the other racial/ethnic groups.*

† *Range refers to the percentage of clients in the three fiscal years.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Data Summary

General Population, Target Population, and BHS Client Populations for San Diego County

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%

** 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.*

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.*

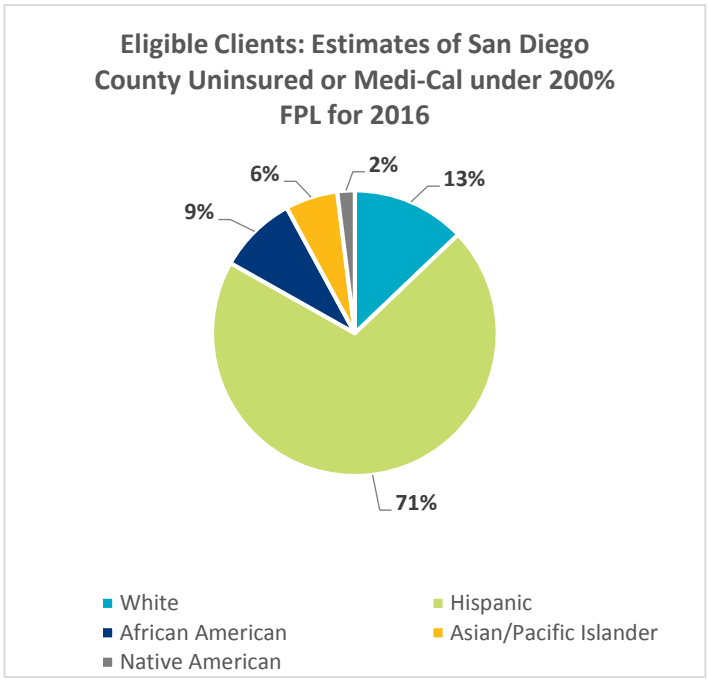
Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

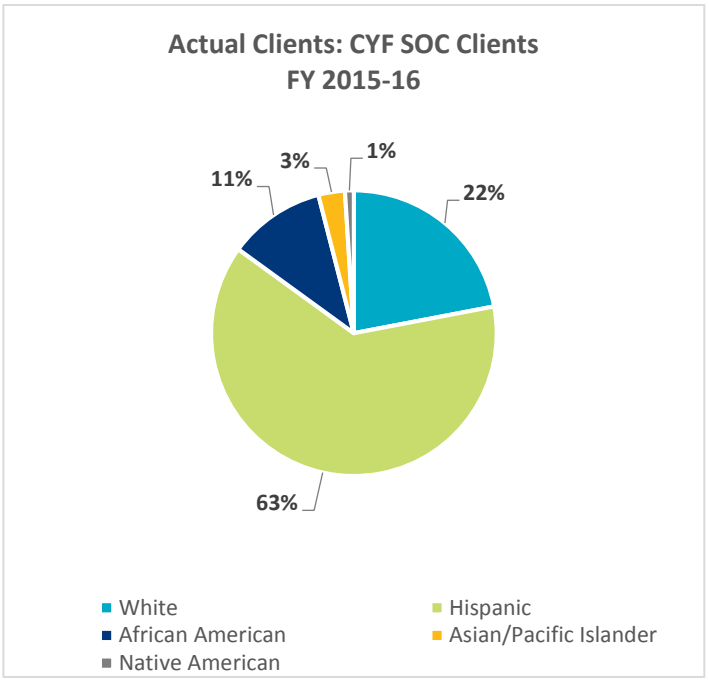
PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

CYF System of Care (SOC) Distribution Rates

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

	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		CYF SOC Clients	
Race/Ethnicity**	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.*

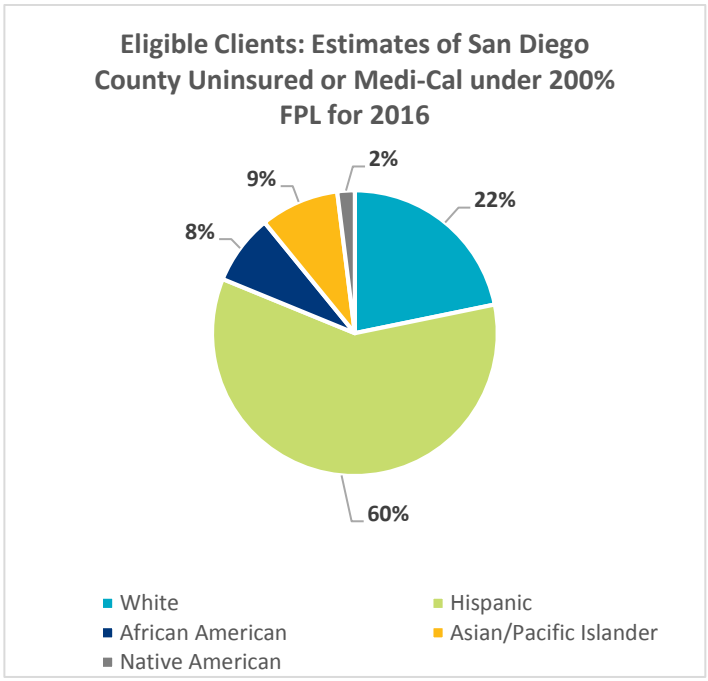
Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

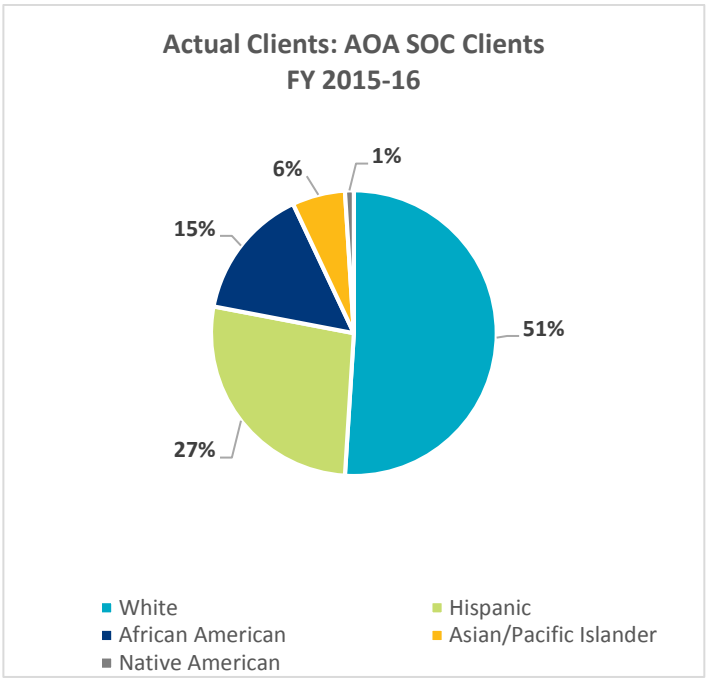
PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA System of Care (SOC) Distribution Rates

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

	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		AOA SOC Clients	
Race/Ethnicity**	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.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: White Children and Youth

Total Clients Served

3,463 White children and youth clients were served by the CYF SOC in FY 2015-16.

Age and Gender

In FY 2015-16, almost half of the White children and youth clients (48%) were 12-17; however, the proportion of this age group has decreased since FY 2009-10. The proportion of White males has decreased since FY 2009-10.

Preferred Language

The vast majority of White children and youth clients (99%) reported English as their preferred language.

Top 3 Diagnoses

1. Stressor & Adjustment disorders (23%)
2. Depressive disorders (20%)
3. Attention-deficit/Hyperactivity disorder (ADHD; 14%)

Service Utilization (Penetration Rates)

FY 2009-10	13.7%
FY 2012-13	11.9%
FY 2015-16	10.1%

Engagement (Retention Rates)

FY 2009-10	<6 sessions	27.4%
	10+ sessions	60.5%
FY 2012-13	<6 sessions	29.7%
	10+ sessions	57.8%
FY 2015-16	<6 sessions	29.1%
	10+ sessions	57.9%

Type of Service Used in FY 2015-16

White children and youth predominantly used outpatient services (96%).

Insurance Status in FY 2015-16

3% of White children and youth were uninsured.

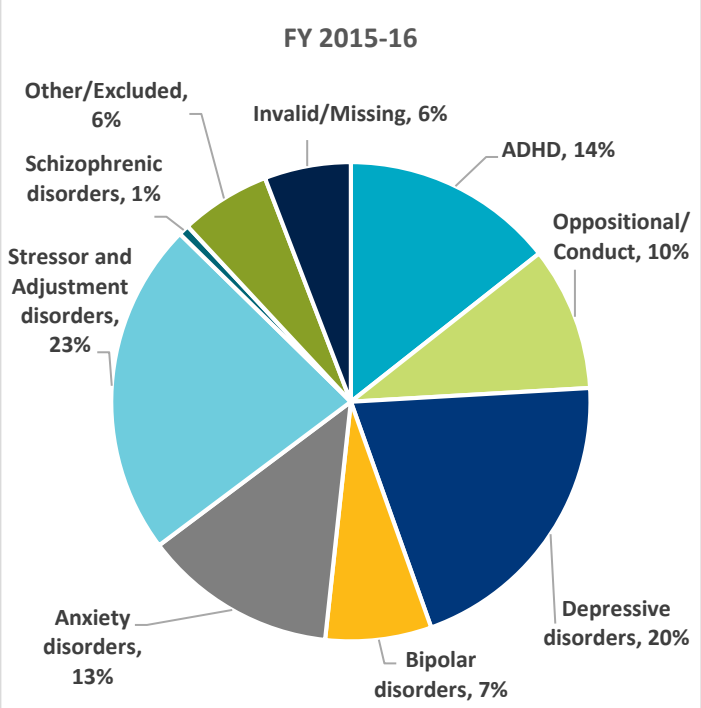
Age

	FY 2009-10	FY 2012-13	FY 2015-16
0-5	9%	10%	13%
6-11	30%	32%	33%
12-17	57%	52%	48%
18+	5%	5%	6%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	38%	43%	46%
Males	62%	57%	54%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: White Adults and Older Adults

Total Clients Served

18,227 White adult and older adult clients were served by the AOA SOC in FY 2015-16.

Age and Gender

The majority of White adult and older adult clients served by the AOA SOC in FY 2015-16 were between the ages of 26 and 59 years (71%). The percentage of White older adults served has increased steadily from 9% in FY 2006-07 (data not shown here). The proportion of White male and female clients remained unchanged from FY 2012-13 to FY 2015-16.

Preferred Language

Almost all White adult and older adult clients (98%) served during FY 2015-16 reported English as their preferred language.

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (34%)
2. Bipolar disorders (25%)
3. Depressive disorders (19%)

Service Utilization (Penetration Rates)

FY 2009-10	30.2%
FY 2012-13	25.9%
FY 2015-16	22.4%

Engagement (Retention* Rates)

FY 2009-10	<6 sessions	33.1%
	10+ sessions	47.7%
FY 2012-13	<6 sessions	26.9%
	10+ sessions	56.4%
FY 2015-16	<6 sessions	32.0%
	10+ sessions	52.3%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

About two-thirds of White adults and older adults used outpatient services (66%), and almost one-quarter (21.0%) used inpatient/emergency services.

Insurance Status in FY 2015-16

14.8% of White adults and older adults were uninsured.

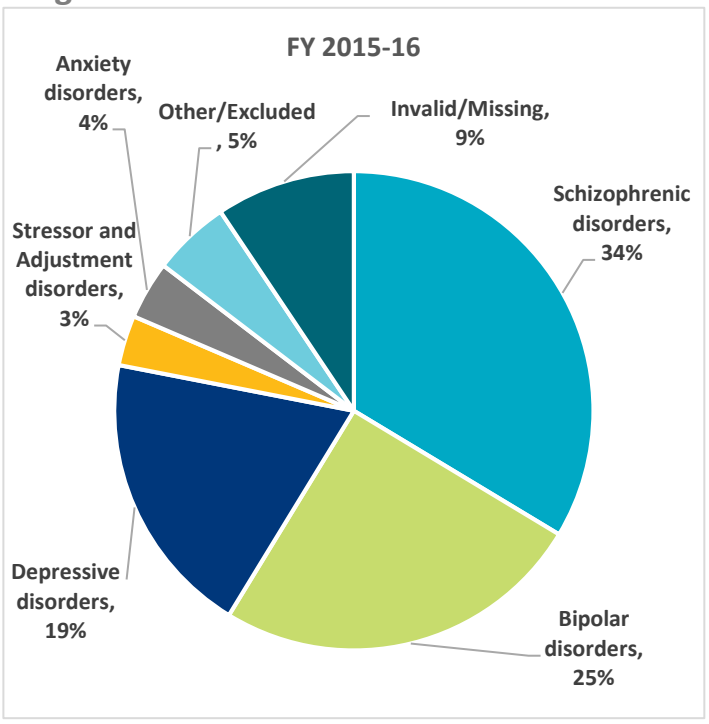
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18-25	15%	14%	13%
26-59	73%	72%	71%
60+	12%	14%	16%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	47%	45%	45%
Males	53%	55%	55%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Hispanic Children and Youth

Total Clients Served

9,777 Hispanic children and youth clients were served by the CYF SOC in FY 2015-16.

Age and Gender

In FY 2015-16, almost half of the Hispanic children and youth clients (49%) served by the CYF SOC were between the ages of 12 and 17 and 56% were male.

Preferred Language

The majority of Hispanic children and youth clients (71%) reported English as their preferred language and 29% reported Spanish as their preferred language.

Top 3 Diagnoses

1. Stressor & Adjustment disorders (24%)
2. Depressive disorders (22%)
3. Oppositional/Conduct disorders (13%)

Service Utilization (Penetration Rates)

FY 2009-10	5.3%
FY 2012-13	5.8%
FY 2015-16	5.1%

Engagement (Retention Rates)

FY 2009-10	<6 sessions	30.8%
	10+ sessions	56.7%
FY 2012-13	<6 sessions	30.4%
	10+ sessions	55.1%
FY 2015-16	<6 sessions	31.9%
	10+ sessions	54.9%

Type of Service Used in FY 2015-16

The majority of services utilized by Hispanic children and youth clients were outpatient services (94%).

Insurance Status in FY 2015-16

4% of Hispanic children and youth clients were uninsured.

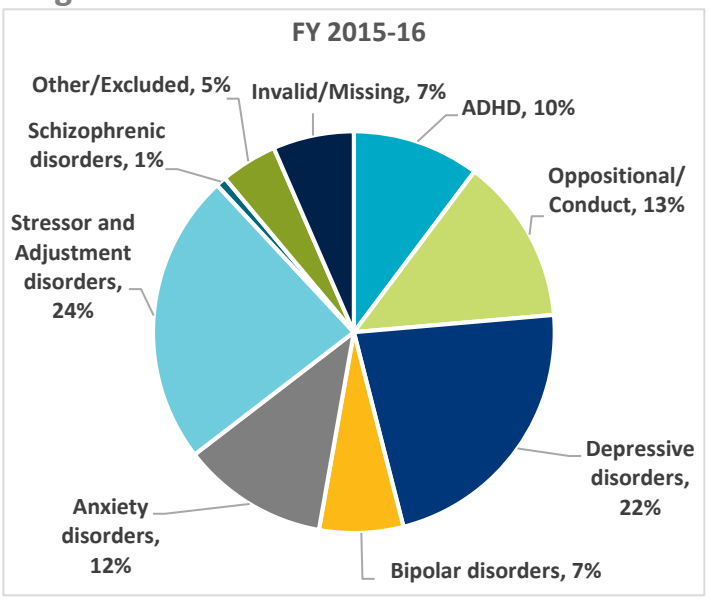
Age

	FY 2009-10	FY 2012-13	FY 2015-16
0-5	11%	11%	12%
6-11	30%	34%	34%
12-17	55%	50%	49%
18+	4%	5%	5%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	38%	40%	44%
Males	62%	60%	56%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Hispanic Ethnic Categories

	N	%
Mexican American/Chicano	7,793	80%
Other Hispanic/Latino	1,805	19%
Puerto Rican	92	1%
Dominican	49	1%
Cuban	21	<1%
Salvadoran	17	<1%
Total	**9,777**	**100%**

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Hispanic Adults and Older Adults

Total Clients Served

9,671 Hispanic adult and older adult clients were served by the AOA SOC in FY 2015-16.

Age and Gender

More than one-quarter of Hispanic adult and older adult clients served were TAY clients (28%), a proportion that has slowly increased since FY 2009-10. More Hispanic adult and older adult males than females were served during FYs 2012-13 and 2015-16 compared to FY 2009-10.

Preferred Language

Almost three-quarters of Hispanic clients served reported that English was their preferred language (74%), and almost one-quarter preferred Spanish (24%).

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (38%)
2. Depressive disorders (23%)
3. Bipolar disorders (18%)

Service Utilization (Penetration Rates)

FY 2009-10	4.3%
FY 2012-13	4.4%
FY 2015-16	4.3%

Engagement (Retention* Rates)

FY 2009-10	<6 sessions	35.5%
	10+ sessions	46.5%
FY 2012-13	<6 sessions	31.3%
	10+ sessions	54.4%
FY 2015-16	<6 sessions	33.8%
	10+ sessions	50.6%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

Most Hispanic adult and older adult clients received outpatient services (69.1%).

Insurance Status in FY 2015-16

12.4% of Hispanic adults and older adults were uninsured.

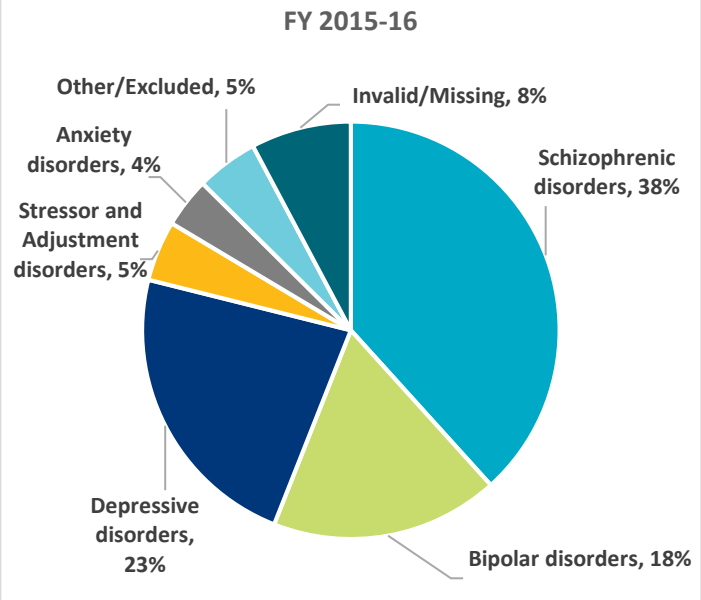
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18-25	25%	26%	28%
26-59	68%	67%	65%
60+	6%	7%	7%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	50%	44%	45%
Males	50%	55%	55%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Hispanic Ethnic Categories

	N	%
Mexican American/Chicano	7,556	78%
Other Hispanic/Latino	1,634	17%
Puerto Rican	230	2%
Dominican	109	1%
Cuban	100	1%
Salvadoran	42	<1%
Total	**9,671**	**100%**

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: African American Children and Youth

Total Clients Served

1,691 African American children and youth clients were served by the CYF SOC in FY 2015-16.

Age and Gender

In FY 2015-16, the majority of the African American children and youth clients (49%) were between the ages of 12 and 17, and the proportion of clients ages 18 and over increased from FY 2009-10. Nearly two-thirds of the clients were male (59%).

Preferred Language

1,686 out of 1,691 African American children and youth clients (nearly 100%) reported English as their preferred language.

Top 3 Diagnoses

1. Stressor & Adjustment disorders (23%)
2. Depressive disorders (18%)
3. Attention-deficit/Hyperactivity disorder (ADHD; 17%)

Service Utilization (Penetration Rates)

FY 2009-10	10.9%
FY 2012-13	9.3%
FY 2015-16	7.2%

Engagement (Retention Rates)

FY 2009-10	<6 sessions	27.9%
	10+ sessions	60.0%
FY 2012-13	<6 sessions	29.4%
	10+ sessions	58.8%
FY 2015-16	<6 sessions	28.5%
	10+ sessions	60.5%

Type of Service Used in FY 2015-16

African American children and youth clients predominantly used outpatient services (91%) and were the largest racial/ethnic group to utilize only JFS services (8.0%).

Insurance Status in FY 2015-16

3% of African American children and youth clients were uninsured.

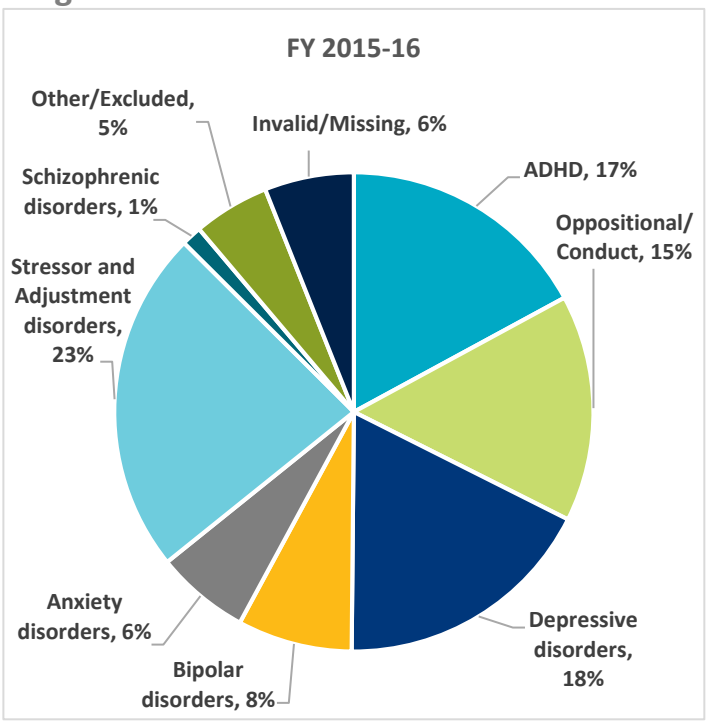
Age

	FY 2009-10	FY 2012-13	FY 2015-16
0-5	9%	9%	11%
6-11	28%	29%	30%
12-17	57%	53%	49%
18+	6%	8%	10%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	38%	38%	41%
Males	61%	62%	59%
Other/Unknown	<1%	<1%	0%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: African American Adults and Older Adults

Total Clients Served

5,211 African American adult and older adult clients were served by the AOA SOC in FY 2015-16.

Age and Gender

The age distribution of African American adult and older adult clients has been relatively constant since FY 2009-10, with a subtle increase in the proportion of older adult clients (7% to 9%). More African American adult and older adult male clients received AOA SOC services than females in FY 2015-16 (61% versus 39%), similar to previous fiscal years.

Preferred Language

Almost all African American adult and older adult clients reported that English was their preferred language (99%).

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (53%)
2. Bipolar disorders (16%)
3. Depressive disorders (15%)

Service Utilization (Penetration Rates)

FY 2009-10	20.5%
FY 2012-13	19.9%
FY 2015-16	18.1%

Engagement (Retention* Rates)

FY 2009-10	<6 sessions	33.3%
	10+ sessions	47.6%
FY 2012-13	<6 sessions	31.4%
	10+ sessions	53.8%
FY 2015-16	<6 sessions	33.2%
	10+ sessions	50.6%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

63.3% of African American adult and older adult clients received outpatient services. Similar proportions of African American adult and older adult clients received only services provided in jail (18.5%) and inpatient/ emergency services (18.2%).

Insurance Status in FY 2015-16

11% of African American adult and older adult clients were uninsured.

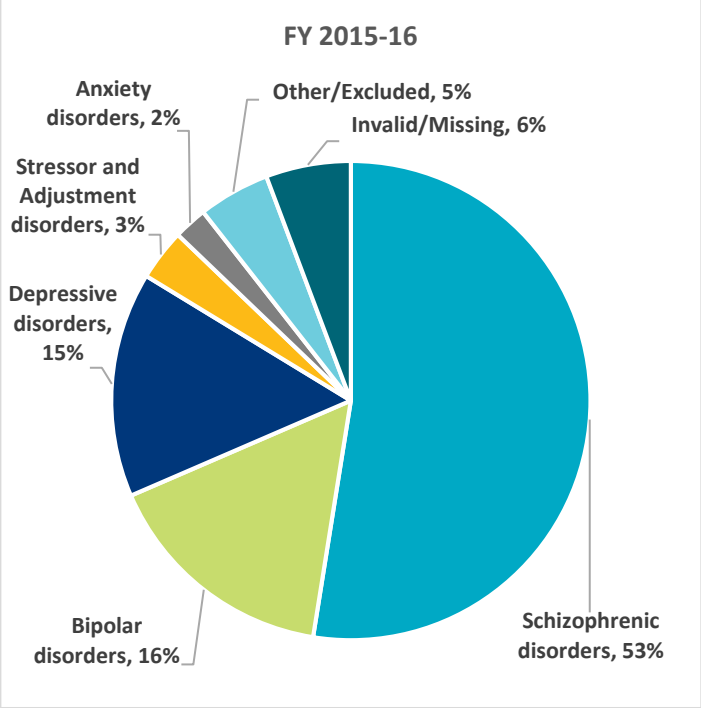
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18-25	19%	19%	19%
26-59	74%	73%	72%
60+	7%	8%	9%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	43%	38%	39%
Males	56%	61%	61%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Asian/Pacific Islander Children and Youth

Total Clients Served

519 Asian/Pacific Islander children and youth clients were served by the CYF SOC in FY 2015-16.

Age and Gender

In FY 2015-16, over half of the Asian/Pacific Islander CYF clients (54%) were between the ages of 12 and 17, a 1% increase from FY 2012-13. The proportion of clients ages 6-11 has decreased from FY 2012-13. Nearly two thirds of the clients were male (59%).

Preferred Language

85% of Asian/Pacific Islander children and youth clients reported English as their preferred language.

Top 3 Diagnoses

1. Depressive disorders (26%)
2. Stressor & Adjustment disorders (15%)
3. Anxiety disorders (11%)

Service Utilization (Penetration Rates)

FY 2009-10	3.4%
FY 2012-13	3.1%
FY 2015-16	3.4%

Engagement (Retention Rates)

FY 2009-10	<6 sessions	30.4%
	10+ sessions	55.2%
FY 2012-13	<6 sessions	31.0%
	10+ sessions	56.8%
FY 2015-16	<6 sessions	33.6%
	10+ sessions	54.9%

Type of Service Used in FY 2015-16

Asian/Pacific Islander children and youth clients predominantly used outpatient services (94%).

Insurance Status in FY 2015-16

4% of Asian/Pacific Islander children and youth clients were uninsured.

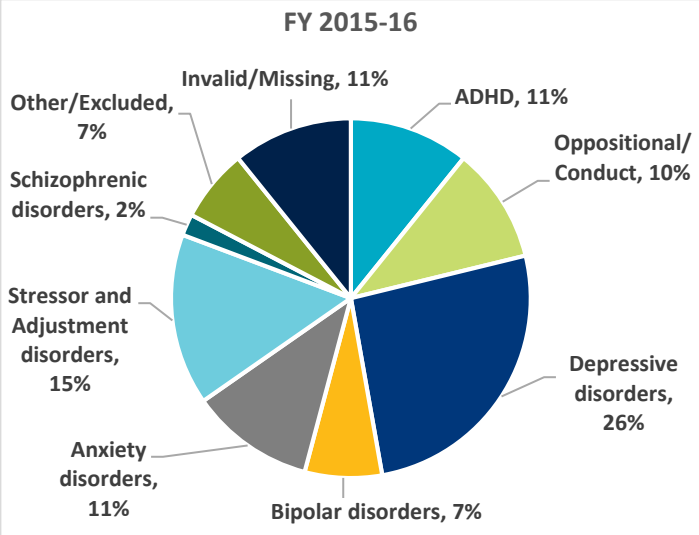
Age

	FY 2009-10	FY 2012-13	FY 2015-16
0-5	8%	8%	12%
6-11	28%	32%	24%
12-17	59%	53%	54%
18+	5%	6%	10%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	38%	39%	41%
Males	62%	61%	59%
Other/Unknown	<1%	<1%	0%

Diagnosis



Asian Subcategories

	N	%		N	%
Filipino	176	34%	**Samoan**	17	3%
Vietnamese	98	19%	**Asian Indian**	15	3%
Other Asian	60	12%	**Cambodian**	15	3%
Chinese	32	6%	**Guamanian**	10	2%
Other Pacific Islander	25	5%	**Hawaiian Native**	9	2%
Laotian	24	5%	**Hmong**	4	1%
Japanese	17	3%	Mien	0	0%
Korean	17	3%	**Total**	**519**	**100%**

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Asian/Pacific Islander Adults and Older Adults

Total Clients Served

2,283 Asian/Pacific Islander adult and older adult clients were served by the AOA SOC in FY 2015-16.

Age and Gender

About two-thirds of Asian/Pacific Islander adult and older adult clients served in FY 2015-16 were between the ages of 26 and 59 years. Slightly more female than male Asian/Pacific Islander clients were served in FY 2015-16.

Preferred Language

More than half of Asian/Pacific Islander adult and older adult clients reported English as their preferred language (59%). The second most preferred language was Vietnamese (18%), followed by Other Asian languages (13%), and Tagalog (5%).

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (45%)
2. Depressive disorders (27%)
3. Bipolar disorders (12%)

Service Utilization (Penetration Rates)

FY 2009-10	8.3%
FY 2012-13	7.0%
FY 2015-16	6.9%

Engagement (Retention* Rates)

FY 2009-10	<6 sessions	37.5%
	10+ sessions	37.0%
FY 2012-13	<6 sessions	24.4%
	10+ sessions	55.6%
FY 2015-16	<6 sessions	26.3%
	10+ sessions	52.2%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

More than three-quarters of Asian/Pacific Islander AOA clients received outpatient services (78.2%).

Insurance Status in FY 2015-16

13% of Asian/Pacific Islander adult and older adult clients were uninsured.

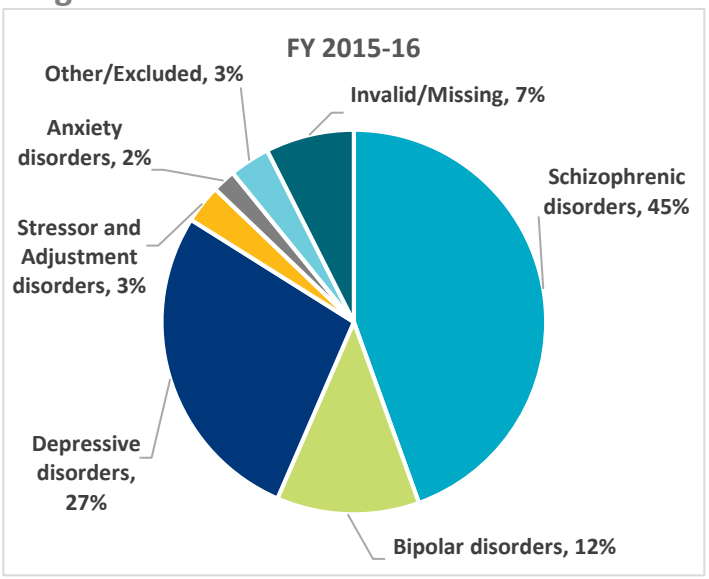
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18-25	13%	12%	14%
26-59	72%	71%	68%
60+	15%	17%	18%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	54%	56%	52%
Males	45%	44%	48%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Asian Subcategories

	N	%		N	%
Filipino	668	29%	**Other Pacific Islander**	62	3%
Vietnamese	552	24%	**Hawaiian Native**	47	2%
Other Asian	229	10%	**Asian Indian**	46	2%
Cambodian	172	8%	**Samoan**	46	2%
Chinese	126	6%	**Guamanian**	37	2%
Laotian	108	5%	**Hmong**	4	<1%
Korean	95	4%	Mien	1	<1%
Japanese	90	4%	**Total**	**2,283**	**100%**

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Native American Children and Youth

Total Clients Served

95 Native American children and youth clients were served by the CYF SOC in FY 2015-16.

Age and Gender

In FY 2015-16, slightly less than half (42%) of the Native American children and youth clients were ages 12-17, and 56% were male.

Preferred Language

99% of Native American children and youth clients reported English as their preferred language.

Top 3 Diagnoses

1. Stressor & Adjustment disorders (24%)
2. Depressive disorders (21%)
3. Attention-Deficit/Hyperactivity Disorder (ADHD; 15%)

Service Utilization (Penetration Rates)

FY 2009-10	2.5%
FY 2012-13	1.8%
FY 2015-16	1.7%

Engagement (Retention Rates)

FY 2009-10	<6 sessions	28.0%
	10+ sessions	60.0%
FY 2012-13	<6 sessions	28.9%
	10+ sessions	62.2%
FY 2015-16	<6 sessions	27.2%
	10+ sessions	56.5%

Type of Service Used in FY 2015-16

Native American children and youth clients predominantly used outpatient services (96%). 4% of Native American clients used JFS only services and no Native American children or youth clients used IP/ESU services.

Insurance Status in FY 2015-16

1% of Native American children and youth clients were uninsured.

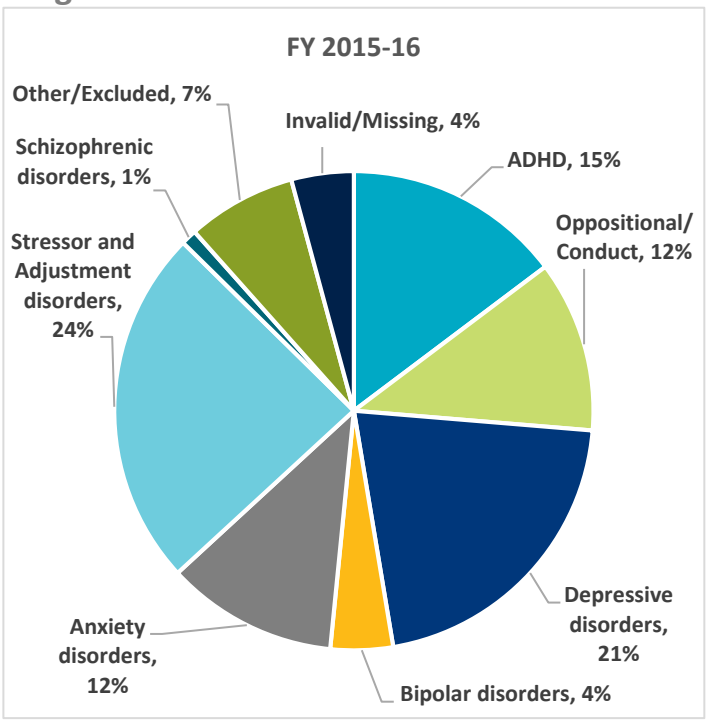
Age

	FY 2009-10	FY 2012-13	FY 2015-16
0-5	6%	11%	16%
6-11	34%	36%	34%
12-17	52%	47%	42%
18+	8%	5%	8%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	42%	51%	44%
Males	58%	49%	56%
Other/Unknown	0%	0%	0%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: Native American Adults and Older Adults

Total Clients Served

309 Native American adult and older adult clients were served by the AOA SOC in FY 2015-16.

Age and Gender

15% of Native American adult and older adult clients served in FY 2015-16 were between the ages of <18 and 25 years, almost three-quarters (74%) were 26 to 59 years, and 11% were 60 years of age or older. The proportion of Native American OA clients has increased from FY 2009-10 to FY 2015-16 (7% to 11%).

Preferred Language

Almost all Native American adult and older adult clients reported that English was their preferred language (98%).

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (50%)
2. Bipolar disorders (22%)
3. Depressive disorders (17%)

Service Utilization (Penetration Rates)

FY 2009-10	4.7%
FY 2012-13	4.0%
FY 2015-16	4.1%

Engagement (Retention* Rates)

FY 2009-10	<6 sessions	33.8%
	10+ sessions	45.9%
FY 2012-13	<6 sessions	23.0%
	10+ sessions	56.5%
FY 2015-16	<6 sessions	33.9%
	10+ sessions	51.6%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

71.8% of Native American AOA clients used outpatient services, 15.9% used inpatient/emergency services, and 12.3% only used services provided in jail.

Insurance Status in FY 2015-16

10.7% of Native American adults and older adults were uninsured.

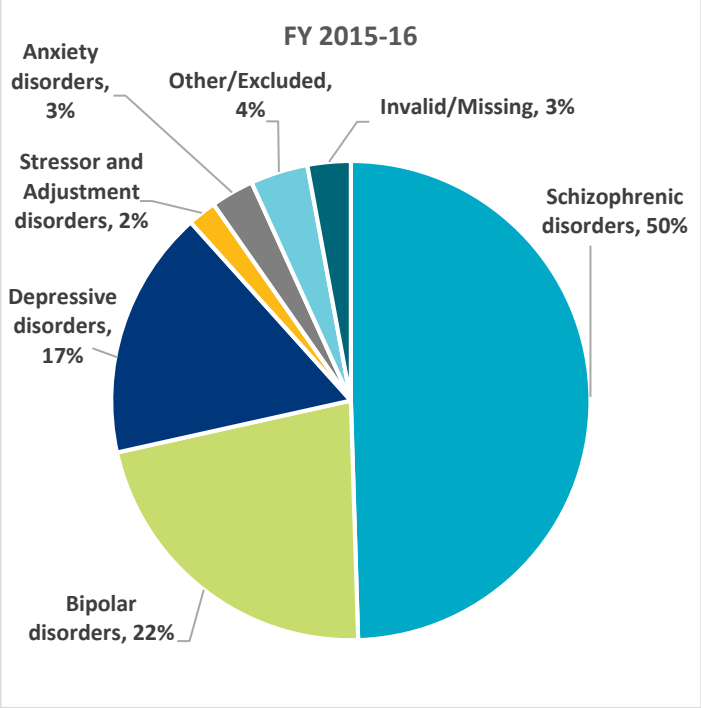
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18-25*	16%	16%	15%
26-59	77%	75%	74%
60+	7%	9%	11%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	52%	53%	49%
Males	48%	47%	51%
Other/Unknown	0%	0%	0%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Service Utilization and Engagement

Disparities in Service Utilization

Analysis of Penetration Rates

In San Diego County, it is estimated that 7.5% of children under the age of 18 have a severe emotional disturbance, and 4.2% of adults age 18 and older have a severe mental illness[1]. Among households below 200% FPL in San Diego County, these estimates increase to 8.9% for children, and 7.9% for adults[1].

Disparities in service utilization were identified by comparing the target population to the number of clients who received San Diego County behavioral health services (penetration rate). An algorithm – based on the 2009-2015 California Health Interview Survey (CHIS) estimates of the proportional representation of the population who were uninsured or Medi-Cal eligible, and were under 200% of the federal poverty level that could potentially have a serious mental illness – was used to estimate the eligible population for each age and racial/ethnic category. This process provided a constant for each category that was applied against the population estimate from the most recent census data to derive the estimate for the eligible target population.

The following section examines the penetration rates for clients across specific age groups within both the CYF and AOA systems of care, and racial/ethnic groups for three fiscal years: 2009-10, 2012-13, and 2015-16.

[1] California Department of Health Care Services (2013). *California Mental Health Prevalence Estimates*. Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf, pg. 129-130.

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

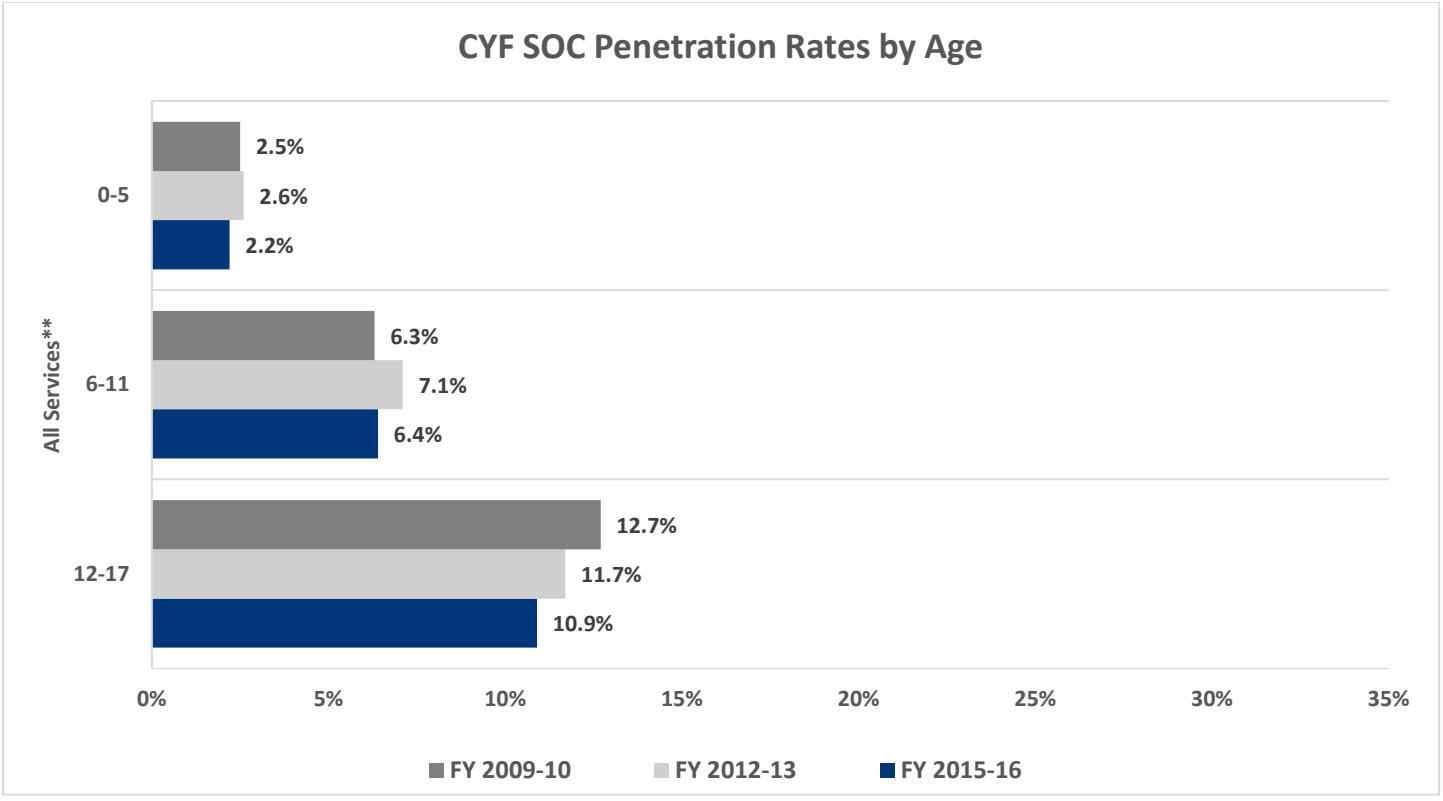
PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

CYF Penetration Rates by Age

Penetration rates for CYF SOC clients were examined across three age groups: 0-5, 6-11, and 12-17 years. Penetration rates were calculated as the number of actual clients within each age group who received services (CYF SOC clients), divided by the number of potential clients within each age group. Potential* clients were defined as the number of San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries, that could potentially have a severe mental illness.

Differences in penetration rates were examined across three fiscal years (FY): 2009-10, 2012-13, and 2015-16. Detailed tabular data for all three FYs are provided in Appendix B, Table 1.

- Clients ages 12 to 17 years had the highest penetration rates across all fiscal years (10.9-12.9%†) compared to the other age groups.
- Clients ages five years and younger had the lowest penetration rates across all fiscal years (2.2-2.5%†).
- Penetration rates for clients in all age groups decreased in FY 2015-16 from FY 2012-13. This trend was most noticeable among clients ages 12 to 17 years (11.7% to 10.9%).



* *Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2016 Census population estimates.*

† *Range refers to the percentage of clients in the three fiscal years.*

** *All CYF services were combined into all services so data would be comparable to how it was generated in previous fiscal years.*

Note: The 12-17 age category includes 8,208 clients ages 12-17 years, plus an additional 929 clients ages 18+ who also received services through the CYF SOC.

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

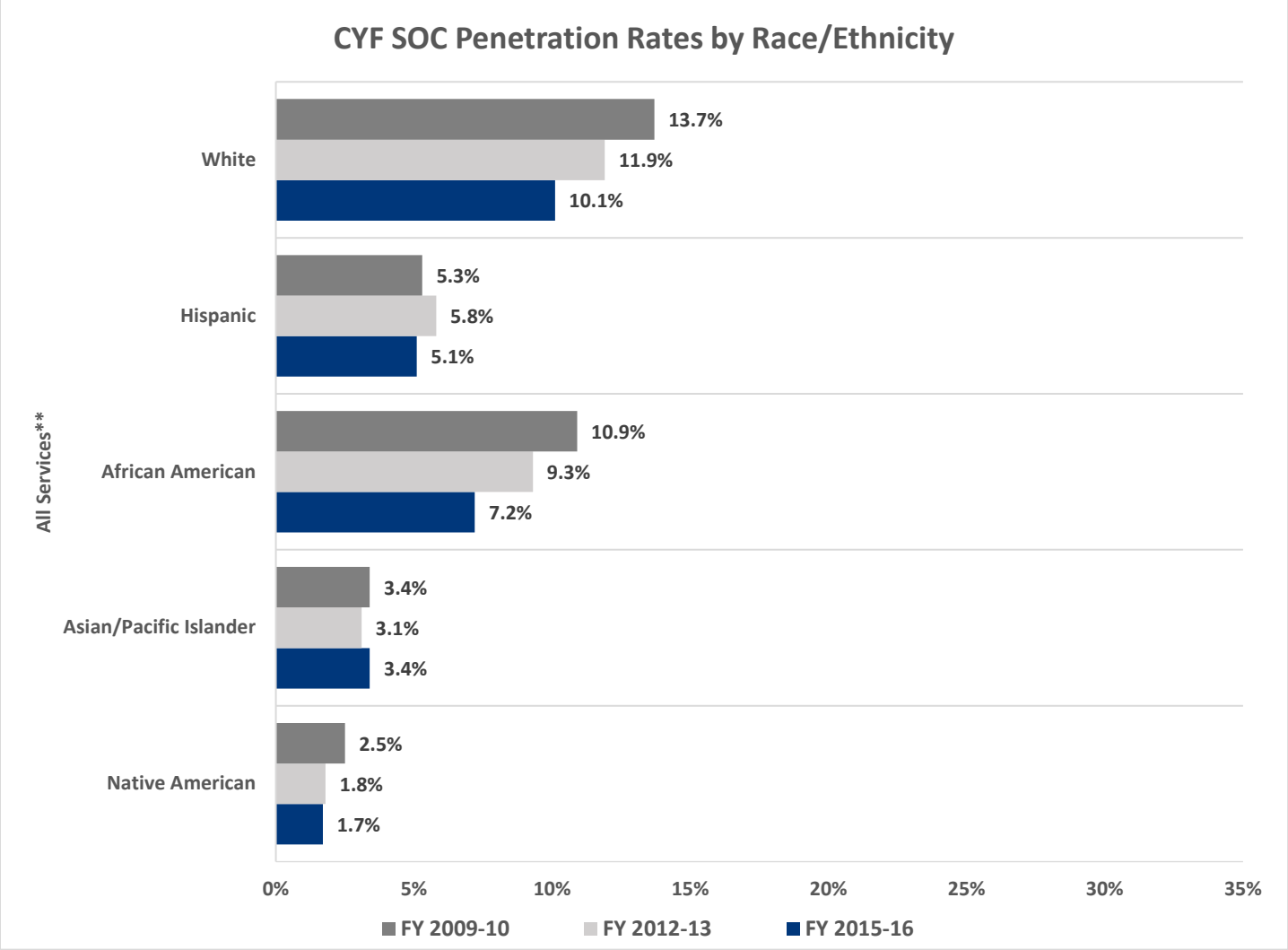
CYF Penetration Rates by Race/Ethnicity

Penetration rates for CYF SOC clients were examined across five racial/ethnic groups: White, Hispanic, African American, Asian/Pacific Islander, and Native American. Penetration rates were calculated as the number of actual clients within each racial/ethnic group who received services (CYF SOC clients), divided by the number of potential clients within each racial/ethnic group. Potential* clients were defined as the number of San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries, that could potentially have a severe mental illness.

Differences in penetration rates were examined across three fiscal years (FY): 2009-10, 2012-13, and 2015-16.

Detailed tabular data for all three FYs are provided in Appendix B, Table 2.

- White clients have the highest penetration rates compared to other racial/ethnic groups in all three fiscal years, penetration rates for White clients have steadily declined since FY 2009-10 (13.7% to 10.1%).
- Penetration rates for African American clients have steadily declined since FY 2006-07 (10.9% to 7.2%).
- Penetration rates for Hispanic clients increased from FYs 2009-10 to 2012-13 (5.3% to 5.8%), but decreased in FY 2015-16 (5.1%).



** Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2016 Census population estimates.*

*** All CYF services were combined into all services so data would be comparable to how it was generated in previous fiscal years.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

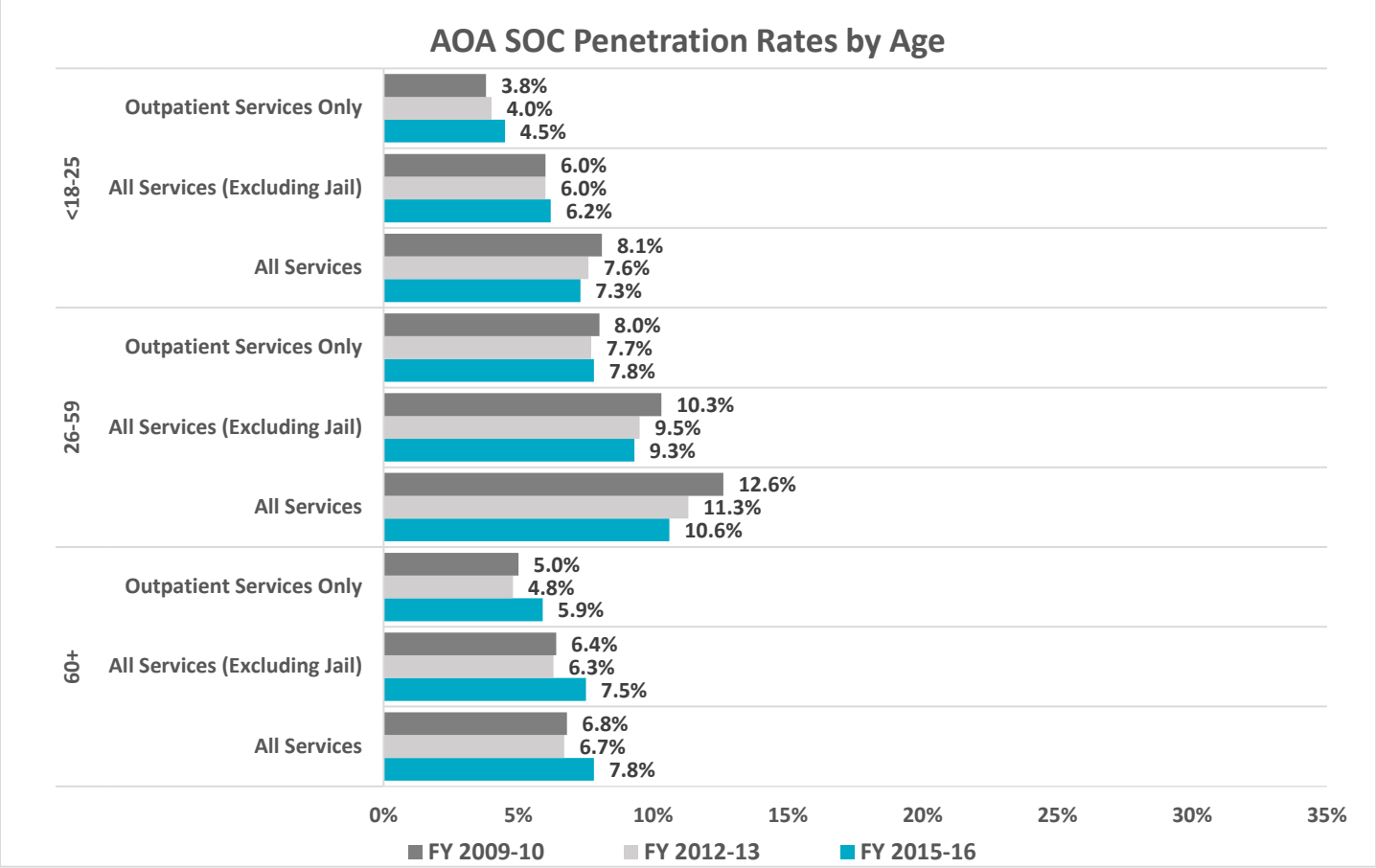
AOA Penetration Rates by Age

Penetration rates for AOA SOC clients were examined across three age groups: <18-25, 26-59, and 60+ years. Penetration rates were calculated as the number of actual clients within each age group who received services (AOA SOC clients), divided by the number of potential clients within each age group. Potential* clients were defined as the number of San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries, that could potentially have a severe mental illness.

Each age group was further broken down by three service categories: (1) outpatient services only, (2) all services (excluding jail), and (3) all services. The category excluding services provided while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.

Differences in penetration rates were examined across three fiscal years (FY): 2009-10, 2012-13, and 2015-16. Detailed tabular data for all three FYs are provided in Appendix B, Table 3.

- While penetration rates for clients ages <18 to 25 years (TAY) decreased in FY 2015-16 from FY 2009-10 when considering all services (8.1% to 7.3%), penetration rates showed an increasing trend across the same time period when considering only TAY who received outpatient services (3.8% to 4.5%).
- Compared to previous fiscal years, penetration rates for clients ages 60 years and older (OA) increased in FY 2015-16 (6.8% to 7.8%).
- Penetration rates for outpatient services increased for TAY and OA clients from FY 2009-10 to FY 2015-16 (3.8% to 4.5% and 5.0% to 5.9%, respectively), but decreased slightly for clients ages 26 to 59 across the same time period (8.0% to 7.8%).



* *Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2016 Census population estimates.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Penetration Rates by Race/Ethnicity

Penetration rates for AOA SOC clients were examined across five racial/ethnic groups: White, Hispanic, African American, Asian/Pacific Islander, and Native American. Penetration rates were calculated as the number of actual clients within each racial/ethnic group who received services (AOA SOC clients), divided by the number of potential clients within each racial/ethnic group. Potential* clients were defined as the number of San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries, that could potentially have a severe mental illness.

Each age group was further broken down by three service categories: (1) outpatient services only, (2) all services (excluding jail), and (3) all services. The category excluding services provided while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.

Difference in penetration rates were examined across three fiscal years (FY): 2009-10, 2012-13, and 2015-16, and these data are presented in the graph on page 27. Detailed tabular data for all three FYs are provided in Appendix B, Table 4.

- Penetration rates decreased for White and Asian/Pacific Islander clients from FY 2009-10 to FY 2015-16 (30.2% to 22.4% and 8.3% to 6.9%, respectively).
- Hispanic and Native American clients had the lowest penetration rates for all three categories of services across all three fiscal years (2.7-4.4%† and 2.9-4.7%†, respectively).
- Penetration rates for Hispanic clients were relatively stable from FY 2009-10 to FY 2015-16 across all three service categories (Outpatient services only: 2.7-2.9%†; All services, excluding jail: 3.5-3.7%†; All services: 4.3-4.4%†).
- White clients had the highest penetration rates, followed by African American clients, for all three categories of service across all three fiscal years.

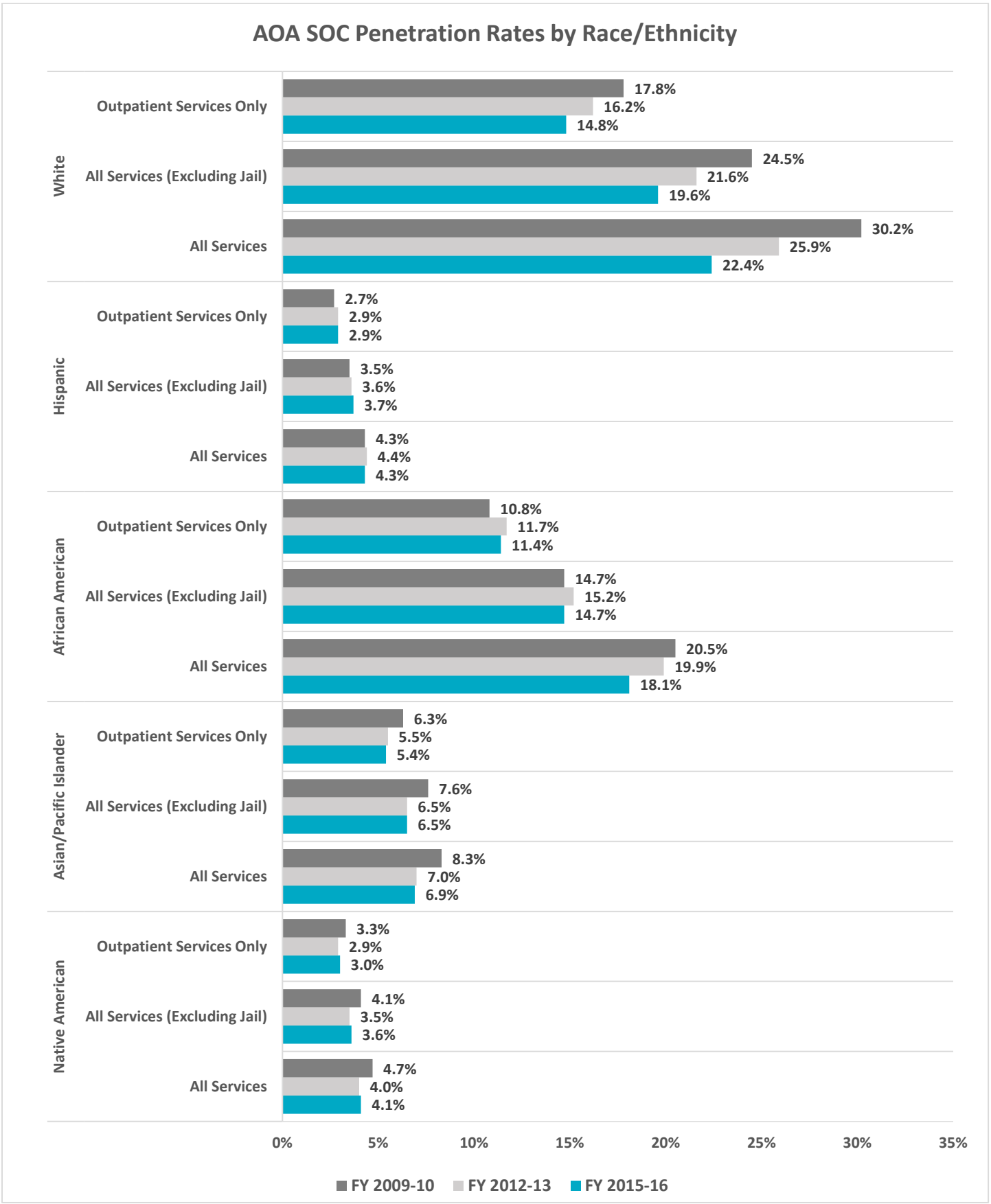
* *Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2016 Census population estimates.*

† *Range refers to the percentage of clients in the three fiscal years.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Disparities in Engagement

Analysis of Retention Rates

Disparities in engagement were identified by analyzing the percentage of clients who continued services by the number of sessions for children, and the number of visits for adults (retention rate). The following section examines the retention rates for CYF and AOA clients receiving outpatient services across specific age groups within each system, and racial/ethnic groups for three fiscal years (FYs): 2009-10, 2012-13, and 2015-16. Retention in the CYF SOC is reported as the proportion of clients attending one session, two to five sessions, six to nine sessions, 10 to 12 sessions, and 13 or more sessions. Retention is the AOA SOC is reported as the proportion of clients attending one session, two to five sessions, six to nine sessions, and ten or more sessions. The additional retention category for CYF was included to more accurately reflect the 13 session model utilized in the CFY SOC.

CYF Retention Rates by Age

Service retention rates for CYF SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across four age groups: 0-5, 6-11, 12-17, and 18+. Retention rates were defined as the number of outpatient visits for each client during the fiscal year. The data presented in the graph on page 29 are the retention rates for all three FYs.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 5.

- Nearly half of all CYF clients (45.0%) were in services for 13 or more sessions in FY 2015-16, which is similar to FY 2012-13 (45.3%), and a slight decrease from FY 2009-10 (48.6%).
- Children ages five years or younger were least likely to receive at least 13 sessions of CYF SOC services, compared to the other age groups (30.6% versus 45.9-47.9%[*]) in FY 2015-16.
- Children ages five and younger were more likely than the other age groups to only receive one session (40.7% versus 8.6-9.7%[*]) in FY 2015-16.
- About one-quarter (23.5%) of CYF clients ages 18 years and older received two to five sessions, compared to 21.5% of 12 to 17 year-olds, 20.1% of six to eleven year-olds, and only 15.0% of children five years of age and younger in FY 2015-16.

CYF Retention Rates by Race/Ethnicity

Service retention rates for CYF SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across five racial/ethnic groups: White, Hispanic, African American, Asians/Pacific Islander, and Native American. Retention rates were defined as the number of outpatient visits for each client during the fiscal year. The data presented in the graph on page 30 are the retention rates for all three FYs.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 6.

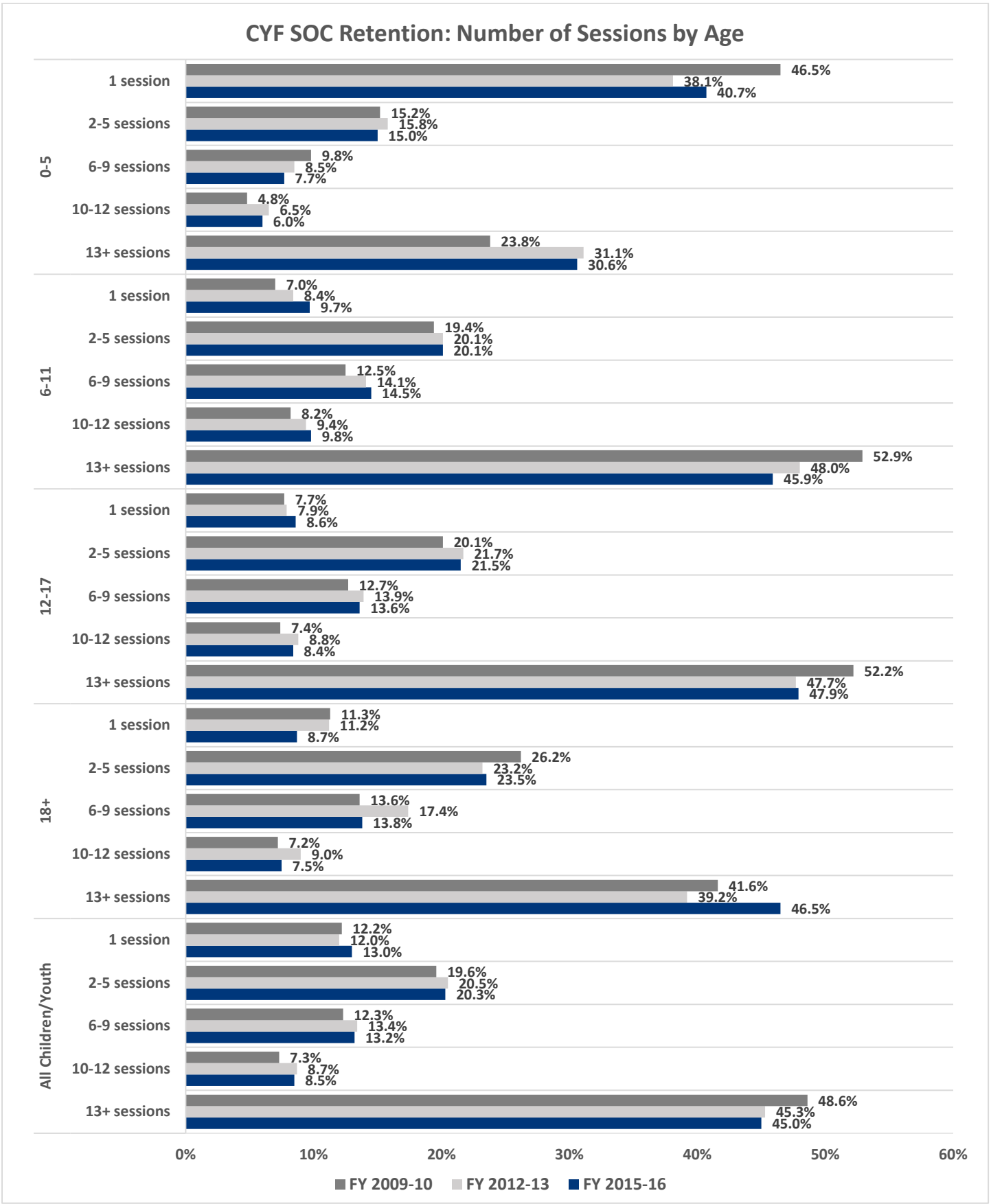
- Asian/Pacific Islander clients were slightly more likely to have only one session than the other racial/ethnic groups in FY 2015-16, and the proportion of these clients has increased over the three FYs reported here (10.8% to 13.8%).
- About half of African American (52.9%), Native American (52.2%), and White (49.9%) clients received 13 or more sessions in FY 2015-16, compared to smaller proportions of Hispanic (46.1%) and Asian/Pacific Islander (45.5%) clients.
- The proportion of Asian/Pacific Islander clients who only received one session has increased.
- The proportion of Native American clients who received between two and five sessions in FY 2015-16 decreased from FY 2012-13 (15.2% from 21.1%), while proportions of Native American clients receiving only one session and those receiving six to nine sessions increased (7.8% to 12.0%, and 8.9% to 16.3%, respectively).

[*] *Range refers to the percentage of clients in the other CYF age groups.*

Data Source: CCBH

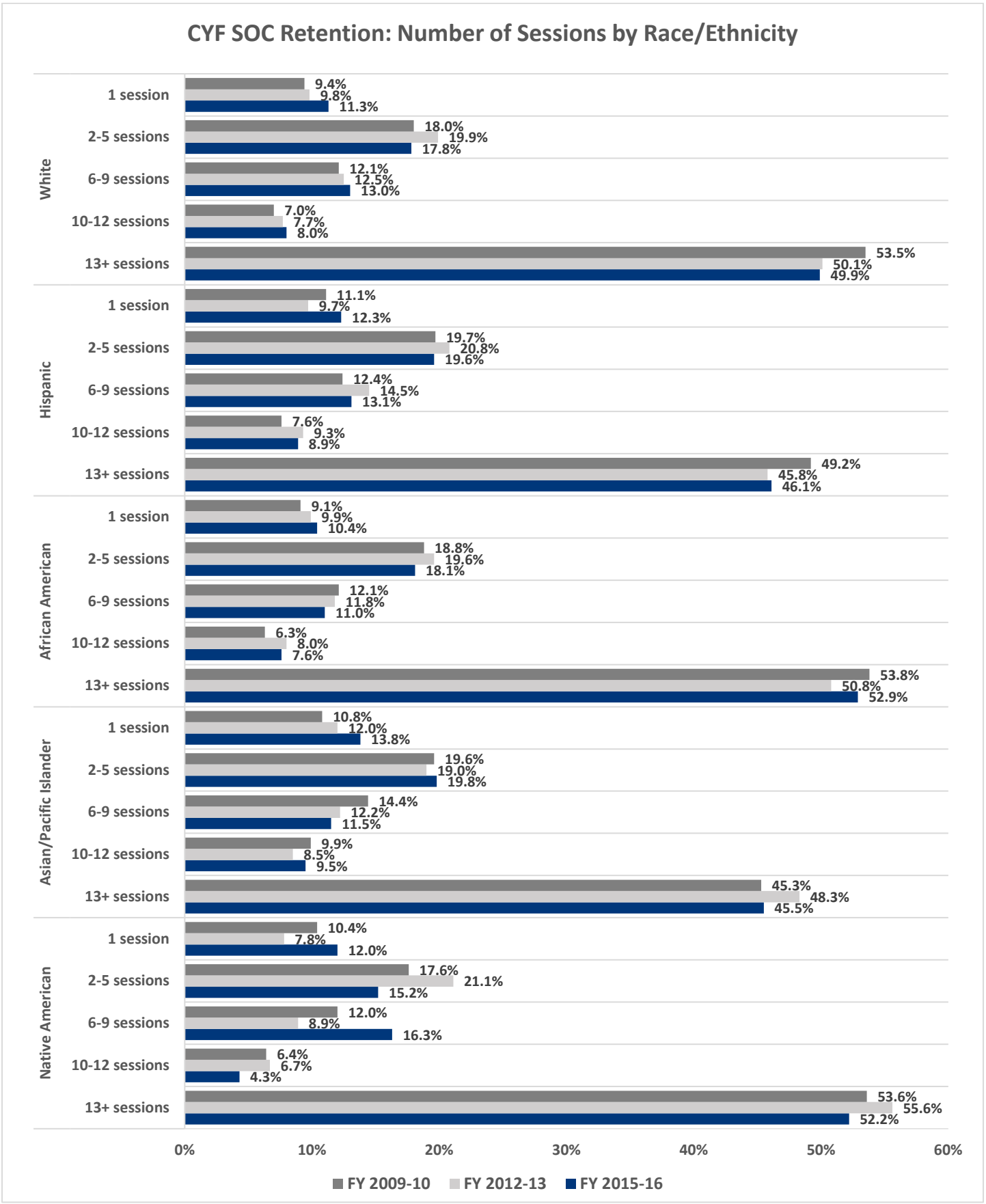
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Retention Rates by Age

Retention rates for outpatient services for AOA SOC clients were examined in FYs 2009-10, 2012-13, and 2015-16 across three age groups: <18-25, 26-59, and 60+. Services considered to be outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-for-Service, and Prevention services.

Retention rates were defined as the number of outpatient visits for each client during the fiscal year. The data presented in the graph on page 32 are the retention rates for all three FYs. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 7.

Findings for all clients

- Less than half of all AOA clients (44.4%) continued services with the AOA SOC for more than ten visits in FY 2015-16, which is a decrease from FY 2012-13 (51.6%), and FY 2009-10 (49.2%).
- TAY clients were less likely to continue services with the AOA SOC for more than ten visits (39.6%) during FY 2015-16, compared to clients ages 26 to 59 years (45.5%) and OA clients (44.2%).
- Almost 20% of TAY clients (19.8%) only attended one AOA SOC visit in FY 2015-16, compared to 14.3% of AOA clients ages 26 to 59 years and 14.2% of OA clients.
- The proportion of AOA clients who only received one AOA SOC visit in FY 2015-16 increased from FY 2009-10 (7.5%) and FY 2012-13 (10.1%) to 15.1% in FY 2015-16.
- About one-quarter of all AOA clients (24.6%) continued services with the AOA SOC for two to five visits in FY 2015-16.

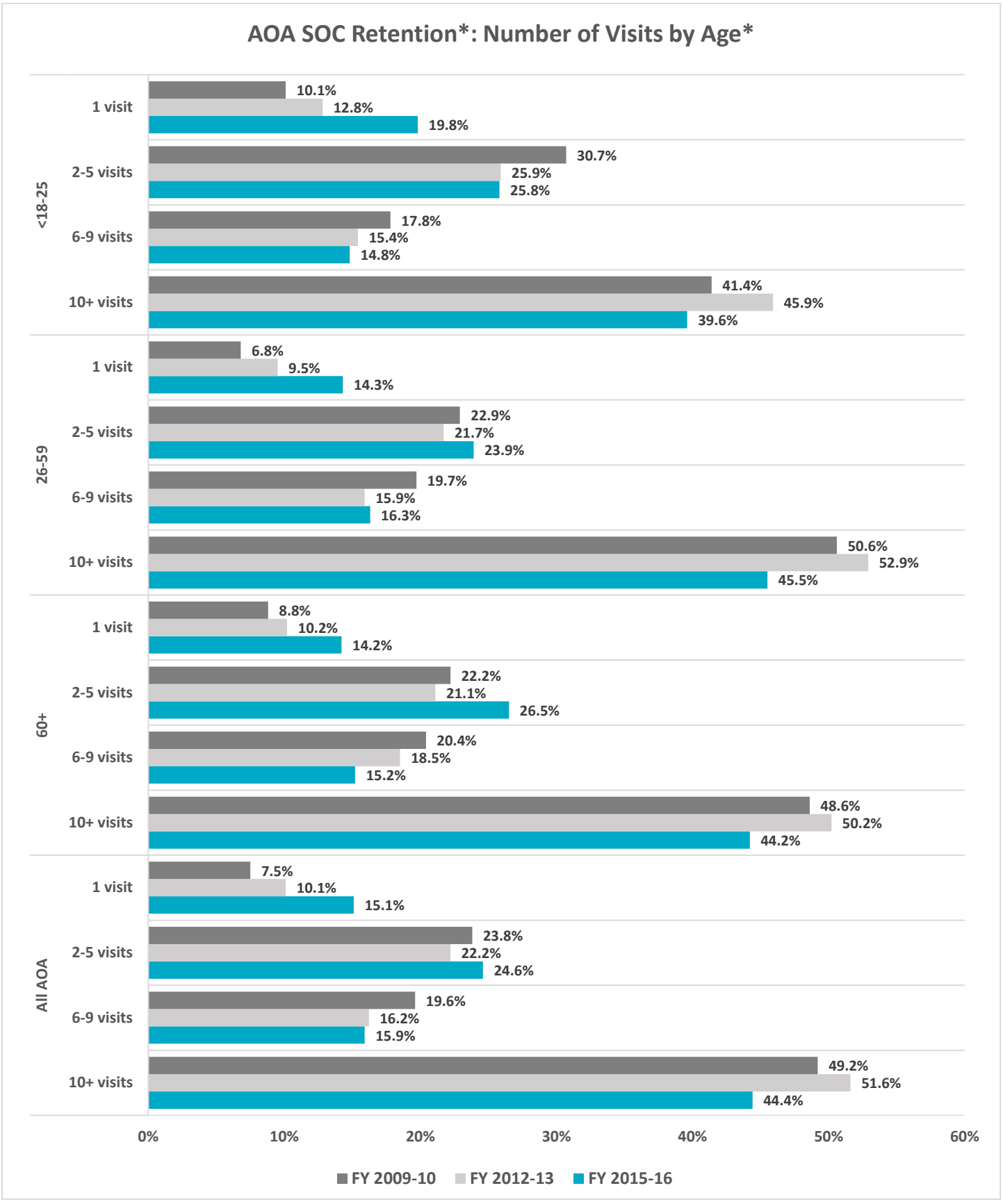
Some clients (n=236) who received services from the AOA SOC only received a behavioral health assessment (BHA), and no additional services. As it could be argued that these clients never engaged in services and should not be counted towards retention rates, the retention rate analysis for FY 2015-16 was also conducted without clients who only received a BHA and no additional AOA services. The graph on page 33 displays the retention rates for clients who received at least one service provided by the AOA SOC during FY 2015-16, in addition to a BHA. Retention rates excluding clients who only received a BHA are not available for previous fiscal years. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 7.

Findings for clients who received only a BHA excluded

- Most clients in the AOA system engaged in services after receiving a BHA in FY 2015-16.
- The removal of clients who only received a BHA and no additional AOA services from the retention rate analysis did not have a noticeable impact on the retention rates of AOA clients as a whole, or across specific age groups.

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

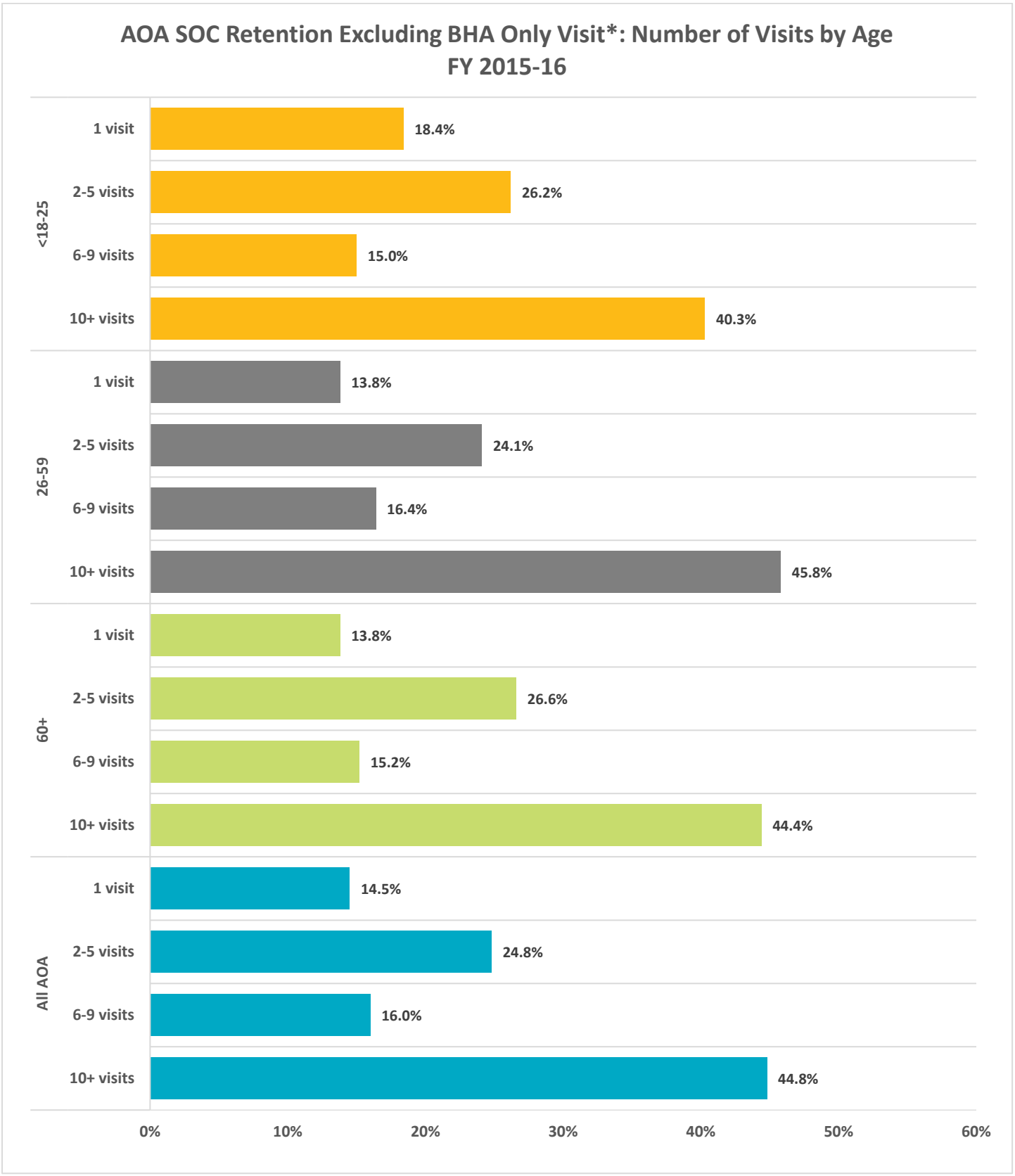


** Clients who only received a behavioral health assessment (BHA) are included for comparison to previous fiscal years.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



** Some clients who received services from the AOA SOC only received a behavioral health assessment (BHA), and no additional services. As it could be argued that these clients never engaged in services and should not be counted towards retention rates, the retention rate analysis for FY 2015-16 is also presented without clients who only received a BHA and no additional AOA services.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Retention Rates by Race/Ethnicity

Retention rates for outpatient services for AOA SOC clients were examined in FYs 2009-10, 2012-13, and 2015-16 across five racial/ethnic groups: White, Hispanic, African American, Asian/Pacific Islander, and Native American. Services considered to be outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-for-Service, and Prevention services.

