COUNTY OF SAN LUIS OBISPO

Behavioral Health Department
Mental Health Services

CULTURAL COMPETENCE PLAN

COUNTY of SAN LUIS OBISPO

COVER SHEET

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Introduction

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

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

This Cultural Competence Plan is produced annually and include revisions. This document has been prepared to provide guidelines to help the Behavioral Health Department in San Luis Obispo County become a more culturally competent organization, and to ensure that diverse populations in the county receive mental health services that are culturally appropriate throughout the mental health system. This document is also inclusive of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) approach. Sections below provide information on which criteria applies to DMC-ODS SUD.

Cultural Competence

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

According to the Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies, culturally competent organizations are ones which:

- ***Continually assesses organizational diversity****: Organizations should conduct a regular assessment of its members' experiences working with diverse communities and focus populations. It also regularly assesses the range of values, beliefs, knowledge, and experiences within the organization that would allow for working with focus communities.*
- ***Invests in building capacity for cultural competency and inclusion****: Organizations should have policies, procedures, and resources in place that make ongoing development of cultural competence and inclusion possible. It must also be willing to commit the resources necessary to build or strengthen relationships with groups and communities. Including representatives of the focus population within the organization's ranks is especially useful.*
- ***Practices strategic planning that incorporates community culture and diversity****: Organizations are urged to collaborate with other community groups. Its members are also encouraged to develop supportive relationships with other community groups. When these steps are taken, the organization is seen as a partner by other groups and their members.*

- ***Implements prevention strategies using culture and diversity as a resource****: Community members and organizations must have an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to ensure they are accessible to and attuned to their community or focus population.*
- ***Evaluates the incorporation of cultural competence****: Community members must have a forum to provide both formal and informal feedback on the impact of all interventions.*

This Plan is part of the Department's efforts to remain a culturally competent, responsive, and supportive community organization.

Key Objectives and Recommendations

In response to the Department of Health Care Services CCPR requirement, the SLOBHD has developed a comprehensive plan and has chosen to include key objectives that align with the CCPR requirement and provide direction.

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

- The SLOBHD will complete the revision of and adopt the Cultural Competence Training Policy which includes requirements for staff development in cultural competence and demonstrated improvements in service to diverse clients.
    - Strategies to be employed include the use of E-Learning to provide core competency training and education for all staff. Other strategies include development of pre-post measurement tools to assess staff capacity, skill development, retention of core competency training and changes in practice and behavior over time. Collaboration and partnering with other county agencies that provide training on core topics vital to staff development will be practiced.

- The Cultural Competence Committee (CCC) will increase cultural competence training for mental health system providers by two activities per year.
    - Strategies to accomplish this objective include the aforementioned networking with community partners who can provide quality training for mental health professionals. The County and its CCC will also broaden the approach to cultural competence training to include activities which improve the mental health system's capacity to serve various cultural populations (e.g. LGBTQ, Veterans, consumers and family members).

- The CCC will increase membership of consumers and family members by one member annually over the next three years.
    - This objective is critical to enhance the diversity of the Committee, which serves to improve cultural competence principles across the SLOBHD's programs. The main strategy employed to accomplish this objective will be the establishment of a membership policy that requires the committee to have at least one seat filled by a consumer/family member. This will increase recruitment efforts and partnerships with community organizations, such as the Peer Advisory and Advocacy Team (PAAT) with Transitions Mental Health Association, a community-based organization.

- The Committee will identify other underserved populations reflecting cultural needs in order to provide services and support within the County system. This will be measured by an increase in CCC membership to include representatives of currently unrepresented communities over the next three years.
    - The strategies to meet this objective include working with the County's Prevention and Early Intervention (PEI) programs, which have built relationships and partnerships with organizations serving cultural populations often underserved in the mental health system, along with expanded services with the Latino population. These include Asian/Pacific Islanders, LGBTQ, veterans, older adults, TAY, and consumers.

- The CCC, as part of its mission to "ensure that cultural diversity is incorporated into all levels of San Luis County Behavioral Health Department," will develop measures over the next three years to guarantee that a process of review and recommendation for each Department service level occurs.
    - This objective will need to include an expansion of the CCC's review process for documents and translation services aimed at the Spanish-speaking community; staffing recruitment and recommendations, and presentations made to various Department programs are not currently represented in the CCC. A strategy to meet this objective involves establishing CCC policy to force reviews of all SLOBHD programs that serve diverse clients (including those of the Drug and Alcohol Services Division) to assure that cultural competence policies and procedures are in place.

CRITERION 1
COUNTY MENTAL HEALTH SYSTEM
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 1:

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.

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization's planning and operations.

15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

The County of San Luis Obispo Behavioral Health Department (SLOBHD), the State-identified Mental Health Provider (MHP), created a Cultural Competence Plan in 1998. That document, provided in response to State managed care requirements, was updated in 2003, 2004, and 2010, and continues to inform policy for the SLOBHD, which houses the County's behavioral health and alcohol and drug departments. This current plan will continue to provide a foundation for policies, procedures, and practices that reflect the SLOBHD's recognition and value of racial, ethnic, and cultural diversity within the County's Mental Health System.

The County of San Luis Obispo Behavioral Health Department established the following Mission Statement, which serves as a banner for all official public records, including the annual budget documents (Appendix 01):

> *The County of San Luis Obispo Behavioral Health Department works in collaboration with the community to provide services necessary to improve and maintain the health and safety of individuals and families affected by mental illness and/or substance abuse. Services are designed to help individuals with mental illness be as functional and productive as possible in the least restrictive and least costly environments, to prevent or reduce the societal problems and high costs to other social services, educational and law enforcement organizations that can result from lack of treatment for the individual with mental illness. Services are also*

designed to help clients with emotional trauma and psychological difficulties transform their lives into healthy and contributing citizens, to provide cost effective mental health services to community residents. And primarily, the services are also intended to ensure equal access and culturally competent services to the diverse populations in the county and treat clients with respect and with consideration for their privacy and dignity.

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

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

Mental Health Services policies include a statement of General Treatment Considerations (Appendix 02), which includes the following statement:

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

As described throughout the rest of this document, training in cultural competence is at the Department's core. SLOBHD's engagement in the Mental Health Services Act (MHSA) components and their planning processes has allowed for the development of training plans and policies which will increase staff and community partner capacity around improved services which value the community's racial, ethnic, and cultural diversity. As demonstrated in the County's Workforce Education and Training Plan's (Appendix 03) "Action #5: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff:"

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

Please see the Appendix section for the following documents:

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

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

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

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

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

- The County Behavioral Health Department Mission Statement, as listed in the annual budget documents.
- Strategic Plans, including the aforementioned Managed Care Cultural Competence plans from 1998, 2003, and 2004, as well as the last Department CCPR from 2010; and MHSA plans which clearly outline the role of cultural competence in providing quality services.
- Policy and Procedure Manuals, including the Department's Cultural Competence Committee guidelines, meeting minutes, and newsletters.
- Human Resource policy documents including the County of San Luis Obispo Civil Service Commission Rules & Ordinances, Procedural Guidelines, and the San Luis Obispo County Policy Against Discriminatory Harassment.
- Contracts, which outline the requirements for culturally competent services.

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

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

The county shall include the following in the CCPR:

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

The Cultural Competence Plan Requirement has been compiled and completed by staff in the County of San Luis Obispo Behavioral Health Department. Due to the agency's important partnerships with

community providers and stakeholders, some sections were completed in collaboration with, or reviewed by, community partners.

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

The most dominant disparity in San Luis Obispo County, which cuts across all of the community issues identified in various MHSA community stakeholder processes, is the under representation of Latino individuals. This imbalance in service accessibility is even more dramatic than it seems, considering the relatively high proportions of Latinos in the poverty population with the health and access problems associated with poverty status. The County has first and foremost sought to engage leaders of the Latino community along with consumers and family members in MHSA planning activities. Meetings, focus groups, presentations, and conversations have been planned throughout the local Latino community to give voice to the needs of many individuals detached from the mental health system by culture and language. Greater efforts have been put into practice to make hiring practices which engage Latino professionals a priority, alongside targeted outreach and clinical operations which provide culturally competent health services.

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

County staff and stakeholders have also identified those groups often left out of age and ethnicity counts when assessing the under-served. Homeless, veterans, and the LGBTQ communities each have unique cultural qualities and are key focus populations for SLOBHD. The homeless population is fluid and difficult to engage for many reasons. Recent efforts have placed more emphasis on outreach in the field and utilizing existing infrastructure (i.e. shelters, Social Services, food banks) to get information and services to homeless individuals and families. In 2013, the Department launched a homeless-specific Full-Service partnership to provide outreach and therapeutic services to the most hard-to-serve, vulnerable population in the County.

Veterans are often at high risk for suicide and depression and although they have distinct cultural needs, efforts have been made to increase the County's outreach and engagement for these communities. Local veterans have been engaged in the creation of MHSA programming to offer unique approaches to combat the impending influx of soldiers returning to the community. San Luis Obispo County has a large concentration of National Guard personnel who are not provided with the same level of mental health care made available to regular military – despite their increased participation in the theater of war. In 2014 the department launched a Veterans Outreach program which paired physical outdoor activities with on-site therapeutic engagement, to increase access for local service men and women. Additionally,

the Department established a therapist to best serve veterans within a culturally competent, comfortable setting.

The Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community representing youth, transitional aged youth, adults, and older adults are part of the stakeholder committee. In 2018, the County launched an LGBTQ Mental Health Needs Assessment countywide in partnership with Cal Poly SLO to better understand the experiences and needs of this community within the mental health system. A larger effort has been made to develop social marketing strategies which address suicide prevention, substance use and abuse, and increasing wellness and resiliency. For college aged students, in 2015, the Department launched a Residential Wellness Counseling program with SAMHSA funds. This program addressed First Episode Psychosis (FEP) issues among college students at California Polytechnic State University, San Luis Obispo. The community has identified a rising need for culturally competent services which address student populations and the increased issues of suicide and substance use disorders.

In each of these identified communities, youth are a focus for outreach and engagement. Latino youth are underserved and in need of both prevention and treatment strategies which address the issues of ethnicity and development. County programs address families at various stages of acculturation and construct skills for managing the pressures and stress of school, work and community, all while building knowledge around the signs and symptoms of mental illness. The ultimate goal is to increase access to these services. Youth are met in schools, churches, and community centers that are safe, welcoming, culturally proficient settings.

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

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

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

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

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

The local Behavioral Health Board has representatives including behavioral health providers and practitioners, professionals from the County Office of Education, law enforcement agencies, local recovery and wellness organizations, community advocates, and members of the local NAMI chapter. To assure engagement with consumers and their families, the Board's bylaws require the following:

> *At least one-half of the seated membership shall be consumers of the public mental health system or family members of consumers. The Board membership should reflect the ethnic diversity of the client population of San Luis Obispo County.*

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

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

The Cultural Competence Committee is made up of staff, partner providers, and consumers. The Committee seeks to provide the County's mental health system with guidance and oversight to assure policies and procedures are in place to improve cultural competence. The group meets quarterly and reviews agency processes, forms, and programs to provide input towards increasing the County's capacity to deliver services which reduce disparities. The Committee produces a quarterly newsletter (Appendix 04) for staff and providers which includes training information and articles on specific wellness and recovery strategies in addition to features that provide deeper insight into the cultural needs of consumers throughout San Luis Obispo County.

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

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

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

SLOBHD WET component continues to make extensive use of community, consumer/family member, and ethnic minority stakeholders to inform our decisions. To identify workforce education and training needs, San Luis Obispo County continues a planning process that includes open dialogue with several ethnic, cultural, and linguistic groups, meetings, and interviews with key stakeholders. These practices are also part of the role of the Cultural Competence Committee.

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

As originally designed, one of our very first activities included a survey to all Behavioral Health Department staff to obtain their input on workforce needs, the direction of the workforce education and training plan, and their personal educational and career goals. A 20-question Staff Education and Training Survey was distributed to all mental health staff. Staff was grouped by level of education to address their specific needs and pathways. Staff feedback was incorporated into meetings with colleges to address workforce needs and potential educational program capacity. Additional planning meetings were held with educational stakeholders including Cuesta College and California Polytechnic State University. Workforce needs and educational institution capacity were discussed, and as a result, new career pathway programs have been added to benefit San Luis Obispo County. This required coordinating and convening several key decision makers and organizational leaders to make informed decisions without the delay of extensive preparatory or follow up meetings that their schedules did not allow. The results of these collaborations were not only strong regional partnerships, but new certificate programs at Cuesta College.

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

In the last 12 months, over 55 hours of training have been offered to Behavioral Health staff, community partners, consumers, and their family members. Over 680 individuals have received training in the following topics: cultural competence, co-occurring disorders, trauma-informed care, child and

adolescent training, journey of hope, solutions to the opioid epidemic, trans-training, and using a trauma-informed lens.

Through the Southern Counties Regional WET Partnership, SLOBHD has joined other counties, including Ventura, Kern, and Santa Barbara, in providing intensive training for behavioral health interpreters. This training has benefitted the community's Promotores program, which serves Latinos throughout the County.

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

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

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

Another area for expansion in the Department, as well as the Cultural Competence Committee, is the engagement of other sub-populations and cultures, such as the spiritual community. Many consumers and family members find their way to services through spiritual outreach, and the SLOBHD has begun exploring more avenues for partnerships. Media contact and advocacy is an additional area where growth is needed, and training is underway with staff to increase the Department's public dialogue around mental health issues.

The Workforce, Education, and Training (WET) efforts of the County have included successful strategies which have already demonstrated improvements in building a culturally competent workforce.

The use of E-Learning to increase cultural competence training has been the Department's most consistent and popular tool. SLOBHD contracts with Relias Learning to provide electronic access to a Behavioral Health Library of curricula for 500 San Luis Obispo County behavioral health providers, consumers, and family members. In FY 15-16 a total of 2,779 hours of training were completed electronically, and 3,699 hours were completed in FY 16-17.

The use of online evaluation tools to assess training have proved useful as well. These surveys have had far higher rates of return than paper/pencil methods of the past, and administrative staff have employed these tools in the development of pre and post testing to further assess the skill development and retention of core competency training.

The WET 3-year training plan has been implemented. The plan addressed some of the lessons learned, including the need to expand training across the service delivery system. Cultural competence training for clerical and administrative staff was created to further improve the Department's service responses. Outreach is still being performed to build partnerships with other community organizations that offer relevant training. Finally, the Department is an active member of the Southern Counties Regional Partnership and will benefit from training opportunities, including upcoming events for interpreter and Mental Health First Aid training.

E. Identify county technical assistance needs

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

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

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

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

The county shall include the following in the CCPR:

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

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

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

In July 2008, Nancy Mancha-Whitcomb, LMFT, was assigned to be the Cultural Competence/Ethnic Services Manager (CC/ESM) for the SLOBHD. This assignment was made by Dr. Karen Baylor, the County Behavioral Health Director. In April 2017, Nestor Veloz-Passalacqua MPP, became the new Cultural Competence/Ethnic Services Manager under direction of Anne Robin, the County Behavioral Health Director.

In his capacity as Ethnic Services Manager, Mr. Veloz-Passalacqua is required to participate in monthly teleconferences hosted by the CMHDA Ethnic Services Committee/Southern Region. He attends quarterly face-to-face meetings of the Southern Ethnic Services Committee, as well as quarterly Statewide meetings for the Ethnic Services Committee in Sacramento. Mr. Veloz-Passalacqua has attended various trainings and conferences that addressed cultural competency and cultural disparities throughout the year, such as the Cultural Competence Summit in October 2018. As ESM, Mr. Veloz-Passalacqua is responsible for disseminating information gained from these meetings and trainings to staff in county clinics as well as participating Community Based Organizations in the County of San Luis Obispo.

In addition, Mr. Veloz-Passalacqua is active in the Cultural Competency Committee in reviewing policy and practices. He has focused on services for the primary threshold populations receiving mental health services, which in San Luis Obispo County is primarily the Spanish speaking population and other underserved populations. Mr. Veloz-Passalacqua is an active leader in assuring MHSA practices remain culturally competent.

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

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

- Takes lead responsibility for the development and implementation of cultural competence planning within the organization.
- Identifies local and regional cultural mental health needs of ethnically and culturally diverse populations as they impact county systems of care, and makes recommendations to the local Mental Health Director, CMHDA, and the State Department of Mental Health.
- Participates and advises on planning, policy, compliance, and evaluation components of the county system of care, and makes recommendations to the County Director or management team that assure access to services for ethnically and culturally diverse groups.
- Promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial and ethnic populations. This includes, but is not limited to, reviewing local proposals to augment or decrease services to the local community, participating in various mental health advisory groups/task forces, and facilitating educational training to organizational units within and outside of the local mental health department.
- Tracks penetration and retention rates of racially and ethnically diverse populations, and develops strategies to eliminate disparities.
- Participates in the cultivation of network to promote an array of mental health programs and activities that are specific to underserved populations.

- Maintains an active advocacy, consultative, and supportive relationship with consumer and family organizations, local planning boards, advisory groups and task forces, the State, and other mental health advocates.
- Assists in the development of system-wide training that addresses enhancement of workforce development and addresses the training necessary to improve the quality of care for all communities and reduce mental health disparities.
- Attends trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system.
- Attends meetings as required by the position including, but not limited to, CMHDA Ethnic Services, Full Association and other committee meetings, regional ESM regular meetings, various State meetings, meetings convened by various advisory bodies, and other meetings as appropriate.
- Responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC). The BCC Committee shall be made of Ethnic Services Manager and three bilingual staff members, at least two of whom will be a native speaker of the threshold languages within the county.

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

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

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

The SLOBHD Cultural Competence /Ethnic Service Manager Areas of Responsibility for FY 2010-2011, a written description of the cultural competence responsibilities of the designated CC/ESM, is provided in Appendix 05.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

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

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

1. Interpreter and translation services;
2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
3. Outreach to racial and ethnic county-identified target populations;
4. Culturally appropriate mental health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

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

A. Below are cultural competent activities included in the FY 2018-19 Adopted Budget for SLOBHD:

- The SLOBHD has appropriated $779,378 for Mental Health Services Act (MHSA) Latino Outreach and Therapy Services (Community Services and Supports program). This program includes 5.47 FTE permanent positions.
- The SLOBHD has appropriated $3,000 for Cultural Competence Training in the MHSA Workforce Education and Training (WET) program.
- The SLOBHD has appropriated $89,734 for the Clinical Bilingual Internship action in the MHSA WET program for bilingual Interns to work in three separate clinics.
- The SLOBHD has appropriated $13,128 for phone interpreter services provided by Language Line for use by all clinics.
- The SLOBHD has appropriated $20,977 for bilingual differential pay for the Mental Health Core Budget ($11,759) and Mental Health Services Act Budget ($9,218). Of the $9,218 for MHSA bilingual pay, $6,500 is reported above for the Latino Outreach and Therapy Services program, and $638 is included above for the Clinical Bilingual Internship action.
- The SLOBHD has appropriated $6,950 for Crisis Intervention Training in the MHSA WET program as part of cultural competent engagement.
- The SLOBHD has appropriated $15,000 for Promotores interpretation services in the MHSA WET program as part of providing additional in-person translation services in all clinics.
- The SLOBHD has appropriated $25,000 for the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Needs Assessment in the MHSA Prevention and Early Intervention program (PEI).
- The SLOBHD has appropriated $25,000 for the Peer Advisory and Advocacy Team (PAAT) in the MHSA WET program as part of the continued effort to highlight the work and reach of peers and their loved ones in the mental health system.
- The SLOBHD has appropriated $284,061 for MHSA Veterans Outreach Program (VOP) Therapy Services (CSS) and Veteran Outreach and Engagement Services (PEI). This program includes 1 FTE Behavioral Health Clinician and 1 FTE Outreach Coordinator.

The total budget for cultural competence activities is $1,262,228.

B. The majority of cultural competence activities in the FY 2018-19 Adopted Budget for SLOBHD are funded by MHSA allocations. Below are details by program:

- The Latino Outreach and Therapy Services program is funded by the MHSA Community Services and Supports allocation ($514,762) and Medi-Cal ($207,106) and EPSDT ($67,509) revenue.
- The Cultural Competence Training is funded by the MHSA WET allocation ($3,000).
- The Clinical Bilingual Internship action is funded by the MHSA WET allocation ($54,205), Medi-Cal ($26,893), and 2011 Realignment ($8,636).

The interpreter services provided by Language Line are funded by County General Fund Support and Realignment ($13,128).

The bilingual differential pay for County staff assigned to Mental Health core is funded by County General Fund ($11,759). The MHSA bilingual pay ($9,218) is funded by Community Services and Supports allocation ($8,850 of which $6,500 is included above in the Latino Outreach and Therapy Services program), and Workforce Education and Training allocation ($638, and this amount is included above in the WET Internship Program).

Crisis Intervention training ($6,950), Promotores interpretation services ($15,000), and PAAT ($25,000) are funded by MHSA WET funds. The LGBTQ Needs Assessment ($25,000) is funded by MHSA PEI, and the Veterans Outreach Program ($284,061) is funded by MHSA CSS ($207,615) for therapy services, and by MHSA PEI ($76,446) for outreach and engagement services.

Total funding required for cultural competence activities is $1,262,228. Note: this does not include the WET regional allocation (to be determined) for cultural competency training.

CRITERION 2
COUNTY MENTAL HEALTH SYSTEM
UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The county shall include the following in the CCPR:

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 2:

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.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service. A new CCP is revised and written annually, which include new data collection reporting and strategies identified, determined, and adopted for the year.

A. **Table 1** displays the most recent published Census data (*www.census.gov*, and *American Community Survey*) for San Luis Obispo County. According to the most recent estimated census data there are 283,405 residents, 104,404 households, with an average of 2.51 persons per household in the county. The racial makeup of the county is 88.9% White, 2.0% Black or African American, 1.4% American Indian or Alaska Native, 4.0% Asian, 0.2% Hawaiian and Pacific Islander, and 3.5% from two or more races. The county's Latino population represents 22.6% of the population (up from 8.65% at last report) identifying as Latino of any race. 17.7% are of Mexican descent, 0.4% are of Central American descend, 0.3% are of South American descend and 1.9% are of Spanish ancestry. The percentage of those speaking only English has decreased to 81% while the population of Spanish speaking individuals has grown to 18.6%. Foreign-born, non-citizens make up 10.4% of the total population.

Of the currently estimated 104,404 households in the County, 26.5% have children under the age of 18 living with them, 50.2% are married couples living together, 9.1% have a female householder with no husband present, and 36.6% are non-families (indicative of a university community). More than twenty five percent (26.4%) of all households are made up of householders living alone, and 10.8% of those householders living alone are 65 years of age or older. The average household size is 2.5, and the average family size is 2.99.

The population age spread is comprised of 18.9% under the age of 18, 23.5% from 10 to 24, 22.9% from 25 to 44, 28.3% from 45 to 64; and 15.2% are 65 years of age or older – a figure that is steadily increasing. The median age has also increased from 37.3 (US Census, 200) to 39.4 years.

TABLE 1. San Luis Obispo - Estimated Demographics	
POPULATION	
Population estimates, July 1, 2017, (V2017)	283,405
Population estimates base, April 1, 2010, (V2017)	269,591
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	5.10%
Population, Census, April 1, 2010	269,637
AGE & SEX	
Persons under 5 years, percent	4.70%
Persons under 18 years, percent	17.80%
Persons 65 years and over, percent	19.40%
Female persons, percent	49.30%
RACE & HISPANIC ORIGIN	
White alone, percent (a)	88.90%
Black or African American alone, percent (a)	2.00%
American Indian and Alaska Native alone, percent (a)	1.40%
Asian alone, percent (a)	4.00%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.20%
Two or More Races, percent (a)	3.50%
Hispanic or Latino, percent (b)	22.60%
White alone, not Hispanic or Latino, percent	68.80%
POPULATION CHARACTERISTICS	
Veterans, 2012-2016	18,452
Foreign born persons, percent, 2012-2016	10.40%
HOUSING	
Housing units, July 1, 2017, (V2017)	121,902
Owner-occupied housing unit rate, 2012-2016	59.00%
FAMILIES & LIVING ARRAGEMENTS	
Households, 2012-2016	104,404
Persons per household, 2012-2016	2.51
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	80.50%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	18.60%

Fact Notes

(a) Includes persons reporting only one race

(b) Hispanics may be of any race, so also are included in applicable race categories

Source: U.S. Census Bureau, 2017 Estimates

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

The county shall include the following in the CCPR:

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

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

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

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

A. **Table 1** is taken from the calendar year 2017 CenCal Health report for San Luis Obispo County and identifies the proportion of White (48%), Latino (31%), Asian/Pacific Islander (3%), African American (1%), Native American (1%) and other (12%) races which make up the County's Medi-Cal population and percentage of clients served.

Table 1.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY17, by Race and Ethnicity					
Race/Ethnicity	**Average Yearly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served/Assigned**	**% Served**	**Penetration Rates**
White	26,153	48%	3,676	68.2%	14.06%
Latino/Hispanic	16,584	31%	1,094	20.2%	6.60%
African-American	724	1%	148	2.74%	20.44%
Alaskan Native / American Indian	318	1%	68	1.26%	21.38%
Asian or Pacific Islander	1,409	3%	72	1.33%	5.11%
Other	6,719	12%	122	2.26%	3.68%
Not Provided	2,310	4%	210	3.89%	9.09%
Total	**54,217**	**100%**	**5,390**	**100%**	**9.94%** Average

Table 2 displays data which gives a snapshot of utilization and penetration rates for age. Adults ages 22-65 make up the largest eligible group, with 15,263 enrollees. Youth ages 0-5 make up 6,870, ages 6-11 make up 7,477, ages 12-21 make up 10,286, and lastly ages 65+ make up 3,925 of the eligibility in the county. The table also demonstrates females as making up more than 55% of the eligibility on a given month.

Disparities and analysis will be described in the next section.

Table 2.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY17, by Age					
Age	**CenCal Population Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served/Assigned**	**% Served**	**Penetration Rates**
0-5	6,870	48%	382	7.09%	5.56%
6-11	7,477	31%	612	11.36%	8.19%
12-21	10,286	1%	1,301	24.15%	12.65%%
22-65	15,263	1%	2,907	53.98%	19.05%
65+	3,925	3%	183	3.39%	4.66%
Total	**43,821**	**100%**	**5,385**	**100%**	**10%** Average

Table 3 below displays data of utilization and penetration rates based on gender. Females represent the larger number of those eligible with 28, 490 enrollees, whereas males represent a total of 25, 727 enrollees.

Table 3.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY17, by Gender					
Gender	**CenCal Population Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served/Assigned**	**% Served**	**Penetration Rates**
Males	25,727	47%	2,766	51.41%	10.75%
Females	28,490	53%	2,614	48.58%	9.17%
Total	**54,217**	**100%**	**5,380**	**100%**	**9.96%** Average

B. As **Table 1 and 2** clearly demonstrates white persons are the largest group of eligibles and beneficiaries. White people make up 48% of the eligible population and receive 68% of services. This creates a disparity for other races which make up an inequity between eligibility and service. The largest inequity is among Latino persons who comprise 31% of the eligible and receive only 20% of services. Another disparity exists for Asian/Pacific Islanders who make up over 3% of the eligible population yet receive less than 2% of services. In contrast, African Americans make up about 1% of the eligible population while receiving just over 2.5% of the County's services. Less than half of the eligible Latino and Asian/Pacific Islander Medi-Cal eligible populations are served.

Both evident disparities possess a common denominator: language. While the Latino population faces a larger disparity, it is also important to note the inequity which exists for Asian clients who make up the County's second largest non-white ethnicity. In both cases, language and the lack of linguistic and culturally competent providers may be barriers for service. As outlined in other sections of this report, the County has made continuous efforts and strides towards building a culturally and linguistically competent workforce. The most critical factor in doing so is to have the ability to serve clients in their native language, and to establish solid trust and communication between them. It is apparent that the lack of bilingual staff available to provide services in a variety of Asian languages is also a barrier in the County.

The County continues to examine the disparity with Latinos and has identified issues of poverty, geographic barriers, transportation, and cultural beliefs as being major factors in determining access for Latino clients. The county also has a large subpopulation of migrant farm workers, and due to recent national events, less of the potential Latino clients have searched for or accessed services. Local school districts and cultural organizations in the county held various community meetings in the North and South county regions to inform the Latino community of the support and continuity of services. This same examination may be important to assess the disparity with Asian/Pacific Islanders, although many of the same barriers will exist. The county's tourism, agriculture, and seasonal economies support opportunities for monolingual Asian immigrants representing many languages not spoken by providers in the mental health system. Also, the local colleges and University have increased Asian populations in the past ten years due to school acceptance for out-of-state and out-of-county students, which has contributed to the overall subpopulation growth. While language may not be a factor in all issues of disparity with Latino and Asian eligibles, it can be assumed that cultural beliefs, stigma, and lack of outreach serve as barriers to access.

Table 2 also demonstrates a disparity amongst the county's youngest (0-5) and oldest (65+) eligibles. Both age categories have a penetration rate of less than 6%. This disparity is being addressed in various County programs which have identified issues such as outreach for older, withdrawn adults as being a strategy to combat this barrier to service. Children under five do not customarily seek services, as mental health issues often go unnoticed or undiagnosed until children are placed in social contexts, such as school. To address this issue, the County's MHSA Innovation Project will conduct a test to study three mechanisms to deliver recurring screenings for children 0-3 years of age. Our goal is to determine which screening method is successful and how it can support mental health knowledge increase for parents/primary caregivers and integrate physical and mental health screenings within one session.

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

The county shall include the following in the CCPR:

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

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

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

The following table should be viewed in the context of data collected for Medi-Cal and uninsured clients as they are the population at or below the 200% poverty line:

A. The following tables provide a 200% of poverty calculation and summary of client utilization. With the implementation of the Affordable Care Act, we are including below a breakdown of uninsured individuals or individuals on Medi-Cal under the 200% FPL for clients who completed all data requirements. The County is streamlining the process to gather this data. The County is also anticipating that new criteria will be provided to address this piece as now most clients who are at or fall under the 200% poverty line are also Medi-Cal clients, and data provided can be a duplicate response to other questions in the CCPR.

Table 4.

San Luis Obispo MHP 200% Poverty Line Data		
Age	**SLO Uninsured & 200% FPL**	**% Enrollees**
0-5	103	20%
6-11	150	29%
12-21	257	50%
22-65	5	1%
Total	**515**	**100%**
Gender	**SLO Uninsured & 200% FPL**	**% Enrollees**
Male	295	57.28%
Female	220	42.71%
Total	**515**	**100%**
Race/Ethnicity	**SLO Uninsured & 200% FPL**	**% Enrollees**
Caucasian	239	46.40%
Mexican American/Chicano	190	36.89%
Other Hispanic	66	12.81%
Other	20	3.88%
Total	**515**	**100%**

The table above provides data for the 200% poverty population based on the most recent updated Census estimate (2017), broken down by age, gender, and race/ethnicity as provided by the clients completing all required documents. The next column details the poverty population (persons with incomes less than 200% of poverty level) provided by the Department of Mental Health (CPES). The numbers are calculated based on extracting data from our Medi-Cal population receiving services.

As described above, children from 0-5 and 6-11 make up almost half of the 200% poverty population at 253 clients. There is a total of 98 (39%) females and 155 (61%) males. By contrast, 126 (50%) Mexican American/Chicano/Latino/Hispanic youth are represented in this group, 120 (47%) White/Caucasian, and 7 (3%) represent other ethnicities. This shows a similar level of clients served under the 200% poverty line for all tracked populations.

For the population comprising ages 12-20, there are 257 total clients. There are 119 (46%) females and 138 (54%) males. By contrast, 128 (50%) Mexican American/Chicano/Latino clients are represented in this group, 120 (46%) White/Caucasian, and 9 (4%) represent other ethnicities. The Adult Poverty Population results yield minimal information for the data obtained in calendar year 2017.

Another important general observation is that both male and female Latinos, and other minorities in the poverty population, face a disparity in service when compared with the general population and those served by Medi-Cal. Although Latino adults make up the second largest beneficiary group, the lack of more detailed data for other minority groups, such as adult Asian/Pacific Islanders (Table 1) also stands to be underserved, based on these estimates.

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

The county shall include the following in the CCPR:

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

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

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

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

A. The following data table, which reflects fiscal year 2017-2018, is a summary of client utilization data by age, gender, and race/ethnicity. The table should be viewed in the context of the 2017 estimate Census report: San Luis Obispo County's population is 88.9% White, 2.0% Black or African American, 1.4% American Indian or Alaska Native, 4.0% Asian, 0.2% Hawaiian and Pacific Islander, and 3.5% from two or more races. The county's Latino population represents 22.6% of the population (up from 8.65% at last report) identifying as Latino of any race. 17.7% are of Mexican descent, 0.4% are of Central American descent, 0.3% are of South American descent and 1.9% of Spanish ancestry. The County has strived to provide the most accurate data for all demographic sections for all populations that identified age, gender, and race/ethnicity.

San Luis Obispo CSS Unduplicated Clients – Race/Ethnicity, Age, and Gender		
Age	**SLO Uninsured & 200% FPL**	**% Enrollees**
0-25 (Youth and TAY)	1,148	43.73%
26-59	1,253	47.73%
60+	224	8.53%
Total	**2,625**	**100%**
Gender	**SLO Uninsured & 200% FPL**	**% Enrollees**
Male	1,319	50.24%
Female	1,298	49.44%
Other	8	0.30%
Total	**2,625**	**100%**
Race/Ethnicity	**SLO Uninsured & 200% FPL**	**% Enrollees**
Caucasian	1,748	66.59%
Mexican American/Chicano	590	22.47%
Other Hispanic	175	6.66%
Other	112	4.26%
Total	**2,625**	**100%**

B. In analyzing disparities among Mental Health recipients, the selected populations were compared across race/ethnic groups, age, and gender. In overall description, the Mexican American and Latino/Hispanic groups represent about 28% of enrolled clients for services, although they represent over 22% of the total county population, which creates a disparity in services. The County has strived to close the gap as we increase our pool of bilingual and bicultural direct service staff under the Latino Outreach Program. In regards to Youth and TAY, the County has made efforts to engage those population sections, which represent about 47% of enrollees receiving services under CSS. On the other hand, older adults construct a population that receives limited access to services. Early Intervention strategies allow us to engage with this population, but intensive outreach and communication is needed to close the gap of insufficient service access. Both female and male individuals are almost equally represented in the use of services, 49% and 50% respectively. The County, under Prevention and Early Intervention, continues to track relevant information regarding other genders who may need CSS services and need to be referred appropriately to gender-affirmative engagement processes.

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

The county shall include the following in the CCPR:

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

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

A. The County chose to address all six of the PEI priority populations in its plan. Priority populations were not ranked, and the PEI plan serves all six groups. The County has worked in collaboration with new stakeholders and new populations have been identified. The County is currently conducting, through a contract, an LGBTQ Needs Assessment that will allow us to understand the needs of this population in our community.

B. Stakeholders in the PEI Planning Process reviewed and analyzed the community's needs and desires expressed though data collection, focus and work groups, and surveys. The stakeholders reviewed over a thousand surveys that gathered public opinion and gauged professional experience around mental health issues. The stakeholders determined the key community needs for response and narrowed priority services to the targeted populations. In order to gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. Each group then addressed the specific nature and needs of the PEI priority populations within each age cohort. Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, and to target groups and strategies that were realistic, feasible, and the best use of PEI funds. Their recommendations were brought to the full PEI Community Planning Team to develop the projects included in the final PEI plan.

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

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

The county shall include the following in the CCPR:

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

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 3:

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.

10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

14) Create conflict and grievance-resolution processes that are culturally and linguistically appropriate to identity, prevent and resolve conflicts or complaints.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service. A new CCP is revised and written annually, which include new data collection reporting and strategies identified, determined, and adopted for the year.

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

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

Medi-Cal population:

- As per the SLOBHD's description of "Medical Necessity" (Appendix 06), the County observes California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity Criteria

for MHP Reimbursement of Specialty Mental Health Services. Medi-Cal beneficiaries must meet criteria outlined below to be eligible for services:

1. Be diagnosed by SLOBHD with a criteria diagnosis in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association.
2. Must have at least one of the criteria impairments because of the mental disorder(s) listed in subdivision (1) above.
3. Must meet each of the intervention criteria listed within the listed Code.
4. Minor beneficiaries are eligible when criteria listed in Section 18310.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age (Appendix 06) are met.

- There is a barrier for those who do not meet required eligibility to access primary Medi-Cal services from the County Behavioral Health Department.

Community Services Support (CSS) Full Service Partnership population:

- As per the SLOBHD's Full Service Partnership (FSP) Program Description (Appendix 27), the County provides several Full Service Partnerships (FSP) utilizing "whatever it takes", wraparound-like, intensive, community-based mental health services and supports to a focal population of individuals with mental illness. The program is founded on a strength-based, solution-focused, culturally-competent, client/family model to help individuals accomplish wellness, recovery, and resiliency in their lives so they may remain in their community. Target populations include:

  1. Children and Youth, 0-17 years old, with one or more of the following characteristics:
  - "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
  - Foster Youth with multiple placements.
  - Risk of out-of-home placement.
  - In juvenile justice system.

  2. Transitional Age Youth (TAY), 16-21 years old, that have one or more of the following characteristics:
  - "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
  - Co-Occurring substance abuse issues.
  - Foster Youth with multiple placements or aging out/have aged out.
  - Recently diagnosed with a mental illness.

  3. Adults, 18-59 years old, that have one or more of the following characteristics:
  - At risk for involuntary institutionalization.
  - "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
  - Co-Occurring substance abuse issues.
  - Homeless or at risk of becoming homeless.

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

- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Homebound – unserved.
- Homeless or at risk of becoming homeless.
- Co-Occurring substance abuse issues.
- Presenting with mental issues at their primary care provider's office.

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

- The County chose to address the following priority populations in its plan, based on its targets to grow a multicultural workforce:

1. Behavioral Health clinicians and support staff
2. Community Based Organizations serving mental health clients
3. Bilingual and culturally diverse clinicians
4. Clinicians specializing in co-occurring disorders
5. Undergraduate and Graduate students seeking a career in Behavioral Health
6. Mental Health consumers seeking education and/or a career in the field of Behavioral Health
7. Criminal justice personnel who intervene with the mental health population.
8. Consumers, family members, reentry and current students interested in working in the mental health field.

Prevention and Early Intervention (PEI) priority populations:

- The County chose to address all six of the PEI priority populations in its plan:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations

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

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

The Planning Team formulated criteria it would use to prioritize options, (such as the balance between prevention and early intervention programming: serve a few groups more in depth rather than many groups "lightly"), and adopted guiding practices that would be universal to the all the PEI projects. These

guiding practices included cooperative and coordinated services, easy access, utilizing existing strategies before starting something new, maximizing existing natural relationships, serving whole family units rather than just the "problem" individual, and varying services to be culturally aware and appropriate (these were themes from the community at large).

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

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

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

A. A significantly dominant disparity in San Luis Obispo County, which cuts across all the Medi-Cal, CSS, WET, and PEI's priority/targeted populations, is the under-representation of Latino individuals. This imbalance in service access is made even more dramatic considering the relatively high proportions of Latinos in the poverty population with the health and access problems associated with poverty status. Latinos are 22.60% of the total county population of 283,405 but they represent about 36% of the poverty population receiving services. To further compound ethnic and cultural barriers, a high percentage of the prevalent unrepresented Latino population in our county reside in the rural areas (communities with populations less than 3000 and/or are located 15-30 miles from services), thus exacerbating access, transportation, and information distribution difficulties associated with serving minority groups.

Medi-Cal and CSS Populations

Within the overarching Latino service imbalance, the disparity between the percentage of Latino Youth and Transition Age Youth receiving services is underrepresented, compared to their numbers in the poverty population. A very telling disproportionate service pattern exists, with approximately 20% of services going to Latinos while representing about 31% of the eligible population. In a similar fashion, when reviewing the unserved population, Latino Youth and Transition Age Youth represent the highest combined percentages of unserved individuals among the youth and transition age groups.

It is estimated that among older adults and adults, Latinos again represent a relatively low percentage of those served compared to their percentage of both in the poverty level population (48%), which includes all Latinos from different origins, and in the total County population (22.6%). Acculturation and assimilation processes impact all Latinos in different degrees, but the experience ultimately brings in even more cultural and linguistic barriers and therefore presents a greater access disparity based on this potential imbalance in cultural and linguistic barriers.

In 2004, SLOBHD conducted a study to assess the characteristics which influence the local Latino population's underutilization of Mental Health Services. The survey was administered to 200 Spanish

speaking low income Latinos who resided in the County. All 200 surveys were completed by those who were Spanish literate and illiterate. The results showed that the following variables affected utilization of mental health services:

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

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

In recent years, the County has increased programming and data collection to assess the needs of the veteran and LGBTQ communities. Both observationally, and anecdotally, County staff and stakeholders have determined the need for more access for these vulnerable populations. No analysis has been done, at this stage, to determine the scope or comparison of the need. However, in 2017-2018, a community-wide research project was launched to study LGBTQ needs and experiences in the community mental health system. In 2014-2015, the County developed MHSA Innovation programming to create access opportunities for veterans.

Workforce, Education, and Training

- **Behavioral Health clinicians and support staff**: There is a need for additional bilingual/bicultural staff in all classifications, especially in the threshold language of Spanish, but it is difficult to recruit these staff members based on community capacity, cost of living, and factors such as limited local schooling for professionals. Psychiatrists and Registered Nurses that work at the Psychiatric Health Facility (PHF), for example, are very hard to recruit. The County faces competition for salary equity from institutions such as the Atascadero State (Psychiatric) Hospital and the California Men's Colony, a State prison; both of which pay much higher wages for qualified staff.
- **Community Based Organizations serving mental health clients**: The County's WET Plan addresses the need for the development of Community Based Organizations (CBOs) who serve mental health clients. The county has tremendous CBOs providing support, education, wellness and recovery services, yet there is still a disparity for those organizations that do not have the capacity or cultural competence to appropriately serve those clients who, for one reason or another, need services outside of what County Behavioral Health can provide.
- **Bilingual and culturally diverse clinicians**: Those staff and clinicians who are bilingual and culturally diverse are often placed in demanding positions to handle larger clinical caseloads while also serving as outreach workers. This places an increased demand on keeping these positions filled.
- **Clinicians specializing in co-occurring disorders**: It is a County priority to have appropriately trained and skilled therapists and clinicians who serve clients presenting both mental illness

diagnoses and addiction issues. Like many other California counties have attempted to do in recent years, SLOBHD has sought to integrate mental health and alcohol and drug services. Disparities which reduce these clinicians' ability to serve include the challenge of having to navigate difficult confidentiality issues, medicinal ethics, and a lack of professional education and development.

- **Undergraduate and Graduate students seeking a career in Behavioral Health**: Local colleges, including California Polytechnic State University, San Luis Obispo (Cal Poly) offer limited psychology and counseling programs. College admissions for native Spanish-speakers in California are traditionally low (Atkinson, 2003). Locally, there is a small pool of graduate students looking for work; however, the pay for license-track trainees is minimal at best.
- **Mental Health consumers seeking education and/or a career in the field of Behavioral Health**: Consumers seeking education which would prepare them for work in the mental health field are faced with several barriers in San Luis Obispo County. These include the cost of University education, impacted schools which only take highly competitive academic applicants and recruitment efforts which rarely target those with mental illness. Of course, the weakened job market in California has also impacted the availability of career positions, making the recruitment even more competitive. Mental health consumers face the stigma of professionals, among others, working alongside peer counselors.
- **Criminal justice personnel who intervene with the mental health population**: The target population of criminal justice personnel who intervene with the mental health population includes those first-responders who have intensive interactions with the mentally ill and their families. Training in mental health issues and cultural competency is often limited by resources and scheduling pressures for other training which may have a more salient impact on communities.
- **Consumers, family members, reentry and current students interested in working in the mental health field**: This is an issue the SLOBHD has worked on significantly since the last CCP was published. The County has supported several programs which develop consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers. In the past decade, the County has increased contractual and grant programs which require peer and family member employment. In 2018, the Department adopted new job classifications which allow lived experience to be equitable to work and educational backgrounds. This allows the County to employ consumer staff in regular benefited positions versus relying on practices including volunteers, stipends, and personal service contracts.

Prevention and Early Intervention:

- **Trauma Exposed Individuals**: Disparities include reduced access by those who may avoid seeking services for the psycho-social effects of the traumas they have experienced.
- **Individuals Experiencing Onset of Serious Psychiatric Illness**: Disparities include reduced access by those unlikely to seek services from traditional mental health services due to stigma, or lack of understanding of their illness.
- **Children and Youth in Stressed Families**: Disparities include lack of services and reduced access due to stigma and inability to engage parents and caregivers in providing access.
- **Children and Youth at Risk for School Failure**: Disparities include lack of services and reduced access due to stigma, and inability to engage school systems in increasing access to services.

- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement**: Disparities include lack of services and reduced access due to stigma, and fear of further juvenile system involvement.
- **Underserved Cultural Populations**: Disparities include lack of services and reduced access due to stigma, language barriers, lack of culturally-sensitive locations and hours, and limited understanding of other systems which may support access (i.e. schools which cannot communicate with monolingual parents).

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

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

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

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

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

Community Services and Supports (CSS)

The County originally established a partnership with a local psychologist to conduct extensive research to determine best practice approaches to overcoming disparities with Latino consumers. The resulting paper, "Servicios Sicológicos Para Latinos: A Latino Outreach Program: Addressing Barriers to Mental Health Service" (Appendix 07) outlined the county's local data, described in the previous Criterion, and outlined the services which continue to anchor the CSS strategies in San Luis Obispo County.

Latino Outreach Program (LOP) offers culturally appropriate psychotherapy services to monolingual, low income Spanish speakers and their bilingual children. The model for LOP is based on the findings of research and the findings of the County study conducted in 2004. The program has been successful in establishing a community-based model that provides psychotherapy, medication evaluation, psychotherapy groups, parenting groups for parents whose child(ren) is(are) a ward of the court, substance abuse groups, and educational workshops (Appendix 08) to the Spanish speaking community and their bilingual children.

The client's access to services is conducted in a manner that minimizes telling the personal story to multiple persons and navigating through a bureaucracy. The clients can access services from either community referrals (e.g. Family Resource Centers, schools, etc.), or directly through the central access service – which now has bilingual, bicultural staff available at all times. This "managed care" team assigns the client to the therapist that conducts the intake and provides therapy. This method of accessing services addresses the barrier described in Criterion 3, Section IIA, which speaks to the difficulty of telling the personal story to various persons prior to receiving treatment, and is respectful of the findings of Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, (2001) and Chung (1990) that indicate clients get lost when trying to navigate through the bureaucracy of the agencies that provide mental health services.

All LOP therapists are bicultural and bilingual. The current staff include two therapists originally from Mexico, and three others are first generation from the United States (Appendix 09). The ethnicity of the therapists and their cultural backgrounds addresses the concerns stated in Criterion 3, Section IIA. By being Spanish speaking Latinos/Latinas, the therapists can increase the probability of retaining the client because as noted by Lehman, E.W., Harrison-Ross, P. & Seigal, K. (1982), there is a decrease in dropout rates when there is an ethnic and language match between the mental health professional and an ethnic minority client. By having therapists with experiences both as immigrants and as first-generation U.S. citizens, staff can share world views and connect with the Latino client's cultural perspectives and experiences.

In 2011, the SLOBHD launched an Innovation (MHSA) project to test improving mental health access for veterans and active military. "Operation Coastal Care" tested a unique community collaboration providing a licensed mental health therapist to be embedded with local "surf" recreation/rehabilitation programs for veterans and other high-risk individuals. Knowing that veterans were more likely to participate in physical, team-based rehabilitative activities than to walk in to a clinic for assessment, the model has proven to be a great success.

Now called the *Veterans Outreach Program*, the County offers monthly outdoor activities, group experiences, and community service for local veterans and their family members. At each event, the participants are introduced to the County's veteran-focused clinician and are offered an opportunity to meet in a relaxed and supportive environment. Veterans seeking further counseling or treatment are provided a safe introduction to services, and often make their first appointments while at the event. The outreach event is funded, now, as part of the Prevention & Early Intervention plan. The clinician is funded with CSS, and now also provides services to the County's Veterans Treatment Court.

Workforce Education and Training (WET)

The County's original WET plan addressed the disparities of recruitment, training, and education of qualified individuals who provide services in this County's Public Mental Health System. The County elected to spend down its WET funding over a ten-year period. Some original WET programs are now being funded with CSS distributions. The County concluded programming associated with the following strategies:

- **Workforce Education and Training Coordinator and Intern:** This strategy reassigned a Mental Health Therapist to 20 hours per week as the WET Coordinator in December of 2008. A part-time WET intern was hired in the second year to assist in the planning and implementation of the WET blueprint. These positions coordinated the implementation of educational and training strategies identified in the County, performing tasks such as conducting assessments of county staff, contract providers, consumers, youth, and family members' training needs; assisting in the

development and implementation of a strategic training plan for SLOBHD; and participating both at a state and regional level to ensure coordination of training and to maximize training opportunities.

- **All Workforce Training in Co-Occurring Disorders:** WET stakeholders expressed extensive interest in promoting system-wide competencies in co-occurring disorders. Based on this interest, the County provided workforce training in treating individuals with co-occurring mental health and substance disorders in a culturally competent manner to staff and volunteers of the County and contracting CBOs, and to consumers and family members.
- **Psychosocial Rehabilitation Certification Program:** This strategy addressed the identified shortages in occupations, skills sets, and individuals with unique cultural and linguistic competence at SLOBHD and community organizations providing services in the public mental health system.
- **Scholarships:** This strategy addressed shortages and diversity needs in the mental health workforce, and increased consumer and family member participation in the workplace by offering stipends and incentives to those individuals interested in pursuing education in delivering mental health care in the county.

Going forward, the current MHSA plan includes the following original WET strategies, funded with CSS dollars:

- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** The County works with Transitions Mental Health Association (TMHA), a community-based organization, and their "Peer Advisory/Advocacy Team" (PAAT), to advocate for and educate the community about mental health, wellness, and recovery. Members of the peer advisory team are consumers and family members that sit on local boards and commissions, provide training and outreach, and co-facilitate recovery groups with SLOBHD staff.
- **E-Learning:** Per a contract with Relias Learning, SLOBHD has developed, delivered, and managed educational opportunities and distance learning for staff, consumers/family members, and community-based organizations. Funding has been used to access an extensive course catalog and to customize courses to meet the specific, diverse needs of our community. Trainings are wellness, recovery, and resiliency oriented. All employees, including consumer and family members, have access to trainings. The Cultural Competence Committee makes recommendations for training curriculum and processes for accessing training.
- **Law Enforcement, First Responders and Crisis Intervention Training (CIT) Description:** This strategy trains law enforcement officers to handle crisis situations involving individuals with serious mental illness. This is conducted in collaboration with the local Police Officers Associations and departments, and involves police personnel, mental health professionals from both adult and children's services, the Cultural Competence Committee, and local consumers and family members.
- **Integrating Cultural Competence in the Public Mental Health System:** While cultural competence was embedded in all actions of the WET Plan, this strategy focused on specific technical assistance and trainings necessary to achieve Cultural and Linguistic Competency within the public mental health system. MHSA staff continues to coordinate and serve on the Cultural Competence Committee (as described in Criterion 4). This committee has taken part in the development of the cultural competence plan and developed recommendations for a year-round training plan.
- **Bilingual Internship Program:** This strategy provides funding to support three part-time Bilingual students to gain experience and knowledge working in the public mental health system within a recovery approach.

- **Consumers, family members, reentry and current students interested in working in the mental health field**: This is an issue the SLOBHD has worked on significantly since the last CCP was published. The County has supported several programs which develop consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers. In the past decade the County has increased contractual and grant programs which require peer and family member employment. In 2018, the Department adopted new job classifications which allow lived experience to be equitable to work and educational backgrounds. This allows the County to employ consumer staff in regular benefited positions versus relying on practices including volunteers, stipends, and personal service contracts.

Prevention and Early Intervention

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

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

II. Medi-Cal Strategies

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

III. 200% of Poverty Strategies

- LOP is embedded in the community to increase access for those unable to meet the economic need for transportation in the vast county. Psychotherapy is offered in Paso Robles, San Luis Obispo, Oceano, Arroyo Grande, and Nipomo at eight community sites (Appendix 10). The clients who receive services from LOP can access therapists, workshops and groups in a familiar community site in their own neighborhood.
- This strategy allows the program to break through the barrier stated in Criterion 3, Section IIA which addresses the discomfort of receiving psychotherapy in a government agency. The community-based model also is consistent with the findings of Cheung's (1990), and Kiselica &Robinson (2001), which stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings".

IV. Community Services and Supports (CSS) Strategies

- **Full Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults and older adults. In the nine years since the last CCPR was issued, the County has launched FSPs focused on homeless populations, and another focused on individuals with judicial and criminal-justice involvement. All services are provided in English and Spanish.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life, feel better and be more satisfied with their lives. Support includes: vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support programs; outreach to unserved seniors; and expand services for persons with co-occurring substance abuse. This includes an Adolescent Co-Occurring Disorder program, launched in 2017.
- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility. In the last year the County has opened its first crisis stabilization unit. All services are provided in English and Spanish.
- **Latino Outreach & Services** program reaches unserved and underserved limited-English speakers and provide community-based, culturally-appropriate treatment and support.
- The **Behavioral Health Treatment Court** offers support to adults who are mentally ill, on probation and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA.
- **The Veterans Outreach and Veterans Treatment Court** therapeutic services invite local service people and their families to access care and referral in a stigma-free, culturally competent settings.
- **School-Based Mental Health Services** for students offers intense, daily contact to address serious emotional disturbances.

V. Prevention and Early Intervention (PEI)

- **Trauma Exposed Individuals**: Strategies include increased engagement with schools, seniors, and high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. One example is the creation of a Student Assistance Program team at two middle schools which serve the largest Latino and poverty-based youth populations. These teams include a counselor specialized in risk assessment and trauma, along with a "Family Advocate" who meets with students and their families to build community linkage to needed resources, such as food, employment, and academic tutoring.
- **Individuals Experiencing Onset of Serious Psychiatric Illness**: Strategies include increased access to care on school campuses and in community centers where high risk populations (as mentioned above) will have more immediate responses from professional care and supports. Stigma reduction communitywide, including the "SLOtheStigma" media campaign, will increase knowledge and selective seeking-out of care. In its first six months, the website www.slothestigma.org attracted over 8500 unique visitors, 96% of whom indicated they would use the resources found on the website.

- **Children and Youth in Stressed Families**: Strategies include parenting education for both universal and selective populations to reduce stress; as well as increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency skills. One rewarding strategy has been the coordination of all county parent education offerings into an online family resource center website, www.sloparents.org. Available in Spanish, the website materials lead parents to targeted training, coaching, and education which deal with reducing stress in families and improving health outcomes.
- **Children and Youth at Risk for School Failure**: Strategies include increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency skills. As mentioned above, the Student Assistance Programs launched countywide as part of PEI serve six high-need middle schools. All county middle schools, through PEI, have received youth development project funding to increase youth opportunities for school bonding and life skill support through Friday Night Live programs.
- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement**: Strategies include increased engagement with transitional age youth, including wards of the court, at highest risk for juvenile system involvement. These strategies include job skills training and academic counseling. The "Successful Launch" program expanded the county's Independent Living program targeted at youth emancipating from foster care. All community school and probationers preparing to graduate can now access life skill training, vocational development, higher education credits, and counseling services.
- **Underserved Cultural Populations**: Strategies include increased engagement with high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. Programs such as the Latino Outreach Program, which was originally created as part of CSS, were provided prevention and early intervention training to expand outreach and education opportunities to engage underserved populations. Veterans Outreach, as described earlier, offers monthly outdoor activities, group experiences, and community service for local veterans and their family members. At each event the participants are introduced to the County's veteran-focused clinician, and offered an opportunity to meet in a relaxed, supportive environment. In 2017-2018 a community-wide research project was launched to study LGBTQ needs and experiences in the community mental health system.

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

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. **Note:** New strategies must be related to the analysis completed in Criterion 2.

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

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

A. Since the development of CSS, the County has focused much of its approach to disparities through strategies brought forth in the MHSA process. Outreach to underserved populations and improved services have been keystones of the past nine years of planning and development since the last CCPR was issued. Some of the strategies that have been developed outside of the Medi-Cal, CSS, WET, and PEI approaches include:

- **Co-Occurring Disorders**: With training initiated through the WET plan, the County has embarked on developing a program of integrated service which will allow individuals with dual diagnoses of mental illness and substance addiction to access integrated treatment. Until recently these individuals were faced with having to select which agency to engage to get help and care. Providers in the mental health system often turned the clients away to deal with their addiction issues first, and those entering the alcohol and drug programs were sent to mental health to get diagnosed before being able to assess their level of abuse or addiction. This created a gap in service and as the County merged its Drug and Alcohol and Mental Health divisions, the problem was identified. In 2015-2016 the SLOBHD incorporated all forensic programs under a co-occurring system of care. This integration of mental health and substance use disorder services provided clients with singular treatment plans and singular access points.
- **Innovation**: The County continues to expand knowledge and services utilizing Innovation (MHSA) component funds, which allow each County to develop projects that will enhance learning around practices and strategies. San Luis Obispo County's stakeholder process has yielded several research-type projects that address cultural competency and assess the efficacy of new practices. As written earlier, the original Veterans Outreach program was designed as an Innovation project. Current projects include program designs which impact vulnerable populations including LGBTQ, Latinas, older adults, young children, and others.

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

The Latino Outreach Program, the major strategy addressing disparities in the Medi-Cal and CSS populations, continues to be a successful model for reducing the disparities in access for Latino and Spanish-speaking clients.

Workforce Education and Training (WET)

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

- The original WET planning did not include funding or development of a training room which could be equipped with computers and technology training aids. This was identified as a need, and the SLOBHD used Capital Facilities and Technology opportunities to develop such a resource.
- The development of the Electronic Learning initiative was a morale boost for staff and created many opportunities for staff to build capacity and for the Department to enhance its services. The Department and its parent Health Agency have used the tool to expand cultural competence and privacy training for all employees and community providers.

- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. The Department has increased data collection in all programs, including its training offerings.

Prevention and Early Intervention

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

- Foremost are the County's PEI projects which sought to reduce and eliminate stigma. The "SLOtheStigma" campaign launched in the winter of 2009-2010 made a major impact on the community. Over 150,000 media impressions were made in its first year, and the www.SlotheStigma.org website demonstrated its capacity to drive individuals to needed mental health services and information. The campaign used traditional media (i.e. billboards, television, print, and web) to show its centerpiece, a documentary short on local people living with and recovering from mental illness. The debut of the documentary also launched a community tradition, the "Journey of Hope" forum which continues to draw large audiences every year. The program has featured nationally-renowned speakers who have addressed the role of mental health and stigma in communities, veteran culture, law enforcement, schools, and families.
- The countywide PEI programs continue to be renewed and expanded whenever possible.

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

The county shall include the following in the CCPR:

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

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

C. Identify county technical assistance needs.

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

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

Community Services and Supports (CSS)

- **Full Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults and older adults. In the nine years since the last CCPR was issued, the County has launched FSPs focused on homeless populations, and another FSP focused on individuals with judicial and criminal-justice involvement. All services are designed to reduce homelessness, jail and inpatient hospitalization, and increase employment and school success. All programs are currently in operation.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life, feel better, and be more satisfied with their lives. Support includes: vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support programs; outreach to unserved seniors; and expanded services for persons with co-occurring substance abuse. This includes an Adolescent Co-Occurring Disorder program, launched in 2017. All services are designed to engage consumers in wellness and recovery and increase employment and school success. All programs are currently in operation.
- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility. In the last year, the County has opened its first crisis stabilization unit. All services are designed to reduce jail and inpatient hospitalization, reduce suicide, and move people from crisis to care. All programs are currently in operation.
- **Latino Outreach & Services** program reaches unserved and underserved limited-English speakers to provide community-based, culturally-appropriate treatment and support. All services are designed to increase access to care, provide culture-affirming care, and increase satisfaction. All programs are currently in operation.
- The **Behavioral Health Treatment Court** offers support to adults who are mentally ill, on probation, and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA. All services are designed to reduce jail and inpatient hospitalization and move people from justice system involvement to recovery. All programs are currently in operation.
- **The Veterans Outreach and Veterans Treatment Court** therapeutic services invite local service people and their families to access care and referral in a stigma-free, culturally competent setting. All services are designed to increase access to care, provide culture-affirming care, and increase satisfaction. All programs are currently in operation.
- **School-Based Mental Health Services** for students offers intense, daily contact to address serious emotional disturbances. All services are designed to reduce crises and increase school success. All programs are currently in operation.

Workforce Education and Training (WET)

- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** This strategy has been in place since 2009 and will continue to be monitored by PAAT activities and enrollment of consumers in education programs.
- **E-Learning** was launched in 2011 and is monitored annually to ensure staff and community partners are receiving current information on issues of culture, wellness, and recovery.

- **Law Enforcement, First Responders and Crisis Intervention Training (CIT) Description:** This strategy was implemented as part of WET in 2009 and continues in partnership with the County's Sheriff Department.
- **Integrating Cultural Competence in the Public Mental Health System:** The Cultural Competence Committee is a strategy monitored with objectives described in Criterion 5.
- **Bilingual Internship Program:** This strategy has been successful in engaging bilingual license-track interns to work within the mental health system. This is monitored by the MHSA team and SLOBHD management on a quarterly basis.

Prevention and Early Intervention

- **The Stigma Reduction Campaign** was implemented in the fall of 2009. This project is reported monthly and quarterly, as well as having site visits conducted by SLOBHD with providers to assess successes and needs.
- **Access Strategies** are embedded in each of the PEI projects. These strategies began in 2009 and are monitored by regular reporting and SLOBHD contract monitoring, including site visits and tests ("secret shoppers"). Hours and availability of short, brief intervention counseling services are being tracked by rosters and client satisfaction rates as well.
- **Cultural competence in providing PEI** is tracked in all programs including provider training events and evaluations, quarterly site visits, and client satisfaction rates.
- **Trauma Exposed Individuals and Children and Youth at Risk for School Failure**: Examples of the strategies addressing these populations and their evaluation are the Student Assistance Program teams at two middle schools, which serve the largest Latino and poverty-based youth populations and were launched in the 09-10 school year. These programs are part of the County's extensive PEI evaluation, which includes regular tracking and reporting of pre-posts, student outcomes, and overall community impacts over time. This evaluation will continue to take place every three years.
- **Children and Youth in Stressed Families** strategies include parenting education for both universal and selective populations to reduce stress and increase family communication outcomes. This adult-based program was implemented in fall of 2009 and the provider reports quarterly to the SLOBHD.
- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement**: The strategies of utilizing job skills training and academic counseling through the "Successful Launch" program are reported quarterly and track measures including participant attendance, skills outcomes, and school performance. The program was launched in the 09-10 school year.
- **Underserved Cultural Populations**: The above-detailed LOP and Veterans Outreach programs were embedded in the PEI plan to increase engagement with high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. These programs are currently in operation and are being tracked by quarterly and annual reports.

Medi-Cal & 200% of Poverty Strategies

- The Latino Outreach Program (LOP), as described above, is also a strategy delivered to decrease disparities amongst Medi-Cal eligible consumers. The strategy is measured quarterly by reports

of service, client outcomes, and client satisfaction. A copy of the LOP Client Survey is available in this document (Appendix 11).