Retention rates were defined as the number of outpatient visits for each client during the fiscal year. The data presented in the graph on page 35 are the retention rates for all three FYs. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 8.

Some clients (n=236) who received services from the AOA SOC only received a behavioral health assessment (BHA), and no additional services. As it could be argued that these clients never engaged in services and should not be counted towards retention rates, the retention rate analysis for FY 2015-16 was also conducted without clients who only received a BHA and no additional AOA services. The graph on page 36 displays the retention rates for clients who received at least one service provided by the AOA SOC during FY 2015-16, in addition to a BHA. Retention rates excluding clients who only received a BHA are not available for previous fiscal years. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 8.

Findings for all clients

- At least half of clients in all racial/ethnic groups received ten or more outpatient services during FY 2015-16 (50.6% - 52.3%[*]).
- The proportion of clients who received ten or more outpatient services in FY 2015-16 decreased for all racial/ethnic groups from FY 2012-13, but was still higher than proportions from FY 2009-10.
- Asian/Pacific Islander clients were least likely to have received only one AOA SOC service in FY 2015-16, compared to the other racial/ethnic groups (6.7%).
- The proportion of clients who received 6-9 services increased for African American clients (14.9% to 16.3%), Asian/Pacific Islander clients (20.0% to 21.5%), and Hispanic clients (14.1% to 15.6%) from FY 2012-13.

Findings for clients who received only a BHA excluded

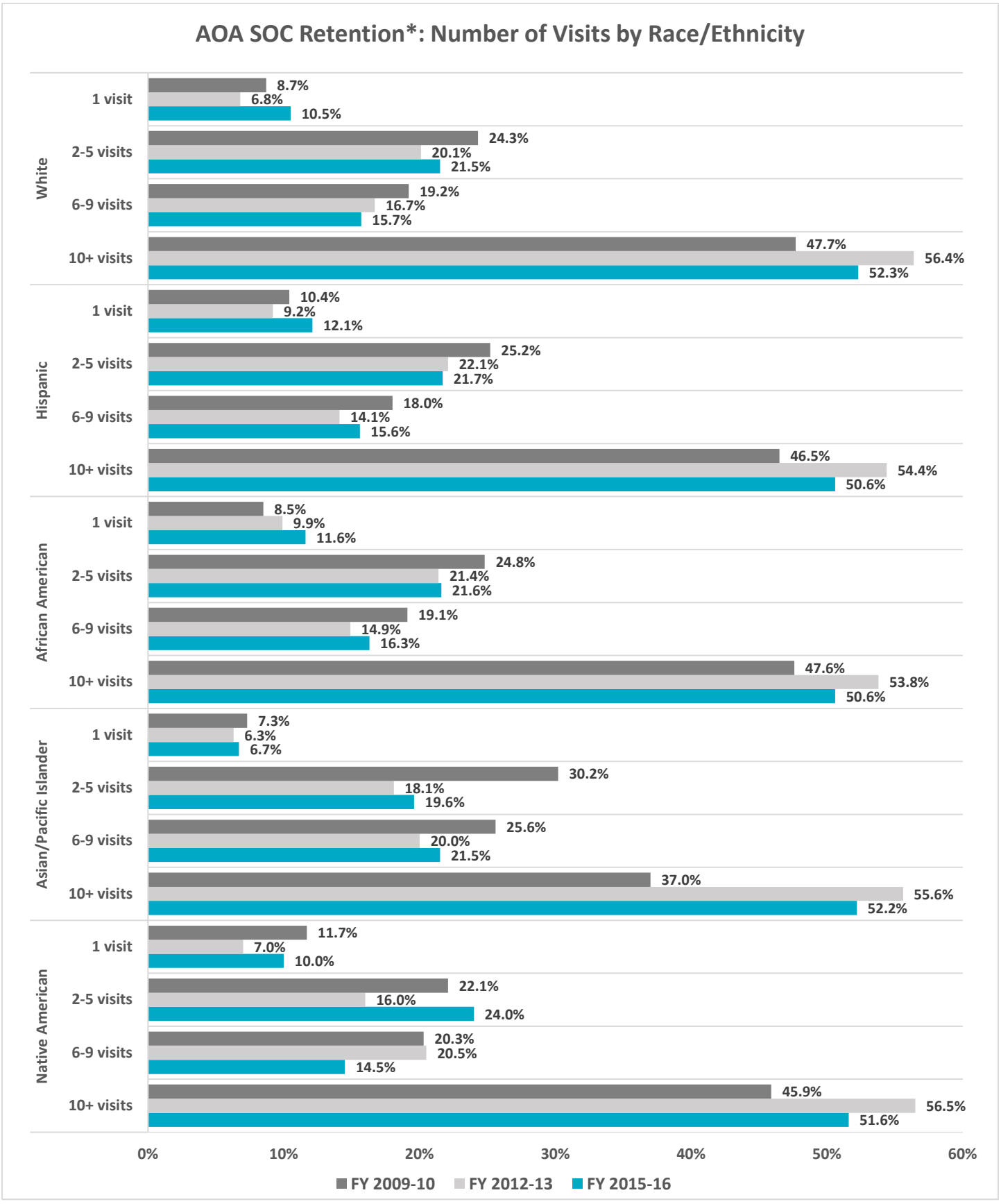
- Most clients in the AOA system engaged in services after receiving a BHA in FY 2015-16.
- When clients who only received a BHA were excluded from the retention rate analysis, the percentage of clients who only received one service visit decreased slightly, and the percentage of clients who received ten or more service visits increased slightly across all racial/ethnic groups.

[*] *Range refers to the percentage of clients in all racial/ethnic groups.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

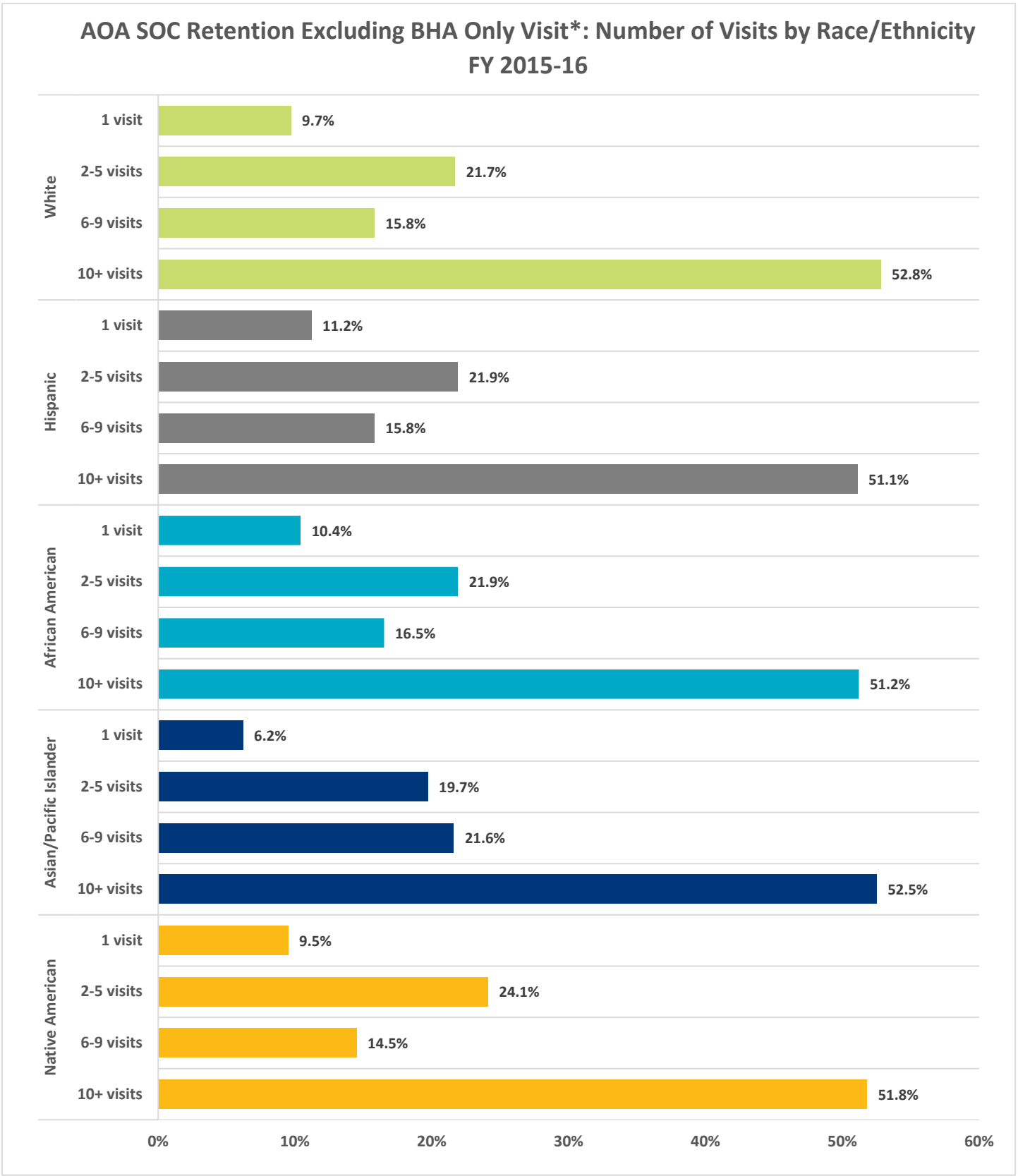


** Clients who only received a behavioral health assessment (BHA) are included for comparison to previous fiscal years.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



** Some clients who received services from the AOA SOC only received a behavioral health assessment (BHA), and no additional services. As it could be argued that these clients never engaged in services and should not be counted towards retention rates, the retention rate analysis for FY 2015-16 is also presented without clients who only received a BHA and no additional AOA services.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Type of Service Used

Disparities in Type of Service Used

A goal of the CYF and AOA Systems of Care has been to increase use of outpatient services and decrease use of inpatient/emergency services. The following section examines the types of services used by all CYF and AOA clients across specific age groups within each system, and racial/ethnic groups for three fiscal years: 2009-10, 2012-13, and 2015-16.

CYF Type of Service Used by Age

A goal of the CYF SOC has been to increase use of outpatient services and decrease use of inpatient/ESU services. Types of services used by all CYF SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across four age groups: 0-5, 6-11, 12-17, 18+. Utilization rates were calculated as the number of clients within each age group who used a specific type of service, divided by the number of total clients within that age group. These data are presented in the graph on page 38.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 9.

- 94.6% of all clients used only outpatient services in FY 2015-16. This represents a 3% decrease from FY 2012-13.
- 4.3% of clients used only juvenile forensic services (JFS) during FY 2015-16.
- Clients ages 18+ used more JFS-only services and less outpatient-only services than the other age groups.
- Utilization rates for JFS-only services increased from FY 2012-13 for clients ages 12-17 (1.5% to 6.4%), and for those 18+ (8.2% to 21.0%), as utilization rates for outpatient services for these clients decreased.

CYF Type of Service Used by Race/Ethnicity

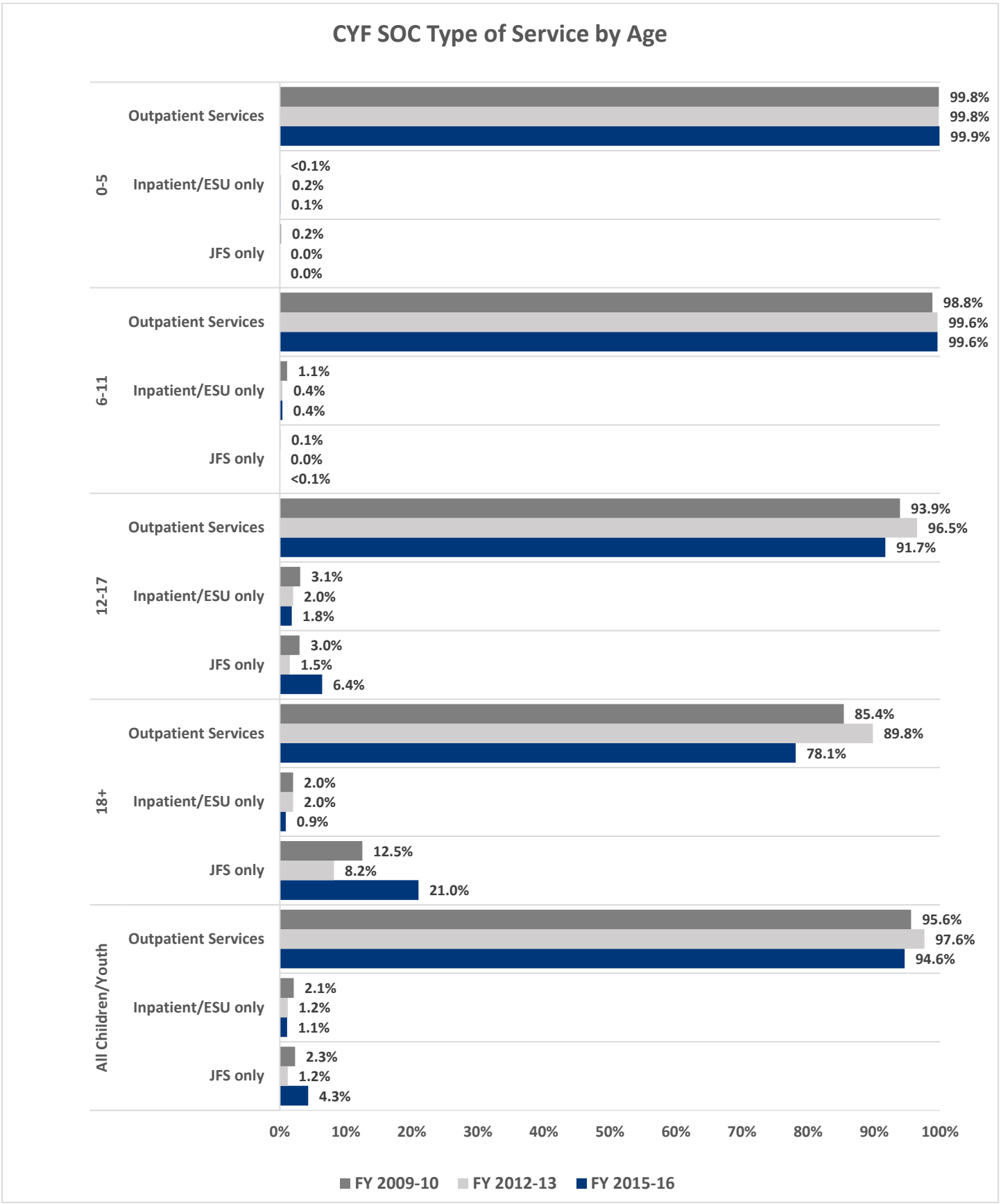
Types of services used by CYF SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across five racial/ethnic groups: White, Hispanic, African American, Asian/Pacific Islander, and Native American. Utilization rates were calculated as the number of clients within a specific racial/ethnic group who used a specific type of service, divided by the number of total clients within that race/ethnicity group. These data are presented in the graph on page 39.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 10.

- The majority of clients in each racial/ethnic group used only outpatient services, while fewer clients used only inpatient/emergency or JFS services.
- Among all racial/ethnic groups, utilization rates for JFS-only services increased since FY 2012-13, but this trend was most noticeable for African American clients (2.2% to 8.0%).
- Use of inpatient/ESU only services decreased for all racial/ethnic groups, except for White clients (1.0% to 1.2%).

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



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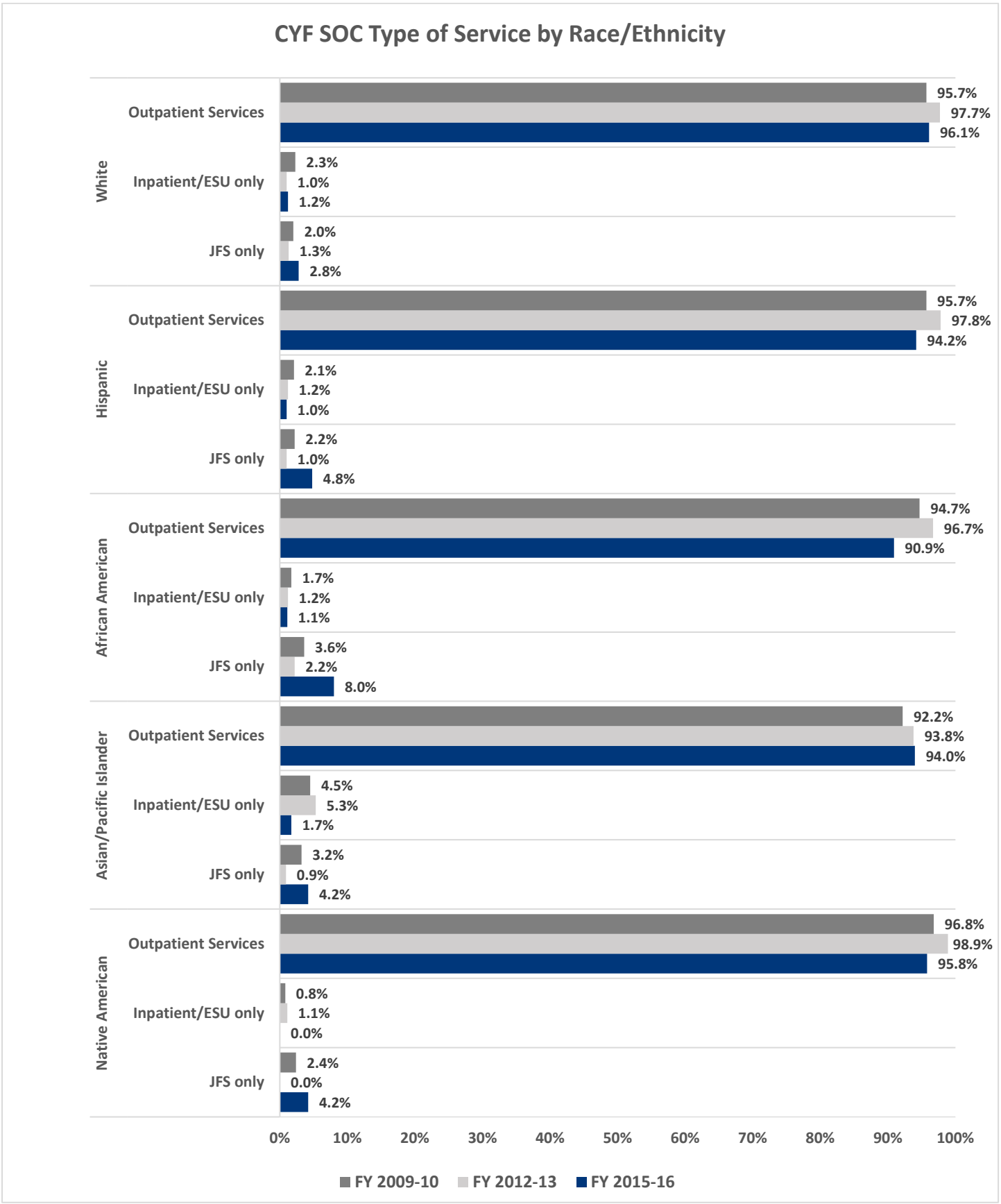
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Type of Service Used by Age

A goal of the AOA SOC has been to increase use of outpatient services and decrease use of inpatient/ emergency services. Types of services used by AOA SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across three age groups: <18-25, 26-59, and 60+. Utilization rates were calculated as the number of clients within each age group who used a specific type of service, divided by the number of total clients with that age group. These data are presented in the graph on page 41.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 11.

- Overall, utilization of outpatient services has steadily increased since FY 2009-10 to FY 2015-16 for the AOA system as a whole (59.7% to 71.4%), and across each age group.
- Less than half (43.5%) of clients ages <18 to 25 years used only outpatient services in FY 2009-10, and this proportion increased to 60.8% of TAY clients by FY 2015-16.
- Older adult clients were more likely than the other age groups to receive only outpatient services during all fiscal years, but by FY 2015-16, the proportion of clients between the ages of 26 and 59 years receiving only outpatient services was almost equal to that of the older adult clients (73.2% and 76.2%, respectively).
- Overall, utilization of inpatient/emergency services has decreased since FY 2009-10 to FY 2015-16 (21.3% to 16.9%).
- Compared to the other age groups, clients ages 18 to 25 years were more likely to use inpatient/ emergency services, with about one-quarter of TAY clients using emergency services each FY (24.2-29.4%[*]).
- Use of jail only services has decreased across all three age groups since FY 2009-10.

AOA Type of Service Used by Race/Ethnicity

Types of services used by AOA SOC clients were examined for FYs 2009-10, 2012-13, and 2015-16 across five racial/ethnic groups: White, Hispanic, African American, Asian/Pacific Islander, and Native American. Utilization rates were calculated as the number of clients within a specific racial/ethnic group who used a specific type of service, divided by the number of total clients within that race/ethnicity group. These data are presented in the graph on page 42.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 12.

- Utilization of outpatient services has steadily increased since FY 2009-10 to FY 2015-16 for White, Hispanic, and African American clients.
- While utilization rates of outpatient services for Asian/Pacific Islander and Native American clients did not increase in FY 2015-16 from FY 2012-13 like the other racial/ethnic groups, utilization rates of outpatient services has historically been higher for Asian/Pacific Islander and Native American clients than the other racial/ethnic groups (72.5-79.1%[†] versus 59.3-65.8%[‡] in FY 2012-13).
- Utilization of jail only services decreased in FY 2015-16 from FY 2012-13 for racial/ethnic groups except Native American clients (11.2% to 12.3%).

[*] *Range refers to the percentage of clients in the three fiscal years.*

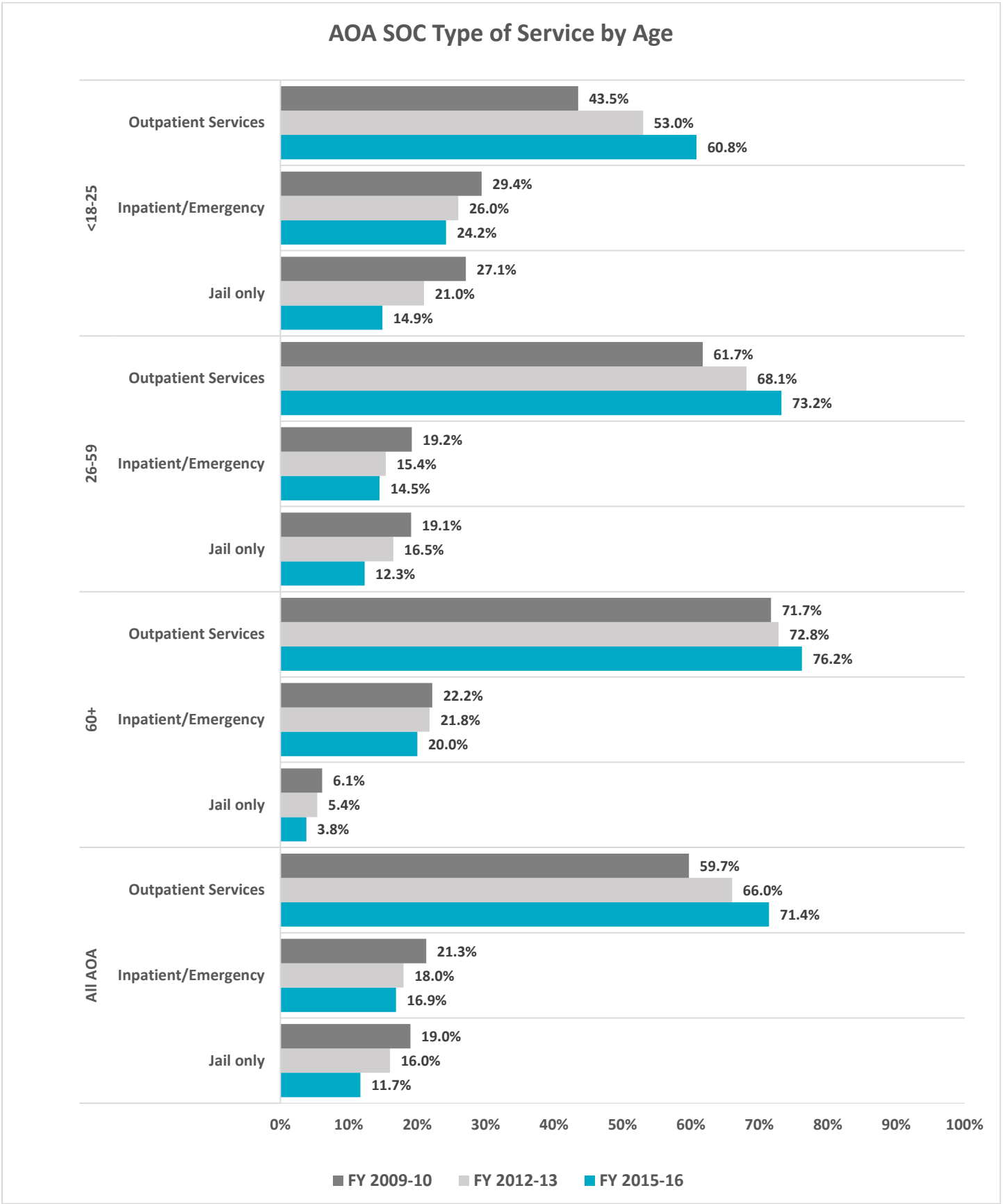
[†] *Range refers to the percentage of Asian/Pacific Islander and Native American clients.*

[‡] *Range refers to the percentage of clients in the other racial/ethnic groups.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



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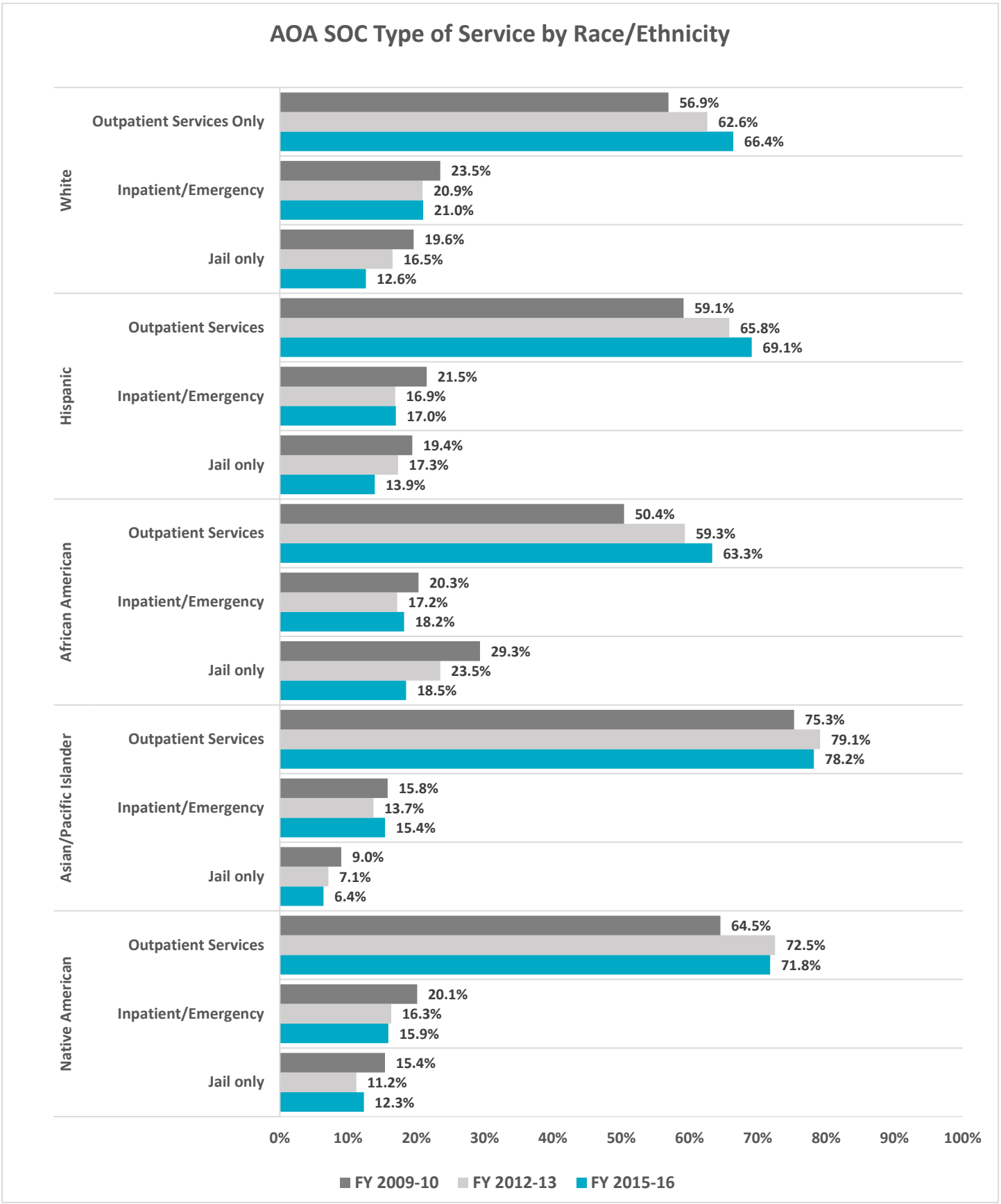
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Diagnosis

Disparities in Diagnosis

Children and Youth (CYF)

Diagnosis by Race/Ethnicity

Diagnosis data for children and youth clients were examined by race/ethnicity, and are displayed graphically on page 44. Due to changes in diagnostic categories to align with the ICD-10 codes during FY 2014-15, only data from FY 2015-16 is displayed on page 44. Trending data from the previous fiscal years with the former diagnostic categories is included in Appendix C. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 14.

- White clients had the highest prevalence rates of anxiety disorders (13%) and the lowest prevalence rates of oppositional/conduct disorders (10%) of all other racial/ethnic groups.
- Hispanic and Asian/Pacific Islander clients had the lowest prevalence rates of ADHD in FY 2015-16 (10% and 11%, respectively).
- African American clients had the highest rates of externalizing disorders [i.e., oppositional/ conduct disorders (15%) and ADHD (17%)] and the lowest rates of internalizing disorders [i.e., depressive (18%) and anxiety disorders (6%)] of all other racial/ethnic groups.
- Asian/Pacific Islander clients had the highest prevalence rates of depressive disorders (26%) and the lowest prevalence rates of stressor and adjustment disorders (15%) of all other racial/ethnic groups in FY 2015-16.
- Hispanic clients had the second highest prevalence rates of both depressive disorders and oppositional/conduct disorders (22% and 13%, respectively).
- Native American clients had the lowest prevalence rates of bipolar disorders (4%) in FY 2015-16.

Adults and Older Adults (AOA)

Diagnosis by Race/Ethnicity

Diagnosis data for adults and older adult clients were examined by race/ethnicity, and are displayed graphically on page 45. Due to changes in diagnostic categories to align with the ICD-10 codes during FY 2014-15, only data from FY 2015-16 is displayed on page 45. Trending data from the previous fiscal years with the former diagnostic categories is included in Appendix C. Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 14.

- The most common diagnosis in FY 2015-16 across all racial/ethnic groups was schizophrenia and other psychotic disorders (34% - 53%*).
- African American and Native American clients had the highest prevalence rates of schizophrenia and other psychotic disorders (53% and 50%, respectively), and the lowest prevalence rates of depressive disorders (15% and 17%, respectively) of all other racial/ethnic groups.
- White clients had the highest prevalence rates of bipolar disorders (25%) compared to other racial/ ethnic groups.
- Asian/Pacific Islander and Hispanic clients had the highest prevalence rates of depressive disorders of all other racial/ethnic groups (27% and 23%, respectively).
- Asian/Pacific Islander and African American clients had the lowest prevalence rates of bipolar disorders (12% and 16%, respectively).
- Native American clients had the lowest prevalence rates of stressor and adjustment disorders (2%), compared to all other racial/ethnic groups.

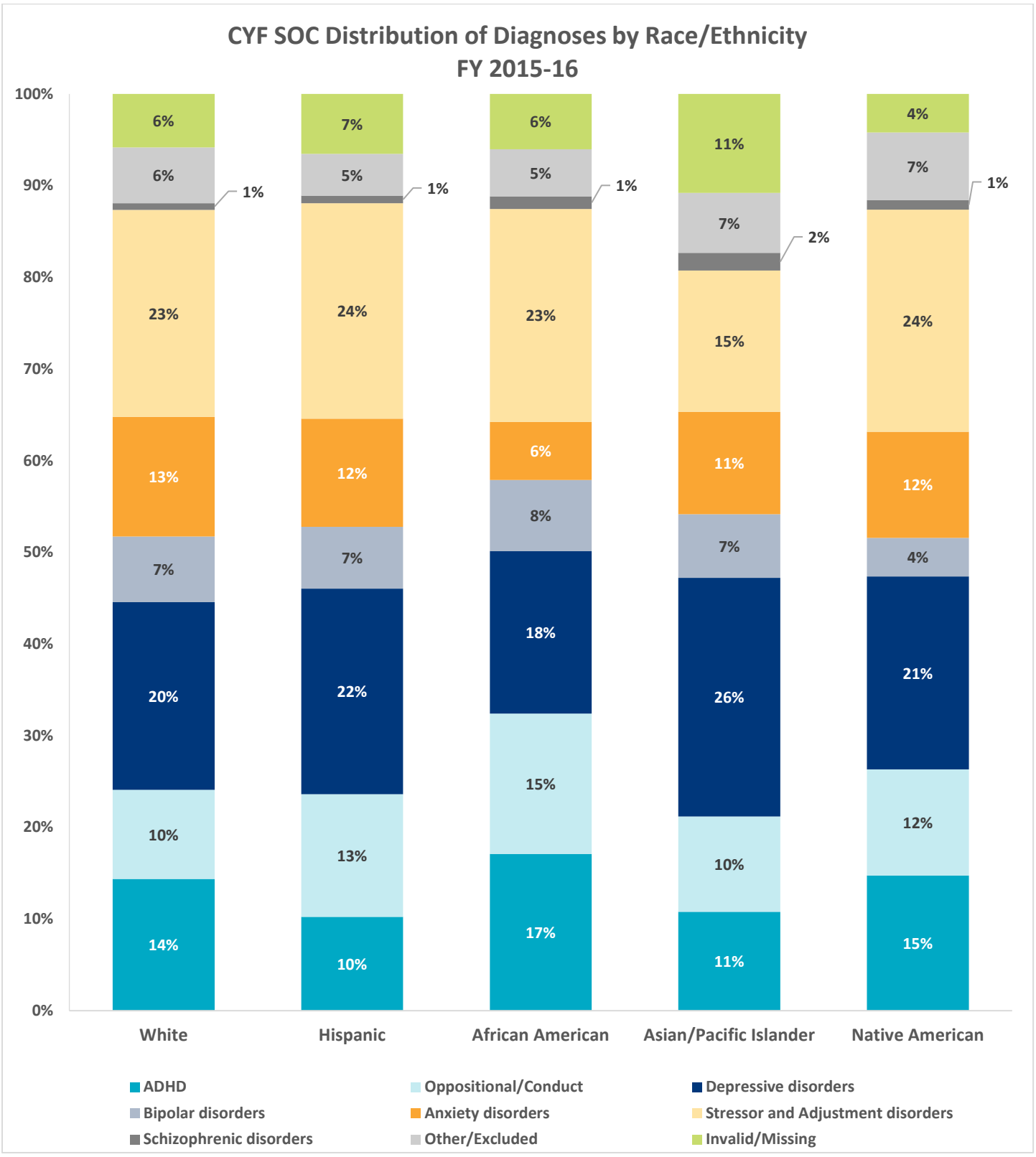
* *Range refers to the percentage of clients in all racial/ethnic groups.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

CYF Disparities by Race/Ethnicity*

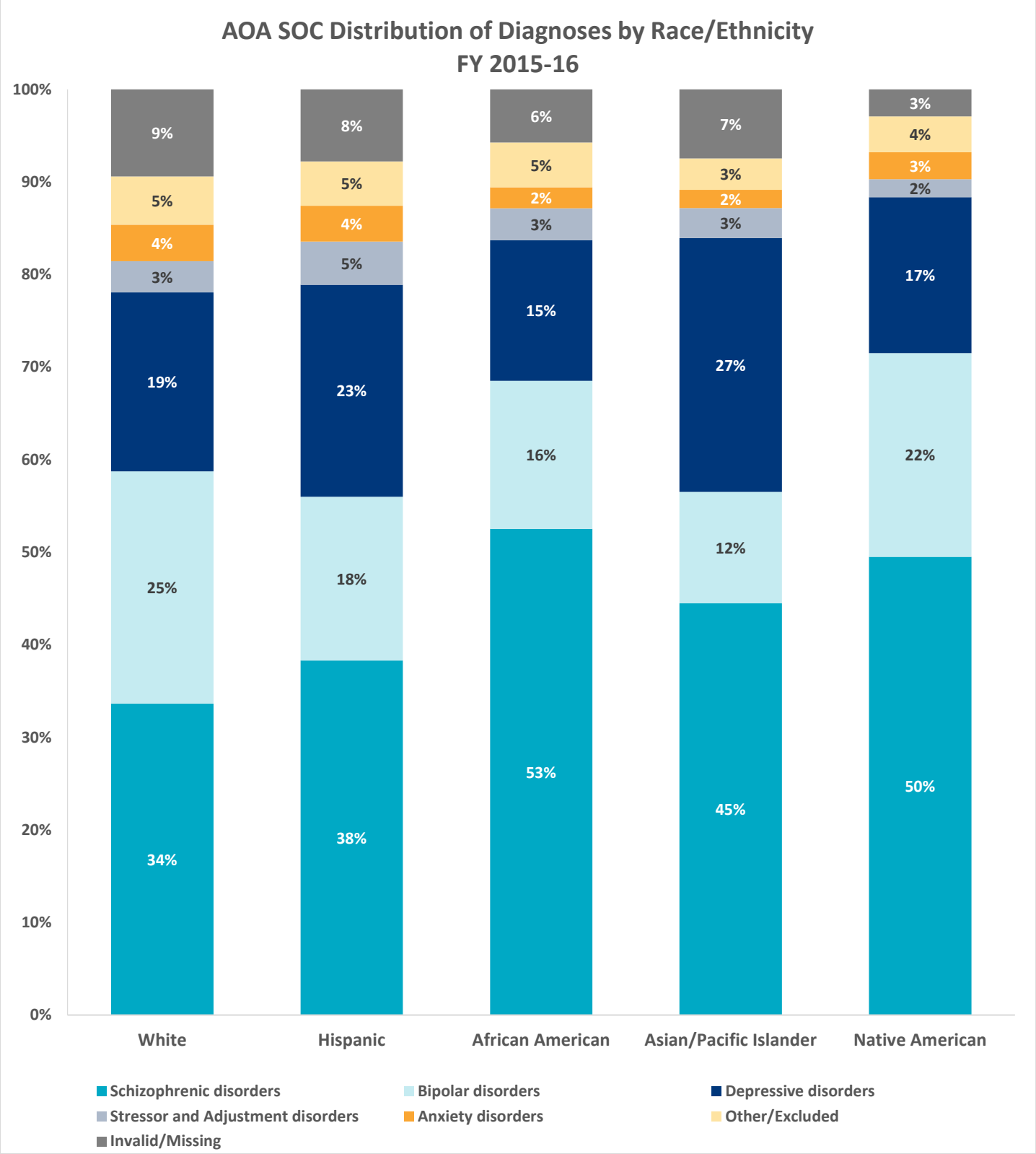


** Due to changes in diagnostic categories to align with the ICD-10 codes during FY 2014-15, data from previous fiscal years are not displayed here. Trending data from the previous fiscal years displaying the former diagnostic categories are displayed in Appendix C.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Disparities by Race/Ethnicity*



** Due to changes in diagnostic categories to align with the ICD-10 codes during FY 2014-15, data from previous fiscal years are not displayed here. Trending data from the previous fiscal years displaying the former diagnostic categories are displayed in Appendix C.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Transition Age Youth (TAY) Ages 18-25

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: TAY

Total Clients Served

7,527 transition-age youth (TAY) clients were served by the AOA SOC in FY 2015-16.

Age and Gender

Half (50%) of TAY clients served in FY 2015-16 were between the ages of 22 and 25 years. More than one-third of TAY clients served were between the ages of 18 and 21 years (38%). More male TAY clients than female TAY clients were served by the AOA SOC in FY 2015-16 (57% versus 43%).

Preferred Language

The majority (82%) of TAY clients reported that English was their preferred language.

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (24%)
2. Depressive disorders (22%)
3. Bipolar disorders (21%)

Service Utilization (Penetration Rates)

FY 2009-10	8.1%
FY 2012-13	7.6%
FY 2015-16	7.3%

Engagement (Retention* Rates)

FY 2009-10	<6 visits	40.8%
	10+ visits	41.4%
FY 2012-13	<6 visits	38.7%
	10+ visits	45.9%
FY 2015-16	<6 visits	45.6%
	10+ visits	39.6%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

More than half of TAY clients used only outpatient services in FY 2015-16 (60.8%), about one-quarter used inpatient/emergency services (24.2%), and the remaining 14.9% used only services provided in jail.

Insurance Status in FY 2015-16

17% of TAY clients were uninsured in FY 2015-16.

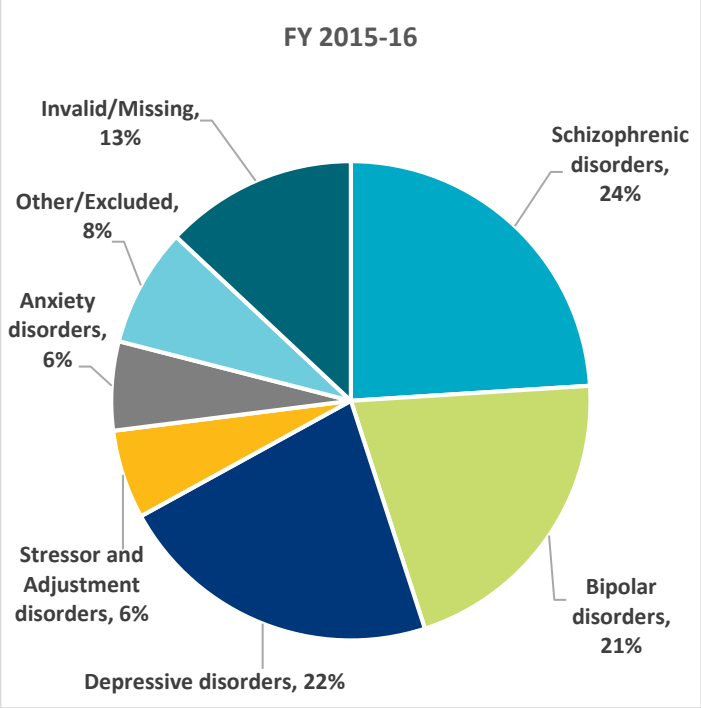
Age

	FY 2009-10	FY 2012-13	FY 2015-16
<18*	9%	12%	12%
18-21	43%	40%	38%
22-25	48%	48%	50%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	41%	38%	43%
Males	59%	61%	57%
Other/Unknown	<1%	<1%	<1%

Diagnosis



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

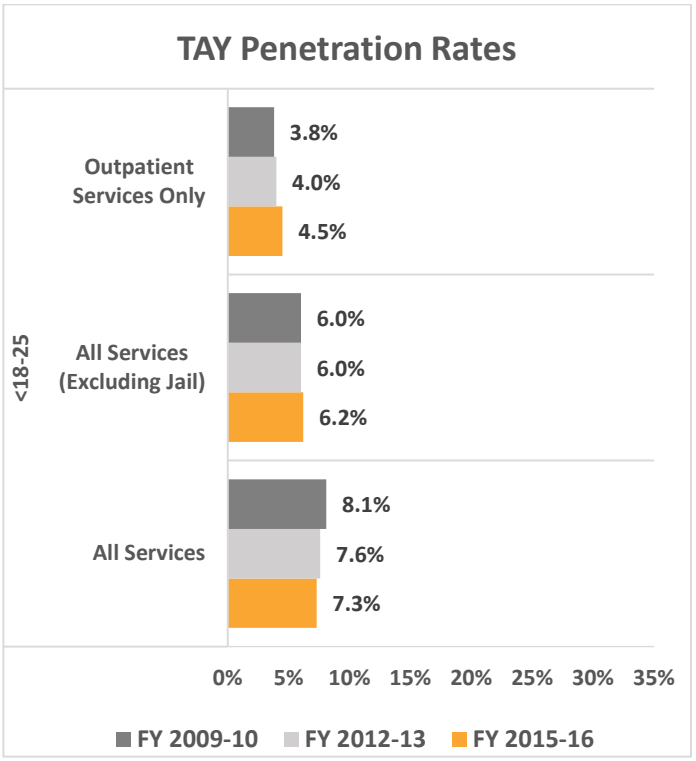
TAY Penetration Rates

Penetration rates for 1) all services, 2) all services (excluding jail), and 3) outpatient only services were examined for TAY in FYs 2009-10, 2012-13, and 2015-16. The category excluding services provided while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.

Penetration rates were calculated as the number of actual TAY clients who received services divided by the number of potential TAY clients (San Diego County TAY residents under 200% FPL who were either uninsured or Med-Cal beneficiaries).

Detailed tabular data for all three fiscal years are provided in Appendix B, Table 3.

- Compared to previous fiscal years, penetration rates for TAY clients decreased when considering all services in FY 2015-16 (8.1% to 7.3%).
- Considering outpatient services only, penetration rates for TAY showed an increasing trend from FY 2009-10 to FY 2015-16 (3.8% to 4.5%).

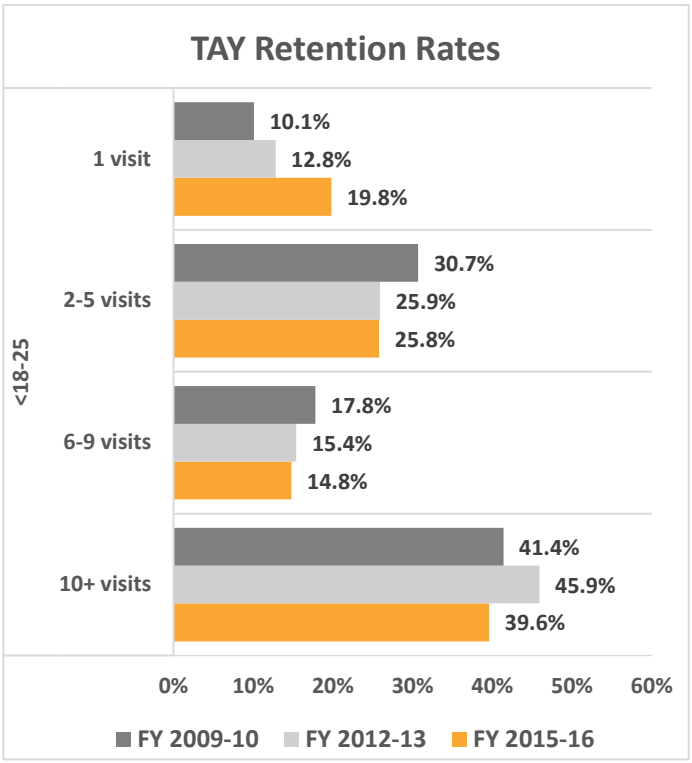


TAY Retention Rates

Retention rates for outpatient services for TAY BHS clients were examined in FYs 2009-10, 2012-13, and 2015-16. Services considered to be outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention services. Retention rates were defined as the number of outpatient visits for each TAY client during the fiscal year.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 7.

- Less than half (39.6%) of TAY clients served by the AOA SOC in FY 2015-16 received 10 or more service visits, which is a decrease from FY 2012-13 (45.9%) and FY 2009-10 (41.4%).
- About one-quarter (25.8%) of TAY clients had 2-5 visits in FY 2015-16, which is similar to the proportion observed in FY 2012-13 (25.9%), and slightly less than in FY 2009-10 (30.7%).
- The proportion of TAY clients who only received one AOA SOC service visit has almost doubled from FY 2009-10 to FY 2015-16 (10.1% to 19.8%).



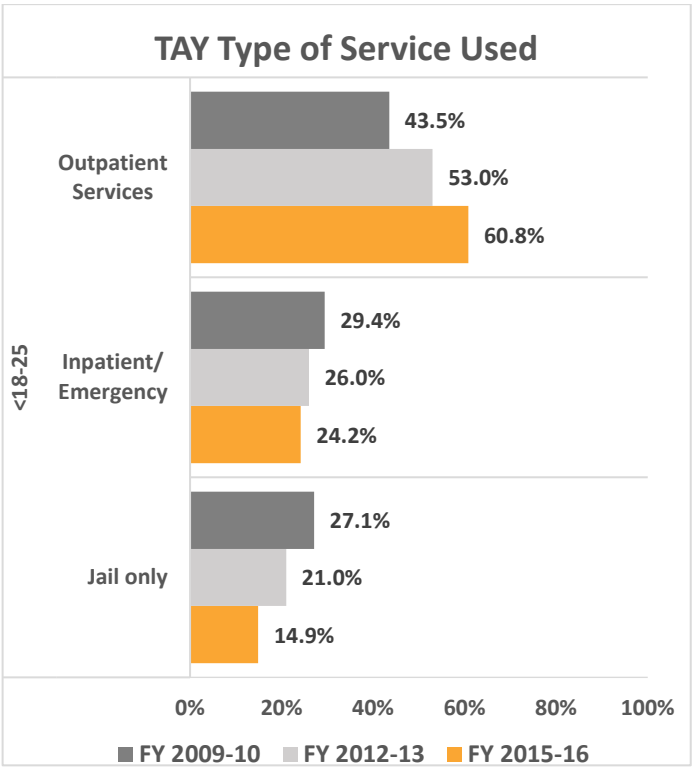
Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

TAY Type of Service Used

A goal of the AOA SOC has been to increase use of outpatient services and decrease use of inpatient/ emergency services. Types of services used by TAY clients were examined for FYs 2009-10, 2012-13, and 2015-16. Utilization rates were calculated as the number of TAY clients who used a specific type of service divided by the number of total TAY clients.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 11.

- TAY clients' usage of inpatient/emergency services has decreased since FY 2009-10 (29.4% to 24.2%)
- TAY clients used more outpatient services in FY 2015-16 than in either FY 2009-10 or FY 2012-13 (60.8% versus 43.5% and 53.0%, respectively).
- Use of jail only services has decreased among TAY clients since FY 2009-10 (27.1% to 14.9%).



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Older Adults (OA) Ages 60+

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Factsheet: OA

Total Clients Served

5,592 older adult (OA) clients were served by the AOA SOC in FY 2015-16.

Age and Gender

Approximately three-quarters (77%) of the OA clients served by the AOA SOC in FY 2015-16 were between the ages of 60 and 69 years. Historically, more female OA clients have been served than male OA clients (55-59%* versus 41-44%*, respectively).

Preferred Language

Most OA clients reported that English was their preferred language (68%). Language preference was unknown or unavailable for 16% of OA clients.

Top 3 Diagnoses

1. Schizophrenia & other psychotic disorders (33%)
2. Depressive disorders (28%)
3. Bipolar disorders (13%)

Service Utilization (Penetration Rates)

FY 2009-10	6.8%
FY 2012-13	6.7%
FY 2015-16	7.8%

Engagement (Retention* Rates)

FY 2009-10	<6 visits	35.7%
	10+ visits	44.5%
FY 2012-13	<6 visits	31.3%
	10+ visits	50.2%
FY 2015-16	<6 visits	40.7%
	10+ visits	44.2%

** Includes clients who received a BHA, but no other AOA SOC services.*

Type of Service Used in FY 2015-16

More than three-quarters of OA clients used outpatient services in FY 2015-16 (76.2%), 20.0% used only inpatient/emergency services, while 3.8% used only services provided in jail.

Insurance Status in FY 2015-16

15% of OA clients were uninsured in FY 2015-16.

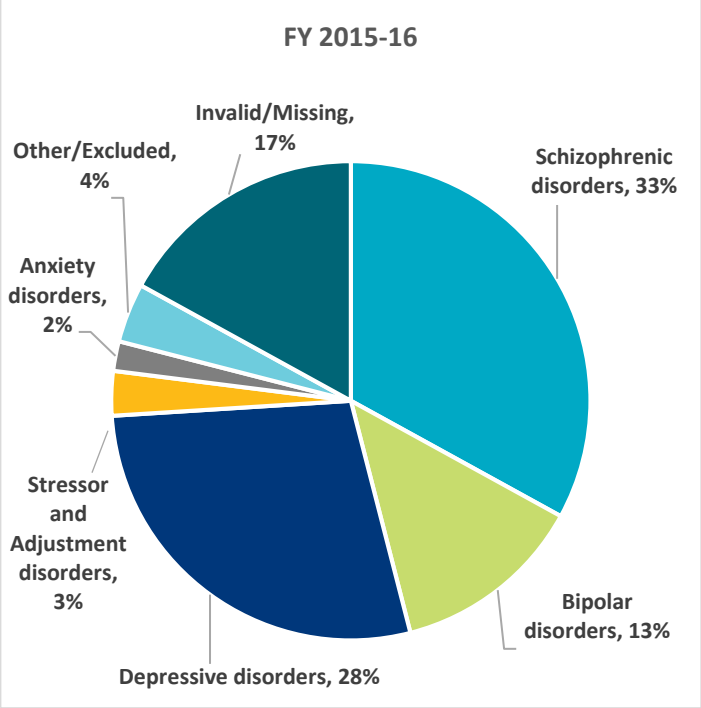
Age

	FY 2009-10	FY 2012-13	FY 2015-16
60-69	75%	76%	77%
70-79	15%	15%	16%
80+	10%	9%	8%

Gender

	FY 2009-10	FY 2012-13	FY 2015-16
Females	59%	57%	55%
Males	41%	43%	44%
Other/Unknown	<1%	<1%	<1%

Diagnosis



* *Range refers to the percentage of clients in the three fiscal years.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

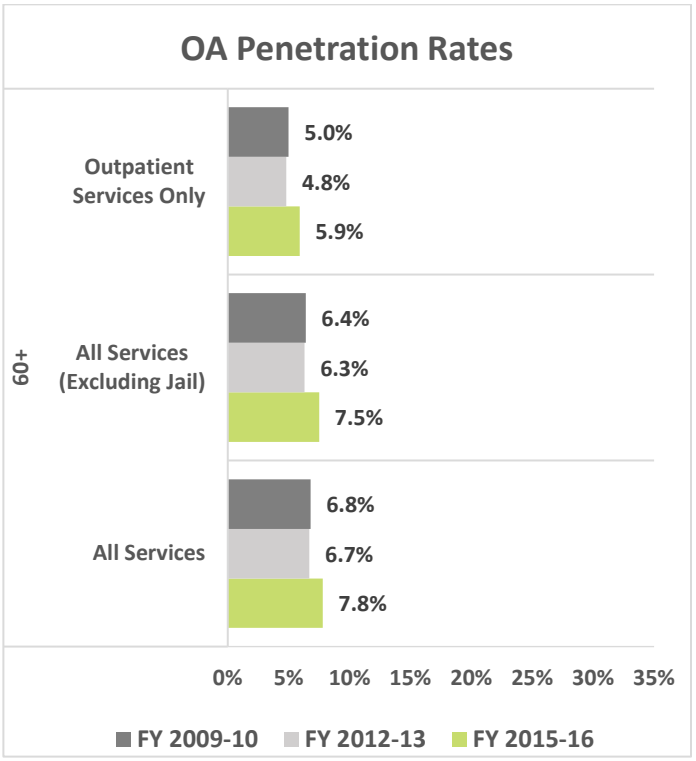
OA Penetration Rates

Penetration rates for 1) all services, 2) all services (excluding jail), and 3) outpatient only services were examined for older adults in FYs 2009-10, 2012-13, and 2015-16. The category excluding services provided while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.

Penetration rates were calculated as the number of actual OA clients who received services divided by the number of potential OA clients (San Diego County residents under 200% FPL who were either uninsured or Med-Cal beneficiaries).

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 3.

- Compared to previous fiscal years, penetration rates for all OA clients increased in FY 2015-16.

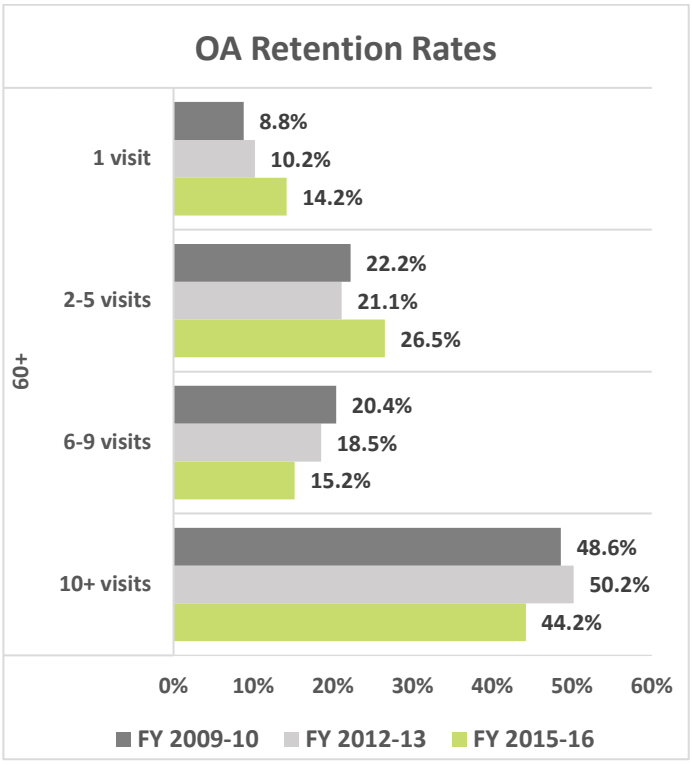


OA Retention Rates

Retention rates for outpatient services for OA SOC clients were examined in FYs 2009-10, 2012-13, and 2015-16. Services considered to be outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention services. Retention rates were defined as the number of outpatient visits for each client during the fiscal year.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 7.

- Less than half (44.2%) of OA clients served by the AOA SOC in FY 2015-16 received more than 10 service visits, which is a decrease from FY 2012-13 (50.2%).
- More than one-quarter (26.5%) of OA clients had 2-5 visits in FY 2015-16.
- The proportion of OA clients only receiving one service visit has increased from previous fiscal years (8.8% to 10.2% to 14.2%).



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

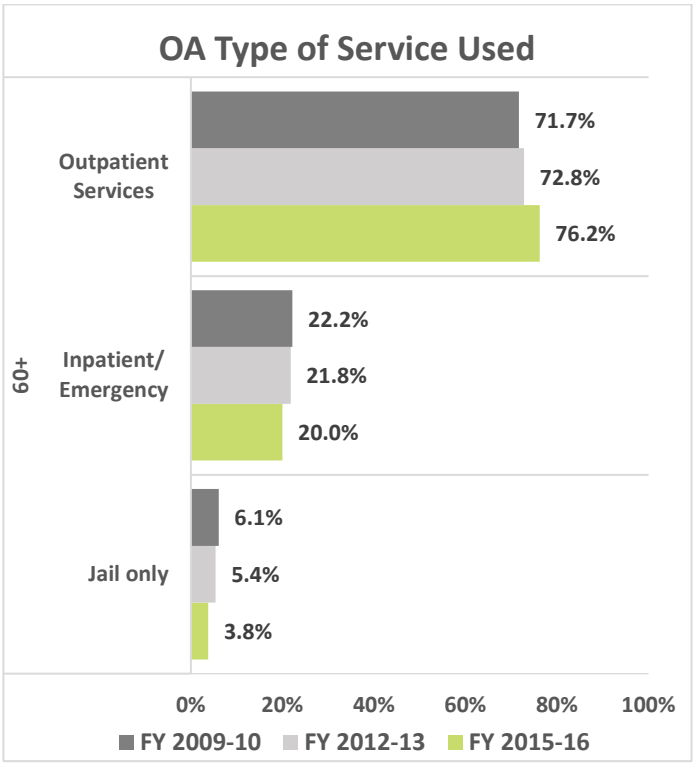
PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

OA Type of Service Used

A goal of the AOA SOC has been to increase use of outpatient services and decrease use of inpatient/ emergency services. Types of services used by OA clients were examined for FYs 2009-10, 2012-13, and 2015-16. Utilization rates were calculated as the number of OA clients who used a specific type of service divided by the number of total OA clients.

Detailed tabular data for FY 2015-16 are provided in Appendix B, Table 11.

- OA clients' usage of inpatient/emergency services decreased slightly in FY 2015-16 from the previous fiscal years (22.2% in FY 2009-10 and 21.8% in FY 2012-13 to 20.0% in FY 2015-16).
- OA clients used a greater proportion of outpatient services in FY 2015-16 compared to previous fiscal years (76.2% compared to 71.7% in FY 2009-10 and 72.8% in FY 2012-13).
- Use of jail only services by OA clients decreased over the last three fiscal years included in this report (6.1% to 3.8%).



Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Appendices

Appendix A: Glossary

200% Federal Poverty Level (FPL): Poverty level requirements to be eligible for the County of San Diego Behavioral Health Services; annual income for family of two is less than $32,000.

Assertive Community Treatment (ACT): ACT is a team-based approach to delivering comprehensive and flexible treatment, support, and services. ACT programs provide extensive service for individuals who experience serious mental illness. People who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive mental health services.

Adult and Older Adult System of Care (AOA SOC): AOA SOC provides services to transition age youth (TAY), adults, and older adults (OA) with severe, persistent mental health needs, or those experiencing a mental health crisis.

Behavioral Health Assessment (BHA): An assessment designed to evaluate the current status of a client's mental, emotional, or behavioral health. The document includes, but is not limited to: mental status determination, analysis of client's clinical history, analysis of relevant cultural issues, client's history, and diagnosis. The BHA justifies whether client meets Title 9 criteria for medical necessity and informs service delivery to be offered to the client.

Behavioral Health (BH) Court: BH Court is an alternative court for a mentally ill offender of the law. BH Court's purpose is to reduce the recidivism of criminal defendants who suffer from serious mental illness by connecting these defendants with community treatment services, and to find appropriate dispositions to the criminal charges by considering the defendant's mental illness and the seriousness of the offense.

Case Management (CM): CM services help and support people with long-term mental health problems to maintain housing, and obtain financial assistance, medical and psychiatric treatment, and assists clients with linking to community services such as education, work, and social programs. The service activities may include, but are not limited to: supportive counseling, coordination, and referral; ensuring access to service delivery system; and assessment, service plan development, and monitoring client progress.

Crisis Outpatient (CO): CO services are provided in an outpatient setting to adults and older adults who are experiencing a crisis and who may require medication support and stabilization.

Crisis Residential (CR): CR services are provided in a 24-hour, acute, outpatient mental health setting to adults who are experiencing a crisis and require 24-hour support and referrals.

Crisis Stabilization (CS): CS services are short-term and are provided to adults with mental health conditions who are experiencing a crisis and are delivered at certified sites.

Children, Youth, and Families System of Care (CYF SOC): CYF SOC provides services to youth with serious emotional disturbances who are ages 0-17 years, with a small number of programs serving young adults ages 18 years and older.

Disparities: Differences of inequalities between groups of people.

Edgemoor: An inpatient skilled nursing facility that provides: 24-hour skilled nursing care; physical rehabilitation; and recreational, occupational, physical, speech, and respiratory therapies.

Eligible Clients (Target Population): Eligible clients were defined as those individuals in San Diego County who were uninsured or Medi-Cal eligible, and under 200% of the FPL that could potentially have a serious mental illness.

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Emergency/Crisis Services: One-time use services, such as Crisis Outpatient (CO), Crisis Stabilization (CS), Crisis Residential (CR), and the Psychiatric Emergency Response Team (PERT).

Externalizing Disorders: Constitutes acting-out behaviors, such as aggression, impulsivity, and noncompliance. Common externalizing disorders include Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional/Conduct Disorders.

Fee-for-Service (FFS): FFS services are primarily from licensed clinicians in private practice who get reimbursed for services rendered to clients. These providers are spread out over the county and represent a diversity of discipline, cultural-linguistic groups, and genders in order to provide choice for eligible clients.

Inpatient Services: Acute services in psychiatric inpatient hospitals.

Internalizing Disorders: Describes withdrawn, depressed, and anxious behaviors. Common internalizing disorders include Depressive and Anxiety Disorders.

Jail Services: Specialty Mental Health services provided to those serving jail sentences.

Juvenile Forensic Services (JFS) Stabilization, Treatment, and Transition (STAT) Team: JFS STAT team provides mental health services to youth in the Department of Probation juvenile detention and rehabilitation institutions. The STAT Team provides crisis intervention, traditional psychotherapy and assessment, psychiatric evaluation and medication management, and innovative mental health services in the institutions.

Long Term Care (LTC): Services provided in residential settings that provide long-term care, offering room, board, 24-hour oversight, health monitoring, and assistance with activities of daily living, and are licensed by the state.

Outpatient Services: Services include case management (CM), individual or group therapy, and/or medication management.

Penetration: The degree to which services are used.

Prevention Services: Programs that bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue.

Psychiatric Emergency Response Team (PERT): PERT pairs licensed, experienced, professional mental health clinicians with specially trained law enforcement officers. They respond to calls for service from the community involving individuals who may be experiencing mental health crises. They intervene to prevent unnecessary hospitalizations and incarcerations while protecting the individuals involved as well as the community.

Racial/Ethnic Identity: Identifying with a specific racial or ethnic group.

Residential Services: Services provided to persons with serious mental illness through a residential setting which provides 24/7 care and supervision as needed (unless otherwise authorized by the County to provide residential services that do not include care and supervision).

Retention: The ability to retain clients in services for a desired or necessary amount of time to maximize treatment effects.

Transition Age Youth (TAY): TAY clients ages 18-25 who received services in the AOA System of Care.

Utilization: The manner in which a service is used.

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Appendix B: Tabular Data

Table 1. CYF SOC Penetration Rates by Age

Age: All Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
0-5	84,348	87,508	95,072	2,075	2,232	2,118	2.5%	2.6%	2.2%
6-11	81,508	84,561	91,870	5,129	5,992	5,836	6.3%	7.1%	6.4%
12-17*	75,830	78,671	85,471	9,623	9,191	9,347	12.7%	11.7%	10.9%
Total	**241,686**	**250,740**	**272,413**	**16,827**	**17,415**	**17,301**	**7.0%**	**6.9%**	**6.4%**

** Category includes a small percentage of total clients served ages 18+ who also received services through CYF SOC.*

Table 2. CYF SOC Penetration Rates by Race/Ethnicity*

Race/Ethnicity: All Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
White	30,705	31,855	34,144	4,198	3,805	3,463	13.7%	11.9%	10.1%
Hispanic	171,177	177,589	190,351	8,990	10,346	9,777	5.3%	5.8%	5.1%
African American	21,212	22,007	23,588	2,318	2,044	1,691	10.9%	9.3%	7.2%
Asian/Pacific Islander	13,667	14,179	15,198	464	437	519	3.4%	3.1%	3.4%
Native American	4,925	5,109	5,476	125	91	95	2.5%	1.8%	1.7%
Total	**241,686**	**250,739**	**268,757**	**16,095**	**16,723**	**15,545**	**6.7%**	**6.7%**	**5.8%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Table 3. AOA SOC Penetration Rates by Age

Age: All Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
<18-25	91,188	94,604	102,781	7,405	7,158	7,527	8.1%	7.6%	7.3%
26-59	248,168	257,464	279,718	31,272	29,157	29,686	12.6%	11.3%	10.6%
60+	69,151	71,741	71,741	4,706	4,809	5,592	6.8%	6.7%	7.8%
Total	**408,507**	**423,809**	**454,240**	**43,383**	**41,124**	**42,805**	**10.6%**	**9.7%**	**9.4%**

Age: All Services, Excluding Jail Only*	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
<18-25	91,188	94,604	102,781	5,463	5,655	6,402	6.0%	6.0%	6.2%
26-59	248,168	257,464	279,718	25,517	24,358	26,028	10.3%	9.5%	9.3%
60+	69,151	71,741	71,741	4,434	4,554	5,380	6.4%	6.3%	7.5%
Total	**408,507**	**423,809**	**454,240**	**35,414**	**34,567**	**37,810**	**8.7%**	**8.2%**	**8.3%**

** Excluding services provided while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Age: Outpatient Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
<18-25	91,188	94,604	102,781	3,426	3,787	4,578	3.8%	4.0%	4.5%
26-59	248,168	257,464	279,718	19,906	19,821	21,694	8.0%	7.7%	7.8%
60+	69,151	71,741	71,741	3,424	3,469	4,215	5.0%	4.8%	5.9%
Total	**408,507**	**423,809**	**454,240**	**26,756**	**27,077**	**30,487**	**6.5%**	**6.4%**	**6.7%**

Table 4. AOA SOC Penetration Rates by Race/Ethnicity*

Race/Ethnicity: All Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
White	73,047	75,783	81,229	22,077	19,619	18,227	30.2%	25.9%	22.4%
Hispanic	204,106	211,751	226,968	8,801	9,294	9,671	4.3%	4.4%	4.3%
African American	25,939	26,911	28,845	5,310	5,348	5,211	20.5%	19.9%	18.1%
Asian/Pacific Islander	29,561	30,668	32,872	2,452	2,147	2,283	8.3%	7.0%	6.9%
Native American	6,703	6,954	7,454	318	276	309	4.7%	4.0%	4.1%
Total	**339,356**	**352,067**	**377,368**	**38,958**	**36,684**	**35,701**	**11.5%**	**10.4%**	**9.5%**

Race/Ethnicity: All Services, Excluding Jail Only**	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
White	73,047	75,783	81,229	17,897	16,394	15,933	24.5%	21.6%	19.6%
Hispanic	204,106	211,751	226,968	7,183	7,692	8,334	3.5%	3.6%	3.7%
African American	25,939	26,911	28,845	3,809	4,095	4,249	14.7%	15.2%	14.7%
Asian/Pacific Islander	29,561	30,668	32,872	2,236	1,994	2,137	7.6%	6.5%	6.5%
Native American	6,703	6,954	7,454	275	245	271	4.1%	3.5%	3.6%
Total	**339,356**	**352,067**	**377,368**	**31,400**	**30,420**	**30,924**	**9.3%**	**8.6%**	**8.2%**

Race/Ethnicity: Outpatient Services	Potential Clients			Actual Clients			Penetration Rate		
	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16	2009-10	2012-13	2015-16
White	73,047	75,783	81,229	13,034	12,242	12,062	17.8%	16.2%	14.8%
Hispanic	204,106	211,751	226,968	5,444	6,106	6,670	2.7%	2.9%	2.9%
African American	25,939	26,911	28,845	2,801	3,156	3,289	10.8%	11.7%	11.4%
Asian/Pacific Islander	29,561	30,668	32,872	1,866	1,694	1,780	6.3%	5.5%	5.4%
Native American	6,703	6,954	7,454	222	200	221	3.3%	2.9%	3.0%
Total	**339,356**	**352,067**	**377,368**	**23,367**	**23,398**	**24,022**	**6.9%**	**6.6%**	**6.4%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

*** Excluding clients who only received services while in jail allows for the examination of penetration rates uninfluenced by mandatory services, such as those provided as part of the justice system.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Table 5. CYF SOC Retention Rates by Age (FY 2015-16)

Age: All Services	1 session		2-5 sessions		6-9 sessions		10-12 sessions		13+ sessions		Overall	
	Clients	Rate*	Clients	Rate*	Clients	Rate*	Clients	Rate*	Clients	Rate*	Clients	Rate*
0-5	862	40.7%	318	15.0%	163	7.7%	127	6.0%	647	30.6%	2,117	100.0%
6-11	565	9.7%	1,168	20.1%	847	14.5%	570	9.8%	2,674	45.9%	5,824	100.0%
12-17	705	8.6%	1,766	21.5%	1,119	13.6%	689	8.4%	3,929	47.9%	8,208	100.0%
18+	81	8.7%	218	23.5%	128	13.8%	70	7.5%	432	46.5%	929	100.0%
Total	**2,213**	**13.0%**	**3,470**	**20.3%**	**2,257**	**13.2%**	**1,456**	**8.5%**	**7,682**	**45.0%**	**17,078**	**100.0%**

** Rate = Retention rate*

Table 6. CYF SOC Retention Rates by Race/Ethnicity* (FY 2015-16)

Race/Ethnicity: All Services	1 session		2-5 sessions		6-9 sessions		10-12 sessions		13+ sessions		Overall	
	Clients	Rate**	Clients	Rate**	Clients	Rate**	Clients	Rate**	Clients	Rate**	Clients	Rate**
White	384	11.3%	608	17.8%	444	13.0%	274	8.0%	1,703	49.9%	3,413	100.0%
Hispanic	1,195	12.3%	1,896	19.6%	1,273	13.1%	858	8.9%	4,460	46.1%	9,682	100.0%
African American	174	10.4%	301	18.1%	183	11.0%	126	7.6%	882	52.9%	1,666	100.0%
Asian/Pacific Islander	70	13.8%	100	19.8%	58	11.5%	48	9.5%	230	45.5%	506	100.0%
Native American	11	12.0%	14	15.2%	15	16.3%	4	4.3%	48	52.2%	92	100.0%
Total	**1,834**	**11.9%**	**2,919**	**19.0%**	**1,973**	**12.8%**	**1,310**	**8.5%**	**7,323**	**47.7%**	**15,359**	**100.0%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

*** Rate – Retention rate*

Table 7. AOA SOC Retention Rates by Age (FY 2015-16)

Age: Outpatient Services* BHA Included	1 visit		2-5 visits		6-9 visits		10+ visits		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
<18-25	905	19.8%	1,181	25.8%	676	14.8%	1,814	39.6%	4,576	100.0%
26-59	3,106	14.3%	5,191	23.9%	3,528	16.3%	9,866	45.5%	21,691	100.0%
60+	597	14.2%	1,117	26.5%	639	15.2%	1,862	44.2%	4,215	100.0%
Total	**4,608**	**15.1%**	**7,489**	**24.6%**	**4,843**	**15.9%**	**13,542**	**44.4%**	**30,482**	**100.0%**

Age: Outpatient Services* BHA Excluded	1 visit		2-5 visits		6-9 visits		10+ visits		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
<18-25	830	18.4%	1,181	26.2%	676	15.0%	1,814	40.3%	4,501	100.0%
26-59	2,964	13.8%	5,191	24.1%	3,528	16.4%	9,866	45.8%	21,549	100.0%
60+	578	13.8%	1,117	26.6%	639	15.2%	1,862	44.4%	4,196	100.0%
Total	**4,372**	**14.5%**	**7,489**	**24.8%**	**4,843**	**16.0%**	**13,542**	**44.8%**	**30,246**	**100.0%**

** Outpatient services include ACT, BH Court, Case Management, FFS, Outpatient, and Prevention type services.*

Note: BHA = Behavioral Health Assessment

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Table 8. AOA SOC Retention Rates by Race/Ethnicity* (FY 2015-16)

Race/Ethnicity: Outpatient Services† BHA Included	1 visit		2-5 visits		6-9 visits		10+ visits		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
White	1,265	10.5%	2,595	21.5%	1,894	15.7%	6,308	52.3%	12,062	100.0%
Hispanic	804	12.1%	1,449	21.7%	1,043	15.6%	3,374	50.6%	6,670	100.0%
African American	380	11.6%	711	21.6%	535	16.3%	1,663	50.6%	3,289	100.0%
Asian/Pacific Islander	120	6.7%	348	19.6%	382	21.5%	930	52.2%	1,780	100.0%
Native American	22	10.0%	53	24.0%	32	14.5%	114	51.6%	221	100.0%
Total	**2,591**	**10.8%**	**5,156**	**21.5%**	**3,886**	**16.2%**	**12,389**	**51.6%**	**24,022**	**100.0%**

Race/Ethnicity: Outpatient Services† BHA Excluded	1 visit		2-5 visits		6-9 visits		10+ visits		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
White	1,160	9.7%	2,598	21.7%	1,891	15.8%	6,307	52.8%	11,956	100.0%
Hispanic	741	11.2%	1,448	21.9%	1,043	15.8%	3,374	51.1%	6,606	100.0%
African American	336	10.4%	711	21.9%	535	16.5%	1,662	51.2%	3,244	100.0%
Asian/Pacific Islander	110	6.2%	348	19.7%	382	21.6%	930	52.5%	1,770	100.0%
Native American	21	9.5%	53	24.1%	32	14.5%	114	51.8%	220	100.0%
Total	**2,368**	**10.0%**	**5,158**	**21.7%**	**3,883**	**16.3%**	**12,387**	**52.1%**	**23,796**	**100.0%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

† *Outpatient services include ACT, BH Court, Case Management, FFS, Outpatient, and Prevention type services.*

Note: BHA = Behavioral Health Assessment

Table 9. CYF SOC Type of Service Used by Age (FY 2015-16)

Age	Outpatient		Inpatient/ESU		JFS Only		Total	
	Clients	%	Clients	%	Clients	%	Clients	%
0-5	2,116	99.9%	2	0.1%	0	0.0%	2,118	100.0%
6-11	5,813	99.6%	21	0.4%	2	<0.1%	5,836	100.0%
12-17	7,659	91.7%	154	1.8%	536	6.4%	8,349	100.0%
18+	779	78.1%	9	0.9%	210	21.0%	998	100.0%
Total	**16,367**	**94.6%**	**186**	**1.1%**	**748**	**4.3%**	**17,301**	**100.0%**

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Table 10. CYF SOC Type of Service Used by Race/Ethnicity* (FY 2015-16)

Race/Ethnicity	Outpatient		Inpatient/ESU		JFS Only		Total	
	Clients	%	Clients	%	Clients	%	Clients	%
White	3,327	96.1%	40	1.2%	96	2.8%	3,463	100%
Hispanic	9,206	94.2%	101	1.0%	470	4.8%	9,777	100%
African American	1,537	90.9%	19	1.1%	135	8.0%	1,691	100%
Asian/Pacific Islander	488	94.0%	9	1.7%	22	4.2%	519	100%
Native American	91	95.8%	0	0.0%	4	4.2%	95	100%
Total	**14,649**	**94.2%**	**169**	**1.1%**	**727**	**4.7%**	**15,545**	**100%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Table 11. AOA SOC Type of Service* Used by Age (FY 2015-16)

Age	Outpatient		Inpatient/Emergency**		Jail Only		Total	
	Clients	%	Clients	%	Clients	%	Clients	%
<18-25	4,578	60.8%	1,823	24.2%	1,125	14.9%	7,526	100.0%
26-59	21,694	73.2%	4,283	14.5%	3,658	12.3%	29,635	100.0%
60+	4,215	76.2%	1,108	20.0%	212	3.8%	5,535	100.0%
Total	**30,487**	**71.4%**	**7,214**	**16.9%**	**4,995**	**11.7%**	**42,696**	**100.0%**

** Edgemoor, Long Term Care, and Residential services are excluded.*

*** Includes Inpatient, Crisis Residential, Crisis Outpatient, Crisis Stabilization, and Psychiatric Response Team (PERT) services.*

Table 12. AOA SOC Type of Service* by Race/Ethnicity† (FY 2015-16)

Race/Ethnicity	Outpatient		Inpatient/Emergency**		Jail Only		Total	
	Clients	%	Clients	%	Clients	%	Clients	%
White	12,062	66.4%	3,810	21.0%	2,294	12.6%	18,166	100.0%
Hispanic	6,670	69.1%	1,643	17.0%	1,337	13.9%	9,650	100.0%
African American	3,289	63.3%	943	18.2%	962	18.5%	5,194	100.0%
Asian/Pacific Islander	1,780	78.2%	351	15.4%	146	6.4%	2,277	100.0%
Native American	221	71.8%	49	15.9%	38	12.3%	308	100.0%
Total	**24,022**	**67.5%**	**6,796**	**19.1%**	**4,777**	**13.4%**	**35,595**	**100.0%**

** Edgemoor, Long Term Care, and Residential services are excluded.*

*** Includes Inpatient, Crisis Residential, Crisis Outpatient, Crisis Stabilization, and Psychiatric Response Team (PERT) services.*

† *For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Table 13. CYF SOC Diagnosis by Race/Ethnicity* (FY 2015-16)

Primary Diagnosis	White		Hispanic		African American		Asian/Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
ADHD	498	14.4%	1,002	10.2%	289	17.1%	56	10.8%	14	14.7%
Opposition/Conduct	336	9.7%	1,308	13.4%	259	15.3%	54	10.4%	11	11.6%
Depressive disorders	709	20.5%	2,190	22.4%	300	17.7%	135	26.0%	20	21.1%
Bipolar disorders	248	7.2%	661	6.8%	131	7.7%	36	6.9%	4	4.2%
Anxiety disorders	452	13.1%	1,152	11.8%	107	6.3%	58	11.2%	11	11.6%
Stressor and Adjustment disorders	782	22.6%	2,298	23.5%	393	23.2%	80	15.4%	23	24.2%
Schizophrenic disorders	25	0.7%	81	0.8%	23	1.4%	10	1.9%	1	1.1%
Other/Excluded	211	6.1%	447	4.6%	87	5.1%	34	6.6%	7	7.4%
Invalid/Missing	202	5.8%	638	6.5%	102	6.0%	56	10.8%	4	4.2%
Total	**3,463**	**100.0%**	**9,777**	**100.0%**	**1,691**	**100.0%**	**519**	**100.0%**	**95**	**100.0%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Table 14. AOA SOC Diagnosis by Race/Ethnicity* (FY 2015-16)

Primary Diagnosis**	White		Hispanic		African American		Asian/Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Schizophrenic disorders	6,130	33.6%	3,704	38.3%	2,737	52.5%	1,016	44.5%	153	49.5%
Bipolar disorders	4,575	25.1%	1,711	17.7%	833	16.0%	274	12.0%	68	22.0%
Depressive disorders	3,523	19.3%	2,215	22.9%	792	15.2%	626	27.4%	52	16.8%
Stressor and Adjustment disorders	618	3.4%	452	4.7%	180	3.5%	74	3.2%	6	1.9%
Anxiety disorders	715	3.9%	373	3.9%	118	2.3%	45	2.0%	9	2.9%
Other/Excluded	954	5.2%	464	4.8%	252	4.8%	78	3.4%	12	3.9%
Invalid/Missing	1,712	9.4%	752	7.8%	299	5.7%	170	7.4%	9	2.9%
Total	**18,227**	**100.0%**	**9,671**	**100.0%**	**5,211**	**100.0%**	**2,283**	**100.0%**	**309**	**100.0%**

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Table 15. CYF SOC Insurance Status by Race/Ethnicity* (FY 2015-16)

Insurance Type	White		Hispanic		African American		Asian/Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Medi-Cal only	2,972	85.8%	8,757	89.6%	1,519	89.8%	440	84.8%	84	88.4%
Any private insurance	189	5.5%	180	1.8%	65	3.8%	30	5.8%	7	7.4%
Other insurance	197	5.7%	489	5.0%	50	3.0%	29	5.6%	3	3.2%
Uninsured/Unknown	105	3.0%	351	3.6%	57	3.4%	20	3.9%	1	1.1%
Total	**3,463**	100.0%	**9,777**	100.0%	**1,691**	100.0%	**519**	100.0%	**95**	100.0%

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Table 16. AOA SOC Insurance Status by Race/Ethnicity* (FY 2015-16)

Insurance Type	White		Hispanic		African American		Asian/Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Medi-Cal only	11,224	61.6%	6,908	71.4%	3,656	70.2%	1,454	63.7%	206	66.7%
Medi-Cal & Medicare	2,607	14.3%	754	7.8%	578	11.1%	323	14.1%	39	12.6%
Medicare only	93	0.5%	16	0.2%	12	0.2%	5	0.2%	3	1.0%
Private insurance	1,609	8.8%	789	8.2%	395	7.6%	213	9.3%	28	9.1%
Uninsured/Unknown	2,694	14.8%	1,204	12.4%	570	10.9%	288	12.6%	33	10.7%
Total	**18,227**	**100.0%**	**9,671**	**100.0%**	**5,211**	**100.0%**	**2,283**	**100.0%**	**309**	**100.0%**

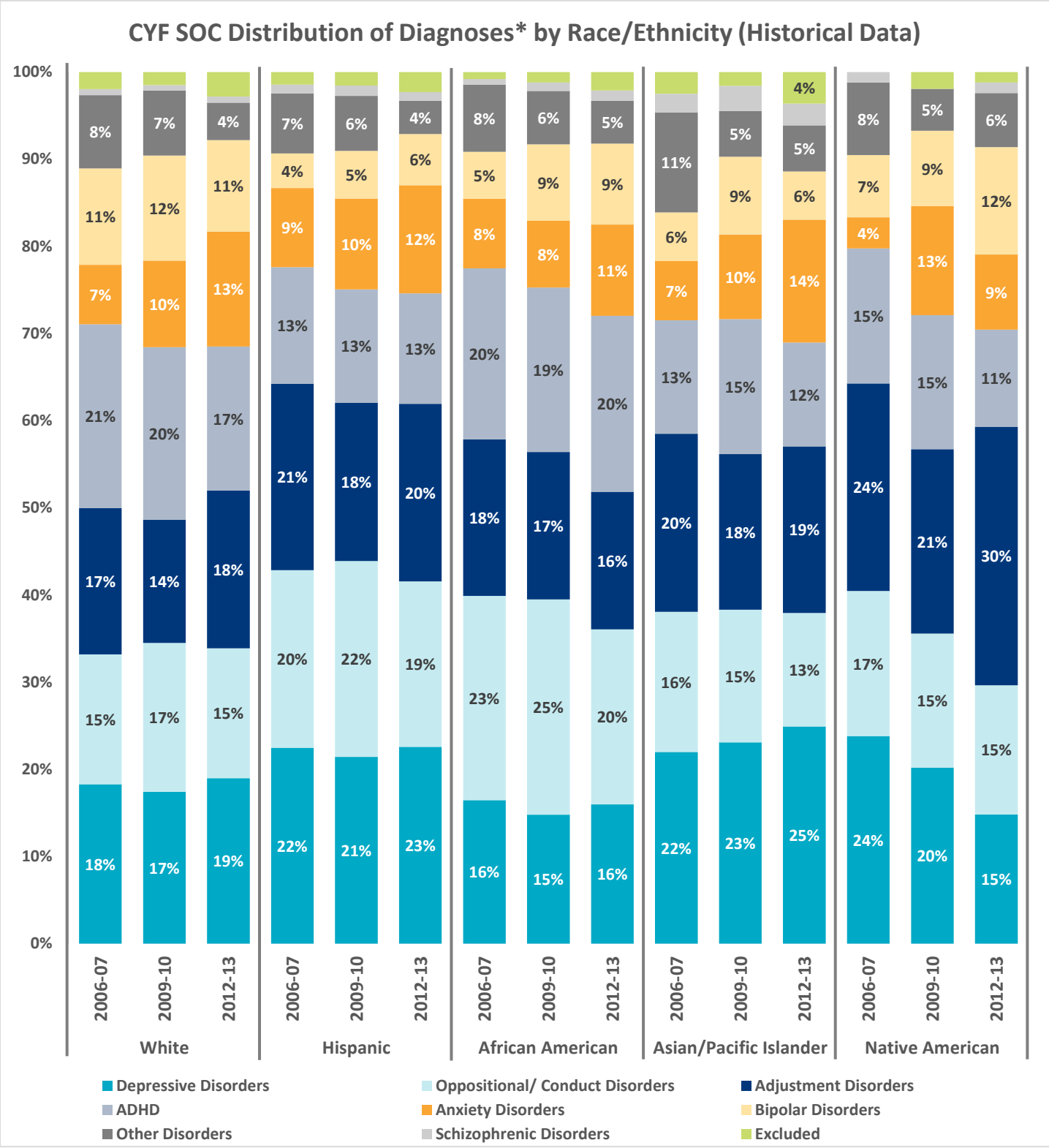
** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported.*

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

Appendix C: Trending Diagnosis Data

CYF Disparities by Race/Ethnicity from Previous Fiscal Years



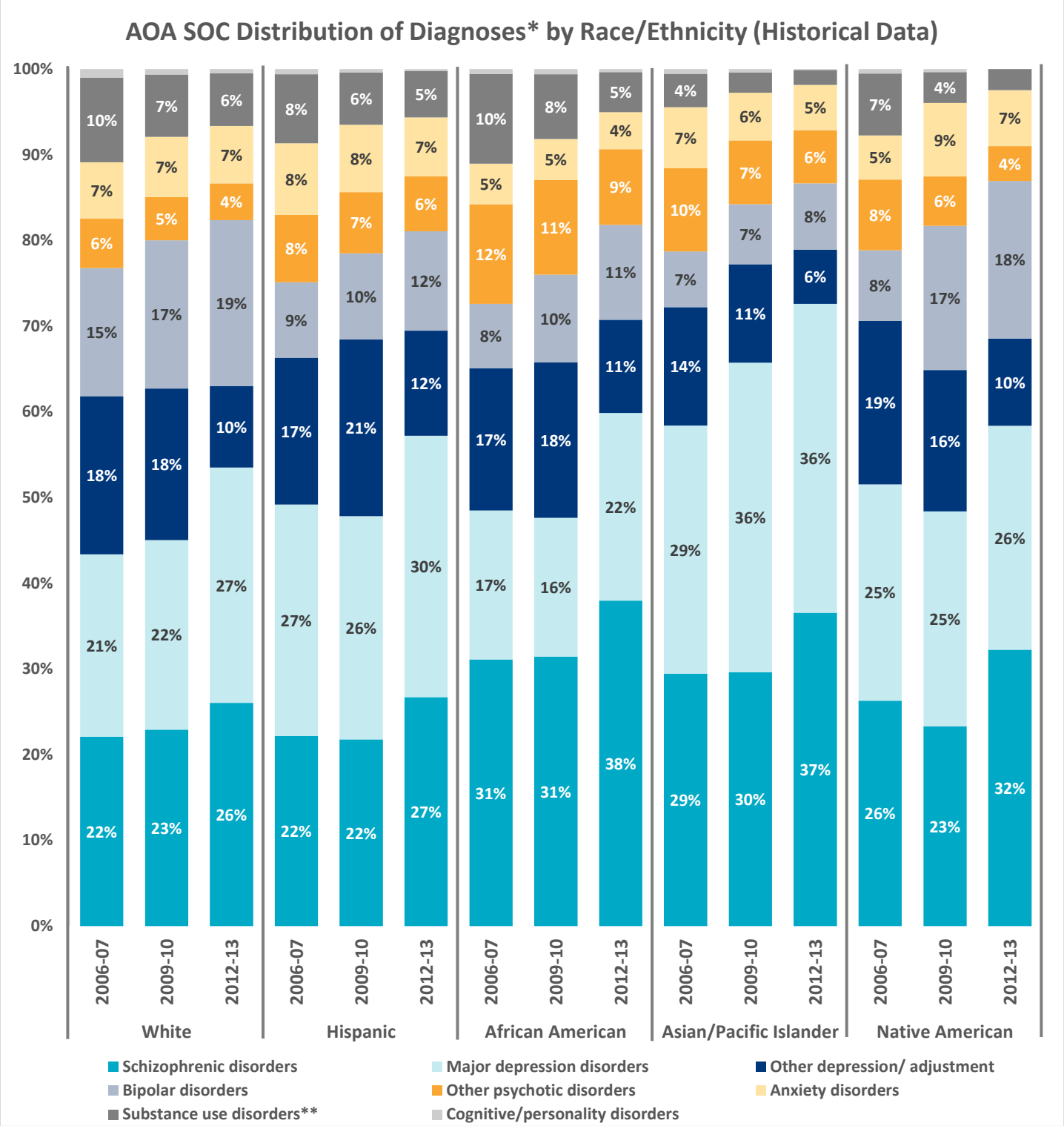
** Data labels for percentages less than 4% are not shown.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

AOA Disparities by Race/Ethnicity from Previous Fiscal Years



** Data labels for percentages less than 4% are not shown.*

*** Although substance use disorders are generally not considered a primary diagnosis in the BHS, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes place at subsequent assessment, the diagnosis remains in the Management Information System. An example of when this may occur is when a client enters the SOC through pathways such as jail or Emergency Psychiatric services.*

Data Source: CCBH

Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Contact Us

This report is available electronically in the Technical Resource Library at http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.

Questions or comments regarding **CYF SOC data** can be directed to
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Telephone: (858) 966-7703 x5548

The Child & Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital; University of California, San Diego; San Diego State University; University of San Diego; and University of Southern California. The mission of CASRC is to improve publicly funded behavioral health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

Questions or comments regarding **AOA SOC data** can be directed to
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UCSD's Health Services Research Center provides a comprehensive variety of research services to academia, health services organizations, corporations, and individuals worldwide. We are a non-profit research organization within the University of California San Diego's School of Medicine, Department of Preventive Medicine and Public Health. Our mission is to support research focused on understanding how clinical and treatment services affect health outcomes. The center brings together experts in the fields of health outcomes, program evaluation, quality of life measurement, and medical research informatics, providing the infrastructure for clinical and academic research and program and performance evaluation studies.

Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

PROGRESS TOWARDS REDUCING DISPARITIES IN MENTAL HEALTH SERVICES

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Data Source: CCBH
Report Source: HSRC (ALP, MCM, ST) and CASRC (BC, AT)

Adult & Older Adult Behavioral Health Services
Mission/Vision/Guiding Principles Statement

BHS MISSION

To make people's lives healthier, safer, and self-sufficient by delivering essential services in San Diego County.

AOA VISION

To provide recovery and wellness services to adults and older adults in the behavioral health system to be healthier and independent.

PRINCIPLES

Guiding principles specify that services shall be:

- Person-centered;
- Comprehensive and integrated with a broad array of services;
- Individualized, culture-centered, and built upon person's strengths;
- Provided in the least restrictive and most appropriate setting;
- Coordinated care both at the system and service delivery levels;
- Delivered with clients as full partners in their treatment and care;
- Protective of client rights.

TREATMENT

Supportive services and care shall be:

- Planned in consideration of the person's individual goals, diverse needs, concerns, strengths, and motivations.
- Culturally, linguistically, and developmentally appropriate to the individual.
- Based on a continuing assessment of the person's needs and flexible enough to incorporate new information and new technology.
- Planned and delivered in a quality care cost-effective manner.
- Built on the assets of the clients and their support systems (family and friends).
- Developed with priority given to services in the community.

County of San Diego
Children, Youth and Families Behavioral Health
System of Care Council
Mission, Vision, and Principles

Council Vision:
Wellness for children, youth and families throughout their lifespan.

Council Mission:
Advance systems and services to ensure that children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families.

Council Principles:

1. **Collaboration of four sectors:** Coordination and shared responsibility between child/youth/family, public agencies, private organizations and education.

2. **Integrated:** Services and supports are coordinated, comprehensive, accessible, and efficient.

3. **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.

4. **Individualized:** Services and supports are customized to fit the unique strengths and needs of children, youth and families.

5. **Strength-based:** Services and supports identify and utilize knowledge, skills, and assets of children, youth, families and their community.

6. **Community-based:** Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.

7. **Outcome driven:** Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.

8. **Culturally Competent:** Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.

9. **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.

10. **Persistence:** Goals are achieved through action, coordination and perseverance regardless of challenges and barriers.

May 1, 2018

H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2010 United States Census reports a 10% population increase in San Diego County, with no single racial/ethnic group comprising a majority. Whites make up 48% of the population, Hispanics – 32%, Asians – 11%, Blacks – 5% and Native Americans/American Indians – 1%.

As the diversity of the population continues to increase, the FY 2015-16 Progress Towards Reducing Disparities Report noted an increase in the number of Medi-Cal mental health clients from various minority populations. Efforts to reduce barriers to behavioral health care across clients in different age groups and racial/ethnic minorities have been a priority for BHS. However, the demographic breakdown of individuals eligible for BHS services differs markedly from the demographic make-up of the county as a whole. For example, although individuals of Hispanic origin make up 30% of the adults in the San Diego County population, this segment accounts for 60% of the eligible client population. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed ethnic, racial and cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The number of older adults living in San Diego is one of the most rapidly increasing populations, with an estimated 23.5% being 55 years of age or older.

Cultural Competence Plan

To address these issues in the 2017 Cultural Competence Plan and the Three-Year Strategic Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

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.
4) Enhance cultural competence training system-wide.
5) Evaluate the need for linguistically competent services through monitoring usage interpreter services.
6) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs.
7) 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.

National Culturally and Linguistically Appropriate Services (CLAS) Standards:

The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice 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. All Statements of Work include the language on the requirement of the programs to implement the CLAS 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.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center (TKC) for County operated program staff at no cost and for a small number of providers on a fee basis.

- Cultural Competence Trainings are available through some of SDCBHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. offer such trainings to their own program staff, but other providers may send staff on a fee basis.
- SDCBHS Contracted Trainings are available through the Behavioral Health Education and Training Academy (BHETA). Limited classroom training and on-line trainings are available at no cost to staff of County contracted and County operated programs. BHETA also offers a one-hour eLearning on the implementation of CLAS Standards.

Cultural Competence Monitoring and Evaluation:

The MHP QI Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QM Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement:

Program Level Requirements:

1. Cultural Competence Plan (CC Plan). CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website at: http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html The CC Plan Component Guidelines are as follows:

   - Current Status of Program
     - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
     - Identify how program administration prioritizes cultural competence in the delivery of services.
     - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
     - Goals accomplished regarding reducing health care disparities.
     - Identify barriers to quality improvement.
   - Service Assessment Update and Data Analysis
     - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
     - Comparison of staff to diversity in community.
     - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.

- Use of interpreter services.
- Service utilization by ethnicity, race, language usage, and cultural groups.
- Client outcomes are meaningful to client's social ecological needs.

➢ Objectives
- Goals for improvements.
- Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
  - Trauma-informed principles and concepts integrated
  - Faith-based services

New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan.

Plans should be sent via email to BHSQIPIT@sdcounty.ca.gov.

2. Annual Program Evaluation – every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided three weeks to complete the survey. The survey can be completed in approximately one hour or less. The tool is available in the CC Handbook on TRL for reference.

3. 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. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

Biennial Staff Evaluation – every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services. The staff are provided two weeks to complete the survey. The tool is available in the CC Handbook on TRL for reference.

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record

of annual minimum four hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

a. All new staff must meet the requirements within 90 days of hire; including temporary staff who have been on site at least 90 days.
b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".
c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

***Consumer Preference – Cultural/Ethnic Requirements**:*
Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

***Consumer Preference – Language Requirements**:*
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the ESU are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
  - EPU
  - All Outpatient and Case Management programs
- Vietnamese
  - UPAC
- Tagalog

  - UPAC
- Arabic
  - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on page 51 of the CC Handbook on TRL.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Sugestions surveys and discussion questions are available on pages 53, 57, and 59 of the CC Handbook on TRL.

E. SUD PROGRAM REQUIREMENTS

Target Population
Programs shall ensure that Substance Use Disorder (SUD) treatment and recovery services are provided to adults and adolescents with a SUD, including those with co-occurring disorders. Programs shall provide these services to a specific subset of this population (e.g., women, probationers) based on the nature of their program. Programs are advised to refer to their contract for detailed information regarding their program's target population. In order to serve the target population to the standards expected by the County of San Diego Behavioral Health Services (COSDBHS), the following admission protocols shall be developed by the Programs:

Admission Policies, Procedures and Protocols
Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that clients are admitted to treatment and recovery services regardless of anticipated treatment outcome. Policies shall also comply with the entry criteria and priority as defined by the contracts. Admission policies and procedures shall be submitted for review and approval by the COR within 60 days of Agreement execution. In the very rare occasions that providers should exclude clients from their program (example: clients become violent), providers are to use case managers to do a warm hand-off to appropriate services. Medi-Cal beneficiaries are entitled to receive DMC services. Providers should consult with their legal entity when excluding DMC beneficiaries from receiving services as this does not align with the SOW and SUDPOH requirements. Legal entities may discuss with CORs.

Geographical Service Area
Programs shall establish and operate substance use disorder treatment and recovery services for individuals in San Diego County. Service area may be specified to one of six HHSA-identified regions (North Coastal, North Inland, North Central, South, East, and Central). Specific service areas are listed in the contracts, but services shall not be limited to geographic/residential criteria and shall be available to individuals seeking treatment in San Diego County.

Facilities
Programs shall provide all facilities, facility management, supplies and other resources necessary to establish and operate the program. The facility shall meet the County of San Diego Behavioral Health Services (COSDBHS) Health, Safety and Appearance Standards as described in the HHSA-BHS-ADS 1077 (See Appendix E.1).

Space
The facility shall have sufficient space for services and activities, specified in the statement of work, as well as staff and administrative offices. The facility shall also include:

- Child Care Space: Programs providing perinatal services shall establish and maintain appropriate space for childcare if serving pregnant and parenting women and their children. The childcare may be state licensed or parent/childcare cooperative but must be supervised by an individual with at least one year of experience in a state licensed facility.

- Service Address and Hours of Operation: Program's business shall be accessible by public transportation in compliance with Americans with Disability Act (ADA) and California State Administrative Code Title 24. Business hours shall be 40 hours per week and shall be posted at the main entrance of the facility. For residential programs, services shall be available to residents 7 days a week, 24 hours a day. Programs shall not change the hours of operation or location from those listed in their County contract without prior written approval from the Contracting Office Representative (COR). Prior to any change in location, the COR reserves the right to conduct a site visit(s), inspect the facility plans, and approve the location and any budget and/or service delivery impact which may result from the proposed move to a new location/facility.

NOTE: Programs licensed and/or certified by DHCS shall also notify DHCS of facility relocation, change of ownership, or change in scope of services, and copy their program COR on such correspondence. See Section H: Administrative Oversight, for further details about changes to DMC Certified programs.

Licensing

The California Department of Health Care Services (DHCS) offers facility certification to both residential and nonresidential SUD programs (AOD Certification), and licensing of residential programs. Additionally, DHCS certifies all programs to bill Drug Medi-Cal (i.e. DMC Certification).

Outpatient SUD programs shall obtain and retain facility certification and DMC certification. Residential programs shall obtain and retain facility certification and licensing as well as DMC Certification. All programs shall comply with provisions obtained in the current State of California, DHCS standards, and the County of San Diego shall utilize these standards in monitoring program's delivery.

AOD Certification and Re-Certification

All outpatient, intensive outpatient, and residential providers are required to obtain and maintain an AOD Certification from DHCS. School site TRC's are exempt from this requirement. Refer to the DHCS AOD Certification Standards for more information.

Initial Certification

A complete application package for a program applying for initial AOD certification consist of the following completed Department of Healthcare Services (DHCS) forms along with all supporting documents required as specified in the forms instructions and application fees:

- DHCS From 5999 – Request for License and/or Certification Extension

Re-certification

Providers are eligible to renew certifications every two years provided the program remains in compliance with these Standards, corrects deficiencies in accordance with section 5000 and does not have its certification suspended, terminated, or revoked.

In accordance with the Alcohol and/or other Drug Program Certification Standards, Section 3000(b), the program shall submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation and renewal fees to the department **120 days prior** to the expiration date reflected on the certificate. Failure to provide all necessary documentation shall result in the termination of the certification in accordance with Section 3000(d).

Drug Medi-Cal Certification and Re-Certification

Initial Certification
A complete application package for a program applying for initial Drug Medi-Cal (DMC) certification consists of the following completed Department of Healthcare Services (DHCS) forms along with all supporting documents required as specified in the form instructions, and application fee via certified check:

- DHCS 6001: Drug Medi-Cal Clinic Application
- DHCS 6009: Drug Medi-Cal Provider Agreement
- DHCS 6207: Medi-Cal Disclosure Statement

For initial DMC certification, the program must also ensure that the Medical Director has completed form DHCS 6010: SUD Medical Director/Licensed Substance Use Disorder Treatment Professional/Substance Use Disorder Non-physician Medical Practitioner Application/Agreement/Disclosure Statement. This form only needs to be completed once regardless of how many programs the Medical Director is overseeing. Additionally, new enrolling entities must complete a Live Scan for any person with a 5% or greater ownership or control and/or the Executive Director and Officers of the Corporation. Note: satellites (e.g. high school sites) are no longer permitted by DHCS and need their own DMC certification, CalOMS number, and NPI number. When applying for DMC certification for school sites, best practice is to use only the school address and avoid using classroom numbers as this limits the DMC certification to a specific classroom; if a room changes are necessary, and services are provided in a non-DMC certified classroom, DMC billing will not be accepted.

Re-certification
All DMC certified Providers shall be subject to continuing certification requirements at least once every five (5) years. DHCS may allow the Providers to continue delivering covered services to clients at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

Re-certification is required for program relocation, remodeling, or change of ownership of greater than 50%. The re-certification process requires the completion of an application package, like an initial DMC certification. Providers are required to contact the program COR regarding any event that would trigger the need for DMC re-certification.

It is the responsibility of the contracted provider to provide updated certifications to the provider's assigned COR and at no time should certifications lapse. Providers shall notify the COR immediately upon notification from DHCS that its license, registration, certification or approval to operate a SUD program or a covered service is revoked, suspended, modified, or not renewed by DHCS.

Other Changes
For other changes (e.g., a change in ownership less than 50%, a change in hours of operation, and a change with the Medical Director, staff, and/or service modality), providers must complete and submit to DHCS form DHCS 6209: Medi-Cal Supplemental Changes.

Resources
- Drug Medi-Cal Continued Certification questions: DHCSDMCRecert@dhcs.ca.gov
- Forms
- Webinars, regulations, etc

- Provider Enrollment Regulations (CCR Title 22, Division 3) in effect on August 17, 2015

The above Provider Enrollment Regulations link includes the amendment to section 51341.1, which addresses abusive and fraudulent practices identified during targeted field reviews and Post Service Post Payment (PSPP) reviews conducted by DHCS. The regulation contains definitions, describes in more detail how counseling sessions are to be conducted, imposes physical examination requirements, distinguishes an initial treatment plan from an updated treatment plan, and requires treatment services to be recorded in more detail.

Incidental Medical Services

Residential programs that have received approval by DHCS may provide Incidental Medical Services (IMS). IMS are services provided at a licensed residential facility by a health care practitioner that address medical issues associated with either detoxification or the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment services.

In order to provide IMS at an approved residential program, the licensed residential provider must adhere to the conditions outlined in sections 11834.03, 118346.36, 11834.025 and 11834.026 of the Health and Safety Code, as well as to DHCS MHSUDS Information Notice Number 16-031.

Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an IMS license through DHCS.

Medications

Clients on medications will seek services. Clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication. Senate Bill No. 992 prohibits a licensee from denying admission to any individual based solely on the individual having a valid prescription from a licensed health care professional for a medication approved by the federal Food and Drug Administration for the purpose of narcotic replacement treatment or medication-assisted treatment of substance use disorders. Accordingly:

- Programs shall not deny services to a client with current, physician-prescribed medications. However, a program shall consider whether the nature and extent of the prescribed medications requires a higher level of care than offered at that program.
- With client consent, providers shall coordinate with the client's physician or health practitioner when she/he enters treatment with prescribed medications that have psychoactive characteristics. Services and support plans shall be reviewed with the prescribing physician or health practitioner.
- If while in treatment, a client exhibits behavior that is a cause for concern, the treatment provider may address this as a program issue with the client and the client's physician or health practitioner.
- Programs shall have a safety policy regarding the use of prescribed medications by a program client, including a provision for taking medications in private, if it must be taken on the premises.

Safeguarding Medications

When applicable, and to ensure appropriate access, Contactor may store clients' medication in the program facility. Contractor staff may assist with client's self-administration of medication in accordance with all relevant regulations and the DHCS Alcohol and/or Other Drug Program Certification Standards. Medication may include over-the-counter (OTC) medicines or prescription medications for specific health conditions, inclusive of medications for substance use disorder, mental health, and physical health conditions.

SUD Provider Operations Handbook

SUD PROGRAM REQUIREMENTS

It is the responsibility of the Substance Use Disorder Program Medical Director to develop and implement medical policies and standards for the provider. At a minimum, Contractors shall ensure adherence to its own entity's policies and procedures, as developed by the Medical Director, to safeguard clients' medication, and follow documentation standards for medication storage and destruction as specified in the Substance Use Disorder Uniform Record Manual (SUDURM). Policies and procedures may include, but are not limited to: process of observing clients' self-administration of medication; security or storage/inventory system; procedure to address clients' adverse reaction to medication (e.g., loss of consciousness, physical difficulties requiring hospitalization, etc.); clients' and program staff's responsibility in reporting loss or theft.

Facility Licensing

Chapter 7.5, Part 2, Division 10.5 of the California Health and Safety Code states that "no person, firm, partnership, association, corporation, or local government entity shall operate, establish, manage, conduct, or maintain an alcoholism or drug abuse recovery or treatment facility in this state without obtaining a current, valid license pursuant to this chapter".

The code defines an alcoholism or drug abuse recovery, treatment, or detoxification facility as any facility, place or building which provides 24-hour residential non-medical services in a group setting to adults. For the purpose of further defining whether licensure is required, alcoholism or drug abuse recovery or treatment services mean services which are defined to promote treatment and maintain recovery from alcohol or drug problems which include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning.

DHCS has the sole authority to license any facility providing 24-hour residential non-medical services to adults who are recovering from problems related to substance use disorders and who need SUD treatment. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or alcoholism or drug abuse treatment or recovery planning. Additionally, facilities may be subject to other types of permits, clearances, business taxes or local fees that may be required by the cities or counties in which the facilities are located.

There are some residential facilities that do not provide SUD services and do not require licensure by the State. These include cooperative living arrangements with a commitment or requirement to be free from substance use, sometimes referred to as a sober living environment, a sober living home, transitional housing, recovery residences, or alcohol and drug free housing. It is important to note that while sober living environments or alcohol and drug free housing are not required to be licensed by DHCS, they may be subject to other types of permits, clearances, business taxes or local fees which may be required by the cities or counties in which they are located.

Residential facilities licensed by other State departments such as adolescent group homes (licensed by the Department of Social Services) or Chemical Dependency Recovery Hospitals (licensed by the Department of Public Health) do not require a residential AOD license by DHCS.

Residential Facility Licensing Requirements

- Code of Federal Regulations (CFR): Title 45 CFR, Part 96 Subpart L: Substance Abuse Prevention and Treatment Block Grant
- Code of Federal Regulations: Title 42, CFR, Part 54: Non-Discrimination Against Individuals on the Basis of Religious Preference
- United States Code (USC): Title 42 USC, Section 300x-21-300x66: Substance Abuse and Treatment Block Grant

Fire Safety Inspection

A valid and appropriate fire clearance issued from the fire authority having jurisdiction over the area in which the facility is located is required. The fire clearance shall include a determination of the number of beds for ambulatory residents and for non-ambulatory residents in the facility and any restrictions regarding non-ambulatory clearances [Regulations Section 10517 (a) (1)]. The fire clearance shall also include the number of dependent children allowed in the total capacity and the age range of the dependent children. If no number of dependent children is indicated, then no dependent children are allowed.

Plan of Operation

Plan of Operation shall include but not be limited to the following:

- Statement of program goals and objectives- written statement to include program goals (intent or purpose of its existence) and objectives of the facility [Regulations Section 10517 (a) (2) (A)].
- Outline of activities and services – written statement listing the activities and services being provided by the facility [Regulations Section 10517 (a) (2) (B)].
- Admission policies and procedures – written statement of admission policies and procedures regarding acceptance of residents [Regulations Section 10517 (a) (2) (C)].
- Assurance of nondiscrimination in employment practices and provision of benefits and services – written assurance of nondiscrimination in employment practices, provision of benefits and services [Regulations Section 10517 (a) (2) (D)].
- Facilities residential admission agreement – [Regulations Section 10517 (a) (2) (E)]. Pursuant to Title 9, California Code of Regulations, Section 10566, current admission agreement used by the facility that specifies all of the following:
    - Services to be provided,
    - Payment provisions including (amount assessed and payment schedule),
    - Refund policy,
    - Those actions, circumstances or conditions which may result in resident eviction from the facility,
    - The consequences when a resident relapses and consumes alcohol and/or non-health sustaining drugs, and
    - Conditions under which the agreement may be terminated.
- Table of administrative organization of the facility – a chart that shows the governing board, advisory groups, including resident councils when applicable, and both lines of authority (straight lines) and communications lines (broken lines) to all staff positions [Regulations Section 10517 (a) (2) (F)].
- Staffing plan, job descriptions, and minimum staff qualifications for each position [Regulations Section 10517 (a) (2) (G)].
- Sample menus and schedule for one calendar week – menu(s) shall include times of food service, food provided for breakfast, lunch, and dinner for one week, and type and availability of snacks [Regulations Section 10517 (a) (2) (J)].
- Consultant and community resources to be utilized by the facility as part of its program. An inventory that shall be used as a resource for assisting participants in securing additional services to meet and maintain their personal well-being while continuing to enhance personal development [Regulations Section 10517 (a) (2) (K)].

Provisions for Safeguarding Residents' Property – the process of safeguarding a resident's personal property if accepted by the licensee for safekeeping and this is in the licensee's policy to accept such valuables.

SUD Provider Operations Handbook

SUD PROGRAM REQUIREMENTS

Operational Procedures
Providers shall develop and maintain written Operational Procedures in accordance with current State of California Standards and the most current and appropriate HHSA requirements. The written procedures shall be submitted to the COR upon request. The written procedures and all updates shall be provided to all employees charging staff hours to a County contract. Changes to a program's functions require a written change to the Operational Procedures. Providers may prepare additional written procedures not in conflict with the contract.

Program Advisory Group (PAG)
Contractor shall conduct a PAG a minimum of two (2) times per year to advise Contractor on program design, practice, and polices. The PAG membership shall consist of at least six (6) members, at least fifty percent (50%) of whom shall be clients or families served by the program, and shall reflect the ages and cultures of the client population.

- Meeting minutes and action items based on PAG input shall be reported to the Contracting Officer's Representative (COR) or designee in the program status report.

Alcohol and Drug Free Environment
Programs shall provide an alcohol and drug-free environment, and all participants shall be alcohol and drug free while participating in program activities.

Recognizing that substance use disorders for many is a chronic, relapsing disease, the program shall make every effort to retain clients in treatment and shall have written policies regarding appropriate supports to the client during a relapse episode. Addressing relapse is a necessary part of the treatment/recovery process, and presents an opportunity to re-engage and re-assess levels of care and motivation to change. Policies relating to relapse shall be consistent with the alcohol and drug-free environment of the program.

Clients may be discharged if they engage in illegal activities or activities listed under Title 9 that compromise their safety or the safety of others, such as possessing, selling, or sharing alcohol or other drugs on-site at a program facility.

Trauma Informed Facilities
Environments that are trauma and developmentally appropriate have been shown to be beneficial to individuals seeking services. Welcoming all clients upon arrival by their first name is a best practice as it can empower the individual and honor who they are as people not just as clients. Contractor shall provide facilities that are in accordance with best practices described by resources such as:

- Creating Trauma- Informed Services: Tip Sheet Series- Tips for Creating a Welcoming Environment
- Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment

Trauma Informed Services
Contractor's systems and services shall be "trauma-informed" and 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 systems 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; and, ongoing performance improvement and evaluation regarding program's provision of trauma-informed services.

Information from the National Center for Trauma Informed Care & Alternatives to Seclusions and Restraint

Trauma-Informed Approach
According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach
A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. Additional information and resources: https://www.samhsa.gov/nctic/trauma-interventions.

Drug Testing
Providers shall conduct observed, random drug testing to all clients as mandated by the referral source(s) and/or the individual treatment plans. All drug testing results shall be documented in client file. Urinalysis shall be observed and staff must be gender appropriate. The providers shall develop, implement, and maintain a testing protocol to ensure against falsification or contamination of urine and oral fluid specimens. Providers shall use the BHS designated urinalysis/oral fluid drug testing vendor unless prior written approval for another vendor is received from the COR.

Drug Testing Results Reporting
All positive drug tests shall be reported to the referring entity within two business days of testing date, if the client has provided appropriate prior consent.

Drug Testing Technologies
Drug testing may include any of the following technologies:

- Urinalysis
- Oral Fluid Testing
- Breathalyzer

Co-Occurring Disorders
In accordance with the Health and Human Services Agency Co-occurring Psychiatric and Substance Abuse Disorders Consensus Document, all SUD programs shall be welcoming to individuals with co-occurring disorders by posting a SUD-approved Welcoming Statement and by providing materials, brochures, posters and other appropriate information regarding co-occurring disorders. Individuals shall receive a helpful and appropriate response whether the help they seek is voluntary or court-mandated. Providers shall have capacity at a minimum to screen and refer clients/residents with co-occurring disorders to identified co-occurring treatment. It is the County of San Diego's expectation that all programs are, at a minimum, Co-Occurring Capable, with the goal of becoming Co-Occurring Enhanced.

CYF Program Requirements

Smoking Prohibition Requirement
Providers shall comply, and require that subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking is not permitted in any portion of any indoor facility owned, leased, or contracted for or by an entity and used to provide services to children under the age of 18.

Taxi Cabs
Providers shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego, BHS.

Public Contact
Providers shall have sufficient staff with adequate knowledge, skills and ability available during operating hours specified in their contracts to ensure that all persons who contact the program in person or by phone during operating hours are quickly and appropriately served with information or a referral to appropriate services.

Linkages with Support Services Organizations
SUD programs shall initiate linkage agreements, which may include a Memoranda of Understanding (MOU), and establish procedures that will ensure strong, reliable linkages with other community service providers, and service organizations for client support. These MOUs and linkages shall be designed to integrate, coordinate, and access necessary support services within the community in order to ensure successful client treatment and recovery. These efforts shall help achieve Federal, State and County goals to integrate services, prevent relapse by using community support services, reduce fragmentation of care, and establish better communication and collaboration at all levels, but particularly among local providers and agencies who work with this target population.

Outreach Services

Documentation of Outreach Services
Documentation of providers' outreach services shall be made available in the event of a County audit.

General and Injection Drug User (IDU) Alcohol and Drug Outreach Services
Providers shall conduct outreach to individuals experiencing substance use disorders problems, with special attention to reaching injection drug users and helping them to access treatment and recovery services.

Information and Education
Providers shall provide information and education to prevent and minimize the health risks of substance use disorders. Providers shall promote awareness about the relationship between substance use and the personal health risks of communicable disease such as Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) and, for pregnant women, the relationship between substance use and the risks to their children.

Homeless Shelter Outreach Services
Providers shall make available staff or volunteer participation in regional homeless shelter outreach services during the cold/wet winter months, which are typically defined as December through March.

Homeless Outreach Worker Services
Designated Regional Recovery Centers and Perinatal programs throughout the county will provide Homeless Outreach Worker (HOW) services to assist with outreach and engagement in the community. Potential clients will be screened and then provided short-term case management and referral services (e.g., housing, primary health, mental health, etc.) as needed. A data collection log is to be completed and submitted monthly to the COR for reporting purposes. Providers with HOW services should follow up with their designated COR for the data collection log and monthly report requirements. For an overview of the HOW services model and documentation requirements, see Appendix E.2 – HOW Service Model & Data Collection Flow Chart (also available on County Technical Resource Library).

Communicable Disease Information, Education, and Prevention
Providers shall provide information, education and prevention services on the following communicable diseases for each individual admitted to the program: Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), Tuberculosis (TB) and Sexually Transmitted Diseases (STD).

Cooperation with Other Agencies
Providers shall cooperate with other agencies and allow presentations to program clients, especially those who are at high risk or who are positive for any of the disease referenced above. Providers shall cooperate with on-site and off-site interventions, medical evaluation, laboratory testing, case management, and pharmaceutical therapy programs that assist participants in preserving their immune system function.

Staff Training on Communicable Diseases
Providers shall ensure that all employees and volunteers receive training in the diseases referenced above, methods of preventing transmission, confidentiality requirements, and available communicable disease-related resources that are appropriate referrals to supportive services. All training shall be documented in each personnel file.

Liaison
Providers shall designate a minimum of one staff person to serve as a liaison between the program site, the program's community and BHS on issues related to communicable disease services. The designated staff person shall attend regularly scheduled BHS and providers facilitated meetings and shall provide staff communicable disease training and update sessions at least once every six months. Providers with multiple programs shall designate additional staff to serve in the liaison role.

HIV/HCV Services

Providers shall provide Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) information and referral services for each individual admitted into the program. Providers can refer a client to Public Health Services for testing, if needed.

TB Control

As specified by the County of San Diego's TB Control, providers shall screen each client admitted into the program for possible signs of tuberculosis and take action based on the results of each individual client's screening within the specified timelines. Refer to the TB Questionnaire Instructions in the SUDURM for additional information.

Emergency Critical Services

The County of San Diego, Behavioral Health Services, has identified, at a minimum, residential contracts as Emergency Critical. If designated and informed by the COR, providers must identify the primary program contact for emergency/disaster communication and any succession of authority should the primary contact be unavailable. Emergency/disaster contacts must be made known to the COR within 15 days of start or annual renewal of the contract, or whenever there is a change in contact person.

If the need to evacuate the primary service site arises, residential program providers must have arrangements for either an alternate site to house program participants, or a plan to discharge clients back to their own homes. The alternate site or plan to discharge to home must be made known to the COR within 15 days of start or annual renewal of contract.

DHCS requires all DMC certified providers to report emergencies to DHCSDMCRecert@dhcs.ca.gov that result in displacement of a DMC certified facility to avoid interruption of or inability to continue billing for DMC services. DHCS will request the following: nature of the emergency including when and where it happened; location of temporary location; what services were provided prior to the emergency and if services will differ at the temporary location; and projected timelines of the temporary site.

Disaster Preparedness

Providers shall contact their COR if there is an evacuation or relocation of services during the provision of services. COR must grant approval for any discontinuation of services. Funding sources specify that funding can only be claimed for services in support of contracted activities. Redirection of staff to other non-evacuation/emergency activities during an emergency/disaster may cause their time to be non-reimbursable, depending on funding availability and regulations. Note that discontinuation of outpatient services shall, in cost reimbursement programs, result in staffing and other service costs being ineligible for reimbursement during the period of program closure. Fixed price and pay for performance contracts may also be reduced if pay points are not achieved or deliverables are interrupted.

Local Emergencies

In the event that a local health emergency or local emergency is declared, or when the State or federal government has declared an emergency that includes areas within the County of San Diego, the prompt and effective utilization of contractor resources essential to the safety, care and welfare of the public shall occur at the direction of the County, to the extent possible. Contractors shall provide assistance in the prevention of, response to, and recovery from, any public health emergency, as applicable. Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a public health disaster or County emergency state of alert. Providers shall work with the County to initiate processes and develop and implement plans, guidelines and procedures as required. As relevant, contractors shall also refer to the disaster preparedness and disaster response language outlined in this section.

Disaster Response

In the event that a local, state or federal emergency is proclaimed within San Diego County, programs shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.

Programs shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

Programs shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. COSDBHS Disaster Training is available through BHETA e-learning, Programs shall advise COR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Programs shall maintain 25% staff deployment capability at all times. (See Appendix E.3 – How to Access BHETA Trainings.)

Charitable Choice Regulations

As recipients of SAPT or PATH grant funds, non-profit religious organizations contracted with the County of San Diego for SUD services must comply with SAMHSA's Charitable Choice provisions and with all the requirements of these provisions. (Reference (CFR) Title 42, Subchapter D, Part 54, Sections 1 – 13).

Nondiscrimination against religious organizations

- A religious organization is a nonprofit organization which is eligible on the same basis as any other organization to participate in applicable programs consistent with the First Amendment to the U.S. Constitution. These applicable programs include those under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, 42 U.S.C. 300x to 300x-66 and the Projects for Assistance in Transition from Homelessness (PATH) Formula Grants, 42 U.S.C. 290cc-21 to 290cc-35 as these programs fund substance abuse and/or treatment services.
- Nothing in these regulations except the provisions provided herein and the SAMHSA Charitable Choices provisions which are the provisions of 42 U.S.C. 300x-65 and 42 U.S.C. 290kk, et seq. shall limit the ability of a governmental entity to have the same eligibility conditions apply to religious organizations and any other nonprofit private organization.
- No governmental entity receiving funds under these programs shall discriminate against an organization on the basis of religion or religious affiliation.

Religious activities, character, and independence

- Programs which receive funds from SAMHSA or a governmental entity will not use these funds for religious activities. The organization's religious activities must be offered in a separate time or location and participation is voluntary for an individual who receives substance use disorders services.
- A religious organization maintains its independence from governmental entities to practice and express its religious beliefs.
- Faith-based organizations which provide services need not remove religious materials from their facilities. A SAMHSA-funded religious organization may keep its structure of governance and include religious terms in its printed material and governing documents.

Non-discrimination requirement

- A religious organization which provides substance abuse services will not discriminate against a program beneficiary or a participant who receives substance abuse services based on religious beliefs or a refusal to participate in a religious practice.

Rights to services from an alternative provider

- An individual who receives or is interested in services and disagrees with the religious nature of the program has a right to obtain a notice, a referral, and alternative services within a reasonable time period.
- A program that provides a referral to an individual or interested individual will provide the participant with a notice of a right to receive services from an alternative provider who will meet the requirements of needed services such as accessibility and timeliness of treatment.
- Programs will maintain a system that ensures that appropriate referrals are made which meets the needs of the individual such as in the geographic area. A SAMHSA treatment locator may be used.
- Referrals will maintain the laws of confidentiality and specifically confidentiality regarding alcohol and drug abuse records (42 CFR Part 2). The program will contact the State regarding the referral and make sure the individual contacts the alternative provider.

Persons with Disabilities (PWD) Access to Services

Any enterprise licensed or certified by the DHCS or any entity (counties and providers) receiving state or federal funding that has been allocated by DHCS must comply with statutory and regulatory requirements such as:

- Americans with Disability Act (ADA) Exhibit 1
- Section 504 and 508 of the Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of
- Handicap in Programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and;
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD).

These statutory and regulatory requirements assist in ensuring Persons with Disabilities (PWD) are provided access to Substance Use Disorder (SUD) prevention, treatment and recovery services. The legislation and implementing regulations require all providers make reasonable accommodations and provide accessible services for PWD, and this also includes providers making electronic and information technology accessible to people with disabilities. These are per program standards within the Legal Entity, so each program site needs to comply with the above statutory and regulatory requirements.

Providers applying for initial licensure or certification must plan to be fully accessible at the time of application. Applicants for renewal of a licensure or certification must have conducted an assessment to identify barriers to service and develop an Access to Service Plan (i.e., corrective action plan) for removing or mitigating any identified barriers. Applicants failing to address these requirements can anticipate denial of their initial application or the withholding of renewals for existing licensed or certified programs until these requirements are adequately addressed.

The county is responsible for ensuring that SUD services and the SUD contracted providers are accessible and do not discriminate against or deny equal opportunity to a PWD to participate in and benefit by the

provided service. Therefore, county-contracted SUD service programs must complete an accessibility assessment (see Appendix E.4 – Program Accessibility Assessment) and based on the results of the assessment, a corrective action plan and submit this to the County Quality Management SUD Unit. The SUD providers must take action to identify all physical and programmatic barriers to services and develop plans for removing or mitigating the identified barriers. If a new SUD county contracted program opens or if an existing SUD program relocates, an updated accessibility assessment must be completed and submitted to the Quality Management SUD unit through the QIMatters.HHSA@sdcounty.ca.gov email within 30 days of opening to ensure continued accessibility for PWD at the SUD program. Failure to do so can result in civil penalties and possible suspension, or revocation of licensure, certification or contract cancellation. The County Quality Management SUD Unit will review these assessments and corrective action plans for compliance and maintain them for reference to provide to DHCS upon request.

PWD SUD Service Report

The County QI department also completes a bi-annual PWD SUD Service Report to determine the extent of the need for PWD SUD services within the county in the six defined geographic locations based on the percentage of clients served with various disabilities (e.g., mobility, hearing, etc.) by extracting client disability information from SanWITS. This PWD SUD Service Report and the individual program accessibility assessments are reviewed by the Quality Management unit. This information is utilized to determine the percentage of PWD in each geographic region and the number of county contracted SUD service providers that accept PWD to ensure that there is a sufficient number of out-patient and residential SUD services providers accessible by PWD strategically placed throughout the county.

If a SUD county contracted program is not able to accept a PWD client for any reason (e.g., facility was built prior to ADA regulations and the program cannot financially make the necessary renovations to be ADA compliant), then the program must provide a direct referral to another SUD provider who can accept this PWD client and provide equivalent services (e.g., residential) in the same geographic region (e.g., Central). The program is to determine the appropriate PWD program referral by utilizing the county's PWD SUD Provider list (see Appendix E.5 – PWD SUD Provider list), which will be updated on a bi-annual basis by the county SUD QM unit. The program is to provide the client with the contact information for the other SUD providers in the same geographic region or another region, if requested by the client. The current program may need to assist the client with contacting the referred PWD SUD program to ensure the PWD client will be accepted and that equivalent services will be provided.

County Access Coordinator (CAC)

The County is also required to designate a County Access Coordinator (CAC) for serving PWD. The role of the CAC is that of a liaison between the SUD provider community, County BHS Administrator's office, and DHCS. The CAC is responsible for ensuring the integrity of the county's compliance with all issues related to PWD SUD services and that all the different types of SUD services are available to all individuals, regardless of mobility, communication and/or cognitive impairments as required by state and federal laws and regulations. If a SUD program requires assistance with completion of an accessibility assessment and/or corrective action plan or a PWD referral, they may contact the CAC: Erin Shapira at 619-584-3093 or Erin.Shapira@sdcounty.ca.gov for assistance.

Ethical and Legal Standards

Programs shall develop and implement policies, procedures and training protocol that ensure that its employees, subcontractors, subcontractor employees and volunteers adhere to the highest ethical and legal conduct standards when performing work under the terms and conditions of the contract.

Code of Conduct

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level. Programs shall have a written code of conduct that pertains to and is known about by staff, paid employees, volunteers, and the governing body and community advisory board members. Each staff, paid employee, and volunteer shall sign a copy of the code of conduct and a copy shall be placed in their personnel file. The program shall post the written code of conduct in a public are that is available to clients. The code of conduct shall include the program policies regarding at a minimum the following:

- Use of alcohol and/or other drugs on the premises and when off the premises
- Personal relationships with participants
- Prohibition of sexual contact with participants
- Sexual harassment
- Unlawful discrimination
- Conflict of interest
- Confidentiality

Counselor/Client Relationships

Relationships between clients and program staff beyond the realm of treatment are prohibited. Staff must maintain healthy boundaries between themselves and their clients at all times. Staff members' failure to adhere to this standard shall be disciplined at the discretion of the program director.

Sexual Contact

Sexual contact shall be prohibited between program staff, including volunteers, and members the Board of directors, and the participants. A written statement explaining the sexual contact policy shall be included in every participant's rights statement given at admission to a program. Programs shall include a statement in every personnel file noting that the employees and volunteers have read and understood the sexual contact prohibition. The policy shall remain in effect for six months after a participant is discharged from services, or a staff member of volunteer terminates employment.

Client Confidentiality

Providers shall comply with federal client confidentiality regulations (Confidentiality of Substance Use Disorder Patient Records- 42U.S.C.290dd-2; 42CFR part 2), and all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

Client File Storage and Transportation

Sites must keep a record of the clients/patients being treated at that location. If it is required to transport records offsite, to maintain the confidentiality of all client files and medical records, the standard protocol for storing confidential material shall be maintained until transport is possible. Client files are to be stored under double lock and key (i.e., locked cabinet in a locked room) at the program location. No client files are to be taken to staff's private residences. The program supervisor shall designate staff members who will be responsible for the transportation of client files. A staff member shall inform the program director if file transport is necessary. Client files shall be transported in a portable locked file box. When transporting identifying client data or medical record such as progress notes or forms requiring signatures, no identifying information shall be put on the documents until which time said documents are secured in the client's medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the client. Under no circumstances are any records to be left unattended.

Off Site Record Storage
DHCS requires notification if client records are moved off site permanently (i.e. records moved to storage). Program is required to notify their program COR when this occurs so that the County may complete the required notification.

SUD Quality Management (QM) Responsibilities & Confidentiality
In order to ensure compliance with confidentiality procedures and protocols, the SUD QM enforces the following procedures:

- Every member of the workforce is informed about confidentiality policies as well as applicable state and federal laws regarding anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement promising to comply with all confidentiality protocols. This statement must include a minimum General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies.
    - The statement must be signed by the workforce member prior to access to protected health information (PHI).
    - The statement must be renewed annually.

Any client treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary are protected through strictly limited access. Program staff has access to case data or files only as necessary to do their jobs.

Providers within the County of San Diego SUD system of care demonstrate ongoing commitment and compliance to the protection of client personal and health information as defined in 42 CFR Part 2, Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State/County agreement, and other Federal, State regulations/laws through:

1. Established written policy and procedure to address workforce members' code of conduct to include protection of client confidentiality while providing services within the SUD system of care. ("Workforce members" includes, but is not limited to, all employee types, including per diem/contracted/temporary volunteers, students/interns, subcontractors, and others with access to clients and/or client data).

2. Verifiable program orientation and/or trainings/staff meetings, with focus on current/updated client confidentiality/disclosure information and applicable Federal and State laws governing such.

3. All workforce members, working within the SUD system of care, are required to sign an agreement to comply with all confidentiality protocol as defined by law, regulation, and program code of conduct policy and procedure.

4. The Confidentiality Agreement must include language in which the workforce member agrees to not divulge personal information (PI), personal identifiable information (PII), and protected health information (PHI) to any unauthorized person or organization unless authorized or required by law. PI, PII and PHI definitions are found in Article 14 of the program's contract with the County.

5. Workforce members will be given access to client PHI after # 1 and # 2 are completed.

6. Workforce members will renew their Confidentiality Agreement annually as verified by signature and date on the statement and placement within their personnel record.

7. Programs will have written policy and procedure which identify potential sanctions should violations of unauthorized release of confidential client health information occur.

8. Providers will respect a client's right to revoke a consent/authorization to disclose information in part or whole. Should this occur, the SUD treatment providers must notify the involved entities of this update immediately.

All substance use disorder treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements. If services were provided in the community, documentation must identify the location and how the provider ensured confidentiality.

Final Rule, 42 CFR Part 2
The SUD system of care is moving into a new era that encourages information sharing with the physical and mental health systems for improvement of care coordination and client health outcomes. (See Examples of Permissible Payment and Healthcare Operations Activities below.)

It is well recognized that SUD clients often have additional health conditions that complicate care and can prevent long-term achievement of recovery goals if left un/under treated.

Final Rule, 42 CFR Part 2, published January 2018, effective February 2, 2018, implements new changes to the federal rules governing confidentiality and disclosures of substance use disorder patient records, known as 42 CFR Part 2 or "Part 2 " to afford persons with substance use disorder, receipt of integrated and coordinated care while still protecting client confidentiality. While the new Final Rule maintains Part 2's core protections, including consent requirements, it expands the ways in which patients' protected substance use disorder information may be shared. For more information, please reference the Final Rule 42 CFR Part 2.

Examples of Permissible Payment and Health Care Operations Activities under 42 CFR Part 2 Section 2.33(b) SAMHSA:

- Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing
- Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services)
- Patient safety activities
- Activities pertaining to the training of student trainees and health care professionals
- Activities pertaining to the assessment of practitioner competencies
- Activities pertaining to the assessment of provider and/or health plan performance, and
- Activities pertaining to the training of non-health care professionals
- Accreditation, certification, licensing, or credentialing activities
- Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care
- Third-party liability coverage
- Activities related to addressing fraud, waste and abuse
- Conducting or arranging for medical review, legal services, and auditing functions
- Business planning and development, such as conducting cost-management and planning related

analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies
- Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations
- Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers
- Resolution of internal grievances
- The sale, transfer, merger, consolidation, or dissolution of an organization
- Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Review of health care services with respect to medical necessity, insurance coverage under a health plan, appropriateness of care, or justification of charges.

SUD providers are advised to contact the legal representative within their organizations for legal interpretation and direction in regards to application of Confidentiality Law/Regulations to program specific policy and procedure. Should legal entities or programs have further questions regarding interpretation of 42 CFR Part 2 Final Rule, please see more information through the County of San Diego Health & Human Services Compliance Office.

Mandated Reporting

All treatment providers shall adhere to mandated reporter requirements regarding child abuse and neglect, elder abuse and neglect, and homicide or homicidal ideations. Mandated reporting as required by law is not to be considered unauthorized release of confidential information. Permissive exceptions to confidentiality may include:

- Danger to self
- Danger to others
- Another's property
- When such disclosure is necessary to prevent the threatened danger (Tarasoff Notification)

Staffing Requirements

The Department of Health Care Services (DHCS) ensures the provision of quality treatment through the enforcement of standards for professional and safe treatment. DHCS does not certify counselors; however, DHCS does ensure counselors provide quality treatment to clients by enforcing the Counselor Certification Regulations found in the California Code of Regulations (CCR), Title 9, Division 4, Chapter 8.

Providers shall:

- Administer, staff, and provide management systems and procedures for programs.
- Recruit, hire, train and maintain staff qualified to provide required services.
- Ensure all staff has appropriate experience and necessary training upon hire.
- Ensure clients currently in treatment are not to be used in staff positions.
- Verify identify and determine the exclusion status of all staff prior to hire (see Federal and State Database Checks below).
- Ensure all personnel are competent, trained and qualified to provide any services necessary.
- Ensure non-professional receive appropriate onsite orientation and training prior to performing assigned duties.

- Ensure professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- Ensure documentation of trainings, certifications and licensure shall be contained in personnel files.
- Ensure professional and/or administrative staff supervise non-professional staff.
- Maintain records of current certification and NPI registration. Registered and certified AOD counselors shall adhere to all requirements in Title 9, Chapter 8.

Discrimination

Providers shall not unlawfully discriminate against any person as defined under the laws of the United States and the State of California. Programs may not discriminate between employees with spouses and employees with domestic partners or discriminates between employees with spouses or domestic partners of a different sex and employees with spouses or domestic partners of the same sex or discriminates between same-sex and different-sex domestic partners of employees or between same-sex and different-sex spouses of employees. (Public Contract Code section 10295.3)

Programs may not discriminate between employees on the basis of an employee's or dependent's actual or perceived gender identity, including, but not limited to, the employee's or dependent's identification as transgender. (Public Contract Code section 10295.35)

Criminal Background Check Requirement

Providers shall ensure that criminal background checks are required and completed prior to employment or placement of program staff and volunteers in compliance with any licensing, certification, or funding requirements, which may be higher than the minimum standard described herein. At a minimum, background checks shall be in compliance with Board of Supervisors policy C-28 and are required for any program staff or volunteer assigned to sensitive positions funded by this contract. Sensitive positions are those that: (1) physically supervise minors or vulnerable adults; (2) have unsupervised physical contact with minors or vulnerable adults; and/or (3) have a fiduciary responsibility to any County client, or direct access to, or control over, bank accounts or accounts with financial institutions of any client.

Providers shall have a documented process to review criminal history of candidates for employment or volunteers that will be in sensitive positions. At a minimum, providers shall check the California criminal history records, or state of residence for out of state candidates. Programs shall review the information and determine if criminal history demonstrates behavior that could create an increased risk of harm to clients. Programs shall document review of criminal background findings and consideration of criminal history in the selection of a candidate. For example, document consideration of such factors as: if there is a conviction in the criminal history, how long ago did it occur, what were the changes, what was the level of conviction, and if selected, where would the individual work and is the conviction relevant to the position. Programs shall either utilize a subsequent arrest notification service during the staff or volunteers employment or check California criminal history annually. Programs shall keep the documentation of their review and consideration of the individual's criminal history on file. All staff must be free of probation or parole supervision for a minimum of one (1) year prior to employment. (This is a County of San Diego BHS standard.)

Providers will ensure that all staff members working with clients are fingerprinted (LiveScan) and pass Department of Justice and Federal Bureau of Investigations background checks.

Volunteer Staff

If a program utilizes the services of volunteers, it shall develop and implement written policies and procedures, which shall be available for, and reviewed with all volunteers. The policies and procedures

shall address all of the following:

1. Recruitment;
2. Screening;
3. Selection;
4. Training and orientation;
5. Duties and assignments;
6. Supervision;
7. Protection of client confidentiality; and
8. Code of conduct.

Professional Staff

Professional stall shall be licensed, registered, certified or recognized under California scope of practice. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, and License Eligible Practitioners working under the supervision of Licensed Clinicians. **NOTE:** DHCS has recently clarified that although RNs are considered LPHAs, they are not permitted to determine a SUD diagnosis because it is not within their scope of practice; therefore, programs shall not use a RN as a LPHA to complete the diagnosis on the DDN (Diagnosis Determination Note) or on the Initial LOC Assessment (note: provisional diagnosis is required on this form for Residential programs)

Counselor Certification

Regulations require licensed and certified Substance Use Disorder (SUD) programs to ensure that their counseling staff are appropriately registered and/or certified at all times by an approved certifying organization, or appropriately professionally licensed. In addition, SUD programs must continue to meet the regulatory requirement that 30% of the staff providing SUD counseling are certified or professionally licensed. SUD programs must also demonstrate that their registered SUD counselors do not exceed the five (5) year registration limit (from the date of initial registration). SUD programs failing to ensure compliance with these requirements will be cited appropriately.

Counselor certification is based upon the Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (TAP 21) published by the Center for Substance Abuse Treatment. Staff who provide counseling services such as intake, assessment of need for services, treatment planning, recovery planning, individual or group counseling to participants, patients, or residents in any substance use disorder (SUD) program licensed or certified by DHCS are required by the State of California to be certified. To obtain certification, counselors must register with one (1) of the approved certifying organizations. From the date of registry, counselors have five (5) years to become certified with any certifying organization (CCR, Section 13035(f)(1)). If a counselor fails to become certified after being registered for five (5) years, the counselor will not be permitted to provide counseling services to clients. The provision which allowed an individual six months from the date of hire to become registered has been repealed. Per DHCS MHSUDS Information Notice 16-058:

> *Health and Safety Code 11833 repeals California Code of Regulations (CCR) Title 9, Section 13035(f), which allowed an individual to provide counseling services, within six months of the date of hire, prior to registering with a certifying organization. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD*

program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization.

Certified counselors are required to provide documentation of completion of a minimum of 40 hours of continuing education and payment of a renewal fee to their certifying organization in order to renew their AOD certification during each two-year period.

Per DHCS, there are two (2) Certifying Organizations (CO) approved by the California Department of Health Care Services (DHCS) to register and certify individuals to provide alcohol and other drug (AOD) counseling. Any AOD counselor registered or certified with a CO no longer approved by DHCS will need to re-register with one of approved CO's to continue providing counseling services.

- California Association of DUI treatment Programs (CATP)-certified Alcohol & Other Drug Counselor
- California Consortium of Addiction Programs and Professions (CCAPP)

Staffing Ratios
The following guidelines for staffing ratios reflect County standards for best practice. Prior discussion with COR is needed if higher caseload ratios are proposed for LPHA, Case Manager, or SUD Counselor based on program design.

Staff Position	Residential Caseload Ratio (Staff to Client)		Outpatient Caseload Ratio (Staff to Client)		Residential Withdrawal Management Caseload Ratio (Staff to Client)	
Title	CYF	AOA	CYF	AOA	CYF	AOA
LPHA	1:25	1:25	1:25	1:50	1:25	1:25
Case Manager	1:25	1:25	1:25	1:50	1:25	1:25
SUD Counselor	1:25	1:25	1:25	1:25	1:25	1:25
HOW (OP)	N/A	N/A	2 FTE	2 FTE	N/A	N/A
Overnight Staff (Residential)	2 staff per shift	2 staff per shift	N/A	N/A	2 staff per shift	2 staff per shift

*****In addition to above position titles, it is required for all programs to have a Medical Director. Contact your program COR with questions regarding withdrawal management nursing requirements and overnight staff questions.

Mental Health Licensed or Licensed Eligible
A California-licensed or license-eligible Mental Health Specialist shall be available to provide clinical consultation as necessary, and to conduct mental health assessments for those clients who have a co-occurring mental health diagnosis. The Mental Health Specialist shall also conduct clinical supervision for staff delivering program services. A plan for provision of services to clients with a co-occurring disorder must be approved by the COR within 60 days of Agreement execution. If providers do not have such consultation available, a documented plan shall be approved by the COR to ensure adequate assessment and referral of co-occurring diagnosed individuals and clinical supervision for program staff.

Mental health licensed or licensed eligible staff shall meet all California Board of Behavioral Sciences or Board of Psychology licensure requirements, as well as having documented experience working with substance abuse services for a minimum of one year. For license verification, click here. The

license shall be in good standing and clear of licensing authority disciplinary actions for a minimum of three years at the date of hire and continuously while employed by Providers as an employee or consultant.

- Registered interns who are receiving clinical supervision may be used to provide direct services in the program.

Medical Director

The typical pre-DMC-ODS role of the medical director was a focus on signing treatment plans. Under the DMC-ODS, the focus is broader and physicians should be engaged and integrated as a significant role into the SUD system.

Medical Directors at SUD provider agencies should ideally perform functions that others within the agency are unable to optimally perform. Some possible ways to maximize the benefit and role of the Medical Director within the program include:

- Provision of Medication Assisted Treatment (MAT) when clinically necessary
- Provision of Withdrawal Management (WM), if within program scope, when clinically necessary
- Provision of clinical supervision for staff
- Assist other professional staff with challenging cases
- Refer/treat co-occurring physical and mental health conditions
- Conduct clinical trainings on issues relevant to staff (e.g., ASAM Criteria, DSM-5, MAT, co-occurring conditions)

[Note: Provision of MAT, WM or treatment of physical health conditions in a residential setting requires an Incidental Medical Services (IMS) license through DHCS.]

The substance use disorder medical director's responsibilities shall at a minimum include all of the following:

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement medical policies and standards for the provider.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries and perform other physician duties, as outlined in this section.

The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.

A substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

Each program’s assigned COR will be responsible for evaluating a medical director’s credentials to

determine the salary cap.

Federal and State Database Checks

Prior to employment, programs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- CMS' Medicare Exclusion Database (MED)
- DHCS' Suspended and Ineligible Provider List

Certification on Disbarment or Exclusion

All claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment of exclusion from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the federal System for Award Management (SAM), the Office of the Inspector General (OIG), Government Services Agency (GSA) and the Suspended and Ineligible Provider (S&I) List.

Provider shall be responsible for checking, on a quarterly basis, the office of the Inspector General (OIG) website that none of the Providers officers, board members, employees, and agents providing services are on the OIG or Medi-Cal list of excluded individuals to provide direct services to County clients. Providers shall notify, in writing within thirty (30) days if any personnel are found listed on this site and the actions taken to remedy the situation.

Verification

- Federal System for Award Management (SAM) list
- OIG Exclusion list and the GSA debarment list
    - Reasons for placement on OIG list
- Medi-Cal Provider Suspension
    - Reasons include:
        - Convicted of felony
        - Convicted of misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.
        - Suspended from the federal Medicare or Medicaid programs for any reasons
        - Lost or surrendered a license, certificate, or approval to provide health care
        - Breached a contractual agreement with the Department of Health Care Services that explicitly specifies inclusion on this list as a consequence of the breach.

Best Practice

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on the OIG, GSA or Suspended and Ineligible Medi-Cal lists are prohibited from working in any County funded program.
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

SUD Provider Operations Handbook

SUD PROGRAM REQUIREMENTS

License Verifications

All SUD providers are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Service Template requirements. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

Personnel Files

Personnel files shall be maintained on all employees and volunteers, and interns. These records will contain: application for employment and/or resume, signed employment confirmation statement, signed annual confidentiality statements, job description (which shall include position title and classification; duties and responsibilities; lines of supervision; and education, training, work experience and other qualifications for the position), performance evaluations, Health records/status as required by program or Title 9 (i.e. health screening report or health questionnaire, including TB results as required), other personnel actions (e.g. commendations, discipline, status change, employment incidents and/or injuries), training documentation relative to substance use disorders and treatment, current registration, certification, intern status or licensure; proof of continuing education required by licensing or certifying agency and program, and program code of conduct (and for registered, certified and licensed staff, a copy of the certifying/licensing body's code of conduct as well).

The program's written code of conduct for employees and volunteers/interns shall be established which addresses at least the following: use of drugs and/or alcohol; prohibition of social/business relationship with clients or their family members for personal gain; prohibition of sexual contact with the clients; conflict of interest; providing services beyond scope of practice; discrimination against clients or staff; verbally, physically, or sexually harassing, threatening, or abusing clients, family or other staff; protecting client confidentiality; the elements found in the code(s) of conduct for the certifying organization(s) the program's counselors are certified under; and, cooperation with grievance investigations.

MD's and LPHA's will receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Such documentation shall be maintained in the file and the last day of the first full month of employment and shall be available for County monitoring purposes.

Provider Directory

Per DHCS Information Notice 18-020, a provider directory captures site-specific content for a contracted program, to include all licensed, waivered, or registered mental health providers and licensed substance use disorder service providers employed within the program*. On a monthly basis, programs shall respond to a polling request for updates to their provider directory, using the following process:

1. Designated program lead shall provide COR with a complete and up-to-date provider directory no later than the 3rd Monday of each month.
2. Directory shall be sent to Program COR via email, utilizing the requested electronic format, and cc'ing program analyst, if applicable.
3. Program shall ensure all of the following data elements are accurately captured:

Provider Directory Content
• Provider's name and group affiliation, if any
• Provider's business address(es) (e.g., physical location of the clinic or office)

• Hours of Operation
• HHSA Region
• Telephone number(s)
• Email address(es), as appropriate
• Website URL, as appropriate
• Specialty, in terms of training, experience and specialization, including board certification (if any)
• Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults)
• Whether the provider accepts new beneficiaries
• The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender)
• The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office
• Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment
In addition to the information listed above, the provider directory must also include the following information for each rendering provider:
• Type of practitioner, as appropriate
• National Provider Identifier number
• California license number and type of license
• An indication of whether the provider has completed cultural competence training

*Registered and Certified AOD counselors are not considered licensed SUD providers and do not need to be reported as part of the Provider Directory. The requirement is referring to licensed providers in SUD programs such as LMFTs, LCSWs, LPHAs, Physicians, etc.

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QM in writing if any of the following changes occurs:

- Any change with DMC Certification, such as surrendering certification or closing program, any event triggering a DMC recertification, such as change in ownership, change in scope of services, or change in location.
- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS& MIS); or
- Proposed change in Program Manager or Head of Service.

Notification of Key Personnel Changes

Programs shall notify the COR within seventy-two (72) hours when there is a change in key personnel funded by the resulting contract.

On-Site Manager/Director

Programs shall provide a full-time on-site Program Manager or Director for each program, unless prior approval received by COR. If the program manager is also serving as the program coordinator, time may be divided between administration and direct services.

Review and Comment on the Qualifications of On-Site Managers, Directors, and Higher Level Staff
The COR shall review and comment on the final candidates under consideration for hire at the Program Manager, Director, or higher level prior to selection. Should the COR choose to provide written comments, the comments shall be provided within five (5) days of receipt of candidates' resumes and supporting documentation.

Residential Programs and Overnight Staffing
Residential programs shall ensure that a minimum of two (2) staff are onsite and on-duty 24 hours a day, 7 days a week, including but not limited to:

- Of the 2 on-duty overnight staff, at least 1 staff shall be a SUD Counselor (Certified or Registered) or LPHA
- An LVN can count toward 1 of the 2 on-duty overnight staff as long as the LVN can manage the intake/screening process.
- Of the 2 on-duty overnight staff, at least 1 staff is CPR-certified and First-Aid trained
- Neither of the 2 on-duty overnight staff is a volunteer nor an active client of the program
- A Security Staff may count towards 1 of the 2 on-duty overnight staff
- Awake overnight staff are required to conduct regular walk-throughs of the facility
- Overnight coverage staffing schedule shall be posted.

Minimum Qualifications
- CPR/First Aid/Safety training and certification maintained;
- Eighteen (18) years or older;
- Trained on AOD confidentiality, ethics, and cultural competence/sensitivity; and,
- Trained and able to respond to emergency situations.

Note: 24/7 residential service hours are to include intake and admissions.

It is recommended that residential programs designated as ASAM Level 3.2 obtain the Incidental Medical Services (IMS) license through DHCS. A minimum of LVN level staff is recommended 24/7 in these programs, and must follow the policies and procedures as established by the program's medical director. Providers are expected to implement policies and procedures that have been developed with the Medical Director, that includes at a minimum, working collaboratively with emergency departments and primary care physicians that the client is safe to return to the WM program when in-house 24/7 nursing staff is not used.

Staff Development and Training Plans
Programs shall develop and maintain a management and staff training (including volunteers and interns) and development plan. The staff training plan shall be updated annually and written reports on management and staff progress in achieving their development goals shall be maintained in the employee's personnel file. Staff training and development plans shall include at minimum: ASAM training for staff completing screening/intake, assessment and treatment planning (must be completed prior to providing these services); specific treatment standards for services provided, client confidentiality, client screening and assessment, client referral, CPR, communicable diseases, cultural diversity, data collection and reporting requirements, drug testing protocols, program admissions procedures, and Evidence Based Practices of at a minimum of Relapse Prevention and Motivational Interviewing.

Some of the following trainings may be tracked on the MSR/QSR:

- ASAM Training: Completion of ASAM A, B & C (via CIBHS) or completion of ASAM e-training Modules 1 and 2 ("Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care" (via the Change Companies) is required prior to provision of screening/intake, assessment and treatment planning services are provided
- Cultural Competency Trainings - Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program. Cultural Competency Trainings are also available through BHETA e-learning
- Evidence Based Practices - Professional staff shall be trained in Motivational Interviewing and Relapse Prevention
- BHS Disaster Training is available through BHETA e-learning. A minimum of 25% of contracted staff need to be disaster trained
- System of Care training is available through BHETA e-learning. All direct service staff shall complete e-learning about BHS System
- CalOMS Web-based Training – For more information regarding this section, please refer to Section 7.
- Continuing Education Units (CEUs) - Contractor shall require clinical staff to meet their licensing requirement. Professional staff (LPHAs) are required to receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year

Comprehensive, Continuous, Integrated System of Care (CCISC) CADRE

Each organization shall have a minimum of one (1) current staff person complete the CCISC CADRE, within the life of the contract.

Completion of CCISC CADRE

When an Agency has completed the CCSC CADRE change agent training, it shall be expected to meet the following minimum requirements:

- Programs shall use an approved SUD tool to measure progress toward co-occurring capability or enhancement and shall identify specific objectives that are measurable and achievable in that time frame. Each program shall document what actions they are taking toward co-occurring capability or enhancement, at a minimum annually and submit to the COR by May 15th of every option year.
- Annual development of Quality Improvement Action Plan for achievement of progress, in consultation with COR and/or designee will identify Agency or Program specific objectives that are measurable and achievable to be reviewed at the time of site visit.
- Ongoing Agency participation in CADRE committees and activities, following CADRE change agent training completion.

Cultural Competence

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

Training
Cultural Competence Trainings are available through some of County of San Diego's Behavioral Health Services' (COSDBHS) larger agencies. These agencies offer their own such trainings to their own program staff, but other providers may send staff on a fee basis. COSDBHS Contracted Trainings are available through the Behavioral Health education and Training Academy (BHETA). Limited classroom training and on-line trainings are available at no cost to staff of County-contracted programs. BHETA also offers a one-hour eLearning on the implementation of CLAS Standards.

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 client' cultural diverse backgrounds ad that programs are reflective of the specific cultural patterns of the service region.

Cultural Competence Plans
The QI Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. Provision of/usages of the tools listed below are cultural competence requirements:

Program-Level Requirements:

1. *Cultural Competence Plan (CC Plan):* CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the County of San Diego Behavioral Health Services Technical Resource Library website.