New Strategies from Section IV

- All strategies described in Section IV, are currently operational. Tracking and monitoring includes provider quarterly reports, site visits, pre and posttests, and client surveys.

B. The County currently has various levels of mechanisms in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. For instance, the PEI Plan and its projects are monitored by site visits, quarterly evaluative reports, and annual data analyses and reporting. Programs within the CSS Plan, including LOP, also collect data at many points along the intervention providing quarterly and annual reporting. Mental Health Service programs collect basic data, which the County then reports as part of EQRO and other audit functions. The County is working to construct outcome measurement systems which will better document the experience of consumers and track the effects of service interventions.

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

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

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

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

The county shall include the following in the CCPR:

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

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

C. Organizational chart; and

D. Committee membership roster listing member affiliation if any.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 4:

13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee addressing issues, participating in decision-making, practices, and evidence of its engagement.

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

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

The Committee operates as an entity of the County of San Luis Obispo Behavioral Health Department. The Chairperson is appointed by, and reports to, The County Behavioral Health Director. The Committee

members are the decision-making body (elected by the Committee) and represent a diverse range of cultural, ethnic, racial and geographic regions of the county. The Committee advises and serves as a resource group to The County Behavioral Health Director, County Mental Health Staff, Performance Quality Improvement (PQI) team, and affiliated agencies. General membership is not a requirement for involvement in the Committee.

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

The goals of the Committee are:

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

B. As outlined in the Cultural Competence Committee guidelines (Appendix 12), the Cultural Competence Committee consists of members from County Mental Health, affiliated agencies, network providers, and consumers. The members of the Committee represent a range of cultural and ethnic backgrounds. The Chairperson is a member of the Latino and LGBTQ community with Native Peruvian, Greek, Italian, Middle Eastern, Portuguese, and Spanish heritage. Anyone interested in serving on the Committee shall state his/her interest to serve by informing a Committee member. A simple majority is required for the election of Committee members. A vacancy exists when a Committee member misses four consecutive Committee meetings without prior notification to the Chairperson or any other member. A vacancy also exists when a Committee member tenders his/her resignation verbally or in writing to the Chairperson. When a vacancy exists, The Committee shall nominate individuals to serve on the Committee.

No meetings shall be held in a facility that prohibits the admittance of any person based on culture, ethnic background, religious beliefs, sex, sexual orientation, or emotional/physical disabilities. Meetings will convene on the second Monday on a quarterly basis per calendar year. The Chairperson convenes the meetings and the Committee members develop the agenda for the meetings. The Committee will strive to make decisions by consensus considering allocated resources. A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by a quorum to be recommended to the County Behavioral Health Director. A quorum is defined as 50% of the Committee. A motion may be

made and seconded by any of the Committee members. Motions require a simple majority to be recommended as action items or task assignments.

C. The Organizational Chart which demonstrates the relationship of the Committee and the Behavioral Health Department is located in the Appendix 13.

D. Please see Appendix 14 for the most recent Cultural Competence Committee Roster and affiliations.

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

The county shall include the following in the CCPR:

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

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

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

- ***Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;***
    - As per the Cultural Competence Committee guidelines - Article II: The Purpose of the Committee, Section 1 (Appendix 12): *The Committee is dedicated to assuring that San Luis Obispo County Mental Health Services becomes a culturally competent health system which integrates the concept of cultural, racial and ethnic diversity into the fabric of its operation. The committee will create agency-wide awareness of the issues relevant to cultural diversity.*
    - Goals of the Cultural Competence Committee (Appendix 12) include:
        - To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
        - To provide recommendations that will increase service delivery to culturally diverse clients.

- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, American Indians, transition age youth and older adults.
- To provide and sponsor trainings focused on expanding and enhancing cultural and linguistic knowledge.

- ***Provides reports to Quality Assurance/Quality Improvement Program in the county;***
    - Goals of the Cultural Competence Committee (Appendix 12) include "To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients." This is done by having the CCC Chairperson provide quarterly information and briefs to both the County's Performance and Quality Improvement (PQI) and Quality Management (QMC) committees.

- ***Participates in overall planning and implementation of services at the county;***
    - Goals of the Cultural Competence Committee (Appendix 12) include:
        - To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
        - To provide recommendations that will increase service delivery to culturally diverse clients.
        - To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.

- ***Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;***
    - As per the Cultural Competence Committee guidelines - Article II: The Purpose of the Committee, Section 2 (Appendix 12): "*The Committee is committed to meeting the goals set forth in this document and will provide recommendations to the County Mental Health Director on issues pertinent to the achievement these goals*."

- ***Participates in and reviews county MHSA planning process***;
    - Nestor Veloz-Passalacqua, M.P.P., the Chairperson of the Cultural Competence Committee is also the Prevention and Early Intervention (PEI) and Innovation (INN) Coordinator under MHSA. Current members of the Committee have participated and are part of the Mental Health Advisory Committee. The MAC continues to meet bi-annually to review MHSA components, programs, and to guide planning.

- ***Participates in and reviews county MHSA stakeholder process;***
    - Cultural Competence Committee members have been active members of MHSA stakeholder planning for each component – CSS, PEI, WET, and Innovation. Cultural competence issues were at the forefront of MHSA planning (including disparities, priority populations, and outreach to consumers and family members) and have been discussed and processed at each level of planning. Committee members have assured that each MHSA stakeholder process included focus groups and feedback sessions that were held in Spanish or were provided in settings accessible and comfortable for diverse populations.
    - The CCC Chairperson is responsible for representing the Cultural Competence Committee in reviewing the MHSA stakeholder process.

- ***Participates in and reviews county MHSA plans for all MHSA components***;
    - Nestor Veloz-Passalacqua, M.P.P., as a staff member of the MAC, is responsible for representing the Cultural Competence Committee in reviewing the MHSA plans for all components. Other members of the Committee, including the Behavioral Health Director, Anne Robin, LMFT, also participate in this oversight.

- ***Participates in and reviews client developed programs (wellness, recovery, and peer support programs)***;
    - The Committee produces a quarterly newsletter (Appendix 04) which addresses issues related to wellness and recovery – and is made available to organizations in the community dedicated to peer support programs.
    - The Committee is proud to have a member of the Peer Advisory and Advocacy Team (PAAT) which is coordinated by TMHA, one of the County's premier MHSA partners, to join the CCC. PAAT members are residents and most have received mental health services in this county. Members enjoy volunteering, whether at community events, on advisory groups and boards; and within the mental health system. Some are also in paid positions within TMHA.

- ***Participates in revised CCPR (2018) development.***
    - Nestor Veloz-Passalacqua, M.P.P., the Chairperson of the Cultural Competence Committee, launched the CCPR preparation sessions and remained on the ad-hoc workgroup charged with preparing the CCPR. Mr. Veloz-Passalacqua has provided content, oversight, and review of each section of the document, while the SLOBHD staff and direction from Committee members representing County staff have taken lead roles in preparing the material included herein (Appendix 19).

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

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

- **Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county**;
    - The Chair of the CCC is responsible for providing a variety of services, including training of Mental Health Services staff in relation to cultural competency issues. This includes cultural competence under Crisis Intervention Training (Appendix 15). In his role as Chairperson of the CCC, Mr. Veloz-Passalacqua also provides reviews of programs and services by participating in the quarterly Performance Quality Improvement (PQI)/Quality Management team (see next).

- **Provides reports to Quality Assurance/Quality Improvement Program in the county**;
    - An agenda for the QST/Quality Management team is included in this document (Appendix 16). The group receives reports from the CCC quarterly.

- **Participates in overall planning and implementation of services at the County**;
    - As identified in CCC agendas and minutes included herein (Appendices 19 and 20), the County Behavioral Health Director, Anne Robin, LMFT, participates as a member of the Committee and provides monthly reports and discussions of County programs and services.

- **Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director**;
    - As explained above, CCC agendas and minutes included herein (Appendices 19 and 20) along with QST agendas (Appendix 16) demonstrate the interaction and reporting transmittal between the CCC and the County Behavioral (Mental) Health Director, Anne Robin, LMFT.

- **Participates in and reviews county MHSA planning process**;
    - The Cultural Competence Chairperson and some members are part of the MHSA Advisory Committee (MAC) and take part in all discussions regarding MHSA planning and major decision making. Included in the Appendix are sign-in sheets (Appendix 49) demonstrating this involvement.

- **Participates in and reviews county MHSA stakeholder process**;
    - In 2008, Dr. Ortiz, along with other members of the CCC, including the Ethnic Services Manager (Nancy Mancha-Whitcomb) were active members of the MHSA stakeholder process, an example of which is demonstrated in the appendix (Appendix 34).

- **Participates in and reviews county MHSA plans for all MHSA components**;
    - The Chairperson of the CCC and members are part of the MAC stakeholder group and take part in reviewing each of the county's MHSA plans and reports; as documented in the included sign-in sheets (Appendix 49).

- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and**
    - The CCC does not currently have a formal objective to review client-developed programs but seeks to increase its engagement with peer advocates and other recovery programs in future years.

- **Participates in revised CCPR (2010) development**.
    - The chairperson and the membership of the CCC have been integral to the development of this Cultural Competence Plan, as evidenced in the agendas and correspondence herein (Appendix 17 and 18).

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

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

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

1. The goals and objectives of the Committee, as outlined above, are listed here with details regarding their successes or next steps:

- To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
  - The Committee was able to obtain a meeting room within SLOBHD, an improvement from the original meeting location away from the County site.
  - The Committee was able to obtain an Administrative Assistant to take the Committee minutes and format them for the Committee.
  - The Committee has increased membership from various sectors of SLOBHD, as well as representation from the community.

- To provide recommendations that will increase service delivery to culturally diverse clients.
  - The Committee has been active in MHSA stakeholder processes, including the Innovation workgroups to keep cultural competence issues at the forefront of service delivery discussions.

- To provide recommendations that address the need of continued training on cultural diversity topics.
  - The Committee is active in training collaborations countywide, including providing input to the SLOBHD three-year training plan. In recent years the Committee has also informed the WET planning process as well as providing training as outlined in the next Criterion.

- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
  - The Committee produces a quarterly newsletter on cultural issues affecting mental health systems and providers. This material is part of the Committee's work to reduce barriers that affect sensitive and competent delivery of service to culturally diverse clients.

- To provide recommendations that address the recruitment and retention of bilingual providers.
  - The Committee, through its involvement in SLOBHD and MHSA workgroups, has provided strong recommendations for workforce improvements, demonstrated by a 20% increase in bilingual staffing since 2006.
  - The Latino Outreach Program is an example of this type of service response supported by the Committee.

- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, Native Americans, and transition age youth, and older adults.
  - The Latino Outreach Program, which has aided a 30% increase in Latino clients since 2006, is an example of this type of service response supported by the Committee.

- To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.

- Minutes from the Cultural Competence Committee (example, Appendix 18) are made available to all SLOBHD employees.
- The Committee's newsletter is produced quarterly and sent to each SLOBHD staff member and mental health partners in the community.

- To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee.
  - The Committee prides itself on its collaborative spirit and diverse membership. The Committee reflects the vast array of service providers and consumers served by the mental health system.
  - The Committee has worked within the WET plan to engage other organizations through training collaboratives,
  - In reporting to the County's PQI team, the Committee is also able to engage providers outside of the SLOBHD system.

- To foster a strong network among community agencies that will facilitate an integrated delivery of services.
  - The Committee prides itself on its collaborative spirit and diverse membership. The Committee reflects the vast array of service providers and consumers served by the mental health system.

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

3. As the committee continues to expand, the Cultural Competence Plan updated their goals in this plan to reflect the current activities held in order to accomplish our goals.

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

5. At this time the Committee does not review the SLOBHD's organizational structure for its Annual Report. A copy of the organization chart outlining the Committee's relationship to the County is included herein (Appendix 13).

6. The Committee has put forward a tentative training priority plan for FY 18-19 as part of their continued efforts to provide learning and enhancing opportunities to the Behavioral Health staff and the community. (Appendix 23).

7. The Annual Report (Appendix 22) included features information on activities and efforts made by the CCC during fiscal year 17-18.

CRITERION 5
COUNTY MENTAL HEALTH SYSTEM
CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR:

A. The county shall develop a three-year training plan for required cultural competence training that includes the following:

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 5:

4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee activities.

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

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

1. The projected number of County staff that will require training is 370 individuals. The projected number of direct services contractual staff is 150 individuals. These numbers were identified in the Workforce Education and Training Plan that was submitted in May of 2009.

2. SLOBHD, as per its WET training plan, has taken the following steps to provide required cultural competence training to 100% of the staff over the training period (2018-2021):

- SLOBHD will liaison with established training partners including local and online Colleges and University and Continuing Education Unit (CEU) providers. These partnerships increase the diversity of training opportunities, as well as increasing the capacity for training larger numbers of staff over time.
- Provide training through an electronic-learning initiative. SLOBHD is now offering training via an "e-learning" company which will provide core competency and cultural competency training menu which staff and contract partner staff can access at their convenience. This type of expansion will build capacity amongst all staff and increase training access and delivery to reduce barriers for staff who have limited hours or assignments which preclude attending training events.
- Throughout the year, additional training needs will be identified through surveys, focus groups, and community outreach. It will also cover the cost of refresher courses for interpreters; specialized training focused on the County's various ethnic populations and attendance at State-wide Cultural Competence trainings.

3. The following section will detail the training events held for SLOBHD staff. Cultural Competence is a key component of each training opportunity and at the core of service delivery. Through its membership in the Southern Counties Regional Partnership (WET), SLOBHD will have the opportunity to work with Dr. Jonathan Martinez, Ph.D., a Professor of Psychology at Cal State Northridge, who has been assisting in the development of a cultural competence assessment that will be used countywide with mental health providers. SLOBHD believes this strategy will result in further integration of cultural competence ideals into the training policies and practices of the County.

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

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

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

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

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).

6. Mental Health Interpreter Training
7. Training staff in the use of mental health interpreters
8. Training in the Use of Interpreters in the Mental Health Setting

The following table (Table 12) provides detail on the cultural competence trainings attended by staff in the past fiscal year. Included in the detail is the name or type of training event, a description of the training, the duration, attendance information, and date of training. In this grid, the *Attendance by Function* lists the identified status of participants. Clients and family members are included in the Community Members/General Public figures.

The Department currently tracks registration for every single attendee based on their professional role and the organization they are coming from. As the committee welcomes and pushes for family and consumers to be part of the training, it is common for each of these training workshops and events to be attended by several members of the consumer and recovery community. The committee has made efforts to ensure family members and consumers continue to attend trainings as we continue to develop a strong relationship with PAAT and other consumer-based organizations.

See **Table 12** below for a description of all training workshops, forums, and events that speak directly to section A and B of the current criterion.

Table 12 – Behavioral Health Training Calendar						
2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Co-Occurring Disorders and their Management Training	Identification of definitions and dilemmas in assessment and treatment in co-occurring disorders. Discussion methods and skills to improve assessment and applying treatment strategies to develop integrated service plans.	4	Direct care staff, therapists, counselors, agency supervisors and managers, medical professionals, MDs and NPs and licensed Psychiatric Technicians.	119	August 28, 2017	Dr. David Mee-Lee, MD
Maternal Mental Health	Describe Perinatal Mood and Anxiety Disorders signs, symptoms, screening and diagnosis. Identify stigmas, biases, and how a lack of knowledge interferes with identification and intervention. Describe effective strategies to use during screening and discussions with women at risk, and list current treatment options for mood disorders during pregnancy and postpartum depression	4	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	41	Nov., 6 2017	Dr. Shannon Easton-Carr, MD, MPH

Table 12 Continued

Table 12 – Behavioral Health Training Calendar 2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Using a Trauma Informed Lens Training	Trauma Informed Care (TIC) integrates core principles of neurodevelopment, trauma and attachment with mindful healing to support a comprehensive approach that can be used by clients, providers, and community members.	6	Direct care staff, therapists, counselors, agency supervisors and managers, medical professionals, MDs and NPs and licensed Psychiatric Technicians.	63	Aug. 4, 2017	Courtney Wagner LMFT, Julie DeFranco MSW, L. Michele Simone LMFT, Rebecca McGarigle LCSW, MSW, Susan Harney, LMFT, Elissa Feld
Using a Trauma Informed Lens Training	Same as above	6	Same as above	62	Aug. 17, 2017	Same as above
Using a Trauma Informed Lens Training	Same as above	6	Same as above	73	Dec. 12, 2017	Same as above
Journey of Hope	Jennifer presents one woman's recovery from addiction, trauma and adversity and identifies key components of what can help a person turn their lives around. She speaks firsthand about the complexities of biological and emotional responses of trauma, sexual assault, and the effects of substance abuse and recovery.	2	Direct care staff, therapists, counselors, agency supervisors and managers, medical professionals, MDs and NPs and licensed Psychiatric Technicians	250	2-Oct-09	Jennifer Storm

Table 12 Continued

Table 12 – Behavioral Health Training Calendar 2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Disaster Mental Health Training	The purpose of the course is to prepare li-censed mental health professionals to pro-vide for and respond to the psychological needs of people throughout the disaster cycle of preparedness, response and recovery.	3	Licensed mental health professionals who have an independent license, a state license of state certification or master's degree, and a state license bachelor's degree.	54	Feb. 2, 2018	Monty Clouse, PhD, and Killorin Riddell PhD.
Trans-Training 101	Enhance attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will engage in experiential activities, watch video clips, and observe mock therapy sessions.	4	Direct Care Staff, Counselors, Support Staff, Agency Super-visors, Managers, Resource (Foster) Parents, Social Workers, Teachers, and Law Enforcement	68	March 13, 2018	Dr. Jay Bettergarcia and Dr. Stacy Hutton

Table 12 Continued

Table 12 – Behavioral Health Training Calendar 2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Using a Trauma Informed Lens Training	Trauma Informed Care (TIC) integrates core principles of neurodevelopment, trauma and attachment with mindful healing to support a comprehensive approach that can be used by clients, providers, and community members.	6	Direct care staff, therapists, counselors, agency supervisors and managers, medical professionals, MDs and NPs and licensed Psychiatric Technicians.	84	March 30, 2018	Courtney Wagner LMFT, Julie DeFranco MSW, L. Michele Simone LMFT, Rebecca McGarigle LCSW, MSW, Susan Harney, LMFT, Elissa Feld
Drug Medi-Cal Organize Delivery System: ASAM Criteria (A) Assessment	General overview of ASAM as well as introduction appropriate patient placement, and guidance for utilizing ASAM criteria to determine the appropriate treatment of patients based upon their level of care.	4.5	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	30	May 4, 2018	Denise Shook
Drug Medi-Cal Organize Delivery System: ASAM Criteria (A) Assessment	Same as above	4.5	Same as above	24	May 14, 2018	Denise Shook
Drug Medi-Cal Organize Delivery System: ASAM Criteria (A) Assessment	Same as above	4.5	Same as above	22	May 21, 2018	Denise Shook

Table 12 Continued

Table 12 – Behavioral Health Training Calendar 2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Solutions to the Opioid Epidemic	Keynote Presentation – Opioid Addiction: Breaking Barriers with Medication Assisted Treatment (MAT). Review basic information, genetics, and the neurobiology of opioid addiction. This training will also discuss the medical standard of care for treating opioid use disorder using MAT. The SLO Opioid Safety Coalition will also present on each Action Team's accomplishments, barriers, and goals addressing the local opioid epidemic.	4	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	74	June 1, 2018	Dr. Lyn Raible and Dr. Herbert Cruz.
CANS Training	Gain Knowledge in smoking cessation issues for pregnant women, people with mental illness and substance use disorders	6	Mental Health Staff, Youth Services Staff, Supervisors and managers	62	June 29, 2018	DR. April Fernando and Chapin Hill

Table 12 Continued

Table 12 – Behavioral Health Training Calendar 2017-2018 FY						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
Crisis Intervention Training – Cultural Competence Training	In Collaboration with the Sheriff Department the CC Chairperson has been providing Cultural Competence Training once a month to law enforcement agencies		Administration/Management; law enforcement agencies	30	May 8, 2018	Stephen Braveman, LMFT and Nickolas McDaniel, LMFT-I
Crisis Intervention Training – Cultural Competence	Same as above		Same as above	30	June 5, 2018	Gerald Clare, LCSW; Patient's Rights Advocate
Crisis Intervention Training – Cultural Competence	Same as bove		Same as above	30	August 7, 2018	Star Graber Ph.D, LMFT
Crisis Intervention Training – Cultural Competence	Same as above		Same as above	30	Sept. 18, 2018	Gerald Clare, LCSW; Patient's Rights Advocate
TOTAL HOURS:		**64.5**		**1,146**		

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

C. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

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

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

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

1. All trainings in recent years were identified and developed through key stakeholder input. Our 2017 Internal Cultural Competence Survey identified the current tentative training priority (Appendix 23) and the committee also identified the same trainings, which include Trans-Training 101, Challenges/Values of Different Cultures, LGBTQ and Gender Identity Training, Poverty and Youth Training, and others. The Internal Cultural Competence Survey employed the document "Building Bridges: Tools for Developing an Organization's Cultural Competence" by La Frontera Center to measure all Behavioral Health staffs' level of competence regarding populations which have disparities in access and treatment. The results indicated a need for further training in the areas of minorities, LGBTQ members, and older adults. Trainings that focused on Co-occurring Disorders were identified through a Workforce Education and Training needs assessment and the SLOBHD Co-Occurring Taskforce. San Luis Obispo County is continuing to further integrate its Drug and Alcohol Services with its Mental Health Services divisions to better serve the needs of co-occurring population. Other identified trainings (such as law and ethics) are yearly requirements for licensed clinicians.

2. The County will be implementing material and language from the California Brief Multicultural Competence Scale (CBMCC) as part of our evaluation process for every training sponsored by the SLOBHD. We plan to develop a retrospective pre/post-test to better gauge the level of competency on a regular basis. The County will continue to develop strategies to evaluate the level of staff competence through pre and post testing over the next years. The County will access technical assistance in developing standardized measures for pre and post testing of clinical skills.

3. Overall, the clinical trainings provided by the SLBHD in the past year were well received. The majority of the trainings were evaluated using an evaluation form that participants could complete through the

SurveyMonkey.com online service. Surveys were made available to participants one day after completing the training to receive Continuing Education Units (CEU). The training evaluation form is a form of post measurement asking demographic information in regards to professional status/licenses held, work location, reasons for choosing the training, rating of the overall value of the training, and three concepts learned from the training. At the current time, the training evaluation form does not measure a level of information or skills learned.

The highest rated training was "Trans Training 101" by Dr. Jay Bettergarcia and Dr. Stacy Hutton. Over 65 individuals registered for the training and 34 participants completed the training evaluation form. For those who completed the form, 88% (30 attendees) rated the training "excellent," 8.82% (3) rated the training "good" and 2.94%% (1) rated it "fair." Concepts that participants learned included the impact of personal stories, understanding identity videos and images, the importance of vocabulary and providing agency to the client, affirmation, gender identity, and local referral resources.

Another highly rated training, sponsored by the Cultural Competence Committee, was "Using a Trauma Informed Lens" by SLO Trauma-Informed Champions of Change. There were 84 participants registered for the training and 40 of them completed the evaluation form. Of those who completed the survey, 87% (35) reported that the training was "excellent." Thirteen percent (13%), or 5 participants rated the training "good". The activities and engagement presentation allowed participants to be fully immerse on topics and definitions of trauma-informed. Due to the popularity of the training, the training continues to be schedule in the year to reach out to all SLOBHD employees and other county agencies. Participants reported a 100% increased awareness of the widespread impact of trauma, 97% is able to recognize three signs and symptoms of trauma in clients, families, staff, ourselves, and others in the community, 95% are able to identify and use one new tool to integrate trauma-informed practices and philosophy, and 95% are able to identify two ways to reduce re-traumatization in clients, families, staff, ourselves, and others.

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

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

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

SLOBHD is currently using "e-learning" to allow each staff and community provider access to competency and mandatory trainings through the use of personal computers. SLOBHD has contracted with Relias Learning to offer this service. This web-based system includes an interface with the County's human resources management software and it has the capacity to track individual staff learning.

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

The county shall include the following in the CCPR:

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

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

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

Co-Occurring Disorders and their Management Training
This workshop was led by David Mee-Lee, who is a leading expert in co-occurring substance use and mental disorders with over 30 years of experience in person-centered treatment and program development. The training main learning objectives include preparing licensed mental health professionals to provide for and respond to the psychological needs of people of various cultural and linguistic backgrounds throughout the disaster cycle of preparedness, response and recovery. Dr. Mee-Lee's past training clients have involved both provider and practitioner groups, as well as managed care organizations. Dr. Mee-Lee has presented such tools as an instrument he co-authored for individualized treatment planning, the Recovery Attitude and Treatment Evaluator (RAATE).

Maternal Mental Health
This interactive workshop addressed and described Perinatal Mood and Anxiety Disorders signs, symptoms, screening and diagnosis. Identify stigmas, biases, and how a lack of knowledge interferes with identification and intervention. Describe effective strategies to use during screening and discussions with women at risk, and list current treatment options for mood disorders during pregnancy and postpartum depression strategies. The workshop was presented by Dr. Shannon Easton-Carr, MD, MPH, who

specializes in women's mental health, and the evaluation and treatment of both pregnant and post-partum women with mood, anxiety, and psychotic disorders. Curriculum topics included: philosophy of PMAD; community partners and defined roles; components of system change; signs, symptoms, screening, and diagnosis of PMAD; stigmas, biases, and identification of screening tools, and current treatment options for mood disorders.

Using a Trauma Informed Lens

This all-day training was developed to help SLOBHD staff better understand and identify trauma and its impact. Trauma Informed Care integrates core principles of neurodevelopment, trauma, and attachment with mindful healing to support a comprehensive approach that can be used by clients, providers, and community members. The training is designed to support a shift in thinking, perception, and behavior. Looking through a Trauma Informed Lens means being sensitive to the impact of trauma on others and yourself, understanding and utilizing tools to support self and others in regulating during times of stress; as well as identifying and supporting the system change needed to reduce re-traumatization. Continuing our efforts toward a Trauma Informed SLO County will enhance resilience, increase connection and support stability within our community. The training objectives include increase awareness of the impact of trauma and understanding one path for recovery, recognize three signs and symptoms of trauma in clients, families, staff, ourselves, and others, identify and use one new tool to integrate trauma informed philosophy, and identify two ways to reduce re-traumatization.

The Journey of Hope

This three-hour training was provided by a consumer and family member to educate about local resources and services available for family members and loved ones of persons with mental illness. Additionally, this workshop developed a heightened understanding of the warning signs leading up to suicidal ideation and behavior. The featuring keynote speaker, Jennifer Storm, presented on her recovery and addiction, trauma and adversity, and identifies key component of what can help a person turn their lives around. She spoke firsthand about the complexities of biological and emotional responses of trauma, sexual assault, and the effects of substance abuse and recovery. Also, it developed an understanding of stigma, how it affects people with mental illness and how it can prevent people from accessing services. The event increased participants' awareness of the concepts of mental health wellness and recovery, including hope, empowerment, spirituality, the importance of developing a support network, and the necessity of having a meaningful role in one's community.

Trans-Training 101

The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics were presented in an informative and accessible manner. Attendees had the opportunity to engage in experiential activities, watch video clients, and observed mock therapy sessions. Attendees were taught about subtleties in language and perspective that make interactions with trans people affirming. Evaluations showed that attendees were able to identify three differences between biological sex, gender identity, gender expression, and gender attribution, they were also able to list two ways in which they can alter their work environment to be more trans-affirming, and identify and categorize a list trans-affirming language, and increase two personal skills to increase confidence in working with trans clients. The training was proctored by Dr. Jay Bettergarcia, a Cal Poly researcher and professor specializing in psychology and mental health, and Dr. Stacy Hutton, a local trans-affirming therapist. The training has also been held in FY 18-19 for its popularity.

Cultural Competence Newsletters:

The Cultural Competence Committee disseminates the Cultural Competence Newsletter on a quarterly basis. This newsletter is a venue to further educate staff to cultural considerations when working with diverse populations. The newsletters have covered topics on the following: Native American, Latino, African American, Veterans, and Gay and Lesbian (Appendix 04).

Table 13

Table 13 – Behavioral Health Training Calendar						
Confirmed Upcoming Trainings in FY 18-19						
Training Event	***Description***	***Hours***	***Attendance by Function***	***# of Attendees***	***Date***	***Name of Presenter***
ALLY	This interactive training provides a basic framework of understanding LGBTQ youth and the unique challenges they often face. This training is designed to create dialogue regarding what it means to be an adult ally for LGBTQ youth by informing participants about terminology used in the LGBTQ community, the process of "coming out" as an LGBTQ person and a discussion of the challenges faced by LGBTQ youth in their homes, schools, and communities. Through activities, participants are encouraged to	2	Family, caregivers and providers who work with families	28	8/24/2018	Shannon Dunlap, MSW and Jeremy T. Goldbach, PhD, LMSW

	explore biases, build knowledge and understanding, enhance self-efficacy, and develop empathy. In addition to providing this framework, the Ally Training offers specific action items to improve the environment for LGBTQ youth.					
Child and Family Team	The CFT model is an individualized planning and decision making process which brings a group together to collaborate and develop a plan to support the safety and wellbeing of a family. The team places the family and their goals, whether a biological family, a foster family, adoptive family or a transitional age youth-at the center of the group decision-making process. The team addresses areas of strength, need and concerns related to safety, family wellness, and/or court	5.5	CWS Social Workers/Supervisors, CASA, Faith-Based Organizations, Family Advocates, Family Care Network, Community Organizations and Providers, Foster Parents, Mental Health, Public Health, Drug and Alcohol Services, Parent Partners, Probation, Law Enforcement, Victim Witness and School Educators/Staff	13	8/24/2018 11/14/2018	Patty Ford, LMFT

	requirements. Plans are regularly adjusted to best meet the desired outcomes of the family.					
How to Support LBGTQ Youth	This interactive training provides an overview of suicide among LGBTQ youth and the different environmental stressors that contribute to their heightened risk for suicide. This training combines research, case studies, best practice recommendations and practical steps for reducing the risk of suicide and promoting resilience in all young people regardless of their sexual orientation or gender identity.	2	Educators and k-12 school staff, university staff, campus life staff, residential advisors, religious leaders/counselors, school counselors, social workers and nurses, mental health professionals, health professionals, including pediatricians and family doctors, youth service providers, other adults working with youth in professional capacities	28	8/24/2018	Shannon Dunlop, MSW and Jeremy Goldbach, PhD, LMSW
Law and Ethics	This course is a review of new legislation effecting healthcare providers and their patients including new rules affecting licensure and training, access to	6	Behavioral Health Staff/Providers	180	10/31/2018	Linda J. Garrett, JD

	records, gender issues, mandated reporters, drug prescribing and involuntary treatment. information will be provided on the new 42 CFR Part 2 substance use disorder confidentiality regulations that became effective on March 21, 2017 and February 3, 2018. The course reviews HIPAA and State law privacy and confidentiality issues, and consent and non-consent as well as a review of "hot topics" in the news and how individual free speech may trigger ethical concerns related to dual relationships and boundary issues					

LGBTQ Awareness, Sensitivity and Competency	This highly interactive training leads participants through the foundational steps of LGBTQ cultural competence, while creating a learning environment that is safe, fun, and comfortable for attendees who may have varying degrees of knowledge or comfort with this subject matter. This training gives staff members a better understanding of sexual orientation and gender identity, addresses myths and negative stereotypes about LGBTQ individuals, and helps develop core competencies towards reducing LGBTQ mental health disparities.	4.5	Providers, Organizational Leadership, Human Resources staff, MHSA/WET coordinators, Clinicians and Clinical staff, Mental Health workers, Social workers and Case Managers	30	8/15/2018	Poshi Walker, MSW

Marijuana, Alcohol and Pregnancy: Implications for Infant and Childhood Outcomes	This course is a review of new research effecting infant and child outcomes as a result of prenatal substance exposures from alcohol, marijuana, opioids and other drugs. The training will introduce and discuss national and local data; neurobiology of exposures; pregnancy outcomes; neonatal outcomes and long-term implications for the exposed child. Information will be provided about screening, assessment, diagnosis and treatment strategies for the child prenatally exposed to substances. Part of the discussion will focus on perinatal mood disorders, the use of marijuana and alcohol, and systems change efforts to prevent substance-exposed pregnancies.	5.5		250-300	10/19/2018	Ira J. Chasnoff, M.D.