   The CC Plan Component Guidelines are as follows:
   - Current Status of Program
     - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
     - Identify how program administration prioritizes cultural competence in the delivery of services.
     - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
     - Goals accomplished regarding reducing health care disparities.
     - Identify barriers to quality improvement.
   - Service Assessment Update and Data Analysis
     - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
     - Comparison of staff to diversity in community.
     - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
     - Use of interpreter services.
     - Service utilization by ethnicity, race, language usage, and cultural groups.
     - Client outcomes are meaningful to client's social ecological needs.
   - Objectives
     - Goals for improvements.
     - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.

- Trauma-informed principles and concepts integrated
- Faith-based services

New contractors need to submit a CC Plan, as specified above, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan. CC Plans can be sent via email to BHSQIPIT@sdcounty.ca.gov.

2. *Annual Program Evaluation*: every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided two weeks to complete the survey. The survey can be completed in approximately one hour or less. For your information, a copy of the assessment is included in the Cultural Competence Handbook.

3. 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. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

- Staff-level Requirements:
    1. *Biennial Staff Evaluation:* Every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services. The staff are provided two weeks to compete the survey. For your information, a copy of the assessment is included in the Cultural Competence Handbook.

    2. *Minimum of 4 hours of Cultural Competence Training Annually:* Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of the annual minimum four hours of training shall be maintained on the Monthly/Quarterly Status Report. The following conditions also apply:
        a. All new staff must meet the requirements within 90 days of hire; including temporary staff who have been on site at least 90 days.
        b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".
        c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

National Culturally and Linguistically Appropriate Services (CLAS Standards)

To ensure equal access to quality care by diverse populations, each service provider receiving funds from the County of San Diego shall adopt the federal Office of Minority Health (OMH) National Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards 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 are comprised of 15 Standards as follows:

- *Principal Standard*
    1) Provide effective, equitable, understandable and respectful quality care and services that are

response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communications 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 heath 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 induvial 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, polices and management accountability, and infuse them throughout the organizations' planning and operations.
  10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS- related measures into assessment 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 community to design, implement and evaluate polices, 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 grievances.
  15) Communicate the organizations progress in implementing and sustaining CLAS to all stakeholders, constituents and the public.

<u>Language Requirement</u>

Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. Programs shall access professional certified interpreter services as needed for deaf, hard of hearing and late deafened participants to facilitate complete communication and to ensure provision of appropriate confidential treatment and recovery services. The offer of interpreter services and the client's response must be documented, as should

the use of an interpreter, and include documentation when services are provided in a language other than English.

Trafficking Victims Protection Act of 2000

The purpose of this Protection Act is to combat trafficking in persons, a contemporary manifestation of slavery whose victims are predominately women and children, to ensure just and effective punishment of traffickers, and to protect their victims. Trafficking in persons is a modern form of slavery, and it is the largest manifestation of slavery today. Trafficking in persons is not limited to the sex industry, but also includes forced labor and involves significant violations of labor, public health, and human rights standards worldwide.

Providers shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). This amendment states that SUD providers and their employees may not engage in severe forms of trafficking in persons, procure a commercial sex act, or use forced labor in the performance of the contract. If any of these violations occur, than the contract and/or funding may be terminated. SUD providers are to have policies and procedures in place to ensure that all SUD provider staff are aware of these requirements and to ensure full compliance with the terms of the statutory requirement. For full text of the award term, see 42 CFR Part 175.

Cultural Competence Handbook

County of San Diego Behavioral Health Services
November 2017

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

Document Prepared by:

County of San Diego Behavioral Health Services (SDCBHS)
Quality Improvement Unit
In collaboration with The Cultural Competence Resource Team

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Cultural Competence Handbook

Introduction

The County of San Diego is richly diverse, beyond ethnicity; cultures are dynamic and unique. We celebrate the wealth of diversity and the demographics below are just one indication of our cultural wealth. The Agency, providers, and community partners face a unique opportunity when engaging culture sensitivity. One way is our continued integration of trauma-informed systems. Being trauma-informed is a philosophy, a component of cultural competence; an approach to engage all people we serve, all staff and those we encounter whilst conducting business. Cultural norms, values, beliefs, customs, and behaviors may influence behavioral health and medical issues, so authentic engagement and developing relationships with those we serve will guide our work with positive outcomes as the intent. On July 13, 2010, the County Board of Supervisors took a bold and innovative leap forward in the area of health policy by adopting a 10-year health strategy agenda to improve the health of our region. This highly innovative strategy agenda aims to improve the health and well-being of county residents through four key pillars: 1) Building a Better Service Delivery System, 2) Supporting Positive Healthy Choices, 3) Pursuing Policy and Environmental Changes, and 4) Improving the Culture from Within County Government.

	2010 United States Census Data	2010 San Diego County Census Data	FY 2015-16 Behavioral Health Services
White	231,040,398 (74.8%)	1,981,442 (64.0%)	21,690 (36.1%)
Hispanic	50,477,594 (16.4%)	991,348 (32.0%)	19,448 (32.4%)
African American	42,020,743 (13.6%)	158,213 (5.1%)	6,902 (11.5%)
Asian/Pacific Islander	17,320,856 (5.6%)	351,428 (11.4%)	2,802 (4.4%)
Native American	5,220,579 (1.7%)	26,340 (0.9%)	404 (0.7%)
LGBTQI	9,083,558* (2.9%)	300,000** (9.6%)	2,131 (3.5%)
Veterans	26,403,703 (8.5%)	292,034 (9.4%)	1,482 (2.5%)
Age 0-17	74,181,467 (24.0%)	821,263 (26.5%)	16,303 (27.1%)
Age 18-24	30,672,088 (9.9%)	270,750 (8.8%)	8,525*** (14.2%)
Age 25-59	146,806,075 (47.6%)	1,502,564 (49.0%)	29,686*** (49.4%)
Age 60+	57,085,908 (18.5%)	500,736 (16.2%)	5,592 (9.3%)
For additional information on BHS client demographics, visit the BHS Technical Resource Library at http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html			

**The information on adult LGBTIQ population in the US was obtained from The Williams Institute, UCLA School of Law.*
***This number is approximate based on the information from Behavioral Health Education and Training Academy*
Note: the percentages are based on the total 2010 US population (308,745,538), 2010 San Diego County (3,095, 313) population, and FY 2015-16 BHS client population (60,106).
****The BHS client age groups are 18-25 and 26-59.*

In alignment with *Live Well San Diego*, the Health and Human Services Agency Behavioral Health Services Division (BHS) continually works toward the complete integration of systems and services. Within this integration process, BHS is working to fully incorporate the recognition of the personal experiences within cultural diversity and sees the creation of an integrated culturally competent and trauma-informed Behavioral Health system as a developmental process. BHS has demonstrated commitment to cultural competence and trauma-informed systems; continually enhancing strategies and efforts for enhancing wellness and reducing all disparities; cultural competence evaluation and training activities; the continued development of a multicultural workforce; and continued integration of systems and services. As part of our goal to enhance well-being and reduce disparities for all populations, the SDCBHS presents this Cultural Competence Handbook. The Handbook contains tools that will assist behavioral health providers in making improvements throughout the system of care.

County of San Diego, Health and Human Services Agency

Vision:

Healthy, Safe, and Thriving San Diego Communities

Mission:

To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. *Building a Better System* focuses on systems and how the County delivers services. How it can further strengthen partnerships to support better health and wellbeing. For example, being trauma-informed is a component of cultural competency therefore the County is integrating physical and mental health given the bi-directional connectivity and making the systems and services easier to access.
2. *Supporting Healthy Choices* provides information and educates residents so they are aware of how their choices may impact their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. *Pursuing Policy Changes for a Healthy Environment* is about creating policies and community changes to support recommended healthy choices.
4. *Improving the Culture from Within*. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk". Simply said, change starts with the County as we practice what we teach.

Behavioral Health Services

Vision:

Safe, mentally healthy, addiction-free communities

Mission:

In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. To foster continuous improvement to maximize efficiency and effectiveness of services.
2. To support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems.
3. To maintain fiscal integrity.
4. To ensure services are: outcome-driven; culturally competent; recovery and client/family centered; innovative and creative; and trauma-informed.
5. To assist County employees to reach their full potential.

The Importance of Cultural Competence

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

The National Center for Cultural Competence has identified six salient reasons to incorporate cultural competence into organizational policy:

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and health outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To decrease the likelihood of liability/malpractice claims.

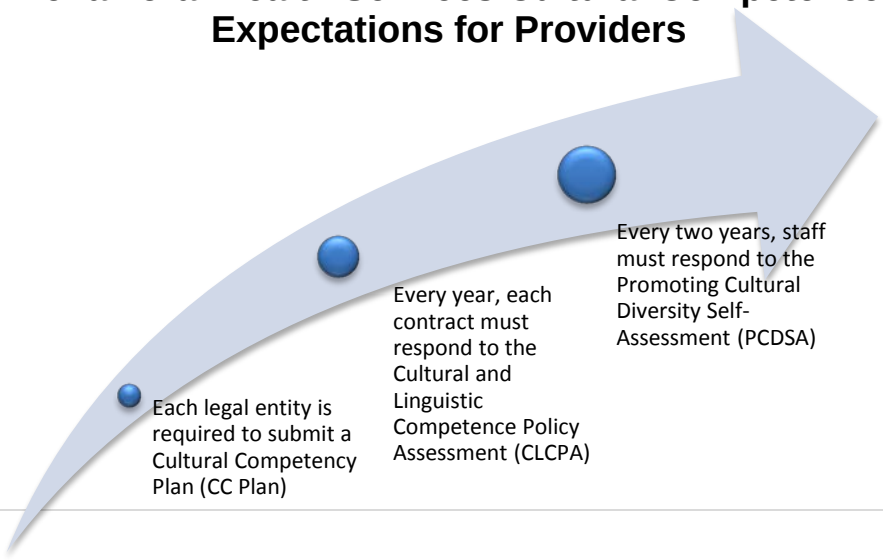
For more details, visit https://nccc.georgetown.edu/foundations/need.php.

To support the needs of our diverse populations SDCBHS recommends that all providers be committed to prioritizing cultural competence. This goal can be achieved through the following:

1. Incorporating trauma-informed and cultural competencies throughout the provider's:
    i. Mission Statements
    ii. Guiding Principles
    iii. Policies and Procedures
2. Development or enhancement of a Cultural Competence Plan.
3. Implementing the National Culturally and Linguistically Competent Services (CLAS) Standards.
4. Periodic evaluation of staff, programs and clients.
5. Ensuring that the clinical practice is based on trauma-informed care, cultural awareness, and life-long enhancement of knowledge and skills.

This Cultural Competence Handbook provides timelines, guidelines, and examples of methods and tools that are recommended and can be used to guide programs in achieving the goal of enhancing wellness and reducing disparities.

Behavioral Health Services Cultural Competence Expectations for Providers



Cultural Competence Rollout			
When	**What**	**Who**	
		Substance Use Disorder Services (SUD)	***Mental Health Services (MHS)***
1 Time	Cultural Competence Plan (CC Plan)	*Required for all Legal Entities as of December 2013* *Updates as needed*	
Annual	Cultural and Linguistic Competence Policy Assessment (CLCPA)	*October 2017* *October 2018* *October 2019*	
2 Years	Promoting Cultural Diversity Self-Assessment (PCDSA)	*February 2018* *February 2020*	

Cultural Competence History		
Cultural Competence Program Annual Self-Evaluation (CC-PAS)	**California Brief Multicultural Competence Scale (CBMCS)**	**CC Plan**
April 2012 (MHS only) April 2013 (MHS only) April 2014 (MHS and SUD) April 2015 (MHS and SUD) April 2016 (MHS and SUD)	October 2011 (MHS only) October 2013 (MHS & SUD) October 2015 (MHS & SUD)	April 2012 (MHS) December 2014 (SUD)

The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) were developed by the Health and Human Services Office of Minority Health and are intended to advance health equity, improve quality, and help eliminate health care disparities (see the Resources section). Implementing strategies to improve and ensure cultural and linguistic competency in the behavioral health care systems using the CLAS standards is a powerful way to address disparities and ensure all populations have equal access to services and supports. In addition to the new requirements in each programs' Statements of Work for adhering to CLAS standards, the following chart shows how CLAS Standards are already embedded into cultural competence evaluation tools provided in the Handbook.

CLAS Standards	CLCPA	PCDSA	CC Plan
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.	•		•

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
For more information and to access CLAS standards visit www.thinkculturalhealth.hhs.gov/clas.

Cultural Competence Plan

An outline for the development of a Cultural Competence Plan

Cultural Competence Plan Development Guidelines

Goal: To provide guidelines to assist and guide programs to develop a plan that enhances their current capability for providing trauma-informed and culturally competent systems and services.

Background: As stated in all SDCBHS contracts, it is an expectation that the organizations develop and provide trauma-informed and culturally competent systems and services, and work to continually enhance levels of cultural competence. This complements the expectation that the California Department of Health Care Services (DHCS) has for each county. The guidelines below, developed by SDCBHS with input from the Cultural Competence Resource Team (CCRT), can be used as a tool as your organization works to assess the current cultural competence and integrate the plan components into the system of care. If you do not have a Cultural Competence Plan in place currently, please ensure the following components are addressed. If you already have a Cultural Competence Plan in place, please evaluate to determine adding any of the elements noted in these guidelines could enhance your plan.

Cultural Competence Plan Component Guidelines:

- Current Status of Program
  - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
  - Identify how program administration prioritizes cultural competence in the delivery of services.
  - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
  - Goals accomplished regarding reducing health care disparities.
  - Identify barriers to quality improvement.

- Service Assessment Update and Data Analysis
  - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
  - Comparison of staff to diversity in community.
  - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
  - Use of interpreter services.
  - Service utilization by ethnicity, race, language usage, and cultural groups.
  - Client outcomes are meaningful to client's social ecological needs.

- Objectives
  - Goals for improvements.
  - Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.
    - Trauma-informed principles and concepts integrated
    - Faith-based services

The checklist on page 13 may serve as a resource for incorporating Cultural Competence Plan components into your policies and procedures. **It's provided for reference only**.

Please note: As of December 2013, Cultural Competence Plans are required for all legal entities for both mental health and alcohol and drug services. For legal entities with multiple programs, please consider a Cultural Competence Plan per program.

Cultural Competence Plan Development Checklist

SDCBHS recommends the use of this tool

CULTURAL COMPETENCE PLAN COMPONENTS:	COMPONENT IMPLEMENTATION					In response to what data or information was the change/innovation/ improvement made?
	In Progress:	Approx. Impl. Date:	Met:	Resources Used:	Date Met:	
Current Status of Program						
Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.	☐		☐			
Identify how program administration prioritizes cultural competence in the delivery of services.	☐		☐			
Agency training, supervision, and coaching incorporate trauma-informed systems and service components.	☐		☐			
Goals accomplished regarding reducing health care disparities.	☐		☐			
Identify barriers to quality improvement.	☐		☐			
Service Assessment Update and Data Analysis						
Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.	☐		☐			
Comparison of staff to diversity in community.	☐		☐			
A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.	☐		☐			
Use of interpreter services.	☐		☐			
Service utilization by ethnicity, race, language usage, and cultural groups.	☐		☐			
Client outcomes are meaningful to client's social ecological needs.	☐		☐			
Objectives						
Goals for improvements.	☐		☐			
Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.	☐		☐			
a) Trauma-informed principles and concepts integrated b) Faith-based services	☐ ☐		☐ ☐			

Example:

Client outcomes are meaningful to client's social ecological needs.	☐		☒	Client Focus Group	Dec 13	Part of client-focused initiative.

The CLAS Standards offer a strong framework to provide culturally and linguistically appropriate services. As they are already embedded into cultural competence evaluation tools in the Handbook, the programs will adhere to the Standards by utilizing the tools, follow the established Cultural Competence Plan, and complete regularly scheduled evaluations as noted in the Rollout on page 9.

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Evaluating Cultural Competence

Available Tools for Program Evaluation

The following tools are included in the Handbook to assist programs with evaluating their cultural and linguistic competence. Programs are required to use the CLCPA and PCDSA as directed by County of San Diego Behavioral Health Services. Evaluations for other areas may be done by using the tools noted or other tools that your program or legal entity has identified that meet the same criteria.

- Cultural and Linguistic Competence Policy Assessment (CLCPA)
- Promoting Cultural Diversity Self-Assessment (PCDSA)
- Certification of Language Competence
- Assessing Cultural Competence – Client Survey
- Assessing Cultural Competence – Client Focus Groups
- Assessing Cultural Competence – Community Focus Groups

Cultural and Linguistic Competence Policy Assessment

CLCPA

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Cultural and Linguistic Competence Policy Assessment (CLCPA)

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The Cultural and Linguistic Competence Policy Assessment (CLCPA) was developed by Georgetown University at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), and the US Department of Health and Human Services (DHHS). The goal of CLCPA is 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. The Assessment is aligned with the National Culturally and Linguistically Appropriate Services (CLAS) Standards.

Before you begin, please identify main cultural groups that your program serves predominantly. Do not limit your groups to solely ethnic cultures. Your groups may be, but are not limited to: LGBTQI, veterans, older adults, Hispanics, African Americans, TAY, homeless, etc. Once you have identified the groups, please refer to them as you answer the CLCPA questions.

Section 1: Knowledge of Diverse Communities

The focus of this section is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics and contextual realities.

1. Is your organization able to identify the culturally diverse communities in your service area?

- ● Not at all
- ● Barely
- ● Somewhat
- ● Fairly well
- ● Very well

2. Does your organization's Cultural Competence Plan identify and support the CLAS Standards?

- ● Yes
- ● No

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

3. Is your organization familiar with current and projected demographics for your service area?

- Not at all
- Barely
- Somewhat
- Fairly well
- Very well

4. Is your organization able to describe the social strengths (e.g., support networks, family ties, spiritual leadership, etc.) of diverse cultural groups in your service area?

- Not at all
- Barely
- Somewhat
- Fairly well
- Very well

5. Is your organization able to describe the social problems (e.g., dispersed families, poverty, unsafe housing, etc.) of diverse cultural groups in your service area?

- Not at all
- Barely
- Somewhat
- Fairly well
- Very well

6. Is your organization familiar with health disparities among culturally diverse groups in your service area?

- Not at all
- Barely
- Somewhat
- Fairly well
- Very well

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

7. Is your organization able to identify the languages and dialects used by culturally diverse groups in your service area?

- ● Not at all
- ● Barely
- ● Somewhat
- ● Fairly well
- ● Very well

8. For the culturally diverse groups in your service area, is your organization familiar with:

The health beliefs, customs, and values?	● Not at all	● Barely	● Somewhat	● Fairly well	● Very well
The natural networks of support?	● Not at all	● Barely	● Somewhat	● Fairly well	● Very well

9. For the culturally diverse groups in your service area, can your organization identify:

Help-seeking practices?	● Not at all	● Barely	● Somewhat	● Fairly well	● Very well
The way illness and health are viewed?	● Not at all	● Barely	● Somewhat	● Fairly well	● Very well
The way mental health is perceived?	● Not at all	● Barely	● Somewhat	● Fairly well	● Very well

If you need technical assistance with becoming more familiar with the items in Section 1, please indicate the specific topics (e.g., organizational policy, Cultural Competence Plan, cultural groups in the service area, CLAS Standards, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 2: Organizational Philosophy

This section focuses on the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with clients/participants and community members, and advocacy.

10. Does your organization have a mission statement that incorporates cultural and linguistic competence in service delivery?

- ● Yes
- ● No

11. Does your organization support a practice model that incorporates culture in the delivery of services?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

12. Does your organization consider cultural and linguistic differences in developing quality improvement processes?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

13. Does your organization advocate for culturally diverse participants regarding quality of life issues (e.g., employment, housing, education) in your service area?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

14. Does your organization systematically review procedures to ensure that they are relevant to delivery of CULTURALLY competent services?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

15. Does your organization systematically review procedures to ensure that they are relevant to LINGUISTICALLY competent services?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

16. Does your organization help participants get the support they need (e.g., flexible service schedules, childcare, transportation, etc.) to access services?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

17. Are there structures in your program to assure for participant and community participation in:

Program planning?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Service delivery?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Evaluation of services?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Quality improvement?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Customer satisfaction?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

18. Does your work environment contain decor reflecting the culturally diverse groups in your service area?

- ● None of the decor reflects the culturally diverse groups.
- ● Yes, but very little decor reflect culturally diverse groups.
- ● Yes, some deco reflects culturally diverse groups.
- ● Yes, all done reflects culturally diverse groups.

19. Does your organization post signs and materials in languages other than English?

- ● No, only in English
- ● Yes, between 1 and 3 other languages
- ● Yes, four or more other languages

If you need technical assistance with becoming more familiar with the items in Section 2, please indicate the specific topics (e.g., CLAS Standards, quality improvement processes, beneficiary materials, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 3: Personal Involvement in Diverse Communities

This section addresses the extent to which an organization and its staff participate in social and recreational events and purchase goods and services within the communities they serve.

20. Does your organization identify opportunities within culturally diverse communities for staff to:

Attend formal cultural or ceremonial functions?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Purchase goods or services from a variety of merchants (either for personal use or job-related activities)?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Subcontract for services from a variety of vendors?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Participate in informal recreational or leisure time activities?	● Not at all	● Sometimes	● Often	● Most of the time	● All the time
Participate in community education activities?	● All the time	● Not at all	● Sometimes	● Often	● Most of the time

21. Does your organization identify opportunities for staff to share with colleagues their experiences and knowledge about diverse communities?

● Not at all

● Sometimes

● Often

● Most of the time

● All the time

If you need technical assistance with becoming more familiar with the items in Section 3, please indicate the specific topics (e.g., CLAS Standards, community events, culturally diverse educational activities, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 4: Resources and Linkages

This section focuses on the ability of the organization and its staff to effectively utilize both formalized and natural networks of support within culturally diverse communities to promote and maintain linkages through structures and resources.

22. Does your organization collaborate with community-based organizations to address the health and mental health related needs of the culturally and linguistically diverse groups in the service area?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

23. Does your organization work with social or professional contacts (e.g., cultural brokers, liaisons, cultural stakeholders) who help understand health and mental health beliefs and practices of culturally and linguistically diverse groups in the service area?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

24. Does your organization establish formal relationships with these professionals and/or organizations to assist in serving culturally and linguistically diverse groups?

- ● Not at all
- ● Sometimes
- ● Often
- ● Most of the time
- ● All the time

25. Does your organization use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about whole person wellness?

- ● Not at all
- ● Sometimes
- ● Often

- Most of the time
- All the time

If you need technical assistance with becoming more familiar with the items in Section 4, please indicate the specific topics (e.g., community resources, CLAS Standards, whole person wellness, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 5: Human Resources

This section focuses on the organization's ability to sustain a diverse workforce that is culturally and linguistically competent.

26. Are members of the culturally diverse groups you identified at the beginning of the survey represented on the staff of your organization?

- ● No, none of the identified culturally diverse groups are represented.
- ● Only some groups are represented.
- ● Most groups are represented.
- ● The staff is fully representative of the identified culturally diverse groups

27. Does your organization have culturally and linguistically diverse individuals as:

Board members?	● None	● Very few	● Some	● Most	● All	● Not applicable
Program directors?	● None	● Very few	● Some	● Most	● All	● Not applicable
Executive management?	● None	● Very few	● Some	● Most	● All	● Not applicable
Physicians/psychiatrists?	● None	● Very few	● Some	● Most	● All	● Not applicable
Clinical staff?	● None	● Very few	● Some	● Most	● All	● Not applicable
Administrative staff?	● None	● Very few	● Some	● Most	● All	● Not applicable
Clerical staff?	● None	● Very few	● Some	● Most	● All	● Not applicable
Support staff?	● None	● Very few	● Some	● Most	● All	● Not applicable
Peer Support Specialists?	● None	● Very few	● Some	● Most	● All	● Not applicable
Volunteers/students?	● None	● Very few	● Some	● Most	● All	● Not applicable

28. Does your organization have incentives for the improvement of CULTURAL competence throughout the organization?

- ● None
- ● Very few
- ● Some
- ● Many

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

29. Does your organization have incentives for the improvement of LINGUISTIC competence throughout the organization?

- ● None
- ● Very few
- ● Some
- ● Many

30. Does your organization have procedures to achieve the goal of a culturally and linguistically competent workforce that includes:

Staff recruitment?	● Yes	● The agency is in the process of developing the procedures	● No
Hiring?	● Yes	● The agency is in the process of developing the procedures	● No
Retention?	● Yes	● The agency is in the process of developing the procedures	● No
Promotion?	● Yes	● The agency is in the process of developing the procedures	● No

31. Are there resources to support regularly scheduled professional development and in-service training for staff at all levels of the organization?

- ● None
- ● Very few
- ● Some
- ● Many

32. Are in-service training activities on CULTURALLY competent services (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the organization?

- ● None
- ● Very few
- ● Some
- ● Many

33. Are in-service training activities on LINGUISTICALLY competent services (e.g., Title VI, CLAS Standards, ADA mandates) conducted for staff at all levels of the organization?

- ● None
- ● Very few

- Some
- Many

If you need technical assistance with becoming more familiar with the items in Section 5, please indicate the specific topics (e.g., CLAS Standards, workforce diversity, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 6: Clinical Practice

This section focuses on the ability of the organization and its staff to adapt approaches to behavioral health care delivery based on cultural and linguistic differences (specifically, assessment/diagnosis, interpretation/translation services and use of community-based resources).

34. Does your organization use health assessment or diagnostic protocols that are adapted for culturally diverse groups?

- Never
- Seldom
- Sometimes
- Regularly
- Not applicable

35. Does your organization use health promotion, disease prevention, engagement, retention and treatment protocols that are adapted for culturally diverse groups?

- Never
- Seldom
- Sometimes
- Regularly
- Not applicable

36. Does your organization connect consumers to natural networks of support to assist with health and mental health care?

- Never
- Seldom
- Sometimes
- Regularly
- Not applicable

37. Does your organization differentiate between racial and cultural identity when serving diverse consumers?

- Never
- Seldom
- Sometimes

- Regularly
- Not applicable

If you need technical assistance with becoming more familiar with the items in Section 6, please indicate the specific topics (e.g., culturally diverse assessments, CLAS Standards, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 7: Language and Interpretation Services Access

This section focuses on the ability of the organization and its staff to ensure access to materials in various languages, offer interpretation/translation services, and implement processes to ensure adherence to National CLAS Standards 5 through 8.

38. Does your organization inform consumers of their rights to language access services under Title VI of the Civil Rights Act of 1964 - Prohibition Against National Origin Discrimination and as required by the CLAS Standards 5-8 for language access?

- ● Never
- ● Seldom
- ● Sometimes
- ● Regularly
- ● Not applicable

39. Does your organization use either of the following personnel to provide interpretation services?

Certified medical interpreters?	● Never	● Seldom	● Sometimes	● Regularly
Trained medical interpreters?	● Never	● Seldom	● Sometimes	● Regularly
Sign language interpreters?	● Never	● Seldom	● Sometimes	● Regularly

40. Does your organization:

Translate and use patient consent forms, educational materials, and other information in other languages?	● Never	● Seldom	● Sometimes	● Regularly
Ensure materials address the literacy needs of the consumer population?	● Never	● Seldom	● Sometimes	● Regularly
Assess the health literacy of consumers?	● Never	● Seldom	● Sometimes	● Regularly
Employ specific interventions based on the health literacy levels of consumers?	● Never	● Seldom	● Sometimes	● Regularly

41. Does your organization evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?

- ● Never
- ● Seldom

- Sometimes
- Regularly

If you need technical assistance with becoming more familiar with the items in Section 7, please indicate the specific topics (e.g., CLAS Standards, beneficiary materials, interpretation resources, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

Section 8: Engagement of Diverse Communities

This section focuses on the organization's and its staff's engagement of diverse communities in health and behavioral health promotion and disease prevention.

42. Does your organization conduct activities tailored to engage culturally diverse communities?
Please reference the culturally diverse groups you identified at the beginning of this survey.

- ● Never
- ● Seldom
- ● Sometimes
- ● Regularly

43. What types of activities does your organization conduct that are tailored to engage culturally diverse communities?
Please provide at least one example and specify the cultural group that the activity/activities is/are tailored to.

44. Do organization brochures and other media reflect cultural groups in the service area?

- ● Never
- ● Seldom
- ● Sometimes
- ● Regularly

45. Does your organization reach out to and engage the following individuals, groups, or entities in whole person wellness, mental health promotion, and disease prevention initiatives:

A. Places of worship or spiritual wellness, and clergy, ministerial alliances, or indigenous religious or spiritual leaders?	● Never ● Seldom ● Sometimes ● Regularly
B. Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?	● Never ● Seldom ● Sometimes ● Regularly

Cultural and Linguistic Competence Policy Assessment (CLCPA)

Fillable Form

C. Primary care providers, dentists, chiropractors, or licensed midwives?	● Never ● Seldom ● Sometimes ● Regularly
D. Providers of complementary and alternative medicine (e.g., homeopaths, acupuncturists, death doulas, or lay midwives)?	● Never ● Seldom ● Sometimes ● Regularly
E. Ethnic/cultural publishers, radio, cable, or television stations or personalities, or other ethnic media sources?	● Never ● Seldom ● Sometimes ● Regularly
F. Human service agencies?	● Never ● Seldom ● Sometimes ● Regularly
G. Tribal, cultural, or recovery advocacy organizations?	● Never ● Seldom ● Sometimes ● Regularly
H. Local business owners such as barbers/cosmetologists, sports clubs, casinos, salons, and other ethnic/cultural businesses?	● Never ● Seldom ● Sometimes ● Regularly
I. Social/cultural organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic/cultural associations)?	● Never ● Seldom ● Sometimes ● Regularly

If you need technical assistance with becoming more familiar with the items in Section 8, please indicate the specific topics (e.g., community engagement, CLAS Standards, culturally diverse activities, etc).

Cultural and Linguistic Competence Policy Assessment (CLCPA)

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Program and Respondent Information

Program name:

What is your program type?

- ● Mental Health Services (MHS)
- ● Substance Use Disorder (SUD) Services

Contract number:
You may have more than one. Please complete ONE survey for EACH contract.

What is your program's legal entity?

What role best describes you at your program?

- ● Program Director
- ● Program Manager
- ● Direct/Indirect Services Staff
- ● Other

Primary clients at your program:
Please check all that apply.

- ☐ Children and youth
- ☐ Transition Age Youth (TAY)
- ☐ Adults
- ☐ Older adults
- ☐ Other

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Promoting Cultural Diversity Self-Assessment

PCDSA

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Promoting Cultural Diversity Self-Assessment (PCDSA)

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The Promoting Cultural Diversity Self-Assessment (PCDSA) was developed by Georgetown University, but has been adapted by the County of San Diego Behavioral Health Services in 2017. The PCDSA is intended to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. It assesses the staff's level of understanding around values and practices that promote a culturally diverse and cultural competent service delivery system.

The PCDSA is aligned with the National Culturally and Linguistically Appropriate Services (CLAS) Standards.

I. Physical Environment, Materials & Resources

1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of communities served by my program or agency.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different communities served by my program or agency.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

3. When using videos, films, CDs, DVDs, or other media resources for Behavioral Health outreach, prevention, treatment, or other interventions, I ensure that they reflect the cultures of communities served by my program or agency.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

4. When offering food, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of the communities served by my program or agency.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

5. I ensure mediums and modalities in reception areas and those, which are used during program services, are representative of the various cultural and ethnic groups within the local community and the society in general.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

II. Communication Styles

6. For people who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during interactions.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

7. I attempt to determine any cultural expressions used by communities served that may impact interactions and services.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

8. I use visual aids, gestures, and physical prompts in my interactions with those who have limited English proficiency.
   - ● Things I do frequently
   - ● Things I do occasionally
   - ● Things I do rarely or never
   - ● Did not occur to me

9. I use trained bilingual or multilingual staff (or appropriate interpreter services) during assessments, treatment sessions, meetings, and for other events for families who would require such level of assistance.
   - ● Things I do frequently
   - ● Things I do occasionally

Promoting Cultural Diversity Self-Assessment (PCDSA)
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- ● Things I do rarely or never
- ● Did not occur to me

10. When interacting with people who have limited English proficiency, I always keep in mind that:

Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.	● Things I do frequently ● Things I do rarely or never	● Things I do occasionally ● Did not occur to me
Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.	● Things I do frequently ● Things I do rarely or never	● Things I do occasionally ● Did not occur to me
They may or may not be literate in their preferred language or English.	● Things I do frequently ● Things I do rarely or never	● Things I do occasionally ● Did not occur to me

11. I ensure that all notices and communication to service participants are available in threshold languages.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

12. I understand that it may be necessary to use alternatives to written communications for some communities receiving information.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

13. I understand the value of linguistic competence and promote it within my program or agency.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

14. I understand the implications of health care and behavioral health literacy within the context of my roles and responsibilities.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

III. Values & Attitudes

15. I use alternative formats and varied approaches to communicate and share information with those we serve who experience disability.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

16. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

17. In delivering program services, I discourage participants from using derogatory slurs (e.g., racial, ethnic, sexist, homophobic, transphobic, etc.) by helping them understand that certain words can hurt others.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

18. I screen books, movies, and other media resources for negative stereotypes before sharing them with those served by my program or agency.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never

Promoting Cultural Diversity Self-Assessment (PCDSA)
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- Did not occur to me

19. I intervene in an appropriate manner when I observe other staff within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

20. I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, family of choice).
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

21. I recognize and accept that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

22. I accept and respect that gender roles and expression of gender identity in families may vary significantly among different cultures.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

23. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest man in families).
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

Promoting Cultural Diversity Self-Assessment (PCDSA)
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24. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
This question is for CYF programs only.
- ● Things I do frequently
- ● Things I do occasionally
- ● Things I do rarely or never
- ● Did not occur to me
- ● Not applicable (my program does not serve children, youth, and their families)

25. I recognize that the meaning or value of behavioral health outreach, prevention, intervention, and treatment may vary greatly among cultures.
- ● Things I do frequently
- ● Things I do occasionally
- ● Things I do rarely or never
- ● Did not occur to me

26. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- ● Things I do frequently
- ● Things I do occasionally
- ● Things I do rarely or never
- ● Did not occur to me

27. I understand that beliefs about mental illness, substance use, and emotional disability are culturally-based. I accept that responses to these conditions and related services are heavily influenced by culture.
- ● Things I do frequently
- ● Things I do occasionally
- ● Things I do rarely or never
- ● Did not occur to me

28. I understand the impact of stigma associated with mental illness, substance use, and behavioral health services within culturally diverse communities.
- ● Things I do frequently
- ● Things I do occasionally
- ● Things I do rarely or never

Promoting Cultural Diversity Self-Assessment (PCDSA)
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- Did not occur to me

29. I accept that religion, spirituality and other beliefs may influence how people respond to mental or physical illnesses, disease, disability, and death.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

30. I recognize and accept that cultural and religious beliefs may influence a family's reaction and approach to a person diagnosed with a physical/emotional disability or special health care needs.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

31. I understand that traditional approaches to disciplining children are influenced by culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

32. I understand that people from different cultures will have different expectations for acquiring self-help, social, emotional, cognitive, and communication skills.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

Promoting Cultural Diversity Self-Assessment (PCDSA)
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34. Before visiting a home setting, or providing services in the community, I seek information or acceptable behaviors, courtesies, customs, and expectations that are unique to specific cultures and ethnic groups served by my program or agency.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

35. I seek information from family members or other key community leaders that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse community members served by my program or agency.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

36. I promote the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

37. I am aware of cultural specific healing methods, particularly as they pertain to the communities served by my program or agency.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

38. I contribute to and/or review current research related to cultural disparities in behavioral health, health care, and quality improvement.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never

- ● Did not occur to me

39. I accept that many evidence-based outreach, prevention, and intervention approaches will require adaptation to be effective with culturally and linguistically diverse groups.
    - ● Things I do frequently
    - ● Things I do occasionally
    - ● Things I do rarely or never
    - ● Did not occur to me

Program & Respondent Information

Please enter your program reference number from the list provided in the email.
Do not leave it blank. If your program is NOT on the list, please write down the full name below.

What is your program type?

- ● Mental Health Services (MHS)
- ● Substance Use Disorder Services (SUD)

Please identify primary clients at your program.
Please check all that apply.

- ☐ Children and youth
- ☐ Transition Age Youth
- ☐ Adults
- ☐ Older Adults

Please select the role that best describes your position.

- ● Manager/Supervisor
- ● Direct Service Provider
- ● Indirect/Support Services
- ● Peer Support

How many years of experience do you have working in the behavioral health field?

- ● 0-1 Year
- ● 2-5 Years
- ● 6-10 Years

Promoting Cultural Diversity Self-Assessment (PCDSA)
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- ● 10+ Years Ago

Please indicate your gender.

- ● Male
- ● Female

Please indicate your race/ethnicity.

- ● African-American
- ● Asian/Pacific Islander
- ● Hispanic
- ● Native American
- ● White

Please indicate your country of origin.

Please indicate which languages you speak besides English.
Mark all that apply.

- ☐ Arabic
- ☐ Farsi
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ I do not speak other languages besides English
- ☐ Other

Please indicate your highest degree or diploma.

- ● High School Diploma
- ● Associate's Degree
- ● Bachelor's Degree
- ● Master's Degree
- ● Doctorate/MD/PhD/PsyD

Certification of Language Competence

Suggested process for certifying language competence

Suggested Process for Certification of Language Competence

In order to establish a process for certifying the ability of bilingual and multilingual staff or interpreters, the following is proposed for the consideration of providers:

- Legal Entities/programs to establish a panel of expert speakers – minimum of 2 persons whenever possible

- Certification process to be conducted by the panel and contain a minimum 30 minutes-worth of material to be reviewed in the designated language

- Material must cover knowledge of behavioral health, clinical terminology, ability to communicate ideas, concerns and the societal framework, familiarity with designated culture and variant beliefs concerning behavioral health

- Written and verbal language assessment:

    - Some language – able to provide basic information
    - Conversational – able to communicate and provide information and support services
    - Fluent – written and verbal. Ability to communicate and converse. Ability to discuss behavioral health terminology, and conduct therapy, if applicable

- Ongoing supervision of each language's certification process by native speaker of language

Survey for Clients to Assess Program's Cultural Competence

Suggested survey tool for clients to assess the cultural competence of the program

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

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Survey for Clients to Assess a Program's Cultural Competence

Program Name: _____ Date: _____

==========

Client Demographics:

Age: _____

Race/Ethnicity: ☐ Hispanic ☐ African American ☐ White ☐ Native American
☐ Asian/Pacific Islander ☐ Other: _____

Language Preference: ☐ Spanish ☐ Vietnamese ☐ Tagalog ☐ English
☐ Chinese ☐ Japanese ☐ Laotian ☐ Cambodian ☐ Farsi ☐ Arabic
☐ Other: _____

Please rate this program on the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. In the last six months, the staff listened to me and my family when we talked to them.	☐	☐	☐	☐	☐	☐
2. The services I received here in the last six months really helped me work towards things like:						
a. Getting a job.	☐	☐	☐	☐	☐	☐
b. Taking care of my family.	☐	☐	☐	☐	☐	☐
c. Going to school.	☐	☐	☐	☐	☐	☐
d. Being active with my friends, family, and community.	☐	☐	☐	☐	☐	☐
3. In the last six months, the staff made an effort to understand the experiences and challenges I once experienced.	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
4. The waiting room and/or facility have images or displays that represent people from my cultural group.	☐	☐	☐	☐	☐	☐
5. In the last six months, the staff respected and supported my cultural and religious beliefs.	☐	☐	☐	☐	☐	☐
6. In the last six months, the staff from this program came to my community to let people like me and others know about the services they offer and how to get them.	☐	☐	☐	☐	☐	☐
7. In the last six months, the staff treated me and my experiences with respect.	☐	☐	☐	☐	☐	☐
8. Some of the staff are representative of my cultural group.	☐	☐	☐	☐	☐	☐
9. In the last six months, there were translators or interpreters easily available to assist me and/or my family if we needed it.	☐	☐	☐	☐	☐	☐
10. In the last six months, the staff made an effort to understand my traditional medicinal practices.	☐	☐	☐	☐	☐	☐

Discussion Questions for Client Focus Groups on Program's Cultural Competence

Suggested discussion questions for client focus groups to assess the program's cultural competence

These questions may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

Client Focus Group Discussion Questions

Program Name: _____ Date: _____

==========

1) Does this program offer a culturally welcoming, comfortable setting to be in?

2) Does the program support and offer trauma-informed practices, policies, language, and environment?

3) Does this program provide you with written materials available in a language or format (large print, color, spacing, etc.) that you can understand?

4) What other materials would you like to have available?
Examples include, but are not limited to: audio tape, CD, VHS Tape, DVD, etc.

5) Does this program provide you with services in your language of choice?

6) Are bilingual, clinical staff linguistically proficient and able to communicate ideas, concerns and the societal framework in your preferred language?

7) Are clinical staff familiar with your cultural beliefs surrounding mental illness?

8) Are clinical staff knowledgeable about how to make culturally appropriate referrals?

9) If you see a program psychiatrist, is s/he familiar with your cultural beliefs surrounding mental illness?

10) If you see a program psychiatrist, has s/he asked about any trauma and or adversity in your past?

11) If you need to use an interpreter provided by the program, is s/he linguistically proficient and able to communicate ideas, concerns and rationales in your language of choice?

Discussion Questions for Community Focus Groups on Program's Cultural Competence

Suggested discussion questions for community focus groups to assess the program's cultural competence

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

Community Focus Group Discussion Questions

Program Name: _____ Date: _____

==========

1) Is this program known within the community?

2) Does the community feel that the services provided by this program are needed?

3) Does the community believe that people who come here for mental health services improve and feel better as a result of the services they receive?

4) Does this program offer a culturally welcoming, comfortable setting to be in?

5) Is this program trauma informed?

6) What are some things we can improve about our program?

7) What are the barriers that people have to coming to this program to receive services?

8) Would you recommend a friend or family to seek services here if they were needed?

9) What else can we do to become an integral part of the community?

Resources

CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The National CLAS Standards were developed by the Health and Human Services Office of Minority Health in 2000 and further enhanced in 2010-2013 to address the importance of cultural and linguistic competency at every point of contact throughout the health care and health services continuum.

The following CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services.

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.

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
For more information and to access a Blueprint for Advancing and Sustaining CLAS Policy and Practice visit www.thinkculturalhealth.hhs.gov/Content/clas.asp.

Context for the Development and Evaluation of Cultural Competences

Summary of the plethora of cultural competence assessments available

(These resources have not been reviewed or approved by the County of San Diego or CCRT and are for additional reference as a supplement to tools in the Handbook)

As background, most of the available assessment scales fall into four broad areas:

1) Multicultural knowledge, self-awareness, and skills for working across cultures;
2) Intercultural skills in working across international borders (i.e., flexibility, sensitivity, open-mindedness, perceptual acuity, personal autonomy, empathy, and respect);
3) Behavioral assessments; and
4) Vignette assessments.

The assessments in the first two categories are primarily self-report scales relying on an individual to report on their personal perceptions of their own competency. The latter two categories attempt to sidestep the limitations of self-report. Many of the multicultural assessments (category #1) are publicly available. Unfortunately, however, most of the intercultural scales (category #2) have been "privatized" and are sold at a fee, with access to a summary report only (rather than item-by-item responses). Assessments in categories #3 and #4 are available either publically or by request to the authors.

Researchers have evaluated the statistical properties of these multicultural and intercultural instruments (categories #1 and #2), so that consumers can have confidence that the questions generate reliable patterns of responses when asked to large numbers of people. Naturally, some of the assessments are more reliable in this respect than others. Whether statistically validated or not, any instrument that relies on people reporting their perceptions of their own cultural competence, the scores can be significantly biased by the respondent's desire to (a) appear better than they are, or (b) by the respondent's lack of insight on where they need to improve. The multicultural and intercultural instruments have also been critiqued for their lack of scope, in that they do not cover the skills needed to work with the more complex issues of (a) power/privilege, and (b) complexities of identity associated when individuals are marginalized by race as well as by sexual orientation, socioeconomic status, religion, gender, body size, immigration status, health, disability, and other dimensions. The *Alliant Intercultural Competency Scale* (AICS) discussed below attempts to overcome this latter critique.

Also, it is important to keep in mind that the quality of any individual's "culturally competent skills" will vary by the context. That is, one may be far more culturally competent with Native American girls in the school setting than with Asian American professional men and women in the hospital setting, solely as a result of where they have done their training. Thus, many organizations may try to overcome this contextual issue by designing their own hybrid scale by selecting individual items from the other previously validated instruments. The *California Brief Multicultural Competence Scale* (CBMCS: Gamst, et al., 2004) is an example of this approach.

Recently scholars have brought forth broader concept of *cultural intelligence*, which refers to an individual's ability to function effectively and fluidly among people of different cultures, in different settings, with the sensitivity to avoid causing the "cultural ruptures" that others with less cultural intelligence will stumble into quickly; the analogy of course is emotional intelligence. Scales assessing Cultural Intelligence may be available. Similarly, the concept of "negotiated space" has also emerged in the literature, which refers to someone's capacity to "share culture" in meetings such that decision-making and problem-solving can be conducted in a milieu were all cultures are present are weighted equally. "Negotiated space" is a concept of full participation where maintaining culturally respectful relationships is as important as the issues being worked through. The AICS is designed to evaluate skills in "negotiated space".

In a manuscript in press, Dr. Sheila Henderson and additional co-authors wrote a brief review of various measures available in the fields of psychology, education, and business. The scales found and discussed were:

- Multicultural scales:
  - *Multicultural Awareness-Knowledge-and-Skills Survey* (MAKSS; D'Andrea, Daniels, & Heck, 1991)
  - *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994)

- *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002)
- *Multicultural teaching competency scale* (Spanierman et al., 2011)

(Please note that reviews and objective statistical testing of these instruments have been conducted by Constantine & Ladany, (2003), Hays (2008), and Ponterrotto, Rieger, Barrett, & Sparks (1994).)

- Intercultural scales:
  - *Assessment of Intercultural Competence* (AIC: Fantini, 2007)
  - *Intercultural Development Inventory* (IDI; Hammer, Bennett, & Wiseman, 1993)
  - *Global Competency and Intercultural Sensitivity Index* (ISI; Olson & Kroeger, 2001)
  - *Intercultural Sensitivity Inventory* (ICSI: Bhawuk & Brislin, 1992)
  - *Cross-Cultural Adaptability Inventory* (CCAI: Kelley & Meyers, 1995)

Alliant International University, concerned about training professionals across business, forensics, education, law, and psychology for both local and global careers has recently developed a scale that spans both the multicultural and international arena with promising statistical properties in initial testing. This instrument is called:

- *Alliant Intercultural Competency Scale* (AICS; 2014)

For available reviews and statistical evaluations of these two categories of scales, see Constantine, Gloria, & Ladany (2002); Constantine & Ladany (2002); Hays (2008); Olebe & Koester (1989); Ponterotto, Reiger, Barrett, & Sparks (1994); Pope-Davis, Coleman, Liu, & Toporek (2003); Sinicrope et al. (2008); and Worthington, Mobley, Franks, & Tan (2000).

There are another two instrument categories—behavioral and vignette assessments—that try to surmount the "self-report" problem referred to above:

- Behavioral assessment instruments:
  - *Multicultural Teaching Competency Scale* (Spanierman et al., 2011)
  - *Missouri Multicultural Counseling Self-Efficacy Scale* (Mobley, Worthington, & Soth, 2006)
  - *Behavioral Assessment Scale for Intercultural Communication* (BASIC: Olebe & Koester, 1989; Ruben, 1976; Ruben & Kealey, 1979)
- Vignette-style measures:
  - *Cross-Cultural Counseling Assessment-Revised* (CCCI-Revised: LaFromboise et al., 1991)
  - *Multicultural Interactive Theatre* (Burgoyne et al., 2007)
  - *Instructor Cultural Competence Questionnaire* (ICCQ: Roberson, Kulik, & Pepper, 2002)
  - *Cultural incidents in the University Classroom Vignettes* (Henderson, Horton, Saito, Shorter-Gooden (in press)

Suggestions for Supplemental Cultural Competence Training

The following list of suggestions is a supplement to the core list of trainings, webinars, and classes offered through Behavioral Health Education and Training Academy (BHETA) at https://theacademy.sdsu.edu/programs/bheta/ and through The Knowledge Center (TKC)*. The suggestions are not comprehensive and are designed to offer you additional options in meeting the annual cultural competence training requirement.

The *Supplemental Cultural Competence Training Evaluation Form* must be completed as part of the requirement if you choose this method of meeting the cultural competence training requirement. The completed Form should be kept on file for future reference.

**TKC is available to County staff only.*

Note: it is important to avoid stereotypes and assumptions regarding any cultural values based on the suggestions listed below.

Fictional Books	
Behold the Dreamers by Imbolo Mbue	Little Bee by Chris Cleave
Chasing Freedom: the Life Journeys of Harriet Tubman and Susan B. Anthony by Nikki Grimes *Based on true story*	Native Son by Richard Wright
Citizen: An American Lyric by Claudia Rankine	The Amazing Adventures of Kavalier & Clay by Michael Chabon

Non-Fictional Books	
A Different Mirror: A History of Multicultural America by Ronald Takaki	Middlesex by Jeffrey Eugenides
A Piece of Cake: A Memoir by Cupcake Brown	My Gender Workbook by Kate Bornstein
Allah Made Us: Sexual Outlaws in an Islamic African City by Rudolf Pell Gaudio	On Edge: A Journey Through Anxiety by Andrea Petersen
Always My Child: A Parent's Guide to Understanding your Gay, Lesbian, Bisexual, Transgendered, or Questioning Child by Kevin Jennings	The Big Sort: Why the Clustering of Like-Minded America is Tearing Us Apart by Bill Bishop
Assessing and Treating Culturally Diverse Clients: A Practical Guide, 4th Edition by Freddy A. Paniagua	The Bisexual Option by Fritz Klein
Between the World and Me by Ta-Nehisi Coates	The Life and Times of Frederick Douglass by Frederick Douglass
Bloods: An Oral History of the Vietnam War by Black Veterans by Wallace Terry	The Night by Elie Weisel
Covering: The Hidden Assault on Our Civil Rights by Kenji Yoshino	The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and The Collision of Two Cultures by Anne Fadiman
Fun Home: A Family Tragicomic by Alison Bechdel	Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context (edited by

	Joop De Jong)
GLBTQ: The Survival Guide for Queer and Questioning Teens by Kelly Huegel	We Should All Be Feminists by Chimamanda Ngozi Adichie
I am Jazz by Jazz Jennings	White Like Me: Reflections on Race from a Privileged Son by Tim Wise
In My Shoes: A Memoir by Tamara Mellon	

Movies	
12 Angry Men (1957)	La Misma Luna/Under the Moon (2007)
13th (2016, documentary)	Milk (2008)
4 Little Girls (1998, documentary)	Moonlight (2016)
American East (2007)	My name is Khan (2010)
American Violet (2008)	Not Without My Daughter (1991)
Amreeka (2009)	Once Were Warriors (1994)
Bordertown (2016, TV series)	Pariah (2011)
Brother Outsider: The Life of Bayard Rustin (2003)	Powwow Highway (1989)
Chasing Freedom (2004)	Pumpkin (2002)
City of Joy (1992)	Rabbit Proof Fence (2002)
Crash (2004)	Real Boy (2016)
Dead Presidents (1995)	Real Women Have Curves (2002)
Dreamkeeper (2003, TV series)	Running with Scissors (2002)
Eat Drink Man Woman (1994)	Smoke Signals (1998)
Fire (1996)	The Danish Girl (2015)
For the Bible Tells Me So (2007)	The Namesake (2003)
God grew Tired of Us (2006, documentary)	The Year We Thought About Love (2015)
Gun Hill Road (2011)	Thunderheart (1992)
Hidden Figures (2016)	What's Cooking (2000)
In America (2002)	

Web-Based Video and Audio Programs

http://fenwayhealth.org/the-fenway-institute/publications-presentations/

https://www.hrsa.gov/culturalcompetence/index.html

http://xculture.org/resources/general-resource-guides/cultural-competence-resources/

http://www.npr.org/podcasts/510317/its-been-a-minute-with-sam-sanders

Academic/Peer-Reviewed Journals

Conner, K.O., et al (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *The American Journal of Geriatric Psychiatry, 18*(6), 531-543.

Malgady, R.G., et al. (1987). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. *American Psychologist, 42*(3), 228-234.

Saha, S., et al. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275-1285.

Wurth, K. & Schuster, S. (2017). Some of them shut the door with a single word, but she was different. A migrant patient's culture, a physician's narrative humility and a researcher's bias. *Patient Education and Counseling, 100*(9), 1772-1773.

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Cultural Competence Training Evaluation Form

The purpose of this checklist is to facilitate a method of tracking cultural competence training that utilizes complementary or adjunct learning courses/materials/activities. This is aligned with the Staffing Requirements of the Organizational Provider Operations Handbook (Mental Health Services): *Require that at a minimum, all provider staff, including support staff dealing with clients or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. Training may include but isn't limited to: attending lectures, written coursework, web training, attending a conference, reading a book/article, or watching a movie/online video. These items can count toward the overall cultural competence enhancement. A record of annual minimum four hours of training shall be maintained at the program site.*

Prior to approval of learning event/activity supervisors should make sure the training will result in staff being able to answer the listed questions. Following the training, staff should be able to discuss the questions listed with their supervisor and/or additional staff.

1. How was your worldview impacted by this learning event?

Worldview: The overall way one sees and interprets the world, including one's understanding of self and others.

2. How will you change your work practice as a result of this learning event?

Participant Name _____

Course/Material/Activity _____

_____

_____

<u>Participant</u> → Prepare an oral presentation (up to 20 minutes) of the course/material/activity to the supervisor addressing:

- ☑ An overview of the culture with some of these possible topics: values, sociological history, family structure, customs, perceptions of assistance or help, support systems, spirituality, health approaches, complementary healing approaches, cultural resilience, and language
- ☑ Effects of inter- and intra- cultural differences, overt/covert racism, generational and gender differences, stereotypes and myths

It is encouraged for the participant to present to other program staff.

<u>Supervisor</u> → Did the participant:

- ☑ Address the need to assess individuals and families based upon a psychosocial/cultural/political/ spiritual perspective
- ☑ Identify experiences, perceptions and biases of the culture
- ☑ Address the need to understand and accept cultural differences when working with clients/customers
- ☑ Articulate culturally appropriate responses that are consistent with cultural norms

<u>Supervisor to discuss with participant</u> → How do the following help improve cultural sensitivity?

- ☑ Identifying and utilizing community resources on behalf of the client
- ☑ Providing services with understanding of cultural differences
- ☑ Advocating - reducing racism, stereotypes and myths

<u>To be completed by the Supervisor</u>:

Signature confirms that the items listed above were discussed with the participant.

Credited number of cultural competence training hours _____ (max of 4 hours) Fiscal Year _____

Approved by (signature) _____ Date _____

Print Name _____

Revised 8/3/2012

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Additional Resources

Implementation of CLAS Standards

Think Cultural Health, Office of Minority Health, US Department of Health & Human Services
www.thinkculturalhealth.hhs.gov/Content/clas.asp

Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence, Georgetown University, Center for Child and Human Development
www.clcpa.info/

SDCBHS Resources

Cultural Competence Plan 2010 and Executive Summary
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetencePlan2010.pdf

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CCP2010ExecSumm110111.pdf

Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/1_C.pdf

Organizational Provider Operations Handbook (section H)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Combined_OPOH_010113_Rev_021214.pdf

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health (Eight Year Comparison: FY 2001-2002, FY 2006-2007, and FY 2009-2010)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/DisparitiesReport110212.pdf

Trauma-Informed Systems and Services

The National Council for Behavioral Health: Trauma Informed Care
www.thenationalcouncil.org/topics/trauma-informed-care/

The Trauma Informed Project
www.traumainformedcareproject.org/

University of North Carolina Family and Children's Resource Program: Trauma and Behavior – How Trauma Affects the Brain
www.youtube.com/watch?v=lPftosmseYE

What Does "Trauma Informed Care" Really Mean? – The Up Center
www.cpe.vt.edu/ocs/sessions/csa-trauma.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Trauma-Informed Approach and Trauma-Specific Interventions
beta.samhsa.gov/nctic/trauma-interventions

Druss B.G. & Reisinger Walker E. (2011). Mental disorders and medical comorbidity. *Research Synthesis Report*, No. 21. Princeton, NJ: Robert Wood Johnson Foundation.
www.rwjf.org/files/research/71883.mentalhealth.report.pdf

Edwall, G.E. (2012, Spring). Intervening during childhood and adolescence to prevent mental, emotional, and behavioral disorders. *The Register Report*, 38, 8-15.

Felitti V. & Anda, R., (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare, In R. Lanius and E. Vermetten, Eds., *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press. 2010.

Finch, R. A. & Phillips, K. (2005). An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services.
www.businessgrouphealth.org/publications/index.cfm

Substance Abuse and Mental Health Services Administration (2011). *Helping Children and Youth Who Have Experienced Traumatic Events.* HHS Publication No. SMA-11-4642.

Substance Abuse and Mental Health Services Administration & National Association of State Mental Health Program Directors. (2004). *The damaging consequences of violence and trauma.*
www.theannainstitute.org/Damaging%20Consequences.pdf

Van der Kolk, B, McFarlane, A, & Weisaeth, L. (2007). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: The Guilford Press.

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Over the past fiscal year (FY 13-14) the Leads for the CCRT CRDP Work Groups volunteered to address the recommendations put forth by the CCRT Chair 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. In this document the CCRT CRDP Leads offer their insight and recommendations. I want to thank and appreciate the diligence and efforts of Dr. Dixie Galapon, Rosa Ana Lozada, Minola Clark-Manson, Dr. Leon Altamirano, Wendy Maramba and Kristina Maxwell for their work and commitment.

Latino Recommendations

Recommendation #2: Access to Mental Health Care – Secure and enhance school based mental health programs.

Focus on adolescents and the impact of failing to adequately screen, detect, and diagnose potential mental health problems in a timely manner. School constitutes a safe setting in which to educate families and their children about mental health. Tie mental health program to academic achievement and performance.

- Secure funding to ensure availability and accessibility of school-based programs for students experiencing mental illness.
- Collaboration with schools as a hub for education and training of teachers and parents on reducing mental health false beliefs of mental illness
- Promote mental health through a mental health career pathway at the high school level that can be integrated into the mental health certificate program at the community college level.
- Work with schools that have an existing conditional use permits allowing for the community to use the school facility during evening and weekend hours.
- Focus on normal transition issues between middle and high school to reduce negative impact
- Apply culturally relevant engagement approaches that include child care. Food and other resources.

School based programs are referenced in the capacity of a community centric location to provide teacher, parenting and community member's classes on mental health. These partnerships will provide access to mental health programs and eliminate the tendencies that schools personal have of misdiagnosing student and labeling them as behavioral issues when in reality the student may have been affected by a mental illness.

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CYF Response

- BHS has School Based Services in more than 360 schools countywide
- **Collaboration among agencies (schools):**
  Global Oversight Analysis Linking Systems (GOALS) MOU signed: Information sharing and cross systems collaboration between San Diego County School District, Law Enforcement, Child Welfare, Probation, and HHSA BHS
- For Full Service Partnership School based services, providers work closely with school personnel to engage and support youth and their families and provide outreach at schools. School based clients may receive individual/group/family treatment, case management/rehabilitative services, crisis intervention, and medication management services. Contractors coordinate with school partners to provide education that assists the schools in understanding the target population eligible for services under EPSDT and MHSA. Contractor also coordinate with schools to identify the SED children and youth most in need of services
- Palomar Family Counseling Services –MHSA Prevention and Early Intervention School Age Services. The Family Community Partnership (FCP) provides behavioral health prevention and early intervention services through a parent-peer partner model. FCP serves the families of children attending one of four elementary schools (Laurel and Mission Elementary Schools in Oceanside Unified School District; Rose and Pioneer Elementary Schools in Escondido Unified School District). The program employs Community Outreach Specialists (COS) as parent peer partners from each of the participating schools' catchment areas. It serves families who are identified by the school, through self-referral, or are engaged through outreach by the COS'. Services are developed through a collaborative process between the FCP staff and the target population for the purpose of determining prevention needs and provide a variety of mental health primary prevention/early intervention services. These services shall focus on family wellness, strengthening resilience, reducing disparities in accessing mental health services, reducing stigma and discrimination and helping families make connections with the schools and other services and supports in the community. PEI activities are delivered in and around the school-community environment. PEI activities are scheduled according to the needs of the target population. Target population is underserved and living in high risk communities. Escondido and Oceanside have high ratios of Latino and socio-economically disadvantaged families, many of whom are unemployed, often burdened with poverty, illiteracy, limited education, and homelessness. Many families are single parent households, monolingual Spanish. Children are at risk for developing social and emotional problems that may include depression, anxiety, and behavioral disorders. Other risk factors include exposure to trauma, violence and substance abuse. Children in stressed families are more vulnerable to school failure and involvement in the juvenile justice system.

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- Rady Children's Outpatient Psychiatry – Central/East/South The FSP/MHSA program provides outreach psychiatric services to children and adolescents at school sites and homes for families without mental health resources who meet SED criteria and are referred by the schools for services. Services are provided in both English and Spanish (5 schools) at 13 schools in the C-E-S regions of the county (Elementary, Middle, High Schools). Services provided consist of individual and family therapy, case management, and medication evaluation and medication management. Specific outreach to underserved Asian and Latino children and youth
- Recommended to Board of Supervisors to: Offer specialty behavioral health services for CAT and Diversion clients through the existing BHS clinic and school based and recovery service networks and enhance existing regional specialty mental health contracts to ensure capacity for services. Recommendations to be presented November 5, 2013
- Incredible Years program
- Children's System of Care Academy
- School Based Suicide Prevention and Early Intervention program serving middle and high school students
- Early Childhood Mental Health (ECMH) Incredible Years for children ages birth to five in San Diego Unified School District pre-school(s) who have been assessed and diagnosed with aggressive behavior problems and other emotional disturbance. Provides school-based mental health services that utilizes the Incredible Years curriculum. Targets Latino and Asian Pacific Islander Severely Emotionally Disturbed children and their families
- Palomar Family Counseling-Childnet in Escondido. Serves Medi-Cal and MHSA eligible, children ages 0-5 and their families. Provides assessment, behavioral intervention, teacher intervention at designated preschools and uses the Incredible Years Curriculum. Provides behavioral intervention and preschool teacher training to assist young children succeed in preschool and the community
- Para Las Familias Center in Imperial Beach serves children, ages 0 - 5, on Medi-Cal and non-insured children. Provides assessment, individual, filial and family therapy. Services provided at clinic, pre-school sites and in-home services

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Recommendation #3: Health Care Navigator Model to promote wellness and symptom management

Promote wellness and symptom management that integrate with other health care and social service through the access of health navigators. Health Care Navigators can strengthen the ability of Latino communities address issues of concerns in the area of health care, confront barriers related to accessing services, inform community of policies changes to improve individual and community health outcomes.

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- Services to be offered by trained community members using concepts of the Promotores model
- Conduct outreach in the community to inform residents of local health resources and assist clients in accessing these services.
- Collaborate with other community leaders
- Help residents identify a medical home and teach residents how to navigate through the health care system.
- Capacity must include navigation beyond physical health and behavioral health to include other healthcare specialists, pharmacy.
- Incorporate health management through management of Personal Health Care Records
- Include a Wellness and Recovery Plan

There are clear gaps in coordinated care between physical, behavioral health other health services providers even when multiple services are being provided at one location.

Workgroup Lead Response

1. Expand the education provided out of the WIC, Women's Programs, HIV Case Management and Elderly programs
   a. Initiate trauma-informed prevention education for expecting & new parents and for those grandparents that are caring for grandchildren (Well-Parent Program).

2. Support the WET Program to help meet the high need for psychiatry and mental health services.
   a. The need for psychological / therapeutic interventions in primary care is critical for this population as mental health stigma results in high "No Show" rates for patients referred to the internal mental health providers.
   b. Warm Hand-off's are received extremely well by Latinos on the medical side and are proving to increase treatment compliance while providing Medical Staff with hands-on suicide prevention and trauma-informed care training/education.
      i. Create/begin a training program in public mental health that provides training and education to interns about taking warm hand-offs in Patient Centered Medical Homes. It would cut the cost for clinics so they could provide more services and fill the gap of not being able to bill for same day services.
   c. Prenatal – Perinatal – Post Partum Screenings for parents with focus on trauma prevention, mental health and wellness (A Latino Live Well, San Diego campaign)
      i. This is an extension of the Well-Parent Program noted above.

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3. Emphasize BH Integration and a greater focus on rising health disparities due to the low utilization of BH Services overall. This is conducted through existing councils and the MHSA Stakeholder process.
4. Initiate or expand Case Management Services to assist Latino Residents navigate the system without having to end up in ER's. This is currently being accomplished through the existing system.
5. Considering the growing Latino population, I think it would be a huge help if BHETA offered a basic cultural competence course for medical/mental health providers that focused on Spanish trauma-informed medical/mental health terminology and prevention education language.
   a. We don't have enough providers to adequately serve the Latino population. This would help close the cultural barrier and better address health disparities.
6. Mobile clinics. This would be a phenomenal option to provide greater services to the many disabled at Independent Living Facilities without transportation (Mobile medical/psychiatric/dental and mental health).

CYF Response

- Family Youth Roundtable completed the Wellness Recovery Action Plan (WRAP) and will train other youth/family partners in WRAP process to implement with youth and families
- CYF worked with Healthy San Diego Health plans to establish a continuum of care and bidirectional interface between Primary Care Mental Health and Specialty Mental Health and implemented Care Coordination form with all BHS programs
- Contractors connect clients to a "**medical home**" for 100% of those clients who do not already have a primary health provider. Contractor shall document information about the medical home and on-going efforts to communicate with the primary care physician in the medical record.
- Contractors assist all parents/caregivers in developing a "**Wellness Notebook**," which is a tool that is used to organize information about a child's health condition and care. The Wellness Notebook is particularly important for clients with chronic health issues including, but not limited to, diabetes, asthma and obesity
- For outpatient services, contractor shall provide **on-site consultation** to teachers regarding specific clients and with regard to the classroom environment as a whole
- RFP for Mental Health First Aid Youth curriculum. Contract anticipated to start January 1, 2014
- CYF SOC goals for FY 13/14 include: to contribute to the development/implementation of Stigma Reduction campaign in alignment with CalMHSA project, including but not limited to make recommendations for Stigma Reduction Strategy and activities for contracted programs.

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FY14-15 Focus
AOA
1. Mobile clinics: work with FQHC to facilitate services to clients in ILF locations identified in the ILF Website that may not have access to transportation to health care services.
2. Discuss with the Council of Community Clinics the possibility of creating an e-learning for medical/mental health providers on basic cultural competence focusing on Latino specific trauma-informed care.
CYF
1. Pre-/Peri-/Post- natal screenings
2.

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African American Recommendations

Recommendation #1: Staff must have experience and/or training on the clients they serve.

A. Continue offering the African American Cultural Competence Academy series
B. Continue to fund and support those programs that are currently providing mental health services to African Americans.
C. Increase and advertise African American internship opportunities.
D. Continue and expand mental health promotion in the African American community.

Workgroup Lead Response

A. African American CCA offered in FY2012-13.The recruitment process was not well established resulting in low turnout. The training demonstrated effectiveness for those who participated.
   Recommendations:
   - Continue offering the clinical track of the CCA African American cohort every other year.
   - CORs to incorporate sustainment of learning for participants, including adding an ongoing cultural competence agenda item for discussion at provider collaboratives.
   - Determine the impact on programs that have participants that completed the CCA.
   - Determine the impact of having multiple CCA graduates has on the whole behavioral health system.

B. Identify and support traditional and nontraditional programs that are providing services to African Americans but might not be contracted with the County or contracted specifically to service African Americans.
   Recommendations:
   - Mental Health America is compiling a list of programs that provide both traditional and nontraditional mental health services to the African American community. Disseminate the list to all providers for reference.
   - Look into recruitment process for African American internship opportunities. Consider tying in volunteerism to WET programs. Look into a connection with High Tech High, focusing on AA youth to volunteer and gain experience within the BH system.
   - Increase the paraprofessional volunteer opportunities for African Americans.

C. Increase and advertise African American internship opportunities.
   - The Association of Black Psychologists (ABPsi) is developing opportunities for African American internships.

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- California School of Professional Psychology (Alliant University) is promoting MFT internships looking for lived experience and diversity.

Recommendations:

- Advertise the application process widely; provide that advertising to BHS for distribution.
- Rate programs on their effectiveness with recruiting diversity matching the need in the community

D. Continue and expand mental health promotion in the African American community.

Recommendation:

- Continue not yet saturated

CYF Response

- CYF is an active participant in the Save Our Children project that serves the southeast community
- CYF enhanced the Cultural Broker program by adding parenting groups for African-American fathers/parents
- CYF supports the African/American Cultural Competence Academy and monitors attendance to ensure that CYF programs access this training

Additional Opportunities for African Americans

1. Provide Mental Health First Aid training for African Americans, once the Request for Proposal process is complete.
2. Stigma and Discrimination campaign plan for next 5 years and how it addresses the African American community to improve access to care.
3. Evaluate the penetration and retention rates of African Americans receiving BH services.

**Submitted by Minola Clark-Manson, May 2014*

FY14-15 Focus
AOA
1. Offer an African-American CCA cohort in FY14-15.
2. Continue to expand mental health promotion in the AA community through the faith based initiative, AB109, outpatient and residential programs.
CYF
1.
2.

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Asian Pacific Islander Recommendations

Recommendation #1: Capacity Building – Empower the community by supporting community capacity building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.

The API Sub Group reviewed the Promising Practices identified in the API Reducing Disparities report. The Sub Group recommended adopting promising programs for San Diego API communities which would emphasize the following:

- behavioral health and physical healthcare integration
- the linkage of mental health and spirituality
- reduction in stigma from a culturally relevant framework

Recommendations:

Item	Feasibility / Additional comments
Behavioral health and physical healthcare integration	This item is already occurring in the Adult/Older Adult System of Care, and also Children's System of Care as it is a contract requirement for contracted providers to link with primary care providers; and/or to identify a medical home for system of care recipients. However, it should be noted that additional supports may be needed if a client is linked with an API private practitioner doctor in the community. Some private API physicians may have limited resources to collaborate for provision of behavioral health services. Some of these physicians may also have some stigma around mental health services.
Linkage of mental health and spirituality	This item is already occurring in the Adult/Older Adult System of Care, and also Children's System of Care as it will be a new contract requirement for contracted providers to integrate with faith-based providers. However, it should be noted that the current faith-based initiative in the County has recruited predominantly Christian-faith representatives from the African American and Latino communities. Additional supports may be needed to recruit faith-based representatives from API Christian-faith communities, as well as Muslim and Buddhist communities. Similar to the API physicians, some API faith-based representatives may have limited

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	resources to collaborate for provision of behavioral health services. Some of these physicians may also have some stigma around mental health services.
Reduction in stigma from a culturally relevant framework	This item is partially being addressed through It's Up to Us Campaign. There are a variety of API videos on the It's Up to Us website. However, these videos have not have sufficient promotion. Recommend additional promotion of API materials; and/or more focus on API communities with Ad Ease project.

The API Sub Group identified 6 **priority** promising programs to be considered at this time. These include:

- API Connections
- Qi-Gong
- Horticultural Therapeutic Community Centers
- Partners in Healing Group
- From Killing Fields to Growing Gardens
- Nikkei Tomadachi (Friendly Visitors)

Action: *AOA and Children's ADD and/or designee with API community to identify and select a promising practice proposal for BHS to consider as part of their planning stakeholder process for Innovations funding for FY 14-15.*

Recommendations:

Item	Feasibility / Additional comments
Action: Select Promising practice proposal for stakeholder process	This Action item has been accomplished. Some of the programs above (From Killing Fields to Growing Gardens; and Nikkei Tomodachi) have been submitted for MHSA Innovations Review
Promising Practices – other	This item has some additional feasibility. Some clubhouses are already doing some type of community gardening. System of Care Leads can review if they can strengthen Scope of Work requirements in this area. Also recommend that "INN" Design Teams review the 6 priority promising programs to consider if the entire program, or a component of the program could be considered during this current review phase.

**Submitted March 4, 2014 by Dr. Dixie Galapon*

Behavioral Health Services
CCRT Chair Recommendations for Implementation
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CYF Response

- Contractor shall connect clients to a "medical home" for 100% of those clients who do not already have a primary health provider. Contractor shall document information about the medical home and on-going efforts to communicate with the primary care physician in the medical record.
- CYF worked with Healthy San Diego Health plans to establish a continuum of care and bidirectional interface between Primary Care Mental Health and Specialty Mental Health and implemented Care Coordination form with all BHS programs
- Contractors assist all parents/caregivers in developing a "Wellness Notebook," which is a tool that is used to organize information about a child's health condition and care. The Wellness Notebook is particularly important for clients with chronic health issues including, but not limited to, diabetes, asthma and obesity
- CYF SOC goals for FY 13/14 include: to contribute to the development/implementation of Stigma Reduction campaign in alignment with CalMHSA project, including but not limited to make recommendations for Stigma Reduction Strategy and activities for contracted programs.
- North and Central regions CYF contracted programs were invited to participate in the Live Well Faith Base Community Dialogues

FY14-15 Focus
AOA
1.
2.
CYF
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2.

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Native American Recommendations

Recommendation #1: Increase mental health services and increase access to care.

Partner with WET, UCSD Psychiatry Residency program, and masters levels (MSW/MFT) of various educational institutions (Alliant University, SDSU).

Recommendations:

- Create a partnership with the University of California at San Diego's Gifford Clinic and Psychiatry Residency program **utilizing telemedicine** that could increase access for all adult AI/ANs living in rural or urban areas that are in need of psychiatric services or for those who have transportation barriers.
  - Indian Health Council & San Diego American Indian Health Center both provide mental health services on site.

  Information below provided in collaboration with Dr. Leon Altamirano

  Rural Southeast San Diego
  - **Southern Indian Health Council** has telemedicine equipment but has not implemented for telepsychiatry. Administration has organizational and complex needs and issues related to implementing mental health services. Challenges regarding documentation and confidentiality as well as concerns about legal/ethical/regulatory/employment practices are concerns due to Sovereign Immunity Protections. Currently, in SIHC there are 2 licensed therapists, a soon-to-be licensed social worker, and one intern. They are seeking to hire another FT intern. They do not have a psychiatrist.
  - **Mountain Health and Community Services** has telemedicine capacity and has used this as a means to serve their service area for both AI/AN and non-Indian patients. They do not currently have a psychiatrist. The clinic has limited mental health with 1 Ft psychologist and 2 interns. MHCS has and would continue to deliver access for psychiatry to the AI/AN population while working with SIHC primary care physicians for continuity and multidisciplinary care coordination. MHCS has clinics in Alpine, Campo, Escondido (Urban Indians) and near Logan Heights (Urban Indians) as well as a community center in Campo.
  - **Sycuan Medical-Dental Health clinic**. This clinic is more isolated as it is located on the Sycuan Reservation. However, the administrator and the tribe have considered expansion to include opening a more accessible, larger health center with behavioral health services. Sycuan does not have mental health therapists or psychiatry. However, they do have a nurse that is assigned to schedule and facilitate all telemedicine and have been effectively using telemedicine for many

services. They have had limited success with its use for psychiatry. They have a primary care and dental clinic that serves AI/AN and non-Indian populations.

Rural Northeast San Diego:

- **Indian Health Council** does provide psychiatry for approximately 8-10 hours per week on two half-days. They have a psychiatrist however, availability is limited. IHC has 2 psychologists and a typically have another therapist. Their restrictions limit services to only AI/AN population and make it an excellent training ground for rural/public health psychiatry. They do have telemedicine capacity and have medical and dental services. The primary challenge falls on the issue of Sovereign Immunity.
- **San Diego American Indian Health Center**: The urban clinic has a dual board certified family medicine-psychiatry medical director. However, they only have 1 part-time therapist and are experiencing multiple demand and capacity challenges. As a consequence, the physician is managing the bulk of the mental health interventions and has stated that approximately 70% of her patients are primarily psychiatry cases. This clinic sees a great deal of clients with trauma histories that, in addition are experience identity and alienation issues as Urban Indians. The additional significant challenge is that this clinic receives significantly less Indian Health Service funding to provide services to the many Urban AI/AN Indians that live in the area. Due to their location, this clinic has the capacity to also serve the many homeless AI/AN veterans in the area. Their current structure would not allow much of an increase in volume for mental health services.

- MHSA Workforce Education and Training (WET) funded programs such as UCSD Community and Child Psychiatry Residency to enhance residency experience by facilitating access to a **rural/public health rotation** in the Native American communities for psychiatry fellows.
  - The Consortium takes interns directly, not through the County.
  - Need to consider identifying providers that serve the Native American population that could be approached to see if they were interested in hosting interns and/or fellows.

    Dr. Melissa Deer, at San Diego American Indian Health Center is dual-board certified and would be willing to take on fellows/residents for psychiatry rotations. This is an administrative and policy question to pursue with SDAIHC.

    Many of the challenges with the Indian clinics is the issue of retaining the protection of sovereign immunity. Despite the benefit to the AI/AN communities served, the clinics regularly seek to avoid any indemnities/waivers of sovereign immunity as tribal politics often dictate practice at the clinics.

In these cases, the regulatory and other provider governing board legal/ethical guidelines are affected.

Mountain Health may be a potential desirable location to explore. Alvarado Parkway Institute may be sought out to support this project by providing Psychiatric Supervision for Interns and training opportunities at their inpatient and outpatient programs. Thereby increasing Native Americans access to care.

Additional challenges to serve the AI/AN population is related to identifying non-Indian interns to work with the AI/AN population. The challenges are of a cultural competence and trauma-informed care nature that can be overcome with appropriate training. The potential challenges that are typically cited can be overcome for the majority of potential clients.

We can also explore psychiatrists that may be interested in an opportunity to work with existing AI/AN providers/clinics in the various locations serving the AI/AN population. As such, an option would be to evaluate the feasibility of an Innovation project specifically to expand the public mental health reach of WET program resources into rural communities for psychiatry, therapy, case management and social services.

- Masters level programs Alliant International University, University of San Diego and San Diego State University (LCSW, MFT , MSW and PsyD programs) to **introduce the availability of rural/urban/public health internship opportunities** while increasing ease of access to affordable therapy and case management services that have traditionally been unavailable to this rural area of the county.
  - See recommendations above.

Recommendation #2: Continue the Cultural Competence Academy with a Native American cohort.

- Piedad to pursue funding for a Cultural Competence Native American Academy.
  - Piedad has pursued with Clinical Director's Office and BHETA to provide this training in FY 14-15.

**Submitted by Kristina Maxwell in collaboration with Dr. Leon Altamirano*

CYF Response

- The Indian Health Council-(IHC) Dream Weaver Consortium offers four different PEI programs provided by the Urban Youth Center, Indian Health Council, Southern Indian Health Council, and the Sycuan Medical/Dental Center. These providers offer prevention activities that promote community and cultural awareness. These activities include: traditional health gatherings, cultural programs, basket

weaving instruction (a local tradition for many tribes), nutrition programs, self-esteem workshops, positive parenting classes, exercise programs, and the promotion of overall increased medical and dental health. Additionally, the Urban Youth Center provides counseling services. All of these activities are intended to prevent the onset of serious mental health problems. Co-occurring Youth Counselor was trained to implement White Bison's 'Mending the Broken Hearts for Youth Healing Unresolved Grief and Intergenerational Trauma with youth.

- The IHC Youth Center provides youth with tours to local colleges and universities. Additionally, clients participate in College and career fairs
- IHC hosted a Sexual Trafficking and Commercial Sexual Exploitation of Children in Indian Country Summit on May 17, 2013. This event was the first of its kind out Indian Country in the US. Federal and local law enforcement as well as northern California and out of state presenters participated in this conference held at Pala reservation

FY14-15 Focus
AOA
1. Provide Native American Cohort of the CCA.
2. WET team to follow up on number of NA pre-med students in any Southern California medical universities. Explore feasibility to attract NA pre-med students via the WET program.
CYF
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2.

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LGBTQ Recommendations - Pending

Recommendation #1: Training

- Coordinate county funded training providers to ensure integrated approaches in content and advancement of practice
- Include LGBTQ in the 4 hours of culture competence
- Require training for all levels of staff including Administrators, QA, Support Staff and COTRs
- Provide training opportunities for system partners

Workgroup Lead Response

- The Cultural Competence Academy- LGBTQI was established in FY 14-15
- A one hour LGBT introductory webinar is available through BHETA
  - System partners have access to the webinar

Recommendations:

- Require all levels of County and program staff to complete the trainings.
  - This would include Administrators, QA, Support Staff and CORs
- Require to include LGBTQ training as one of the 4 hours of culture competence training options.

Recommendation #2: Learning Community

- Increase collaboration with the local San Diego LGBTQ Project
- Collaborate in training activities

Action: BHS has 2 LGBTQ contracts. AOA and Children's Services designees to identify increased learning opportunities and capacity building with these contractors.

Action: CCRT member added in FY 2012-2013. Consult with representatives as to opportunities to broaden BHS collaboration and partnership.

Recommendation #3: Practice

A. Culturally relevant LGBTQ services integrated between Alcohol/Drug, Mental Health, and Physical Health Providers
B. Anasazi- new forms have a section for sexual orientation and sexual identity

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C. Include LGBTQ culturally specific services in all levels of care (outpatient, day treatment, residential) and throughout all age groups Children, TAY, Adult/Older Adult
D. Incorporate LGBTQ training awareness/orientation for caretakers including foster parents including areas such as:
    - risk and Wellness and Recovery Plans
    - spirituality
    - identity
    - sexual orientation

Recommendation:

A. CORs to review and evaluate BHS programs/contracts for language integrating LGBTQ services. This can also be done through the Provider Manual
B. Ensure providers are proficient to address gender identity and/or gender preference issues through their own education, training, and transcendence of personal values. Provide training opportunites via organizational provider or via BHS training opportunities.
B. Increase assessment and treatment attention to risk factors and suicide. Can be achieved through High Risk evaluation.

<u>Additional Recommendations by Workgroup Lead</u>

2. Continue to track status of 2013- 2014 Recommendations
    - All areas are at least partially achieved; continue to work toward full achievement
    - Track the status
    - Establish outcome indicators

3. Incorporate Academy Participant Feedback *(see attachment)*
    - Review evaluations and projects from the Cultural Competence Academy, LGBTQI participants. This information will be useful to determine next steps for planning, understanding system impact, and setting forth priorities.
    - Review and integrate specific recommendations from Academy participants to improve the Children and Adult County Behavioral Health Assessments

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4. Health Outcomes Management System (HOMS)
   Currently some adult mental health providers are required to input data through the HOMS (Health Outcomes Management System). The Sexual Orientation/Gender Identity is not consistent with the County Behavioral Health Assessment. Recommend review and modification of forms as needed for consistency.
5. Ongoing Training
   The establishment of the Cultural Competence Academy for LGBTQI populations is a comprehensive design. If the Cultural Competence Academy for LGBTQI will not be sustained, it is recommended that an alternate plan be identified for ongoing trainings.

**Submitted by Rosa Ana Lozada*

FY14-15 Focus
AOA
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CYF
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Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's Full Service Partnership (FSP)	Counseling Cove	Locates and engages homeless and runaway youth for the purpose of increasing access to mental health services and family reunification. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services Counseling Cove 3427 4th Ave., 2nd floor San Diego, CA 92104 (619) 525-9903	1, 4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Child/Youth Case Management	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2130 National Ave. San Diego, CA 92113 (619) 515-2382 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-7520	1, 2, 3, 4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Counseling and Treatment Center - School Based Outpatient Children's Mental Health Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	1, 4, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Crossroads Family Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 1679 E. Main St., Suite 102 El Cajon, CA 92021 (619) 441-1907	2
CY-FSP	Children's School Based Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21, involved in Child Welfare Services and residing in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children FFAST 8825 Aero Dr., Suite 110 San Diego, CA 92123 (858) 633-4102	All

Community Services and Supports (CSS - CYF)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	Learning Assistance Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724	2, 3, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	Merit Academy	Day School Services provides individual, group and family services at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Mobile Adolescent Services Team (MAST)	Mental Health assessment and treatment services for students and their families at the Momentum Learning School sites, home, office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 attending a Momentum Learning School who meet medical necessity and serious emotional disturbance criteria and who may be involved with the juvenile justice system	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation 1202 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-3261	All
CY-FSP	Children's School Based Full Service Partnership (FSP)	Multi-Cultural Community Counseling - Full Service Partnership (FSP)	Culture specific Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	New MHSA FSP - Children's Mental Health - ALLY	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Prime Healthcare Paradise Valley LLC 2400 East 4th St. National City, CA 91950 (619) 470-4155	1
CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700	2
CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Lifeline	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	3, 5

Community Services and Supports (CSS - CYF)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Nueva Vista Family Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
CY-FSP	Children's School Based Full Service Partnership (FSP)	Palomar Family Counseling Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	2, 3, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familias	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 5 who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and Engagement	Episcopal Community Services Para Las Familias 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
CY-FSP	Children's School Based Full Service Partnership (FSP)	Pathways Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady Outpatient Psychiatry N.Inland	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 625 W. Citracado Pkwy., Suite 102 Escondido, CA 92025 (760) 294-9270	2, 3, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Outpatient Counseling Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 7339 El Cajon Blvd., Suite K La Mesa, CA 91942 (619) 668-6200	2
CY-FSP	Children's School Based Full Service Partnership (FSP)	School-Based Central-East- South	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471	1, 2, 4

Community Services and Supports (CSS - CYF)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	School-Based Outpatient Behavioral Health Services	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Social Advocates for Youth 4275 El Cajon Blvd., Suite 101 San Diego, CA 92105 (619) 283-9624	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	South Bay Community Services (Mi Escuelita)	Culture specific Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
CY-FSP	Children's School Based Full Service Partnership (FSP)	Youth Enhancement Services	Culture specific Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd., Suite E-101 San Diego, CA 92154 (619) 428-5533	1
CY-FSP	Children's School Based Full Service Partnership (FSP)	Mental Health Systems Inc.	Culture specific Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Culture specific Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 and their families who are underserved with a focus on Latino and Asian-Pacific Islanders	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4394 30th St. San Diego, CA 92104 (619) 543-9850	4
CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services	Intensive, individualized, one- to-one behavioral coaching program available to children/youth up to 21 years old who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children up to age 21 who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services	• One on one behavioral coaching	New Alternatives - TBS 2535 Kettner Blvd., Suite 1A4 San Diego, CA 92101 (619) 615-0701	All
CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	Wraparound	Wraparound offers team based intensive and individualized case management to a child or youth within the context of their support system, leveraging both formal and informal supports	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children and youth up to age 21 who are involved with Child Welfare Services or Probation	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	Fred Finch Wraparound 3434 Grove St. Lemon Grove, CA 91945 (619) 281-3706	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	WrapWorks	Wraparound offers team based intensive and individualized case management to a child or youth within the context of their support system, leveraging both formal and informal supports	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children and youth up to age 21 who are involved with Child Welfare Services or Probation	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 633-4100 North County 235 W. 5th Ave., Suite 130 Escondido, CA 92025 (760) 466-3984	All
CY-FSP /CY-OE	Children's School Based Full Service Partnership (FSP)	Douglas Young Youth and Family Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Douglas Young Youth and Family Services 7907 Ostrow St., Suite F San Diego, CA 92111 (858) 300-8282	3, 4
CY-FSP CY-OE	Children's School Based Full Service Partnership (FSP)	Rady OutPatient Psychiatry N.Coastal	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co- occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3142 Vista Way, Suite 205 Oceanside, CA 92056 (760) 758-1480	3, 5
CY-SD	Adolescent Day Rehabilitation	San Diego Center for Children Residential Outpatient Children's Mental Health Services	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills (ILS) services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders.	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills (ILS)	San Diego Center for Children 3003 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CY-SD	BHS Children, Youth and Families (CYF) Liaison	Family Youth Liaison (FYL)	The Family Youth Liaison collaborates with Children, Youth and Families (CYF) administrative staff to ensure family and youth voice and values are incorporated into service development, implementation plans, and service delivery	Advance, train, and coordinate family/youth partnership in CYF programs	Children and youth up to age 21 served by CYF providers and their families	• Coordinates administrative functions in which family/youth participate • Trains CYF programs management staff to work with support Family/Youth Partners • Develops and provides CYF system trainings and coaching sessions • MHSA Issue Resolution point of contact	NAMI San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6580	All
CY-SD	Breaking Cycles Graduated Sanctions Program	San Diego Youth Services - Breaking Cycles	Groups, case management and referrals for youth detained in two of the Department of Probation juvenile detention facilities who are at risk for or are victims of commercial sexual exploitation	Screening, identification, groups and referrals for services upon release of youth who are victims of or at risk for commercial sexual exploitation. Services are in collaboration with juvenile probation, child welfare services, and multi-disciplinary teams	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation	• Screening/identification • Group treatment • Care coordination • Case management • Consultation • Community stabilization	San Diego Youth Services Breaking Cycles 2901 Meadow Lark Dr. San Diego, CA 92123 (858) 492-2324	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	BridgeWays Program Services	BridgeWays Program Services	Individual/group/family services provided at office/clinic, home, school or other community locations. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families who are at risk of involvement or currently involved in the Juvenile Justice System	Children and youth up to age 21, who are at risk of involvement or currently involved in the Juvenile Justice System, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Substance use services	TBD	All
CY-SD	County of San Diego - Juvenile Forensic Services	Juvenile Forensics Services Stabilization Treatment and Transition	Individual/group/family treatment for youth in the Department of Probation juvenile detention facilities and transitional mental heath and case management services for those youth who meet criteria upon release	Ensure probation children and youth with mental illness have access to mental health services, with successful reintegration into the community and potential reduction in recidivism	Probation children and youth up to age 21 currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Individual/group/family treatment • Crisis intervention • Care coordination • Case management • Medication management • Community based mental health services	County of San Diego Juvenile Forensic Services 2901 Meadowlark Dr. San Diego, CA 92123 (858) 694-4680	All
CY-SD	County of San Diego - Probation	Probation After Hours (STAT Team)	Multi-disciplinary team provides transitional services as youth rejoin the community following incarceration	Ensure probation children and youth with mental illness have access to mental health services, with successful reintegration into the community and potential reduction in recidivism	Probation children and youth up to age 21currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Individual/group/family treatment • Crisis intervention • Care coordination • Case management • Medication management • Community based mental health services	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
CY-SD	Crisis Action and Connection	Crisis Action & Connection	Provides intensive support and linkage to services and community resources for children/youth who have had a recent psychiatric episode	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services	Children and youth up to age 21 who meet medical necessity and meet set criteria	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Crisis Action & Connection 730 Medical Center Crt. Chula Vista, CA 91911 (619) 591-5740	1
CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit (ESU)	Provides crisis stabilization to children and youth experiencing a psychiatric emergency	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth up to age 18 who are experiencing a psychiatric emergency	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502	All
CY-SD	Incredible Families	Incredible Families	Outpatient mental health treatment and support services for children and families involved in Child Welfare Services	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Families and their children 2-14 years old who are dependents of Juvenile Dependency Court due to abuse and/or neglect	• Weekly multi-family parent and child visitation event and meal for all family members • Utilization of the Incredible Years evidence-based curriculum • A primary therapist is assigned to each family • Clinical support during family visitation events, as well as, during individual and family therapy	Vista Hill Foundation East/South Incredible Families Program 4990 Williams Ave. La Mesa, CA 91942 (619) 668-4263 Central/North Central Incredible Families Central 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5160	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Incredible Years	Childnet Seriously Emotionally Disturbed	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management and family partner support	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children through five years old, and their families, using Incredible Years evidence-based program which includes parent training, teacher training and child treatment within school based programming	Children through age 5 who meet medical necessity and serious emotional disturbance criteria, and their families	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	2, 3, 5
CY-SD	Medication Support for Wards and Dependents	Vista Hill - Juvenile Court Clinic	Provides short term (no more than three months) individual/family treatment, psychotropic medication and linkage to community-based provider for on-going treatment to children and youth who may be involved in the juvenile justice or child welfare systems	Assist the youth and family with stabilization, support, linkage and coordination to community provider for ongoing mental health services if needed	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria and who are in the juvenile justice or child welfare systems	• Individual/family treatment • Care coordination • Case management • Rehabilitative services • Medication services	Vista Hill Juvenile Court Clinic 2851 Meadow Lark Dr. San Diego, CA 92123 (858) 571-1964	All
CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	San Diego Youth Services - Our Safe Place	Individual/group/family services provided at schools, home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Supportive services at 4 drop-in centers	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth who identify as LGBTQ and their families	LGBTQ Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria. Any LGBTQ youth who would benefit from supportive services at the drop-in centers	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • GED preparation • Support groups • Youth Partners • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. San Diego, CA 92103 (619) 525-9903	All
CY-SD	Multi-Systems Therapy (MST)	San Diego Unified School District - Multi-Systemic Therapy (MST) / Assertive Community Treatment (ACT)	Offers Multi-Systemic Therapy and Assertive Community Treatment services to children who are at risk of entering the juvenile justice system and are referred by the Department of Probation	Reduce recidivism, prevent youth from entering into the juvenile justice system, and maximize their success in the community	Children and youth up to the age 21 referred by the department of probation who meet medical necessity and serious emotional disturbance criteria	• Individual/family treatment • Care coordination • Case management • Rehabilitative services • Medication services	San Diego Unified School District 4166 Euclid Ave. San Diego, CA 92105 (619) 344-5636	4
CY-SD	Peer Mentoring	San Pasqual Academy Children's Mental Health Services	Individual/group/family services to children and youth in an academy setting to support self- sufficiency. Provides peer mentorship services to Child Welfare Services youth in placement to foster adolescent growth towards independence and self sufficiency	Support adolescent growth towards independence and self sufficiency for youth preparing to exit the foster care system	Children and youth at San Pasqual Academy ages 12-21 years old who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills (ILS)	New Alternatives Inc. San Pasqual Academy 17701 San Pasqual Valley Rd. Escondido, CA 92025 (760) 233-6005	All
CY-SD	Placement Stabilization Services	CASS	Provides mental health services to children and youth who are placed through Child Welfare Services in various foster home placements. Services available by referral from Child Welfare Services	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families	Foster children and youth up to age 18 who meet medical necessity and serious emotional disturbance criteria who are at risk of changing placement to a higher level of care	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 3517 Camino Del Rio South, Suite 599 San Diego, CA 92108 (858) 357-6239	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Placement Stabilization Services	Polinsky	Provides mental health assessment and treatment services to children and youth for a short term assessment period while at Polinsky Children's Center. Collaboration with Child Welfare Services for transition plan to enhance permanency and stability	Return children and youth to their family or family-like setting, support permanency and link children, youth and families to support services when indicated	Children and youth up to age 18 who meet medical necessity and serious emotional disturbance criteria brought to Polinsky Children's Center by Child Welfare for a short assessment period	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 9400 Ruffin Ct. San Diego, CA 92123 (858) 357-6879	All
CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health & Primary Care Services	Paraprofessionals within rural community clinics provide behavioral health education to prevent development of serious mental illness or addiction. Help patients manage health, emotional, and behavioral concerns	Prevention and early intervention	Children, Transition Age Youth, Adults/Older Adults	• Rural integrated behavioral health and primary care services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5400	2, 5
CY-SD	Walk-In Assessment Clinic and Mobile Assessment Team	Behavioral Crisis Center and Mobile Assessment Team Services	Provides mobile crisis mental health services in conjunction with walk-in assessment clinics for the North County region	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth who are experiencing a mental health crisis or urgent need for mental health services	• Crisis response • Assessment • Information • Referral • Medication management • Linkage to hospital when required • Follow-up visits	New Alternatives, Inc. North County Crisis Intervention and Response Team 225 West Valley Pkwy., Suite 100 Escondido, CA 92025 (760) 233-0133 1020 S. Santa Fe Ave. Suite B-1 Vista, CA 92084	5
CY-OE	Children's Full Service Partnership (FSP)	Family/Youth Support Partnership Services	Outreach and Engagement mental health services to Latino, Asian, and African American children, youth and their families	Outreach and Engagement services for children, youth, up to age 21, and their families	Latino, Asian, and African American children and youth up to age 21	• Outreach and Engagement • Family Support Partners • Case management • Focus groups • Support and Education Groups • Community Presentations	Harmonium Inc. 5275 Market St., Suite E San Diego, CA 92114 (619) 857-6799	4
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (N. Inland)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	5
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (N. Central)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	4
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (East)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	2
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (South)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	1

Community Services and Supports (CSS - CYF)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (Central)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	4
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (Central)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services.	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	Healthrite 360 1563 Mission St. San Francisco, CA 94103 (415) 762-3700	3

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Adult Residential Treatment	Changing Options	Residential facility for adults with serious mental disorders	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach	Adults 18 years and older with disabling psychiatric disorder requiring a 24-hour Mental Health Rehabilitation Center	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All
TAOA-FSP	Assisted Outpatient Treatment (AOT)	Assisted Outpatient Treatment (AOT)	Intensive community-based services for persons who establish an Assisted Outpatient Treatment court settlement agreement, persons who are court-ordered, persons who otherwise meet the eligibility criteria and voluntarily accept alternative services prior to an Assisted Outpatient Treatment petition being filed	Integrate behavioral health and rehabilitation treatment and recovery services for adults with a serious mental illness and have been identified as potential candidates by the In-Home Assessment Team, have agreed to an Assisted Outpatient Treatment court settlement, or have Assisted Outpatient Treatment status resulting from a contested court hearing	Adults 18 years and older meeting Title 9 criteria as established under Laura's Law	• Assertive Community Treatment with a rehabilitation and recovery focus	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840	All
TAOA-FSP	Behavioral Health Court	Collaborative Behavioral Health Court	Uses the Assertive Community Treatment model to enhance the lives of individuals experiencing a serious mental illness and co-occurring conditions through case management and mental health services	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system	Underserved adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176	4
TAOA-FSP	County of San Diego - Probation	Probation Officer for BH Court	Probation Office for Behavioral Health Court	Stabilization and linkage to services	Transition Age Youth, Adults/Older Adults	• Transition services	County of San Diego	All
TAOA-FSP	County of San Diego - Institutional Case Management	Institutional Case Management	Provides 5 Full Time Equivalent positions of Institutional Case Management	Stabilization and linkage to services	Children, Transition Age Youth, Adults/Older Adults	• Case Management	County of San Diego	All
TAOA-FSP	County of San Diego Probation	Probation-FSP-ACT Team	Interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts	Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	Transition Age Youth and Adults who have a serious mental illness	• Mental health assessments • Interventions • Case management • Outreach and engagement	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
TAOA-FSP	Crisis Residential Services - North Inland	Esperanza Crisis Center	Twenty-four hours a day, seven days a week service provided as an alternative to hospitalization or step down from acute inpatient care within a hospital for adults with acute symptoms of serious mental illness, including those who may have a co-occurring substance use disorder	Provide alternative to hospital or acute inpatient care	Voluntary adults 18 years and older with acute and serious mental illness, including those who may have a co-occurring substance use disorder	• Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation 337 West Mission Ave. Escondido, CA 92025 (760) 975-9939	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Star ACT SBCM	Full Service Partnership / Assertive Community Treatment with supportive housing and Strengths-Based Case Management. Project-One-For-All (POFA) 100 Central/North Central Housing	Reduce homelessness and provide comprehensive ACT 'wraparound' mental health services for adults with most severe illness, most in need due to severe functional impairments, and who have not been adequately served by the current system	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless. Adults 18-59 years old who are eligible for Medi-Cal funded services or are indigent	• Strengths-based case management • Rehabilitation and mental health services with a focus on adults who meet eligibility criteria • Full Service Partnership - Assertive Community Treatment Team services in the North County • Supportive housing component	MHS, Inc. Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	All

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION Central	The 100 Homeless Project is a collaborative effort between the County of San Diego and San Diego Housing Commission which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Integrate wrap-around services with accessible housing that supports the homeless population	Homeless Transition Age Youth, Adults/Older Adults who have a serious mental illness and may have a co-occurring diagnosis of substance use disorder	• Medication management and monitoring • Individual therapy • Outpatient substance use disorder treatment • Intensive case management; Employment support • Peer counseling • Supportive housing component	ACTION Central 6244 El Cajon Blvd., Suites 15-18 San Diego, CA 92115 (858) 380-4676	1
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Star - Strengths Based Case Management (SBCM)	Full Service Partnership Strengths-Based Case Management	Recovery-oriented strength-based clinical case management services to persons with serious mental illness	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless.	• Strengths based case management	MHS, Inc. Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION East	Services for homeless persons with serious mental illness or substance use disorder	Planned hybrid model will integrate Assertive Community Treatment intensive case management services with substance use disorder treatment and recovery services	Homeless Transition Age Youth, Adults/Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	• Mental health rehabilitation • Treatment and recovery services for clients with substance use disorder • Integrated case management services with substance use disorder treatment and recovery services • Supportive housing component	ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868	2
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	IMPACT/ Downtown IMPACT	Fully integrated services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or at-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults 18 years and older who have a serious mental illness and have been homeless, who may be high users of acute inpatient care and medical services and who have resided in the urban downtown area of the City of San Diego	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation IMPACT 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-0355 Downtown IMPACT 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156 Community Research Foundation 490 N. Grape St.	1, 4
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA - South Region (100 SMI Slots) Housing	Full Service Partnership Assertive Community Treatment team and recovery services Program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the South Region of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Supportive Housing	Community Research Foundation 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 398-0355	1
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA - 100 City Star	Full Service Partnership Assertive Community Treatment team and recovery services program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the Central and North Central Regions of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Supportive Housing	Mental Health Systems Inc. 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Catalyst	Transition Age Youth Assertive Community Treatment Full Service Partnership. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a participant-to-staff ratio that is approximately 10-12:1	Provide Assertive Community Treatment Team intensive, multidisciplinary, wraparound treatment and rehabilitation services for Transitional Age Youth who have a serious mental illness, may be on LPS Conservatorship, and have needs that cannot be adequately met through a lower level of care.	Transition Age Youth with a serious emotional disturbance or serious mental illness (who may have a co-occurring mental illness and substance use disorder) that have been homeless or may be at risk of being homeless	• Assertive Community Treatment (ACT) mental health services for transition age youth • Includes housing component	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Center Star ACT	24-hour community-based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults 25 to 59 years old who have a serious mental illness and adults 18 years and older who may have been homeless	• Clinical case management • Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Gateway to Recovery	Provides an Assertive Community Treatment, Full Service Partnership program for persons 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Probation-funded Assertive Community Treatment component • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Start ACT	Provides an Assertive Community Treatment, Full Service Partnership program for persons 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	MHS, Inc. Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Pathways to Recovery	Assertive Community Treatment and In-Reach for adults in and discharged from long-term care	Services are designed using the Assertive Community Treatment model and provided by a multi-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialists, vocational specialists, housing specialists, nurses, physician's assistants, medical doctors, and substance use disorder specialists	Adults 18 to 59 years old with serious mental illness and are, or recently have been, in a long-term care institutional setting	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a serious mental illness and needs that cannot be adequately met through a lower level of care • Includes an in-reach component for some persons served by the county institutional case management program • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Senior IMPACT	Offers intensive, comprehensive, community- based integrated behavioral health services	Increase timely access to services and supports to assist Older Adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes	Adults 60 years and older who are homeless or at risk of homelessness and have serious mental illness	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Senior IMPACT 928 Broadway San Diego, CA 92102 (619) 977-3716	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	TBD	Full Service Partnership/Assertive Community Treatment - Justice Integrated Services	Provide Assertive Community Treatment Services to persons with serious mental illness, who may have a substance use disorder, are homeless or at risk of homelessness, who are justice involved and are eligible for probation and not supervised by AB109 or parole and are in detention and referred by the Public Defender and Sheriff	Adults 18 years and older who have serious mental illness, whose needs cannot be addressed through a lower level of care, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services • Includes housing component • Staff trained on working with the justice involved population	TBD	All

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	TBD	Full Service Partnership/Assertive Community Treatment - Justice Integrated Services	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from an acute setting (Behavioral Health unit)	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment Services • Includes housing component	TBD	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	TBD	Full Service Partnership/Assertive Community Treatment - Justice Integrated Services	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from long term care (IMD, Skilled Nursing Facility, State Hospital)	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment Services • Includes housing component	TBD	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Casa Pacifica	Transitional residential program serves abused and neglected children and adolescents, and those with severe emotional, social, behavioral, and mental health challenges	Increase independent living and reduce hospitalizations through educational and employment opportunities	Adults/Older Adults who are homeless with a serious mental illness	• Medication support • Case management/Brokerage • Crisis intervention • Rehabilitative and recovery interventions in a transitional residential setting	Casa Pacifica 321 Cassidy St. Oceanside, CA 92054 (760) 721-2171	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Uptown Safe Haven	Residential transitional housing program that provides supportive services for those who are homeless and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services	Adults/Older Adults who are homeless with a serious mental illness	• Temporary housing for eligible individuals • Provide food • Linkage to transitional housing • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 (619) 294-7013	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	TBD	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	TBD	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	TBD	TBD	
TAOA-FSP/SD	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) Institutional Case Management (ICM)	Telecare Agewise	Strengths-Based Case Management, Full Service Partnership program for Older Adults in addition to having an Institutional case management component	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services plus assist clients in long term care to graduate and be placed in the community	Adults 60 years and older with a serious mental illness who may be on LPS Conservatorship or who have needs that cannot be adequately met by a lower level of care	• Care coordination and rehabilitation • Field-based services have a participant-to- staff ratio that is approximately 25:1. • Case management for adults 60 years and older who are on Public Conservatorship and reside in a skilled nursing facility or other County- identified long-term care institution	Telecare Corporation Telecare Agewise 6160 Mission Gorge Rd., Suite 108 San Diego, CA 92120 (619) 481-5200	All
TAOA-FSP	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Clinic and Vista BPSR Clinic	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase mental health services for Transition Age Youth. Decrease incidence of homelessness. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth emphasis	• Outpatient mental health clinic • Treatment, rehabilitation, and recovery services	MHS North Coastal Mental Health Center 3209 Ocean Ranch (TEMP SITE) Oceanside, CA 92058 (760) 967-4483 MHS BPSR Vista 550 West Vista Way, Suite 407 Vista, CA 92083 (760) 758-1092	5
TAOA-FSP	Payee Case Management Services	Rep Payee	Payee case management services	Key component of the program is increasing clients' money management skills	Adults 18 years and older	• Payee Case Management with a rehabilitation and recovery focus to adults who meet eligibility criteria • Increasing clients' money management skill • Bio-Psycho-Social Rehabilitation (BPSR) principles, shall be evident and operationalized in Contractor's policies, program design and practice	NAMI San Diego Adult Outpatient 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Transition Team	Provides Short-term Intensive Transition Team to serve individuals 18 years and older who are or have recently been hospitalized	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 years and older	• Short-term Intensive Transition Team to serve individuals 18 years and older who are or have recently been hospitalized	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Strengths Based Case Management (SBCM)	Maria Sardiñas Center	South Region (Southern Area) Strengths-Based Case Management	Provide strengths-based case management services	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth population and Probation- funded AB109 component	• Outpatient mental health clinic • Strengths- based case management	Maria Sardiñas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
TAOA-FSP/SD	Strengths Based Case Management (SBCM) Bio-Psychosocial Rehabilitation (BPSR)	South Bay Guidance Wellness and Recovery Center	South Region (Northern Area) strengths-based case management	Provides strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	South Bay Guidance Wellness and Recovery Center 835 3rd Ave., Suite C Chula Vista, CA 91911 (619) 429-1937	1
TAOA-SD	Augmented Services Program (ASP)	Carroll's Community Care	Augmented Services Program	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Carroll's Community Care 523 Emerald Ave. El Cajon, CA 92020 (619) 442-8893	2
TAOA-SD	Augmented Services Program (ASP)	Carroll's Residential Care	Augmented Services Program	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Older Adults who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Carroll's Residential Care 655 S. Mollison St. El Cajon, CA 92020 (619) 444-3181	2
TAOA-SD	Augmented Services Program (ASP)	Country Club Guest Home	Augmented Services Program	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Country Club Guest Home 25533 Rua Michelle Escondido, CA 92026 (760) 747-0957	3
TAOA-SD	Augmented Services Program (ASP)	Fancor Guest Home	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Fancor Guest Home 631-651 Taft Ave. El Cajon, CA 92020 (619) 588-1761	2
TAOA-SD	Augmented Services Program (ASP)	Friendly Home II	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Liliosa D. Vibal Friendly Home II 504 Ritchey St. San Diego, CA 92114 (619) 263-2127	1, 4
TAOA-SD	Augmented Services Program (ASP)	Friendly Home of Mission Hills	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Liliosa D. Vibal Friendly Home of Mission Hills 3025 Reynard Way San Diego, CA 92103 (619) 297-1841	4

Community Services and Supports (TAOA)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Augmented Services Program (ASP)	Luhman Center for Supportive Living	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Volunteers of America 3530 Camino Del Rio N., Suite 300 San Diego. CA 92108 (619) 282-8211	All
TAOA-SD	Augmented Services Program (ASP)	Mark Alane Inc. Chipper's Chalet	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Chipper's Chalet Augmented Services Program 835 25th St. San Diego, CA 92102 (619) 234-5465	4
TAOA-SD	Augmented Services Program (ASP)	Mark Alane, Inc. The Broadway Home	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	1, 4
TAOA-SD	Augmented Services Program (ASP)	Nelson-Haven	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Nelson-Haven Board and Care 1268 22nd St. San Diego, CA 92102 (619) 233-0525	1, 4
TAOA-SD	Augmented Services Program (ASP)	Orlando Residential Care	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Orlando Guest Home LLC 297-299 Orlando St. El Cajon, CA 92021 (619) 444-9411	2
TAOA-SD	Augmented Services Program (ASP)	Troy Center for Supportive Living	Augmented Services Program	Maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Volunteers of America Troy Center for Supportive Living 8627 Troy St. Spring Valley, CA 91977 (619) 465-8792	2
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Areta Crowell Clinic	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older who have a serious mental illness living in San Diego County	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder • Services provided at a Bio-Psychosocial Rehabilitation Wellness Recovery center with Supported Housing	Areta Crowell BPSR Program 1963 4th Ave. San Diego, CA 92101 (619) 233-3432 ext. 1308	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Community Wellness Center	Certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older who have a serious mental illness living in San Diego County	• Outpatient mental health clinic providing Medi-Cal certified treatment, rehabilitation, and recovery services to adults 18 years and older, living in San Diego County who have serious mental illness, including those who may have a co-occurring substance use disorder • This clinic offers walk in service during their normal hours of operation	New Leaf Recovery Center 3539 College Ave. San Diego, CA 92115 (619) 818-1013	4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Douglas Young BPSR Ctr.	North Central Region Adults/Older Adults Bio-Psychosocial Rehabilitation Wellness Recovery Center	Increase the number of Transition Age Youth with serious mental illness receiving integrated, culturally specific mental health services countywide	Adults/Older Adults who have a serious mental illness, including those with co-occurring substance use disorder, and Medi-Cal eligible or indigent	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support for clients 18 years and older with serious mental illness, including those who may have a co-occurring substance use disorder	CRF - Douglas Young 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Heartland Center	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery services	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	East Region CRF Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Wellness & Recovery Center	Walk-in Services - Assessment Center	Provide one time, short-term mental health evaluation, psychiatric consultation, and linkage in the community to assist clients on their path to recovery	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder	• Walk-In access and assessment • Treatment, rehabilitation, and recovery services	Jane Westin Wellness & Recovery Center (CRF) 1568 6th Ave. San Diego, CA 92101 (619) 235-2600 ext. 201	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Logan Heights Family Counseling	Provides outpatient, case management, brokerage and vocational support services	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults/Older Adults individuals who have serious mental illness/co-occurring disorder and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation wellness recovery center • Outpatient treatment, case management/brokerage, and peer support • Rehabilitative, recovery and vocational services and supports	Family Health Centers Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2355	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Project Enable Outpatient Program	Provides a Short-Doyle Medi-Cal certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Provide outpatient mental health rehabilitation, recovery services, an urgent walk-in component, and case management brokerage. Transitions Transition Age Youth and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other Transition Age Youth providers	Transition Age Youth, Adults and Older Adults with a serious mental illness, including those who may have a co-occurring substance use disorder; Adults/Older Adults who are low income or Medi-Cal eligible	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage • Transitions Transition Age Youth and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other providers	NHA Project Enable 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
TAOA-SD	Client Liaison Services	Liaison Services	Client liaison services aims to increase client participation and involvement in the Behavioral Health Services Adult and Older Adult System of Care through peer advocacy	Develop and coordinate increasing client involvement and partnership in the development of policies, practices and programs to ensure client needs are accommodated	Adults 18 years and older who have a serious mental illness and receive services through Behavioral Health Services	• Peer advocacy • Engagement and education	Recovery Innovations, Inc. 2701 North 16th St. Phoenix, AZ 85006 (602) 650-1212	All
TAOA-SD	Client Operated Peer Support Services	Client Operated Peer Support Services	Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to relevant support agencies	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults 18 years and older who have a serious mental illness living in San Diego County	• Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to relevant support agencies • Skill development classes to adults with serious mental illness	Recovery Innovations, Inc. 2701 North 16th St. Phoenix, AZ 85006 (602) 636-4400	All
TAOA-SD	Clubhouse	Casa Del Sol Clubhouse	South Region (Southern Area) Clubhouse	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	CRF South Bay Casa del Sol Clubhouse 1157 30th St. San Diego, CA 92154 (619) 429-1937	1

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Clubhouse	East Corner Clubhouse	East Region member-operated clubhouse	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Community Research Foundation East Corner Clubhouse 1060 Estes St. El Cajon, CA 92020 (619) 631-0441	2
TAOA-SD	Clubhouse	Episcopal Community Services Friend to Friend (F2F) Clubhouse Central	Provides a street outreach and site-based program to engage homeless adults with serious mental illness, including Veterans, who may also have co-occurring substance use disorder	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Homeless Adults/Older Adults who have a serious mental illness	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services • Services are in Central Region with an emphasis in downtown San Diego	Episcopal Community Services Homeless Services Program 2144 El Cajon Blvd. San Diego, CA 92104 (619) 228-2800	4
TAOA-SD	Clubhouse	Escondido Clubhouse	Clubhouse services in the North Inland Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Inland Region Mental Health Systems, Inc. 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125	3
TAOA-SD	Clubhouse	Mariposa Clubhouse	Clubhouse services in the North Coastal Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Coastal Region Mental Health Systems, Inc. 2964 Oceanside Blvd., Units E-G Oceanside, CA 92054 (760) 439-2785	5
TAOA-SD	Clubhouse	Neighborhood House Association Friendship Clubhouse	Serial Inebriate Program (SIP) Non-residential substance use disorder treatment and recovery services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults 18 years and older who have a serious mental illness and who are eligible for Medi- Cal funded services or are indigent, including those with co-occurring substance use disorders	• Provides rehabilitation services to adults/older adults who are low income or Medi-Cal eligible and are diagnosed with a serious mental illness and/or may have a co-occurring substance use disorder • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Neighborhood House Association 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
TAOA-SD	Clubhouse	Oasis Clubhouse	Transition Age Youth Member Operated Clubhouse	Member-driven center that assists to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Transition Age Youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	• Provides clubhouse services to transitional-age youth 16 to 25 years old diagnosed with a serious mental illness and/or have a co-occurring substance use disorder	Pathways Community Services 3330 Market St., Suite C San Diego, CA 92102. (858) 300-0460	All
TAOA-SD	Clubhouse	The Corner Clubhouse (Areta Crowell)	Member-operated clubhouse program in the Central Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	The Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4
TAOA-SD	Clubhouse	The Meeting Place & Warm Line	Mental Health Clubhouse-Supplemental Social Security Income Advocate and Peer Support Line. The program offers a non-crisis phone service seven hours a day, seven days a week that is run by adults for adults who are in recovery from mental illness	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills. The aim of the program is for the support line to be an essential support service for persons recovering from mental illness	Underserved Adults/Older Adults 18 years and older with a serious mental illness including those who may have a co-occurring substance use disorder	• Provides rehabilitative, recovery, health and vocational services and supports to the target population	The Meeting Place 2553 & 2555 State St., Suite 101 San Diego, CA 92103 (619) 294-9582	4
TAOA-SD	Clubhouse	Visions Clubhouse	South Region (Northern Area) Clubhouse	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder and reside in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Association Visions Clubhouse 226 Church Ave. Chula Vista, CA 91911 (619) 420-8603	1

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Clubhouse - BPSR	BPSR Center (Mid City) BPSR Center (Serra Mesa) EAST WIND	Provides outpatient, case management brokerage, clubhouse and vocational support services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Monolingual and/or limited English proficient Asian/Pacific Islander adults who have a serious mental illness	• Case management • Mobile outreach • Long-term vocational services, outpatient mental health rehabilitation; recovery services	UPAC BPSR Mid City 5348 University Ave., Suites 101 &120 San Diego, CA 92105 (619) 229-2999 UPAC BPSR Serra Mesa 8745 Aero Dr., Suite 330 San Diego, CA 92123 (858) 268-4933	1, 4
TAOA-SD	Crisis Residential Services - North Coastal	Crisis Stabilization Unit	Provides a 24-hour, seven days a week hospital-based Crisis Stabilization Unit in the North Inland Region for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Impact unnecessary and lengthy involuntary inpatient treatment, as well as to promote care in voluntary recovery oriented treatment settings	Voluntary and involuntary adults with a serious mental illness	• Provide a twenty-four hour, seven days a week hospital-based Crisis Stabilization Unit (CSU) in the North Inland Region for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder induced problems	Palomar Health 555 E. Valley Pkwy. Escondido, CA 92025 (760) 739-3000	3, 5
TAOA-SD	Crisis Residential Services - North Inland	Crisis Stabilization Unit	Provides a 24-hour, seven days a week hospital-based Crisis Stabilization Unit in the North Coastal Region for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Impact unnecessary and lengthy involuntary inpatient treatment, as well as to promote care in voluntary recovery oriented treatment settings	Voluntary and involuntary adults with serious mental illness	• Provide a twenty-four (24) hour, seven (7) days a week hospital-based Crisis Stabilization Unit (CSU) in the North Coastal Region for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder induced problems	Tri-City Medical Center 4002 Vista Way Oceanside, CA 92056 (760) 724-8411	3, 5
TAOA-SD	Family Mental Health Education & Support	Family Mental Health Education & Support	Provides a series of educational classes presented by family members using an established family education curriculum to provide education and support for persons who have relatives (or close friends) with mental illness	Promote integration of family education services. Increase family involvement, coping skills and improve supportive relationships	Family members and friends of persons who have a serious mental illness	• Provides a series of educational classes presented primarily by family members of persons with serious mental illness using an established family education curriculum to provide education and support for persons who have relatives or close family friends with mental illness • Increase family member's coping skills and support increased involvement and partnership with the mental health system	NAMI San Diego Family Education Services 5095 Murphy Canyon Rd., Suite 125 San Diego, CA 92123 (619) 398-9851	All
TAOA-SD	Home Finder	Homefinder	Housing support for BHS adult clinics	Identify and secure safe and affordable housing	Adults 18 years and older who are enrolled in BHS programs with serious mental illness who are homeless or at risk	• Support identifying and securing safe and affordable housing (both single and shared occupancy). • Create and update a centralized hub for housing resources and roommate matching services • Provides flex funds to support resident retention. • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project for the Homeless 3860 Calle Fortunada San Diego, CA 92113 (619) 542-1877	1, 4
TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT Central/East/ South	Mobile In-Home Outreach Teams in the South Regions	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment	• In Home Mobile Outreach for Adults/Older Adults with a serious mental illness	Telecare Corporation - IHOT 1080 Marina Village Pkwy., Suite 100 Alameda, CA 94501 (619) 961-2120	1, 2, 4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT - North Inland, North Central	Mobile In-Home Outreach Teams Outreach and Linkage North Coastal, North Inland, North Central	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment	• In Home Mobile Outreach for Adults/Older Adults with a serious mental illness	Mental Health Systems - IHOT North Coastal, North Inland, North Central 365 Rancho Santa Fe Rd., Suite 100 San Marcos, CA 92078 (760) 591-0100	5
TAOA- SD	In-Home Outreach Teams (IHOT)	UCSD IHOT and AOT Service Evaluation	Conduct outcome and program evaluation of In-Home Outreach Teams and Assisted Outpatient Treatment services by: 1) Conducting client, family and staff focus groups 2) Evaluating program and outcome data 3) Preparing and submitting reports of findings and recommendations	Provide outcome and program evaluations of In-Home Outreach Teams and Assisted Outpatient Treatment services	Clients of the IHOT and AOT programs	• Data analysis/ evaluation of serviced provided by In Home Outreach Teams and Assisted Outpatient Treatment	Regents of the University of California 9500 Gilman Dr. La Jolla, CA 92093 (619) 619-471 ext. 9396	All
TAOA-SD	Inpatient and Residential Advocacy Services	Patient Advocacy Services	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities	Provide on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities. Expands services for County-Appointed Patient Advocate	Children, Transition Age Youth, Adults/Older Adults	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24-hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
TAOA-SD	Justice System Discharge Planning	Project In-Reach (AKA Project Enable)	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and community aftercare	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	NHA Project In-Reach 286 Euclid Ave., Suite 102 San Diego, CA 92114 (619) 266-9400	All
TAOA-SD	Mental Health Advocacy Services	CCHEA	Mental Health Advocacy Services	Improved access to services	Eligible clients of Consumer Center for Health Education and Advocacy	* Mental Health Advocacy	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3258	All
TAOA-SD	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Serial Inebriate Program (SIP)	Mental Health Systems, Inc. Serial Inebriate Program (SIP)	Serial Inebriate Program Non-residential substance use disorder treatment and recovery services	Support integrated treatment of chronic serial inebriants. Stabilization, recovery and reducing stigma associated with mental health concerns and provides additional support or referrals	Adults/Older Adults who may have a co-occurring mental health disorder and chronic inebriants referred by SDPD SIP Liaison Officer; working with Homeless Outreach Team	• Non-residential substance use disorder treatment and recovery service center focus of court sentenced chronic public inebriates as an alternative to custody • Individual and group counseling, case management, housing and linkages to other relevant services	MHS SIP Program 3340 Kemper St. San Diego, CA 92118 (619) 523-8121	4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Center	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	MHS North Inland Mental Health Center 125 W. Mission Ave. Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Ave. Escondido, CA 92025 (760) 480-2255 Kinesis North WRC- Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 MHS-WRC with MHSA and Satellite North Inland 474 West Vermont Ave., Suite 101 Escondido, CA 92025 (760) 480-2255	3
TAOA-SD	Public Defender - Behavioral Health Assessor	Public Defender Discharge	Licensed mental health clinicians will provide discharge planning, care coordination, referral and linkage, and short term case management to persons with a serious mental illness who have been referred by the Court for services	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care	Adults 18 years and older with a serious mental illness who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B St., Ste 1100 San Diego, CA 92101	All
TAOA-SD	San Diego Employment Solutions	San Diego Employment Solutions	Supported employment services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness	Increase competitive employment of adults 18 and older who have a serious mental illness and who want to become competitively employed	Adults 18 years and older who have a serious mental illness and need assistance with employment	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment • Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	Mental Health Systems, Inc. Employment Solutions 10981 San Diego Mission Rd. # 100 San Diego, CA 92108 (619) 521-9569	4
TAOA-SD	San Diego Housing Commission	TBD	New Housing Coordinators for San Diego Housing Commission (Access to 100 Vouchers)	Provide housing	Adults 18 years and older who have a serious mental illness	• Housing Vouchers	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	4
TAOA-SD	Short Term Acute Residential Treatment (START)	START Vista Balboa, New Vistas, Halcyon, Crisis Center, Turning Point, Jary Barreto, Isis Crisis Center	Mental Health Short Term Acute Residential Treatment (START)	Provide urgent services in North Coastal, Central, East and South Regions of San Diego to meet the community-identified needs	Voluntary adults 18 years and older who may have a serious mental illness and who may have a co-occurring substance use disorder that are experiencing a mental health crisis, in need of intensive, non-hospital intervention	• 24-hour, 7-day a week, 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use disorders, and are residents of San Diego County	CRF Vista Balboa (619) 233-4399 CRF New Vistas Crisis Center (619) 239-4663 CRF Halcyon Crisis Center (619) 579-8685 CRF Turning Point (760) 439-2800 CRF Jary Barreto Crisis Center (619) 232-7048 CRF Isis Crisis Center (619)-575-4687	All
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Supplemental housing for Transitional Age Youth in an independent living environment	The provision of housing and support services to homeless mentally ill Transition Age Youth by providing accessible short-term and transitional beds for identified clients	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring mental illness	• Emergency shelter and transitional beds * Case Management	Urban Street Angels, Inc. 3090 Polk Ave. San Diego, CA 92104 (619) 415-6616 Shelter Sites: 5308 Churchward St. San Diego, CA 92114 (male house) 4634 Bancroft St. San Diego, CA 92116 (female house)	4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Interfaith Community Services	Emergency shelter services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380	4
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Ruby's House Independent Living	Emergency shelter services for mentally ill adults (Females)	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Provide shelter and food in a residential setting that has staff available during all operating hours • Provide safe and sanitary quarters on a nightly basis and in a location acceptable to the County • Coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	2
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	The Broadway Home	Emergency shelter services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	4
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	United Homes	Emergency Shelter Services for Adults with serious mental illness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic level of care	United Homes-Emergency Shelter Beds 336 South Horne St. Oceanside, CA 92054 (760) 612-5980	5
TAOA-SD	Telemedicine	Exodus Recovery, Inc.	Telepsych Hub Telemedicine Expansion - On Demand	Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology	Exodus Clients	• Telehealth prescriber services	Exodus Recovery, Inc. 2950 El Cajon Blvd. San Diego, CA 92104 (619) 528-1752	All
TAOA-SD	Tenant Support Services	TBD	Project One for All (POFA) Outpatient Hub for 357 Clients (Tenant Peer Support Services)	TBD	TBD	TBD	TBD	4
TAOA-SD	Walk-In Assessment Center	Exodus Recovery, Inc.	Walk-in services assessment center	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder	• Walk-In treatment center • Rehabilitation and recovery services	North County Walk In Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 871-2020 Vista Walk In Assessment Center 524 & 500 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5
TAOA-SD/CY-SD	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3258	All

Community Services and Supports (TAOA)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Substance Use Disorder Recovery Center	Non-residential substance use disorder treatment and recovery for adults and Transition Age Youth	Support integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals according to needed	Adults 18 years and older who are Asian and Pacific Islander	• Non-residential substance use disorder treatment • Family education	UPAC 3288 El Cajon Blvd., Suites 3,6,10,11,12 & 13 San Diego, CA 92104 (619) 521-5720	4
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	East Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of substance use disorder problems addressing both disorders for adults experiencing co-occurring substance use disorder and mental health problems	Adults 18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	•Non-residential substance use disorder treatment rehabilitation services • Treatment and recovery service center for substance use disorder clients who may also have co-occurring mental health disorders	McAlister Institute for Treatment and Education East Regional Recovery 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Coastal Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of substance use disorder. For clients with co-occurring disorders, the goal is to ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders	Adults18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	• Evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety • Provide PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	5
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	South Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder, including those who may have a co-occurring mental health disorder. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education South Regional Recovery Center 1180 Third Ave., Suite C-3 Chula Vista, CA 91911 (619) 691-8164	1
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Inland RRC	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder, including those who may have a co-occurring mental health disorder. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education South Regional Recovery Center 200 East Washington Ave., Suite 100 Escondido, CA 92025 (760) 741-7708	5
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Mid-Coast Regional Recovery	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder, including those who may have a co-occurring mental health disorder. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	4

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International	Outpatient mental health services to Adults/Older Adults who are victims of trauma and torture with serious mental illness and children who suffer from a severe emotional disturbance	Improve access to mental health services, culture specific, outreach and education to persons with a serious mental illness or emotional disturbance who have been victims of torture and provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity	Transition Age Youth, Adults/Older Adults with serious mental illness who are victims of trauma and torture	• Bio-psychosocial rehabilitation services recovery • Strength based, client and family driven and culturally competent programs	Survivors of Torture International Confidential location for office (619) 278-2400	All
ALL-OE	Behavioral Health Services and Primary Care Integration Services	Mental Health and Primary Care Services Integration Services	Provides services and treatment to adult patients with behavioral health problems through the Enhanced Screening, Brief Intervention and Referral to Treatment model	Provide effective, evidence-based treatment for behavioral health interventions in a primary care setting	Adults 18 to 59 years	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network 7535 Metropolitan Dr. San Diego, CA 92108 (619) 542-4300	All
ALL-OE	Behavioral Health Services for Deaf & Hard of Hearing	Deaf Community Services	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within San Diego County	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Children, Transition Age Youth, Adults/Older Adults who are deaf or hard of hearing and who have a serious mental illness or substance use disorder	• Outpatient mental health services • Case management • Integrated substance use disorder treatment and rehabilitation	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
ALL-SD	Chaldean and Middle-Eastern Social Services	Chaldean and Middle-Eastern Social Services	Outpatient mental health clinic provides treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	Provide culturally competent treatment, services and referrals for individuals of Middle Eastern descent who experience mental health issues or a serious mental illness	Adults 18 years and older and eligible for Medi-Cal funded services	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services 436 S. Magnolia Ave., Suite 201 El Cajon, CA 92020 (619) 401-7410	All
ALL-OE	Clubhouse - Deaf or Hard of Hearing	Deaf Community Services Clubhouse	Recovery and skill center/clubhouse for the Deaf and Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Transition Age Youth, Adults/Older Adults, who are deaf or hard-of-hearing who have or are at risk of a serious mental illness or co-occurring disorder	• Member-operated recovery and skill development clubhouse program • Services include social skill development, rehabilitative, recovery, vocational and peer support	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Services SmartCare	Provides Psychiatric and Addiction Consultation and Family Support Services for primary care, pediatric and obstetric providers who serve patients with Medi-Cal or who are uninsured, throughout San Diego County, Transition Age Youth, Adults/Older Adults	Improve the confidence, competence, and capacity of primary care pediatrics, and obstetricians in treating behavioral health conditions; increase identification of behavioral health issues, including suicide risk; provide education, referrals, and linkages to support families	Children, Transition Age Youth, Adults/Older Adults	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	All
ALL-SD	Psychiatric Emergency Response Team (PERT)	Psychiatric Emergency Response Team	Connects law enforcement officers with psychiatric emergency clinicians to serve children and adults throughout the County	Improve collaboration between the mental health and law enforcement systems with the goal of more humane and effective handling of incidents involving law enforcement officers and mentally ill and developmentally disabled individuals	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, homeless and the Native American community	• Case coordination • Linkage and limited crisis intervention services • Training for law enforcement personnel	Community Research Foundation 8775 Aero Dr. San Diego, CA 92123 (858) 836-1090	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Adult Drug Court Treatment and Testing	Collaborative Drug Court - South	Provides Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential AOD treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	Mental Health Systems Inc. San Diego Center For Change 3340 Kemper St., Suite 103 San Diego, CA 92110 (619) 758-1434	1, 4
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - North	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	Mental Health Systems Inc. North County Center For Change 504 W. Vista Way Vista, CA 92083 (760) 940-1836	2, 3, 5
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - East Case Management	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services. • Outpatient Drug-Free treatment and intensive Day Care Habilitative service in an environment free of substance use disorder • Mental health screening	Mental Health Systems Inc. East County Center For Change 545 N. Magnolia Ave. El Cajon, CA 92020 (619) 579-0947	2
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - Central Case Management	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services • Mental health screening	Mental Health Systems Inc. San Diego Center For Change 3340 Kemper St., Suite 103 San Diego, CA 92110 (619) 758-1433	4
PS-01	Breaking Down Barriers (BDB) Initiative	Breaking Down Barriers (African American Fathers/Caregiver - Southeast - Father2Child	Conducts outreach and engagement to underserved groups throughout the county. Father2Child is a parenting program for African American fathers/caregivers in southeastern San Diego	Reduce mental health stigma to culturally diverse, unserved and underserved populations	Unserved and underserved populations; Latino; Native American; African; LGBTQ; African-American	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Mental Health Association of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412 ext.102	All
OA-06	Caregiver Support for Alzheimer & Dementia Patients	Caregivers of Alzheimer's Disease and Other Dementia Clients Support Services	Provides caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers	Reduce incidence of mental health concerns in caregivers of Alzheimer's patients. Improve the quality of well-being for caregivers and families. Provides services to an underserved/unserved population	Adult Caregivers 18 years and older	• Outreach • Information dissemination • Early intervention • Education	Southern Caregiver Resource Center 3675 Ruffin Rd. San Diego, CA 92123 (858) 268-4432	All
DV-04	Community Services for Families - CWS	CSF Central & North Central Regions	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and wellbeing of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148	4

Prevention and Early Intervention (PEI)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
DV-04	Community Services for Families - CWS	CSF East Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and wellbeing of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 692-0727	2
DV-04	Community Services for Families - CWS	CSF - North Coastal/North Inland	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and wellbeing of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	3, 5
DV-04	Community Services for Families - CWS	CSF - South Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and wellbeing of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • STEP Training • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
DV-03	Community Violence Services (South - Alliance for Community Empowerment)	Alliance for Community Empowerment	Provides trauma informed, community centered, family driven and evidenced based Community Violence Response services. Central Region, but may serve clients outside the region Middle school aged boys and girls affected by violence	Increase in resilience; improvement in parenting knowledge; increases problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Middle school-age youth	• Direct counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities 5348 University Ave., Suites 101 and 102 San Diego, CA 92105 (619) 232-6454	4
FB-01	Early Intervention for Prevention of Psychosis (TAY & Children)	Kickstart	Provides Prevention and Early Intervention (PEI) services for persons10-25 years old who have emerging 'prodromal' symptoms of psychosis	Reduce incidence and severity of mental illness and increase awareness and usage of services	Countywide youth 10-25 years old in San Diego County and their families & substantial public component on psychosis	• Prevention through public education • Early intervention, through screening potentially at risk youth • Intensive treatment for youth who are identified as at-risk and their families	Pathways Community Services, LLC 4281 Katella Ave., Suite 201 Los Alamitos, CA 90720 (562) 467-5532 6160 Mission Gorge Rd,. Suite 400 San Diego, CA 92120 (858) 637-3030	All
OA-01	Elder Multicultural Access & Support Services (EMASS)	Elder Multicultural Access & Support Services (EMASS)	Provides outreach and support to older adults, especially non-Caucasian/ non-English speaking	Reduce ethnic disparities in service access and use. Increases access to care	Multicultural Seniors, refugees, 60 years and older who are at risk of developing mental health problems	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community based services	Union of Pan Asian Communities 9360 Activity Rd., Suite B San Diego, CA 92126 (619) 238-1783 ext.30	All
PS-01	Family Peer Support Program	Family Peer Support Program (In Our Own Voice & Friends in the Lobby)	Provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes	Family members and friends of psychiatric inpatients	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	NAMI San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6597	All
OA-02	Home Based Services (Older Adults)	Positive Solutions	Provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services	Homebound older adults 60 years and older who are at risk for depression or suicide	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities 9360 Activity Rd., Suite B San Diego, CA 92126 (619) 238-1783 ext.30	1, 4, 5

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
RE-01	Independent Living Association (ILA)	CHIP Independent Living Association (ILA)	Creates an Independent Living Facility Association with voluntary membership	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PS-01	Inreach Services	Neighborhood House Association	Bio-Psychosocial Rehabilitation - Central Region Inreach - Outreach (Project Enable)	Transitional services	At risk African-American and Latino citizens who are incarcerated adults or Transition Age Youth at designated detention facilities and will be released in San Diego County	• Advocacy, assessment, engagement, and resource connection	Neighborhood House Association 5660 Copley Dr. San Diego, CA 92114 (619) 244-8241	All
CO-03	Integrated Peer & Family Engagement Program - Next Steps	Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and /or substance use disorder	Provide mental health screening and services to adults 18 years and older, including transition age youth and older adults with substance use disorder	Adults 18 years and older	• On call either in person or via mobile devices • Screening tool for mental health and substance use disorder	NAMI SD 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 643-6580	All
PS-01	Mental Health First Aid	Mental Health First Aid	Mental Health First Aid is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Provide county-wide community- based mental health literacy education and training services	Adults/Older Adults who work with youth	• Interactive class that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
NA-01	Native American Prevention and Early Intervention	Indian Health Council, Inc.	PEI and substance use disorder treatment services to Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; North Region of San Diego County	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in North County	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5
NA-01	Native American Prevention and Early Intervention	San Diego American Indian Health Center	Provides PEI services for Native American Indian/Alaska Native urban youth	Increase community involvement and education through services designed and delivered by Native American communities	At risk and high risk urban American Indian and Alaska Natives children and Transitional Age Youth	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave., Suite 105 San Diego, CA 92103 (619) 234-1525	4
NA-01	Native American Prevention and Early Intervention	Southern Indian Health Council, Inc.	Provides PEI and substance use disorder treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in South and East County	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
NA-01	Native American Prevention and Early Intervention	Sycuan Medical/Dental Center	Provides specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the Sycuan tribal community	Reduce ethnic disparities in service access and use. Increases access to care	American Indians; Alaska Natives; tribal members of the Sycuan tribal reservation; and qualified family members residing on reservations; All age groups	• Provides specialized culturally appropriate behavioral health prevention and early intervention services	Sycuan Band of Kumeyaay Nation 5442 Sycuan Rd. El Cajon, CA 92019 (619) 445-0707 ext.114	2

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program (Triple P)	Provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum	Specialized culturally and developmentally appropriate mental health PEI services to promote social and emotional wellness for children and their families	Countywide parents and families; parents and Guardians of children enrolled in Head Start, Early Head Start, Elementary School and Community Center locations	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
RC-01	Rural Integrated Behavioral Health & Primary Care Services	Integrated Behavioral Health and Primary Care Services in Rural Communities	Provides Rural Integrated Behavioral Health and Primary Care Services for prevention and early intervention services	Increase access to and usage of services	Children, Transition Age Youth, Adults/Older Adults	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5122	All
SA-01	School Based PEI - N. Inland	Vista Hill - School Based PEI North Inland	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126	5
SA-01	School Based PEI - South	South Bay Community Services - School Based PEI South	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and North Central	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4300	3, 4
SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and Southeastern	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4301	4
SA-01	School Based Prevention and Early Intervention	San Diego Youth Services - School Based PEI East	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools. Refugee children pre-school through 3rd grade who struggle with transitioning and would benefit from small groups	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement • assimilation groups for refugee children/parents. • Community linkage/referrals • Outreach and engagement	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877	2

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
SA-01	School Based Prevention and Early Intervention	Palomar Family Counseling - School Based PEI North Coastal Region	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public schools	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
SA-02	School Based Suicide Prevention & Early Intervention (Children's)	HERE Now	Provides school based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth	Reduce suicides and the negative impact of suicide in schools. Increases education of education community and families	Middle school, high school, and Transition Age Youth	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All
PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Suicide Prevention & Stigma Reduction Media Campaign	Countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services	Countywide individuals with mental illness; families of individuals with mental illness; general public	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials	Civilian Inc. 2468 Historic Decatur Rd., Suite 250 San Diego, CA 92106 (619) 243-2290	All
PS-01	Suicide Prevention Action Plan	Suicide Prevention Action Plan	Provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes	General population, mental health service consumers, local planners, and mental health organizations	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	Provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated through BHS to develop new employment resources	Employment is an essential element of comprehensive mental health services for adults with serious mental illness. Supported Employment is a key strategy for meeting both the employment and service needs of adults with serious mental illness and the MHSA target populations. These services improves access to employment opportunities	Service providers, employers, agencies, government organizations, and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 3910 University Ave., Suite 400 San Diego, CA 92105 (619) 228-2952	All
VF-01	Veterans & Family Outreach Education-	Courage to Call	Provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors or stressors. Improves access to mental health and PEI services, information and support	Veterans, active duty military, Reservists, National Guard, and family members	• Education • Peer counseling • Linkage to mental health services • Mental health information • Support hotline	Mental Health Systems, Inc. 9445 Farnham St., Suite 100 San Diego, CA 02123 (858) 636-3604	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-13	Faith Based Initiative	Faith-Based Initiative - Community Education Task Order 2a - Com. Ed	Provides faith-based mental health community education in North Inland Region	Collaborate and participate with identified Faith Based and Behavioral Health Champions from Faith Based Academies. To facilitate community education presentations to faith communities and behavioral health providers with HHSA North Inland Region	Faith leaders, behavioral health providers, and members of congregations and community	• Community education	NAMI San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6580	2, 3, 5
INN-13	Faith Based Initiative	Faith-Based Initiative - Community Education - Task Order 2b - Com. Ed	Provides outreach, engagement, training and community education	Collaborate and participate with identified Faith Based and Behavioral Health Champions from Faith-Based Academies. Facilitates community education presentations to faith communities and behavioral health providers with HHSA Central Region	Children, Transition Age Youth, Adults/ Older Adults in Central Region	• Outreach, engagement and training • Community Education	Total Deliverance Worship PO Box 1698 Spring Valley, CA 91979 (619) 670-6208	1, 2, 4
INN-13	Faith Based Initiative	Faith-Based Initiative - Faith Based Academy - Task Order 1a - North Inland	Design, develop, and implement a Faith Based Academy	Develop an educational curriculum and joint training that includes material to address faith/spirituality principles and values, wellness, mental health conditions, and resource information to faith communities and behavioral health providers in the North Inland Region	Faith leaders, behavioral health providers, and members of congregations and community	• Education and Training	Interfaith Community Services 550 West Washington Ave. Escondido, CA 92025 (760) 489-6380	2, 3, 4, 5
INN-13	Faith Based Initiative	Faith Based Initiative - Task Order 3b - Crisis Response (Central)	Pairs a licensed or license eligible mental health clinician/registered intern with faith based clergy to respond to individual and family crisis situations including, but not limited to, suicides, homicides, and domestic violence.	Provide support during crises, assess and de-escalate serious situations, and provide linkage and referrals to community behavioral health providers for ongoing care	Children, Transition Age Youth, Adults/ Older Adults with a focus on African-American and Latino communities.	• Crisis intervention • Linkage and referrals	Total Deliverance Worship Center 7373 University Ave., Suite 201 La Mesa CA 91942 (619) 670-6208	4
INN-13	Faith Based Initiative	Faith-Based Initiative - Wellness and Health Ministry Task Order 4b - W&H Ministry (Central)	Implement a Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a serious mental illness while in jail	Provide a jail In-reach program for adults with a serious mental illness that includes spiritual support, mental and physical health wellness, counseling on untreated mental illness and co-occurring disorders, linkage to resources for and assistance with re-integration back into the community, and support services consistent with pastoral counseling and the individual's faith of choice	Incarcerated adults 18 years and older diagnosed with a serious mental illness in the Central Region	• Mental health and co-occurring disorders support and counseling. • Spiritual support • Community reintegration	Training Center Ephesians 525 Grand Ave. Spring Valley, CA 91977 (619) 327-5400	1, 2, 4
INN-13	Faith Based Initiative -	Faith-Based Initiative - Wellness and Health Inreach Ministry Task Order 4a - W&H Ministry (North)	Implement a Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a serious mental illness while in jail	Provide an jail In-reach program for adults with a Serious Mental Illness that includes spiritual support, mental and physical health wellness, counseling on untreated mental illness and co-occurring disorders, linkage to resources for and assistance with re-integration back into the community, and support services consistent with pastoral counseling and the individual's faith of choice	Incarcerated adults 18 years and older diagnosed with a serious mental illness in the North Region	• Mental health and co- occurring disorders support and counseling. • Spiritual support • Community reintegration	Training Center Ephesians 525 Grand Ave. Spring Valley, CA 91977 (619) 327-5400	2, 3, 4, 5
INN-22	Med Clinics	Center for Child and Youth Psychiatry (CCYP)	Provides ongoing medication management for children and youth with complex psychiatric pharmacological needs	Promote stabilization by providing accessible follow up for complex psychiatric pharmacological needs	Children and youth up to age 21	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	New Alternatives (Location TBD)	All
INN-17	Mobile Hoarding Intervention Program	Cognitive Rehabilitation and Exposure Sorting Therapy (CREST) mobile hoarding units (formerly IMHIP)	Diminishes long term hoarding behaviors in Older Adults	Improve health, safety, quality of life, and housing stability through provision of comprehensive hoarding treatment	Older Adults 60 years and older with hoarding disorder and a serious mental illness in the Central, South, and North regions	• Community outreach and engagement • In-home therapy • Family support	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All

Innovation (INN)

Work Plan	RER Revised Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-15	Peer Assisted Transitions	Peer Assisted Transition	Provides peer specialist coaching, incorporating shared decision-making and active social supports. Services will be focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services	Increase depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports	Transition Age Youth, Adults/Older Adults in Central, North Coastal & North Inland regions	• Peer specialist coaching • Connecting to relevant services	NAMI San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6586	All
INN-18	Peripartum Program	TBD	Identifies at-risk peripartum women for engagement and provides services for women and spouses	Reduce incidence and impact of postpartum depression	Peripartum women and partners, especially in communities at-risk of trauma	• Outreach and engagement through public health nurses • Interventions to prevent and treat postpartum depression	Pending MHSOAC approval	All
INN-14	Ramp Up to Work	Supported Employment Initiative - Ramp Up 2 Work	Engages and retains employment opportunities for Transition Age Youth and Adults/ Older Adults with serious mental illness in the behavioral health system through an enhanced array of supported and competitive employment options	Expand employment opportunities for Transition Age Youth and Adults/Older Adults with a serious mental illness and to promote self-determination and empowerment. The program helps clients overcome barriers to employment	Transition Age Youth, Adults/Older Adults who have a serious mental illness	• Client functional assessment • Employment reediness assessment • Job coaches • Computer skills support	UPAC 1031 25th St. San Diego, CA 92102 (619) 232-6454	All
INN-21	ReST Recuperative Housing	Recuperative Services Treatment (ReST)	Provides post-institutionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevent re-institutionalization and homelessness; encourages successful re-integration following institutionalization	Transition Age Youth	• Wrap-around services • Case management • Voluntary residential services • Employment and permanent housing support	Program approved May 25, 2017; RFP Pending.	1, 2, 4
INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the North Inland Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Indian Health Council, Inc. 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	2, 5
INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Southern Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the East Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
INN-19	Telemental Health	TBD	Provides post psychiatric emergency services follow-up treatment and stabilization via electronic devices for tele-therapy	Prevent re-hospitalization and psychiatric emergency services with follow up mental health services for successful connection to mental health treatment following a psychiatric emergency	Children, Transition Age Youth, Adults/ Older Adults	• Follow-up mental health treatment and stabilization via tele-therapy • Case Management • Access to tele-therapy platform for treatment and resources • Outreach and engagement	Program approved Oct 26, 2017 Procurement Pending	All
INN-16	Urban Beats	Urban Beats	Provides an artistic expression that includes the use of multiple models of artistic expression including visual arts, spoken word, music, videos, and performances and social media created and developed by Transition Age Youth	Increase the engagement and retention rates in mental health treatment of serious emotional disturbance and serious mental illness and at risk Transition Age Youth by incorporating a Transition Age Youth focused recovery message into an artistic expression and social marketing	Transition Age Youth who are clients of the mental health system with serious emotional disturbance/serious mental illness or at-risk of mental health challenges	• Develop youth leaders within TAY community • Increase access to services • Whole health and prevention services	Pathways Community Services 3330 Market St. San Diego, CA 92101 (858) 227-9051	1, 2, 4

Innovation (INN)

Work Plan	RER Revised Program Name	Program	Program Name & Contract Agency	Program Description	Contract Information	Districts
WET-02	Training and Technical Assistance	Training and Technical Assistance (Big Why Conference, We Can't Wait Conference)	Regional Training Center (RTC)	Provide administrative and fiscal training support services to HHSA Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop and execute training contracts between RTC and trainers/consultants, coordinate with HHSA BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs	Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040	All
WET-02	Cultural Competency Academy	Cultural Competency Academy	TBD	The CCA will provide awareness, knowledge, and skill based trainings that focus on clinical and recovery interventions for multicultural populations while ensuring that all trainings focus on being trauma informed from environmental to clinical applications	TBD	All
WET-02	Behavioral Health Training Curriculum	Behavioral Health Training Academy	BHETA	MHSA, Workforce Education and Training: Training and Technical Assistance. Includes Justice Involved Training Academy; CYF Outcomes coordination of the Child and Adolescent Needs and Strengths outcomes measure; and Drug Medi-Cal, Organized Delivery System	San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182 (619) 594-1900	All
WET-03	Public Mental Health Academy	Public Mental Health Academy - Academic Counselor	San Diego Community College District	Provide an academic counselor to support student success in the community based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an AA and/or BA program to assist in the career pathway continuum	San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555	All
WET-03	Consumer and Family Academy	RI International	Consumer/Family Academy, TAY/Adult/Older Adult Peer Specialist Training	Provide recovery-oriented, Peer Specialist training to adults 18 years and older to prepare them to work in the County of San Diego's public behavioral health system. Using the training participants' personal recovery experiences as a foundation to prepare participants to work as partners at the practice, program and policy levels. Additional training will be provided to behavioral health providers to facilitate the best use of the unique skills Peer Specialist staff	Recovery Innovations, Inc. 2701 North 16th St., Suite 316 Phoenix, AZ 85006 (602) 650-1212	All
WET-04	Community Psychiatry Fellowship	Residency, Internship Programs; Community Psychiatry Fellowship	Regents of the University of California, UCSD Community Psychiatry Fellowships	Programs are for physicians- one for adult psychiatry residents and fellows and the second for child and adolescent psychiatry residents and fellows. Programs foster the development of leaders in Community Psychiatry and provide exposure to the unique challenges and opportunities, targeted approaches to ethnically and linguistically diverse populations	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All

Work Plan	RER Revised Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-9	BHS Financial Management System	Financial Management System	The Financial Management System will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, contract tracking and business analytics tools, including standard reporting, dashboards and queries	The business areas and programs served including the following: Registration/ Administration; Service Recording; Electronic Health Record; Medi-Cal Billing; Other Billing; Managed Care Functionality	• This system will streamline financial data collection and reporting, including potentially assisting with the annual MHSA Revenue & Expenditure Report (RER), maintain the integrity of data with system securities and prevent duplication of effort to ensure resources are fully maximized	County IT - Behavioral Health Services 3255 Camino del Rio South. San Diego, CA 92120 (619) 563-2700	All
SD-8	Data Exchange (Interoperability)	Connect Well San Diego	Program identifies opportunities to aggregate data across the continuum of care from disparate systems, creating a longitudinal patient record containing information that supports programs such as decision support, quality measurement, and analytics for population management. The Connect Well platform will be developed to create a Health Information Exchange to provide the means for this interoperability project	The primary users of the system will include County of San Diego employees, contracted service providers and the contracted Administrative Services Organization	• Creates a secure platform where System Users can work together across programs to serve a particular customer • Allows System Users to search for County and partner service providers – and even filter by language, location, etc. • Using modern technology to share information will help staff improve their ability to provide person-centered service	TBD	All
SD-6	Management Information System (MIS) Expansion	Road Map into the Millennium	This project replaces the core information system used by virtually all providers in the extended system of care, including all clinical and billing information. The new Practice Management and Managed Care System replaces in their entirety the legacy applications that were in use	The main users of the system will be County of San Diego employees, County Service Providers, Administrative Support Organizations (ASO's) and Fee For Service Providers	• InSyst application – supported by Echo Management, Inc. and resides on VAX hardware. It is a client and service tracking and billing application that is used by CoSD and contract mental health providers to coordinate client care, perform required State reporting requirements and bill Medi-Cal and other payers; eCura application – supported by InfoMC and used for Managed Care. The end users are United Behavioral Health Administrative Services Organization employees	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All
SD-3	Personal Health Record	Personal Health Record	The Personal Health Record embedded in the InteliChart Patient Portal enables patients to both securely view and update their records in a timely manner	Children, Transition Age Youth, Adults/Older Adults	• PHR is constructed from patients existing behavioral health medical record. InteliChart provides and supports mobile apps that enable patients to make appointments, view lab results, and securely communicate with their healthcare providers conveniently using mobile technology	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Heartland Bio- Psychosocial Rehabilitation WRC	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	Community Research Foundation, Heartland Center 460 N. Magnolia Ave. El Cajon, CA 92020 (619) 440-5133	2
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at South Region Biopsychosocial Rehabilitation Wellness Recovery Center	Adults 18 years and older who have a serious mental illness, including those who may have a co- occurring substance use disorder. Transition Age Youth population and Probation-funded AB109 component	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older Transition Age Youth & AB109 who have serious mental illness, including those who may have a co-occurring substance use disorder	Community Research Foundation, Maria Sardiñas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1

Technological Needs (TN)

Work Plan	RER Revised Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness, including those who may have a co- occurring substance use disorder, Transition Age Youth, AB109	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older	Community Research Foundation, South Bay Guidance Wellness and Recovery Center 835 3rd Ave., Suite C Chula Vista, CA 91911 (619) 427-4661	1
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at UPAC	Monolingual and/or limited English proficient Asian/Pacific Islander adults 18 years and older with a serious mental illness who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient case management, vocational support services for indigent clients with a serious mental illness	UPAC Mid-City BPSR 5348 University Ave., Suites 101 & 120 San Diego, CA 92105 (619) 229-2999 UPAC Serra Mesa 8745 Aero Dr., Suite 330 San Diego, CA 92123 (619) 268-0244	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at North Central Region Adult/Older Adult Bio-Psychosocial Rehabilitation Wellness Recovery Center	Children, Transition Age Youth, Adults/Older Adults	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	CRF Douglas Young Center 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Project Enable	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Stabilization and recovery services with the expectation that with treatment, clients will effectively recover and graduate from the program	Neighborhood House Association 286 Euclid Ave., Suite 102 San Diego, CA 92114 (619) 266-9400	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	Southeast Mental Health Center 3177 Ocean View Blvd. San Diego, CA 92113 (619) 595-4400	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	MHS, Inc. North Inland Mental Health Center 125 W. Mission Ave., Suite 103 Escondido, CA 92025 (760) 747-3424 Kinesis Wellness & Recovery Center 474 W. Vermont Ave., Suite 101 Escondido, CA 92025 (760) 480-2255 Fallbrook Satellite 1328 S. Mission Rd. Fallbrook, CA 92028 (760) 451-4720 Ramona Satellite 1521 Main St. Ramona, CA 92065 (760) 736-2429	3, 5

Technological Needs (TN)

Work Plan	RER Revised Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	MHS, Inc. North Coastal Mental Health Center 1701 Mission Ave. Oceanside, CA 92058 (760) 967-4475 MHS, Inc. Vista 550 West Vista Way, Suite 407 Vista, CA 92083 (760) 758-1092	4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Children, Transition Age Youth, Adults/Older Adults who are deaf or hard of hearing and who have a serious mental illness or substance use disorder	• Clinic services supported: Outpatient mental health services, case management, and substance use disorder services are provided for deaf and hard of hearing adults	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an outpatient psychiatric medication services clinic	Children, Transition Age Youth, Adults/Older Adults	• Clinic services supported: Outpatient psychiatric medication services to consumers utilizing Telehealth practices and technology	Exodus Recovery, Inc. 524 W. Vista Way Vista, CA 92083 (760) 758-1150 1520 S. Escondido Blvd. Escondido, CA 92025 (760) 871-2020	3, 5
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Walk-in outpatient mental health assessments and psychiatric consultation, medication management services; crisis intervention, and case management brokerage	Community Research Foundation, Jane Westin Wellness & Recovery 1045 9th Ave. San Diego, CA 92101 (619) 235-2600	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	East County Mental Health Center 1000 Broadway, Suite 210 El Cajon, CA 92021 (619) 401-5500	2
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services, including those who may have a co-occurring substance use disorder	North Central Mental Health Clinic 1250 Morena Blvd. San Diego, CA 92110 (619) 692-8750	4
SD-5	Telemedicine	Community Research Foundation-Crossroads	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation Crossroads Family Center 1679 E. Main St., Suite 102 El Cajon, CA 92021 (619) 441-1907	2
SD-5	Telemedicine	Community Research Foundation-Douglas Young	Provides technological support for telemedicine at Douglas Young Youth and Family Services Outpatient Children's Mental Health Services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0822	3, 4

Technological Needs (TN)

Work Plan	RER Revised Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Community Research Foundation-Nueva Vista	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
SD-5	Telemedicine	Community Research Foundation-Mobile Adolescent Service Team (MAST)	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	Utilizing telemedicine for psychiatry services by offering: • Video Conferencing • Secure email • Phone consultation	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-3261	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at short-term, acute residential treatment clinics	Voluntary adults who have a serious mental illness, including those who may have a co-occurring substance use disorder, are experiencing a mental health crisis and in need of intensive, non-hospital intervention	• Clinic services supported: 24-hour, 7-day a week 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions, and are residents of San Diego County	Vista Balboa 545 Laurel Ave. San Diego, CA 92101 (619) 233-4399 New Vistas 734 10th Ave. San Diego, CA 92101 (619) 239-4663 Halcyon 1664 Broadway El Cajon, CA 92021 (619) 579-8685 Turning Point 1738 S. Tremont St. Oceanside, CA 92054 (760) 439-2800 Jary Barreto 2865 Logan Ave. San Diego, CA 92113 (619) 232-4357 Del Sur (formerly Isis) 892 27th St. San Diego, CA 92154 (619) 575-4687	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Areta Crowell	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support, including those who may have a co-occurring substance use disorder	Community Research Foundation Areta Crowell Center 1963 4th Ave. San Diego, CA 92101 (619) 233-3432	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at North Inland Crisis Residential	Voluntary adults 18 years and older with acute and a serious mental illness including those who may have a co-occurring substance use disorder and are residents of San Diego County	• Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All
SD-6	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Esperanza Center	Voluntary adults 18 years and older with acute and a serious mental illness including those who may have a co-occurring substance use disorder and are residents of San Diego County	• Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9940	4

Technological Needs (TN)

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
Key Words: (CCRT, Cultural Competence)

SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
		PAGE:	1 OF 3
		DATE:	**02/24/2018**
REFERENCE			

PURPOSE
To establish a Behavioral Health Services (BHS) Cultural Competence Resource Team (CCRT) to advise the BHS Executive Team of Adult/Older Adult (AOA), Clinical Director's Office (CDO), and Children, Youth and Families (CYF) BHS Systems of Care (SOC) on issues of cultural competency.