Suicide Prevention Forum	The integration of personal storytelling within the larger context of educational lectures offers providers a first-hand account of recovery and survival. This program illustrates the need and importance of hearing firsthand from individuals in the transgender community as their experiences and insights may help improve practices for underserved populations. Drawing from evidence based practices within psychology, sociology, as well as physical medicine and rehabilitation, this program will address the presenter's personal experience traversing the complexities of gender transition as an individual with a complex history and layered identity. Basic suicide prevention skills will be woven in	1.5	Educators and School Staff, Community Members, School Counselors, Social Workers and Nurses, Mental Health Professionals, Health Professionals, including Pediatricians and Family Doctors, Youth Service Providers, Adults working with youth in professional capacities.	250	10/17/2018	Nathan Cannon

	to personal experiences through hearing survivors first hand accounts. Local community resources will be on hand to share specific services both before and after the program.					
Trans Training 101	: The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy sessions. Attendees will be taught about the subtleties in language and perspective that make interactions with trans people truly affirming.	4	Direct Care Staff, Counselors, Support Staff, Agency Supervisors, Managers, Resource (Foster) Parents, Social Workers, Teachers, and Law Enforcement	67	7/10/2018	Dr. Jay Bettergarcia and Dr. Stacy Hutton

Using a Trauma Informed Lens	This training is designed to support a shift in thinking, perception, and behavior. Looking through a Trauma Informed Lens means being sensitive to the impact of trauma on others and yourself, understanding and utilizing tools to support self and others in regulating during times of stress; as well as identifying and supporting the system change needed to reduce re-traumatization. Continuing our efforts toward a Trauma Informed SLO County will enhance resilience, increase connection and support stability within our community	6.5	Direct Care Staff, Therapists, Counselors, Resource (Foster) Parents, Social Workers, Teachers, Law Enforcement Staff, Support Staff, Agency Supervisors and managers	72 65	7/20/2018 9/21/2018	Cortney Wagner LMFT, Julie DeFranco MSW, L. Michele Simone LMFT, Rebecca McGarigle LCSW, MSW, Elissa Feld and Daniel Carlisle LMFT

CRITERION 6
COUNTY MENTAL HEALTH SYSTEM
COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE:
HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

The county shall include the following in the CCPR:

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 6:

3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

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

A. The Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component is included herein (Appendix 23).

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

B. Tables and analysis included in the WET Plan's workforce assessment demonstrate full-time staff-to-client ratios by race and ethnicity. An overall shortfall was indicated in the mental health workforce regarding meeting the prevalence needs within San Luis Obispo County. The County and its providers continue to work in collaboration to close the gap and provide culturally and linguistically appropriate programs to consumers who need mental health services. Our efforts for the last eight years include expanding services in Spanish and subsequently hiring more bilingual and bicultural staff. We have also strengthened our collaboration for CBOs to ensure to offer professional training opportunities to enhance knowledge and impact skills.

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

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

C. The County of San Luis Obispo did not receive cultural consultant technical assistance recommendations as part of any review of the WET Plan submission to the State. However, the County has taken part in several cultural competence capacity-building activities, funded through statewide WET initiatives. This has included attending underserved population conferences produced as part of the Southern California Regional (WET) Partnership. The Partnership has also sponsored training for County staff (and its contracted partners) on culturally-appropriate service provision, as well as workforce development tools for high school students, clinical supervision training, and a job search website.

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

D. The targets that have been reached based on past ten years of programming include:

- Bilingual clinical interns have been hired and placed in the county regionally.
- Over 75 scholarships were awarded to individuals working in the mental health field or wanting to seek employment in the field;
- Hundreds of hours of training reaching out to thousands of individuals have been provided;
- The Transitions Mental Health Association Peer Advisory and Advocacy Team is meeting weekly and provides stigma reduction education and peer counseling throughout the community;
- The Co-occurring taskforce helped integrate services, providing several trainings hosted by Dr. Mee Lee and the taskforce used his 5-part training DVD's to train over 50 SLOBHD staff during their lunch time breaks;
- Crisis Intervention Training has been provided to hundreds of law enforcement personnel; and,
- The Cultural Competence Committee has provided several trainings to support competence in the mental health field. Additional trainings have been provided to meet licensing and state regulations.

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

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

- WET funding for a training room equipped with computers and technology training aids was not originally conceived or proposed in the planning process; consequently, Behavioral Health created a designated computer training room for training.
- The development of the Electronic Learning initiative has been a morale boost for staff and has created many opportunities for staff to build capacity and for the Department to enhance its services. The SLOBHD created policy and procedures so that the product is used to an effective purpose.
- "Action 5" of the WET plan, Integrating Cultural Competence, has been adapted to provide stakeholders with better monitoring of funds. A need was identified to assure stakeholders that funds were being used efficiently, for instance training or hiring staff that were already proficient in Spanish or bicultural instead of trying to train a staff member to learn Spanish.
- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. This has included the ongoing Cultural Competence Committee work which has identified other needs as mentioned in this document, including expanding services for veterans and the LGBTQ community. This Committee has been successful in guiding training decisions and developing core competencies.

F. Identify county technical assistance needs.

F. The County has identified the need for further technical assistance in the arena of data collection, evaluation and statistical reporting to further improve SLOBHD's ability to analyze the efficacy of its cultural competence. The County has developed standardized measures to evaluate learning outcomes and best practices in providing training. It would be useful to view standardized models of pre and posttests to evaluate levels of learning in best practices and cultural competence.

CRITERION 7
COUNTY MENTAL HEALTH SYSTEM
LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

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

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 7:

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.

8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee trainings for administrative, management, and staff providing SMHS and providers.

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

A. SLOBHD has committed resources and developed strategies in each of its MHSA plans to grow bilingual staff capacity. In 2005, during the planning process for the first MHSA plan (CSS), a study was done to determine the need for increased staff capacity which would better serve the Latino population in the county. Clearly the most underserved population in need throughout the county, Spanish-speakers were often unable to access services due to limited language proficiency on the part of County and community providers. Since that initial MHSA plan, it has been the SLOBHD's goal to increase bilingual staff as the Latino population client figures have grown 8.65% since 2010.

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

Another strategy that has emerged from these MHSA discussions and studies is the need to increase the exposure of position postings. The County's Human Resources Department traditionally only advertises open positions through the county's major newspaper and its own website, neither of which are available in Spanish. Since the launch of MHSA programs, the SLOBHD has advertised its bilingual staffing recruitments in a variety of Spanish-language forums. Advertisements have been placed in "Latino Today," a web-based newspaper circulated from Santa Maria, a large city just south of San Luis Obispo County. Positions have also been advertised through presentations to local cultural organizations, such as the Latino Outreach Council and "Vision Unida." Both organizations have shared the postings with their constituents through email and mailing lists. SLOBHD has also taken advantage of multiple social media platforms to promote job postings in Spanish and English to the community.

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

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

- SLOBHD, partly due to the CSS strategy which created the Latino Outreach Program (LOP), has increased to a total of five (5) LOP bilingual and bicultural staff over the past three years.
- Other CSS programs, including the supports provided by community partner agencies, have increased overall community bilingual capacity. Programs like TMHA's peer recovery programs are now available in Spanish.
- All five of the PEI programs are being implemented in Spanish and English. For instance, the SLOtheStigma campaign and subsequent public presentations are available in Spanish; the school-based wellness programs feature bilingual and bicultural "Family Advocates;" and all parent education programs and coaches are offered in Spanish as well.

3. The total annual amount of dedicated resources for interpreter services is $15,310. This is funded by the MHSA Workforce, Education, and Training component.

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

The county shall include the following in the CCPR:

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

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

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

A. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 24): "Mental Health Services is committed to providing multi-lingual and culturally appropriate services to the diverse populations in the County including Telecommunication Device for the Deaf (TDD) and California Relay Services (CRS)."

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

2. SLOBHD has expanded its use of technology to further improve access. The Department is currently using Anazasi or Cerner as the Electronic Health Record System, and Relias E-Learning to improve training outcomes. In the Department's desire to move forward with new technology, technical assistance and support from the State and other counties' feedback will be sought.

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

1. Caller requests services in another language.
2. Staff member answering the phone identifies the language and, if Spanish, reads instructions to client in Spanish to hold while the staff member contacts an interpreter.
3. Staff member calls AT&T language Line at 800-523-1786 and asks for an interpreter.
4. Staff Member informs caller through the interpreter in caller's language that interpretation services are free of charge and then ascertains caller's needs through the interpreter. If applicable, services are scheduled with a provider who speaks the caller's language. Language and cultural requests are documented on the Service Request form.

As described in the aforementioned document (Appendix 24) the Department's language line policy consists of the following standards:

1. Interventions in alternative languages are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care database.

2. Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.

3. Interventions in alternative, culturally-competent approaches are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care data base.

4. Each clinic site has the capacity to provide services in the County's primary threshold language upon request (i.e. Spanish).

5. All new employees are given a brochure on the use of the AT&T Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure.

6. Linguistic translation and interpretation services are provided in a confidential manner. As a general policy, family members will not be relied on as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.

7. When culturally-appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.

8. If there is a need for services not currently available, the following progression of referral is followed:

a. From Therapist or receptionist to Program Supervisor.
b. Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.

4. All new employees are given a brochure on the use of the Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure. Additionally, The After-Hours Crisis Worker on the Psychiatric Health Facility (PHF) is currently training all PHF staff in the use of the Language Line.

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

B. SLOBHD clients are informed in writing in their primary language, of their rights to language assistance services. Clients are informed of the right to free interpretation services via the Language Line and an option available on the Service Request (Appendix 32). This information is also posted in the Lobby of each SLOBHD center (Appendix 25).

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

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

C. According to SLOBHD's Bilingual Certification Policy (Appendix 26) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services." This is exhibited in the following procedures and practices.

1. Staff at SLOBHD routinely make accommodations to persons who have LEP, getting help for consumers and family members who need bilingual staff or interpreter services.

The Department also has staff certified in American Sign Language (ASL). Knowledge of those language and interpretation skills possessed by all members of the organization has increased the Department's capacity to meet the needs of a diverse population.

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

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

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

E. Identify county technical assistance needs.

E. San Luis Obispo County Behavioral Health would be interested in any developments which may increase the County ability to provide services to persons who have Limited English Proficiency (LEP) using technology. The Department does not have staff capacity to develop computer or telecommunication solutions to this issue but would welcome technical assistance made to increase the County's awareness

of technological solutions – such as expanded telephone services, video-conferencing, and other web-based language communication technologies.

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

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

The county shall include the following in the CCPR:

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

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

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

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

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

A. The flier displayed in each Mental Health center countywide (Appendix 25) demonstrates SLOBHD's availability of interpreter and/or bilingual staff availability for the languages spoken by community. Signs in Spanish and English indicating the availability of free translation services and help with paper work are posted in the lobby/reception area of each County Mental Health Services center.

B. The standard Service Plan (Appendix 32) demonstrates that SLOBHD's interpreter services are offered and provided to clients and the response to the offer is recorded. Once interpretation services are offered, the offer/response is documented on the Service Request. Additionally, Care Plans, Master Service Plans, and Progress Notes each document whether interpretation services were utilized. These forms are available for review upon State site visit.

C. The included list of bilingual staff (Appendix 31), as well as the County client services brochure (Appendix 29) demonstrates that SLOBHD provides contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

D. According to SLOBHD's Bilingual Certification Policy (Appendix 26) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services." The following procedures are in place to monitor and certify bilingual staffing:

Procedure:

1. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).
2. The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members, at least one of whom is a native speaker of the threshold languages in the county.
3. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a total of 100. The checklist will include, but not be limited to:

a. Fluency, the ability to communicate with ease, both verbally and non-verbally.

b. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.

c. Grammar, appropriate use of tense and grammar.

d. Cultural considerations related to potential client.

4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.
5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

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

The county shall include the following in the CCPR:

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

According to SLOBHD's Services for Provider List Availability Policy (Appendix 30), "Mental Health Services provides clients with a list of specialty internal health providers upon first receiving mental health services, upon request, and on an annual basis." The Culturally Competent, Multi-Lingual Services Policy (Appendix 24) adds important procedures which assure clients receive the services they seek.

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

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

B. The following procedure, from the Services for Provider List Availability Policy (Appendix 30), outlines how clients who do not meet the threshold language criteria are assisted to secure, or linked to culturally and linguistically appropriate services.

Procedure

1. Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations and telephone numbers of current contracted providers in the beneficiary's service areas by category.

2. Each service site has a list of service providers available and will provide this list to any applicant upon request.

3. Upon completion of an application for services at the time of the first specialty mental health service, the applicant is offered a list of service providers.

4. The offer of this list is confirmed by the therapist or support staff checking the box labeled "list of service providers available to applicant" on the application form.

5. The list of providers is available at any time upon request at all service sites and offered on an annual basis. The annual offer of the list is recorded on the Application for Services.

The Culturally Competent, Multi-Lingual Services Policy (Appendix 24), adds the following procedures which assure clients get the culturally and linguistically-specific services they seek:

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

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

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

C. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 24), the following procedures are in place to assure the Department complies with Title VI of the Civil Rights Act of 1964, including the above-mentioned requirements:

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

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

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

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

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

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

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

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

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

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

Member service handbook or brochure:

1. The County provides Media-Cal beneficiaries with a Beneficiary Handbook (Appendix 40) and other informing materials at the time of admission into the system, annually thereafter, and at any time upon request. The Beneficiary Handbook policy specifies that these materials are available in Spanish and for disabled clients. (Appendix 33).
2. An example of general correspondence template is included herein (Appendix 31).
3. Beneficiary problem, resolution, grievance, and fair hearing materials are included in the Beneficiary Handbook and the Department's Grievance Process materials (Appendix 45).
4. The Latino Outreach Program has created a satisfaction survey used for both Medi-Cal beneficiaries and community clients. This questionnaire is included (Appendix 11); along with results from the past year (Appendix 35).
5. The Department's Informed Consent for Medication form is included (Appendix 36).
6. The Department's Confidentiality and Release of Information form is included (Appendix 37).
7. Service orientation for clients includes information about specialty services, including the Latino Outreach Program. The brochure provided for consumers and the community is included (Appendix 38)
8. SLOBHD makes several publications and mental health education materials available to the public and the clients visiting each of its centers. An example of materials is included in the Lobby Materials Checklist (Appendix 39).
9. The Lobby Materials Checklist (Appendix 39) and Policy for the Distribution of Translated Materials (Appendix 46) provide further evidence of appropriately distributed and utilized translated materials.

B. The County requires staff to accurately document that clinical findings/reports are communicated in the clients' preferred language. Bilingual staff are required to document key findings and reports for clients using their preferred language within the Master Service Plan (Appendix 32). Elements of the plan which are written in both English and Spanish include desired goals, target symptoms and functions, and objectives. This material is reviewed with the clients.

C. As referenced above, the Department's Latino Outreach Program is utilizing a consumer satisfaction survey translated in the threshold language of Spanish (Appendix 11); and results from the past year are provided herein (Appendix 35).

D. As per the County's "Readability of Medi-Cal Informing Materials" Policy (Appendix 47), San Luis Obispo Mental Health Services periodically involves clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level. The Patients' Rights Advocate periodically meets face to face with a representative sample of beneficiaries and guides a process for reviewing the Handbook for readability.

SLOBHD does not currently have a further mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing). Current practice involves consultation with the Department's Ethnic Services Manager to assure necessary documents are made available in Spanish, and that consumers can access needed information. This process will be explored by the Cultural Competency Committee over the next year. SLOBHD has established a Translation Committee led by the Ethnic Services Manager, Nestor Veloz-Passalacqua, and other members of the Cultural Competence Committee and bilingual/bicultural staff. The Translation Committee ensures that translated materials are at an appropriate (6th grade) reading level, and that necessary documents are made available in Spanish. This process will be explored further by the Cultural Competency Committee over the next year.

CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

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

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

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 8:

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.

SLOBHD is committed to providing opportunities which enhance client-driven recovery and wellness programs (Appendix 48). The County has established critical partnerships with community-based recovery and wellness programs to expand the capacity of the mental health system to provide culturally appropriate recovery services.

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

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

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

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

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

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

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

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

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

TMHA offers **Peer Support Groups** run by and for people with mental illness. The groups provide peer-to-peer interaction, the sharing of stories, education, and a sense of community. Currently groups are run in Arroyo Grande, San Luis Obispo, and Atascadero. **Peer-to-Peer** is a formatted peer support group for any person with serious mental illness who is interested in establishing and maintaining wellness. This nine-week course (two hours per week) developed by NAMI uses a combination of lecture, interactive exercises, and structured group processes to explore recovery. Peer Support Groups are held at TMHA's Wellness Centers.

1. The County has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences. As described throughout this Criterion section and subsequent Appendices, the County has policies and practices in

place (including those with its community partners) to provide language support along with alternatives which meet a minimum standard of cultural competence.

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

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

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

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

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

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

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

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

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

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

Currently, the County does not have a uniform listing of available alternatives and options of cultural/linguistic services that can be provided to clients upon request. To begin addressing this need, SLOBHD promotes the use of interpretation services for our threshold language population and has streamlined a process to set appointments for Promotores to assist clients as needed, which increases access to services. SLOBHD is also conducting an LGBTQ Needs Assessment to better understand how to reach and provide the appropriate services to the community. SLOBHD's current efforts are designed to provide us with information on how the recommended alternative services in the community can meet the County's standards of service.

A. The primary resource provided to clients is the SLOBHD Mental Health and Drug & Alcohol Services brochure in English and Spanish (Appendix 29). This lists all local programs and services known to meet the mental health and wellness needs of clients within the mental health system. The Provider List includes language and cultural services as well as any other alternative supports available. This list is available to all SLOBHD Mental Health Services clients.

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

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

- The Human Services and Support Groups Directory published by Hotline/211 (local crisis prevention/intervention phone services, although the publication is no longer in print).
- Contact information for LGBTQ resources including PFLAG (Parents & Friends of Lesbians and Gays) www.pflagcentralcoastchapter.net; GALA (Gay and Lesbian Alliance of the Central Coast) www.ccgala.org; Tranz Central Coast http://tranzcentralcoast.web.officelive.com.
- Spiritual resources including all church services found in local directories, drumming circles found in the New Times (popular alternative weekly newspaper), and Salinan Tribe of San Luis Obispo (http://salinantribe.com/)
- Drug and alcohol recovery resources including lists and schedules of all local 12-Step (AA, NA, Al-Anon, etc.) which are available at each SLOBHD site; Christian-based 12-step groups, such as

Celebrate Recovery at ABC Church in Atascadero, and specific neighborhood recovery centers such as North County Connection - (Alano club, 12-step & general info.) http://www.northcountyconnection.com/meetings.html.

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

B. The County informs clients of the availability of the above-mentioned listings primarily via the Beneficiary Handbook and the Provider List of Behavioral Health Clinics and Contract Providers (Appendix 30) and the Member Services Brochure which will include all alternatives and options described in the previous section.

The Beneficiary Handbook is given to MediCal beneficiaries at their intake assessment and subsequently annually thereafter. SLOBHD Policy 2.04 (Appendix 33) outlines the Beneficiary Handbook protocol, which includes the engagement of clients regarding linguistic and cultural treatment options, as described in the Provider List. The Provider List Policy 11.17 (Appendix 30) states that "Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations, and telephone numbers of current contracted providers in the beneficiaries' service areas by category."

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

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

C. The County conducts several practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. These practices include internal policies which mandate staff to provide information regarding available services under consolidation of specialty mental health services, as described in the previous section. The County informs clients of the availability of the above-mentioned listings primarily via the Beneficiary Handbook and the Provider List of Behavioral Health Clinics and Contract Providers (Appendix 40 and 32).

Therapeutic Behavioral Services (TBS) are a specialty mental health service for children and youth under age 21 receiving EPSDT mental health services who are placed in or are being considered for Rate Classification Level 12 or higher; **or** have received psychiatric hospitalization in the past 24 months; **or** are being considered for psychiatric hospitalization. SLOBHD held forums (Appendix 41) to educate the public and providers as to how these services are engaged. Materials for these forums were distributed in English and Spanish.

Other efforts include outreach services, including those of the **Latino Outreach Program** (LOP). As described in Criterion 3, LOP engages the Latino and monolingual community during the year so that Medi-Cal beneficiaries (including those yet to engage the system) are made aware of the cultural and linguistic capacities of the mental health system locally.

County partners, such as Transitions Mental Health Association (TMHA) and Family Care Network, Inc. (FCNI) utilize professional websites which disseminate information regarding specialty mental health services. FCNI's website provides information regarding its provision of **TBS services** (http://www.fcni.org/about/services/family-support). TMHA's website (http://www.t-mha.org/main/main_ps_hs.html) outlines services including their **Supported Employment Program** (SEP), which provides on-going job support services necessary for individuals with mental illnesses to choose, receive, and keep competitive employment while working in jobs and environments they prefer and with the level of professional support they desire.

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

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

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

1. The SLOBHD maintains a Provider List of Behavioral Health Clinics and services available to all the community (Appendix 29). This document is available to clients and the public, and includes information about provider services, operating hours, and location including access points near public transportation. Each County facility offers the public current and relevant public transportation informational brochures and schedules. Some providers have contracted services with local transportation companies, outside of the scope of County services.

2. The SLOBHD clinics and offices are ADA compliant and accessible to all citizens. The Department maintains a Provider List of Behavioral Health Clinics which includes information about provider services, language capacity, and ADA access. Department and provider sites are warm, comfortable, and inviting to persons of diverse cultural backgrounds.

3. The County has been a progressive leader in developing collaborative and integrated services for several years. Systems Affirming Family Empowerment (SAFE) is the County's foundational integrated services system and continues to offer community members access to integral social and health services in warm, neighborhood settings.

The SAFE Children's System of Care has been evolving since the original Healthy Start Programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) Children's System of Care grant

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

The County's Mental Health Services and Office of Education have a long history of collaborative programming for Seriously Emotionally Disturbed (SED) children. Mental Health has a contract with many school districts to provide Mental Health services in classes for children designated as SED. The County continues to provide AB3632, Individual Education Plan (IEP) driven services for children that qualify throughout the SELPA. Collocation allows for coordinated treatment planning. As a Children's System of Care County, the values of family inclusion, strength, and needs-driven services provided in the community by culturally competent trained staff permeates the entire system.

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

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

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

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

A. Each of the County's MHSA plans has outlined the critical link between community provision of service and the need to improve cultural competence throughout the mental health system. As described in previous sections of this document, the original CSS plan for the County created the Latino Outreach and Engagement Program (LOP), which focused the County's attention on improving services for monolingual and bicultural consumers who made up the county's most significant disparity. This service is provided by

a community organization which has a unique capacity to provide quality mental health services in both a linguistic and culturally competent manner.

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

> ***Cultural Competence:*** *Describe your organization's cultural competence in program approach, staffing and organization governance.*
>
> *A. Describe how services proposed will meet the requirements of cultural competence set forth the County's PEI plan.*

Subsequently, contract language for those receiving funding includes the following in the Special Conditions section, Exhibit E (Appendix 42):

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

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

B. In 2009, all Mental Health Services staff were asked to participate in the California Brief Multicultural Competence Scale (Appendix 43). This survey was sent to all staff via email, and returned surveys were kept confidential. This survey assessed staff comfort and proficiency with handling issues of cultural competence.

As part of the County's Behavioral Health Department efforts to ensure cultural competence, the committee, in collaboration with Cal Poly, conducted a Cultural Competence Study and Survey in fall of 2017. Results from the study allowed the Committee to concentrate efforts in developing a training list that addresses the employees' experience and needs to better engage our community (Appendix 44).

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

C. The following paragraph from SLOBHD policy 11.07, Grievance Process (Appendix 45), details how the complaints, grievances, and appeals are reviewed and analyzed (See page 2, No. 9.):

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

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

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

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Mission

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

Reference:
Welfare and Institutions Code, Section 5600

Departmental Goals

1. To save lives and preserve the safety of individuals with mental illness and the community.

2. To help individuals with mental illness be as functional and productive as possible in the least restrictive and least costly environments.

3. To prevent or reduce the societal problems and high costs to other social services, educational and law enforcement organizations that can result from lack of treatment for the individuals with mental illness.

4. To help clients with emotional trauma and psychological difficulties transform their lives into healthy and contributing citizens.

5. To provide cost effective mental health services to community residents.

6. To ensure equal access and culturally competent services to the diverse populations in the county.

7. To treat clients with respect and with consideration for their privacy and dignity.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 02/27/2009
Revision dates: 02/27/2009, 10/12/2012

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

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

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

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

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

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

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 2/27/2009
Revision dates: 2/27/2009

Appendix 02

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 2/27/2009
Revision dates: 2/27/2009

Appendix 02

Workforce Training Education Plan
Action #5 – Title: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff:
Description:
While cultural competence is embedded in all actions of the WET Plan, this action focuses on specific technical assistance and trainings necessary to achieve Cultural and Linguistic Competency within the public mental health system. We will be coordinating the BHS Cultural Competence Committee comprised of direct care staff from Behavioral Health Services, Drug and Alcohol Services, Gay and Lesbian Alliance (GALA,) Community Based Organizations, consumer and family members. This committee will create the cultural competency plan and develop recommendation for a year-round training plan. As this training program is completed, additional training needs will be identified and supported. Also covered will be the cost of a refresher course for interpreters, specialized training focused on the County's various ethnic populations, and attendance at State-wide Cultural Competence trainings.

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

The California Brief Multi-Cultural Competence Scale (CBMCS) and Training Program will be an integral component of the training curriculum for staff. The CBMCS is designed to measure and improve the self-reported multicultural competence of mental health service providers. Training will focus on the disparities identified in the planning process and work with administration and programs to apply the strategies created in the Community Services and Support (CSS) plans. Trainings will also include continued culturally focused discussions with community-based organizations, community agencies, community leaders, clients and family members for their perspectives on the cultural aspects of the organization's MHSA and cultural competence plan. Trainings will consult with the Multi-Cultural Services Development Center of the California Institute for Mental Health (CiMH.).

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

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

JULY–DECEMBER 2017

CULTURAL COMPETENCE newsletter

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Appendix 04

CULTURAL COMPETENCE

Mission

Dear Reader, am delighted to introduce this new Cultural Competence newsletter. The Cultural Competence Committee (CCC) intends to make it a regular publication and use it to keep you informed with news and developments related to the County of San Luis Obispo Behavioral Health Department Cultural Competence Committee and its work. In this and future editions, we will be reporting information regarding mental health and the efforts made to ensure culturally and linguistically competent services and programs in our community. We shall also include details of the current committee members, and specific topics related to mental health as it applies to cultural competence.The Cultural Competence Committee was formed in 1996 and it currently consists of staff members from various programs of the Behavioral Health Department as well as community partners. The CCC continues to assess, advise, implement, and monitor policies and practices which assure effective services are provided in cross-cultural situations. The committee members, representing diverse cultural backgrounds and other special interests, will continue to provide input and insight in order to make the next Cultural Competence Plan an active document, which will inform the County's mental health system for years to come.

As the new fiscal year continues to unravel, we are excited to announce that we will be working closely with community partners and experts to launch trainings in the upcoming year. Our first training will focus on trans-youth and mental wellness and it will consist of two sessions covering information pertinent to mental health, youth, and physical health. As we move forward, we can't wait to share more information and the work we do to better serve our community.

Sincerely,

Nestor Veloz-Passalacqua, M.P.P.

Cultural Competence &
Ethnic Services Manager

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Committee MEMBERS:

Nestor is originally from Peru and moved to the U.S. in 2004. He has traveled through South America, Europe, and Asia and has had the opportunity to fully engage culturally and linguistically. He earned his bachelor's degree in Ethnic Studies from Cal Poly-SLO in 2011, and his Master of Public Policy in 2016. He has worked closely with the Latino population in the educational and health service fields. He is currently the Administrative Service Officer for the Prevention & Early Intervention division, and the new Ethnic Services Manager and currently appointed Cultural Competence Coordinator.

Nestor believes that cultural competence is an important framework that allows to build culturally and linguistically appropriate services and programs that responds to a community various backgrounds and needs. Nestor envisions cultural competence as an active and ever-evolving influential component for public and private organization to engage their community through activities, workshops, and events based from integrative and informed decision making.

Nestor Veloz-Passalacqua
Cultural Competence & Ethnic Services Manager

Maria Troy
RN, BS, MPA

Maria was born in Mexico, immigrated to the U.S. at age 11. Fluent in Spanish and English. Retired from Atascadero State Hospital after 24 years working as a Psychiatric Registered Nurse and as a Nurse Instructor. Volunteer with the Promotores, a program of the Center for Family Strengthening in San Luis Obispo County.

I believe that Cultural Competence is important for the effectiveness of the way that services are provided in our community. The Promotores function as a liaison between the Latino community and resources available to them of which they may not be aware due to barriers such as: language, legal residency status, unfamiliarity with the health care system, lack of medical insurance, cultural beliefs regarding mental health, and health in general.

I believe in a humanistic, inclusive model of treatment and advocacy for consumers as well as a supportive helpful milieu for clinicians. As Editor of the Central Coast Psychological Association newsletter (up to 50 pages quarterly since 2012) we achieved the outstanding newsletter award of 2017. I am a member of the California Psychological Association (CPA) which has a progressive stance to societal issues. Their latest magazine addresses the role

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of gender and CPA has been on the forefront of LBGT rights for many years. In the past I held positions in the Alameda County Chapter and now the San Luis Obispo Chapter. I am a 2018 candidate for a Director at Large position for CPA.

A past team leader in community mental health, adjunct instructor at Antioch West in 1990s, staff psychologist in the Dept. of Corrections, contract psychologist at various non-profits for children and adults , victims and perpetrators of sexual assault, and deprivation, neurologically disabled young adults, California Dept. of Disability Evaluations (for over 25 years) , I am currently in private practice. In the 1970s and 80s I worked with refugees from SE Asia: the Hmong peoples, political refugees from Afghanistan and with African American families in foster and relative care due to the crack cocaine epidemic. Currently there is a wave of political refugees and I am in the process of further writing on the experiences of an 89 year old survivor of the Nazi invasion of what is now a Ukrainian country.

The American Psychological Association, of which I have Life Member status, made egregious mistakes in supporting and designing a torture regimen of individuals at Abu Graib prison. I believe we must learn from this and take a forward stand to ensure that clinicians are serving the public well. In my long career I have observed many instances of patient neglect, mistreatment, and abuse. Populations have often been African American, Hispanic, LTBG as well as economically deprived persons across all races. I helped arrange training of staff through the Patients Right Dept.; in a county mental health program in the late 1980s to better serve LGBT clients as a result of a crisis case I was working with. I believe I have stood up for the clients when I have seen these abuses at cost to myself of retaliation, feelings of alienation and emotional distress also that I am willing to address my own lack of knowledge /competence in a clinical or personal area.

I carry all these experiences into my daily work. As a member of the Cultural Competence Committee in San Luis Obispo County I address with the members ways to engage and serve diverse cultures, race, and gender identifications with trauma -informed quality mental health treatment. I believe to not do so is to collude with mediocre care. I am proud to have the opportunity to meet with San Luis Obispo County Behavioral Health team as they are consumer driven reaching for quality in their service delivery. E.g. The Promotores system is a competent and humane way to help Spanish speaking consumers in this county.

Taking on another culture through a 38 year marriage I encountered not only the experience of being a forward professional woman in a patriarchal society but also the differences of living in another cultural reality. Through the latter I again learnt of the inadequacy of a private/insurance mental health system that is not acculturated to a European male dominated society and I have written on this experience.