BACKGROUND
None

DEFINITIONS
None

POLICY
It is the policy of BHS to promote mental health, wellness and recovery, eliminate the debilitating effects of psychiatric and alcohol and other drug conditions in a culturally centered manner and to promote cultural competence. To accomplish this goal, the CCRT was established and will be maintained within the BHS. The purpose and structure of this team supports the local Cultural Competence Plan as mandated by the California Department of Public Health's Office of Health Equity.

PROCEDURES
The CCRT was established and charged as follows:

1. Members of the CCRT shall be appointed by the Deputy Directors of BHS. Appointees will be from various organizational units and disciplines within BHS as well as member-at-large appointees from the community to include consumers and family representatives. Representation from key groups, such as BHS, Quality Improvement (QI), the Mental Health Contractors Association (MHCA), the Behavioral Health Advisory Board (BHAB) will be requested.

2. The charge of the CCRT is:

    a. To serve as the "eyes, ears and conscience" of the County of San Diego's A/OA and CYF systems regarding the development and integration of cultural competence in the delivery of behavioral health services to culturally diverse populations and

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
Key Words: (CCRT, Cultural Competency)

SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
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		DATE:	**02/24/2018**
REFERENCE			

system-wide adherence to the local Cultural Competency Plan. The CCRT is a formal mechanism for providing to the Behavioral Health Administration, to County and contracted individual providers input and feedback to:

1) Monitor and evaluate the cultural competence of the BHS system of care.
2) Recommend performance outcomes and standards for assessing the behavioral health system's cultural competence in serving culturally diverse populations.
3) Review performance outcomes and recommend strategies to address gaps.
4) Recommend corrective action when the system's performance does not meet expected standards of cultural competence.
5) Recommend system of care training to address gaps.

3. BHS primary staff support to the CCRT will include the Ethnic Services **Coordinator** (currently the Director of the A/OA SOC). Other support necessary for the CCRT to fulfill its charge will be made available to the extent feasible.

4. The CCRT chair shall be appointed by the Behavioral Health Director and shall be at a Chief or Program Coordinator level or above. CCRT members will also be appointed by the Director upon recommendation of the Chair. The Chair will serve as the link between the CCRT and the BHS Deputy Directors.

5. Formal actions of the CCRT will occur under Robert's Rules of Order.

6. Members will be expected to participate in a subcommittee where work assignments will be completed.

7. CCRT members are expected to observe confidentiality in regard to information obtained during the work of the Team.

QUESTIONS / INFORMATION
Piedad Garcia, Deputy Director
BHS Adult Older Adult System of Care
(619) 563-2757

ATTACHMENTS/RELATED DOCUMENTS
None

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
Key Words: (CCRT, Cultural Competency)

SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
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SUNSET DATE: This policy will be reviewed for continuance on or before February 28, 2021.

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	1 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

PURPOSE
To assure improvements in the access and availability of culturally and linguistically competent services in County Behavioral Health Services (BHS).

BACKGROUND
For detail information, please see the most recent update of the Cultural Competence Plan. The Mental Health Plan (MHP) Cultural Competence Plan is available from the Quality Improvement (QI) Unit.

DEFINITIONS
None

POLICY
Cultural competence is a key element in providing high-quality behavioral health care to the diverse population of San Diego County. The County BHS will make ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of San Diego residents.

PROCEDURES
The MHP, with the guidance of the Cultural Competence Resource Team (CCRT), will ensure ongoing progress toward meeting service access and availability based on the cultural and linguistic needs of the population of San Diego County requiring mental health services by:

1. Analyzing County demographic information changes periodically, to determine or identify gaps in service provision.

2. Reflecting cultural and linguistic needs in strategic plans, policies and procedures, human resource training and recruitment, and contracting requirements.

3. Ensuring involvement of diverse populations in planning processes.

4. Periodically analyzing the human resources composition of MHP and provider staff in comparison to the cultural, ethnic, and linguistic characteristics of Medi-Cal beneficiaries and adjusting training, recruitment, and retention efforts accordingly.

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	2 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

5. Ensuring Clinical Practice Standards for Cultural Competence will be incorporated in the mental health service provision.

6. Ensuring that programs adhere to the guidelines and requirements of the most recent Cultural Competence Handbook.

7. Periodically assessing and adjusting contract language to reflect changing cultural competence needs in the selection of contract providers.

8. Providing and fostering the provision of training and staff development in cultural competence on a wide variety of cultures and diverse communities, including client culture for provider staff, support staff, administration, and interpreter services.

9. Analyzing consumer and staff satisfaction survey results, and grievances and appeals, to determine areas of needed cultural and linguistic service improvement.

10. Evaluating site review and medical record review findings to ensure: 1) that all provider sites are able to assist consumers with diverse threshold and non-threshold language needs, through in-house staff capabilities or interpreter services; and 2) that there is an array of written materials at provider sites in the threshold languages of the County.

11. Evaluating progress in the development of a program or system to evaluate the cultural competence of staff and interpreters and making interventions, as needed.

12. Analyzing outreach and engagement strategies, results of culture-specific staff recruitment efforts, and the effectiveness of providing culture-specific provider listings in reaching underserved populations.

QUESTIONS / INFORMATION
Piedad Garcia, Director
Adult Older Adult System of Care
(619) 563-2757

ATTACHMENTS/RELATED DOCUMENTS
A - Cultural Competence Clinical Practice Standards Attach-A, Cult Comp Clinical Standards

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	3 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

B - Cultural Competence Handbook link:
http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetenceHandbook11-1-11.pdf

This handbook outlines cultural competence guidelines and requirements in implementing programs and systems of care that are culturally competent.

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

August 2, 2019 | 10:00 am – 11:30 am| RIHS Academy: 6367 Alvarado Court, Ste 105, San Diego, CA 92120

In Attendance: Awichu Akwanya (UWEA), Elisa Barnett (TCSD), Juan Camarena (SDSU), Martin Dare (MHSA-PPU), Elizabeth Dauz (JFS), Andrea Duron (AOA), Liz Gambini (RII), Piedad Garcia (AOA), Gebaynesh Gashaw-Gant (HM), Christopher Guevara (QIPIT), Shadi Haddad (SYHC-CMSS), Diane Hasan (AOA), Rick Heller (HSRC), Celeste Hunter (CASRC), Minola Clark Manson (RIHS),Gabriela Masuda (JFS), Liz Miles (QIPIT), Danyte Mockus-Valenzuela (MHSA-PPU), Edith Mohler (CYF), Bardia Moojedi (QIPIT), Donna Moore (AOA), Kimberly Pettiford (PEI), Ezra Ramirez (QIPIT), Nilanie Ramos (BHS-CDO), Jennifer Santos (BHS), Ann Vilmenay (AOA), Sten Walker (NAMI).

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Called to order at 10:00 am by Piedad Garcia.	
II. Approval of June 2019 Minutes	• Minutes for June 2019 were moved and motioned for approval as written by Juan Camarena and Jennifer Santos.	***Action Item:*** Danyte requested to change date of the Network of Care website from June 30th to December 31st.
III. Chair's Report (Piedad Garcia)	• Charity has been working with Dr. Martinez on making further edits to the recommendations based on the focus group and will present in October. • Update with System of Care Development; ✓ North County is currently experiencing, and will continue to experience, great change as related to crisis stabilization units in North Inland that is being expanded by 6 recliners. ✓ Crisis Stabilization Units are 24/7. ✓ The EPU, San Diego County Psychiatric hospital is a crisis stabilization unit. ✓ In the North County, there are two CSUs in Palomar. Tri-City being in the North Coastal area and Palomar in the North Inland area, with currently only half North Inland. ✓ Currently expanding the crisis stabilization by 6 recliners and these programs can take PERT referrals. Four of those recliners will be at the Emergency department at Palomar. • All this information is provided by the Board of Supervisors direction. • Palomar is experiencing a decrease in their 16 beds in the next year, however, BHS will be replacing those 16 beds as Palomar begins to work on ligature issues at their Behavioral Health unit. • Beginning discussions with a non-Law Enforcement crisis mobile team, all related to the North County. ✓ Crisis mobile team will be implemented by accessing the crisis line; by law and regulation the Law-Enforcement team cannot be accessed through 911. ✓ 911 releases Law-Enforcement or PERT. ✓ 50% of the PERT calls do not need a Law-Enforcement response. ✓ 20 years ago, the community was pushing for a law-enforcement team, but the consumer community did not want a law-enforcement team.	***Action Item:*** CYF director or AMSA to be able to speak in September regarding schools.

	✓ The District Attorney's office is initiating a PERT clinician team to responds to schools. • There is a lot of movement around Housing for homeless from the City of San Diego (San Diego Housing Commission) and the County of San Diego (Housing and Community Development); ✓ Applying for grants (C3 Grant) ✓ Purchasing property ✓ Homeless for housing grant through Integrative Services Department • All these grants are for people with mental illness and complex conditions. • BHS has executed contracts for the triple RFP's (Request for Proposal). These Triple RFP's are one specifically for Justice Involved, clients with serious mental illness, countywide. Second one is for Step-Down Acute Care, from psychiatric hospitals. Third one is for Step-Down Long-term care, mental disease. • There are over 250 long-term beds in San Diego (Alpine and Crestwood are two of the biggest ones). The length of treatment is about 9 months. • Three ACT Teams that will serve 50% of the clients who are in these institutions will be homeless. There are housing funds and the opportunity for a housing subsidy. • AOA currently has 13 full-service partnership ACT programs for transitional age youth, older adult, justice involved and adult populations. • The Justice Involved RFP will serve 100 clients, yet 8,000 clients in jail who have a diagnosis of serious mental illness with co-occurring disorder. • AOA is preparing for the BHS Ops (Behavioral Health Services Operational Budget Process), beginning September, October, November, and December. • AOA manages 147 contracts.	
IV. MHSA Updates (Danyte Mockus-Valenzuela)	**Handouts were distributed at meeting for discussion** • Today, August 2, 2019, starts the 30-day Public Review Period for the Mental Health Services Act (MHSA) Fiscal year 2019-20 Annual Update. • Recommendation to add comments, suggestions and/or questions on the MHSA and County website. • September 5th is the next Behavioral Health Advisory Board (BHAB) meeting at 2:30pm. The meeting is open for public comments. • Investment of Resources (MHSA Fiscal Year 2019-20 Annual Update chart). • Per new regulations, 3-year evaluations were included. • Danyte discussed the Strategic Plan to Address Opioid and Prescription Drug Misuse (handout).	
V. QI Updates (Liz Miles)	• Introduced student worker (Bardia Moojedi) and what he is assisting with – Reports (PIT itself has 500 reports) and requesting feedback/recommendations. • Bardia Moojedi will be meeting with all executives to obtain feedback. • SUD Databook:	

	✓ SUD Interactive Datebook Fiscal Year 2017-18, Christopher Guevara discussed data chart ✓ Available to all county staff	
VI. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Edith Mohler)	**Education & Training** • No Education & Training updates. **Children's Update** • The CYF Council has held three Strategic Planning meetings: ✓ May 13, 2019 - Focused on Assessment of Psychiatric care in San Diego County. ✓ June 10, 2019 - Focused on CYF System of Care intersection with the Justice system/School Threats. ✓ August 12, 2019 - Focused on Addressing School Based Crisis/Threat. • The attendees participated in facilitated group discussions and provided recommendations on strengths, gaps, Innovation, and next steps. • CYF staff is working on consolidating recommendations into one report that will be ready in about a month.	
VII. CCRT Future Discussion	• CYF director or AMSA director to speak regarding schools. • Begin discussions regarding population-based disparities in jails. • QI to discuss Cultural Logistics Competence report.	
VIII. Announcements	• The next Board meeting, addressing Behavioral Health Continuum of Care, is scheduled for September 24th. • "Vivir La Vida" event is scheduled for Saturday, August 10th • Senior Art show scheduled for August 17th at the LGBT Community Center. • Partnered with SDSU to conduct a survey for community engagement that will be taking place August 6th at the LGBT Community Center.	

NEXT MEETING: September 6, 2019 10:00 AM - 11:30 AM | RIHS Academy: 6367 Alvarado Court, Ste 105, San Diego

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsibleness"

County priorities related to System of Care

How can the CCRT move the needle regarding system integration

Expectation vs. practice

Presentations

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

September 6, 2019 | 10:00 am – 11:30 am| Academy for Professional Excellence:
6367 Alvarado Court, San Diego - Training Room 105

In Attendance: Awichu Akwanya (UWEA), Elisa Barnett (TCSD), Martin Dare (MHSA-PPU), Nora David (AOA), Yen Du (UPAC), Andrea Duron (AOA), Danielle Eguiza (AOA), Liz Gambini (RII), Piedad Garcia (AOA), Winona Garcia (SOT), Rick Heller (HSRC), Celeste Hunter (CASRC), Nicole LeFol (TKC), Rosa Ana Lozada (CFYC), Minola Clark Manson (RIHS), Marcus McGuire (RII), Liz Miles (QIPIT), Danyte Mockus-Valenzuela (MHSA-PPU), Vanessa Pineda (JGFS), Kimberly Pettiford (PEI), Ezra Ramirez (QIPIT), Jennifer Santos (BHS), Angela Solom (QI), Sten Walker (NAMI), Charity White-Voth (AOA).

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Called to order at 10:02 am by Piedad Garcia.	
II. Approval of August 2019 Minutes	• Minutes for August 2019 were moved and motioned for approval as written by Minola Clark Manson and Celeste Hunter.	**Action Item:** Add Minola Clark Manson to August's attendance.
III. Chair's Report (Piedad Garcia and Charity White-Voth)	• Structure changes/hiring staff within AOA. • Charity White-Voth has been promoted to Assistant Medical Services Administrator (AMSA). • Changes in the Housing Team; ✓ Received over 115 million dollars over the next 3 years for No Place Like Home (NPLH) to be able to match persons with serious mental illness across the County with support of Housing. Many county directors did not agree, as it was taken from other funding amounts. ✓ 500 people with serious mental illness will be housed in support of housing over the next 3 years, Piedad Garcia had to increase her Housing team to manage all the increasing programs. ✓ Jason Miller has been promoted to Administrative Analyst III in the Housing team. Jason came to Adult and Older Adult System of Care as an Administrative Analyst I. ✓ Jason Miller and both AMSA's will be reporting directly to Piedad Garcia. AOA's Behavioral Health Program Coordinators (BHPC's) will be split between both AMSA's, giving Piedad more flexibility and availability to focus more in the system of care needs and regional needs. • Received additional 4 RFP's; 2 RFP's for this fiscal year and 2 for the next. One of the positions is for a Behavioral Program Manager. • At the direction of the Board of Supervisors, BHS have to address and mitigate the issues, particularly as it relates to the downsizing of acute care beds at Palomar, acute care beds at Tri-City hospital, and thus the Board office directed AOA to develop strategies to address the short falls of acute care beds. • In the last four months, Piedad has been working with Luke, Aurora and Yael addressing increasing the Palomar crisis stabilization unit beds, amending their contract with additional two recliners, increasing care coordination and increasing proving flex funds for short-term shelters for those that are homeless.	**Action Item:** Law prevention questions to Yael and Edith.

	• BHS will also be developing approximately 4 additional recliners or beds at the Emergency Department at Palomar Hospital. • BHS will be replacing those 16 beds as Palomar begins to work on ligature issues that needs to get fixed for patients' safety. • The Non- Law Enforcement crisis mobile team will not go through 911. ✓ 911 releases Law-Enforcement or PERT. ✓ 50% of the PERT calls do not need a Law-Enforcement response. • PERT will also be initiated at the North County. • BHS will be discussing the plan as to how the calls will come in and how public notification needs to be done for the North County. • BHS is working with Law Enforcement regarding Children and Youth school developments, in increasing safety and training in preventing violence. • BHS is also exploring a different model for the North Coastal Region, which closed a year ago in Tri-City. • It's anticipated that each region will have a crisis stabilization unit. • The plan for UCSD Hospital is to be rebuilt in the next two years. • BHS is developing the BHS Ops plan process. Looking at the following: ✓ What programs are going to be right-sized ✓ What programs are going to be enhanced ✓ What are the opportunities • Helen Robbin-Meyer have committed funding for these endeavors.	
IV. MHSA Updates (Danyte Mockus-Valenzuela)	• Public comments for 30-day period, which closed by holding a public hearing during the Behavioral Health Advisory Board meeting. • MHSA did not receive any public input during the BHAB meeting, but over the 30-day period they did receive 41 separate comments. • Many of the public comments were for support of the CREST Mobile program, which is one of the innovation programs that Dr. Piedad Garcia's unit monitors. • The 3-year expenditure plan has already begun. • Planning for community engagement activities are beginning. MHSA's plan this year is to host 6 regional forums, one in each region, as well as several focus groups. Planning for end of October, beginning of November. • 2019 Recovery Happens event is scheduled for Saturday, September 14th at Waterfront Park. • The Board of Supervisors (BOS) are accepting and adopting the updated strategic plan for the prevention of the Opioid and Prescription of Drug Misuse. • Behavioral Health Services and Public Health Services jointly submitted a grant to the CDC. • HHSA Agency announced that 900 Million dollars was awarded across almost all 50 states for the CDC Data Actions Surveillance and Prevention grant opportunity around the Opioid Overdose Prevention. • The County of San Diego was awarded 6.6 million dollars to work on overdose hot spots in areas of needs. MHSA will be working directly with Public Health to address issues.	**Action Item:** Update on grant in January. Provide at the September CCRT meeting the 2018 MHSA Annual Update.

V. QI Updates (Liz Miles)	• The Quality Improvement team has been asking for every legal entity's cultural competence plan since 2013. QI has not requested since but planning on redoing the same process. • Liz Miles proposed that the CCRT Workgroup would review the plans and provide individual feedback. • Liz discussed the Cultural and Linguistic Competence Policy Assessment 2019 report (handouts distributed) ✓ Recommendation is for each County to develop at least 8 statewide mental health disparity reductions. • Quality Improvement (QI) has asked the assistance of the CCRT Education and Training Subcommittee to help in the review of all the Cultural Competence Plans received for each of the contracted legal entities. • Refugee Report (handouts distributed) ✓ Request from the August CCRT meeting ✓ Last Fiscal year, there were only 171 unique individuals with Refugee Medi-Cal Aid Codes. ✓ 156 of the 171 individuals received Outpatient/Fee Service Outpatient service. ✓ 46 of the individuals were Youth under 18 and 125 were adults, over the age of 18. ✓ 81% of clients live independently. ✓ Arabic is the most common primary language at 42%. • Mental Health Program-Level results report (handouts distributed) ✓ Report will be distributed to all the COR's	
VI. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Piedad Garcia on behalf of Edith Mohler)	**Education & Training:** • Rolling 18-19 accomplishments and looking into 19-20 Goals; ✓ How do we inform the general system of care, outside the county, as to what's occurring in CCRT. ✓ Have accomplishments updates in January • Roles of CORs and supporting Cultural Competence ✓ Jennifer will lead presentation to the COR group **Children's Update:** • The CYF Council has held three Strategic Planning meetings: ✓ May 13, 2019 focused on Assessment of Psychiatric care in San Diego County. ✓ June 10, 2019 focused on CYF System of Care intersection with the Justice system/School Threats. ✓ August 12, 2019 focused on Addressing School Based Crisis/Threat. • The attendees participated in facilitated group discussions and provided recommendations on strengths, gaps, Innovation, and next steps. • CYF staff is working on consolidating recommendations into one report that will be ready in about a month and that we can send to you (once Dr. Bergmann approves) should you want to share it with the CCRT.	
VII. CCRT Future Discussion	• Justice Involved Population Data Review (November)	

VIII. Announcements	• Binational Mental Health Symposium Conference scheduled for October 10th at SDSU Imperial Valley Campus in Calexico, CA. Focus is about migrants and their mental health. • San Diego Symposium "Alcanzando Nuevos Caminos" scheduled for November 15th at SDSU Campus. • LGBT Center Final calls for strategic planning process scheduled for September 19th. • San Diego Planning Group: City of San Diego Housing Element Workshops (Flyer to be distributed).	

NEXT MEETING: October 4, 2019 10:00 AM - 11:30 AM | ***Academy* for Professional Excellence:**
6367 Alvarado Court, San Diego - Training Room 105

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsiveness"

County priorities related to System of Care

How can the CCRT support efforts regarding system integration

Expectation vs. practice

Presentations

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

October 4, 2019 | 10:00 am – 11:30 am| Academy for Professional Excellence: *6367 Alvarado Court, San Diego, CA 92120 – Training Room 105*

In Attendance: Awichu Akwanya (UWEA), Ingrid Alvarez-Ron (NAMI), Diana Anderia (SYHC), Elisa Barnett (TCSD), Yen Du (UPAC), Luisa Dones (AOA), Andrea Duron (AOA), Winona Garcia (SOT), Ai Johnson (TFSS), Nicole LeFol (TKC), Rosa Ana Lozada (CFYC), Minola Clark Manson (RIHS), Patricia Marquez (QIPIT), Edith Mohler (CYF), Kimberly Pettiford (PEI), Ezra Ramirez (QIPIT), Jennifer Santos (BHS), Angela Solom (QI), Ann Vilmenay (AOA), Charity White-Voth (AOA).

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Called to order at 10:00 am by Charity White-Voth.	
II. Approval of September 2019 Minutes	• Minutes for August 2019 were moved and motioned for approval as written by Rosa Ana Lozada and Elisa Barnett.	**Action Item:** Non-Law Enforcement for PERT.
III. Chair's Report (Charity White-Voth)	• CAO Director's Report included an update on the ROAM project ✓ An opening ceremony for the first unit occurred at Southern Indian Health Council in late summer; the second opening ceremony for the second unit in North Inland is scheduled for late October. ✓ ROAM stands for Roaming Outpatient Access Mobile ✓ ROAM will provide both mental health and substance use disorder services via mobile outreach and utilizing a strong cultural component to support engagement and ongoing treatment. ✓ The mobile unit will provide services to Native Americans living on the reservations in East Region and North Inland Region. ✓ Two units operated by two FQHC's, Southern Indian Health Council in East Region and Indian Health Council in North Inland Region. ✓ Services are for all ages	
IV. MHSA Updates (Kimberly Pettiford)	• Discussed Cultural Competency Highlights (packet distributed) ✓ Culturally and Linguistically competent services ✓ Lack of culturally sensitive assessments and interventions ✓ Creating housing for single-father families • Report was obtained from the annual update.	
V. QI Updates (Liz Miles)	• Thank you to the Education workgroup for volunteering to review the Cultural Competence plans by legal entity and provide feedback. • Next step is to bring a summary report with the obtained feedback. • As a follow-up request in August, Liz provided the refugee report at the September meeting.	

VI. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Edith Mohler)	**Education & Training:** • Meeting with Dr. Martinez: ✓ Obtained feedback and recommendations. Charity will review and present at the November meeting. ✓ Those recommendations and executive summary will go to the BHS Executives for next steps. • The workgroup is also reviewing the cultural competence plans. • Workgroup meetings are always an hour prior to the CCRT meeting. **Children's Update:** • Continue to work on the summary of recommendations. • CYF Administrative team had their Annual Cultural Competency event • Received positive feedback	
VII. CCRT Future Discussion	• Mobilizing team input discussions • Review FY 18-19 Accomplishments and discuss goals for FY 19-20.	
VIII. Announcements	• 2020 Children's Mental Health Wellbeing Celebration Planning Committee – November 2019 • Children, Youth & Family Liaison – October 29, 2019	

***NEXT MEETING: November 1, 2019 10:00 AM - 11:30 AM | Academy* for Professional Excellence:**
6367 Alvarado Court, San Diego - Training Room 105

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsiveness"

County priorities related to System of Care

How can the CCRT support efforts regarding system integration

Expectation vs. practice

Presentations

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

November 1, 2019 | 10:00 am–11:30 am| Academy for Professional Excellence: *6367 Alvarado Ct., San Diego, CA 92120 – Training Room 105*

In Attendance: Awichu Akwanya (UWEA), Diana Anderia (SYHC), Luisa Dones (AOA), Andrea Duron (AOA), Piedad Garcia (AOA), Winona Garcia (SOT), Ai Johnson (TFSS), Nestor Kensinger (AOA), Nicole LeFol (TKC), Rosa Ana Lozada (CFYC), Gina Mittal (JFS), Danyte Mockus-Valenzuela (PPU), Kimberly Pettiford (PEI), Sara Pirayesh (TKC), Ezra Ramirez (QIPIT), Jennifer Santos (BHS), Angela Solom (QI), Sten Welker (NAMI), Charity White-Voth (AOA).

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Called to order at 10:03 am by Piedad Garcia.	
II. Approval of October 2019 Minutes	• Minutes for August 2019 were moved and motioned for approval as written by Rosa Ana Lozada and Jennifer Santos.	
III. Review Action Items (Piedad Garcia)	**Non-Law Enforcement Mobile Crisis Team** • Yael Koening has been speaking to the Executive team, Dr. Luke Bergmann and additional members, because the recommendation came from the district attorney's office, Summer Stephan, in her blueprint for mental health. • The current plan is being drafted and there will be several levels in the unified school district, as well as in the Community College. • PERT will not be the first responder at the unified school district to respond to calls for intervention. • The first responder will be the school personnel. Some schools, not all, have security guards and some schools have crisis teams. • The second piece that still needs to be determined is if additional PERT clinicians are to be added, to respond to the school. • LAPD (Los Angeles Police Department) have embedded PERT teams in jail, also have a Vet PERT exclusively for Veterans, and have on school campus, at the college level, PERT teams. • LAPD PERT teams are called MET's (Mental Evaluation Teams) and are solely to respond as a PERT unit. • LAPD has a call center that receives all calls. • Ideas will be proposed in the upcoming request for proposal; however, Law Enforcement needs to be in agreement. • HEAT maps of all calls from PERT (calls are received between 8:00 am – 10:00 am). • The Board of Supervisors requires an update every 90 days.	**Action Item:** Piedad to follow up with Yael regarding recommendations regarding Non-Law Enforcement Mobile Crisis Team.
IV. FY 18-19 Accomplishments	• Requesting to review the FY18-19 Accomplishments and provide feedback to Piedad Garcia and Charity White-Voth. • Charity White-Voth will send current FY 18-19 Accomplishments to the workgroup and will work on making needed changes.	**Action Item:** Charity to remove "Adult and Older Adult" from the headline. Add "Justice Involved Data chart" as a discussion item to the December agenda.

V. Chair's Report (Piedad Garcia and Charity White-Voth)	**Behavioral Health Continuum of Care** • BHS continues to develop the Palomar campus for the Crisis Stabilization Unit, increasing from 6 to 8 recliners. • BHS will be moving forward with additional amendments to enhance the emergency department at Palomar, effective July 2020. • Submitting an RFP (Request for Proposals) in the 78 Corridor for up to 16 crisis residential treatment beds. • In North Coastal, BHS continues to work with the City of Vista and Exodus to develop a community-based crisis stabilization unit. • Will be enhancing PERT, not only with the children's piece but also with training for public safety group personnel. • There are currently 28 Request for Proposal (RFP's) in AOA for this FY.	
VI. MHSA Updates (Danyte Mockus-Valenzuela)	• MHSA has engaged SDSU institute for public health to the consultant for this years' Community Forum focus groups. • The timeline for this year will be November and in early December for the focus groups, holding 6 forums in each region. • MHSA will be focusing the conversations on prevention, as well as, innovation ideas throughout the forums. • MHSA would like to invite individuals to meet, discuss, and brainstorm ideas for outreach to other communities/populations. • On November 14th, MHSOAC staff will be traveling to San Diego to visit the migrant shelter and attend a community forum in the afternoon to discuss trauma at the border and in the migrant shelters. • On November 15th, SDSU will be hosting the San Diego Symposium: Alcanzando Nuevos Rumbos.	**Action Item:** Andrea to distribute the Community Forum information to the CCRT distribution team.
VII. QI Updates (Ezra Ramirez)	• QI is currently collecting feedback on their cultural competence plans. Will provide feedback, through formal letters, to the workgroup. • 90% of adult clients report that staff was sensitive to their cultural background in the state required consumer perceptions surveys. • A minimum of 85% of adult satisfactions survey respondents will agree that their staff recapacitates to their cultural background. • QI is preparing for the external quality review, which is the annual state-required review for mental health, which is scheduled January 7th- 9th.	
VIII. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Edith Mohler)	**Education & Training** • Workgroup has been reviewing the Cultural Competence plans. There are more to review and anyone outside the workgroup is welcome to provide feedback. • Updating the Cultural Competence Handbook and soliciting feedback from workgroup members **Children's Update** • Yael requested to share presentation regarding the Continuum of Care. • Board Meeting - October 29th (Flyers distributed)	

IX. CCRT Future Discussion		
X. Announcements	• Piedad and Charity attended the Binational Mental Health Symposium on October 10th. Piedad did a presentation.	**Action Item:** Bring copies of the CLAS Standards to the December meeting.

NEXT MEETING: December 6, 2019 | 10:00 AM - 11:30 AM | Academy for Professional Excellence: 6367 Alvarado Court, San Diego - Training Room 105

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsiveness"

County priorities related to System of Care

How can the CCRT support efforts regarding system integration

Expectation vs. practice

Presentations

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

December 6, 2019 | 10:00 am–11:30 am| Academy for Professional Excellence: *6367 Alvarado Ct., San Diego, CA 92120 – Training Room 105*

In Attendance: Piedad Garcia (AOA), Andrea Duron (AOA), Luisa Dones (AOA), Awichu Akwanya (UWEA), Mahvash Alami (SOT), Shadi Haddad (SYHC), Rick Heller (HSRC), Rosa Ana Lozada (CYF), Michelle Ly (UPAC), Liz Miles (QI), Edith Mohler (CYF), Nilanie Ramos (CDO), Nancy Rodriguez (CM), Ann Vilmenay (AOA), Charity White-Voth (AOA), Kimberly Pettiford (PPU), Gina Mittal (JFS), Ingrid Alvarez Ron (NAMI), Vanessa Pineda (JFS)

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Meeting called to order at 10:13 am by Dr. Piedad Garcia	
II. Approval of November 2019 Minutes	• Minutes for November 2019 were moved and motioned for approval as written by Rosa Ana Lozada and Awichu Akwanya	
III. Review Action Items		
IV. Justice Involved Data Chart (Liz Miles)	**Justice Involved Adult and Older Adult Mental Health Clients (FY 2017-2018)** • Chart displays adult client data only • Justice-Involved Column: Data on clients listed in the CRM system as being involved in justice • Jail Column: Data on clients who are enrolled specifically in jail mental health services • Caucasian, Hispanic, and African American clients have the highest prevalence in the jail system • Clients diagnosed with schizophrenia have a higher prevalence in the jail system (42%) versus the system overall (36%) • Substance use within the Justice- Involved (74%) versus the system overall (47%) • 70% of 15,000 clients in the jail system have a serious mental illness • Upstream prevention is needed to address homelessness through employment and housing opportunities • Examples of upstream prevention: In-Reach Reentry, Just in Time Access, low barrier employment, and creating incentives for small businesses that provide hands-on training to clients. • Added a Justice-Involved Step Down, La Luz, specifically for clients who are coming out of jail • Added Acute Care Step Down from psychiatric hospitals and Institutes of Mental Disease, providing treatment and housing for 40% of the clients	**Action Item:** Acquire data crosswalk that shows the number of clients who are connected to the mental health system upon release from jail. Add data regarding homelessness to report and data for 18-25-year-olds who are Justice Involved, Jail Only, or in Treatment from the last two years. Compile a 1-pager with ideas regarding innovative employment strategies for clients coming out of jail, to be presented at upcoming meeting

V. Chair's Report (Piedad Garcia and Charity White-Voth)	**MHSA Community Forum and Asylee Shelter Tour** • The County had the chance to work with OAC during the MHSA Community Forum on November 14th – focused on asylees/immigrants at the Border and toured the asylee shelter that HHSA funds with Jewish Family Services and UCSD • Met with OAC staff and a resident with his child to speak about his crossing, what he was doing at the shelter, and what is next • Guests are already processed by ICE, received an ankle bracelet, and screened for medical services • Meeting with JFS to include a question about mental health in the screening	
VI. MHSA Updates (Kimberly Pettiford)	• Two CCRT members participated in the call regarding data input for surveys; went over guidance that must be followed (i.e. Demographic categories) • Additional choices and rewording were discussed so that the survey aligns with state guidelines while also meeting our needs • SDSU is working on revising the survey based on the meeting • End of survey has additional choices such as Veterans, Refugee/Newcomer, and Provider Identifier • Two community forums upcoming focusing on innovation and engagement— Kearny Senior High School on January 9th, 2020 and Bonita Vista High School on February 2nd, 2020 • In the process of confirming four additional forum locations • Focus group scheduled for December 19th , with target audience being aging-out and aged- out foster youth	
VII. QI Updates (Liz Miles)	• External Quality Review (EQR), an annual review conducted by the State, is scheduled for January • EQR will be reviewing quality, timeliness, and access • The County is required to conduct 15 focus groups this year made up of clients, staff, and contractor	
VIII. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Edith Mohler)	**Children's Update** • Managing Change in a Changing World Conference is scheduled for March, discussing topics such as immigration, family separation, self-regulation, suicide, and bullying • CYF staff is preparing a document with framework that combines CYF Council principles and Live Well concepts • Yael will present the document at Monday's CYF Council meeting	

	Education & Training • Continuing to look at cultural competency plans at the legal entity level, one-pager of accomplishments will be finalized soon • Working on a quarterly update of high-level items that CCRT representatives can bring back and communicate consistently across all council meetings • First step: Take CCRT Accomplishments & Goals back to councils to share during meetings • A new version will be sent out in March and continuously updated on a quarterly basis • Working with QI to update movies, books, and other media that can be sent out as suggestions in the Technical Resource Library in the Suggested Resources section • Suggested content for the TRL can be sent to Charity, Ann, or Luisa	
IX. CCRT Future Discussion		
X. Announcements		

NEXT MEETING: January 3, 2020 10:00 AM - 11:30 AM | Academy for Professional Excellence: 6367 Alvarado Court, San Diego - Training Room 105

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsiveness"

County priorities related to System of Care

How can the CCRT support efforts regarding system integration

Expectation vs. practice

Presentations

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

January 3, 2020 | 10:00 am–11:30 am| Academy for Professional Excellence: *6367 Alvarado Ct., San Diego, CA 92120 – Training Room 105*

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Meeting called to order at 10:03 am by Dr. Piedad Garcia	
II. Approval of December 2019 Minutes	• Minutes for December 2019 were moved and motioned for approval with edits by Elisa Barnett and Awichu Akwanya	

III. Review Action Items	**Justice Involved Data Chart**
	• Living Arrangement was added as a category on the data chart
	  ○ 22% of Justice Involved clients are homeless
	  ○ 14% of the overall AOA population are homeless
	
	Jail and JFS Report Crosswalk
	• Jail data pertains to adult clients while JFS data pertains to clients 18-years-old and under
	• Data compares CM or OP connection within 90 days and 180 days
	• 51% of adults' first admission for treatment after jail discharge was back in Jail Services
	• 24% of adults were not connected to services after jail discharge
	• 63% of youth's first admission for treatment after JFS discharge was back in JFS Services
	• 15% of youth were not connected to services after JFS discharge
		Action Item:
		Review FY 18/19 Data once it is available

IV. Chair's Report (Piedad Garcia and Charity White-Voth)	**Behavioral Health Advisory Board** • Dr. Luke Bergmann provided an update on the Continuum of Care • Development started in North Coastal and North Inland as a result of reducing psychiatric acute care beds at Tri-City and Palomar • Development is under way for a Crisis Stabilization Unit at Palomar—Includes eight recliners, 24/7, LPS • In the process of developing a CSU in Vista and Oceanside • Up to 14 Crisis Residential Treatment Beds will be coming online around the 78 Corridor, proposals expected by mid-January • A non-law enforcement Crisis Mobile Response Team is being developed in Vista, expected to be finalized within the next six months • Third Avenue Complex: Scripps and UCSD are exploring the possibility of a joint venture for care coordination with a variety of treatment services on one campus	**Action Item:** Review data on Medi-Cal population and penetration rate of Behavioral Health Services in East and South Region Review Interpreters Report with additional data on age populations based on need

	• Development of centralized care coordination resources in East and South Regions are in the works **Continuum of Care** • All are encouraged to bring representatives of the community to the upcoming MHSA Forums in order to address specific needs **CCRT FY 18/19 Accomplishments and FY 19/20 Goals** • Continuation of educating contractors on CLAS Standards • Continuation of Cultural Competence Academies through RIHS • Workgroup will revisit bylaws and potentially develop additional workgroups in order to accomplish FY 19/20 Goals	
V. MHSA Updates (Danyte Mockus-Valenzuela and Kimberly Pettiford)	**Updates** • Community Forums begin next week, starting with East Region on Wednesday, January 8, 2020 • Focused on prevention and substance use • Opportunity to provide information regarding innovations projects/ideas • Inviting input from the community regarding how they want to be engaged • Forums will take place at schools, after work hours with food and other incentives provided • Flyers translated into the five threshold languages are available on the BHS website or ListentoSanDiego.org • SDSU has started focus groups • Foster Youth Focus Group met on December 19th , next one scheduled for January 15th • BHS will be meeting with BHAB members who would like to provide input into other focus groups • BHS will be utilizing the Friday Night Live Programs to create a focus group of high school-aged youth starting in February • Looking at multi-year procurement for community engagement forums, more focus groups, and intercept interviews	

VI. QI Updates
(Liz Miles)
	External Quality Review
	• External Quality Review (EQR), an annual review conducted by the State, is scheduled for January 7th through January 9th
	• EQR will be reviewing quality, timeliness, and access
	  ○ Over 40 different sessions during the EQR
	• The County is required to conduct 15 focus groups this year made up of clients, staff, and contractors
	  ○ Examples of Focus Groups: Parents and Caregivers, Foster Parents and Caregivers, Adult Clients in East County, and ROAM	

VII. Committee Updates **Education & Training** (Charity White-Voth) **Children's Update** (Edith Mohler)	**Education & Training** • CCRT representatives are encouraged to share accomplishments and goals at other meetings they attend • An updated CCRT report will be distributed on a quarterly basis to share with other councils or groups **Children's Update** • Yael Koenig created a memo detailing Continuum of Care recommendations to present to Dr. Luke Bergmann • Managing Change in a Changing World will take place on March 12th and 13th at the Double Tree Hotel	
VIII. CCRT Future Discussion		
IX. Announcements	• The Division of Filipino American Psychological Association will be hosting a conference on Saturday, January 25th at Alliant University ($55 registration fee)	

NEXT MEETING: February 7, 2020 10:00 AM - 11:30 AM | Academy for Professional Excellence: 6367 Alvarado Court, San Diego - Training Room 105

Hot Topics

"Cultural Competence" vs "Cultural Affirmation" vs "Cultural Humility" vs "Cultural Responsiveness"

County priorities related to System of Care

How can the CCRT support efforts regarding system integration

Expectation vs. practice

Presentations

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

February 7, 2020 | 10:00 am–11:30 am| Academy for Professional Excellence: *6367 Alvarado Ct., San Diego, CA 92120 – Training Room 105*

AGENDA ITEM	SUMMARY	ACTION
I. Welcome and Introductions	• Meeting called to order by Charity White-Voth at 10:07 AM	
II. Approval of January 2020 Minutes	• Minutes for January 2020 moved and motioned for approval as written by Celeste Hunter and Shadi Haddad	

III. Review Action Items	• Penetration Rate of Medi-Cal Mental Health Beneficiaries served in San Diego region
	  ○ 65,738 total unique clients served
	  ○ 46,971 unique Medi-Cal clients served
	  ○ 5.3% medical penetration rate
	  ○ 889,207 Medi-Cal clients
	• Language and Interpreter Services by Age Category
	  ○ The majority are Spanish speakers and 26 through 59 years old
		Action Item:
		Liz Miles to add dot points to break down information on penetration rate of Medi-Cal Mental Health Beneficiaries

IV. Chair's Report (Piedad Garcia and Charity White-Voth)	**Continuum of Care**
	• Piedad Garcia provided update on North Inland Services Esperanza Crisis Residential Treatment Program
	  ○ The vision is a network of homeless services including short term and transitional housing.
	  ○ One of the concepts that has been looked at is a "store front" in the campus providing primary care services, outreach and engagement component, supportive employment, mental health services and substance use services.
	
	Medication Assistance Treatment
	• The Crisis Stabilization Unit will be on County property located in the North Coastal Health and Human Services Agency's Family Resource Center
	  ○ It will take approximately 9-12 months to rehab and establish 12 recliners.
	
	Mobil Crisis Response Team
	• A meeting is being held on February 7, 2020 to finalize the design of the non-law enforcement MCRT
	• North Costal and North Inland law enforcement agencies will be conducting a pilot program in conjunction with MCRT to address "5150" calls
	
	Crisis Stabilization Unit
	• In reference to the Third Avenue Complex, UCSD will be the hub that will have a hospital and care coordination component
		Action Item:
		Danyte Mockus-Valenzuela to give an update at March meeting on campaign for Prevention and Early Intervention of Substance Use

	• There is anticipation to establish east and south crisis stabilization units
	• Behavioral Health Services Ops plan is still being decided on due to MHSA revenue predicted to decrease in the next two years
	
	Behavioral Health Advisory Board
	• On February 6th, 2020 Dr. Esposito gave a presentation regarding stigma around Medical Assisted Treatment
	  ○ There is a board letter regarding community engagement and education.
	
	• Children, Youth and Family and Adult and Older Adult teams are on standby for repatriation of flights coming from China and other areas due to the Corona Virus
	
	  ○ Funding has been established for two licensed mental health clinicians with bilingual capabilities.	

V. Mental Health Services Act Updates (Danyte Mockus-Valenzuela and Kimberly Pettiford)	**Updates provided by Martin Dare** • Community Engagement Forums are near completion • 7 forums took place in each region of the county • North Coastal registration was approximately 257 with attendance approximately 230 • North Coastal had high attendance of high school students • 30% of attendees identified as family/consumer • Focus groups included Voices for Children, LGBT, Friday Night Live • Continue working on putting together a childcare provider group • Report of feedback will be drafted in the next month	
VI. Quality Improvement Updates (Liz Miles)	• External Quality Review Organization had the largest turnout to date with over 350 participants • Substance Use Disorder External Quality Review Organization coming in May 2020, more details to come • Cultural Competency Plan is coming up soon, more details to come • Quality Improvement will be sending out a survey looking at what's working, what's not, what are the needs/gaps within the next week • Cultural Competency Plan is due to the State by June 30, 2020 • Quality Improvement will identify themes and bring back for discussion in April 2020 • Final draft expected to be done by end of May • SMARTIE Goals: ○ For goals to be effective in an organization's performance they need to be strategic, measurable, ambitious, realistic, time-bound, inclusive and equitable.	
VII. Committee Updates **Education & Training** (Charity White-Voth)	**Education & Training** • Orientation packet for CCRT is being finalized • The SMARTIE model will be used to address CCRT goals	

Children's Update (Edith Mohler)	**Children's Update** • NAMI Training on February 12th, 2020 • NAMI Annual Youth Mental Health Wellbeing celebration on May 8th, 2020 • Managing Change in an Aging World Conference Early Bird Registration ends February 28th, 2020	
VIII. Cultural Competence Resource Team Future Discussion		
IX. Announcements	• Cultural Competence Summit in progress, set to occur in the Tri-City area, more to come • Meeting adjourned at 11:31 AM	

NEXT MEETING: March 6, 2020 10:00 AM - 11:30 AM | Academy for Professional Excellence: 6367 Alvarado Court, San Diego - Training Room 105

Presentations

FY 2019-2020 Goals

Best Practice:

•Highlight effective programs serving culturally diverse communities for providers to integrate appropriate services.
•Develop a Recognition Award criteria and process to recognize organizations who are providing exemplary Cultural Competence activities.

- To be presented at the Behavioral Health Recognition Dinner (BHRD).

•**Identify gaps in representation with CCRT and develop targeted outreach for those agencies/community groups for participation.

- Invite additional Ethnic Community Based Organizations (ECBO) who align with CCRT as well as system of care partner representatives from Probation, Education, DA, etc. to move toward system wide improvement.

•**Dedicate time and space within CCRT (or as a separate workgroup) to review and analyze data related to underserved populations including linguistic findings, interpreter services, utilization rates, jail in-reach outcomes, etc.

- Address the Justice Involved population, specifically the overrepresentation of African Americans and Latinos and develop recommendations for services.

•Develop recommendations for the MHSA Fiscal Year 2019-20 Annual Update.
•Provide quarterly, uniform CCRT Updates to various meetings and Councils to provide consistent messaging.

- Develop a standardized tool to provide consistent CCRT highlights at the various Councils at the beginning of the fiscal year.

•Provide COR training to County staff on CLAS standards – and how to monitor effectively for CC.
•**Provide dedicated support to contractors and community agencies who request technical assistance and guidance around cultural competence efforts within their agency, workforce, client served, etc.

- Review organizational CC Plans by Legal Entity.

Program:

•Advance culturally responsive community-based organizations to evidence-based standards.
•Increase CCRT Substance Use Disorder provider and consumer membership.
•Invite programs/providers to present on their respective Cultural Competence (CC) Plans, including approaches, implementation, challenges and goals at CCRT meetings.
•**Develop a process for dissemination of resources that are readily available not only to BHS contractors, but to the general community and BHS staff.

Policy:

•Submit culturally responsive recommendations for the MHSA Fiscal Year 2019-20 Annual Update.
•Identify and implement strategies to strengthen system wide advance of cultural competence standards consistent with the State Plan and CLAS standards.

- CCRT members will use a standardized tool to review provider organizational CC Plans by Legal Entity and provide recommendations for continuous improvement.

•**Address workforce development focused on recruiting and hiring a diverse workforce within BHS and with County contractors.

**Recommendations from Strategic Planning/Focus Group

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2018—2019 Year In Review

Serving the Health and Human Services Community

Adult Services ■ Behavioral Health ■ Child Welfare ■ Indian Child Welfare

69,061 Learning Experiences Provided

31,167 COMPLETED ELEARNINGS	27,633 CLASSROOM TRAINED	7,613 RECEIVED COACHING	716 PARTICIPATED IN SIMULATIONS
1,932 RECEIVED PEER EDUCATION	988 TRAINING DAYS	1,294 COACHING DAYS	37 SIMULATION DAYS

Our Mission

We provide exceptional learning and development experiences for the transformation of individuals, organizations, and communities.

Our Vision

We envision a world where the quality of life for individuals, organizations, and communities is transformed to a healthier place.

Our Programs

CWDS Child Welfare Development Services

RIHS Responsive Integrated Health Solutions

APSWI Adult Protective Services Workforce Innovations

LIA Leaders in Action

Tribal STAR

SACHS Southern Area Consortium of Human Services

APEX

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College of Health & Human Services

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Responsive Integrated Health Solutions

GUIDELINES FOR TRAINERS

(Ethics, Standards & Performance)

The following guidelines encompass the guiding ethics, values and training principles applicable to the trainers with the Responsive Integrated Health Solutions (RIHS). RIHS holds all trainers and coordinators accountable to these principles in our work of delivering training to behavioral health staff, people receiving services, and their families.

1. **CORE VALUES:**
    a. Every effort should be made to ensure the physical and emotional safety of all trainees.
    b. Learning and development: facilitate knowledge acquisition; skill demonstration and practice; utilize strategies to promote transfer of learning; and, advocate for the development of learning organizations/communities.
    c. Cultural Competence: promote competence in understanding the uniqueness of individuals within their environment and recovery.
    d. Integrity: Promote a climate of trust and mutual respect.

2. **ETHICAL STANDARDS:**
    A. Person/Consumer or Family Focused:
    a. Advocate for the well-being of people receiving services and their families.
    b. Preserve and promote the dignity of people discussed in training and development activities.
    c. Maintain the confidentiality of service recipients and their families during training activities.
    d. Provide training activities that help trainees better understand and promote recovery of consumers, people receiving services and their families.
    e. Promote the philosophy of resilience and self-reliance in consumers, people receiving services and their families.
    f. Promote resiliency and recovery oriented communication in all modalities through the use of trauma informed and person-first language.
    B. Participant/Trainee Focused:
    a. Recognize, protect and where possible, enhance the dignity and worth of all trainees.
    b. Clarify expectations regarding:
        - training goals
        - roles of those involved in training activity
        - rules/policies impacting trainee:
        - interpersonal behavior in the classroom
    c. Provide a safe learning environment

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- Where content areas have the potential for causing emotional reactions, have a plan on how to handle reactions that support the trainee without distracting other trainees from their learning process.
- Promote a climate of trust and mutual respect in training so that trainees feel supported enough to take risks to promote their learning and development.

d. Promote trainee acquisition of knowledge and skills
e. Help trainees plan for application of learning to the job.

3. TRAINER PERFORMANCE

A. Training Design:

a. Demonstrate ability to write appropriate content for the instructional objectives
b. Demonstrate ability to organize instructional material in sequencing, integration of theory and practice, pacing of material, and depth of material in relation to audience
c. Demonstrate the information to be delivered is relevant, current, based on evidence based practice, current research, literature and/or law review and best practice
d. Demonstrate the ability to integrate BHS specific information and/or values.
e. Demonstrate understanding of adult learning theory in designing curriculum.
f. Incorporate a variety of methodologies to enhance learning
g. Demonstrate the ability to use feedback and evaluation data to revise training curriculum

B. Integration of BHS Themes:

a. cultural competence
b. resilience
c. recovery
d. integrated co-occurring treatment
e. Wrap-around

4. COMPETENCIES DURING PRESENTATION OF TRAINING:

A. Training Delivery:

a. Demonstrate mastery of subject matter to be presented in curriculum
b. Make effective use of multiple presentation styles (lecture, facilitated discussion, small group breakouts, role plays, case examples, technology, and handouts) to illustrate key points in training.

NOTE:

- Not all presentation styles need to be incorporated during the training day.
- Technology may include the use of video clips, music, PowerPoint presentation, etc.

c. Clearly state identified competencies and learning objectives
d. Manage conflict
e. Encourage audience participation
f. Create an environment where participants feel safe to explore ideas or disagree

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g. Provide clear instructions for activities
h. Provide learning opportunities for the variety of learning styles defined by Adult Learning Theory

5. Training Logistics

- **Training Coordination:**
  - Prior to the training date, you will be corresponding with a RIHS training coordinator. The coordinator is who you will be submitting all materials for review to and working with throughout the process of coordinating the training.
    - Learning objectives are pre-determined and will be sent to the trainer by the RIHS coordinator.
  - You will also be working with an Assistant Training Coordinator who will send you your deliverable summary and forms that you will need to complete to train for RIHS.
  - Lastly, you will also be hearing from the Academy's contracting department for your official contract and for instructions on invoicing.
- **Materials:**
  - Trainers will provide an outline/agenda, PowerPoint, and training handouts to the coordinator of training by posted due dates.
  - Bibliography and references are required for all materials.
  - The coordinator will print any training handouts/activities will be used during class instruction. PowerPoints will be sent to participants electronically as we strive to be as green as possible with our printing.
  - Trainer must submit a short updated biography to be used on the RIHS website
  - Trainer is required to submit a current resume/curriculum vitae which reflects expertise in training subject
- **Cancellation Policy:**
  - Training can be canceled up to one week prior to the training date. The trainer and participants will be notified by the training coordinator.
- **CE/Attendance policy:**
  - All participant CE and attendance questions should be directed to the training coordinator.
  - Participants have been reminded ahead of time, including the day of the training, that CEs are only available to those participants who stay for the entire training day or series, not missing 15 or more minutes of any day. There are no partial CEs.
  - Participants are also made aware that missing more than 30 minutes of a training day or series results in no completion credit for the day and series if applicable.
- **Training Day:**
  - The trainer is required to arrive 30-minutes prior to the scheduled training start time.

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- ❏ RIHS training coordinator will be present at the training, manage attendance and begin class with an introduction to the training covering the following:
  - ❏ How training relates to the County's vision, logistics of the day.
  - ❏ Show a 2-minute video on person-first language as it sets the tone for how we will be using language throughout the day.
- ❏ A full-day training is scheduled from 8:30 am-4:30 pm.
- ❏ Full-day trainings have two 15-minute breaks, one mid-morning, and one mid-afternoon, as well as, a 1-hour lunch typically scheduled from 12-1 pm.
- ❏ Half-day trainings are scheduled from 8:30 am - 12:30 pm.
- ❏ Half-day trainings have one 15-minute break mid-morning and no lunch break as the class is dismissed at 12:30 pm.

CULTURAL AND LINGUISTIC COMPETENCE POLICY ASSESSMENT

2020 REPORT

One of the Quality Improvement strategies in the County of San Diego Behavioral Health Services (BHS) Cultural Competence Plan is to survey all program managers annually to evaluate their perception of their programs' cultural and linguistic competence. Accordingly, all County and County-contracted programs are required to complete the Cultural and Linguistic Competence Policy Assessment (CLCPA). The assessment was administered for the first time in 2017, as a replacement of the annual CC-PAS.

The CLCPA was developed by Georgetown University's National Center for Cultural Competence and adapted by BHS to align with the expectations recommended by the Cultural Competence Resource Team (CCRT) and the National Culturally and Linguistically Appropriate Services (CLAS) Standards. The goal of the CLCPA is 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.

BACKGROUND

The Google survey was distributed via email to all County-contracted and County-operated Program Managers in February 2020. The Program Managers were asked to first identify the main cultural groups that their program predominantly serves so they could refer to them as they completed the survey. They also had the opportunity to request technical assistance in becoming familiar with the items in each of the eight sections. The response options were based on a Likert scale and assigned a numerical value, ranging from 1 to 5.

A total of 228 programs responded to the survey: 161 (70.6%) Mental Health Services (MHS) and 67 (29.4%) Substance Use Disorder Services programs. The self-reported responses are shown in this report as combined percentages, as well as broken down into MHS and SUD responses to show a contrast between the two systems of care. Responses were compared to those received in 2019; changes in percentages are depicted within each table using arrows.

SUMMARY OF FINDINGS

- 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 respondents indicated that they were fairly or very familiar with the diverse communities and the demographic makeup of their service areas *(Section 1)*. These results were almost identical to those from 2019.
- The majority of respondents indicated support for cultural competence in the overall organizational philosophy most of the time or all the time *(Section 2)*.
- The majority of respondents indicated some form of personal and program staff involvement in the communities' culturally diverse activities *(Section 3)*.
- 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 (Section 4).
- 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 *(Section 5)*.
- 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 evaluates the quality and effectiveness of these services, about a fifth reported not doing so (*Section 7)*.
- Most of the technical assistance (TA) requests were related to community engagement, the CLAS Standards, interpretation services, beneficiary materials, assessment tools, and whole person wellness.

ASSESSMENT RESULTS

Section 1: Knowledge of Diverse Communities

The focus of this section is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics, and contextual realities.

- The majority of the respondents in MHS and SUD rated their organizations' familiarity and ability to identify diverse communities in their service areas as fairly well or very well *(Question 1)*.
- Nearly all respondents (98.7%) indicated that their organizations' Cultural Competence Plans identified and supported the CLAS Standards *(Question 2)*.
- *Question 8*, which pertains to the organizations' familiarity with the natural networks of support for culturally diverse groups in their service area, had the largest proportion (15.0%) of the rating somewhat. A total of 11.2% of MHS respondents gave this rating, compared to 24.2% for SUD respondents.
- The most common TA requests were related to becoming more familiar with the cultural groups in the community, and with the CLAS Standards. Other requests were related, but weren't limited to: continuous training aimed at cultural competence.

2020 CLCPA: SYSTEMWIDE REPORT

Section 1: Knowledge of Diverse Communities *(continued)*

Section 1 Questions	Not at all	Δ	Barely	Somewhat	Fairly Well	Δ	Very Well	Δ	Yes	Δ	No	Δ
1. Is your organization able to identify the culturally diverse communities in your service area?	0.0%		0.0%	2.2%	34.4%	↑	63.4%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	1.2%	36.0%	↑	65.2%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	6.1%	33.3%	↓	63.6%	↑	N/A	N/A	N/A	
2. Does your organization's Cultural Competence Plan identify and support the CLAS Standards?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98.7%	↓	1.8%	↑
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98.1%	↓	1.9%	↑
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	98.5%	↓	1.5%	↑
3. Is your organization familiar with current and projected demographics for your service area?	0.4%		0.0%	7.9%	41.4%	↑	50.2%	↓	N/A	N/A	N/A	N/A
	0.0%	↓	0.0%	8.1%	42.2%	↑	49.7%	↓	N/A	N/A	N/A	N/A
	1.5%	↑	0.0%	7.6%	39.4%	↑	51.5%	↓	N/A	N/A	N/A	N/A
4. Is your organization able to describe the social strengths (e.g., support networks, family ties, spiritual leadership, etc.) of diverse cultural groups in your service area?	0.4%		0.0%	8.8%	45.4%		45.4%	↓	N/A	N/A	N/A	N/A
	0.6%		0.0%	7.5%	47.8%	↑	44.1%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	12.1%	39.4%	↓	48.5%	↑	N/A	N/A	N/A	N/A
5. Is your organization able to describe the social problems (e.g., dispersed families, poverty, unsafe housing, etc.) of diverse cultural groups in your service area?	0.0%		0.0%	4.0%	34.8%	↑	61.2%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	8.2%	35.4%	↑	61.5%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	6.1%	33.3%	↓	60.6%	↑	N/A	N/A	N/A	N/A
6. Is your organization familiar with health disparities among culturally diverse groups in your service area?	0.4%	↑	0.9%	12.8%	40.1%	↑	45.8%	↓	N/A	N/A	N/A	N/A
	0.6%	↑	1.2%	12.4%	38.5%	↑	47.2%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	13.6%	43.9%	↑	42.4%	↑	N/A	N/A	N/A	N/A
7. Is your organization able to identify the languages and dialects used by culturally diverse groups in your service area?	0.0%		0.0%	13.2%	43.2%	↑	43.6%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	11.8%	42.9%	↑	45.3%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	16.7%	43.9%	↑	39.4%	↓	N/A	N/A	N/A	N/A
8. For the culturally diverse groups in your service area, is your organization familiar with:	0.0%		0.9%	13.7%	54.2%	↑	31.3%	↓	N/A	N/A	N/A	N/A
	0.0%		1.2%	13.0%	54.7%	↑	31.1%	↓	N/A	N/A	N/A	N/A
The health beliefs, customs, and values?	0.0%		0.0%	15.2%	53.0%	↑	31.8%	↓	N/A	N/A	N/A	N/A
	0.0%		1.3%	15.0%	53.3%	↑	30.4%	↓	N/A	N/A	N/A	N/A
The natural networks of support?	0.0%		1.2%	11.2%	55.9%	↑	31.7%	↓	N/A	N/A	N/A	N/A
	0.0%		1.5%	24.2%	47.0%	↓	27.3%	↓	N/A	N/A	N/A	N/A
9. For the culturally diverse groups in your service area, can your organization identify:	0.4%	↑	0.4%	9.7%	53.7%	↑	35.7%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	9.9%	55.3%	↑	34.8%	↓	N/A	N/A	N/A	N/A
Help-seeking practices?	1.5%	↑	1.5%	9.1%	50.0%	↑	37.9%	↓	N/A	N/A	N/A	N/A
	0.4%	↑	0.0%	11.9%	52.0%	↑	35.7%	↓	N/A	N/A	N/A	N/A
The way illness and health are viewed?	0.0%		0.0%	11.2%	50.3%	↑	38.5%	↓	N/A	N/A	N/A	N/A
	1.5%	↑	0.0%	13.6%	56.1%	↑	28.8%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	7.0%	41.9%	↑	51.1%	↓	N/A	N/A	N/A	N/A
The way mental health is perceived?	0.0%		0.0%	6.8%	42.9%	↑	50.3%	↓	N/A	N/A	N/A	N/A
	0.0%		0.0%	7.6%	39.4%	↑	53.0%	↓	N/A	N/A	N/A	N/A

Note: N/A in the above graph indicates that the answer option was not available for these questions.

Legend: Combined | MHS | SUD | Δ :Change compared to 2019

Section 2: Organizational Philosophy

This section focuses on the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with clients/participants and community members, and advocacy.

- The majority of respondents indicated support for cultural competence in the overall organizational philosophy most of the time or all the time *(Section 2)*.
- A total of 9.3% of the respondents indicated that their organizations' mission statement does not incorporate cultural and linguistic competence in service delivery *(Question 10)*. This number has decreased by about 3% compared to the 2019 data.
- Nearly half of respondents indicated that they reviewed procedures to ensure that they are relevant to culturally (53.7%) or linguistically (49.3%) competent services all the time. A total of 13.0% of MHS respondents indicated that their organizations often reviewed procedures to ensure relevance to linguistically competent services, compared to 13.6% of SUD respondents *(Questions 14 and 15)*.
- About one in ten respondents indicated that only sometimes were there any structures in their programs to assure participant and community participation in program planning, making it the least inclusive organizational practice reported by respondents *(Question 17)*.
- A total of 21% of respondents indicated that none or very little of the décor reflected the culturally diverse groups in the programs' service area *(Question 18)*. The distribution of responses from MHS respondents and SUD respondents were similar.
- Overall, about four out of five respondents (83%) indicated that their programs posted signs and materials in four or more other languages besides English. Most MHS and SUD respondents (84% and 81%, respectively) indicated that materials were posted in 4 or more other languages (Question 19).
- The most common TA requests were related to becoming more familiar with the beneficiary materials in threshold languages that are available to the programs. Several programs requested quality improvement process and CLAS Standards training refreshers.

Section 2 Questions	Not at all	Δ	Sometimes	Often	Δ	Most of the Time	Δ	All the Time	Δ	Yes	Δ	No	Δ
10. Does your organization have a mission statement that incorporates cultural and linguistic competence in service delivery?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90.7%	↑	9.3%	↓
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90.1%	↑	9.9%	↓
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	92.4%	↑	7.6%	↓
11. Does your organization support a practice model that incorporates culture in the delivery of services?	0.0%		2.6%	5.3%	↓	26.9%	↑	65.2%		N/A	N/A	N/A	N/A
	0.0%		1.9%	3.7%	↓	24.8%	↑	69.6%	↑	N/A	N/A	N/A	N/A
	0.0%		4.5%	9.1%	↑	31.8%	↓	54.5%	↓	N/A	N/A	N/A	N/A
12. Does your organization consider cultural and linguistic differences in developing quality improvement processes?	0.4%	↑	3.5%	10.1%	↓	28.6%	↑	57.0%	↓	N/A	N/A	N/A	N/A
	0.6%	↑	1.9%	9.9%	↑	29.8%	↑	57.8%	↓	N/A	N/A	N/A	N/A
	0.0%		7.6%	10.6%	↓	25.8%	↓	56.1%	↑	N/A	N/A	N/A	N/A
13. Does your organization advocate for culturally diverse participants regarding quality of life issues (e.g., employment, housing, education) in your service area?	0.0%	↓	1.8%	4.0%	↓	26.0%	↑	68.3%	↓	N/A	N/A	N/A	N/A
	0.0%		1.2%	4.3%	↓	29.2%	↑	65.2%	↓	N/A	N/A	N/A	N/A
	0.0%	↓	3.0%	3.0%	↑	18.2%	↓	75.8%	↑	N/A	N/A	N/A	N/A
14. Does your organization systematically review procedures to ensure that they are relevant to delivery of CULTURALLY competent services?	0.4%	↑	5.3%	12.3%	↓	28.2%	↓	53.7%	↑	N/A	N/A	N/A	N/A
	0.6%	↑	4.3%	14.9%	↓	26.7%	↓	53.4%	↑	N/A	N/A	N/A	N/A
	0.0%		7.6%	6.1%	↓	31.8%	↑	54.5%	↑	N/A	N/A	N/A	N/A

Note: N/A in the above graph indicates that the answer option was not available for these questions.

Legend: Combined | MHS | SUD Δ :Change compared to 2019

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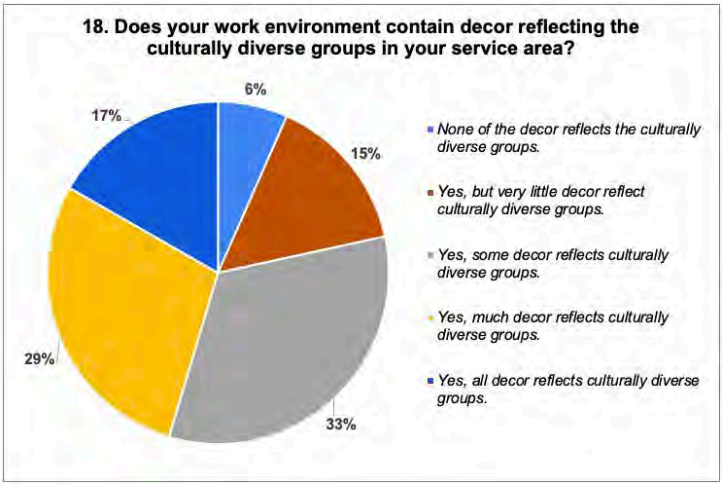
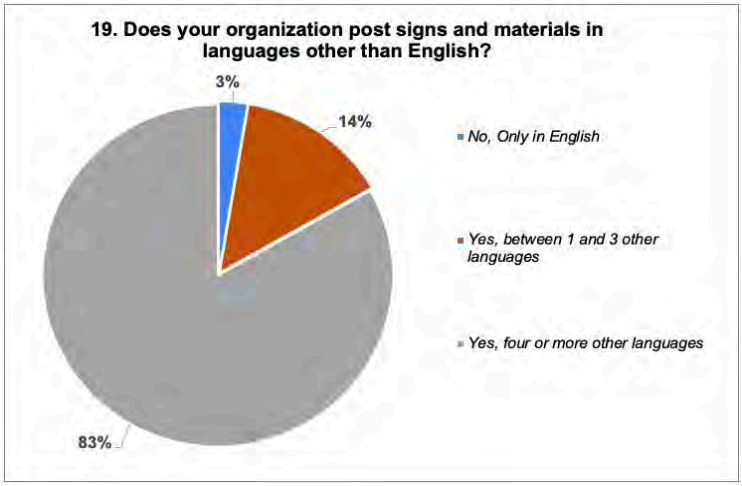
Section 2: Organizational Philosophy *(continued)*

Section 2 Questions	Not at all	Δ	Sometimes	Often	Δ	Most of the Time	Δ	All the Time	Δ	Yes	Δ	No	Δ
15. Does your organization systematically review procedures to ensure that they are relevant to LINGUISTICALLY competent services?	**0.4%**	↓	**4.8%**	**13.7%**	↓	**32.2%**	↑	**49.3%**	↑	N/A	N/A	N/A	N/A
	0.6%	↓	**3.1%**	**13.0%**	↓	**32.9%**	↑	**50.3%**	↑	N/A	N/A	N/A	N/A
	0.0%		**9.1%**	**13.6%**	↑	**30.3%**	↑	**47.0%**	↑	N/A	N/A	N/A	N/A
16. Does your organization help participants get the support they need (e.g., flexible service schedules, childcare, transportation, etc.) to access services?	0.0%	↓	**3.1%**	**11.5%**	↑	**26.4%**	↓	**59.0%**	↓	N/A	N/A	N/A	N/A
	0.0%	↓	**3.1%**	**13.7%**	↑	**24.8%**	↓	**58.4%**		N/A	N/A	N/A	N/A
	0.0%	↓	**3.0%**	**6.1%**	↑	**30.3%**	↑	**60.6%**	↓	N/A	N/A	N/A	N/A
17. Are there structures in your program to assure for participant and community participation in: Program planning?	**1.3%**	↑	**11.9%**	**17.6%**	↑	**27.8%**	↑	**41.4%**	↓	N/A	N/A	N/A	N/A
	0.6%	↑	**13.7%**	**18.6%**	↑	**26.1%**	↓	**41.0%**	↓	N/A	N/A	N/A	N/A
	3.0%	↑	**7.6%**	**15.2%**	↑	**31.8%**	↑	**42.4%**	↓	N/A	N/A	N/A	N/A
Service delivery?	**0.9%**	↓	**5.7%**	**18.1%**	↑	**28.6%**	↓	**46.7%**	↓	N/A	N/A	N/A	N/A
	0.0%	↓	**5.0%**	**20.5%**	↑	**28.0%**	↓	**46.6%**	↓	N/A	N/A	N/A	N/A
	3.0%	↑	**7.6%**	**12.1%**	↑	**30.3%**	↓	**47.0%**	↓	N/A	N/A	N/A	N/A
Evaluation of services?	0.0%	↓	**5.3%**	**12.8%**	↑	**22.9%**	↓	**59.0%**	↓	N/A	N/A	N/A	N/A
	0.0%	↓	**5.0%**	**14.3%**	↑	**19.3%**	↓	**61.5%**	↓	N/A	N/A	N/A	N/A
	0.0%		**6.1%**	**9.1%**	↓	**31.8%**	↑	**53.0%**	↓	N/A	N/A	N/A	N/A
Quality improvement?	0.0%	↓	**6.2%**	**15.0%**	↑	**27.3%**	↑	**51.5%**	↓	N/A	N/A	N/A	N/A
	0.0%	↓	**5.6%**	**16.8%**	↑	**24.8%**	↓	**52.8%**	↑	N/A	N/A	N/A	N/A
	0.0%	↓	**7.6%**	**10.6%**	↓	**33.3%**	↑	**48.5%**	↓	N/A	N/A	N/A	N/A
Customer satisfaction?	0.0%	↓	**3.1%**	**11.0%**	↑	**24.2%**	↑	**61.7%**	↓	N/A	N/A	N/A	N/A
	0.0%	↓	**2.5%**	**12.4%**	↑	**21.1%**	↑	**64.0%**	↓	N/A	N/A	N/A	N/A
	0.0%		**4.5%**	**7.6%**	↓	**31.8%**	↑	**56.1%**	↓	N/A	N/A	N/A	N/A

Note: N/A in the above graph indicates that the answer option was not available for these questions.

Legend: Combined | MHS | SUD Δ :Change compared to 2019





The pie graphs for Questions 18 and 19 each indicate the percentages for combined responses from MHS and SUD respondents.

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Section 3: Personal Involvement in Diverse Communities

This section addresses the extent to which an organization and its staff participate in social and recreational events, and purchase goods and services within the communities they serve.

- ◊ Over one-tenth of respondents (11.9%) indicated that their organization did not identify opportunities within culturally diverse communities for staff to subcontract for services from a variety of vendors *(Question 20)*. This number has increased by about 3% compared to the 2019 data.
- ◊ 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 *(Question 21)*.
- ◊ The most common TA requests were related to becoming more familiar with the culturally diverse community events and activities.

Section 3 Questions	Not at all	Δ	Sometimes	Often	Δ	Most of the Time	Δ	All the Time	Δ
20. Does your organization identify opportunities within culturally diverse communities for staff to: Attend formal cultural or ceremonial functions?	5.7%	↓	34.8%	15.9%	↓	24.7%	↓	18.9%	↓
	4.3%	↓	35.4%	16.8%	↓	28.6%	↓	14.9%	↓
	9.1%	↑	33.3%	13.6%	↓	15.2%	↓	28.8%	↑
Purchase goods or services from a variey of merchants (either for personal use or job-related activities)?	5.3%	↓	29.5%	15.9%	↓	28.2%	↓	21.1%	↓
	3.7%	↓	30.4%	18.6%	↑	28.6%	↓	18.6%	↓
	9.1%	↑	27.3%	9.1%	↓	27.3%	↑	27.3%	↓
Subcontract for services from a variety of vendors?	11.9%	↑	19.8%	18.9%	↑	24.7%	↓	24.7%	↓
	12.4%	↑	21.1%	18.0%	↑	26.7%	↑	21.7%	↓
	10.6%	↑	16.7%	21.2%	↓	19.7%	↓	31.8%	↑
Participate in informal recreational or leisure time activities?	6.2%	↑	32.6%	17.6%	↓	23.3%	↓	20.3%	
	4.3%	↑	34.2%	18.0%	↑	24.8%	↓	18.6%	↓
	10.6%	↑	28.8%	16.7%	↓	19.7%	↓	24.2%	↑
Participate in community education activities?	1.8%	↑	17.2%	26.9%	↑	28.6%	↓	25.6%	↓
	0.6%	↑	16.8%	26.7%	↑	29.2%	↓	26.7%	↓
	4.5%	↑	18.2%	27.3%	↑	27.3%	↓	22.7%	↓
21.Does your organization identify opportunities for staff to share with colleagues their experiences and knowledge about diverse communities?	0.0%		7.9%	14.5%	↑	26.9%	↓	50.7%	↓
	0.0%		6.8%	13.7%	↑	28.6%	↓	50.9%	↓
	0.0%		10.6%	16.7%	↑	22.7%	↓	50.0%	↓

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 4: Resources and Linkages

This section focuses on the ability of the organization and its staff to effectively utilize both formalized and natural networks of support within culturally diverse communities to promote and maintain linkages through structures and resources.

- Majority of respondents (79.3%) indicated that their organization collaborated with community-based organizations organizations most of the time or all the time to address the needs in their service area *(Question 22)*.
- Over half of the respondents (55.5%) indicated that their organizations work most of the time or all the time with social or professional contacts who help understand health and mental health beliefs and practices of culturally and linguistically diverse groups in the service area *(Question 23)*. This number has decreased by about 3% compared to the 2019 data.
- The most common TA requests were related to additional trainings on CLAS Standards, and becoming more familiar with whole person wellness.

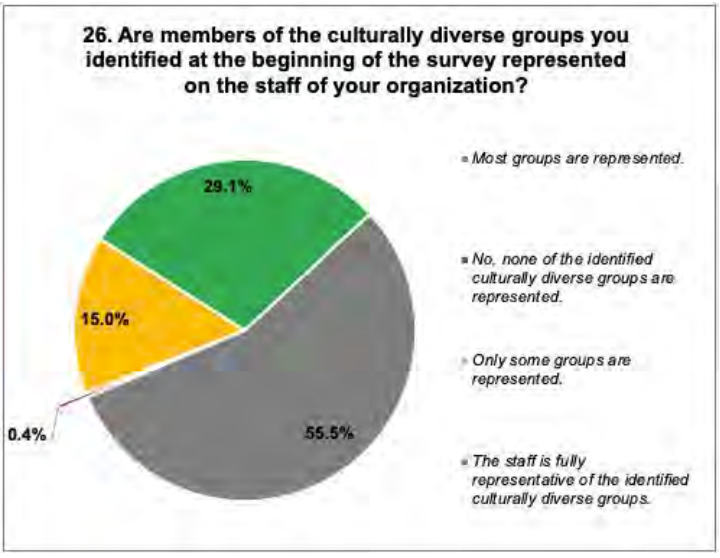
Section 4 Questions	Not at all	Δ	Sometimes	Often	Δ	Most of the Time	Δ	All the Time	Δ
22. Does your organization collaborate with community-based organizations to address the health and mental health related needs of the culturally and linguistically diverse groups in the service area?	0%		5.3%	15.4%	↑	27.3%	↑	52.0%	↓
	0%		6.2%	14.9%	↑	29.2%	↑	49.7%	↓
	0%		3.0%	16.7%	↑	22.7%	↑	57.6%	↓
23. Does your organization work with social or professional contacts (e.g., cultural brokers, liaisons, cultural stakeholders) who help understand health and mental health beliefs and practices of culturally and linguistically diverse groups in the service area?	4.0%	↑	21.1%	19.4%	↓	22.5%	↓	33.0%	↑
	3.7%	↑	21.1%	21.1%	↓	23.0%	↓	31.1%	↑
	4.5%	↑	21.2%	15.2%	↓	21.2%	↓	37.9%	↑
24. Does your organization establish formal relationships with these professionals and/or organizations to assist in serving culturally and linguistically diverse groups?	3.1%	↑	20.3%	16.7%		23.8%	↓	36.1%	↓
	1.9%	↑	24.2%	16.8%	↑	24.2%	↓	32.9%	↓
	6.1%	↑	10.6%	16.7%	↓	22.7%	↓	43.9%	↑
25. Does your organization use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about whole person wellness?	2.6%	↑	15.9%	20.3%	↑	22.0%	↓	39.2%	↓
	1.9%		14.3%	22.4%	↑	21.7%	↓	39.8%	↓
	4.5%	↑	19.7%	15.2%	↓	22.7%	↑	37.9%	↓

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 5: Human Resources

The focus of this section is on the organization's ability to sustain a diverse workforce that is culturally and linguistically responsive.