Marne Ann Trevisano

Ed.D. Ph.D. Psychologist

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Lisa Huet, LCSW, is a full-time Program Supervisor at Family Care Network Inc. as well as a part time instructor at Cuesta College. Lisa has lived in San Luis Obispo, California for the past 34 years. She has worked in many different fields before deciding to resume her education and become a Social Worker. She began by attending Cuesta College part time, and later transferred to Cal Poly where she completed a Bachelor of Science in Psychology. She then attended a Masters Degree Program in Social Welfare at UC Berkeley. While at Cal Poly, Lisa worked for the Department of Social Services in San Luis Obispo County as a Parent Educator. While at UC Berkeley, she completed fieldwork in Hospital settings, first at Kaiser San Francisco, and then at Lucile Packard Hospital for Children in Palo Alto. After graduation, she continued to work at DSS and soon was introduced to Family Care Network Inc. and hired as a Social Worker and Therapist there. She was promoted to Supervisor in 2005. She really enjoys seeing the success that clients and family served through this agency experience, and she continues to appreciate each new challenge as they present themselves. At this agency, Lisa is also responsible for several trainings, including Cultural Competency and Diversity, a topic that passionate her. Twelve years ago, Lisa became licensed as a Clinical Social Worker (LCSW). Around this time, she also worked for Hospice Partners in San Luis Obispo for about a year, and began to teach at Cuesta College as well. Lisa loves to teach, travel, exercise, be in nature, explore museum, and listen to and play music.

Lisa Huet
Wrap Program Supervisor

Amber Trigueros
M.H. Therapist IV

Amber Trigueros is bicultural by heritage of African-American and Mexican lineage. She has had the honor of traveling extensively in Argentina, Africa, Mexico and Canada. Amber has been an enthusiastic member of the cultural competence committee as she believes building culturally and linguistically competent staff will lend itself to providing first class treatment to the under-served within the community.

Amber Trigueros is a Licensed Marriage and Family Therapist who has enjoyed working as a clinician in various programs within the Health Agency of San Luis Obispo County. She graduated from San Diego State University, with a Bachelor of Arts in Psychology and minor in Africana Studies. She attended Pepperdine University and completed a Masters of Arts in Clinical Psychology with a Specialization in Marriage and Family Therapy. She has a wealth of experience offering drug alcohol services and mental health treatment to youth and adults. She commenced her career with the Health Agency of San Luis Obispo County in 2008 within the Mental Health Services Act, Full Service Partnership Program. She presently is working in the Managed Care Department for both Drug and Alcohol and Mental Health Services.

Dr. Jay Bettergarcia, PhD, is a Counseling Psychologist and an Assistant Professor in the Psychology and Child Development Department at California Polytechnic State University, San Luis Obispo. Dr. Bettergarcia's research explores internalized stigma and minority stress as it pertains to LGBTQ

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mental health and wellness, evidence-based models for diversity training, and affirming therapy with transgender and non-binary clients. Dr. Bettergarcia has worked in community mental health for a number of years. Currently, Dr. Bettergarcia is working with a group of students and community partners on the Queer C.A.R.E.S. Project (Community Action, Research, Education, & Support) to identify barriers and improve access to affirming mental health services for LGBTQ+ youth and adults across San Luis Obispo County.

I believe cultural competence means that providers are able to thoughtfully and respectfully assist and support individuals while acknowledging and truly valuing the clients' diverse constellations of identities. Our ability to support the mental health needs of our communities requires that we are aware of our own biases, knowledgeable about communities that are different from our own, and that we have the skills necessary to provide these services. Our communities deserve nothing less!

Dr. Jay BetterGarcia
Director of the Queer Community Action

Leah DeRose
M.H. Therapist IV

I graduated from California State University, Chico with my Bachelors and Masters in Psychology. After graduating, I began working for Glenn County as a therapist and was there for four years before moving to San Luis Obispo. I was hired as the Juvenile Hall therapist for San Luis Obispo County and then accepted the position as Patients' Rights Advocate less than a year later, in August 2014. I have been in this position for three years now and have enjoyed learning the Patients' Rights Advocate role, as well as continuing to develop and grow it. Recently I became the Patients' Rights Advocate for Drug and Alcohol Services and am enjoying the opportunity to develop this new program. I also opened my private practice a little over a year ago and enjoy working with college students and young professionals in reducing anxiety and depression.

I am married with three girls and enjoy the beach, bike riding, reading, hiking and spending time with friends and family. We recently bought a fixer upper home and as a family are excited to renovate it. We have goats, chickens and cats and dogs, which have kept us busy, if we weren't already!

Laura Gabriela Zarate is an Executive Assistant for Jeff Hamm, Director of the Health Agency and for Anne Robin, Administrator for Behavioral Health. She has worked for San Luis Obispo County for 15 years. Laura was born in Guadalajara Jalisco, Mexico and was brought to the US when she was 8 years old. Her father who is now retired, was a farm worker for 20 years and her mother worked as a seamstress in a sports-clothing factory. Laura is proud to have both Nationalities and is fluent in both English and Spanish. Enjoys helping the Spanish-Speaking community as well as translating documents into Spanish. Thanks to her background, Laura understands the difficulties and challenges the migrant community faces daily as well as the stigma around Mental Illness in the Hispanic community.

Laura Gabriella Zarate
Health Agency Secretary

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Monica Reyes
Staff Support

Monica is a 1st generation college student at Cal Poly. Before beginning her college career, Monica lived abroad for a year. Immersing herself in different cultures such as Dutch and Polish, Monica thrives in sharing and learning about different cultures.

Cultural Competence is important in order for a community to work cohesivley. Understanding the needs of different groups within the community is the first step to provinding the resources and information to the communtiy as a whole.

Ellen has identified as a community organizer from an early age, inspired first in the '70s by Ralph Nader, Bella Abzug and the first Earth Day. In 1994, Ellen moved to San Luis Obispo to work as its first County Franchise Administrator, providing consumer protection involving cable television and solid waste services. She also helped establish the county's first off-leash dog park as well as the Coastal Alliance on Plant Expansion, which spotlighted the proposed Morro Bay Power Plant enlargement's adverse impact on the national estuary and air quality.

Spurred by the passage of Proposition 8, Ellen turned her attention to full-federal equality for the LGBTQ community. Recently returned to the Central Coast after a decade away, Ellen is focused on LGBTQ work, seeking to enhance communication, coordination and collaboration among San Luis Obispo area queer groups. She serves as a member of the San Luis Obispo Police and Community Together initiative (The PACT) and advocates for the LGBTQ community's integration into the County's mental health services.

Why Cultural Competency Is Important
In order for us to engage in creating a better community for all, we must make sure we are including all of us. This often means getting out of our comfort zone, and learning more about the most vulnerable amongst us. When we are employed through a government agency, non-profit organization or business, we have a special responsibility to serve all in the best way possible. Cultural Competency helps make this happen.

Ellen Sturtz
GALA Volunteer

Kiana Shelton
ACSW Therapist IV

Kiana Shelton is an Associate Clinical Social Worker with the Health Agency of San Luis Obispo serving as a Mental Health Therapist. Kiana received the Diversity Leadership scholarship at Concordia University, Irvine, where she was responsible for coordinating programs throughout the year that celebrated diversity. After she received her BA in Psychology/Anthropology; Kiana received the California Title IV-E Stipend for graduate school.

During her time at California State University, Dominguez Hills, Kiana served on the Critical Race Theory committee; which focused on obtaining research and advocating for ethnically diverse representation among employees in settings that serve the public. Kiana Shelton also enjoys educating

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the community through the visual arts as a painter and member of the San Diego Social Workers; a collective of social artists who seek to create literacy, understanding and inspire solidarity within youth and communities through education and creative arts.

Other Members:

Kim Mott, Program Supervisor Drug and Alcohol

Jill Rietjens, LMFT Mental Health Program Supervisor

Anne Robin, LMFT Behaviroal Health Administrator

Bonita Thomas, PAAT Member, Peer Advisory and Advocate Team

Frank Warren, M.P.P.Division Manager, Prevention & Outreach Behavioral Health Department

Appendix 04

FEATURED I

Suicide and Aging

Marne Ann Trevisano - Ed.D. Ph.D. Psychologist

Angels come in all places not just on the Cultural Competence Committee who contacted me with condolences when my husband John died. Another angel I met was a presenter at a conference on suicide given by the Central Coast Psychological Association in conjunction with Transitions Mental Health 6 months after my husband's death. I continue to see this psychotherapist. It saddened me that I was a psychologist feeling I needed to be around persons familiar with suicide. (I had gone to Hospice in SLO immediately following John's death for 10 sessions they were going to run a group but wanted to serve younger survivors. I could not readily go to a group for widows at the Hospice in my community as I had already referred several of my clients there.)

My grown married children came to the open house after my husband died and my daughter who lives in Illinois stayed a week which is the last time she has come to visit. Her husband travels most of each week; she works from home and has two school aged children. My son came out from the Bay Area and said he would help but lives 4 hours away working up to 6 days a week.

When raising children I was busy working as a psychologist and teaching evenings at a local college. There was joy, energy, and hope during the 1960s when John, my Sicilian husband, fought to have Hispanic and African American applicants to be employed in the adult and juvenile services of Contra Costa County also with union fights for proper wages. Earlier he had been involved with rights for farmworkers. We kept moving south out of concern for poor urban schools in Oakland for our son, but found that moving to safer schools and better areas did not fix the family issues. A Sicilian man does not readily engage in family therapy as sharing of personal matters is not culturally acceptable. John was also involved in Gay rights standing in front of the Atascadero Post Office in about 2006 when there was a push for acceptance of Gay marriage. Therapists, I saw and who he would reluctantly see, did not understand the culture from which he came and the importance of the 'Bella Figura' which meant one always was supposed to have a sociable countenance and hide one's feelings. Just like sheep in Scotland learn over generations to known their own boundaries, even without walls, a Sicilian had to learn to hide his truth from others due to the many island invaders who had to be adjusted to. Life raced by as my husband had a chronic heart disease and was unable to work. Finances were a struggle as we dealt with a grown child with chemical dependency issues and the care of his child .I put off retirement and still work part time. Eventually we had some time and at my husband's wish took a cruise in 2011 taking our grandson along at which time a growth was removed from John's back , in 2014 another growth on his rib cage turned out to me a recurrence of melanoma which John knew had a very bad prognosis.

Yesterday I met with a psychiatrist I was interviewing for an article in the newsletter I write, and he talked of giving oneself up to a higher goal: To meditate and engage in mindfulness practices. I agree with him as certainly focusing only on one's losses is painful. Meaningful work, social involvement and love do help with aging. However I believe attachment to another may be the only truth and solace. Sexuality continues throughout the lifespan. The table below does not address sexuality which I believe is a major factor in adult adjustment and one that I am addressing for the older client in my practice. E.g. Effects of medication on sexuality and education about sexuality in general. Essentially life is always in process, relationship is a fundamental need and there is never a time one can give up; when one's life is complete.

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Table: Suicide in Older Adults

- Depressed older adults, tend to use health services at high rates, engage in poorer health behaviors, and evidence what is known as "excess disability."
- Older adults have the highest rates of suicide of any age group, and this is particularly pronounced among men. Some late-life problems that can result in depression and anxiety include coping with physical health problems, caring for a spouse with dementia or a physical disability, grieving the death of loved ones, and managing conflict with family members.
- Specific factors in domains of psychiatric illness, social connectedness of the older person with his or her family, friends, and community, physical illness and functional capacity appear to influence risk for suicide. They in turn operate against a backdrop of individual's culture, personality, and neurobiological milieu.
- Psychiatric illness is present in from 71% to 97% of suicides, with affective disorder being the most common. In particular, major depression is most closely associated.
- Psychiatric illness, physical ill health and functional impairments contribute to risk for suicide in later life. Studies have consistently found that individuals with malignancies (other than common skin cancers) are at approximately 2 times greater risk for suicide than those without .Other diverse conditions such as HIV/AIDS, epilepsy, Huntington's disease and multiple sclerosis, renal and peptic ulcer disease, heart and lung diseases, spinal cord injury and systemic lupus erythematosus have also been found to be associated with increased suicide risk in some studies. Risks for suicide associated with these conditions are in the range of 1.5 to 4 times higher.
- Perceived health status may ultimately prove to have greater salience to late life suicide and its prevention than objective measures, just as has been observed in association with natural death and all-cause mortality.
- Frontal executive function may be particularly pertinent to suicidal behavior in older adulthood because of its role in effective management of stressful circumstances. Social connectedness as a buffer that serves to reduce suicide risk. Indeed, the Centers for Disease Control has identified as a key strategy for preventing suicidal behavior at all ages "the promotion and strengthening of connectedness at personal, family, and community levels"
- The Interpersonal Theory of Suicide articulated by Joiner and colleagues offers one way of understanding the relationship of social connectedness with suicide It proposes that there are two proximal causes of the desire for suicide -- thwarted belongingness and perceived burdensomeness -- with a particularly dangerous level of suicidal desire resulting from the simultaneous presence of both factors. In the presence of an acquired capability for suicide (e.g., prior experience with pain or well developed "need to belong reflected in indices of social isolation that have been empirically linked with late life suicide such as living alone, loss of spouse, loneliness, and low social support.
- Spirituality and religiousness have been cited as protective factors against the development of the depression and suicidality a relationship that might also be understood as a function of connectedness at a spiritual or instrumental level (e.g., support provided to an isolated elder by their faith community.)
- As well, differences in suicide risk as a function of gender and race/ethnicity with aging might be understood in part by the stronger ties to supportive others that woman and some minority communities have capacity to establish relative to men and white race groups in general.
- Genetically mediated abnormalities in central nervous system processes predispose individuals to act impulsively and aggressively in the face of dysphoria, hopelessness, and emergent suicidal ideation in the depressed state. Furthermore, they suggest a possibility that age-related changes in these systems may further account for the rise in suicide rates in later life, particularly if these differences were shown to be more pronounced in men than women.
- The older population's tendency to use more immediately lethal means with greater planning and determination the implications are clear: interventions to prevent the development of the suicidal state are especially critical in this age group.
- Collaborative care delivered by primary care providers informed by mental health expertise has shown promise as an indicated preventive intervention, although its effect in reducing suicide among elderly men remains to be determined.
- Consideration must be given to universal preventive approaches such as restricting access to highly lethal means by at-risk elders and changing attitudes and biases that inhibit older adults from accessing effective and affordable mental health care
- Cognitive activity prolongs life. About 16% of the population over 65 is employed.

Adapted from Psychiat Clin NorthAm.2011 June; 34(2):451-468 and American Psychological Association article on Aging. Sept. 2009

Appendix 4

FEATURE II

Can '13 Reasons Why' Help Latino Families Talk About Mental Health?

BY KELLY CARRION

A hit show about a young woman's suicide has generated buzz over whether it glamorizes the ending of a life or helps foster healthy discussions on mental health. One thing Latinos agree on: It has gotten the conversation going.

The popular Netflix series '13 Reasons Why' announced Sunday it was returning for a second season. The show has stirred controversy among mental health professionals and several school districts around the country have warned parents about the effects that such an impactful show can have on children and teens.Topics such as mental illness, suicide, and depression, which are at the center of the '13 Reasons Why' series, are generally becoming less of a taboo. But in many Latino homes, families don't openly talk about these topics.

"In my family, we don't discuss mental health and suicide as often as we should, it is viewed as a stigma in the Latino culture," said Maggie Fuentes, a recent college graduate from Denver, Colorado, who has seen the series. "Oftentimes we perceive mental health as something negative and usually something that you don't talk about," said Fuentes.

Compared to white and black high school students, Latinos reported more suicide attempts, including those resulting in injury or overdoses, and higher incidences of thinking or planning an attempt, according to a 2015 Centers for Disease Control (CDC) report. Latinas in grades 9-12 had reported significantly higher suicide attempts than black and white teen girls.

'13 Reasons Why' centers on a high school aged girl named Hannah. She is a teenage girl who encounters several instances of bullying which eventually lead her to commit suicide. But, before she dies, Hannah leaves 13 tapes with the reasons why she decided to end her life."I thought it was a good series because it really gave us adults and professionals a glimpse inside the world of what teens struggle with today," said Dr. Ingrid Diaz, a New Jersey-based clinical psychologist who works with Latino adolescents and children.

Other professionals feel that the show is troubling because it does not provide a different option.

"Since the show is already here, it has to be used as a teachable moment. said Dr. Tami Benton, associate professor of psychiatry in the Perelman School of Medicine at the University of Pennsylvania. "Unfortunately, it glamorizes suicide and makes it seem as if there isn't any other option, and that is really a problem."

The actress Selena Gomez, one of the show's executive producers, told the Associated Press that the show hued very close to the book on which it's based — "a beautifully tragic, complicated yet suspenseful story and I think that's what we wanted to do."

Does the show resonate with Latinos?

Lulu Guerrero, 25, is an actress who lives in New York City. She has watched the series and believes it's important for people to see it. While she doesn't think the show "glamorizes" suicide, she thinks the plot simplifies the situation.

"I don't agree with the story's build, like Hannah blaming everyone for her suicide. I don't think [suicide] is as black and white as the show makes it out to be," she said.

When it comes to her own experience, Guerrero says her family was very open about discussing mental illness.

"When I started showing signs of depression at the age of 13, my parents took the necessary steps to get me help as soon as possible. I was

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very vocal and showing of my emotions and what I was going through, so I was lucky to have had such involved parents who reacted quickly. Not everyone is so lucky, as you learn from the show," she said.Fdoes the

Juan Jaramillo, a student from Boston, Massachusetts, thinks mental health was stigmatized while he was growing up and was not discussed in his household.

"To be honest, I wish every Latino household should watch this show," said the Colombia native. "People need to watch this show because it's raw and the emotions it evokes can really put into perspective why mental health is so important and why we shouldn't discourage our youth from seeking a professional and getting the tools to get better," he said.

"In our culture, we are brought up thinking those tools don't even exist," said Jaramillo.

Navigating two worlds

Diaz says that many Latino teens in the U.S. live a dual experience which sometimes can make acceptance among their peers harder. She cites her own experience as a young pre-teen and not being able to do things that are seen as normal in the mainstream, such as sleepovers.

This dual existence of trying to fit in two different worlds, such as having immigrant parents and also trying to adapt to the mainstream culture, can cause struggles among teens who want to feel accepted, "a disparity in acceptance in the mainstream experience," said Diaz, who talks about these issues when she travels around the country and does suicide assessment training.

Diaz sees this struggle among Latina girls more so than boys; in general Hispanic young men are generally given more freedom to blend in.

Dr. Luis H. Zayas, PhD, the Dean and Robert Lee Sutherland Chair in Mental Health and Social Policy at the University of Texas at Austin is the author of the book Latinas Attempting Suicide: When Cultures, Families and Daughters Collide. It focuses on why young Latinas have reported higher rates of suicide attempts.

Zayas says that apart from a teen's individual development, clashes between cultures at home (whether they come from a first, second or third generation immigrant family) and family dynamics come into play.

"Sometimes immigrant families have more restrictions for their daughters," said Zayas, "such as how a lady should act, how she should be more family-oriented and she also might have more restrictions than her male siblings."

In his research, Zayas also found that peers were not as large an influence on teens and their suicide attempts compared to their white counterparts.

Though '13 Reasons Why' is centered on a group of teenagers and their experiences, it might not be the same experiences that some young Latinos are facing.

"We have to ask the question whether Latinas can identify with the show and whether the character's life story resonated with the 'average' Latina experience in the U.S., which also has a lot of different factors," said Zayas.

Opening up, getting help

The takeaway from shows like '13 Reasons Why,' say experts, is that parents should have an open dialogue with their children about mental health.

"I watched the series with my 14-year-old daughter. I saw it as an educational moment about pivotal experiences in a teenager's life," said Diaz. "Parents are afraid of the taboo and about talking about it because it can give them 'ideas,' but the truth is that children already know about this from social media and their friends, but they should know that they can come and talk to you about it, that you [parents] are a resource to them. They should know that suicide is never the answer."

Zayas says children should understand where their parents are coming from, and why they were raised the way they were, and parents should understand what it's like for their own children.

"It's about them trying to understand each other's perspectives. It's about building bridges," he said.

Diaz says there is a stigma across all races and nationalities — including many Latino households —that problems or mental health issues should be only handled inside the family.

And Latinos who are very religious, especially immigrants, may not feel comfortable talking openly about mental illness. According to Diaz, many prefer to rely on their clergy before seeking professional help so they are not seen as 'lacking faith.'

But issues surrounding mental health are legitimate medical issues.

"I think human beings are spiritual, physical and emotional. You have to combine all three aspects of that when you are healing, not just one," said Diaz.

Teens and adults, say experts like Diaz and Zayas, should not be afraid to seek help.

In New York City, the organization Comunlife began a program called 'Life is Precious,' that helps prevent suicide in young Latinas by providing counseling, academic support and therapy. In 2016, they helped 189 Latinas in the New York City area get access to their services.

In response to the outpouring of opinions and concerns surrounding the show, Netflix announced it would add more content warnings to the series. It also created a site, 13ReasonsWhy.info, "a global resource center that provides information about professional organizations that support help around the serious matters addressed in the show," according to their press release.

If a teen or adult is experiencing suicidal thoughts, they should reach out to a health care professional, especially one with which they are comfortable. If no one is available, anyone can call the National Suicide Prevention Lifeline at 1-800-273-TALK, which is open 24 hours, seven days a week.

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FEATURE III

Suicide Prevention and LGBTQ Communities

BY DR. JAY BETTERGARCIA

Imagine that half of our lesbian, gay, bisexual, and transgender (LGBT) youth have seriously considered ending their life— unfortunately, you wouldn't be far off. In San Luis Obispo County, 48% of our LGBT youth reported having seriously considered attempting suicide in the past 12 months (California Healthy Kids Survey, 2015). That translates to approximately 570 San Luis Obispo county middle and high school LGBT youth who are seriously considering ending their life.

We've known for quite some time that LGBT youth across the country are struggling with higher rates of mental illness, substance abuse, suicidal ideation and this is usually attributed to the additional stress, social stigma, and discrimination one faces as a sexual or gender minority in this county (Meyer, 2012). With the most recent slew of anti-LGBT events, policies, and legal actions at the local, national, federal levels, it is not difficult to imagine how our queer and questioning youth and adults might feel increased levels of fear, anxiety, depression, hopelessness, and yes, suicidal ideation. LGBT people might even feel as though they are not welcome in our schools, workplaces, places of worship, or even our society at large— and we need this to change!

Unfortunately, we also know LGBT people don't always feel comfortable seeking community support or mental health services. How well are we serving the mental health and wellness needs of our LGBT community? How does one of the "happiest cities in the America" fair when it comes to supporting, including, and truly valuing our LGBT youth, adults, and aging community members? A 2003 study conducted with San Luis Obispo county LGBT community members found barriers to mental health care included fear of being mistreated by providers and insufficient services, specifically transgender services, youth services, and support groups (Growing Together Initiative: Focus Group Project, 2003).

In San Luis Obispo county, LGBT community members have identified supportive mental health services and youth services as two of the most important service needs (Growing Together Initiative: Community Survey Report, 2015). However, San Luis Obispo county currently has no mental health programs directly addressing the unique needs of local LGBT communities in a comprehensive manner. Though some programs may support the needs of sub-populations within the LGBT community, it is unclear how well these programs are serving local LGBT populations and whether or not LGBT individuals face additional barriers to seeking mental health services in San Luis Obispo County, specifically.

So, what can you do? How can we change the health outcomes for our LGBT community members, so people feel and believe their sexual orientation or gender identity will not only be tolerated, but truly valued? And how can we make our agencies and programs truly inclusive?

- Start by looking inward and consider how your implicit biases and stereotypes get in the ways of supporting and serving our diverse communities.
- Consider how you can speak up and speak out against homophobia and transphobia with families, neighbors, staff, employees, and co-workers.
- Explore what your organization is doing to support the needs of LGBT staff, clients, and students. How can you move forward and do more?

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- You may want to consider revising your intake forms to be inclusive and include space for people to indicate their sexual orientation, gender identity, and pronouns.
- You might also start to purposefully collect data about the sexual orientation and gender identities of the people you are serving and see what the data tells you.
- You might consider advertising services in a more inclusive way or starting new groups for LGBT community members.
- Perhaps you've changed all your single-stall restrooms to all-gender restrooms in accordance with California's AB1732? Wonderful! If not, consider doing so ASAP –that law went into effect March 1, 2017.

Perhaps what you and your staff really need is additional training about best practices for working with transgender and non-binary people? ...people with bisexual, pansexual, or asexual identities? ... the experiences of homeless, aging, or (dis) abled LGBT people? Luckily, there are several resources available to help on this front (see the resource list below)! When we think about cultural competence or cultural humility, we need to know we're never done learning and we can't stop challenging ourselves and others to know better and do better.

And as community and society, we must not forget that all oppression is connected—racism, sexism, ableism, classism, eurocentrism, and ageism are all inextricably connected to heterosexism and cissexism. We have to be willing to see how racism plays a role in the number of trans women of color who are killed each year. We need to look at the ways poor, (dis)abled, and aging LGBT people might not always feel welcome at Pride festivals. As Audre Lorde once said, "There is no such thing as a single-issue struggle because we don't live single issue lives." We have to consider the intersections of all of these identities if we truly want to work toward cultural competence and cultural humility among services providers.

And although sexual and gender minorities face higher rates of victimization, distress, and suicide attempts, people in the LGBT community are also fiercely resilient. LGBT people and communities are resilient because we've had to be. In the face of stigma, oppression, and anti-LGBT laws, we, as a community, have fought for our right to be treated with dignity and respect— and we continue to fight hard for civil rights. Family support, community support, and activism can go a long way toward helping LGBT youth and adults feel welcomed, valued, and empowered. We cannot do it alone and we need straight and cisgender allies to help change the hearts and minds of those who just don't yet understand love is love, sex and gender don't have to match, and gender can be fluid.

So, what about the 570 LGBT youth who are seriously considering suicide?

How can we, as a community of providers who care about the health, safety, wellbeing of vulnerable populations— How can we wrap around those who are struggling?

How can we support those who might be reluctant to reach out for support?

How can outreach be targeted toward segments of the community like youth, transgender people, and older adults, who might feel left out and ostracized?

How do we engage peer-to-peer support in data-driven and evidence-based ways?

How can we incorporate cultural humility trainings into the foundation and framework of our organizations to ensure that services are delivered in culturally competent ways?

These are the conversations agencies, schools, and businesses need to have if we are going to think seriously about ameliorating the mental and

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physical health disparities that exist for LGBT communities.

To create positive social change, there are several organizations working to make San Luis Obispo county more inclusive around mental health services. In particular, Dr. John Elfers, co-chair of the Central Coast Coalition for Inclusive Schools (CCC4IS); Ellen Sturtz, Activist and GALA Volunteer; and Dr. Jay Bettergarcia, director of the Queer Community Action, Research, Education, and Support (Q.C.A.R.E.S.) program at Cal Poly, San Luis Obispo have been working together to collect data about LGBT mental health and wellness, community connectedness, barriers to care, and people's experience of mental health services on the central coast.

Our goal is to create innovative LGBT-focused wellness programs to meet the needs of the community and to support existing programs to become more culturally competent via training initiatives and creative programming. We are committed to these efforts and we call on all community members to consider the ways in which they are actively supporting the needs of our LGBT community. How can you make a change? What difference can you make in the lives of our LGBT youth? Older adults? Transgender employees? For many in our communities, it has been a matter of life and death. We cannot afford another queer life lost to suicide or senseless violence- it is time to move our communities forward, together.

Appendix 04

FEATURED I

Committee Member Spotlight

AWARD WINNING DR. MARNE A. TREVISANO

Marne A. Trevisano was raised in England and emigrated to the United States of America in the mid 1960's. In her time here, she has had many accomplishments in her life, not only as a psychologist but as a writer as well. Dr. Trevisano has her own psychology practice, is the editor of the Central Coast Psychological Association Newsletter, and is also a member of the California Psychological Association.

Dr. Trevisano has volunteered at the YMCA. Always wanting to help community members and aware of prejudice held against people of color, she made her clinic in Richmond, California available to those who were underserved or who were simply too poor. Dr. Trevisano has continued her practice since moving to the central coast.

Since 2013, Dr. Trevisano has held the editoral position at the Central Coast. Through her writing in the Central Coast Psychological Association Newsletter, Dr. Trevisano has brought light to many various social issues in different communities and brought unique people's stories to life. She enjoys getting to know people of various backgrounds. Finding what makes them unique, and writes about their story. A member of the California Psychological Association has let her also shed light on progressive stance to societal issues.

The passion Dr. Trevisano has for writing was recently awarded. A Fulbright Scholar Dr. Sari Dworkin submitted three of Dr. Trevisano's newsletters and hers was selected out of 20 other chapter newsletters. She earned the California Psychological Association Award for Outstanding Chapter Newsletter 2017 at the California Psychological Association Convention.

"It was **their achievement** through me."

This award was received as a great fulfillment for Dr. Trevisano. The award reflected goals set by her family, especially her father, and her own values as well.

A current project of hers is focusing on the wave of political refugees. Dr. Trevisano is writing on the expereinces of an 89 year old survivor of the Nazi invasion of what is now a Ukrainian country.

Dr. Trevisano is a community member who strives to bring awareness on cultural and social issues within the psychological world and within her own community in San Luis Obispo. The work and insight she brings to the Cultural Competence Committee helps us become more aware of the needs of the great population.