- The respondents were asked to identify the main cultural groups that their programs served predominantly *(Question 26)*. The majority of respondents indicated that most culturally diverse groups were represented on the program staff (55.5%); about a third indicated that their staff was fully representative (29.1%).
- Less than a fifth of respondents (16.2%) indicated that their organizations had very few or no culturally and linguistically diverse staff in executive management *(Question 27)*. In addition, 14.7% indicated that none or very few of the board members are culturally and linguistically diverse. The same proportion of respondents (13.2%) indicated similar sentiments regarding physicians/psychiatrists in their organization, with 17.3% of SUD respondents reporting very few or no culturally and linguistically diverse physicians/ psychiatrists in their program, compared to 11.5% of respondents in MHS.
- Majority of respondents indicated that most or all of their organizations' support staff (79.8%) and Peer Support Specialists (75.3%) were culturally and linguistically diverse *(Question 27)*.
- More than a third of respondents (39.2%) indicated that their organizations had very few or no incentives for the improvement of cultural competence throughout their organizations *(Question 28)*.
- The two areas identified by respondents that reflect the most need for organizational procedures to achieve the goal of a culturally and linguistically competent workforce were promotion (14.9%) and retention (14.0%). This was reflected in the results for *Question 30*.
- About three out of four respondents (69.6%) reported that there were many resources to support regularly scheduled professional development and in-service training for all levels of staff *(Question 31)*.
- While about two out of three respondents (67.4%) indicated that most or many in-service training activities on culturally competent services were conducted for staff at all levels of the organization, only about one in three of respondents (38.3%) indicated the same for linguistically competent services *(Questions 32 and 33)*.
- The most common TA requests were related to becoming more familiar with the CLAS Standards, training on workforce diversity, and training for improved linguistically competent services.



Note: The pie graphs for Questions 26 and 30 each indicate the percentages for combined responses from MHS and SUD respondents.

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Section 5: Human Resources *(continued)*

Section 5 Questions	None	Δ	Very Few	Some	Δ	Most/ Many	Δ	All	Δ
27. Does your organization have culturally and linguistically diverse individuals as: Board members?* (n=204)	2.9%	↑	11.8%	37.3%	↓	31.9%	↑	16.2%	↓
	2.9%	↑	11.4%	38.6%	↓	32.9%	↑	14.3%	↓
	3.1%	↑	12.5%	34.4%	↑	29.7%	↑	20.3%	↓
Program directors?* (n=224)	3.1%	↑	5.4%	29.9%	↑	42.0%	↑	19.6%	↓
	1.9%	↑	6.3%	32.9%		42.4%	↑	16.5%	↓
	6.1%	↑	3.0%	22.7%	↑	40.9%	↑	27.3%	↓
Executive management?* (n=216)	6.0%	↑	10.2%	31.9%	↑	34.3%	↑	17.6%	↓
	5.2%	↑	13.7%	32.0%	↑	32.7%	↓	16.3%	↓
	7.9%	↑	1.6%	31.7%	↑	38.1%	↑	20.6%	↓
Physicians/psychiatrists?* (n=174)	4.6%	↑	8.6%	36.2%	↑	31.0%	↓	19.5%	↑
	3.3%	↑	8.2%	32.8%	↑	35.2%	↓	20.5%	↑
	7.7%	↑	9.6%	44.2%	↑	21.2%	↓	17.3%	↓
Clinical staff?* (n=211)	0.0%		2.4%	22.3%	↑	43.1%	↓	32.2%	↓
	0.0%		2.1%	24.8%	↑	41.4%	↓	31.7%	↓
	0.0%		3.0%	16.7%	↑	47.0%		33.3%	
Administrative staff?* (n=222)	0.9%	↑	4.5%	23.0%	↑	42.8%	↓	28.8%	↑
	0.6%	↑	4.5%	23.7%	↑	43.6%	↓	27.6%	↑
	1.5%		4.5%	21.2%	↑	40.9%	↓	31.8%	↑
Clerical staff?* (n=197)	1.0%		3.6%	21.3%	↑	43.7%	↓	30.5%	↑
	1.4%	↑	3.6%	21.0%	↑	44.9%	↓	29.0%	↑
	0.0%	↓	3.4%	22.0%	↑	40.7%	↓	33.9%	↑
Support staff?* (n=213)	0.0%	↓	0.9%	19.2%	↑	48.8%	↓	31.0%	↑
	0.0%		1.3%	19.7%	↑	50.7%	↑	28.3%	
	0.0%	↓	0.0%	18.0%	↓	44.3%	↑	37.7%	↑
Peer Support Specialists?* (n=166)	1.2%	↓	3.0%	20.5%	↑	39.8%	↓	35.5%	↑
	0.0%	↓	3.0%	21.6%	↑	41.0%	↓	34.3%	↑
	6.3%	↓	3.1%	15.6%	↓	34.4%	↓	40.6%	↑
Volunteers/students?* (n=171)	1.8%	↑	2.9%	25.1%	↑	40.9%	↓	29.2%	↓
	1.6%	↑	4.0%	25.6%	↑	43.2%	↓	25.6%	↓
	2.2%	↑	0.0%	23.9%	↑	34.8%	↓	39.1%	↑

**Percentages exclude responses marked "not applicable". This option was available as a response for programs that may not have the specified job classifications in their organizations.*

Legend: Combined | MHS | SUD Δ :Change compared to 2019

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Section 5: Human Resources *(continued)*

Section 5 Questions	None	Δ	Very Few	Some	Δ	Most/ Many	Δ	All	Δ
28. Does your organization have incentives for the improvement of CULTURAL competence throughout the organization?	22.0%	↓	17.2%	42.3%	↓	18.5%	↑	N/A	N/A
	17.4%	↓	17.4%	44.7%	↓	20.5%	↑	N/A	N/A
	33.3%	↑	16.7%	36.4%	↓	13.6%	↓	N/A	N/A
29. Does your organization have incentives for the improvement of LINGUISTIC competence throughout the organization?	21.1%	↑	14.1%	49.8%	↓	15.0%	↓	N/A	N/A
	16.1%	↑	11.8%	56.5%	↑	15.5%	↓	N/A	N/A
	33.3%	↑	19.7%	33.3%	↓	13.6%	↓	N/A	N/A
31. Are there resources to support regularly scheduled professional development and in-service training for staff at all levels of the organization?	0.4%	↑	1.3%	28.6%	↑	69.6%	↓	N/A	N/A
	0.6%	↑	1.9%	26.1%	↑	71.4%	↓	N/A	N/A
	0.0%		0.0%	34.8%	↑	65.2%	↓	N/A	N/A
32. Are in-service training activities on CULTURALLY competent services (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the organization?	0.9%	↑	3.1%	28.6%	↓	67.4%	↑	N/A	N/A
	1.2%	↑	3.7%	28.0%	↑	67.1%	↓	N/A	N/A
	0.0%		1.5%	30.3%	↓	68.2%	↑	N/A	N/A
33. Are in-service training activities on LINGUISTICALLY competent services (e.g., Title VI, CLAS Standards, ADA mandates) conducted for staff at all levels of the organization?	3.5%	↓	13.2%	44.9%		38.3%	↑	N/A	N/A
	3.7%	↓	14.9%	47.8%		33.5%	↑	N/A	N/A
	3.0%	↓	9.1%	37.9%	↓	50.0%	↑	N/A	N/A

Note: N/A in the above graph indicates that the answer option was not available for these questions.

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 6: Clinical Practice

This section focuses on the ability of the organization and its staff to adapt approaches to behavioral health care delivery based on cultural and linguistic differences.

- ◊ The majority of the respondents indicated that their programs regularly engaged in activities focused on adapting behavioral health care delivery to cultural and linguistic diversity *(Section 6)*.
- ◊ A total of 8.2% of respondents indicated that their programs never or seldom used health assessments or diagnostic protocols adapted for culturally diverse groups *(Question 34)*.
- ◊ The most common TA requests were related to access to culturally appropriate assessment, diagnostic, and health promotion tools.

Section 6 Questions	Never	Δ	Seldom	Sometimes	Regularly	Δ
34. Does your organization use health assessment or diagnostic protocols that are adapted for culturally diverse groups?* (n=195)	4.1%	↑	4.1%	19%	72.8%	↑
	3.0%	↑	5%	19%	72.7%	↑
	6.3%	↑	2%	19%	73.0%	↓
35. Does your organization use health promotion, disease prevention, engagement, retention and treatment protocols that are adapted for culturally diverse groups?* (n=205)	1.0%	↑	2%	27%	69.8%	↑
	0.7%		3%	30%	66.0%	↑
	1.6%	↑	2%	19%	78.1%	↓
36. Does your organization connect consumers to natural networks of support to assist with health and mental health care?* (n=214)	0.0%	↓	2%	12%	85.5%	↓
	0.0%	↓	2%	14%	84.0%	↓
	0.0%	↓	3%	8%	89.1%	↑
37. Does your organization differentiate between racial and cultural identity when serving diverse consumers?* (n=213)	2.3%	↑	4%	12%	81.7%	↓
	0.7%	↑	4%	12%	83.2%	↓
	6.3%	↑	3%	13%	78.1%	↑

*Percentages exclude responses marked "not applicable". This option was available as a response for programs that do not provide clinical services.

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 7: Language and Interpretation Services Access

This section focuses on the ability of the organization and its staff to ensure access to materials in various languages, offer interpretation/translation services, and implement processes to ensure adherence to National CLAS Standards.

- ◊ A total of 20.7% of respondents indicated that their organizations never or seldom evaluated the quality and effectiveness of interpretation and translation services they either contracted or provided *(Question 41)*.
- ◊ Majority of the respondents (89.0%) indicated that their organizations regularly informed consumers of their rights to language access services under Title VI of the Civil Rights Act of 1964 and as required by the CLAS Standards *(Question 38)*.
- ◊ Less than half (48.9%) of all respondents indicated that their organizations never or seldom used certified medical interpreters, showing improvements compared to the 2019 data *(Question 39)*. This response was more prevalent among SUD respondents (63.6%) compared to MHS respondents (42.9%) *(Question 39)*.
- ◊ A total of 66.7% of SUD respondents indicated that their organizations never or seldom used trained medical interpreters compared to 37.9% of MHS respondents *(Question 39)*.

Section 7 Questions	Never	Δ	Seldom	Sometimes	Regularly	Δ
38. Does your organization inform consumers of their rights to language access services under Title VI of the Civil Rights Act of 1964 - Prohibition Against National Origin Discrimination and as required by the CLAS Standards 5-8 for language access?	0.4%	↓	2.6%	7.9%	89.0%	↑
	0.6%	↓	3.7%	10.6%	85.1%	
	0.0%	↓	0.0%	1.5%	98.5%	↑
39. Does your organization use either of the following personnel to provide interpretation services? Certified medical interpreters?	24.7%	↓	24.2%	22.0%	29.1%	↑
	22.4%	↓	20.5%	21.1%	36.0%	↑
	30.3%	↓	33.3%	24.2%	12.1%	↑
Trained medical interpreters?	26.0%	↓	20.3%	22.5%	31.3%	↑
	24.2%	↓	13.7%	22.4%	39.8%	↑
	30.3%	↓	36.4%	22.7%	10.6%	↓
Sign language interpreters?	20.7%	↑	28.2%	24.2%	26.9%	↑
	19.9%	↑	26.7%	21.7%	31.7%	↑
	22.7%	↑	31.8%	30.3%	15.2%	↑
40. Does your organization: Translate and use patient consent forms, educational materials, and other information in other languages?	5.3%	↓	10.1%	21.6%	63.0%	↓
	3.1%	↓	7.5%	19.9%	69.6%	↓
	10.6%	↓	16.7%	25.8%	47.0%	↑
Ensure materials address the literacy needs of the consumer population?	1.8%		6.6%	22.0%	69.6%	↓
	1.2%		6.2%	19.9%	72.7%	↓
	3.0%	↑	7.6%	27.3%	62.1%	↑
Assess the health literacy of consumers?	4.0%	↑	7.0%	26.0%	63.0%	↑
	3.1%	↑	6.8%	28.6%	61.5%	↑
	6.1%	↑	7.6%	19.7%	66.7%	↑
Employ specific interventions based on the health literacy levels of consumers?	2.6%	↓	7.5%	28.6%	61.2%	↑
	1.9%	↓	6.8%	29.8%	61.5%	↑
	4.5%	↑	9.1%	25.8%	60.6%	↑
41. Does your organization evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?	8.8%	↑	11.9%	32.6%	46.7%	↓
	8.1%	↑	9.9%	34.2%	47.8%	↓
	10.6%	↓	16.7%	28.8%	43.9%	↑

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 8: Engagement of Diverse Communities

This section focuses on the organizations' and staff's engagement of diverse communities in health and behavioral health promotion and disease prevention.

- ◊ Majority of respondents (89.5%) indicated that their organizations regularly or sometimes conducted activities tailored to engage culturally diverse communities *(Question 42)*.
- ◊ Over two out of three respondents (69.6%) indicated that their organizations regularly engaged human service agencies for initiatives in whole person wellness, mental health promotion, and disease prevention. Meanwhile, more than half of respondents (63.0%) indicated the same level of engagement with primary care providers, dentists, chiropractors, and/or licensed midwives. However, about a quarter of all respondents indicated that their organizations never engaged traditional healers (26.4%); complementary and alternative medicine providers (24.7%); and ethnic media sources (30.8%). These results are reflected in *Question 45*.
- ◊ The most common TA requests were related to becoming more familiar with local cultural organizations, community engagement and culturally diverse activities.

Section 8 Questions	*Never*	Δ	*Seldom*	*Sometimes*	*Regularly*	Δ
42. Does your organization conduct activities tailored to engage culturally diverse communities?	6.2%	↑	4.4%	41.0%	48.5%	↓
	5.0%	↑	3.7%	44.1%	47.2%	↓
	9.1%	↑	6.1%	33.3%	51.5%	↓
44. Do organization brochures and other media reflect cultural groups in the service area?	1.8%	↓	6.2%	26.0%	66.1%	↑
	1.2%	↓	2.5%	28.0%	68.3%	↑
	3.0%	↓	15.2%	21.2%	60.6%	↑
45. Does your organization reach out to and engage the following individuals, groups, or entities in whole person wellness, mental health promotion, and disease prevention initiatives: A. Places of worship or spiritual wellness, and clergy, ministerial alliances, or indigenous religious or spiritual leaders?	10.6%	↑	15.0%	44.1%	30.4%	↓
	5.0%	↑	18.6%	47.8%	28.6%	↓
	24.2%	↑	6.1%	34.8%	34.8%	↑
B. Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?	26.4%	↑	34.4%	30.0%	9.3%	
	19.3%	↓	36.6%	34.2%	9.9%	↓
	43.9%	↑	28.8%	19.7%	7.6%	↑
C. Primary care providers, dentists, chiropractors, or licensed midwives?	4.0%	↓	8.8%	24.2%	63.0%	↑
	3.7%	↑	7.5%	23.0%	65.8%	↑
	4.5%	↓	12.1%	27.3%	56.1%	↓
D. Providers of complementary and alternative medicine (e.g., homeopaths, acupuncturists, death doulas, or lay midwives)?	24.7%	↑	28.2%	35.2%	11.9%	↑
	18.2%		29.7%	38.2%	11.5%	↑
	39.4%	↑	22.7%	25.8%	12.1%	↑
E. Ethnic/cultural publishers, radio, cable, or television stations or personalities, or other ethnic media sources?	30.8%	↑	31.7%	25.6%	11.9%	↓
	27.3%	↑	31.7%	29.8%	11.2%	↓
	39.4%	↑	31.8%	15.2%	13.6%	↓

Note: For Question 43, the Program Managers were asked to list the types of activities their organizations conducted that were tailored to engage culturally diverse communities. The responses are excluded from this systemwide analysis and will be included in the program-level reports. The most common themes in the responses revolve around community, outreach, homelessness, culture, family, and the Spanish language.

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Section 8: Engagement of Diverse Communities (*continued*)

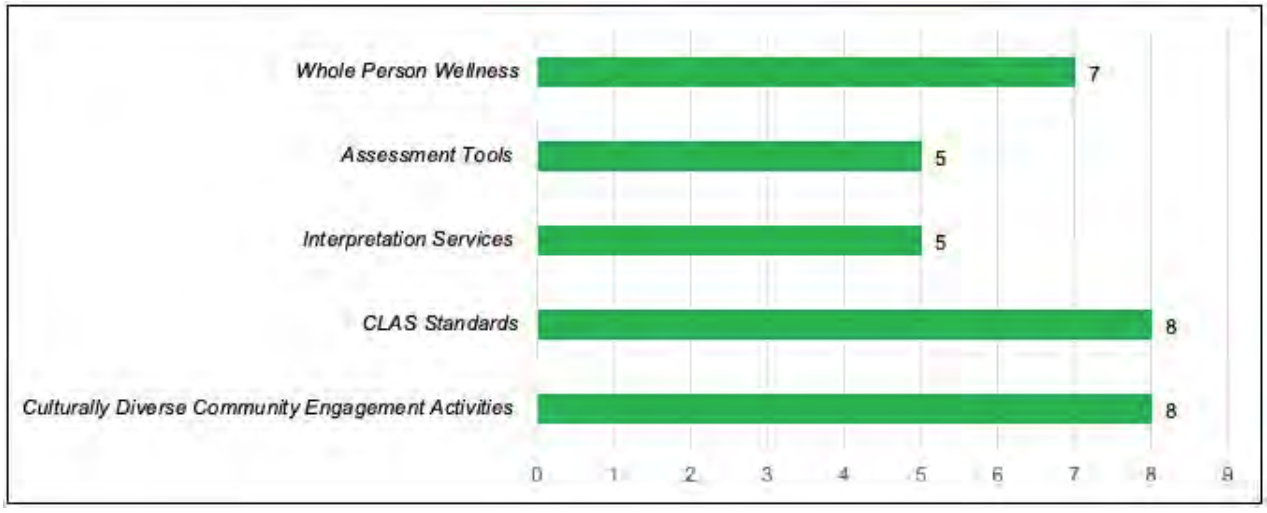
Section 8 Questions	Never	Δ	Seldom	Sometimes	Regularly	Δ
F. Human service agencies?	3.1%	↓	5.3%	22.0%	69.6%	↓
	1.9%	↓	6.2%	23.0%	68.9%	↓
	6.1%	↑	3.0%	19.7%	71.2%	↑
G. Tribal, cultural, or recovery advocacy organizations?	6.2%	↓	23.3%	42.7%	27.8%	↓
	3.7%	↓	26.1%	44.7%	25.5%	↓
	12.1%	↓	16.7%	37.9%	33.3%	↓
H. Local business owners such as barbers/cosmetologists, sports clubs, casinos, salons, and other ethnic/cultural businesses?	17.6%	↑	25.6%	30.4%	26.4%	↑
	14.9%	↑	26.1%	31.7%	27.3%	↑
	24.2%	↑	24.2%	27.3%	24.2%	↑
I. Social/cultural organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic/cultural associations)?	11.9%	↑	22.5%	38.3%	27.3%	↓
	10.6%	↑	18.6%	42.2%	28.6%	↓
	15.2%	↓	31.8%	28.8%	24.2%	↓

Note: For Question 43, the Program Managers were asked to list the types of activities their organizations conducted that were tailored to engage culturally diverse communities. The responses are excluded from this systemwide analysis and will be included in the program-level reports. The most common themes in the responses revolve around community, outreach, homelessness, culture, family, and the Spanish language.

Legend: Combined | MHS | SUD Δ :Change compared to 2019

Technical Assistance Requests

This section highlights the six most-requested technical assistance (TA) topics throughout the survey. There were a total of 56 TA requests ranging from community engagement activities, to policy information, to connection to resources, and training opportunities. A more detailed review will be included in the program-level report.

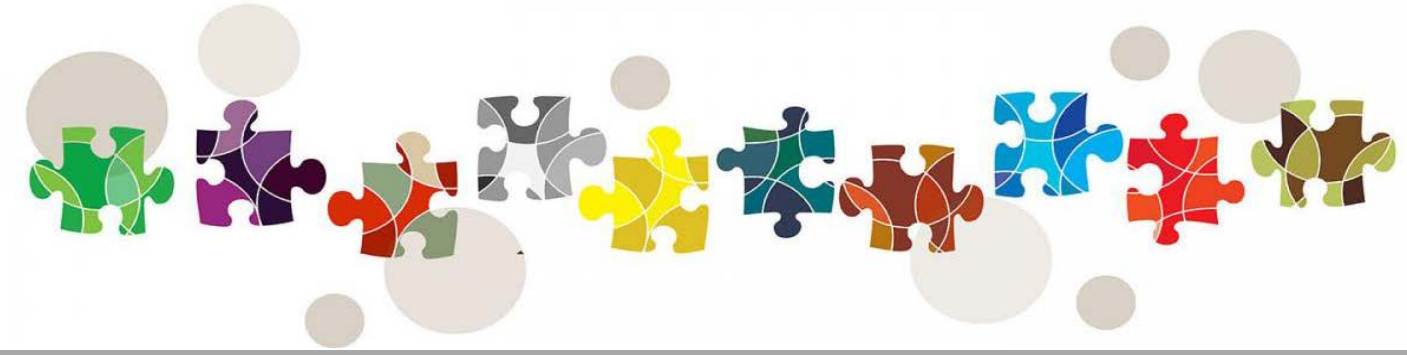


NEXT STEPS

- The CLCPA supports the BHS' commitment to a culturally and linguistically responsive workforce, as well as the guidelines described in the Cultural Competence (CC) Plan and the CC Handbook. These documents can be accessed in the Technical Resource Library at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.
- The CLCPA results will be disseminated systemwide and to stakeholders such as the BHS leadership, CCRT, the Quality Review Council (QRC), the BHS Training and Education Committee (BHSTEC), and Responsive Integrated Health Solutions (RIHS).
- CCRT will review the technical assistance requests and strategize solutions for recommendation.
- The program-level results will be provided to the program monitors who will be encouraged to discuss the report with the program managers, in order strategize how their organizations can enhance the quality of services within culturally diverse and under-served communities.
- The next CLCPA will be administered in February 2021. The data will be trended during the analysis of the results, and the noteworthy findings will be highlighted.
- For more information or for any questions, contact BHSQIPIT@sdcounty.ca.gov.

County of San Diego Behavioral Health Services

Promoting Cultural Diversity Self-Assessment (PCDSA) Biennial Report: 2018



Introduction

One of the quality improvement strategies in the County of San Diego Behavioral Health Services (SDCBHS) Cultural Competence Plan is to survey all programs to assess for culturally competent service provisions. Accordingly, all County and County-contracted programs are required to complete the Promoting Cultural Diversity Self-Assessment (PCDSA). 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 survey to their organization and complete the survey. 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/COR in October 2018.

The PCDSA supports the SDCBHS' commitment to a culturally competent workforce and upholds the guidelines described in the Cultural Competence Plan and Handbook. These documents can be located in the SDCBHS Technical Resource Library at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.

For more information contact the Quality Improvement, Performance Improvement Team at BHSQIPIT@sdcounty.ca.gov.

Background and Method

The PCDSA was developed by Georgetown University's National Center for Cultural Competence. The assessment's goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence.

The PCDSA is administered to all staff of County-operated and County-contracted mental health and substance use disorder programs in February every two years. A Google survey was distributed to all program managers on February 14, 2018 and they were asked to ensure that all program staff receive a copy of the link to complete the survey.

What does the data mean?

The PCDSA results show the providers and their organizations' awareness and understanding of the diverse cultural groups in the County, and may reveal opportunities to provide better communication and access to treatment for diverse populations. As this is the first PCDSA assessment conducted by BHS, the results would also provide a baseline for subsequent assessments. The survey data shows that the providers' self-reported Values and Attitudes are in general, attuned to the diverse populations they serve. The most opportunity for improvement is in the area of sites' Physical Environment, Materials, and Resources. Additional efforts to ensure physical elements in the sites reflect the various cultural and ethnic groups of their clients could be considered as a step towards enhancing cultural competence.

NOTE: Percentages in this report may not add up to 100% due to rounding.

County of San Diego Behavioral Health Services

Demographics

Key findings:

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%).

Gender (MHS & SUD)	Staff Survey Respondents		FY 2016-17 Clients	
	Count	%	Count	%
Female	2,023	76%	31,783	43%
Male	594	22%	42,383	57%
Other gender	4	0.1%	164	0.2%
Prefer not to state	51	2%	N/A	N/A

Gender (MHS)	Staff Survey Respondents		MHS Clients FY 2016-17	
	Count	%	Count	%
Female	1,703	78%	26,452	45%
Male	445	20%	32,006	55%
Other gender	4	0.2%	148	0.3%
Prefer not to state	43	2%	N/A	N/A

Gender (SUD)	Staff Survey Respondents		SUD Clients FY 2016-17	
	Count	%	Count	%
Female	320	67%	5,331	34%
Male	149	31%	10,377	66%
Other gender	0	0%	16	0.1%
Prefer not to state	8	2%	N/A	N/A

County of San Diego Behavioral Health Services

Key Findings (Race and Language):

- 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.
- 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.

Race (MHS & SUD)	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

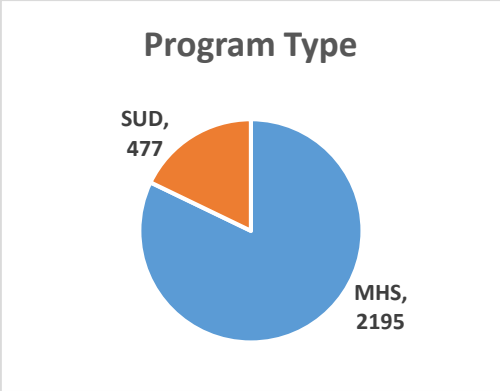
County of San Diego Behavioral Health Services

Education Level (MHS & SUD)	Staff Survey Respondents	
	Count	%
High School Diploma	412	15%
Associate's Degree	284	11%
Bachelor's Degree	695	26%
Master's Degree	1,115	43%
Doctorate/MD/PhD/PsyD	126	5%

Key Findings:

Education levels among staff survey respondents are diverse, with majority holding a Master's degree (43.2%).

Programs



Key findings:

- There are 477 SUD Staff that responded to the survey, compared to 2,195 Mental Health Services Staff.
- 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.

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%

County of San Diego Behavioral Health Services

Years in Service	Staff Survey Respondents					
	MHS		SUD		Combined (MHS & SUD)	
	Count	%	Count	%	Count	%
0-1 year	278	13%	59	12%	337	13%
2-5 years	885	40%	160	34%	1,045	39%
6-10 years	422	19%	107	22%	529	20%
10+ years	610	28%	151	32%	761	28%

Key findings:

- The majority of respondents (39%) reported having been in service at the program for 2-5 years.
- The second highest number of respondents have been in service with the program for 10+ years.

County of San Diego Behavioral Health Services

Staff Survey Answers

Key findings:

- The majority of staff survey respondents answered "Things I do occasionally" or "Things I do frequently".
- Section 1, questions 1 to 5 (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.

Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
I. Physical Environment, Materials and Resources					
1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of communities served by my program or agency.	8%	20%	22%	50%	0%
	0%	7%	21%	71%	0%
	9%	**19%**	**31%**	**41%**	**0%**
2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different communities served by my program or agency.	4%	16%	27%	52%	0%
	0%	14%	0%	86%	0%
	8%	**18%**	**25%**	**49%**	**0%**
3. When using videos, films, CDs, DVDs, or other media resources for Behavioral Health outreach, prevention, treatment, or other interventions, I ensure that they reflect the cultures of communities served by my program or agency.	3%	20%	22%	55%	0%
	7%	14%	7%	71%	0%
	7%	**16%**	**25%**	**53%**	**0%**
4. When offering food, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of the communities served by my program or agency.	12%	26%	26%	35%	0%
	7%	14%	50%	29%	0%
	12%	**28%**	**26%**	**33%**	**0%**
5. I ensure mediums and modalities in reception areas and those, which are used during program services, are representative of the various cultural and ethnic groups within the local community and the society in general.	9%	13%	29%	50%	0%
	7%	14%	0%	79%	0%
	8%	**18%**	**26%**	**48%**	**0%**
II. Communication Styles					
6. For people who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during interactions.	1%	3%	37%	56%	0%
	0%	0%	43%	57%	0%
	3%	**10%**	**30%**	**57%**	**0%**

County of San Diego Behavioral Health Services

Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
II. Communication Styles (continued)					
7. I attempt to determine any cultural expressions used by communities served that may impact interactions and services.	3%	6%	26%	65%	0%
	0%	21%	21%	57%	0%
	2%	**7%**	**28%**	**63%**	**0%**
8. I use visual aids, gestures, and physical prompts in my interactions with those who have limited English proficiency.	1%	8%	26%	66%	0%
	7%	7%	21%	64%	0%
	2%	**7%**	**26%**	**64%**	**0%**
9. I use trained bilingual or multilingual staff (or appropriate interpreter services) during assessments, treatment sessions, meetings, and for other events for families who would require such level of assistance.	1%	10%	15%	74%	0%
	0%	7%	0%	93%	0%
	4%	**11%**	**14%**	**71%**	**0%**
10.1 When interacting with people who have limited English proficiency, I always keep in mind that limitations in English proficiency are in no way a reflection of their level of intellectual functioning.	0%	2%	3%	96%	0%
	0%	0%	0%	100%	0%
	1%	**2%**	**6%**	**92%**	**0%**
10.2 When interacting with people who have limited English proficiency, I always keep in mind that their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.	1%	1%	6%	92%	0%
	0%	0%	0%	100%	0%
	1%	**2%**	**7%**	**90%**	**0%**
10.3 When interacting with people who have limited English proficiency, I always keep in mind that they may or may not be literate in their preferred language or English.	4%	2%	8%	86%	0%
	7%	0%	7%	86%	0%
	3%	**4%**	**14%**	**79%**	**0%**
11. I ensure that all notices and communication to service participants are available in threshold languages.	1%	12%	23%	64%	0%
	7%	7%	29%	57%	0%
	3%	**10%**	**22%**	**65%**	**0%**
12. I understand that it may be necessary to use alternatives to written communications for some communities receiving information.	2%	5%	28%	65%	0%
	0%	14%	21%	64%	0%
	3%	**7%**	**26%**	**64%**	**0%**
13. I understand the value of linguistic competence and promote it within my program or agency.	1%	4%	24%	71%	0%
	0%	0%	36%	64%	0%
	3%	**7%**	**23%**	**67%**	**0%**
14. I understand the implications of health care and behavioral health literacy within the context of my roles and responsibilities.	1%	3%	13%	84%	0%
	0%	7%	21%	71%	0%
	1%	**3%**	**15%**	**80%**	**0%**
III. Values and Attitudes					
15. I use alternative formats and varied approaches to communicate and share information with those we serve who experience disability.	1%	2%	15%	83%	0%
	0%	7%	14%	79%	0%
	2%	**5%**	**21%**	**72%**	**0%**

County of San Diego Behavioral Health Services

Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
III. Values and Attitudes (continued)					
16. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.	1%	1%	11%	87%	0%
	0%	0%	0%	100%	0%
	2%	**2%**	**11%**	**85%**	**0%**
17. In delivering program services, I discourage participants from using derogatory slurs (e.g., racial, ethnic, sexist, homophobic, transphobic, etc.) by helping them understand that certain words can hurt others.	0%	2%	15%	83%	0%
	0%	0%	14%	86%	0%
	1%	**4%**	**14%**	**81%**	**0%**
18. I screen books, movies, and other media resources for negative stereotypes before sharing them with those served by my program or agency.	6%	15%	17%	62%	0%
	7%	21%	21%	50%	0%
	7%	**14%**	**19%**	**60%**	**0%**
19. I intervene in an appropriate manner when I observe other staff within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.	1%	7%	27%	65%	0%
	7%	21%	29%	43%	0%
	3%	**11%**	**26%**	**60%**	**0%**
20. I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, family of choice).	0%	0%	9%	91%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**7%**	**91%**	**0%**
21. I recognize and accept that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.	2%	1%	8%	90%	0%
	0%	0%	7%	93%	0%
	1%	**2%**	**11%**	**85%**	**0%**
22. I accept and respect that gender roles and expression of gender identity in families may vary significantly among different cultures.	1%	1%	8%	91%	0%
	0%	7%	0%	93%	0%
	1%	**1%**	**8%**	**90%**	**0%**
23. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest man in families).	0%	0%	7%	93%	0%
	0%	0%	7%	93%	0%
	1%	**2%**	**10%**	**87%**	**0%**
24. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.	1%	2%	11%	63%	23%
	0%	0%	7%	64%	0%
	1%	**1%**	**8%**	**63%**	**27%**
25. I recognize that the meaning or value of behavioral health outreach, prevention, intervention, and treatment may vary greatly among cultures.	0%	1%	11%	88%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**8%**	**90%**	**0%**
26. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.	0%	0%	6%	94%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**8%**	**90%**	**0%**
27. I understand that beliefs about mental illness, substance use, and emotional disability are culturally-based. I accept that responses to these conditions and related services are heavily influenced by culture.	2%	1%	11%	86%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**9%**	**89%**	**0%**

County of San Diego Behavioral Health Services

Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
III. Values and Attitudes (continued)					
28. I understand the impact of stigma associated with mental illness, substance use, and behavioral health services within culturally diverse communities.	0%	2%	5%	93%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**6%**	**92%**	**0%**
29. I accept that religion, spirituality and other beliefs may influence how people respond to mental or physical illnesses, disease, disability, and death.	0%	0%	8%	92%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**6%**	**92%**	**0%**
30. I recognize and accept that cultural and religious beliefs may influence a family's reaction and approach to a person diagnosed with a physical/emotional disability or special health care needs.	0%	0%	9%	91%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**7%**	**91%**	**0%**
31. I understand that traditional approaches to disciplining children are influenced by culture.	1%	2%	13%	85%	0%
	7%	0%	7%	86%	0%
	2%	**2%**	**12%**	**84%**	**0%**
32. I understand that people from different cultures will have different expectations for acquiring self-help, social, emotional, cognitive, and communication skills.	0%	0%	8%	92%	0%
	7%	0%	7%	86%	0%
	1%	**1%**	**7%**	**91%**	**0%**
33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.	1%	1%	12%	86%	0%
	0%	7%	7%	86%	0%
	1%	**2%**	**9%**	**88%**	**0%**
34. Before visiting a home setting, or providing services in the community, I seek information or acceptable behaviors, courtesies, customs, and expectations that are unique to specific cultures and ethnic groups served by my program or agency.	6%	15%	20%	60%	0%
	7%	21%	14%	57%	0%
	6%	**15%**	**27%**	**53%**	**0%**
35. I seek information from family members or other key community leaders that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse community members served by my program or agency.	3%	13%	20%	64%	0%
	7%	14%	36%	43%	0%
	4%	**12%**	**27%**	**58%**	**0%**
36. I promote the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.	2%	8%	28%	62%	0%
	7%	14%	14%	64%	0%
	3%	**9%**	**21%**	**67%**	**0%**
37. I am aware of cultural specific healing methods, particularly as they pertain to the communities served by my program or agency.	3%	9%	30%	58%	0%
	29%	14%	0%	57%	0%
	4%	**11%**	**29%**	**56%**	**0%**
38. I contribute to and/or review current research related to cultural disparities in behavioral health, health care, and quality improvement.	6%	12%	29%	53%	0%
	0%	21%	36%	43%	0%
	4%	**15%**	**33%**	**48%**	**0%**
39. I accept that many evidence-based outreach, prevention, and intervention approaches will require adaptation to be effective with culturally and linguistically diverse groups.	2%	3%	17%	78%	0%
	14%	0%	14%	71%	0%
	2%	**4%**	**16%**	**78%**	**0%**

Mental Health Plan (MHP)
Beneficiary Material Order Form

This form is for hard copy requests only.

All forms are available in electronic format on www.optumsandiego.com.
Complete the form below by indicating the number of copies you would like to receive in the designated box for each threshold language.

Program Name:							
Contact Name:		**Phone or Email:**					
PLEASE CHECK:	☐ Inpatient or 24 hour care facility	☐ Outpatient					
County of San Diego MHP Beneficiary Informing Materials		**Specify the number of copies below**					
		English	**Spanish**	**Vietnamese**	**Arabic**	**Tagalog**	**Farsi**
Access and Crisis Line Posters							
Limited English Proficiency (LEP) Posters							
Grievance and Appeal Poster							
Grievance and Appeal Brochure (Limit of 50 per request)							
Recovery Brochures (Limit of 50 per request)							
Quick Guide to Mental Health Services for Adults, Older Adults, and Children Brochure (Limit of 50 per request)							
MHP's (County Operated) Notice of Privacy Practices – **County Programs Only**		Only available for printing at www.optumsandiego.com (Beneficiary Tab)					
County of San Diego MHP Beneficiary Handbook		Only available for printing at www.optumsandiego.com (Manuals Tab) Beneficiaries may access Handbook online at www.optumsandiego.com (Consumers & Families Tab)					
Grievance and Appeal Client Form		Only available for printing at www.optumsandiego.com (Beneficiary Tab)					
Self-Addressed envelopes for Grievance or Appeal		Contact the Advocacy Agencies (JFS or CCHEA) directly. They will provide programs with postage paid self-addressed envelopes for clients. Postage paid self-addressed envelopes is required to be provided to clients for mailing grievances and appeals.					
Advance Directive Brochure		Only available for printing at www.optumsandiego.com (Beneficiary Tab)					
Fee-For-Services Provider List		English and threshold languages only available for printing at www.optumsandiego.com (Access & Crisis Line Tab)					
Behavioral Health Services Provider Directory		English Provider Directory and link for threshold languages Provider Directory available at the link below https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs.html Threshold languages Provider Directory are only available at the link below http://sandiego.networkofcare.org/mh/index.aspx					
Physicians Notice to Patients – California Regulation		Only available for printing at www.optumsandiego.com (Beneficiary Tab)					

Send all orders to QIMatters.hhsa@sdcounty.ca.gov or fax to 619-236-1953

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Drug Medi-Cal Organized Delivery System (DMC-ODS)
Beneficiary Material Order Form

This form is for hard copy requests only.
All forms are available in electronic format on www.optumsandiego.com.
Complete the form below by indicating the number of copies you would like to receive in the designated box for each threshold language.

Program Name:		Contact Person:	
Email Address:		Phone Number:	
PLEASE CHECK:	☐ Residential ☐ Outpatient ☐ Withdrawal Management ☐ OTP (Opioid Treatment Provider)		

County of San Diego DMC-ODS Materials	*Specify the number of copies below*					
	English	Spanish	Vietnamese	Arabic	Tagalog	Farsi
County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook						
County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS) Quick Guide						
Grievance and Appeal Procedures Brochure						
Grievance and Appeal Client Form	Only available for printing at www.optumsandiego.com (On the Beneficiary Tab on the "Drug Medi-Cal Organized Delivery System" page)					
Self-Addressed Envelopes for Grievances and Appeals	Contact the Advocacy Agencies (JFS or CCHEA) directly. They will provide programs with postage paid self-addressed envelopes for clients. Postage paid self-addressed envelopes are required to be provided to clients for mailing grievances and appeals. For Residential Services, call JFS at 800-479-2233 For Outpatient Services, call CCHEA at 877-734-3258					
Grievance and Appeal Poster						
Access and Crisis Line Poster						
Limited English Proficiency (LEP) Posters						
Behavioral Health Services Provider Directory	The English Provider Directory and link for threshold languages Provider Directory are available at the link below: http://sandiego.networkofcare.org/mh/services/content.aspx?id=6572					

Send all request forms to QIMatters.hhsa@sdcounty.ca.gov or fax to 619-236-1953

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Nam	Cas	Page: 1 of 2
Type: CYF Outpt / FSP Client Plan		Date: 05/09/2018 - 05/09/2019
Printed on 05/30/2018 at 01:58 PM		(Final Approved on 05/16/2018 at 11:06 AM)

Individual Progress Note (05/15/2018)

Services

PSYCHOTHERAPY- FAMILY 32				*Provided to*	Client and Family
05/15/2018				*Provided at*	Office
Form#	6654120			*Outside Facility*	
Unit	SYHC BHG YES			*ContactType*	Face to Face
SubUnit	SYHC BHG YESVS FSP MHSA			*ApptType*	Scheduled
Server	MARYSOL OLIVARRIA			*BillingType*	Spanish
Supervisor				*Intensity*	BILINGUAL PROGRAM STAFF
Collateral				*Lab*	
	Start	*Duration*		*Total Server Time*	0 Hours, 47 Minutes
Service		0:41		*Participants*	0
Travel		0:00		*Days*	0
Documentation		0:06		*Quantity*	0
Diagnoses	F90.9 - Attention-deficit hyperactivity disorder, unspecified type				

Client Narratives

Client Narrative *MARYSOL OLIVARRIA for 05/15/2018*

7200/7207

FAMILY'S CHIEF COMPLAINT: (Appearance and Cognitive capacity, Current impairment, symptoms/behavior affecting functioning):
Client presented well groomed, with congruent thought process according to age, and full affect. Client was presente in session with his mother at all times.

INTERVENTION: (Describe how interventions are addressing the client's mental health condition/impairment):
Clinician utlized active listening skills and attunement with client in order to keep him engaged in session. Clinician prevously prepared session with six different activities that aimed at developing client's listening, and waiting skills. Activities include: cotton ball blow, balancing bean bags, karate punch, lotion, a book at the beggining and a snack at the end. Clinician did the games with client one by one, and then passed the batton to mother who was assisted by this writer on providing structure, and playfully setting limits and also helping him wait.

RESPONSE:
Client and mother were cooperative with this writer at all times. Client was excited and was able to follow through all activities succesfully.

PROGRESS TOWARDS OBJECTIVES:
Client started working towards his objectives in today's session.

PLAN OF CARE: (Change in client plan, homework, next steps, referrals given):
Mother will practice some of the activities learned today in session during the week whenever she feels might be appropiate.

OVERALL RISK: (Based on current service, including mitigating factors, evaluate and determine if the client is at an elevated risk for:)

Danger to self: Client is not a danger to self or others.

Name:	Case#:	Page: 1 of 2
Type: OTP Outpt / FSP Client Plan		Date: 12/22/2017 - 12/22/2018
Printed on 05/30/2018 at 01:26 PM		(Final Approved on 05/20/2018 at 04:15 PM)

Individual Progress Note (05/07/2018)

Services

COLLATERAL 33
05/07/2018

Form#	6663982
Unit	UPAC MULTI COMM COUNSEL MHSA
SubUnit	UPAC MCC MHSA
Server	TUAN TO
Supervisor	
Collateral	

Provided to	Client and Family
Provided at	School
Outside Facility	MANN MIDDLE-SD
ContactType	Face to Face
ApptType	Scheduled
BillingType	Vietnamese
Intensity	BILINGUAL PROGRAM STAFF
Lab	

	Start	*Duration*
Service		0:37
Travel		0:13
Documentation		0:08

Total Server Time	0 Hours, 58 Minutes
Participants	0
Days	0
Quantity	0

Diagnoses	F32.2 - Major depressive disorder, single episode, severe without psychotic features Z60.3 - Acculturation difficulty

Client Narratives

Client Narrative *TUAN TO for 05/07/2018*

7440/7441

COLLATERAL NOTE

drove round trip from UPAC-MCC in City Heights to Mann Middle School in City Heights for an IEP meeting. T met with client, fathers, Vietnamese interpreter [redacted] school physiologist (Amy Clarey), School psychologist intern, Special Education (Patricia Reese), School Nurse (Bishop Esmeralda), Jean Foster, MHRS therapist (Stephanie Mcdaniel), and Principal Teng. Total time of meeting was over an hour of which 37 min that T was an active participant.

Staff reported client's testing results. T inquired if father understood the results. Father reported that he did not understand the results but trusted school staff decisions. School staff inquired about treatment T is currently providing client. T provided staff with update on treatment progress and goals. T informed staff of activities client enjoys in therapy. MHRS therapist discuss about their treatment plans and goals. School presented goals for client. T inquired with father to see if her understood the goals. Father reported that he is unable to provide transportation for client modified schedule due to work. T and Staff discussed ways to support client in attending school. Father agreed to IEP plan.

PLAN OF CARE
T will meet with family to ensure father understood IEP goals.

Name:	Case#:	Page: 1 of 2
Type: CYF Outpt / FSP Client Plan		Date: 03/01/2018 - 03/01/2019
Printed on 05/30/2018 at 01:21 PM		(Final Approved on 05/15/2018 at 12:09 AM)

Individual Progress Note (05/03/2018)

Services

REHAB-FAMILY 36 **05/03/2018**		*Provided to*	Family / Legal Guardian
		Provided at	Home
Form#	6646438	*Outside Facility*	
Unit	UPAC MULTI COMM COUNSEL MHSA	*ContactType*	Face to Face
		ApptType	Scheduled
SubUnit	UPAC MCC MHSA	*BillingType*	Vietnamese
Server	AMIE TON	*Intensity*	BILINGUAL PROGRAM STAFF
Supervisor		*Lab*	
Collateral			

	Start	*Duration*			
Service		1:00	*Total Server Time*	2 Hours, 6 Minutes
Travel		0:55	*Participants*	0
Documentation		0:11	*Days*	0
			Quantity	0

Diagnoses	F34.1 - Dysthymic disorder F91.9 - Conduct disorder, unspecified F90.0 - Attention-deficit hyperactivity disorder, predominantly inattentive type

Client Narratives

Client Narrative *AMIE TON for 05/03/2018*

7440/7441
TRAVEL TO/FROM:

FSP travelled round - trip from UPAC MCC office in City Heights to client's home at Mira Mesa to meet wit

FAMILY'S CHIEF COMPLAINT: (Appearance and Cognitive capacity, Current impairment, symptoms/behavior affecting functioning):

dressed approriately seemed anxious, and tired during the session. Session was conducted in Vietnamese.

INTERVENTION: (Describe how skill building interventions are addressing the client's functional impairment(s):

FSP followed with about the contract between and client. FSP empathized with for her concerns about client. FSP asked open-ended and closed-ended questions to understand better how handles with client when client does not follow through with the contract. FSP provided with emotional support. FSP also praised for following through with the contract. FSP encouraged to continue to follow though with the contract, and provide client with positive disciplines when client misbehaves or does not follow through the contract.

FSP also discussed with about termination and the transfering process after this FSP leaves. FSP told about the next FSP who will continue to meet with to continue to provide support. FSP showed appreciation to for having FSP to provide services, and to be open to work with this FSP.

RESPONSE:

said client never follows through the contrac nas a difficult time to provide client with disciplines. Mo does not know how Mo can handle client. Mo said Mo follows through the contract. Mo agreed to continue to follow through the contract and discipline client when client misbehaves.

Mo understood about the termination and transfering process. Mo agreed to continue to meet with another FSP. Mo also showed her appreciation to FSP for providing Mo with support.

Nam	Case#:	Page: 1 of 2
Type: CYF Outpt / FSP Client Plan		Date: 03/01/2018 - 03/01/2019
Printed on 05/30/2018 at 01:22 PM		(Final Approved on 05/26/2018 at 02:00 PM)

Individual Progress Note (05/15/2018)

Services

COLLATERAL 33
05/15/2018

Form#	6684245
Unit	UPAC MULTI COMM COUNSEL MHSA
SubUnit	UPAC MCC MHSA
Server	TIFFANY LIN
Supervisor	
Collateral	

	Start	*Duration*
Service		0:10
Travel		
Documentation		0:05

Provided to	Family / Legal Guardian
Provided at	Office
Outside Facility	
ContactType	Telephone
ApptType	Unscheduled/Walk-in
BillingType	Vietnamese
Intensity	INTERNAL INTERPRETER ORG LEVEL
Lab	
Total Server Time	0 Hours, 15 Minutes
Participants	0
Days	0
Quantity	0

Diagnoses	F91.9 - Conduct disorder, unspecified

Client Narratives

Client Narrative *TIFFANY LIN for 05/15/2018*

7440/7441 5/15/18
COLLATERAL NOTE
Mo contacted T due to concerns about client not wanting to go school today, and Mo expressed worries about client missing his IEP meeting with Mo and school staff. Mo attempted to put client on the phone to speak with T, but client refused and appeared to be tired and trying to sleep. Mo continued yelling at client to get up from bed.

T provided Mo with reflective listening and validated Mo's worries about client missing the IEP meeting. T reminded Mo to provide client with empathic listening and to not physically prompt client out of bed, as he has a history of becoming aggressive towards Mo if she does. T informed Mo that it is important that Mo does not miss the meeting, and that Mo should still attend the meeting even if client does not go.

PLAN OF CARE
T will follow up with client regarding his refusal to go to school.

A Vietnamese language FSP staff member from UPAC MCC helped translate for Mo.

Nam	Case#	Page: 1 of 2
Type: AOA Outpt / FSP Client Plan		Date: 04/11/2018 - 04/11/2019
Printed on 05/30/2018 at 01:56 PM		(Final Approved on 05/04/2018 at 02:20 PM)

Individual Progress Note (05/04/2018)

Services

PSYCHOTHERAPY - INDIVIDUAL 30
05/04/2018

Form#	6619336
Unit	SYHC CHALDEAN MID EAST (A)
SubUnit	SYHC CHALDEAN MID EST (A) MHSA
Server	VIAN ASMARO
Supervisor	
Collateral	

Provided to	Client
Provided at	Office
Outside Facility	
ContactType	Face to Face
ApptType	Scheduled
BillingType	Arabic
Intensity	BILINGUAL PROGRAM STAFF
Lab	

	Start	*Duration*
Service		1:01
Travel		
Documentation		0:24

Total Server Time	1 Hour, 25 Minutes
Participants	0
Days	0
Quantity	0

Diagnoses: F33.2 - Major depressive disorder, recurrent severe without psychotic features
F43.12 - Post-traumatic stress disorder, chronic

Client Narratives

Client Narrative — *VIAN ASMARO for 05/04/2018*

TRAVEL FROM/TO: None.

INDIVIDUAL PSYCHOTHERAPY/REHAB PROGRESS NOTE
CURRENT CONDITION (Include complaints, symptoms, appearance, cognitive capacity, changes from previous visits, potential for harm, precipitators, strengths):
Clt presented in session with good hygiene, Ox4. depressed mood and affect. Clt was dressed appropriately. Clt report symptoms of depression and PTSD including: nightmares of her past trauma, fears, and excessive worries about her kids. Client denied SI, HI, VH, AH. No safety issues were reported by clt at this time. No safety issues were noted.

THERAPEUTIC INTERVENTION:
The goal of this session was to help clt improve daily functioning and to assist clt in learning coping skills. Clinician joined in with clt due to clt being new to treatment. Clinician provided empathy, active and reflective listening. Clinician psycho-educated clt on normalization and validation coping skills and the importance to practice learned skills.

RESPONSE TO TREATMENT:
Client was engaged AEB facial expressions, eye contact, and body language. Clt processed her concerns, worries. Clt responded to clinician's intervention and verbalized her understanding of the importance of learning and practicing coping skills to manage her symptoms. Clt was able to practice normalization and validation skills during session and stated that " it is normal to have little worry about my kids." Clt agreed to commit to therapy and practice learned skills including: normalization and validation skills. Clt had an appt. with Dr. Sinno, MD for psychiatric evaluation this week and client agreed to adhere to medications.

PROGRESS TOWARD MEASURABLE GOALS/OBJECTIVES:
Reviewed goal1/Obj1: clt agreed to practice validation and normalization coping skill to manage her depression and PTSD symptoms.

PLAN OF CARE (include indicated client plan changes, next steps, referrals given):
Clt agreed to continue with supportive counseling, agreed to follow up with medication management services, and case management services as needed.

Continued

Individual Progress Note (05/04/2018)

Client Narrative *Continued*

OVERALL RISK: Client denied any SI, HI, VH, AH. No safety issues were reported by the client at this time.

Based on current service, including mitigating factors, evaluate and determine if the client is at an elevated risk for:

Danger to self: Client did not report any plan or intent to harm self.

Danger to others: Client did not report any plan or intent to hurt others.

Linked Objectives

1.1.1 - Learn/Practice Coping Skills

(OBJECTIVE(S) SHALL BE SPECIFIC, OBSERVABLE, MEASURABLE AND RELATED TO THE AREA OF NEED.)

1. UNIT/SUBUNIT: 4230/4231 DATE: 04/11/2018

OBJECTIVE NARRATIVE: Client will learn CBT and DBT coping skills including: positive thinking, mindfulness, re-framing, positive self talk, gratitude practice, utilizing her strength of faith, and relaxation tools. Client will practice one skill la week for the next 6-12 months.

Signatures

Service Provider Signature- Electronic, Staff
VIAN ASMARO, ASSOCIATE SOCIAL WORKER (BEHAVIORAL HEALTH THERAPIST) on 05/04/2018 at 02:20 PM

Name
Type: AOA Outpt / FSP Client Plan
Printed on 05/30/2018 at 02:01 PM
Case#
Page: 1 of 2
Date: 05/04/2018 - 05/04/2019
(Final Approved on 05/23/2018 at 04:19 PM)

Individual Progress Note (05/23/2018)

Services

CASE MGT/ BROKERAGE 50
05/23/2018

Form#	6676935
Unit	SURVIVORS OF TORTURE (A)
SubUnit	SURVIVORS OF TORTURE (A) MHSA
Server	MAHVASH ALAMI-RAD
Supervisor	
Collateral	

Provided to	Client
Provided at	Office
Outside Facility	
ContactType	Face to Face
ApptType	Unscheduled/Walk-in
BillingType	Farsi
Intensity	BILINGUAL PROGRAM STAFF
Lab	

	Start	*Duration*
Service		0:28
Travel		0:00
Documentation		0:18

Total Server Time	0 Hours, 46 Minutes
Participants	0
Days	0
Quantity	0

Diagnoses: F33.2 - Major depressive disorder, recurrent severe without psychotic features

Client Narratives

Client Narrative — *MAHVASH ALAMI-RAD for 05/23/2018*

3160/3161 5/23/2018 Client walk-in and asked if he can talk to program manager. Client dressed casually, good hygiene and clean. Client speech was pressured, thought pattern was circumstantial and coherent, denied any SI and HI. Client talked about his recent self cut that happened over the weekend. "I got the letter from SSI on Sunday and I asked my sister to read it and I went upstairs and called the 888 no that you gave me to talk to them, I also took a knife with me upstairs too, I called them and told them either do something for me or I do not know what to do." Client stated that he was on the phone with the person who was asking him question about his address. Client added that while he was an the phone he used the knife to do some cut on his arm too. "I was surprised how they do not know my street name and was asking me how do you spell and then that person told me go downstair and I did and I saw the police at the door." Client stated that the police handcuffed him and took him to the Sharp hospital and he stayed there overnight and was released the next day. "It was so embarrassing to have the police there and I do not know how the neighbor think about me." "I would never call them anymore. Client seemed to have difficult time to accept that his SSI application was denied, as he does not know how to handle the conflict. Client also added that he also had prior history of self cut when he was in Turkey about 4 and half years ago due to the conflict with his refugee status. Client stated that he has a hard time to make living for self as he has both physical al and mental health problem. "They saw my scan and they should know that my scan was not ok but the doctor wrote that all is fine." "The doctor in Turkey told me that I have low IQ becasue of I have and I cannot work." Client was provided support to consider completing a release of information for the SSI so his mental health record be released to support his SSI case. In addition client was provided psychoeducation to complete a safety plan so he can have it when he feels that he cannot manage his anxiety he can read the safety plan and follow the instruction. Client was open to complete the safety plan and he received a copy too. The safety plan was completed both in Farsi and English. Client was encouraged to review the safety plan when he has thoughts of hurting self and use the coping skills to manage his thoughts. Client expressed his appreciation and stated that he will keep the safety plan and review it when he felt that he needs to reach out and ask for help.

Name:	Case	Page: 1 of 1
Type: AOA Outpt / FSP Client Plan		Date: 11/08/2017 - 04/24/2018
Printed on 05/30/2018 at 02:22 PM		(Final Approved on 03/09/2018 at 02:44 PM)

Individual Progress Note (03/08/2018)

Services

MED SERVICES COMPREHENSIVE 20		*Provided to*	Client
03/08/2018		*Provided at*	Office
Form#	6456400	*Outside Facility*	
Unit	UPAC MIDTOWN CENTER	*ContactType*	Face to Face
SubUnit	UPAC MIDTOWN CENTER MHSA	*ApptType*	Scheduled
Server	MARITA FERRER	*BillingType*	All Filipino Dialects (Tagalog)
Supervisor		*Intensity*	BILINGUAL PROGRAM STAFF
Collateral		*Lab*	

	Start	*Duration*			
Service		0:16	*Total Server Time*	0 Hours, 27 Minutes
Travel			*Participants*	0
Documentation		0:11	*Days*	0
			Quantity	0

Diagnoses	F20.1 - Disorganized schizophrenia

Client Narratives

Client Narrative — *MARITA FERRER for 03/08/2018*

3000/3002
Client in for TX plan evaluation and injection of Haldol Dec. 100 mg. , one (1) cc given IM to right upper outer quadrant , tolerated OK.
Appeared cleanly and cassually dressed, groomed OK, engaged in session, cooperative and good eye contact.
No reported and/ observed side effects from medications , is adherent, per client.
Sleep is OK, at 8 hours per noc. most of the time.
Appetite is fine, 3 meals per day . Weight - Temp - 98.3 F. BP - 118/76. Pulse - 86.
Denies AVH (-). No SI / HI.
R.N. appointment in 4 weeks.
M.D. / N.P. appointment per scheduler. Has enough medications till 4/12/18.

Linked Objectives

1.1.1 - Develop/Follow Routine or Structure

(OBJECTIVE(S) SHALL BE SPECIFIC, OBSERVABLE, MEASURABLE AND RELATED TO THE AREA OF NEED.)

1. UNIT/SUBUNIT: 3000/3002 DATE: 11/7/17
OBJECTIVE NARRATIVE: CLT reported going to the senior center on days and writting as a hobby, however, she does not have a routine that she follows on a daily basis. In the next 12 months, CLT will develop a routine and follow the schedule she made for no less than 4 days a week.

Signatures

Service Provider Signature- Electronic, Staff
MARITA FERRER, REGISTERED NURSE (RN) — on 03/09/2018 at 02:44 PM

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (cultural, linguistic)

SUBJECT:	**Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services**	**REFERENCE #**	5977
		PAGE:	1 OF 4
		DATE:	**06/01/2018**
REFERENCE	**42 Code of Federal Regulations 438.10, CCR, Title 9, Chapter 11, §1810.41(a); DMH Information Notice 02-03, Pages 13, 17, DHCS All County Welfare Directors Letter No.: 10-03, and Title VI Civil Rights Act of 1964 (42 U.S.C., §2000(d), 45 C.F.R., Part 80)**		

PURPOSE
To ensure that all individuals requesting services at Mental Health Plan (MHP) programs providing Specialty Mental Health Services have been evaluated for needing culturally/linguistically specialized services and linked with services or referred appropriately.

BACKGROUND
Based on the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410(a); DMH Notice No. 97-14, Page 18, Civil Rights Act of 1964 (42 U.S.C., Section 2000(d), 45 CFR, Part 80), when a need is determined, the County of San Diego Health and Human Services Agency (HHSA) – Behavioral Health Services (BHS) shall ensure that a process is in place for accommodating and referring clients to available culturally and/or linguistically appropriate services. Title VI of the Civil Rights Act of 1964 prohibits the denial of access to federally assisted programs and activities because of limited English proficiency. Providers are required to provide language assistance to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

The MHP Cultural Competence Clinical Practice Standards (found in Section H of the Organizational Provider Operations Handbook (OPOH)) help ensure culturally sensitive practice in assessments, referrals, treatment, testing, staffing, and community outreach.

DEFINITIONS
None

POLICY
Clients have a right to a choice of providers whenever possible, and cultural and linguistic issues shall be considered in making appropriate referrals. At the point of entry into a program, the cultural and/or linguistic needs of an individual shall be assessed and all reasonable efforts made to accommodate, refer and/or link them to appropriate services reflecting those preferences. In this context, cultural needs may include special referral needs, such as homelessness, dual diagnosis, and children under the age of six (6). Clients shall be informed of the availability and how to access free interpretation

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services which shall be available in threshold and non-threshold languages. Written materials specified by state and federal regulations shall be available in threshold languages.

PROCEDURES

All persons with LEP speaking threshold or non-threshold languages shall be informed in a language they understand that they have a right to free oral interpretation assistance and that there is no expectation that family members provide interpreter services. Please call the BHS Administration Front Office at 619-563-2700 for LEP Posters in the five threshold languages. A consumer 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. The availability of free interpretation assistance will be publicized in the Guide to Medi-Cal Mental Health Services and the Quick Guide to Mental Health Services and reinforced by signs that will be provided by the county for display in behavioral health service waiting areas.

Providers will log all contacts (phone, walk-in) on a Request for Services Log/Access to Services Log (See Section-C of the OPOH) that will be kept on-site and stored to maintain the confidentiality of the individual.

<u>For Individuals Walking in or Telephoning Provider Sites with Language Needs that Cannot Be Determined</u>

- If the provider has no on-site staff that can provide appropriate language assistance in the threshold or non-threshold language spoken by the individual, the staff should call OptumHealth (OH) Access & Crisis Line at **1-888-724-7240** for assistance.
- OptumHealth will utilize its staff when a member has the appropriate language expertise, or connect with the Language Line to facilitate a brief assessment of the individual's problem and cultural and/or linguistic needs.
- Based on the brief assessment, OH, the provider, and the individual will reach a consensus about the plan of action to best address the individual's problem and consider any cultural and linguistic needs. This may include, but not be limited to, a referral for mental health assessment and/or, as appropriate, a referral to a community organization or social service agency.

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- If a mental health assessment is indicated, an appointment or referral will be made, making all reasonable effort to accommodate the individual's linguistic and/or cultural preferences as soon as possible.

If there are no providers who can provide services in the primary language of the client, the site staff providing the assessment or referral will arrange with the County's Interpreter Services to provide needed language assistance for the subsequent appointments (see Section-C of the OPOH).

For Person Seeking Services with Language Needs Which Can Be Determined

- If the provider has staff that speaks the individual's language, the provider will utilize this staff to determine service needs. The individual will also be asked about cultural preferences.
- Based on a brief assessment, the staff person will work with the individual to determine a plan of action to best address the individual's problem, in view of any cultural and linguistic needs. This may include, but not be limited to, setting up an appointment or referral for a mental health assessment, and/or, as appropriate, a referral to a needed community or social service(s). The staff member will make all reasonable efforts to meet the individual's cultural and linguistic preferences.
- If there is no staff or other providers who can provide services in the primary language of the client, the provider will arrange with the County's Interpreter Services Contractors to provide needed, free, language assistance for the subsequent appointments (see Section-C of the OPOH for details). Individuals speaking threshold languages will also be informed about the availability of written information in threshold languages and how to access that material.

Documentation of the Provision of Culturally/Linguistically Appropriate Services

- Interpreter services shall also be documented in CCBH or an excel log provided by QI fi the provider does not enter into CCBH.
- Suggestions and Transfer Forms (as reported in the Monthly Status Report (MSR) or Quarterly Status Report (QSR) will reflect requests for transfer to a different provider because of cultural or linguistic issues.

Monitoring Provision of Culturally/Linguistically Appropriate Services

- The BHS-Quality Improvement (QI) Unit will review the Request for Services Log/Access to Services Log periodically to ensure referrals are being made and logged.

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- The BHS-QI Unit will periodically review the reported usage of interpreter services and produce an annual report on interpreter usage.

QUESTIONS / INFORMATION
Liz Miles, PAA
BHS Quality Improvement
(619) 584-5015

ATTACHMENTS/RELATED DOCUMENTS
None

SUNSET DATE: This policy will be reviewed for continuance on or before October 31, 2020.

Youth Services Survey (YSS)

May 2019 Survey Period

San Diego County

Children, Youth & Families Behavioral Health Services

Report prepared by the
Child & Adolescent Services Research Center (CASRC)

September 2019

FOR INTERNAL USE ONLY

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Overview

One way to ensure that services are responsive to consumer needs is to collect information from youth and families about their satisfaction with services and their perspectives on the quality of services. In San Diego County, data on consumer satisfaction was collected through the Youth Services Survey (YSS), which is completed by **all youth (ages 13+)** and **all available parents/caregivers**, regardless of the youth/client age. The majority of questions on the YSS focus on satisfaction with the provision and results of services.

This report focuses on results of the YSS from the May 13-17, 2019 survey administration period. Two YSS measures were independently evaluated: **YSS compliance** and **YSS results.**

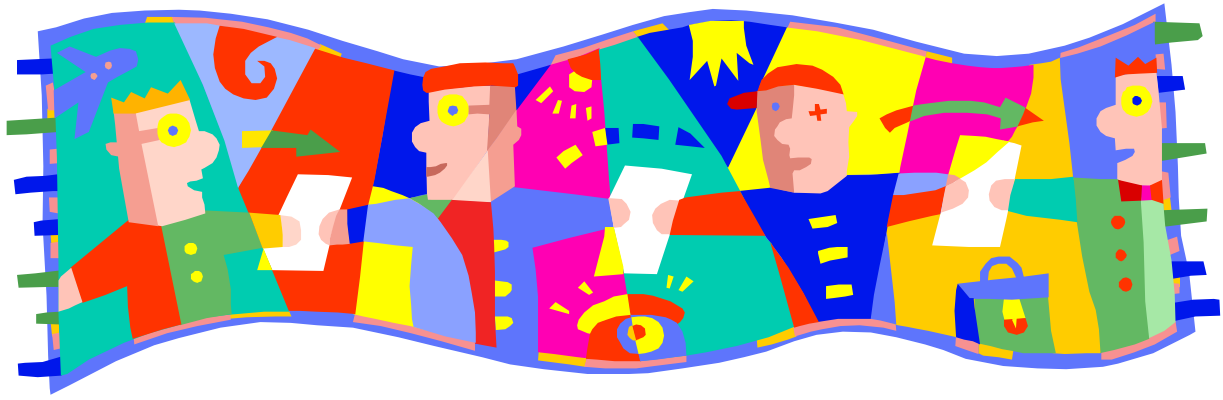
YSS compliance is determined by using Client ID numbers to compare the number of clients receiving services as reported in Cerner Community Behavioral Health system (CCBH) to the number of clients who submitted surveys during the May 2019 YSS period. During the survey period, 318 (10.2%) of the 3,110 completed forms did not match to a client with a billed service. There are several reasons why this may have occurred: 1) Client ID number error on the survey, 2) delays in billing data entered into CCBH; i.e., client got a billed service, but it had not yet been entered in CCBH at the time of data download, or 3) client should not have been given a survey (client had an open treatment episode, but did not receive a billed service during the YSS period).

YSS results are calculated directly from submitted surveys. The YSS gives a snapshot in time of youth receiving behavioral health services, and whether client data changes with duration of services received. Specifically, the YSS provides data regarding three outcome areas of interest: consumer satisfaction, recent substance use, and recent arrests.

Individual items on the YSS are grouped into seven domains for analysis:

1. General Satisfaction
2. Perception of Access
3. Perception of Cultural Sensitivity
4. Perception of Participation in Treatment Planning
5. Perception of Outcomes of Services
6. Perception of Functioning
7. Perception of Social Connectedness

Clients may receive multiple services from more than one program during the YSS period; therefore, a single client may submit multiple forms. Results are evaluated by item and by domain, at the systemwide, level of care, and program levels.



Key Findings—May 2019

1. The County process objective of 80% of clients submitting a YSS form was met and exceeded in May 2019: 88% of the 3,346 clients receiving a service during the administration period submitted a YSS form.
2. The County outcome objective of 80% of clients responding "agree" or "strongly agree" for at least 75% of the satisfaction survey items was met for parents/caregivers and youth.
3. Both parents/caregivers and youth were most satisfied with the *Perception of Cultural Sensitivity* domain. Parents/caregivers and youth were least satisfied with the *Perception of Outcomes of Services* domain.
4. Parents/caregivers reported higher satisfaction than youth on every domain.
5. The greatest disparity in satisfaction between youth and parents/caregivers was found on the *Perception of Participation in Treatment Planning* domain.
6. Satisfaction and perception of outcomes varied among different levels of care in the Children, Youth and Families Behavioral Health Services (CYFBHS) system. On average, parents/caregivers of youth receiving Therapeutic Behavioral Services (TBS) or Outpatient services were most satisfied, and youth receiving Outpatient services were most satisfied. Lowest satisfaction was reported by youth and parents/caregivers of youth receiving Day Treatment services.
7. Satisfaction and perception of outcomes also varied widely among different racial/ethnic groups. Overall, Native American youth and their parents/caregivers reported the highest satisfaction averaged across domains; however, only 15 completed surveys were submitted for Native American youth and their parents/caregivers, which means the averages may not be generalizable to the population. African-American youth and their parents/caregivers reported the lowest satisfaction averaged across domains; these clients reported most satisfaction on the *Perception of Cultural Sensitivity* domain. Asian/Pacific Islander clients and their parents/caregivers were more satisfied with *Perception of Social Connectedness* than any other racial/ethnic group. Among Hispanic and White youth and their parents/caregivers, highest levels of satisfaction were reported on the *Perception of Cultural Sensitivity* domain and lowest levels of satisfaction were reported on the *Perception of Outcomes* domain.
8. On average, satisfaction and perception of outcomes were highest among parents/caregivers of children ages 0 to 11 years.
9. Twenty-four percent of youth who responded to the recent substance use question on the May 2019 YSS reported using substances within the past month. The most commonly used substances remain consistent with previous years: marijuana (20%), alcohol (11%) and cigarettes (5%). Over the past five years, reported recent use of marijuana has increased (14% in May 2015), reported recent use of cigarettes has decreased (11% in May 2015), and reported recent use of alcohol has fluctuated between 9% and 11%.
10. Five percent of youth who responded to the recent arrest question on the YSS reported being arrested within the past month. Overall, clients in services more than one year had fewer arrests than clients who received less than one year of treatment services.

CYFBHS Process Objective

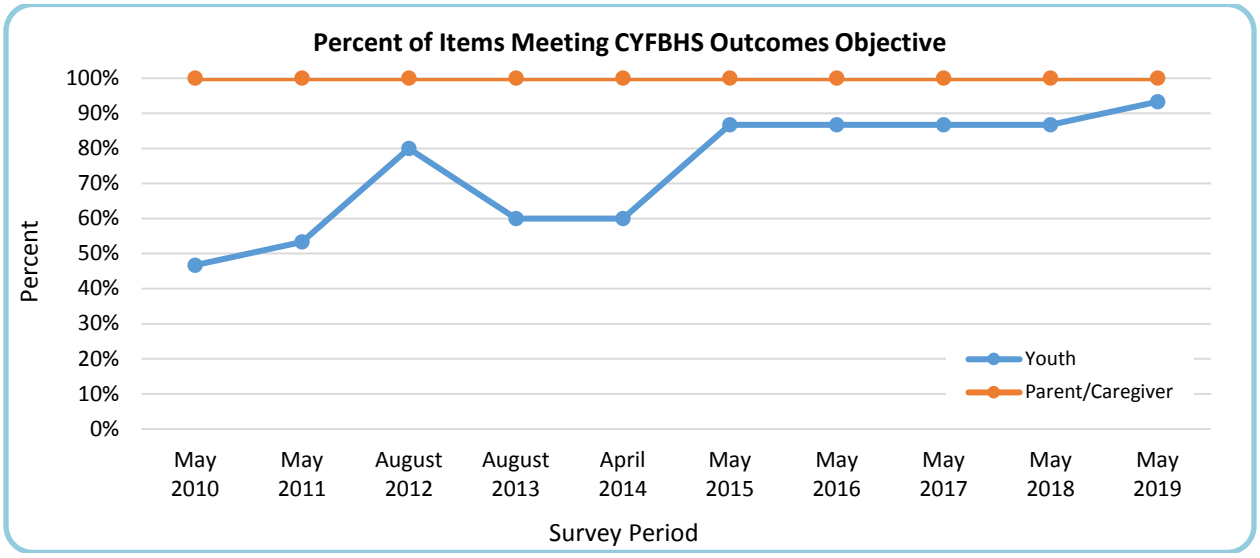
Providers are tasked with the administration of a YSS survey to every client (and/or parent/caregiver) receiving a service during the survey period. The process objective set by the County is 80% of eligible clients submitting a YSS form; this objective has been met and exceeded during every survey period since November 2006. The process objective is calculated using the number of clients served during the survey period, as opposed to the number of forms received. In the current survey period, **2,947 (88%) of 3,346 clients receiving a service *submitted* a YSS form,** and 2,192 (66%) of 3,346 clients receiving a service *completed* a YSS form.

CYFBHS Outcomes Objective

More than 5,000 survey forms were submitted for the May 2019 YSS (3,377 forms from parents/caregivers and 1,669 forms from youth). More than 3,100 of the forms were completed and had useable data (1,996 forms from parents/caregivers and 1,114 forms from youth). Overall, **62% of the forms that were turned in were completed.** Reasons for non-completion include refusals, parent/caregiver not available (e.g., for a child in out-of-home care), and parent/caregiver or child not showing up for a scheduled appointment.

The first 15 items on the YSS address satisfaction, while the remaining items cover client demographics, outcomes of services, and involvement with police and schools. The County has established an **outcome objective for the satisfaction items** which applies to all contractors: Aggregated scores on the Youth Services Survey (YSS) and the Youth Services Survey Family (YSS-F) shall show an average of 80% or more of clients responding in the two most favorable categories (Agree and Strongly Agree) for at least 75% of the individual survey items. Countywide data on the outcomes objective are presented in this report.

Parents/caregivers were more satisfied with services than Youth respondents. Since the outcomes objective was initiated in November 2006, **parent/caregiver scores have been above 80% for all of the satisfaction items on the survey**, and the objective has been satisfied. For youth respondents, the scores are lower; this has been true since the inception of these YSS measures. The County's objective was met during the May 2019 YSS; at least 80% of youth responded in the two most favorable categories for 93% of the individual survey items. Only one individual item fell below the threshold of 80% of youth responding favorably: "I helped to choose my services."



Survey Response Rate

	Parent/Caregiver	Youth	TOTAL
Forms Submitted	3,377	1,669	5,046
Forms Completed	1,996	1,114	3,110

Satisfaction by Item Response: Systemwide

Parent/Caregiver Satisfaction by Item*		
Questions based on services received in last 6 months:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. Overall, I am satisfied with the services my child received	1.8%	93.4%
2. I helped to choose my child's services	3.6%	91.3%
3. I helped to choose my child's treatment goals	2.7%	94.0%
4. The people helping my child stuck with us no matter what	2.8%	92.2%
5. I felt my child had someone to talk to when he/she was troubled	2.2%	93.0%
6. I participated in my child's treatment	2.4%	94.7%
7. The services my child and/or family received were right for us	1.8%	91.6%
8. The location of services was convenient for us	4.4%	92.9%
9. Services were available at times that were convenient for us	2.6%	94.1%
10. My family got the help we wanted for my child	2.2%	89.5%
11. My family got as much help as we needed for my child	2.7%	85.5%
12. Staff treated me with respect	1.3%	97.8%
13. Staff respected my family's religious/spiritual beliefs	1.1%	96.7%
14. Staff spoke with me in a way that I understood	1.0%	98.3%
15. Staff were sensitive to my cultural/ethnic background	1.6%	96.4%
At least 80% of clients responded "Agree" or "Strongly Agree" to 15 of 15 questions – 100%		
As a result of the services received:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
16. My child is better at handling daily life	5.4%	73.4%
17. My child gets along better with family members	6.9%	74.6%
18. My child gets along better with friends and other people	4.8%	74.2%
19. My child is doing better in school and/or work	8.6%	71.0%
20. My child is better able to cope when things go wrong	8.7%	65.9%
21. I am satisfied with our family life right now	11.5%	69.9%
22. My child is better able to do things he or she wants to do	6.6%	73.0%
23. I know people who will listen and understand me when I need to talk	2.4%	92.1%
24. I have people that I am comfortable talking with about my child's problem(s)	2.2%	93.8%
25. In a crisis, I would have the support I need from family or friends	3.8%	89.4%
26. I have people with whom I can do enjoyable things	3.0%	92.2%

**Percent may not add up to 100, as "Undecided" response is not reported here.*

Youth Satisfaction by Item*		
Questions based on services received in last 6 months:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. Overall, I am satisfied with the services I received	3.9%	88.0%
2. I helped to choose my services	11.6%	70.3%
3. I helped to choose my treatment goals	4.2%	86.0%
4. The people helping me stuck with me no matter what	3.9%	86.1%
5. I felt I had someone to talk to when I was troubled	5.8%	84.0%
6. I participated in my own treatment	2.2%	87.2%
7. I received services that were right for me	3.9%	84.5%
8. The location of services was convenient for me	4.6%	85.0%
9. Services were available at times that were convenient for me	4.1%	86.2%
10. I got the help I wanted	4.4%	82.3%
11. I got as much help as I needed	3.8%	80.0%
12. Staff treated me with respect	2.7%	92.1%
13. Staff respected my religious/spiritual beliefs	1.8%	91.9%
14. Staff spoke with me in a way that I understood	2.6%	93.2%
15. Staff were sensitive to my cultural/ethnic background	3.8%	86.2%
At least 80% of clients responded "Agree" or "Strongly Agree" to 14 of 15 questions – 93%		
As a result of the services received:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
16. I am better at handling daily life	6.0%	70.0%
17. I get along better with family members	10.9%	61.8%
18. I get along better with friends and other people	5.4%	72.7%
19. I am doing better in school and/or work	10.7%	63.2%
20. I am better able to cope when things go wrong	8.3%	70.3%
21. I am satisfied with my family life right now	13.2%	61.0%
22. I am better able to do things I want to do	8.9%	68.2%
23. I know people who will listen and understand me when I need to talk	3.8%	85.4%
24. I have people that I am comfortable talking with about my problem(s)	5.8%	84.1%
25. In a crisis, I would have the support I need from family or friends	5.2%	79.8%
26. I have people with whom I can do enjoyable things	3.8%	87.6%

**Percent may not add up to 100, as "Undecided" response is not reported here.*

Satisfaction by Domain: Systemwide

DOMAIN	Percent Stating Agree or Strongly Agree	
	Parent/Caregiver (N=1,966)	Youth (N=1,114)
General Satisfaction (Items 1, 4, 5, 7, 10, 11)	92.1%	85.3%
Perception of Access (Items 8, 9)	91.1%	81.9%
Perception of Cultural Sensitivity (Items 12, 13, 14, 15)	97.8%	91.3%
Perception of Participation in Treatment Planning (Items 2, 3, 6)	94.4%	82.3%
Perception of Outcomes of Services (Items 16, 17, 18, 19, 20, 21)	68.6%	65.6%
Perception of Functioning (Items 16, 17, 18, 20, 22)	71.9%	71.6%
Perception of Social Connectedness (Items 23, 24, 25, 26)	91.7%	83.0%

Satisfaction by Level of Care

Parent/Caregiver Satisfaction by Level of Care			
DOMAIN	Percent Stating Agree or Strongly Agree		
	Outpatient (N=1,885)	Day Treatment (N=10)	TBS (N=101)
General Satisfaction	92.1%	90.0%	90.9%
Perception of Access	91.1%	60.0%	94.0%
Perception of Cultural Sensitivity	97.8%	100.0%	97.9%
Perception of Participation in Treatment Planning	94.4%	88.9%	94.8%
Perception of Outcomes of Services	68.4%	70.0%	71.6%
Perception of Functioning	71.9%	60.0%	73.4%
Perception of Social Connectedness	92.0%	90.0%	87.5%

Youth Satisfaction by Level of Care			
DOMAIN	Percent Stating Agree or Strongly Agree		
	Outpatient (N=982)	Day Treatment (N=86)	TBS (N=46)
General Satisfaction	88.1%	56.6%	80.4%
Perception of Access	84.5%	50.0%	87.0%
Perception of Cultural Sensitivity	93.5%	61.3%	100.0%
Perception of Participation in Treatment Planning	84.4%	63.1%	71.7%
Perception of Outcomes of Services	66.6%	53.6%	66.7%
Perception of Functioning	72.5%	61.4%	71.4%
Perception of Social Connectedness	84.4%	66.3%	83.7%

NOTE: Not every youth/caregiver completed responses for every domain.

Satisfaction by Client Race/Ethnicity

DOMAIN	Percent Stating Agree or Strongly Agree							
	White (N=447)	Hispanic (N=2,027)	African-American (N=140)	Asian/ Pacific Islander (N=55)	Native American (N=15)	Mixed Race/ Ethnicity (N=185)	Other (N=42)	Unknown/ Missing (N=199)
General Satisfaction	87.3%	91.4%	84.3%	92.7%	100.0%	86.3%	95.2%	80.2%
Perception of Access	81.1%	90.0%	85.6%	85.2%	100.0%	86.5%	85.7%	84.1%
Perception of Cultural Sensitivity	95.3%	96.4%	94.0%	96.1%	92.9%	94.4%	89.5%	88.0%
Perception of Participation in Treatment Planning	87.4%	92.0%	85.2%	94.2%	100.0%	85.4%	85.7%	81.3%
Perception of Outcomes of Services	60.3%	71.1%	60.6%	71.7%	80.0%	55.6%	68.3%	59.6%
Perception of Functioning	67.3%	74.8%	65.9%	79.6%	84.6%	60.5%	75.6%	60.0%
Perception of Social Connectedness	87.6%	89.4%	88.0%	90.7%	85.7%	87.0%	90.5%	82.2%

Satisfaction by Client Age

DOMAIN	Percent Stating Agree or Strongly Agree				
	0-5 years (N=235)	6-11 years (N=819)	12-15 years (N=1,192)	16-17 years (N=707)	18-25 years (N=144)
General Satisfaction	94.1%	91.4%	88.2%	88.3%	91.5%
Perception of Access	89.7%	91.2%	86.1%	86.4%	86.7%
Perception of Cultural Sensitivity	98.6%	98.0%	94.1%	94.5%	91.9%
Perception of Participation in Treatment Planning	93.2%	95.3%	86.2%	88.5%	92.9%
Perception of Outcomes of Services	72.5%	67.2%	66.2%	68.2%	69.1%
Perception of Functioning	72.8%	70.8%	71.3%	72.4%	77.9%
Perception of Social Connectedness	95.8%	91.4%	85.5%	89.4%	83.0%

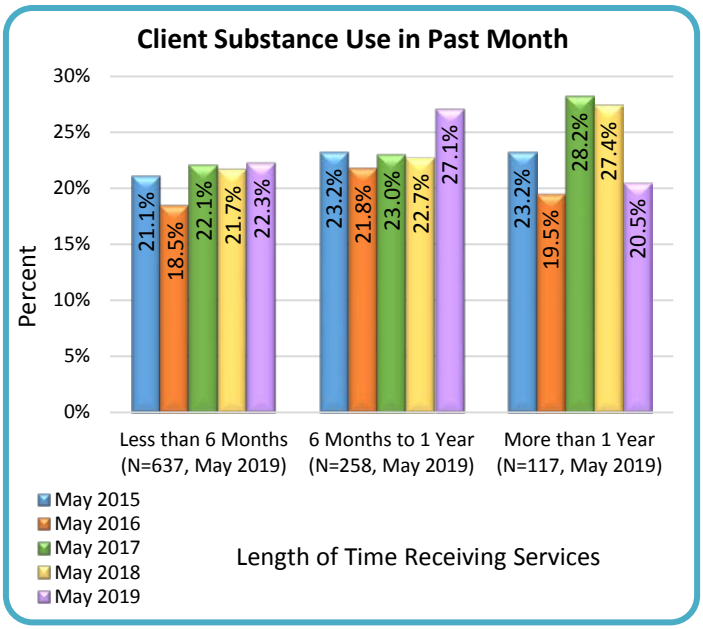
NOTE: Not every youth/caregiver completed responses for every domain.

Substance Use by Length of Service

On the YSS, youth ages 13+ were asked whether they had used any of a list of substances (alcohol, cigarettes, ecstasy, cocaine, marijuana, crystal meth, inhalants, hallucinogens, opiates, injected drugs) in the past month. During the May 2019 survey period, 1,050 youth responded to the substance use question.

Overall, 24% of youth stated that they had used one of these substances at least once in the past month.

The three most commonly used substances in the past month were: Marijuana (20.1%), Alcohol (11.0%), and Cigarettes (5.0%).

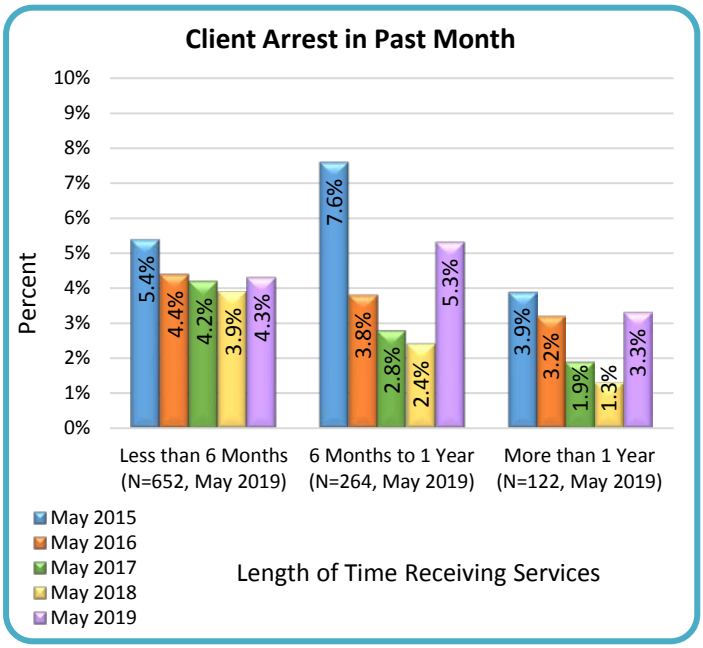


Arrests by Length of Service

On the YSS, youth ages 13+ were asked to report on whether they had been arrested for any crimes in the past month. During the May 2019 survey period, 1,114 youth responded to the arrest question.

Overall, clients in services more than one year had fewer arrests than clients who received less than one year of treatment. It is important to note that due to the small number of clients systemwide (N=55 in May 2019) who reported arrests, small changes in numbers can have large effects on proportion.

Fifty of 55 youth who reported arrests also responded to the substance use question; of these, 31 (62%) reported use of a substance in the past month.



The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded behavioral health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

Consumer Satisfaction Survey Results

Survey Period: May 13-17, 2019

The County of San Diego's Adult and Older Adult Behavioral Health Services (AOABHS): Adult Mental Health Services

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Consumer Satisfaction Survey Results

Survey Period: May 13-17, 2019

Summary

Consumer Satisfaction

- 90% of consumers were generally satisfied with services received (as indicated by either having agreed or strongly agreed with the General Satisfaction domain).

Consumer Satisfaction: Trends Across Time

- Perception of Participation in Treatment Planning and Perception of Social Connectedness scores were slightly lower across all domains in the Spring 2019 survey period as compared to the Spring 2018 survey period.

Satisfaction by Level of Care

- Consumers who received Assertive Community Treatment (ACT) and Outpatient (OP) services reported lower mean scores in the following three domains than consumers receiving Case Management (CM), Crisis Residential (CR), or Other services:
  - ✓ Perception of Outcome Services
  - ✓ Perception of Functioning
  - ✓ Perception of Social Connectedness
- Across all levels of care, consumers who received Other services reported higher percentages of dissatisfaction in the Perception of Access (42%), Perception of Outcome Services (33%), Perception of Functioning (42%), and Perception of Social Connectedness (33%) domains.

Satisfaction by Race/Ethnicity

- Hispanic and African American consumers had higher mean scores than any other racial/ethnic group across all domains.
- Native American consumers reported the highest proportion of dissatisfaction among all racial/ethnic groups in Perception of Access, Perception of Outcome Services, and Perception of Functioning.

Total Number of Surveys Returned: 2,997

- **2,406 completed**
- **591 incomplete***

To calculate response rates, surveys were counted as incomplete if the survey had insufficient data to compute the "General Satisfaction" domain score of the MHSIP, meaning that all three of the first three items of the questionnaire were missing.

NOTE: All surveys (complete and incomplete) were included in the aggregate analyses.

Satisfaction by Age

- All age ranges have equally as high mean scores for four out of the seven domains: General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, and Perception of Participation in Treatment Planning.
- Consumers ages 18-25 years and 26-59 years reported the highest proportion of dissatisfaction in two out of the seven domains: Perception of Outcome Services, and Perception of Social Connectedness.

Length of Services

- 62% of consumers who participated in the survey had been receiving mental health services with AOABHS for more than one year.

Arrests

- Among the 38% of consumers who received services for one year or less, 64% reported reduced encounters with police since they began receiving mental health services.
- Among the 62% of consumers who received services for more than one year, 60% reported reduced encounters with police since they began receiving mental health services.

Consumer Demographics

- A little over half (52%) of the consumers who participated in the Spring 2019 survey were male.
- Each racial/ethnic group was represented in the Spring 2019 survey period, with White, Hispanic, and African American persons representing 85% of the total population surveyed (41%, 30%, and 14%, respectively).

Language Availability

- 98% of consumers reported that services were provided in the language they prefer.

Reason for Involvement with Program

- The majority (58%) of persons who received mental health services reported that someone else recommended that they go.

Response Rates

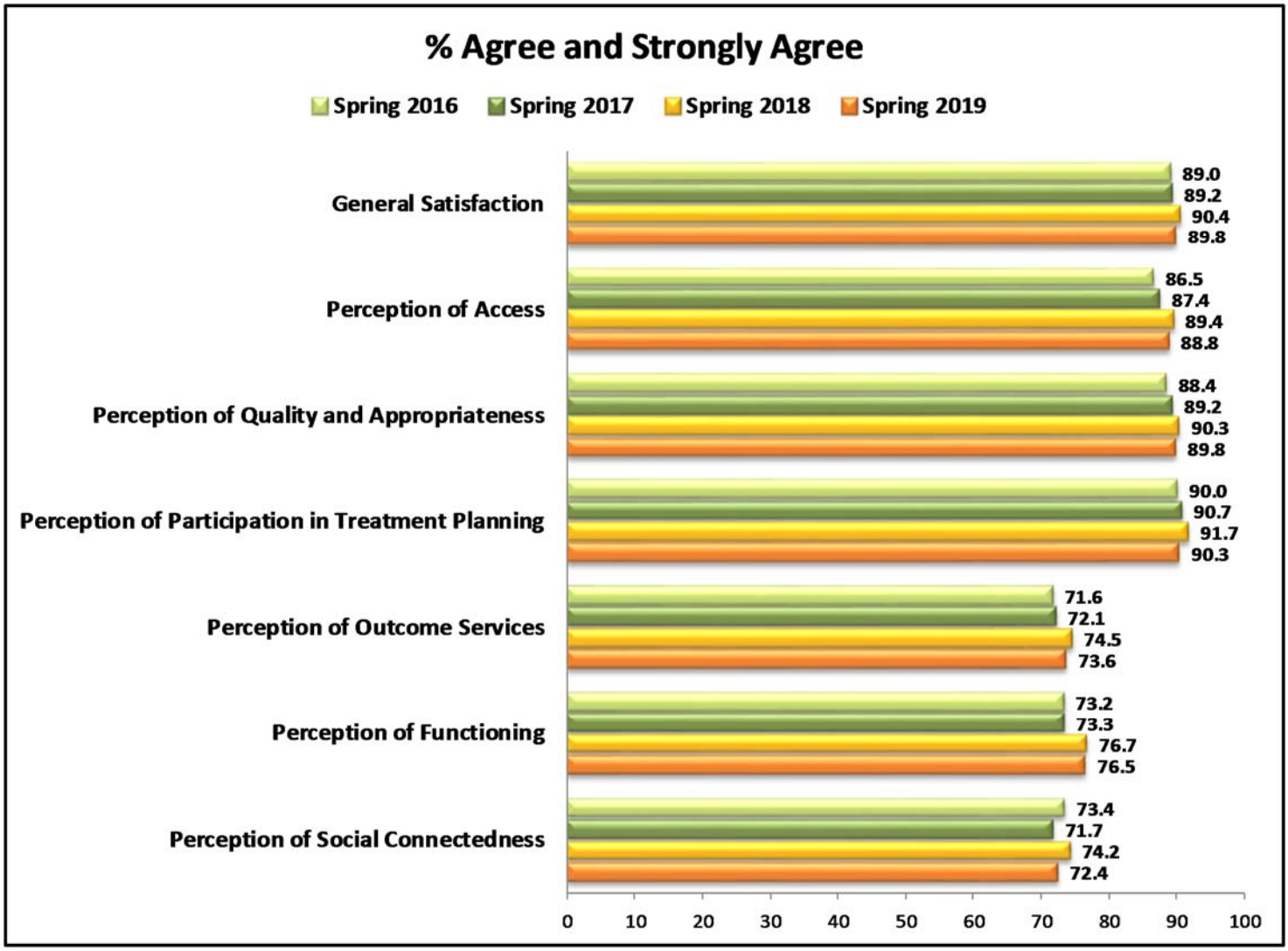
- 80% of consumers who received face to face services during the survey period completed a survey (NOTE: this calculation excludes incomplete surveys).

Consumer Satisfaction (Domains: All Programs)

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree (N=2,406*)

DOMAIN	% below 3.5	% over 3.5	Mean
General Satisfaction (Items: 1-3)	10.2	89.8	4.4
Perception of Access (Items: 4-9)	11.2	88.8	4.2
Perception of Quality and Appropriateness (Items: 10, 12-16, 18-20)	10.2	89.8	4.3
Perception of Participation in Treatment Planning (Items: 11, 17)	9.7	90.3	4.3
Perception of Outcome Services (Items: 21-28)	26.4	73.6	3.9
Perception of Functioning (Items: 29-32)	23.5	76.5	3.9
Perception of Social Connectedness (Items: 33-36)	27.6	72.4	3.9

Consumer Satisfaction: Trends Across Time



** The total number of responses for domain scores may be less than the reported number of completed surveys, as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.*

Consumer Satisfaction (Item Responses: All Programs)

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree (N = 2,406*)

Questions based on services received in last 6 months	% Disagree/ Strongly Disagree	% Agree/ Strongly Agree
1. I like the services that I received here.	2.1	92.8
2. If I had other choices, I would still get services from this agency.	4.2	86.2
3. I would recommend this agency to a friend or family member.	3.0	88.9
4. The location of services was convenient (parking, public transportation, distance, etc.).	4.6	84.3
5. Staff were willing to see me as often as I felt it was necessary.	3.9	87.5
6. Staff returned my calls within 24 hours.	6.0	81.4
7. Services were available at times that were good for me.	2.8	88.6
8. I was able to get all the services I thought I needed.	5.0	84.8
9. I was able to see a psychiatrist when I wanted to.	5.2	80.9
10. Staff here believe that I can grow, change, and recover.	1.7	89.8
11. I felt comfortable asking questions about my treatment and medication.	2.6	89.6
12. I felt free to complain.	5.5	82.0
13. I was given information about my rights.	2.6	88.4
14. Staff encouraged me to take responsibility for how I live my life.	2.4	87.1
15. Staff told me what side effects to watch out for.	5.3	81.5
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	2.1	90.6
17. I, not staff, decided my treatment goals.	4.7	81.2
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	2.4	86.0
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	2.8	86.8
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	3.4	85.9

As a direct result of the services I received:	% Disagree/ Strongly Disagree	% Agree/ Strongly Agree
21. I deal more effectively with daily problems.	4.0	79.9
22. I am better able to control my life.	4.7	76.7
23. I am better able to deal with crisis.	5.6	77.6
24. I am getting along better with my family.	9.2	70.6
25. I do better in social situations.	8.9	67.8
26. I do better in school and/or work.	9.9	59.0
27. My housing situation has improved.	12.0	64.4
28. My symptoms are not bothering me as much.	13.1	66.0
29. I do things that are more meaningful to me.	7.4	72.2
30. I am better able to take care of my needs.	6.0	75.3
31. I am better able to handle things when they go wrong.	7.5	71.0
32. I am better able to do things that I want to do.	7.7	71.7
33. I am happy with the friendships I have.	8.2	70.6
34. I have people with whom I can do enjoyable things.	9.8	71.2
35. I feel I belong in my community.	11.0	63.5
36. In a crisis, I would have the support I need from family or friends.	9.8	72.3

** The total number of responses for domain scores may be less than the reported number of completed surveys, as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.*

NOTE: The three highest percentages of "% Agree/Strongly Agree" are highlighted green. The three highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Level of Care

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

DOMAIN	Means				
	OP (N=1,440)	ACT (N=1,202)	CM (N=257)	CR (N=82)	Other (N=16)
General Satisfaction	4.5	4.2	4.4	4.5	4.1
Perception of Access	4.4	4.1	4.3	4.4	4.1
Perception of Quality and Appropriateness	4.4	4.2	4.3	4.5	4.2
Perception of Participation in Treatment Planning	4.4	4.2	4.3	4.5	4.3
Perception of Outcome Services	3.9	3.9	4.0	4.0	4.0
Perception of Functioning	3.9	3.9	3.9	4.2	4.1
Perception of Social Connectedness	3.9	3.8	3.9	4.0	4.2

DOMAIN	% over 3.5				
	OP	ACT	CM	CR	Other
General Satisfaction	93.0	86.0	91.0	94.7	75.0
Perception of Access	92.5	84.8	88.7	93.3	58.3
Perception of Quality and Appropriateness	91.1	88.3	87.8	96.0	75.0
Perception of Participation in Treatment Planning	91.9	88.6	87.6	96.0	83.3
Perception of Outcome Services	72.6	74.6	77.4	68.5	66.7
Perception of Functioning	73.3	80.2	73.7	78.9	58.3
Perception of Social Connectedness	73.2	71.6	72.9	71.4	66.7

DOMAIN	% below 3.5				
	OP	ACT	CM	CR	Other
General Satisfaction	7.0	14.0	9.0	5.3	25.0
Perception of Access	7.5	15.2	11.3	6.7	41.7
Perception of Quality and Appropriateness	8.9	11.7	12.2	4.0	25.0
Perception of Participation in Treatment Planning	8.1	11.4	12.4	4.0	16.7
Perception of Outcome Services	27.4	25.4	22.6	31.5	33.3
Perception of Functioning	26.7	19.8	26.3	21.1	41.7
Perception of Social Connectedness	26.8	28.4	27.1	28.6	33.3

Legend	
OP	Outpatient
ACT	Assertive Community Treatment
CM	Case Management
CR	Crisis Residential
Other	Includes: Residential and Prevention

NOTES: The total number of responses for domain scores may be less than the reported number of completed surveys, as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The four highest percentages of "% Agree/Strongly Agree" are highlighted green. The four highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Race/Ethnicity

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

DOMAIN	Means				
	White (N=1,229)	Hispanic (N=889)	African American (N=422)	Asian/ Pacific Is. (N=248)	Native American (N=28)
General Satisfaction	4.3	4.5	4.4	4.3	4.2
Perception of Access	4.2	4.3	4.3	4.1	4.0
Perception of Quality and Appropriateness	4.2	4.3	4.3	4.1	4.2
Perception of Participation in Treatment Planning	3.9	4.0	4.0	3.7	3.8
Perception of Outcome Services	3.9	4.0	4.0	3.8	3.7
Perception of Functioning	3.8	4.0	4.0	3.9	3.9
Perception of Social Connectedness	4.3	4.3	4.3	4.1	4.2

DOMAIN	% over 3.5				
	White	Hispanic	African American	Asian/ Pacific Is.	Native American
General Satisfaction	88.2	90.9	92.1	88.5	81.8
Perception of Access	87.1	91.4	91.0	84.7	68.2
Perception of Quality and Appropriateness	88.7	90.7	91.8	85.0	86.4
Perception of Participation in Treatment Planning	89.9	90.8	91.2	86.6	86.4
Perception of Outcome Services	74.8	74.2	74.5	69.1	59.1
Perception of Functioning	76.4	76.9	81.7	70.8	59.1
Perception of Social Connectedness	69.6	76.4	73.2	73.4	76.2

DOMAIN	% below 3.5				
	White	Hispanic	African American	Asian/ Pacific Is.	Native American
General Satisfaction	11.8	9.1	7.9	11.5	18.2
Perception of Access	12.9	8.6	9.0	15.3	31.8
Perception of Quality and Appropriateness	11.3	9.3	8.2	15.0	13.6
Perception of Participation in Treatment Planning	10.1	9.2	8.8	13.4	13.6
Perception of Outcome Services	25.2	25.8	25.5	30.9	40.9
Perception of Functioning	23.6	23.1	18.3	29.2	40.9
Perception of Social Connectedness	30.4	23.6	26.8	26.6	23.8

NOTES: Other (N = 134) and Unknown (N = 47) racial/ethnic categories are not displayed above.

The total number of responses for domain scores may be less than the reported number of completed surveys, as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The three highest percentages of "% Agree/Strongly Agree" are highlighted green. The four highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Age

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

DOMAIN	Means		
	<18-25 (N=418)	26-59 (N=2,133)	60+ (N=446)
General Satisfaction	4.4	4.4	4.4
Perception of Access	4.3	4.2	4.2
Perception of Quality and Appropriateness	4.3	4.3	4.3
Perception of Participation in Treatment Planning	4.3	4.3	4.3
Perception of Outcome Services	3.9	3.9	3.9
Perception of Functioning	3.9	3.9	3.9
Perception of Social Connectedness	3.9	3.9	3.9

DOMAIN	% over 3.5		
	<18-25	26-59	60+
General Satisfaction	87.4	89.9	91.6
Perception of Access	88.7	88.3	91.0
Perception of Quality and Appropriateness	86.2	89.6	93.6
Perception of Participation in Treatment Planning	88.2	90.0	93.9
Perception of Outcome Services	71.5	73.6	75.6
Perception of Functioning	74.1	76.9	76.7
Perception of Social Connectedness	73.6	71.4	76.1

DOMAIN	% below 3.5		
	<18-25	26-59	60+
General Satisfaction	12.6	10.1	8.4
Perception of Access	11.3	11.7	9.0
Perception of Quality and Appropriateness	13.8	10.4	6.4
Perception of Participation in Treatment Planning	11.8	10.0	6.1
Perception of Outcome Services	28.5	26.4	24.4
Perception of Functioning	25.9	23.1	23.3
Perception of Social Connectedness	26.4	28.6	23.9

NOTES: The total number of responses for domain scores may be less than the reported number of completed surveys, as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The three highest percentages of "% Agree/Strongly Agree" are highlighted green. The four highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Length of Services

How long have you received services here? (N=2,176)	%	N
This is my first visit here	4%	77
I have had more than one visit but I have received services for less than one month	5%	101
1 - 2 months	8%	171
3 - 5 months	9%	199
6 months to 1 year	13%	275
More than 1 year	62%	1,353

Arrests: Services One Year or Less

Were you arrested since you began to receive mental health services?	%	N
Yes	10%	70
No	90%	660
Were you arrested during the 12 months prior to that?	**%**	**N**
Yes	16%	114
No	84%	608
Since you began to receive mental health services, have your encounters with the police . . .?	**%**	**N**
Been reduced	64%	166
Stayed the same	30%	78
Increased	7%	17

Arrests: Services More than One Year

Were you arrested since you began to receive mental health services?	%	N
Yes	6%	82
No	94%	1,207
Were you arrested during the 12 months prior to that?	**%**	**N**
Yes	9%	111
No	91%	1,168
Since you began to receive mental health services, have your encounters with the police . . . ?	**%**	**N**
Been reduced	60%	188
Stayed the same	28%	89
Increased	12%	36

Consumer Demographics

AOABHS Spring 2019 Survey Takers

Gender	%	N
Female	46%	1,375
Male	52%	1,563
Transgender	1%	18
Another Gender Identity, Genderqueer	< 1%	13
Questioning/Unsure	< 1%	9
Decline to State	1%	19

All AOABHS Consumers in FY 2018-19

Gender	%	N
Female	44%	18,400
Male	55%	22,988
Transgender	< 1%	85
Another Gender Identity	< 1%	80
Genderqueer	< 1%	23
Questioning/Unsure	< 1%	67
Decline to State	< 1%	65

AOABHS Spring 2019 Survey Takers

Race/Ethnicity	%	N
White	41%	1,229
Hispanic	30%	889
African American	14%	422
Asian/Pacific Islander	8%	248
Native American	1%	28
Other	4%	134
Unknown	2%	47

Data above includes all returned surveys from clients with valid Race/Ethnicity or Gender data in CCBH (N=2997).
NOTE: Values of <5 were merged with another category to protect confidentiality of the individuals summarized in the data.

All AOABHS Consumers in FY 2018-19

Race/Ethnicity	%	N
White	41%	17,198
Hispanic	27%	11,280
African American	13%	5,219
Asian/Pacific Islander	5%	2,231
Native American	1%	302
Other	4%	1,824
Unknown	9%	3,654

Data Source: CCBH download (7/2019)
NOTE: These data are preliminary and subject to change in the publication of the AOABHS Databook for FY 2018-19.

Language Availability

Were the services you received provided in the language you prefer?	%	N
Yes	98%	2,033
No	2%	45

Reason for Involvement with Program

What was the primary reason you became involved with this program?	%	N
I decided to come in on my own	36%	751
Someone else recommended that I come in	58%	1,207
I came in against my will	6%	125

NOTE: Percentages in the tables above may not add up to 100% due to rounding.

Response Rates

SPRING 2019 SURVEY	
Total Number of Visits Reported Across Programs (during survey period)	4,127
Total Number of Clients Who Received Services Across Programs (during survey period)	3,237
Total Number of Surveys Received	2,997
Number of Incomplete Surveys Received	591
Number of Completed Surveys Received	2,406
Proportion of Returned Surveys Completed	80%
Proportion of Returned Surveys Incomplete*	20%
BY VISIT Response Rate Including Incompletes	73%
BY VISIT Response Rate NOT Including Incompletes	58%
BY CLIENT Response Rate Including Incompletes	93%
BY CLIENT Response Rate NOT Including Incompletes	74%

**To calculate response rates, surveys were counted as incomplete if the survey had insufficient data to compute the "General Satisfaction" domain score of the MHSIP which meant that all three of the first three items of the questionnaire were missing.*

NOTE: All surveys (complete and incomplete) were included in the aggregate analyses.

Report prepared by:

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA SAN DIEGO

Youth Treatment Perceptions Survey (TPS)
October 2019 Survey Period

San Diego County Behavioral Health Services

Substance Use Disorder Services

Report prepared by the
Health Services Research Center (HSRC)

March 2020

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Overview

The Centers for Medicare and Medicaid Services (CMS) requires counties opting into the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS) to collect and submit client satisfaction data. The California Department of Health Care Services monitors each county at least once a year through an External Quality Review Organization (EQRO) to ensure compliance and proper delivery of quality care is provided in alignment with the DMC-ODS requirements. In order to meet the requirements for the assessment of client satisfaction data, the validated Youth Treatment Perception Survey (TPS) was developed by the University of California, Los Angeles (UCLA) to collect client satisfaction data for programs within the DMC-ODS.

In San Diego County, data on consumer satisfaction is collected by youth clients through the Youth TPS, which is completed by any client 18 years old or younger served by a substance use disorder program contracted by San Diego County Behavioral Health Services (SDCBHS) during the survey period. The majority of questions of the TPS focus on client access and satisfaction with services provided through the substance use disorder system of care. This report focuses on results of the Youth TPS administered during the survey period of October 7-11, 2019.

TPS results are calculated directly from submitted surveys. The TPS gives a snapshot in time of the youth population receiving substance use disorder services within San Diego County.

Individual items on the Youth TPS are grouped into six domains for analysis:

1. Perception of Access
2. Perception of Quality and Appropriateness
3. Perception of Therapeutic Alliance
4. Perception of Care Coordination
5. Perception of Outcome Services
6. General Satisfaction

Clients may receive services from more than one program during the TPS period; therefore, a single client may submit multiple forms. Results are evaluated by item and domain systemwide, by level of care, and by program.

Key Findings—October 2019

Key Findings from Each Domain

- **Perception of Access**
  - Youth clients reported having a good experience enrolling in treatment with the highest dissatisfaction compared to any other item in the TPS (8%).
- **Perception of Quality and Appropriateness**
  - 84% of youth clients agreed or strongly agreed the staff treated them with respect.
- **Perception of the Therapeutic Alliance**
  - 85% of the 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, 78% of youth clients reported satisfaction within the *Perception of Care Coordination* domain.
- **Perception of Outcome Services**
  - Three quarters (75%) of the youth clients agreed or strongly agreed to that they are better able to do things they want to do as a result of the services they received.
- **General Satisfaction**
  - Compared to other items on the TPS, a smaller proportion of youth clients reported overall dissatisfaction with services (1%).

Satisfaction by Level of Care

- The youth clients who received services through the residential level of care reported higher mean scores on average in five of the six domains compared to the youth who received outpatient or intensive outpatient services.
- The residential level of care was the only level of care with 100% of youth clients that agreed or strongly agreed they would recommend services to a friend who needed similar help.

Satisfaction by Race/Ethnicity

- Satisfaction and perception of outcomes within all six domains varied widely among different racial/ethnic groups. Overall, Black/African-American youth reported the greatest satisfaction averaged across all six domains.
- Multiracial youth reported the lowest satisfaction averaged across all six of the domains.
- Black/African-American and Native Hawaiian/Pacific Islander reported the greatest satisfaction averages in the *Perception of Therapeutic Alliance* domain compared to the other racial/ethnic groups.

Satisfaction by Age

- Compared across age groups, youth between the ages of 10 and 14 years old reported the greatest satisfaction averages in the *Perception of Outcome* domain, while youth aged 15 to 17 years old reported the greatest satisfaction among the *Perception of Therapeutic Alliance* domain.

TPS Response Rate

Providers are tasked with the administration of the Youth TPS to every youth client receiving a service during the survey period. San Diego County received 137 Youth TPS forms for the October 2019 survey period. All 137 surveys were complete, which was defined as having data in the first three questions. Overall, 80% of consumers who had a billed face-to-face service in San Diego Web Infrastructure for Treatment Services (SanWITS) during the survey period completed a survey (NOTE: this calculation excludes incomplete surveys).

Satisfaction by Item Response: Systemwide

Youth Satisfaction by Item*			
Questions based on services received within the last year:	N	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. The location of services was convenient for me.	135	5%	75%
2. Services were available at times that were convenient for me.	134	5%	73%
3. I had a good experience enrolling in treatment.	132	8%	67%
4. My counselor and I worked on treatment goals together.	132	2%	81%
5. I received services that were right for me.	130	2%	77%
6. Staff treated me with respect.	136	2%	84%
7. I feel my counselor took the time to listen to what I had to say.	135	2%	85%
8. I developed a positive, trusting relationship with my counselor.	133	4%	74%
9. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	126	4%	68%
10. I feel my counselor was sincerely interested in me and understood me.	131	3%	79%
11. I liked my counselor here.	134	3%	82%
12. My counselor is capable of helping me.	131	2%	82%
13. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).	134	2%	77%
14. Staff here helped me with other issues and concerns I had related to legal/probation, family, and educational systems.	130	3%	80%
15. My counselor provided necessary services for my family.	124	6%	69%
16. As a result of the services I received, I am better able to do things I want to do.	130	5%	75%
17. Overall, I am satisfied with the services I received.	130	1%	77%
18. I would recommend the services to a friend who is in need of similar help.	129	6%	76%

**Percent may not add up to 100%, as "I am Neutral" responses are not reported here.*

Satisfaction by Domain: Systemwide

Youth Satisfaction by TPS Survey Domain	
DOMAIN	Proportion Stating Strongly Agree or Agree
	Youth (N=137)
Perception of Access (Items 1, 2, 3)	71%
Perception of Quality (Items 5, 6, 9, 15)	74%
Perception of Therapeutic Alliance (Items 4, 7, 8, 10, 11, 12)	81%
Perception of Care Coordination (Items 13, 14)	78%
Perception of Outcome (Items 16)	75%
General Satisfaction (Items 17, 18)	77%

Satisfaction by Level of Care

Youth Satisfaction by Level of Care			
DOMAIN	Proportion Stating Strongly Agree or Agree		
	Outpatient (N=130)	Residential (N=7)	Overall (N=137)
Perception of Access	71%	81%	71%
Perception of Quality	74%	82%	74%
Perception of Therapeutic Alliance	81%	86%	81%
Perception of Care Coordination	78%	86%	78%
Perception of Outcome	76%	71%	75%
General Satisfaction	76%	93%	77%

Satisfaction by Client Race/Ethnicity

DOMAIN	Proportion Stating Strongly Agree or Agree							
	American Indian/Alaskan Native (N=0)	Asian (N=5)	Black/African-American (N=12)	Latino (N=96)	White (N=8)	Multiracial* (N=6)	Other (N=6)	Unknown/ Missing (N=4)
Perception of Access	N/A	73%	78%	72%	58%	67%	67%	67%
Perception of Quality	N/A	73%	83%	74%	66%	74%	71%	75%
Perception of Therapeutic Alliance	N/A	80%	93%	80%	75%	83%	81%	75%
Perception of Care Coordination	N/A	80%	82%	79%	69%	67%	75%	75%
Perception of Outcome	N/A	80%	73%	78%	50%	40%	83%	100%
General Satisfaction	N/A	80%	92%	76%	75%	50%	67%	88%

**Multiracial was determined if client selected two or more races not including Latino; If Latino was selected, the client was reported as Latino.*

Satisfaction by Client Age

DOMAIN	Proportion Stating Strongly Agree or Agree		
	10-14 years (N=23)	15-17 years (N=107)	18+ years (N=2)
Perception of Access	72%	72%	83%
Perception of Quality	71%	77%	88%
Perception of Therapeutic Alliance	77%	84%	58%
Perception of Care Coordination	78%	79%	100%
Perception of Outcome	77%	75%	50%
General Satisfaction	74%	78%	100%

Youth TPS 2019 Demographics

Length in Treatment	Percentage	N
Less than 1 month	34%	47
1-5 months	55%	75
6 months or more	9%	13
Missing	2%	2

Gender Identity	Percentage	N
Female	31%	42
Male	65%	89
Transgender	0%	0
Other Gender Identity	0%	0
Decline to Answer	2%	3
Missing	2%	3

Race/Ethnicity	Percentage	N
American Indian/Alaskan Native	0%	0
Asian	4%	5
Black/African American	9%	12
Latino	70%	96
Native Hawaiian/ Pacific Islander	1%	1
White/Caucasian	6%	8
Multiracial*	4%	6
Other	4%	5
Missing	3%	4

**Multiracial was determined if client selected two or more races not including Latino; If Latino was selected, the client was reported as Latino.*

Age	Percentage	N
10-14 years	17%	23
15-17 years	78%	107
18+ years*	1%	2
Missing	4%	5

**Although the Youth TPS is intended for clients younger than 18 years of age, a few clients served in the youth programs had turned 18 years old.*

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA SAN DIEGO

Adult Treatment Perceptions Survey (TPS)
October 2019 Survey Period

San Diego County Behavioral Health Services

Substance Use Disorder Services

Report prepared by the
Health Services Research Center (HSRC)

March 2020

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Overview

The Centers for Medicare and Medicaid Services (CMS) requires counties opting into the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS) to collect and submit client satisfaction data. The California Department of Health Care Services monitors each county at least once a year through an External Quality Review Organization (EQRO) to ensure compliance and proper delivery of quality care is provided in alignment with the DMC-ODS requirements. In order to meet the requirements of the assessment for client satisfaction data, the validated Adult Treatment Perception Survey (TPS) was developed by the University of California, Los Angeles (UCLA) to collect client satisfaction outcomes within the DMC-ODS.

In San Diego County, data on consumer satisfaction is collected by adult clients through the Adult TPS, which is completed by any adult client served by a substance use disorder program contracted by San Diego County Behavioral Health Services (SDCBHS) during the survey period. The majority of questions on the TPS focus on client access and satisfaction with services provided through the substance use disorder system of care. This report focuses on results of the Adult TPS administered during the survey period of October 7-11, 2019.

TPS results are calculated directly from submitted surveys. The TPS gives a snapshot in time of the adult population receiving substance use disorder services within San Diego County.

Individual items on the Adult TPS are grouped into five domains for analysis:

1. Perception of Access
2. Perception of Quality and Appropriateness
3. Perception of Care Coordination
4. Perception of Outcome Services
5. General Satisfaction

Clients may receive services from more than one program during the TPS period; therefore, a single client may submit multiple forms. Results are evaluated by item and domain systemwide, by level of care, and by program.

Key Findings—October 2019

Key Findings from Each Domain

❖ Perception of Access

- 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.

❖ Perception of Quality and Appropriateness

- 93% 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 (82%).

❖ Perception of 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.

❖ General Satisfaction

- 92% of adult clients agreed or strongly agreed they felt welcomed at the place where they received services.

Satisfaction by Level of Care

- The adult clients who received services through the outpatient and intensive outpatient level of care reported greater overall satisfaction with services received through the substance use disorder system of care than other levels of care.
- The adult clients who received services through the withdrawal management or detox level of care reported the lowest overall satisfaction with services received through the substance use disorder system of care compared to other levels of care.

Satisfaction by Race/Ethnicity

- Results among the domains of *General Satisfaction* and the *Perception of Outcomes* varied widely among different racial/ethnic groups. However, the domain of *Perception of Quality* reported one of the highest percentages of agree or strongly agree across all racial/ethnic groups.
- Native Hawaiian/Pacific Islander 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 within the substance use disorder system of care.

Satisfaction by Age

- In general, the adult clients between the ages of 46 and 55 years old reported the greatest satisfaction across all five domains.
- 90% of adults ages 56 years or older reported they agreed or strongly agreed with the quality of services they received from the substance use disorder system of care.

TPS Response Rate

Providers are tasked with the administration of Adult TPS to every client receiving a service during the survey period. San Diego County received 2,424 Adult TPS forms for the October 2019 survey period. A total of 2,412 surveys were completed, defined as having the first two questions completed. Overall, nearly 100% of the forms that were submitted were completed. Overall, 61% of consumers who had a billed face to face service in San Diego Web Infrastructure for Treatment Services (SanWITS) during the survey period completed a survey (NOTE: this calculation excludes incomplete surveys).

Satisfaction by Item Response: Systemwide

Adult Satisfaction by Item*			
Questions based on services received within the last year:	N	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. The location was convenient (public transportation, distance, parking, etc.).	2,373	5%	85%
2. Services were available when I needed them.	2,388	4%	86%
3. I chose the treatment goals with my provider's help.	2,350	3%	87%
4. Staff gave me enough time in my treatment sessions.	2,381	2%	91%
5. Staff treated me with respect.	2,392	3%	91%
6. Staff spoke to me in a way I understood.	2,390	2%	93%
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	2,361	2%	88%
8. Staff here work with my physical health care providers to support my wellness.	2,298	4%	83%
9. Staff here work with my mental health care providers to support my wellness.	2,199	4%	82%
10. As a direct result of the services I am receiving, I am better able to do things that I want to do.	2,378	3%	85%
11. I felt welcomed here.	2,393	2%	92%
12. Overall, I am satisfied with the services I received.	2,386	2%	91%
13. I was able to get all the help/services that I needed.	2,390	4%	86%
14. I would recommend this agency to a friend or family member.	2,387	3%	90%

**Percent may not add up to 100%, as "I am Neutral" responses are not reported here.*

Satisfaction by Domain: Systemwide

Adult Satisfaction by TPS Survey Domain	
DOMAIN	Proportion Stating Strongly Agree or Agree
	Adult (N=2,424)
Perception of Access (Items 1, 2)	86%
Perception of Quality (Items 3, 4, 5, 6, 7)	90%
Perception of Care Coordination (Items 8, 9)	82%
Perception of Outcome (Items 10)	85%
General Satisfaction (Items 11, 12, 13, 14)	90%

Satisfaction by Level of Care

Adult Satisfaction by Level of Care				
DOMAIN	Proportion Stating Strongly Agree or Agree			
	Outpatient/Intensive Outpatient (n=1,009)	Residential (n=634)	Detox (n=18)	NTP/OTP (n=763)
Perception of Access	87%	81%	72%	88%
Perception of Quality	93%	85%	77%	91%
Perception of Care Coordination	85%	79%	78%	81%
Perception of Outcome	86%	78%	72%	91%
General Satisfaction	93%	85%	78%	90%

Satisfaction by Client Race/Ethnicity

DOMAIN	Proportion Stating Agree or Strongly Agree								
	American Indian/Alaskan Native (n=47)	Asian (n=30)	Black/African-American (n=181)	Latino (n=754)	Native Hawaiian/ Pacific Islander (n=25)	White (n=1,083)	Multiracial* (n=64)	Other (n=122)	Unknown/ Missing (n=118)
Perception of Access	83%	82%	85%	87%	82%	86%	78%	83%	86%
Perception of Quality	94%	88%	88%	90%	88%	92%	91%	84%	87%
Perception of Care Coordination	81%	75%	79%	84%	71%	84%	79%	72%	80%
Perception of Outcome	91%	83%	81%	87%	76%	86%	84%	82%	79%
General Satisfaction	96%	90%	88%	91%	78%	90%	89%	82%	86%

**Multiracial was determined if client selected two or more races not including Latino; If Latino was selected, the client was reported as Latino.*

Satisfaction by Client Age

DOMAIN	Proportion Stating Agree or Strongly Agree				
	18-25 years (n=248)	26-35 years (n=756)	36-45 years (n=549)	46-55 years (n=402)	56+ years (n=308)
Perception of Access	84%	85%	85%	89%	85%
Perception of Quality	89%	90%	90%	93%	90%
Perception of Care Coordination	83%	81%	83%	85%	79%
Perception of Outcome	85%	83%	84%	91%	87%
General Satisfaction	89%	88%	89%	93%	90%

Adult TPS 2019 Demographics

Length in Treatment	Percentage	N
First visit/day	6%	134
2 weeks or less	12%	300
More than 2 weeks	79%	1,917
Missing	3%	73

Gender Identity	Percentage	N
Female	36%	884
Male	58%	1,408
Transgender	<1%	15
Other Gender Identity	<1%	6
Decline to Answer	1%	33
Missing	3%	78

Race/Ethnicity	Percentage	N
American Indian/Alaskan Native	2%	47
Asian	1%	30
Black/African American	7%	181
Latino	31%	754
Native Hawaiian/ Pacific Islander	1%	25
White/Caucasian	45%	1,083
Multiracial*	3%	64
Other	5%	122
Missing	5%	118

**Multiracial was determined if client selected two or more races not including Latino; If Latino was selected, the client was reported as Latino.*

Age	Percentage	N
18 – 25 years	10%	248
26 – 35 years	31%	756
36 – 45 years	23%	549
46 – 55 years	17%	402
56+ years	13%	308
Missing	7%	161

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA SAN DIEGO

Behavioral Health Cultural Competence Plan Scoring Tool

Program/Legal Entity:

Current Status of Program

The Cultural Competence Plan includes:	Included			Quality	Strengths/Needs
	Yes	No	Page #	1-adequate 2-good 3-exemplary	
How the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.					
How program administration prioritizes cultural competence in the delivery of services.					
Goals accomplished regarding reducing health care disparities.					
Barriers to quality improvement.					

Service Assessment Update and Data Analysis

The Cultural Competence Plan includes:	Included			Quality	Strengths/Needs
	Yes	No	Page #	1-adequate 2-good 3-exemplary	
An assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.					
Comparison of staff to diversity in community.					
A universal awareness of trauma that is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.					
Use of interpreter services.					
Service utilization by ethnicity, race, language usage, and cultural groups.					
Client outcomes that are meaningful to client's social ecological needs.					

Objectives

The Cultural Competence Plan includes:	Included			Quality	Strengths/Needs
	Yes	No	Page #	1-adequate 2-good 3-exemplary	
Goals for improvements.					
Processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practices in service delivery.					
a) Trauma-informed principles and concepts integrated.					
b) Faith-based services.					

Culturally and Linguistically Appropriate Services (CLAS) Standards

CLAS Standards are embedded into the Cultural Competence Plan.					

Behavioral Health Cultural Competence Plan Scoring Tool

Notes

Reviewer Name _____

Review Date _____

Supplemental Information			
	Yes	**No**	**COMMENTS**
Cultural and Linguistic Competence Policy Assessment (CLCPA)			
Promoting Cultural Diversity Self-Assessment (PCDSA)			
Certification of Language Competence			
Cultural Competence Focus Groups for Program Clients			
Other:			
Other:			
Other:			

Behavioral Health Cultural Competence Plan Scoring Tool

Culturally and Linguistically Appropriate Services (CLAS) Standards						
The Cultural Competence Plan includes:	**Included**			**The extent to which this CLAS Standard is being implemented** (check applicable box)		
	Yes	**No**	**Page #**	**Not implemented**	**Partially implemented**	**Fully implemented**
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.						
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.						
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.						
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.						

Additional CLAS-specific notes: _____

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (Beneficiary Packet)

SUBJECT:	**Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services**	**REFERENCE #**	6030
		PAGE:	1 OF 3
		DATE:	**10/19/2016**
REFERENCE	**42 Code of Federal Regulations, Section 438.10; CCR, Title 9, Chapter 11, Section 1810.410(B.3)**		

PURPOSE

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 to access Specialty Mental Health Services.

BACKGROUND

Based on 42 of the Code of Federal Regulations (CFR), Section 438.10, all enrollees or potential enrollees must be provided with mandated information to assist them in accessing services including, but not limited to, the beneficiary brochure and beneficiary problem resolution/fair hearing process, as well as information on Advance Directives. This information shall be available in threshold languages and alternate formats to assist clients with special needs.

A “threshold language” is defined by Title 9, California Code of Regulations (CCR), Section 1810.410 (f)(13) as a language that has been identified as the primary language indicated on the Medi-Cal Eligibility Data System by at least 3,000 beneficiaries or 5% of the beneficiary population, whichever is lower, in an identified geographic area.

DEFINITIONS

None

POLICY

The San Diego County Health and Human Services (HHSA) – Behavioral Health Services (BHS) Mental Health Plan (MHP) shall distribute written information to all organizational providers to assist English and other threshold language speaking clients access services. The County shall also provide this information in alternate formats for the visually limited and for those with limited reading proficiency. All enrollees and potential enrollees into the MHP shall be informed that the information is available in alternate formats and how to access them. San Diego County HHSA-BHS-MHP shall distribute materials in compliance with the Annual Department of Health Care Services (DHCS) Information Notice regarding threshold languages, and such materials to providers who will make them available to clients.

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

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		PAGE:	2 OF 3
		DATE:	**10/19/2016**
REFERENCE	**42 Code of Federal Regulations, Section 438.10; CCR, Title 9, Chapter 11, Section 1810.410(B.3)**		

PROCEDURES

When an individual contacts the provider, the provider will have written materials available at appropriate literacy levels and at a minimum offer: 1) beneficiary brochure; and 2) problem resolution information.

1. The MHP will distribute mandated written information to providers. The MHP will distribute the following materials in the threshold languages (currently English, Spanish, Vietnamese, Arabic, and Tagalog) and in alternate formats, when appropriate:
    a. County of San Diego Guide to Medi-Cal Mental Health Services,
    b. Quick Guide to Mental Health Services for Adults, Older Adults, and Children's Brochure,
    c. Grievance and Appeal Procedure Brochure,
    d. Grievance and Appeal Form with Self Addressed Envelopes,
    e. Grievance and Appeal Poster,
    f. MHP's Notice of Privacy Practices (MHP-NPP),
    g. Advance Directive Brochure,
    h. Access and Crisis Line Posters, and
    i. Limited English Proficiency (LEP) posters.

2. Periodic reminders of the availability of materials will be given at provider meetings and through the QI "Up To The Minute" newsletter.

3. Each service provider may order additional materials by calling the number below or submitting the Order Request Form (see Attachment-A) to:

    County of San Diego
    Health and Human Services Agency
    Behavioral Health Services Division
    3255 Camino Del Rio South
    San Diego, CA 92108
    Interoffice Mail: Mail Stop P531-J
    ATTN: BHS Reception Desk at:
    (619) 563-2700
    (619) 584-5080 – fax

4. Additionally, the MHP providers shall pick up current material at the BHS Reception Desk.

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

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		PAGE:	3 OF 3
		DATE:	**10/19/2016**
REFERENCE	**42 Code of Federal Regulations, Section 438.10; CCR, Title 9, Chapter 11, Section 1810.410(B.3)**		

5. HHSA-BHS Administrative Support Unit (ASU) will maintain a record of materials distributed to each service provider.

6. Materials shall be monitored by the Quality Management (QM) Unit through Medi-Cal site reviews.

QUESTIONS / INFORMATION
Elizabeth Miles
BHS Quality Improvement
(619) 584-5015

ATTACHMENTS/RELATED DOCUMENTS
6030 Attach-A, Beneficiary Packet Materials Order Form_rev8-3-16 (MHS-01-04-210)

SUNSET DATE: This policy will be reviewed for continuance on or before October 31, 2019.

County of San Diego
Daily 2019 Novel Coronavirus (COVID-19)
Race/Ethnicity Summary

Data are preliminary and subject to change

Data through 5/24/2020, updated 5/25/2020 8:00 AM

Summary of COVID-19 Cases by Race/Ethnicity

COVID-19 Case Summary	San Diego County Residents		
Total Positives	**6,797**		
Race and Ethnicity	**Count**	**% of Total with Known Race/Ethnicity (N=5,402)**	**Rate per 100,000***
Hispanic or Latino	3,439	63.7%	298.8
White	1,257	23.3%	82.4
Black or African American	212	3.9%	143.5
Asian	391	7.2%	107.4
Pacific Islander	43	0.8%	292.3
American Indian	11	0.2%	
Multiple Race	49	0.9%	43.7
Race/Ethnicity Unknown	1,395		

*Rates are calculated using 2018 population estimates from the San Diego Association of Governments. Rates are not calculated for counts under 20 cases.

Data are preliminary and subject to change.
Sources: San Diego County Communicable Disease Registry, SANDAG 2018 Population Estimates (Prepared July 2019)

Prepared by County of San Diego, Health and Human Services Agency, Public Health Services, Epidemiology and Immunization Services Branch

Institute For Human Development
San Diego City College

PUBLIC MENTAL HEALTH ACADEMY

WET ANNUAL REPORT 2018-2019
Organization Name: **San Diego City College**
Contract #: **555642**
Program Name: **Public Mental Health Academy/Mental Health Work Certificate of Achievement**
Program Manager: **Kristen Cole, Ph.D.**

BRIEF OVERVIEW AND BACKGROUND

The Public Mental Health Academy (PMHA) at San Diego City College was established in 2010 with funds provided through the Mental Health Services Act, Workforce Education and Training to address the shortage and lack of diversity in mental health service providers. The PMHA facilitates workforce development and career pathways in public mental health by offering coursework leading to a Mental Health Work Certificate of Achievement (MHWCA) as well as academic counseling services, conferences and workshops.

The PMHA Certificate program prepares students for local employment opportunities in entry level mental health work. At the same time, the Certificate program serves as an academic stepping stone toward higher academic degrees in the broad field of mental health and human services. Potential students are recruited from the community and internally from existing students at City College. The courses offered in the Certificate program include:

- General Psychology (3 units)
- Introduction to Counseling (3 units)
- Abnormal Psychology (3 units)
- Introduction to Community Psychology (3 units)
- Public Assistance & Benefits Programs (1 unit)
- Family Support Model (3 units)
- Field Work in Psychological Services (3 units)

The initial five years of funding for the PMHA helped establish the coursework and the certificate application process to create a program that was eventually embedded within the Psychology Department program offerings of the college. The funding also supported an Academic Counselor dedicated to the support of the PMHA students, a part time outreach coordinator, a Program Specialist who provide administrative support and event coordination and a Program Director.

When 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. This report provides outcomes for the 2018-2019 academic year.

FUNDING FOR ACADEMIC COUNSELOR

An Academic Counselor was hired specifically for the PMHA. The Counselor maintains consistent communication with students providing academic guidance that includes goal setting, educational planning, and course selection that lead to the completion of Certificates, Associate degrees and transfer to four year institutions. In addition, the counselor shares valuable resources and provides services that help elevate student success including resume building, scholarship opportunities, employment opportunities, financial aid appeals, transfer application assistance, mental health career pathways, and referral to mental health services when needed. Thus, the strong relationship the counselor develops with the PMHA students plays a crucial role in student academic success, retention, completion of the Mental Health Work Certificate of Achievement, transfer to universities and employment opportunities.

During the 2018-2019 academic year the PMHA counselor provided over 355 counseling appointments to new and current PMHA students, as well as communicated twice per month to provide program updates and share information on campus and community jobs, trainings, events and fairs. The support PMHA students feel through this connection to a counselor not only contributes to their success while at San Diego City College, but also enhances their future opportunities and potential to reach their full capacity. Students have reported that having a face and space on campus where they feel connected and supported has been tremendous in terms of their interest in school and their retention from semester to semester.

PROGRAM SUSTAINABILITY

The PMHA Mental Health Work Certificate courses and faculty are now sustained as a program embedded within the Psychology Department offerings of the college. One of the most impactful courses in the program for the students is the Field Placement in Psychological Services course. During this course, students volunteer in mental health settings where they come into contact with individuals and families struggling with mental health issues and have the opportunity to observe professionals in the field first hand. Issues that frequently arise in mental health agencies are taught in the classroom and covered in assigned readings so that students may apply their knowledge directly to their volunteer experience. This placement helps students gain a realistic view of the field and a chance to assess their interest in this career path. The feedback and reflections they pass on during and after this course are both positive and powerful. A testament to the strength of our coursework and preparation of students for entry-level work is that over half of the students who complete the course continue to volunteer after their placement ends or they transition into paid positions. Exceeding our own expectations, we have been able to enlist the participation of over 70 unique field placement sites. Between the Fall 2018 and Spring 2019 semesters, 44 students volunteered 2817 hours at 24 local mental health agencies.

OUTCOME DATA/STUDENT PROFILE

For the 2018-2019 academic year 97 students were enrolled in the PMHA/Mental Health Work Certificate program with 40 students completing the certificate, contributing to the 270 total graduates since the program's inception. Over 355 academic counseling appointments were held to provide individual on-going support and guidance.

Most of our students continue their education at City College after receiving the Mental Health Work Certificate. Several of our students are transferring and will be attending SDSU, UCSD, UC Berkeley, Springfield College, National University, Capella University and Azusa Pacific University. One of our students was accepted at several universities including UCSD, UCLA, UC Riverside and SDSU, and another received a full scholarship to complete her BA at National University. Most students are majoring in Psychology but one is majoring in Ethnic Studies with a minor in Education, and another is majoring in Human Services.

We've heard from a few past graduates and one just completed her MA in Psychology from Capella University, another completed a BA in Psychology at Penn State, another graduated with a BA from SDSU and is applying at USC for the MSW program, and additional SDSU graduates were accepted into the Rehabilitative Counseling Master's degree and MFT programs at SDSU.

Our most recent graduates are also working in the field. Below are the positions and locations where they are employed:

- Peer Support Specialist, NAMI Next Steps
- Behavioral Health Assistant, Rady Children's Hospital
- AOD Counselor, Fashion Valley Comprehensive Treatment Center
- Mental Health Worker, Aurora Psychiatric Hospital
- Outreach Specialist, San Diego City College
- Residence Manager, Ruby's House
- Outreach Specialist, Urban Street Angels

SUMMARY

The 2018-2019 year was a success as we enrolled almost 100 new students into the Public Mental Health Academy and 40 completed the Mental Health Work Certificate. There are 428 currently enrolled in the program and 270 total graduated since the program's inception. With over 355 counseling sessions provided PMHA students are feeling supported and receiving important services to effectively support their educational and career goals.
This is an increase of 49% (117 more counseling appointments from year prior), which were mainly current PMHA students demonstrating the need for these students to have on-going support while participating in the program. Many students share their gratitude for the academic counselor support. A frequent phrase our counselor hears is "I couldn't have made it without you."

Below are a few comments from our 2018-2019 PMHA Graduates:

- I truly enjoyed all the support from my teachers and staff from the Mental Health Certificate program.

- I think the mental health work program is great! I was unfortunate to have only had one class with Dr. Cole, but she was really an incredibly instructor.

- LOVED taking these classes. The professors were beyond great and provided so much support and guidance through each course/semester. Plus it encouraged me to stay in school even after completing my certificate. Also having Dawn as a counselor for guidance in our education plan is a major plus too.

- Ms. Taft really helped me out. She has no idea how much stress she helped relieve by guiding me in the right direction. I definitely walked away from our meeting with a big smile.

- Overall, I really enjoyed the program. The majority of the professors were good especially Dr. Cole, my favorite. Dawn Taft is hands on, approachable and seems to really care about students and their academic growth and accomplishments.

- Thank you to Dr. Cole and Dawn Taft from the bottom of my heart for the time, energy and effort they took in helping me.

- The professors were very knowledgeable and supportive to my learning and development as a professional. Thank you City college MHW Cert. Program for increasing my skills and confidence to help people and professionals in the community

- Can't thank Dawn enough for her support as it really helps keep me on track and aware of what courses I need to meet my goals. So lucky to have a counselor like her.

- The course material & discussions were extremely helpful to developing my abilities in the helping field. The material was directly related to the population I was working with. I really felt knowledgeable and supported by the feedback I received in class.

Fall 2018 PMHA Graduates

Spring 2019 PMHA Graduates

Behavioral Health Services Community Engagement Forums

Share Your Ideas!

Supporting healthy, safe, and thriving communities.

Everyone Welcome!

Forum Discussion Topics: Mental Health and Substance Use Prevention, Innovation and Engagement

Date: Wednesday, January 8 **Time:** 6:30pm to 8:00pm	**Lemon Grove Academy Elementary School** 7885 Golden Ave, Lemon Grove, 91945	**Check In: 6:15pm** Dinner Provided
Date: Thursday, January 9 **Time:** 6:30pm to 8:00pm	**Kearny Senior High School, Room 301** 1954 Komet Way, San Diego, 92111	**Check In: 6:15pm** Dinner Provided
Date: Saturday, January 11 **Time:** 10am to 11:30am	**Country Club Senior Center** 455 Country Club Lane, Oceanside, 92054	**Check In: 9:45am** Breakfast Provided
Date: Wednesday, January 22 **Time:** 6:30pm to 8:00pm	**Normal Heights Community Center** 4649 Hawley Blvd, San Diego, 92116	**Check In: 6:15pm** Dinner Provided
Date: Saturday, January 25 **Time:** 10am to 11:30am	**Woodland Park Middle School, PAC** 1270 Rock Springs Rd, San Marcos, 92069	**Check In: 9:45am** Breakfast Provided
Date: Saturday, February 1 **Time:** 10am to 11:30am	**Bonita Vista High School, Library** 751 Otay Lakes Rd, Chula Vista, 91913	**Check In: 9:45am** Breakfast Provided

Community members will be eligible to receive a $10 gift card for participating.

Register at: ListenToSanDiego.org

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

SAN DIEGO STATE UNIVERSITY Institute for Public Health

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
3255 CAMINO DEL RIO SOUTH, MAIL STOP P-531
SAN DIEGO, CA 92108-3806
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LUKE BERGMANN, Ph.D
DIRECTOR, BEHAVIORAL HEALTH SERVICES

January 22, 2020

TO: Luke Bergmann, Ph.D., Director
Behavioral Health Services
Aurora Kiviat, Asst. Director of Operations, Chief Operations Officer
Behavioral Health Services
Cecily Thornton-Stearns, Asst. Director of Operations, Chief Program Officer
Behavioral Health Services

FROM: Piedad Garcia, Deputy Director, Ethnic Services Manager
Behavioral Health Services

CULTURAL COMPETENCE RESOURCE TEAM (CCRT)
ACCOMPLISHMENTS/GOALS AND FOCUS GROUP RECOMMENDATIONS

In the past year, the CCRT, with participation from Quality Improvement, Children, Youth & Families, contractors and advocates, have contributed to the development of the systems of care that I would like you to review.

Included are the CCRT's 2018-2019 Accomplishments and 2019-2020 Proposed Goals comprised of actions taken in the following areas:

- Direct services;
- Program (service design); and
- Policy (principles/guidelines).

In addition, under the guidance of the CCRT Education and Training Subcommittee, led by Charity White-Voth, I am including the Executive Summary from a Focus Group facilitated by Dr. Juan Martinez from California State University – Northridge. The document provides a summary of Highlights and Recommendations on behalf of Behavioral Health Services' Cultural Competence Resource Team (CCRT).

The CCRT accomplishments/proposed goals and recommendations for this year demonstrate the commitment and interest that the members have in ensuring the system of care is a culturally responsive system to meet the needs of our diverse

community. The CCRT members have thoroughly reviewed and approved. We welcome your feedback.

If you have questions or need further clarification, please contact Charity-White Voth, Assistant Medical Services Administrator at (858) 514-3235 or Charity.White-Voth@sdcounty.ca.gov. Thank you.

PIEDAD GARCIA, ED.D., LCSW, Deputy Director
Adult and Older Adult System of Care
Behavioral Health Services

PG/cw/av

Cc: CCRT
Yael Koenig
Tabatha Lang
Melinda Nickelberry
Danyte Mockus-Valenzuela
Dr. Krelstein
Dr. Esposito

County of San Diego, Health and Human Services Agency - Behavioral Health Services

Cultural Competence Resource Team (CCRT)

Purpose

The CCRT addresses the County's dynamic demographics and serves as an advisory group to the Behavioral Health Services (BHS) Director to enable BHS systems of care to work effectively in cross-cultural integration of services.

2018 - 2019 Accomplishments

Best Practice *(Day-to-day services and client interaction)*:

- Fiscal Year 18-19 Mental Health Services Act (MHSA) Community Program Planning forums by San Diego State University (SDSU) Research Foundation Consultants to encourage broad outreach with under-represented community members.
  - Developed a list of resources for MHSA Forum Consultants of local public engagement and outreach events/summits. The aim of the MHSA Consultants was to meet with local community groups to collect data in September and October that focused on a variety of mental health topics.
- San Diego State University Social Policy Institute on the MHSA Innovation Human-Centered design proposal BEHEALTH.TODAY, https://behealth.today/.
- Cultural Competency Academy (CCA) Foundational Training series. First meeting was held on March 15, 2019.
  - Collaborated with Responsive Integrated Health Solutions (RIHS) to develop a list of needed topics for the CCA Training series.
  - Made recommendations to recruit members to serve on a CCA monthly curriculum subcommittee.
- Strategic Planning/Focus Group: Southern California Regional Partnership contracted with Dr. Jonathan Martinez of California State University-Northridge as the consultant to support government agencies in cultural competence development and policy. Executive Summary provided to BHS Executives for review and implementation.
- The Knowledge Center (TKC) offered the following training topics to HHSA staff and licensed professionals to align with the needs and goals identified by the CCRT Education & Learning Workgroup. These classes support Live Well San Diego by promoting a better service delivery system that is culturally competent and trauma-informed driving the County's ongoing effort to support a community that is building better health, living safely and thriving.
  - Understanding Diversity in Homelessness - Education about diversity within the community of those who are experiencing homelessness aimed to increase participants ability to provide culturally competent services and address disproportionality.
  - Understanding Trauma and Its Impact on the Families We Serve - This training aimed to increase understanding of Secondary Trauma in alignment with HHSA Trauma Informed Principles, and its impact to individuals, staff and the community.
  - Stigma and Opioid Use Disorder - This class addressed the opioid crisis and supported the need for training in response to the expansion of the Substance Use Disorder (SUD) program. Participants identified strategies of how to use less stigmatizing language when addressing substance use disorders as well as treatment options available.

Program *(Approach model and service design)*:

- Implemented 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 Region and North Inland Region, respectively.
- Behavioral Health Services Training and Education Committee (BHSTEC) and the development of Cultural Competence (CC) training needs.
- Warrior Spirit: "Calling Upon the Warrior Spirit to Heal Historical Trauma" hosted by the Viejas Band of Kumeyaay Indians.
- 2018 Cultural Competence Summit "Honoring California's Diversity: A Call to Action" held October 23-24, 2018. Dr. Piedad Garcia presented best practices learned with the Urban Beats program for underserved TAY.
  - Instrumental in conference and design, including speakers and topics.
- Binational Mental Health Symposium, held in Tijuana, Mexico at the Universidad Autonoma de Baja California reflecting the strong behavioral health partnership between San Diego County and Tijuana, Mexico.
- BHS role with the Asylee Shelter, which included integrating services to include behavioral health services within a public health emergency context.
  - "Trauma Informed Care within a Cultural Context and Self-Care" training for staff working at the Migrant Asylee Shelter due to symptoms of vicarious traumatization.

Policy *(procedures and laws that guide decisions toward specific outcomes)*:

- Cultural Competency Assessments implemented at the contractor level as a requirement:
  - Surveyed a total of 2,672 MHS and SUD direct program staff on their own perception along with their programs' commitment to upholding cultural competence standards (Promoting Cultural Diversity Self-Assessment/PCDSA).
  - Surveyed a total of 251 MHS and SUD programs on their perception of their programs' commitment to upholding cultural competence standards (Cultural and Linguistic Competence Policy Assessment/CLCPA). Identified programs' technical assistance requests to support their cultural competence efforts at a program level.
- Updated the Cultural Competence Plan and 3-Year Strategic Plan.

2019 - 2020 Proposed Goals

Best Practice:

- Highlight effective programs serving culturally diverse communities for providers to integrate appropriate services.
- Develop a Recognition Award criteria and process to recognize organizations who are providing exemplary Cultural Competence activities.
  - To be presented at the Behavioral Health Recognition Dinner (BHRD).
- **Identify gaps in representation with CCRT and develop targeted outreach for those agencies/community groups for participation.
  - Invite additional Ethnic Community Based Organizations (ECBO) who align with CCRT as well as system of care partner representatives from Probation, Education, DA, etc. to move toward system wide improvement.
- **Dedicate time and space within CCRT (or as a separate workgroup) to review and analyze data related to underserved populations including linguistic findings, interpreter services, utilization rates, jail in-reach outcomes, etc.
  - Address the Justice Involved population, specifically the overrepresentation of African Americans and Latinos and develop recommendations for services.
- Develop recommendations for the MHSA Fiscal Year 2019-20 Annual Update.
- Provide quarterly, uniform CCRT Updates to various meetings and Councils to provide consistent messaging.
  - Develop a standardized tool to provide consistent CCRT highlights at the various Councils at the beginning of the fiscal year.
- Provide COR training to County staff on CLAS standards – and how to monitor effectively for CC.
- **Provide dedicated support to contractors and community agencies who request technical assistance and guidance around cultural competence efforts within their agency, workforce, client served, etc.
  - Review organizational CC Plans by Legal Entity.

Program:

- Advance culturally responsive community-based organizations to evidence based standards.
- Increase CCRT Substance Use Disorder provider and consumer membership.
- Invite programs/providers to present on their respective Cultural Competence (CC) Plans, including approaches, implementation, challenges and goals at CCRT meetings.
- **Develop a process for dissemination of resources that are readily available not only to BHS contractors, but to the general community and BHS staff.

Policy:

- Submit culturally responsive recommendations for the MHSA Fiscal Year 2019-20 Annual Update.
- Identify and implement strategies to strengthen system wide advance of cultural competence standards consistent with the State Plan and CLAS standards.
  - CCRT members will use a standardized tool to review provider organizational CC Plans by Legal Entity and provide recommendations for continuous improvement.
- **Address workforce development focused on recruiting and hiring a diverse workforce within BHS and with County contractors.

**Recommendations from Strategic Planning/Focus Group

Revised on 12/30/19

Cultural Competence Resource Team (CCRT)

Executive Summary
Focus Group Highlights and Recommendations
Facilitated by Dr. Jonathan Martinez
April 26, 2019

Objective: To understand perspectives from the Cultural Competence Resource Team (CCRT) on the strengths, challenges, and areas of need in providing culturally competent care at the County of San Diego, Health & Human Services Agency, Behavioral Health Services (BHS).

Aim and Questions:

- To increase understanding of the CCRT's perspectives on the goals and objectives of the workgroup.
- To increase understanding of the strengths and challenges in the delivery of culturally competent care.
- To increase understanding of additional support and resources that may assist in the delivery of culturally competent care at the County of San Diego BHS.

Method:

- 90-minute focus group conducted on **April 26, 2019**.

Goals and Objectives of CCRT:

- To serve as a conduit by making efforts to connect with community partners, identify needs, and relay this information to executive leadership.
- To ensure the needs of all cultural, ethnic groups and backgrounds within the community are served in a culturally-responsive way and that there are supporting policies to provide quality care.
- To be the driving force in identifying training needs to best serve the community and to voice and share these needs with the County leadership.
- To learn from one another and to provide updates regarding County and system-level initiatives and resources on cultural competency.

Strengths in Delivering Culturally Competent Care:

- Strong training structure, including funds to provide training at various levels for skill building.
- Outcome data and countywide assessments used to drive funding and deliverables.
- Peer Liaison program and services.
- Cultural Competency Handbook and Quality Improvement data and outcomes.
- Cultural Competency Academy.
- Culturally competent staff and program assessment tools.

Challenges in Delivering Culturally Competent Care:

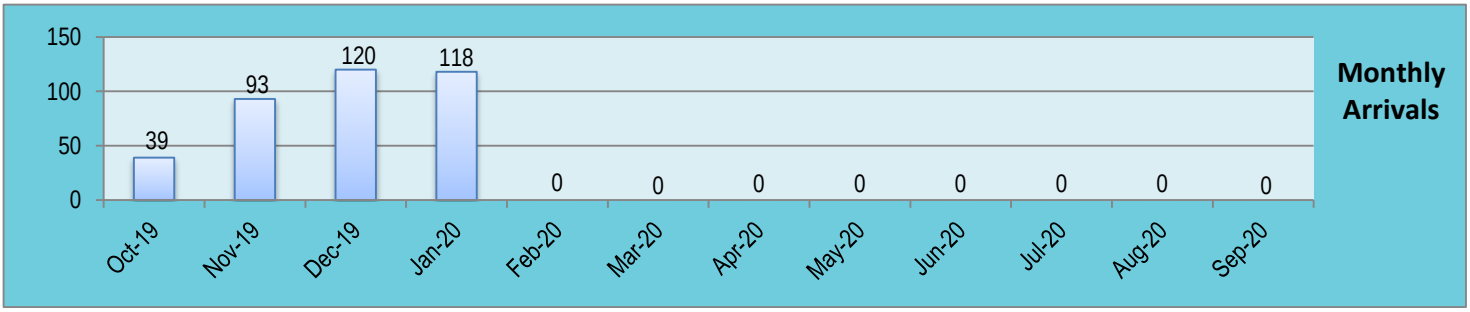
- Limitations around training opportunities (i.e. training contracts are primarily for current County contractors, not the general community).
- Lack of awareness regarding the Technical Resource Library (TRL) and available resources on cultural competence.
- Limited time to analyze data to adequately inform next steps for deliverables.
- Limited representation of underserved groups in CCRT, including SUD program staff.
- Definitions related to cultural competence and how that may be interpreted systemwide.

Recommendations to Aid in the Delivery of Culturally Competent Care:

- Process for dissemination of resources to BHS contractors, the general community and BHS staff.
- Workforce development focused on recruiting and hiring a diverse workforce within BHS and with County contractors.
- Dedicate time and space within CCRT (or as a separate workgroup) to review and analyze data related to underserved populations including linguistic findings, interpreter services, utilization rates, jail in-reach outcomes, etc.
- Provide dedicated support to contractors and community agencies who request technical assistance and guidance around cultural competence efforts within their agency, workforce, client served, etc.
- Identify gaps in representation with CCRT and develop intentional outreach to engage agencies/community groups to provide input.

San Diego County Resettlement Agencies
Monthly Refugee Arrivals Report for FFY 19 - 20 by Country of Origin

Country of Origin	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	FFY Total
Afghanistan	28	35	52	35									150
Angola	-	-	1	-									1
Burma	-	8	-	-									8
Burundi	-	-	-	-									0
Cambodia	-	-	-	-									0
Cameroon	2	-	-	-									2
Colombia	-	-	-	-									0
Cuba	1	-	1	-									2
Democratic Republic of Congo	-	5	10	2									17
El Salvador	1	-	-	-									1
Eritrea	-	-	-	-									0
Ethiopia	-	-	-	-									0
Georgia	-	-	-	-									0
Guatemala	1	1	-	-									2
Haiti	6	33	47	60									146
Honduras	-	-	-	-									0
Iran	-	-	-	-									0
Iraq	-	8	4	12									24
Lebanon	-	-	-	-									0
Mexico	-	-	-	-									0
Moldova	-	-	1	3									4
Nicaragua	-	-	-	-									0
Nigeria	-	-	-	-									0
Pakistan	-	1	-	-									1
Republic of Congo	-	2	-	-									2
Russia	-	-	3	-									3
Ukraine	-	-	1	5									6
Uzbekistan	-	-	-	-									0
Venezuela	-	-	-	1									1
Overall Total	39	93	120	118	0	0	0	0	0	0	0	0	370
Number of Individuals Eligible for RCA (Single Adults/Couples with no Children under 18)	9	11	12	11	0	0	0	0	0	0	0	0	43
Number of Individuals Eligible for CalWORKs (including children)	30	82	108	107	0	0	0	0	0	0	0	0	327
Number of Potential CalWORKs Cases Referred to County	7	24	28	26	0	0	0	0	0	0	0	0	85

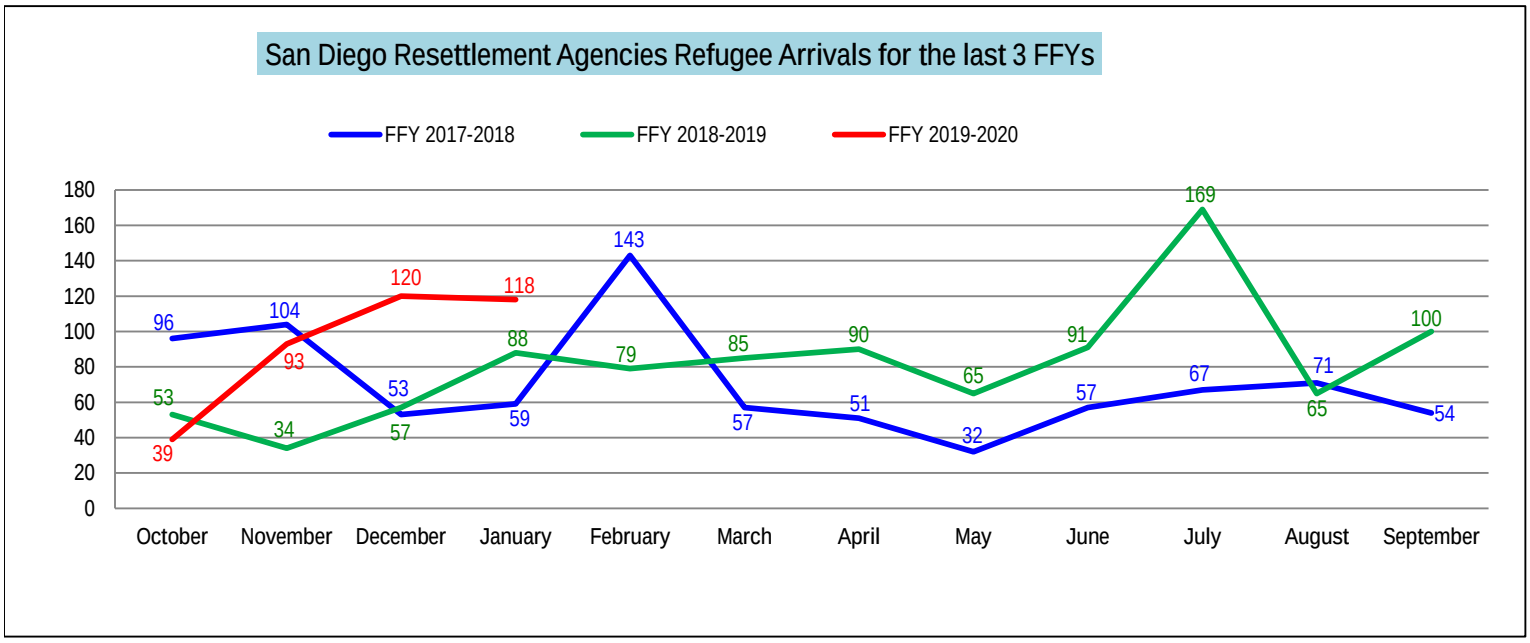


Top Three Arrivals for FFY 19 - 20	
Afghanistan	41%
Haiti	39%
Iraq	0%
Remainder	18%

Source: San Diego County Resettlement Agencies

By AA: 02/05/2020

San Diego County Resettlement Agencies
Monthly Refugee Arrivals Report for FFY 19 - 20 by Country of Origin



SUMMARY OF THE ARRIVALS REPORT

Total for January 2020	118	
• Primary Refugees =	17	14%
• Secondary Refugees =	0	0%
• Asylee =	2	2%
• Cuban/Haitians =	60	51%
• Trafficking Victims =	0	0%
• Special Immigrant Visa (SIVs) =	39	33%

Total for the Year to Date FFY 19-20	370	
• Primary Refugees =	74	20%
• Secondary Refugees =	0	0%
• Asylee =	10	3%
• Cuban/Haitians =	147	40%
• Trafficking Victims =	0	0%
• Special Immigrant Visa (SIVs) =	139	38%

Source: San Diego County Resettlement Agencies

By AA: 02/05/2020