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FOR MORE INFORMATION

Please consider **The following resources**

Mental Health Services

SAN LUIS OBISPO YOUTH 0-5
MARTHA'S PLACE CHILDREN'S ASSESSMENT CENTER
2925 MCMILLAN AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4948

SAN LUIS OBISPO YOUTH
1989 VICENTE,
SAN LUIS OBISPO, CA 93401
(805)781-4179

SAN LUIS OBISPO ADULTS
2178 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4700

SAN LUIS OBISPO PSYCHIATRIC HEALTH FACILITY
2178 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4711

ATASCADERO YOUTH & ADULTS
5575 HOSPITAL DRIVE,
ATASCADERO, CA 93422
(805)461-6060

ARROYO GRANDE ADULTS
1650 GRAND AVE,
ARROYO GRANDE, CA 93420
(805)474-2154

ARROYO GRANDE YOUTH
345 S. HALCYON,
ARROYO GRANDE, CA 93420
(805)473-7060

Drug & Alcohol Services

SAN LUIS OBISPO ADULTS
2180 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4275

SAN LUIS OBISPO YOUTH
277 SOUTH ST. SUITE T,
SAN LUIS OBISPO, CA 93401
(805)781-4754

PASO ROBLES ADULTS & YOUTH
1763 RAMADA DRIVE,
PASO ROBLES, CA 93446
(805)226-3200

ATASCADERO YOUTH & ADULTS
5575 HOSPITAL DRIVE
ATASCADERO, CA 93422
(805)461-6080

PREVENTION & OUTREACH
277 SOUTH ST. SUITE T,
SAN LUIS OBISPO, CA 93401
(805)781-4754

More Resources in The Community

TRANZ OF THE CENTRAL COAST
(805)242-3821
SAN LUIS OBISPO AND NORTH COUNTY SUPPORT GROUPS
WWW.TRANZCENTRALCOAST.ORG/

ACCESS SUPPORT CENTER
1320 NIPOMO ST.
SAN LUIS OBISPO, CA 93401
(805)781-3660

RISE | RESPECT. INSPIRE. SUPPORT. EMPOWER.
LGBTQ HEALTHY RELATIONSHIPS SUPPORT GROUP
(805)226-6791

GAY AND LESBIAN ALLIANCE (GALA) OF THE CENTRAL COAST
(805)541-4252

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Dates To Remember

January

- National Stalking Awareness Month
- Mental Wellness Month
- National Drug Facts Week (Jan.23-29)

February

- African American History Month
- Ethnic Equality Month
- International Boost Self-Esteem Month
- Teen dating violence awareness month
- American Heart Month
- Eating disorders Awareness and Screening Week (Feb. 25-Mar 3)
- National School Counseling Week
- National School Counseling Week (Feb. 5-8)
- Random Acts of Kindness Week (Feb.11-17)

March

- National Nutrition Month
- Employee Spirit Month
- Developmental Disabilities Awareness Month
- Self-injury Awareness Day (SIAD) (Mar. 1)
- National Sleep Awareness Week (Mar. 4-11)
- Brain Awareness Week (Mar. 12-18)
- World Bipolar Day (Mar.30)

Appendix 04


Happy Holidays
Masaya Pista Opisya
Forhe Feiertage
Felices Fiestas
Glade feriedage
Jiérì Kuàilè
Boas Festas
NEWSLETTER
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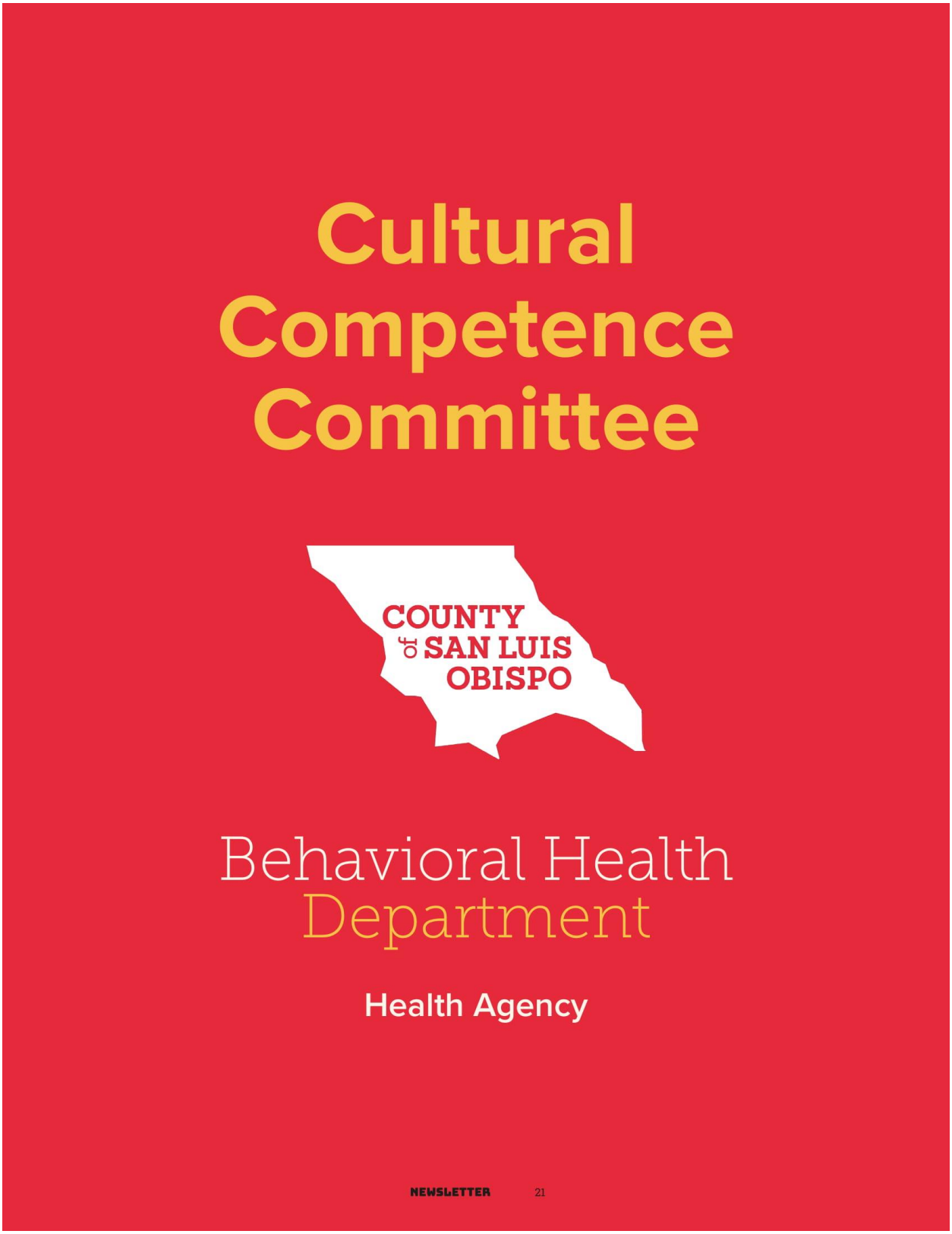
Appendix 04


Cultural
Competence
Committee
COUNTY
of SAN LUIS
OBISPO
Behavioral Health
Department
Health Agency
NEWSLETTER
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Appendix 04

Ethnic Services Manager Areas of Responsibility
FY 2017-2018

The Cultural Competence/Ethnic Services Manager (CC/ESM) promotes and monitors quality and equitable care as it relates to diverse racial, ethnic and cultural populations served by both county-operated and contracted behavioral health programs.

County CC/ESMs are key members of the executive leadership team with a sustained and meaningful role in helping shape the county service delivery system in a way that advances health equity and cultural responsiveness. The Behavioral Health Director recognizes the essential role and function of the CC/ESM within the organization and allocates sufficient time and resources for the performance of job responsibilities and duties.

It is recommended that the county CC/ESM is a manager that reports directly to, and has direct access to, the Behavioral Health Director regarding issues impacting the behavioral health of diverse racial, ethnic and cultural populations within the county. Especially at a time when there is greater federal and State emphasis on health disparities and county accountability, CC/ESMs provide critical leadership and valuable expertise on their agency. There are few issues in county administration that do not impact the behavioral health of diverse racial, ethnic and cultural populations.

The importance of the CC/ESM position necessitates individuals with a level of expertise and professionalism that leads to results – better services and outcomes for diverse racial, ethnic and cultural populations experiencing health disparities. One approach to achieving this level of expertise and professionalism is to build on the strengths of existing staff members in the CC/ESM role, address barriers and enhance their capacity to be effective. Another approach consists of careful selection of new staff to fill the role.

The recommended qualifications for new staff members serving as the CC/ESM include the following:

- Professional education (meeting county manager level requirements) in relevant fields like sociology, psychology, public health and healthcare administration
- Training and/or experience in areas pertaining to equity, community engagement and program and staff management
- A proven track record of demonstrating understanding and application of cultural humility, awareness and competence
- Knowledge of best practices for tracking and addressing disparities
- Demonstrated capacity to interact with individuals from various diverse communities with respect and commitment
- Demonstrated understanding of the impact of differing world views on the experience of mental health and substance use disorders, help-seeking behaviors and the conceptualization of what is appropriate care

Appendix 05

- Demonstrated understanding of key drivers of system change and an ability to effectuate organizational change
- Demonstrated ability to effectively identify and collaborate with diverse community-focused service and civic organizations including faith communities, youth and senior organizations, business owners and social service providers

The scope of CC/ESM duties varies by county due to county size and available resources. Some CC/ESMs have multiple overlapping job responsibilities and may need the support of other staff members who take shared ownership of these responsibilities.

In all counties, the CC/ESM is an essential resource for helping the county to meet a growing number of local, State and federal cultural competence requirements. CC/ESMs regularly review service utilization data, actively participate in local behavioral health planning and projects that respond to the needs of the county's diverse racial, ethnic and cultural populations, and review and comment on numerous major State policy and legislative proposals that would impact those populations.

Since counties are increasingly being held accountable for performance, CC/ESMs offer more to the county than just being the designated person to complete any paperwork relating to cultural competence. Counties should designate the following responsibilities to the CC/ESM and designated staff members (in small counties these duties are often divided among administrative team members; in large counties, they may be shared among a team led by the CC/ESM):

- ❖ Participating as an official member of the local behavioral health management/leadership team that makes programs and procedural policy recommendations to the Behavioral Health Director
- ❖ Participating and providing advice in planning, policy, compliance and evaluation components of the county system of care and making recommendations to county Directors that assure access to services or ethnically and culturally diverse groups
- ❖ Promoting the development of responsive behavioral health services that will meet the diverse needs of the county's racial, cultural and ethnic populations. This includes, but is not limited to, reviewing local proposals to augment or decrease services to the local community, participating organizational units within and outside the local behavioral health department
- ❖ Participating in the development and implementation of local policies and procedures that would potentially impact services for racially, ethnically and culturally diverse consumers
- ❖ Reviewing and providing feedback to the county Director on materials generated at the State and local levels, including but not limited to, proposed legislation, State plans, policies and other documents

Appendix 05

- Monitoring of county and service contractors to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations
- Identification of local and regional cultural behavioral health need of ethnic and culturally diverse populations as they impact county systems of care and making recommendations to local Behavioral Health Directors, CBHDA and the State Department of Health Care Services.
- Working with the county's Quality Improvement team, tracking penetration and retention rates and outcome data for racially, ethnically and culturally diverse populations, and developing strategies to eliminate disparities
- Participating in the cultivation and maintenance of relationships with cultural, racial, ethnic community leaders and cultural-specific community organizations to promote an array of behavioral health programs and activities that are specific to underserved populations
- Maintaining an active advocacy, consultative and supportive relationships with consumer and family organizations, local planning boards, advisory groups and task forces, the State and other behavioral health advocates
- Working with the county's Human Resources office to help ensure that the workforce is ethnically, culturally and linguistically diverse. Assisting the Equal Employment Opportunity Office to ensure the recruitment, retention and upward mobility of staff
- Assisting in the development of system-wide training that addresses enhancement of workforce development and addressing the training necessary to improve quality of care for all communities and reduce behavioral health disparities
- Lead responsibility for the development and implementation of cultural competence planning within the organization
- Attending trainings that inform, educate and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the behavioral health system
- Attending meetings as required by the position including, but not limited to, CBHDA CCESJC, Full Association and other committee meetings, regional ESM regular meetings, various State meetings, meetings convened by various advisory bodies and other meetings as appropriate
- Establishing and continuing operation of a Bilingual Certification Committee (BCC); the BCC shall be comprised of the ESM and two bilingual staff members, at least two of whom is a native speaker of the threshold languages within the county
- Developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification
- Developing an evaluation checklist that includes, but is not limited to: fluency, the ability to communicate with ease (verbally and non-verbally,) depth of vocabulary including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language question, grammar, and cultural considerations related to a potential client
- Conducting the certification process of a candidate with the BCC

Appendix 05

Medical Necessity

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

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

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

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

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

iii. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment."

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

(a) "For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3,) medical necessity criteria for specialty mental health services covered by this chapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1,)

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 2, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met."

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

Silvia Ortiz, PhD

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

In 1988, the APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations. In July 1991 the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse populations were published (American Psychological Association, 1993). In 1989, the Council for Children with Behavioral Disorders (CCBD) established the Committee on Ethnic and Multicultural Concerns (Bullock, 1999). In January1999, at the first Multicultural Conference coordinated by the American Psychological Association, the importance of developing cultural competence in mental health services was emphasized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Servicios Sicológicos Para Latinos
A Latino Outreach Program

Presentations: The following presentations have been provided in Spanish to the monolingual population as part of the outreach process at the beginning of the program.

DATE	PRESENTATION TITLE	LOCATION
1.24.08	Living in Two Cultures	Pacheco Health Fair
1.25.08	Domestic Violence in Latinos	Oceano Adult Education
2.14.08	Living in Two Cultures	Los Osos Middle School
3.19.08	Latino Leadership	Nipomo Leadership Program
5.23.08	Bicultural Parenting	Cuesta College
6.18.08	Bicultural Parenting	EOC Head Start
9.2.08	Leadership Program	Latino Youths
9.19.08	Parent Workshop	Nipomo Parent's Group
9.23.08	Vision Unida	Cuesta College
10.09.08	Parenting Adolescents	Paso Robles High School
10.09.08	Latino Needs	Health Services Advisory Board
11.09.08	Depression and Suicide in Latinos	Cuesta College
11.19.08	Living in Two Cultures	Pacheco School
1.22.09	Bicultural Parenting	Migrant Parents
1.27.09	Bicultural Parenting	Virginia Peterson
1.29.09	Bicultural Parenting	Piefer School
2.12.09	Career Planning	Los Osos Middle School
2.24.09	Bicultural Parenting	SLO High School
3.9.09	Substance Use	Paso Recreation Center
5.5.09	Living in Two Cultures	Cuesta College/ELAC Students
5.13.09	Relationships	Probation
5.14.09	Career Planning	Nipomo Leadership Group

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5.20.09	Relationships	Probation
5.27.09	Relationships	Probation
6.3.09	Relationships	Probation
6.10.09	Bicultural Parenting	Bakari Program
6.17.09	Bicultural Parenting	Bakari Program
6.24.09	Bicultural Parenting	Bakari Program
8.5.09	Substance Abuse	Probation
8.19.09	Substance Abuse	Probation
9.14.09	Substance Abuse	Probation
9.15.09	Bicultural Parenting	Paso Recreation Center
10.08.09	Gang Identity	Paso Recreation Center
10.15.09	Acculturation: Infancy to Adulthood	Paso Recreation Center

The following presentations have been provided to persons who offer services to the threshold population:

DATE	PRESENTATION TITLE	LOCATION
4.2.08	High Risk Adolescents	Morro Bay High School
4.10.08	High Risk Adolescents	Paso Robles High School
4.28.08	Wrap Around Latinos	SAFE
5.2.08	Keynote Speech	Cuesta College
9.2.08	Leadership Program	Cuesta College
9.18.08	Cinco de Mayo	Latino Outreach Council
9.24.08	Counseling Latinos	Social Workers Forum
10.09.08	Latino Needs	Health Service Advisory Board
11.04.08	Therapeutic Issues with Latinos	Cal Poly
11.09.08	Elder Latinos	Nipomo Elders Group
11.10.08	Depression and Suicide in Latinos	Cuesta College
6.1.09	Latinos Mental Health	Paso Robles School District

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9.24.09	Latinos and Drug Abuse	School Board
10.29.09	Psychotherapy with Latinos	Cal Poly MFT Class
12.09.09	Psychotherapy with Latinos	Morro Bay High School

Appendix 8

Servicios Sicológicos Para Latinos
A Latino Outreach Program
Staff

NAME	TITLE	E-MAIL	PHONE NUMBER
Lupita Vargas, LMFT	B.H. Clinician III	lvargas@co.slo.ca.us	805-461-6054
Marisol Mariscal	B.H. Clinician II	mmariscal@co.slo.ca.us	805-474-2028
Mayra Lopez	B.H. Clinician II	mglopez@co.slo.ca.us	805-781-4179
Jakelyn Llamas	B.H. Clinician II	jllamas@co.slo.ca.us	805-474-2105
Claudia Lopez	B.H. Clinician II	cblopez@co.slo.ca.us	805-781-4960

Appendix 09

Servicios Sicológicos Para Latinos
A Latino Outreach Program

Community Sites

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

CA Rural Legal Assistance (a.k.a.- Oak Park office)
3350 Park St.
Paso Robles, CA 93446
(805) 239-3708 FAX (805) 239-4912

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

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

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

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

South County SAFE Family Resource Center
1086 Grand Ave.
Arroyo Grande, CA 93420
(805) 474-210 Fax (805) 474-2025

San Luis Obispo High School
1499 San Luis Drive
San Luis Obispo, Ca. 93401

Appendix 10

LATINO OUTREACH PROGRAM

	Refuse to answer survey

Age Group

□ 0-15 y/o □ 16-25 y/o □ 26-59 y/o □ 60+ y/o

Race

□ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino

□ Native Hawaiian/Pacific Islander □ White □ More than 1 race □ Decline to Answer

Ethnicity

□ Caribbean □ Central American □ Mexican/Mexican American/Chicanx □ Puerto Rican

□ South American □ African □ Asian Indian/South Asian □ Cambodian

□ Chinese □ Eastern European □ European □ Filipino

□ Japanese □ Korean □ Middle Eastern □ Vietnamese

□ More than 1 ethnicity □ Decline to Answer □ Other:

Country of Origin: **Primary Language:**

Sex: Please share what sex you were assigned at birth.

□ Male □ Female

Gender: Please select the option that best describes you.

□ Male □ Female □ Transgender □ Genderqueer/fluid

□ Questioning □ Another gender identity

Sexual Orientation: Please select the option that best describes you.

□ Gay/Lesbian □ Heterosexual/Straight □ Bisexual □ Questioning

□ Queer □ Another Sexual Orientation identity

Disabilities

□ Difficulty seeing □ Difficulty hearing □ Learning/developmental □ Physical mobility

□ Chronic health □ None □ Decline to answer □ Other

PLEASE RATE YOUR OVERALL EXPERIENCE WITH THE SERVICES PROVIDED:

Statements	Prefer Not to Answer	N/A	Strongly Disagree	Disagree Slight	Neutral	Agree	Strongly Agree
The therapy was sensitive to the Latino culture and language.		0	1	2	3	4	5
Therapy helped me understand and resolve my mental health needs.		0	1	2	3	4	5
Therapy helped me gain internal strength and feeling better about life.		0	1	2	3	4	5
I have learned coping skills		0	1	2	3	4	5
I am now familiar with mental health resources.		0	1	2	3	4	5
My resilience and positive outlook in life has improved.		0	1	2	3	4	5
Therapy has helped me improve when I feel nervous, anxious, or scared.		0	1	2	3	4	5
Therapy has improved my sleep quality.		0	1	2	3	4	5

PROGRAMA DE BIENESTAR PARA LATINOS

	Prefiero no contestar encuesta

Grupo de Edad

□ 0-15 años □ 16-25 años □ 26-59 años □ 60+ años

Raza

□ Indio Americano / Nativo de Alaska □ Asiático □ Negro/Afroamericano □ Hispano/Latino

□ Nativo de Hawai / Isleño del Pacífico □ Blanco □ Más de un raza □ Prefiero no Contestar

Etnicidad

□ Caribeño □ Centroamericano □ Mexicano/Mexicano americano/Chicanx □ Puertorriqueño

□ Sudamericano □ Africano □ Asiatico Hindú / Sur Asiático □ Camboyano

□ Chino □ Europeo Oriental □ Europeo □ Filipino

□ Japonés □ Coreano □ Medio Este □ Vietnamita

□ Más de un grupo étnico □ Prefiero No Contestar □ Otro:

País de Origen: **Idioma Principal**

Sexo Por favor seleccione que sexo fue asignado en su ficha ó certificado de nacimiento

□ Masculino □ Femenino

Género Por favor seleccione el género que mejor lo describa

□ Masculino □ Femenino □ Transgénero □ Genderqueer/fluido

□ Cuestionando □ Otra identidad de género

Orientación Sexual Por favor seleccione la orientación sexual que mejor lo describa

□ Gay/Lesbiana □ Heterosexual □ Bisexual □ Cuestionando

□ Queer □ Otra identidad sexual

Disabilidades

□ Dificultad para ver □ Dificultad para escuchar □ Aprendizaje y Desarrollo □ Mobilidad Física

□ Salud crónica □ Ninguna □ Negar a contestar □ Otro

POR FAVOR CALIFIQUE SU EXPERIENCIA CON LOS SERVICIOS PROPORCIONADOS:

Declaraciones	Prefiero No Contestar	N/A	Totalmente en Desacuerdo	En desacuerdo	Neutral	De Acuerdo	Totalmente deacuerdo
La terapia proporcionada abarca la cultura y el idioma latino.		0	1	2	3	4	5
La terapia proporcionada ayuda a entender y resolver mis necesidades de salud mental.		0	1	2	3	4	5
Los terapia proporcionada me ayuda a obtener fortaleza interna y me siento mejor acerca de la vida.		0	1	2	3	4	5
He aprendido formas que me ayudan a calmarme y sentirme mejor.		0	1	2	3	4	5
Ahora estoy mas familiarizado con los recursos de salud mental.		0	1	2	3	4	5
Mi capacidad de recuperación y mi actitud positiva en la vida han mejorado.		0	1	2	3	4	5
El terapia proporcionada me ha ayudado a mejorar cuando me siento nervioso, ansioso, ó asustado.		0	1	2	3	4	5
El terapia proporcionada ha mejorado mi calidad al dormir.		0	1	2	3	4	5

Cultural Competence Committee

Mission

The County of San Luis Obispo Behavioral Health Department (SLOBHD) is committed to Cultural Competence through promoting respect and understanding of diverse cultures, ethnic, social, and linguistic groups, and individuals. To achieve that commitment, SLOBHD is devoted to developing, enhancing, and maintaining a high performing workforce that provides meaningful service access and improves outcomes for all clients. We deliver culturally, and linguistically responsive services and our workforce reflects the diversity of the communities we serve. SLOBHD staff and administration ensures Cultural Competence is integrated into the overall organizational culture and ongoing business practices.

Goals

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

Committee Guidelines

Article I: Name of Committee

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

Appendix 12

Article II: Purpose of the Committee

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

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

Article III: Structure of the Committee

Section 1: The Committee operates as an entity of the County of San Luis Obispo Behavioral Health Department.

Section 2: The County Behavioral Health Director appoints the Chairperson.

Section 3: The Chairperson reports to the County Behavioral Health Director.

Section 4: The Committee members are the decision-making body of the Committee. The members are elected by the Committee and represent a diverse range of cultural, ethnic, racial and geographic regions of the country.

Section 5: The Committee will advise and serve as a resource group to the County Behavioral Health Director, the County Behavioral Health Training Committee, County Behavioral Health staff, and affiliated agencies.

Section 6: General membership is not a requirement for involvement in the Committee. Visitors are welcome to attend Committee meetings and provide input.

Article IV: General Membership

Section 1: The Committee consists of approximately ten (10) members from County Behavioral Health, affiliated agencies, network providers, consumers, and community advocates. The members of the Committee represent a range of cultural and ethnic backgrounds.

Section 2: The Chairperson is part of the Committee.

Section 3: Anyone interested in serving on the Committee shall state his/her interest to serve by informing a current Committee member.

Section 4: A simple majority vote is required for the election of Committee members.

Section 5: A vacancy exists when a Committee member misses four consecutive Committee meetings without prior notification to the Chairperson or any other member. A vacancy also exists when a Committee member tenders his/her resignation verbally or in writing to the Chairperson.

Section 6: When a vacancy exists, the Committee shall nominate individuals to serve on the Committee.

Article V: Meetings

Appendix 12

Section 1: No meetings shall be held in a facility that prohibits the admittance of any person based on their culture, ethnic background, religious beliefs, sex, sexual orientation, or emotional/physical disabilities.
Section 2: Meetings will convene the second Monday on a quarterly basis, with a minimum of four meetings in one fiscal year.
Section 3: The Chairperson convenes the meetings.
Section 4: The Committee members develop the agenda for the meetings.
Section 5: The Committee will strive to make decisions by consensus.
Section 6: A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by a quorum to be recommended to the County Behavioral Health Director.
Section 7: A quorum is defined as 50 percent of the Committee.
Section 8: A motion may be made and seconded by any of the Committee members.
Section 9: Motions require a simple majority to be recommended as action items or task assignments.

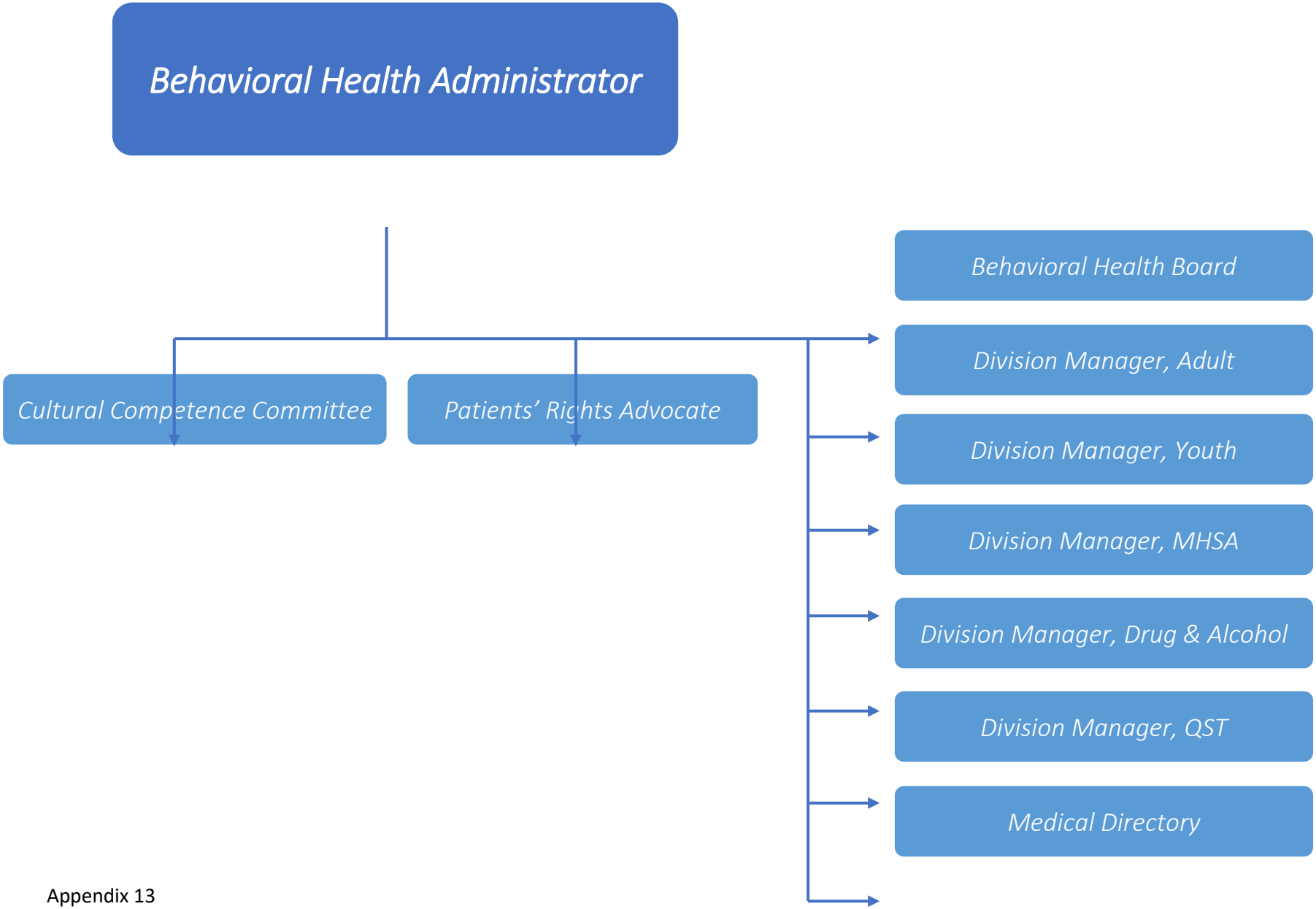
Article VI: Amendments

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

Approved by the Director of Behavioral Health: _____

Date: _____

Appendix 12


Behavioral Health Administrator
Behavioral Health Board
Division Manager, Adult
Division Manager, Youth
Division Manager, MHSA
Division Manager, Drug & Alcohol
Division Manager, QST
Medical Directory
Cultural Competence Committee
Patients' Rights Advocate

Appendix 13

2016-2017 Cultural Competence Committee - Roster		
Name	**Title**	**Agency**
Nestor Veloz-Passalacqua, M.P.P.	Cultural Competence Coordinator	Behavioral Health Department
Anne Robin, L.M.F.T.	Behavioral Health Administrator	Behavioral Health Department
Joe Madsen	Division Director	Transitions-Mental Health Association
Desiree Troxell	Patient Rights Advocate	Behavioral Health Department
Lisa Huet, L.C.S.W.	Program Supervisor for Family Care Network	Family Care Network Inc.
Kimberly Mott	Program Supervisor, Prevention & Outreach	Behavioral Health Department
Jill Rietjens	Program Supervisor, Youth Services	Behavioral Health Department
Bonita Thomas	PAAT Member	Peer Advisory & Advocacy Team - TMHA
Marne Travisano, Ph.D.	Licensed Psychologist Private Practice	Private Practice – Community Member
Amber Trigueros, M.A., L.M.F.T.	Mental Health Therapist III	Behavioral Health Department
Ellen Sturtz	GALA Volunteer	Gay & Lesbian Alliance of the Central Coast
Jay Bettergarcia, Ph.D	Assistant Professor	California Polytechnic State University – San Luis Obispo
Kiana Shelton	Mental Health Therapist IV	Behavioral Health Department
Laura Zarate	Secretary I	Behavioral Health Department
John Aparicio	Outreach Coordinator	Veteran Services Office
Lilia Rangel-Reyes	Multicultural Specialist	Tri-Counties Regional Center
Barry Johnson	Division Director	Transitions-Mental Health Association
Katherine Soule	Director	UC Cooperative Extension & Youth, Families, & Communities
Yesenia Mora	B.H. Clinician II	Drug & Alcohol Division SUD
Leola Dublin Macmillan	Professor & Community Member	Race Matters

Appendix 14

CULTURAL COMPETENCY – CRISIS INTERVENTION TRAINING (CIT)

OVERVIEW

Activity: Unpacking
Implicit Bias
Social Identity Wheel
Race & Ethnicity
Acculturation & Assimilation
Intersectionality
Culture
Cultural Competence & Humility
Cultural Competence & CIT
Mental Health & Culture

SLO COUNTY & MENTAL HEALTH

Mental Health Services Act (2004)
Community Services & Supports
FY 15-16 4,143 clients/community members served
FY 16-17 4,924 clients/community members served (children & youth, transitional-aged youth, adults, older adults, client & family wellness, Latino Outreach, Crisis & Aftercare, School & Family Empowerment, and Forensic Mental Health Services)
Prevention & Early Intervention
FY 15-16 13,483 clients/community members served
Children (1,089); TAY (4,270); Adult (4,440), and Older Adults (3,684)
Native American (60); Asian Indian (20); Asian (102); African American (445); Caucasian (9,252); Chinese (32); Filipino (58), Hispanic/Latino (2,585); Japanese (28); Korean (14); Multi-Racial (368); Pacific Islander (6); Russian (2); Vietnamese (12).

UNPACKING

Recognizing Biases/Perceptions
Becoming Aware
Actionable Changes

IMPLICIT BIAS

SOCIAL IDENTITY WHEEL
Identity which you are most aware of
Identity which you think about least often
Identity that has the greatest effect on how others see you
Identity that gives you power and privilege
Identity that has the strongest effect on how you see yourself as a person

INTERSECTIONALITY

RACE & ETHNICITY

Race: category of people who share certain inherited physical characteristics, such as skin color, facial features, and stature. – Race is a social construct/category.

Appendix 15
Ethnicity: refers to the shared social, cultural, and historical experiences, stemming from common national or regional backgrounds that make subgroups of a population different from one another. (Source: Sociology: Understanding & Changing the Social World, 2016)

CULTURE
"Meanings, values, and behavioral norms that are learned and transmitted in society and within social groups." (Source: Guarnaccia, 2006)

CULTURE
Culture influences:
How people communicate and manifest their symptoms
Their style of coping
Their willingness to seek treatment
Their expectations of law enforcements
Their family and community support

Source: Culture, Race, and Ethnicity; A supplement to Mental Health: A report of the Surgeon General, 2001

CULTURAL COMPETENCE
Is the ability to interact effectively and appropriate with people of different cultures.
Is the ability of systems to provide care to individuals with diverse values, beliefs, behaviors, backgrounds, including tailoring delivery to meet individuals' social, cultural, and linguistic needs.

CULTURAL HUMILITY
Cultural humility is about accepting our limitations. Those who practice cultural humility work to increase self-awareness of their own biases and perceptions and engage in a life-long self-reflection process about how to put these aside and learn from clients. (Source: Hohman, Cultural Humility: A Lifelong Practice, 2013.)

CULTURAL COMPETENCE & C.I.T.
Cultural competence provides a framework for assessing and understanding each client and family's unique rules, roles, habits, activities, and beliefs in the context of their cultural, linguistic, and ethnic identity.

CULTURAL COMPETENCE & C.I.T.
Breaks down barriers that impede communication and limits the effectiveness of intervention
Assists officers in being able to better detect and react to or defuse a threat
Increases officer and public safety
Increases success in dealing with mental health situations

CULTURAL COMPETENCE & C.I.T.
4 ELEMENTS
Become aware of the diversity of the populations with which the system is working.
Acknowledge variations in acceptable behaviors, beliefs and values in accessing and treating a person's mental health or problems.

Appendix 15
The knowledge, skills, and attitudes to work within consumers' and their families' values and reality conditions.
BECOME AWARE OF THE STEREOTYPES (BIASES/PERCEPTIONS) YOU CARRY AND MAKE AN EFFORT TO SET THEM ASIDE WHEN INTERACTING WITH PEOPLE OF OTHER CULTURAL/ETHNIC/RACIAL GROUPS.

MENTAL HEALTH & CULTURE
Different cultures treat illness differently – family and societal norms are different in different cultures.
Acceptable treatment varies:
No treatment
Herbal remedies
Traditional medicine (healers)
Mainstream medical care
Spiritual Healing

MENTAL HEALTH & CULTURE
Culture influences many aspects of mental illness:
Clients' culture expression and manifestation of symptoms
Style of coping
Family and community supports, and
Willingness to seek treatment
The cultures of the clinician and the service system influence diagnosis, treatment, and service delivery.
Cultural and social influences are not the only determinants of mental illness and patterns of service utilization for racial and ethnic minorities, but they do play important roles.

MENTAL HEALTH & CULTURE
Mistrust of mental health services is an important reason deterring minorities from seeking treatment.
Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.
The extent to which clinician bias and stereotyping explain disparities in mental health services is not known.

MENTAL HEALTH & CULTURE
2 strategies to engage:
Become familiar with the culture(s) of the people you serve
Become familiar with how you are perceived by the people you serve

QUESTIONS?

Appendix 15

agenda – MH QST

San Luis Obispo County Health Agency

MH Quality Support Team/Quality Management

September 20, 2018

1:30pm – 3:00pm

1. **Welcome and introductions**

2. **Review and approval Minutes of July 2018**

3. **Follow-Up Old Business:**
   a. Cen-Cal patient transportation updates

4. **New Items or Updates**

5. **Monthly Statistics – July & August 2018**
   a. Assessment Wait Times (14 Day)
   b. Post (7 Day)
   c. Martha's Place
   d. MD Fail to Show
   e. Intake Assessment Attendance
   f. CSU Discharge Data
   g. Risk Management

6. **Consumer/Family Advocate**

7. **Morbidity and Mortality Committee Report (Dr. Ilano)**

8. **Round table:**

Next QST Meeting: October 18, 2018 – PHF data will be presented

Appendix 16

Cultural Competence Committee Meeting
Agenda
April 10, 2017

1. **Leadership Updates**
2. **Introduction**
3. **Review of minutes**
4. **Sponsor Youth Training Update**
5. **MHSA "Superar" Project**
6. **Promotoras Update**
7. **Newsletter**
8. **Updates and Announcements**
9. **Next Meeting, July 10, 2017**

Appendix 17

Cultural Competence Committee Meeting
Agenda
July 10, 2017

10. **Leadership Updates**

11. **Introduction**

12. **Update: Sponsor Youth Training**

13. **New Business:**

    - **Monthly Calenda**
    - **Newsletter**
    - **Needs assessment**

14. **Training Budget:**
    - **Trans Youth Training**

15. **Review of Minutes**

16. **Updates and Announcements**

17. **Next Meeting, October 16, 2017**

AGENDA

Cultural Competence Committee Meeting
277 South St., Suite T., San Luis Obispo – Conference Room
October 16, 2017
Time: 10:30 AM – 11:00AM

Rebecca Carroll, Leah DeRose, Laura Esquivel, Reggie Holmes, Kati Rose Lorent, Nancy Mancha-Whitcomb, Lisa Huet, Kim Mott, Jill Rietjens, Debi Rodriguez, Silvia Ortiz, Rachel Tarver, Bonita Thomas, Marne Trevisano, Amber Trigueros, Ellen Sturtz, Maria Troy, Laura Zarate
Administrator: Anne Robin
Chair: Nestor Veloz-Passalacqua

Attendees:

I. Welcome

II. Introduction

III. Updates

a. Trans-Youth/Trans Awareness Training
b. Tentative: January 23rd/24th

IV. New Business

a. Revision of Committee's Goals

V. Business Updates

a. Cultural Competence Newsletter
b. Review of Minutes

VI. Announcements

VII. Next Meeting

a. January 8th 2018 – 10:00am – 11:00am South St. Office

AGENDA

Cultural Competence Committee Meeting
277 South St., Suite T., San Luis Obispo – Conference Room
January 8, 2018
Time: 10:00 AM – 11:00AM

Attendees:

VIII. Welcome

IX. Introduction

a. New Members

X. Leadership Updates

a. Cal Poly – Cultural Competence Project Results

XI. New Business

a. CCC Goals Revision
b. Mental Health Calendar (Jan – March)
c. Cultural Competence Training Development
d. Updates to Contract Boilerplates

XII. Business Updates

a. Review of Minutes – approve July & October

XIII. Announcements

a. Trans-Training 101: March 13th - Copeland Health Education Pavilion 8-12:30pm

XIV. Next Meeting

a. April 9th 2018 – 10:00am – 11:00am

Appendix 17

AGENDA

Cultural Competence Committee Meeting
277 South St., Suite T., San Luis Obispo – Conference Room
April 9, 2018
Time: 10:00 AM – 11:00AM

Attendees:

XV. Welcome

XVI. Introduction

a. Members Updates

XVII. Leadership Updates

a. Trans-Training 101 – Results
b. LGBTQ Needs Assessment Contract
c. Southern Region Task Force – Task Force
d. Community Action Team – Cultural Competence Training
e. Ethnic Services Managers Institute - Update

XVIII. New Business

a. Fewer Latino clients seeking services
b. Mental Health Calendar (April – June)
c. Newsletter
d. Cultural Competence Training Development
e. Extending the meeting to 90 minutes

XIX. Announcements

a. Trans-Training 101: June 13th? - Copeland Health Education Pavilion 8-12:30pm

XX. Next Meeting

a. July 9th 2018 – 10:00am – 11:00am
b. Possibly schedule another meeting? Cal Poly – Ethnic Services Department

Appendix 17

San Luis Obispo County
Cultural Competence Meeting
April 10, 2017
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Leah DeRose, Patient Rights Advocate
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Laura Zarate, Executive Assistant, BH
Lisa Huet, LCSW, (FCNI)
Jill Rietjens, Program Supervisor, Youth Services
EllenSturtz, GALA
Maria Troy, Promotoras
Anne Robin, Behavioral Health Administrator

Members Absent:

Reggie Holmes, MHT III
Debbie Rodriguez (PAAT)
Amber Trigueros, M.A., LMFT, M.H. Therapist III, (MHSA/FSP)
Bonita Thomas, PAAT
Julia Richardson
Kimberly Mott, Program Supervisor, Prevention and Outreach
Nancy Mancha-Whitcomb, LMFT, Program Supervisor

Topic	Discussion	Recommendations/Actions
Leadership Updates	Thank you Nancy Mancha-Whitcomb for your leadership. Nestor Veloz-Passalacqua will be our Cultural Ethnic Services Officer Starting in July. Nancy is now Therapist of Latino Outreach in South County.	Thank you Nancy! Welcome Nestor!
Introductions:	Round-table introductions.	
Sponsored Youth Training Update:	Update: Will catch-up with Kim and give us an update. One of the components is suicide prevention. 13 Reasons Why Not- The Author was here in SLO High. LGBT students are particularly at higher risk for suicide.	Nestor to follow up with Kim.

Topic	Discussion	Recommendations/Actions
New Business:	• Will develop a monthly calendar for the next 3 months and a quarterly Newsletter. The Newsletter will include a current topic. Committee members will add feedback and topics and will be in charge of different writings. • Members: Please send a small Bio to Monica. State requires us to track Committee member's attendance as part of our Policy. Bio should be no more than two paragraphs explaining your cultural background. • October 11 is National Coming Out Date. Newsletter intent is to give awareness and find resources. Develop Community Awareness. Here are some topics for our next Newsletter: ➢ Marne Interview ➢ October 11th ➢ September: National Recovery Month ➢ September 10-16th: Suicide Prevention Week • Dr. Bettergarcia from Cal-Poly will work with Nestor on needs in the Community. This will be part of the Cultural Plan.	Monica will work on Newsletter. Committee members to send information to Monica.
Training and Budget:	The Trans Youth Training is not substantial. What we have is from the WET funding and is going away. We will do our best to offer services needed as a committee. Santa Barbara would like to collaborate with us with the Trans Youth Training. They used State WET funding to create an awesome curriculum and Anne would like us to use it.	
Updates and Announcements:	○ Nancy Mancha-Whitcomb is no longer employed with the County. She is working at her private practice. ○ Nestor met with Erica from Promotores- will add Confidentiality Training. ○ World Café: The Behavioral Health Board will have its Annual World Café after their normal monthly meeting on August 16, 2017 at 2:30pm at the Vets Hall, 801 Grand Ave., San Luis Obispo. Any questions, call Laura Zarate 781-4719. ○ Frank Warren has identified two internal trainings: ✓ Identifying and Preventing Child Abuse ✓ Identifying and Preventing Dependent Adult Abuse	
Next Meeting:		

Topic	Discussion	Recommendations/Actions
	Our next meeting will meet on Monday, October 16, 2017.	

Cultural Competence Meeting
July 10, 2017
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Leah DeRose, Patient Rights Advocate
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Laura Zarate, Executive Assistant, BH
Lisa Huet, LCSW, (FCNI)
Jill Rietjens, Program Supervisor, Youth Services
EllenSturtz, GALA
Maria Troy, Promotoras
Anne Robin, Behavioral Health Administrator

Members Absent:

Rachel Tarver
Reggie Holmes, MHT III
Frank Warren
Debbie Rodriguez (PAAT)
Amber Trigueros, M.A., LMFT, M.H. Therapist III, (MHSA/FSP)
Bonita Thomas, PAAT
Julia Richardson
Kimberly Mott, Program Supervisor, Prevention and Outreach
Nancy Mancha-Whitcomb, LMFT, Program Supervisor

Topic	Discussion	Recommendations/Actions
Leadership Updates	Thank you Nancy Mancha-Whitcomb for your leadership. Nestor Veloz-Passalacqua will be our Cultural Ethnic Services Officer Starting in July. Nancy is now Therapist of Latino Outreach in South County.	Thank you Nancy! Welcome Nestor!
Introductions:	Round-table introductions.	
Sponsored Youth Training Update:		Nestor to follow up with Kim.

Topic	Discussion	Recommendations/Actions
New Business: **Training and Budget:** **Updates and Announcements:**	Update: Will catch-up with Kim and give us an update. One of the components is suicide prevention. 13 Reasons Why Not- The Author was here in SLO High. LGBT students are particularly at higher risk for suicide. • Will develop a monthly calendar for the next 3 months and a quarterly Newsletter. The Newsletter will include a current topic. Committee members will add feedback and topics and will be in charge of different writings. • Members: Please send a small Bio to Monica. State requires us to track Committee member's attendance as part of our Policy. Bio should be no more than two paragraphs explaining your cultural background. • October 11 is National Coming Out Date. Newsletter intent is to give awareness and find resources. Develop Community Awareness. Here are some topics for our next Newsletter: ➢ Marne Interview ➢ October 11th ➢ September: National Recovery Month ➢ September 10-16th: Suicide Prevention Week • Dr. Bettergarcia from Cal-Poly will work with Nestor on needs in the Community. This will be part of the Cultural Plan. The Trans Youth Training is not substantial. What we have is from the WET funding and is going away. We will do our best to offer services needed as a committee. Santa Barbara would like to collaborate with us with the Trans Youth Training. They used State WET funding to create an awesome curriculum and Anne would like us to use it. o Nancy Mancha-Whitcomb is no longer employed with the County. She is working at her private practice. o Nestor met with Erica from Promotores- will add Confidentiality Training. o World Café: The Behavioral Health Board will have its Annual World Café after their normal monthly meeting on August 16, 2017 at 2:30pm at the Vets Hall, 801 Grand Ave., San Luis Obispo. Any questions, call Laura Zarate 781-4719. o Frank Warren has identified two internal trainings: ✓ Identifying and Preventing Child Abuse	Monica will work on Newsletter. Committee members to send information to Monica. L

Topic	Discussion	Recommendations/Actions
Next Meeting:	✓ Identifying and Preventing Dependent Adult Abuse Our next meeting will meet on Monday, October 16, 2017.	

San Luis Obispo County
Cultural Competence Meeting
October 16, 2017
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Leah DeRose, Patient Rights Advocate
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Laura Zarate, Executive Assistant, BH
Lisa Huet, LCSW, (FCNI)
Jill Rietjens, Program Supervisor, Youth Services
EllenSturtz, GALA
Anne Robin, Behavioral Health Administrator
Bonita Thomas, PAAT
Dr. Jay Bettergarcia, CalPoly
Monica Stagg, BH Nurse
Amber Trigueros, M.A., LMFT, M.H. Therapist III
Kimberly Mott, Program Supervisor, Prevention and Outreach

Members Absent:

Rachel Tarver
Reggie Holmes, MHT III
Frank Warren
Debbie Rodriguez (PAAT)
Julia Richardson
Maria Troy, Promotoras

Topic	Discussion	Recommendations/Actions
Introductions:	Round-table introductions.	
Updates:	❖ Trans-Youth/Trans Awareness Training: Met with Dr. Bettergarcia. Training will cover Mental Health, Youth and Culture Health and Physical Health. It would be a 2-4 hour training (tentative January 23/24th) depending on the material. Here are some ideas:	

Topic	Discussion	Recommendations/Actions
	• Ask French Hospital to use the Copeland Center • Looking for someone to donate his or her professional video services. • Add Substance Use/Drug and Alcohol Awareness to the training. • Having three separate dates for each: MH, Youth and Culture, Physical Health.	Nestor to follow up with Dr.Bettergarcia.
New Business:	❖ Revision of Committee's Goals: We will be conducting a Health Agency Cultural Competence Survey. Students from the Statistics Department in Cal-Poly will conduct it. The survey consists of about 45 questions that will give us an idea of where we stand as an organization. Cal-Poly students will interview about 120 randomly selected staff members. Results from this survey will drive this Committee.	Cal-Poly Students: Mary, Naomi and Allie to follow up with in-person interviews.
Business Updates:	❖ Cultural Competence Newsletter: Newsletter Draft went out to Cultural Committee members. If you have feedback or suggestions, please contact Nestor. Also, if you have not done so, send Nestor your Bio and photo. ❖ Gender Pronouns: Nestor passed around a Draft for Gender Pronouns and gave an example of how to use them in the email signature line. Please Review. More to come on this subject.	Monica will work on Newsletter. Committee members to send information to Monica.
Next Meeting:	Our next meeting will meet on Monday, January 8, 2017 at our South St. Office.	L

San Luis Obispo County
Cultural Competence Meeting
January 8, 2018
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Leah DeRose, Patient Rights Advocate
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Laura Zarate, Executive Assistant, BH
Lisa Huet, LCSW, (FCNI)
Jill Rietjens, Program Supervisor, Youth Services
Ellen Sturtz, GALA
Bonita Thomas, PAAT
Kimberly Mott, Program Supervisor, Prevention and Outreach
Kiana Shelton
Maria Troy, Promotoras

Members Absent:
Anne Robin, Behavioral Health Administrator
Dr. Jay Bettergarcia, CalPoly
Monica Stagg, BH Nurse
Amber Trigueros, M.A., LMFT, M.H. Therapist III
Rachel Tarver
Reggie Holmes, MHT III
Frank Warren
Debbie Rodriguez (PAAT)
Julia Richardson

Topic	Discussion	Recommendations/Actions
Introductions: **Leadership Updates:**	Welcome and Round-table introductions. Happy New year! New Members: Kianna Shelton – New Therapist in San Luis Obispo. Joe Madsen from THMA will join us next meeting. a) Cal-Poly Cultural Competence Project Results: Nestor briefly reviewed results and statistics from this project. This will help develop our Cultural Competence Plan.	Welcome new CCC Members!

Topic	Discussion	Recommendations/Actions
	Key Findings: • 83% feel their cultural competence increased. • 25% Felt unprepared to provide services because of culture. • 21% felt not ready to provide services because of cultural differences. We use Building Bridges to develop the Cultural Competence Plan. Nestor will soon show us.	We thank Cal-Poly Students: Mary, Naomi and Allie for this important work.
New Business:	a) CCC Goals Revision: Last revision was in 2013. Need the State to release guidelines. Nestor has met twice with State. He continues to be in contact with them. We will work with what we have available to us, make our own guidelines, show them our accomplishments and standings. We need to have a yearly plan. b) Mental Health Calendar (Jan-March): Our Newsletter will be brief. We will highlight more resources in the next issue. If you have ideas on topics, or general information, email Monica or Nestor. c) Cultural Competence Training Development: Currently working with Joe Madsen on this. d) Updates to Contract Boilerplates: Nestor is working with Ellen.	Monica will work on Newsletter. Committee members to send information to Monica. Nestor and Joe to follow up on Training.
Business Updates:	a) Review of minutes: New change: Laura to send both Agenda and Minutes a week before to this Committee for approval. We will then bring items/issues to the meeting if needed. Members may suggest items to Agenda as well.	Nestor and Ellen to follow.
Announcements:	a) Trans-Training 101: March 13th- Copeland Health Education Pavilion 8-12:30pm. This year, this training will be primarily for BH Staff. Then will be opened to other County agencies if space is available.	
Next Meeting:	Our next meeting will meet on Monday, April 9, 2018, 10-11am at our South St. Office.	L

2018 Cultural Competence Plan Requirements

Outline Completion

Criterion I – Commitment to Cultural Competence
1. Nestor Veloz-Passalacqua

Criterion II – Updated Assessment of Service Needs
1. Nestor Veloz-Passalacqua
2. Kristin Ventresca
3. Frank Warren
4. Greg Vickery

Criterion III – Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
1. Frank Warren
2. Nestor Veloz-Passalacqua

Criterion IV – Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
1. Nestor Veloz-Passalacqua

Criterion V – Culturally Competent Training Activities
1. Nestor Veloz-Passalacqua
2. Rebecca Redman
3. Caroline Johnson

Criterion VI – County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
1. Frank Warren
2. Nestor Veloz-Passalacqua

Criterion VII – Language Capacity
1. Nestor Veloz-Passalacqua
2. Frank Warren

Criterion VIII – Adaptation of Services
1. Nestor Veloz-Passalacqua
2. Frank Warren

Appendix 19

County of San Luis Obispo Behavioral Health Department
Cultural Competence Plan
Annual Update - December, 2017

Summary

The County of San Luis Obispo Behavioral Health Department, which houses the Mental Health and Drug & Alcohol Services Divisions, is committed to developing a system of care which serves an increasing, changing and diverse population in the County. The system must strive to ensure cultural competence at all levels of the organization. A Cultural Competence Plan is at the heart of the efforts to develop and maintain effective providers of health care for diverse communities.

The Cultural Competence Plan, originally developed in 2009-2010, provides guidelines to help the Behavioral Health Department become a more culturally competent organization and to ensure that diverse populations in the county receive mental health services that are culturally appropriate throughout the mental health system. The Plan is reviewed annually by both the Department's Management Team, as well as the Cultural Competence Committee.

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

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

As the Department continues to seek methods to engage staff and community providers with modern, effective cultural competence training and practices, a commitment to organizational growth is a Department value. According to the Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies, culturally competent organizations are ones which:

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- ***Continually assesses organizational diversity****: Organizations should conduct a regular assessment of its members' experiences working with diverse communities and focus populations. It also regularly assesses the range of values, beliefs, knowledge, and experiences within the organization that would allow for working with focus communities.*
- ***Invests in building capacity for cultural competency and inclusion****: Organizations should have policies, procedures, and resources in place that make ongoing development of cultural competence and inclusion possible. It must also be willing to commit the resources necessary to build or strengthen relationships with groups and communities. Including representatives of the focus population within the organization's ranks is especially useful.*
- ***Practices strategic planning that incorporates community culture and diversity****: Organizations are urged to collaborate with other community groups. Its members are also encouraged to develop supportive relationships with other community groups. When these steps are taken, the organization is seen as a partner by other groups and their members.*
- ***Implements prevention strategies using culture and diversity as a resource****: Community members and organizations must have an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to ensure they are accessible to and attuned to their community or focus population.*
- ***Evaluates the incorporation of cultural competence****: Community members must have a forum to provide both formal and informal feedback on the impact of all interventions.*

The Cultural Competence Plan is part of the Department's efforts to remain a culturally competent, responsive, and supportive community organization.

Key Objectives and Annual Results

In response to the Department of Health Care Services CCP requirement, the SLOBHD has developed a comprehensive Plan and has chosen to include key objectives to monitor.

- The SLOBHD will develop and institute a Training Policy which includes requirements for staff development in cultural competence and demonstrated improvements in service to diverse clients.
    - In 2016-2017, the Department continued the use of the Relias E-Learning system to provide core competency training and education for all staff, as well as community partners, consumers, and family members.
        - The Department provided access to 500 providers, consumers, and family members with a total of 3,699 completed hours in fiscal year 2016-2017. The assigned curriculum included the completion of two courses:
            - Working With People in Recovery
            - Consumers in The Workplace

Appendix 20

- Other strategies include development of pre-post measurement tools to assess staff capacity, skill development, retention of core competency training and changes in practice and behavior over time.
  - In the Fall of 2017, the Department collaborated with a Statistics class from California Polytechnic State University (Cal Poly) to conduct a staff cultural competence survey. The results will be posted in the Plan update in 2017-2018.
- Other strategies included collaboration and partnering with other county agencies that provide training on core topics vital to staff development.

- The Cultural Competence Committee (CCC) will increase cultural competence training for mental health system providers by two activities per year.
  - Strategies to accomplish this objective include the aforementioned networking with community partners who can provide quality training for mental health professionals.
    - In 2016-2017, the Department co-sponsored, or supported training from community organizations related to working with consumers in recovery, children with co-occurring disorders, the LGBTQ population, veterans, and healthcare language interpretation services.
  - The County and its CCC will also broaden the approach to cultural competence training to include activities which improve the mental health system's capacity to serve cultural populations (e.g. LGBTQ, Veterans, consumers and family members).
    - In 2016-2017, the Department presented a film to the community ("El Canto del Colibri") which reflected on the issues for Latinos "coming out" to their families and friends. This project partnered with local LGBTQ partners, including the non-profit Gay and Lesbian Alliance (GALA) of the Central Coast. From that event, organization representatives began attending and actively participating in the Behavioral Health Board, MHSA, and other community stakeholder meetings.
    - The Department has adopted an "Innovation" project (now funded with ongoing MHSA allocations) which provides improved service engagement and access to veterans and their families. In 2016-2017 nine events were offered to 119 veterans, which 51 were unique or new participants, with a total of 219 participants. Out of the 219 clients served, a total of 77 participants were surveyed and a total of 90% (69/77) reported a reduction in stigma association with mental illness, and 79% (61/77) reported feeling better informed about mental illness in the veteran community.

- The CCC will increase membership of consumers and family members by one member annually over the next three years.
  - This objective is critical to enhance the diversity of the Committee which serves to improve cultural competence principles across the SLOBHD's programs. The main strategy to accomplish this objective will be the establishment of membership policy requiring the committee to have at least one seat filled by a consumer/family member. This will increase recruitment efforts and partnerships with community

organizations, such as the Peer Advisory and Advocacy Team (PAAT) with Transitions Mental Health Association, a community-based organization.

- In 2016-2017, the Department assigned Nestor Veloz-Passalacqua to be the Ethnic Services Manager, and assume the leadership of the CCC in July 2017. In his immediate tenure, as mentioned above, he increased the membership to include representatives from the LGBTQ advocacy community.

- The Committee will identify other underserved populations reflecting cultural needs in order to provide services and support within the County system. This will be measured by an increase in CCC membership to include representatives of currently unrepresented communities over the next two years.
  - The strategies to meet this objective include working with the County's Prevention and Early Intervention (PEI) programs which have built relationships and partnerships with organizations serving cultural populations often underserved in the mental health system, along with expanded services with the Latino population. These include Asian/Pacific Islanders, LGBTQ, veterans, older adults, TAY, and consumers.
    - In 2016-2017, advocacy from the CCC membership influenced the MHSA stakeholder group to provide funds to conduct a one-year evaluation of mental health services for the local LGBTQ community. The research will help the County identify gaps and needs for training. The results will be published in next year's CCP update.

- The CCC, as part of its mission to "ensure that cultural diversity is incorporated into all levels of the Behavioral Health Department," will develop measures over the next year to ensure a process of review and recommendations for each Department service level.
  - This objective will need to include an expansion of the CCC's review process for documents and translation services aimed at the Spanish-speaking community; staffing recruitment and recommendations, and presentations made to various Department programs currently not represented in the CCC. Strategies to meet this objective include establishing CCC policy to review all SLOBHD programs that serve diverse clients (including those of the Drug and Alcohol Services Division) to assure cultural competence policies and procedures are in place.

San Luis Obispo County Behavioral Health Department
Cultural Competence Committee
Annual Report 2016-2017

The Cultural Competence Committee
The Cultural Competence Committee is dedicated to assure that the County of San Luis Obispo Behavioral Health Department becomes a culturally competent health system which integrates the concept of cultural, racial, and ethnic diversity into the fabric of its operation and organization.

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The committee creates agency-wide awareness of the issues relevant to cultural diversity and provides recommendations to the County Behavioral Health Administrator (Mental Health Director) on issues pertinent to the achievement of these goals.

The Committee members are the decision-making body and represent a diverse range of cultural, ethnic, racial and geographic regions of the county. The Committee advises and serves as a resource group to the Behavioral Health Director, County Health Agency Staff, Quality Support Team (QST), and affiliated agencies. Meetings are held quarterly. Visitors are welcome to attend committee meetings and provide input.

The goals of the Committee are:

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

2016-2017 Meetings

Cultural Competence Meetings:	
Date	**Discussion**
07-11-2016	• The CCC discussed the additions of three new items to the cultural competence curriculum for fiscal year 2016-2017: a. Consumers as Service Providers b. Recovery Promoting Relationships c. Cultural Competence Plan Overview • The CCC approved the expense (partial funding) of $1,000 for the training “Beyond The Bench: Keeping Kids in School and Out of Courts” proctored by Jude Hurst. The training provides entities with tools and

	capacity to keep kids from going into the criminal justice systems. The targeted audiences are juvenile judges and youth probation officers. The training took place on August 16th, 2016 from 8:00am – 5:00pm. • The new employee Cultural Competence Training was internally added to Relias Learning, the online leaning training tool required for all employees to complete. All other users, such as community-based organizations, and other providers can access the official YouTube channel of the Health Agency Compliance Officer to complete the training (https://www.youtube.com/watch?v=vM71PvPzATE). • The CCC recommended including alcohol and drug vocabulary to the cultural competence training uploaded on Relias Learning, and exalted the role of the Cultural Competence Coordinator as it upholds the County values of a World Class Organization. • The CCC announced that the Latino Outreach Program had openings for bilingual Youth Clinicians and Therapists IV.
Date	**Discussion**
10-03-2016	• No Cultural Competence Meeting was scheduled for the month of October due to staff changes.
Date	**Discussion**
01-09-2017	• The CCC approved $1,000 of expenses for co-sponsoring youth training. • Cultural Competence Coordinator had started a process to update the cultural competence plan summary for the upcoming fiscal year. • Cultural Competence Coordinator met with the Mental Health Services Act Coordinator to make a list of trainings for Cultural Competence. • The CCC discussed the interpretation services provided by the Promotores. It was announced that the Promotores staff have dropped out. The CCC made requests to ensure that translators have medical terminology knowledge and are able to translate for patients. The Promotores are providing classes on medical terminology. • The CCC announced and supported Deanna Strachan-Wilson, who oversees the Employment Pathways program, which offers different trainings and classes for employment development. Some of the classes offered involved: Job Clubs, Retail Sales Clerk Training, Office Skills Training, and Intensive Employment Services.
Date	**Discussion**
04-10-2017	• The CCC announced changes to the committee: The Cultural Competence Coordinator resigned from the chair position and it is now a therapist for the Latino Outreach Program for the South County clinic. Nestor Veloz-Passalacqua was announced as the new Cultural

	Competence Coordinator and Ethnic Services Manager officially starting July 1st, 2017. • The CCC provided an update to the Youth Training, which included the participation of the author of "13 Reasons Why Not." • The new Cultural Competence Coordinator proposed some new ideas for the upcoming fiscal year: a. Development of a quarterly calendar with mental health and drug and alcohol topics as reported state and nationwide; b. Revitalization of the Cultural Competence Newsletter with the intent to release one every quarter with assistance from the committee members; • The CCC identified the dire need to include trans-youth training for all behavioral health staff. • The Cultural Competence coordinator provided to the Promotores with the County Confidentiality training. • The CCC promoted the Behavioral Health Board World Café to be held on August 16th from 2:30pm-5:00pm with various mental health and drug and alcohol providers. • The CCC worked with the MHSA Coordinator to identify two internal trainings that are to be completed by all staff, these trainings include: a. Identifying and Prevention Child Abuse b. Identifying and Prevention Dependent Adult Abuse

Cultural Competence Training

- Journey of Hope is a community forum presented in partnership with Transitions Mental Health Association. This year's featured keynote speaker was Gabriella Grant, who is the Director of the California Center of Excellence for Trauma-Informed Care. The theme of the evening focused on conceptualizing and understanding the impact of trauma in various levels of development, and the approach of Trauma-Informed Care as a program, organization, or system that is informed by the events and effects of trauma and the potential paths for recovery. The discussion revolved around recognizing signs and symptoms of trauma in clients, families, staff, and others involved in the mental health system and the various ways to fully integrate knowledge about trauma into policies, procedures, and practices.
- Relias "E-Learning": The County of San Luis Obispo Behavioral Health Department provided access to 500 providers, consumers, and family members with a total of 3,699 completed hours in fiscal year 2016-2017. The assigned curriculum included the completion of two courses:
    - Working With People in Recovery
    - Consumers in The Workplace
- Promotores Collaborative: the Cultural Competence work plan includes cultural competence based workforce development and training. The funds are used with stakeholder approval to offer translation and interpretation services for the Latino

Outreach Program (LOP) clients across the county. The Promotores Collaborative goal is to develop a sustainable, diverse, and comprehensive culture that promotes equal access to community resources and services among all members of the Latino community in the County of San Luis Obispo.

2016-2017 Cultural Competence Committee - Roster		
Name	**Title**	**Agency**
Nestor Veloz-Passalacqua, M.P.P.	Cultural Competence Coordinator	Behavioral Health Department
Anne Robin, L.M.F.T.	Behavioral Health Administrator	Behavioral Health Department
Joe Madsen	Division Director	Transitions-Mental Health Association
Leah DeRose,	Patient Rights Advocate	Behavioral Health Department
Lisa Huet, L.C.S.W.	Program Supervisor for Family Care Network	Family Care Network Inc.
Kimberly Mott	Program Supervisor, Prevention & Outreach	Behavioral Health Department
Jill Rietjens	Program Supervisor, Youth Services	Behavioral Health Department
Bonita Thomas	PAAT Member	Peer Advisory & Advocacy Team - TMHA
Marne Travisano, Ph.D.	Licensed Psychologist Private Practice	Private Practice – Community Member
Amber Trigueros, M.A., L.M.F.T.	Mental Health Therapist III	Behavioral Health Department
Ellen Sturtz	GALA Volunteer	Gay & Lesbian Alliance of the Central Coast
Jay Bettergarcia, Ph.D	Assistant Professor	California Polytechnic State University – San Luis Obispo
Kiana Shelton	Mental Health Therapist IV	Behavioral Health Department
Laura Zarate	Secretary I	Behavioral Health Department

Appendix 20

Q1 Please complete for certificate

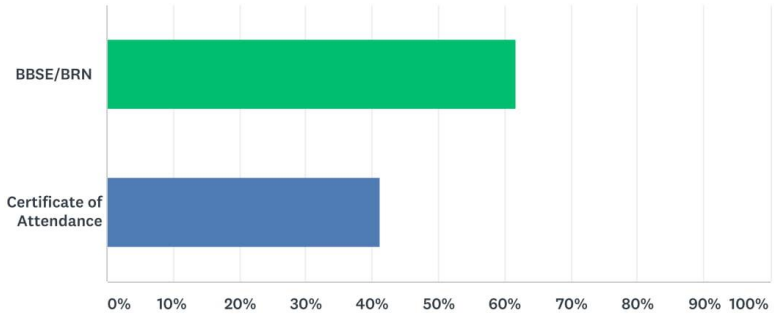
Answered: 34 Skipped: 0

ANSWER CHOICES	RESPONSES	
Last name, First	100.00%	34
Organization	100.00%	34
Address	0.00%	0
Address 2	0.00%	0
City/Town	0.00%	0
State/Province	0.00%	0
ZIP/Postal Code	0.00%	0
Country	0.00%	0
Email Address	100.00%	34
Phone Number	100.00%	34

Appendix 21

Q2 Please choose which certificate you need:

Answered: 34 Skipped: 0



ANSWER CHOICES	RESPONSES	
BBSE/BRN	61.76%	21
Certificate of Attendance	41.18%	14
Total Respondents: 34		

Appendix 21

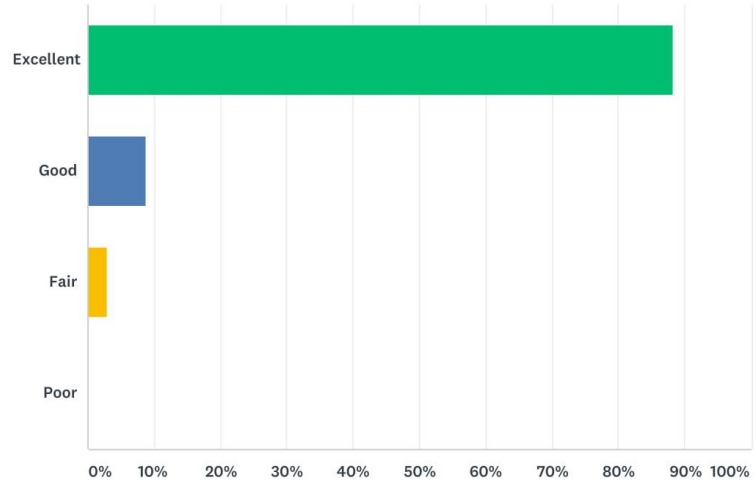
Q3 Enter your license number below (license number is required to issue a BBSE or BRN CEU certificate, make sure to enter information correctly, if you don't have a license number, please enter N/A):

Answered: 34 Skipped: 0

Appendix 21

Q4 Please rate your overall experience of this training?

Answered: 34 Skipped: 0

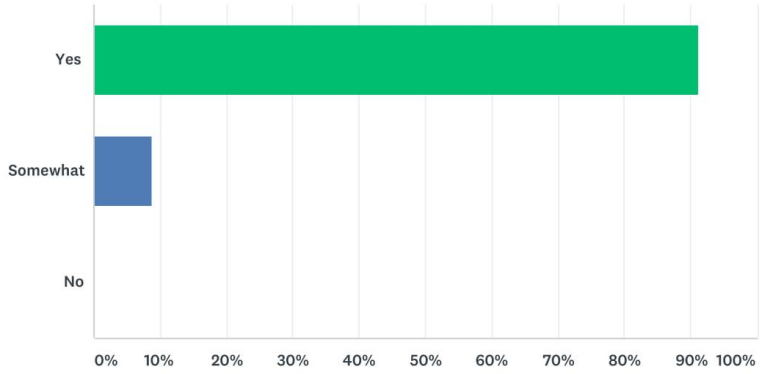


ANSWER CHOICES	RESPONSES	
Excellent	88.24%	30
Good	8.82%	3
Fair	2.94%	1
Poor	0.00%	0
TOTAL		34

Appendix 21

Q5 Did the training meet your expectations?

Answered: 34 Skipped: 0

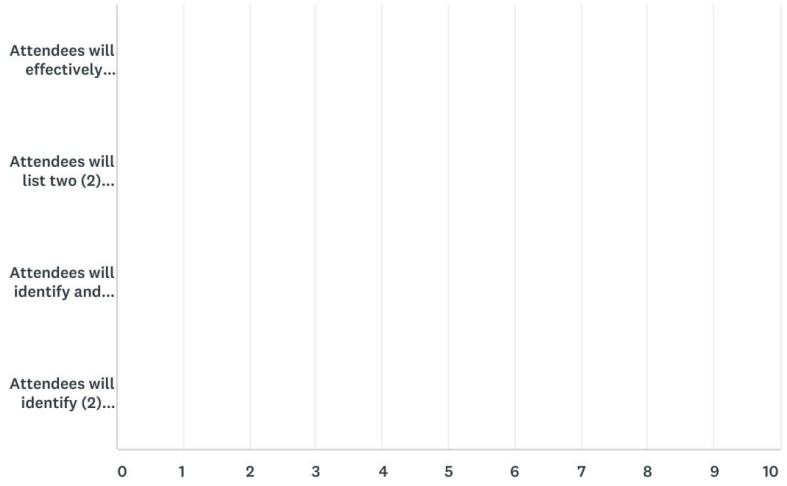


ANSWER CHOICES	RESPONSES	
Yes	91.18%	31
Somewhat	8.82%	3
No	0.00%	0
TOTAL		34

Appendix 21

Q6 Learning goals and objectives:

Answered: 34 Skipped: 0

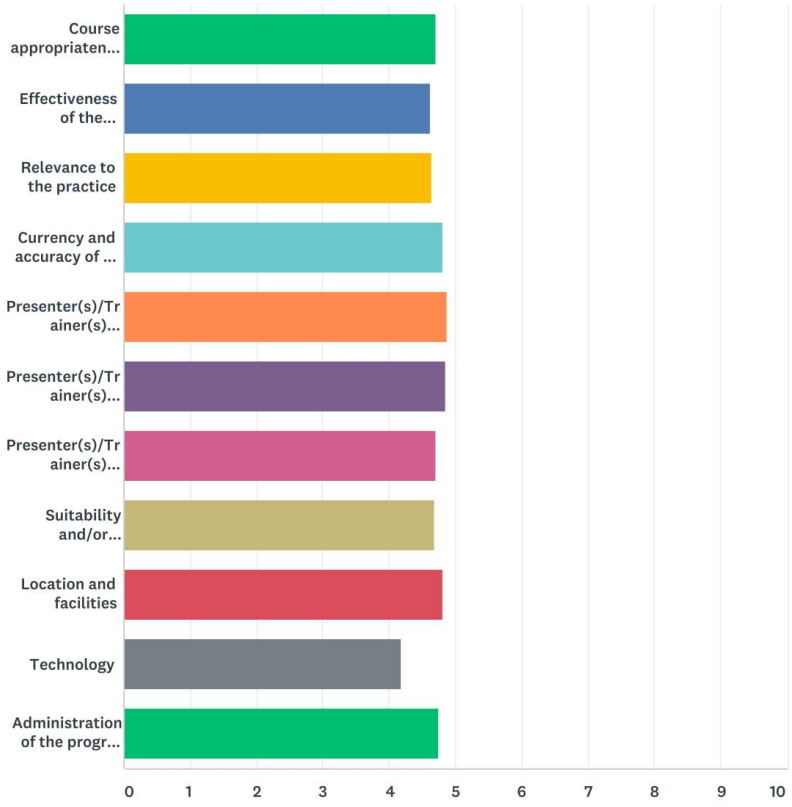


	YES	N/A	NO	TOTAL	WEIGHTED AVERAGE
Attendees will effectively identify three (3) differences between each of the following: biological sex, gender identity, gender presentation, and gender attribution.	100.00% 34	0.00% 0	0.00% 0	34	0.00
Attendees will list two (2) ways in which they can alter their work environment to be more trans-affirming.	100.00% 34	0.00% 0	0.00% 0	34	0.00
Attendees will identify and categorize a list of 10 statements into trans-affirming and non-affirming columns.	82.35% 28	8.82% 3	8.82% 3	34	0.00
Attendees will identify (2) two personal skills that increases their confidence in working with trans clients across the lifespan.	97.06% 33	2.94% 1	0.00% 0	34	0.00

Appendix 21

Q7 Rate, on a scale of 1 to 5 with 1 being "Needs Improvement" and 5 being "Excellent", the following areas:

Answered: 34 Skipped: 0



	1	2	3	4	5	N/A	TOTAL	WEIGHTED AVERAGE
Course appropriateness to participants' education, experience, and licensure level	0.00% 0	0.00% 0	5.88% 2	17.65% 6	76.47% 26	0.00% 0	34	4.71
Effectiveness of the presentation, including use of experiential or active learning	0.00% 0	0.00% 0	8.82% 3	20.59% 7	70.59% 24	0.00% 0	34	4.62
Relevance to the practice	0.00% 0	0.00% 0	8.82% 3	17.65% 6	73.53% 25	0.00% 0	34	4.65
Currency and accuracy of the information	0.00% 0	0.00% 0	2.94% 1	11.76% 4	85.29% 29	0.00% 0	34	4.82
Presenter(s)/Trainer(s) knowledge of the subject matter and clarity of delivery	0.00% 0	0.00% 0	2.94% 1	5.88% 2	91.18% 31	0.00% 0	34	4.88
Presenter(s)/Trainer(s) responsiveness to participants	0.00% 0	0.00% 0	2.94% 1	8.82% 3	88.24% 30	0.00% 0	34	4.85

Appendix 21

Presenter(s)/Trainer(s) ability to utilize course-appropriate technology to support participant learning	0.00% 0	0.00% 0	5.88% 2	17.65% 6	76.47% 26	0.00% 0	34	4.71
Suitability and/or usefulness of instructional materials	0.00% 0	0.00% 0	8.82% 3	14.71% 5	76.47% 26	0.00% 0	34	4.68
Location and facilities	0.00% 0	0.00% 0	2.94% 1	11.76% 4	85.29% 29	0.00% 0	34	4.82
Technology	0.00% 0	2.94% 1	20.59% 7	32.35% 11	44.12% 15	0.00% 0	34	4.18
Administration of the program (overall course organization)	0.00% 0	0.00% 0	2.94% 1	20.59% 7	76.47% 26	0.00% 0	34	4.74

Appendix 21

Q1 Please complete for certificate

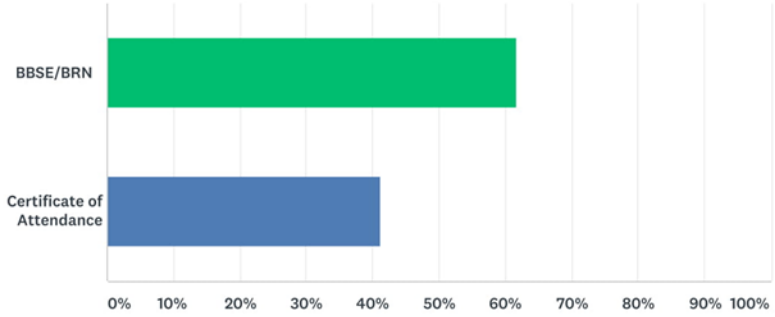
Answered: 34 Skipped: 0

ANSWER CHOICES	RESPONSES	
Last name, First	100.00%	34
Organization	100.00%	34
Address	0.00%	0
Address 2	0.00%	0
City/Town	0.00%	0
State/Province	0.00%	0
ZIP/Postal Code	0.00%	0
Country	0.00%	0
Email Address	100.00%	34
Phone Number	100.00%	34

Appendix 21

Q2 Please choose which certificate you need:

Answered: 34 Skipped: 0

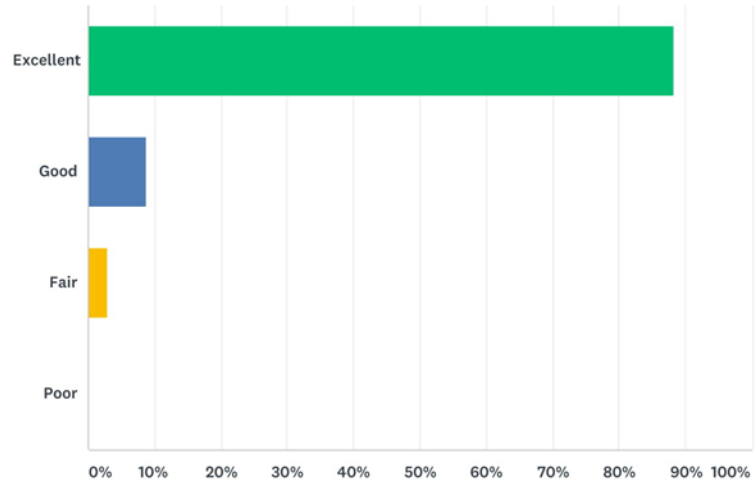


ANSWER CHOICES	RESPONSES	
BBSE/BRN	61.76%	21
Certificate of Attendance	41.18%	14
Total Respondents: 34		

Appendix 21

Q4 Please rate your overall experience of this training?

Answered: 34 Skipped: 0

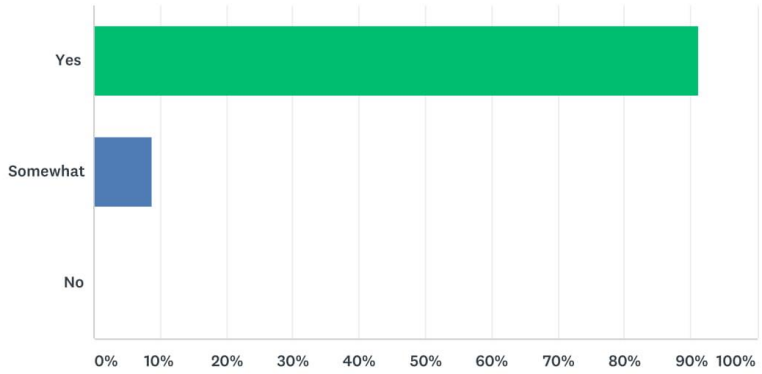


ANSWER CHOICES	RESPONSES	
Excellent	88.24%	30
Good	8.82%	3
Fair	2.94%	1
Poor	0.00%	0
TOTAL		34

Appendix 21

Q5 Did the training meet your expectations?

Answered: 34 Skipped: 0

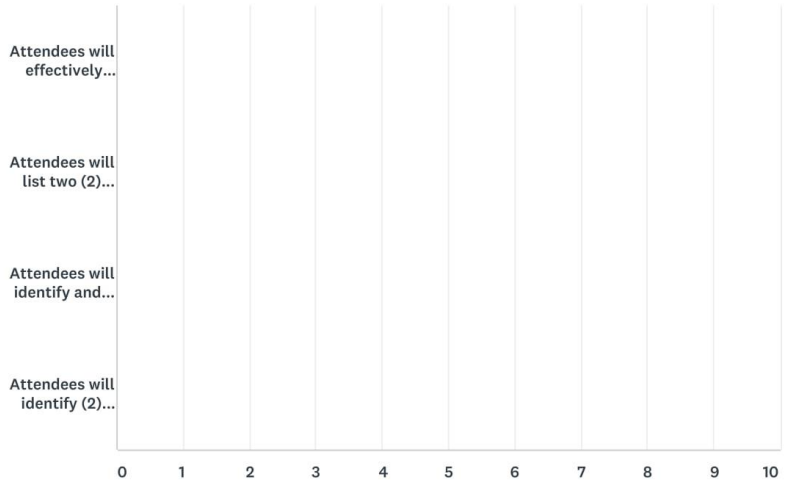


ANSWER CHOICES	RESPONSES	
Yes	91.18%	31
Somewhat	8.82%	3
No	0.00%	0
TOTAL		34

Appendix 21

Q6 Learning goals and objectives:

Answered: 34 Skipped: 0

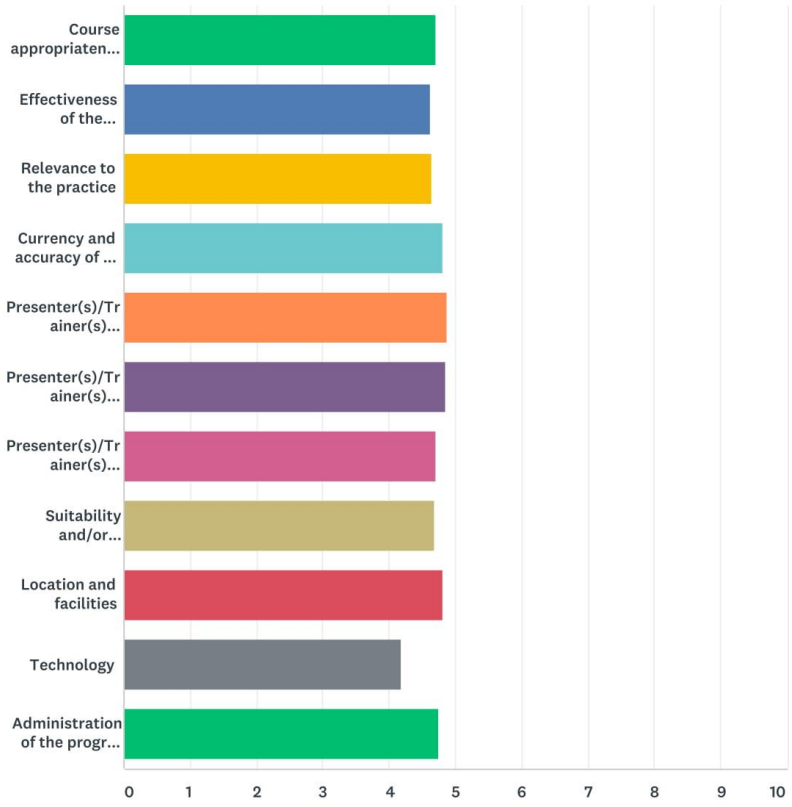


	YES	N/A	NO	TOTAL	WEIGHTED AVERAGE
Attendees will effectively identify three (3) differences between each of the following: biological sex, gender identity, gender presentation, and gender attribution.	100.00% 34	0.00% 0	0.00% 0	34	0.00
Attendees will list two (2) ways in which they can alter their work environment to be more trans-affirming.	100.00% 34	0.00% 0	0.00% 0	34	0.00
Attendees will identify and categorize a list of 10 statements into trans-affirming and non-affirming columns.	82.35% 28	8.82% 3	8.82% 3	34	0.00
Attendees will identify (2) two personal skills that increases their confidence in working with trans clients across the lifespan.	97.06% 33	2.94% 1	0.00% 0	34	0.00

Appendix 21

Q7 Rate, on a scale of 1 to 5 with 1 being "Needs Improvement" and 5 being "Excellent", the following areas:

Answered: 34 Skipped: 0



	1	2	3	4	5	N/A	TOTAL	WEIGHTED AVERAGE
Course appropriateness to participants' education, experience, and licensure level	0.00% 0	0.00% 0	5.88% 2	17.65% 6	76.47% 26	0.00% 0	34	4.71
Effectiveness of the presentation, including use of experiential or active learning	0.00% 0	0.00% 0	8.82% 3	20.59% 7	70.59% 24	0.00% 0	34	4.62
Relevance to the practice	0.00% 0	0.00% 0	8.82% 3	17.65% 6	73.53% 25	0.00% 0	34	4.65
Currency and accuracy of the information	0.00% 0	0.00% 0	2.94% 1	11.76% 4	85.29% 29	0.00% 0	34	4.82
Presenter(s)/Trainer(s) knowledge of the subject matter and clarity of delivery	0.00% 0	0.00% 0	2.94% 1	5.88% 2	91.18% 31	0.00% 0	34	4.88
Presenter(s)/Trainer(s) responsiveness to participants	0.00% 0	0.00% 0	2.94% 1	8.82% 3	88.24% 30	0.00% 0	34	4.85

Appendix 21

Presenter(s)/Trainer(s) ability to utilize course-appropriate technology to support participant learning	0.00% 0	0.00% 0	5.88% 2	17.65% 6	76.47% 26	0.00% 0	34	4.71
Suitability and/or usefulness of instructional materials	0.00% 0	0.00% 0	8.82% 3	14.71% 5	76.47% 26	0.00% 0	34	4.68
Location and facilities	0.00% 0	0.00% 0	2.94% 1	11.76% 4	85.29% 29	0.00% 0	34	4.82
Technology	0.00% 0	2.94% 1	20.59% 7	32.35% 11	44.12% 15	0.00% 0	34	4.18
Administration of the program (overall course organization)	0.00% 0	0.00% 0	2.94% 1	20.59% 7	76.47% 26	0.00% 0	34	4.74

Appendix 21

Policy:
It is the policy of the Behavioral Health Department to provide education and training to employees, contracted employees, and volunteers that is in accordance with State requirements and Departments goals.

Purpose:
To assist employees, contracted employees and volunteers to meet training and licensing requirements and to ensure our workforces ability to provide quality of care and culturally and linguistically competent services to the community.

Definitions:

Competency Based Training:
Trainings/classes within a group of trainings/classes deemed a "competency", for a specific job classification to be completed in order to meet the Department's training requirements and or attain job related knowledge.

Mandatory Training:
Training required by BH, the supervisor or training necessary to maintain licensing and certification requirements for job classifications or job related duties.

Orientation Training:
Training provided by the Department during a new employee's orientation process.

Training Types:
Training may be delivered by any of the following sources:

* Online/Web – Essential Learning (E-Learning)
* County – BH or another County department
* Private – Contracted consultant or organization

Mental Health Services Act:
As part of the Mental Health Services Act (MHSA) Workforce Education and Training Component, the Departments education and training program is dedicated to:

* Maintaining a curriculum to train and retrain staff to provide services that are in accordance with provision under Act
* Establishing partnerships among the behavioral health system and educational system to expand outreach to multicultural communities
* Increasing the diversity of the behavioral health workforce to reduce the stigma associated with mental illness, co-occurring illness, and addiction
* Promoting the use of web-based technologies and distance learning techniques.
* Promoting the inclusion of behavioral health consumers and family members' viewpoints and experiences in the training and education program.
* Promoting the inclusion of the cultural competency in the training and education programs.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, MFT, Date 08/2010

Revision dates:

Appendix 22

Cultural Competence:
As defined by the California Code of Regulations (CCR) Title 9 § 3200, 100, cultural competence means incorporating and working to achieve the items listed below, into all aspects of policy-making, program design, administration and service delivery.

Goals of cultural competence:

* Equal access to services
* Treatment interventions and outreach
* Reduction of disparities in services
* Understanding of the diverse belief system concerning behavioral illness
* Understanding the impact of historical bias, racism, and other discriminations have on behavioral health.
* Improvement of services and support unique to individuals racial/ethnic, cultural and linguistic populations.
* Development and implementation of strategies to promote equal opportunities for administrators, service providers and others involved in service delivery who share the diverse racial/ethnic and linguistic characteristics of individuals being served

Cultural Competency Training:
In accordance with the Cultural Competency Plan, it is required that all new employees attend the mandatory cultural competency training that the Department offers. In addition, administrative and management employees, as well as direct service providers are required to attend more extensive cultural competency trainings.

On a continuous basis, all BH employees are required to take cultural competency training annually.

Continuing Education (CE) Credit Training:
The Department will offer several training opportunities to obtain CE credits to meet licensing and certification requirements as needed.

Other Trainings:
Trainings related to the Departments rules, regulations, goals, as well competency based trainings, and those required under CCR, Title 9 §1922, will also be offered through the Department.

References:

* California Code of Regulations, Title 9, Division 1, Chapter 11 §1810.410, Chapter 12, § 1922, and Chapter 14, §3200.100
* Behavioral Health Department, (2010) Cultural Competency Plan
* Welfare and Institution Code, Division 5, Chapter 4 §5820 - §5822

Approved by Behavioral Health Administrator: Karen Baylor, PhD, MFT, Date 08/2010

Revision dates:

Appendix 22

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	0	0	0							
Case Manager/Service Coordinator	2.0	0	4.0							
Employment Services Staff	0	0	0							
Housing Services Staff	0	0	0							
Consumer Support Staff	1.0	0	2.0							
Family Member Support Staff	0	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	1.0	0	2.0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	**4.0**	**0**	**8.0**	**3.0**	**1.0**	**0**	**0**	**0**	**0**	**4.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	60.4	1.0	120.8							
Case Manager/Service Coordinator	29.5	0	59.0							
Employment Services Staff	5.5	0	11.0							
Housing Services Staff	19.3	1	38.6							
Consumer Support Staff	16.0	0	32.0							
Family Member Support Staff	6.0	1.0	12.0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	22.0	1.0	44.0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	**158.7**	**4.0**	**317.4**	**115**	**31.7**	**7**	**2**	**1**	**2**	**158.7**
Total, A (County & All Other):	**162.7**	**4.0**	**325.4**	**118**	**32.7**	**7**	**2**	**1**	**2**	**162.7**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	10.0	1.0	20.0							
Psychiatrist, child/adolescent	1.0	1.0	2.0							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	4.0	1.0	8.0							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	34.0	0	68.0							
Licensed Clinical Psychologist	3.0	0	6.0							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	11.0	1.0	22.0							
MSW, registered intern (or waivered)	2.0	1.0	4.0							
Marriage and Family Therapist (MFT)	35.0	0	70.0							
MFT registered intern (or waivered)	12.0	0	24.0							
Other *Licensed* MH Staff (direct service)	1.0	0	2.0							
Sub-total, B (County)	**113.0**	**5.0**	**226**	**86**	**7**	**1**	**2**	**0**	**2**	**98**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	0	0	0							
Psychiatrist, child/adolescent	0	0	0							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	0	0	0							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	5.5	0	0							
Licensed Clinical Psychologist	3.0	0	6							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	2.5	0	4							
MSW, registered intern (or waivered)	2.0	0	0							
Marriage and Family Therapist (MFT)	18.4	0	22							
MFT registered intern (or waivered)	12.8	0	2							
Other *Licensed* MH Staff (direct service)	0	0	0							
Sub-total, B (All Other)	**44.2**	**3.0**	**88.2**	**38.2**	**4.5**	**1.5**	**0**	**0**	**0**	**44.2**
Total, B (County & All Other):	**157.2**	**8.0**	**314.2**	**124.2**	**11.5**	**2.5**	**2.0**	**0**	**2.0**	**142.2**

(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	1.0	0	2.0							
Registered Nurse	8.0	1.0	16.0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ↓						
Sub-total, C (County)	**9.0**	**1.0**	**18.0**	**9.0**	**0**	**0**	**0**	**0**	**0**	**9.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0	0	0							
Registered Nurse	1.5	1.0	3.0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0	(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ↓						
Sub-total, C (All Other)	**1.5**	**1.0**	**3.0**	**1.5**	**0**	**0**	**0**	**0**	**0**	**1.5**
Total, C (County & All Other):	**10.5**	**2**	**21.0**	**10..5**	**0**	**0**	**0**	**0**	**0**	**10.5**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	7.0	0	14.0	(Managerial and Supervisory; Sub-Totals Only) ↓						
Supervising psychiatrist (or other physician)	1.0	0	2.0							
Licensed supervising clinician.....	7.0	0	14.0							
Other managers and supervisors.....	2.0	1	4.0							
Sub-total, D (County)	**17.0**	**1**	**34.0**	**15.0**	**1.0**	**0**	**0**	**0**	**1.0**	**17.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....	11.0	1.0	14.0	(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Supervising psychiatrist (or other physician)	0.5	1.0	1.0							
Licensed supervising clinician.....	7.5	1.0	4.0							
Other managers and supervisors.....	22.0	2.0	14.0							
Sub-total, D (All Other)	**41.0**	**5.0**	**33.0**	**40.5**	**0**	**0**	**0**	**0**	**.5**	**41.0**
Total, D (County & All Other):	**58.0**	**6.0**	**67.0**	**55.5**	**1.0**	**0**	**0**	**0**	**1.5**	**58.0**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	**3.0**	**0**	**6.0**	(Support Staff; Sub-Totals Only) ↓						
Education, training, research	**1.0**	**1.0**	**2.0**							
Clerical, secretary, administrative assistants	**28.0**	**0**	**56.0**							
Other support staff (non-direct services).....	**11.0**	**0**	**22.0**							
Sub-total, E (County)	**43.0**	**1.0**	**86.0**	**37.0**	**6.0**	**0**	**0**	**0**	**0**	**43.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....	**10.5**	**0**	**4.0**	(Support Staff; Sub-Totals and Total Only) ↓						
Education, training, research	**4.0**	**0**	**2.0**							
Clerical, secretary, administrative assistants	**13.8**	**0**	**4.0**							
Other support staff (non-direct services).....	**8.8**	**0**	**1.0**							
Sub-total, E (All Other)	**37.2**	**0**	**11.0**	**30.4**	**6.0**	**0**	**0.8**	**0**	**0**	**37.2**
Total, E (County & All Other):	**80.1**	**1.0**	**97.0**	**67.4**	**12**	**0**	**0.8**	**0**	**0**	**80.2**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

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

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
County (employees, independent contractors, volunteers) (A+B+C+D+E).....	**186.0**	**8.0**	**372.0**	**150.**	**15.0**	**1.0**	**2.0**	**0**	**3.0**	**171.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)	**282.5**	**13**	**452.6**	**225. 6**	**42.2**	**8.5**	**2.8**	**1.0**	**2.5**	**282.5**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**468.5**	**21**	**824.6**	**375. 6**	**57.2**	**9.5**	**4.8**	**1.0**	**5.5**	**453.5**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**3382**	**684**	**131**	**50**	**49**	**113**	**4409**
G. TOTAL % PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**77.%**	**16%**	**3.0%**	**1.0%**	**1.0%**	**2.0%**	**100%**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff.....	7.0	0	7.0
Family Member Support Staff	6.0	1.0	6.0
Other *Unlicensed* MH Direct Service Staff.....	4.0	0	0
Sub-Total, A:	**17.0**	**1.0**	**13**
B. *Licensed* Mental Health Staff (direct service).....	**16.2**	**0**	**0**
C. Other Health Care Staff (direct service)	**0**	**0**	**0**
D. Managerial and Supervisory.....	**10.5**	**1.0**	**2.0**
E. Support Staff (non-direct services).....	**25.3**	**0**	**0**
GRAND TOTAL (A+B+C+D+E)	**69.0**	**2.0**	**15.0**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. __ SPANISH_____	Direct Service Staff __44.0___ Others __10.0__	Direct Service Staff __88.0__ Others __20.0__	Direct Service Staff _132.0__ Others _30.0____
2. __VIETNAMESE_____	Direct Service Staff __0___ Others __0__	Direct Service Staff __2.0___ Others __1.0__	Direct Service Staff _2.0____ Others _1.0____
3. __CANTONESE_____	Direct Service Staff __0_ Others __0___	Direct Service Staff __1.0__ Others __1.0__	Direct Service Staff _1.0____ Others _1.0____
4. __ HMONG_____	Direct Service Staff _ 1.0___ Others __0___	Direct Service Staff __1.0___ Others __0___	Direct Service Staff _1.0____ Others _0____
5. __ _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

IV. REMARKS: Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

Methodology: The projections of estimated need for staff were based on a comparison of the overall prevalence of mental illness in San Luis Obispo County with the proportion of that prevalent need currently being met by existing providers. In general, San Luis Obispo County needs to increase its current providers by three times the current level. This Needs Assessment attempted to capture the current workforce within the San Luis Obispo County Public Mental Health Service System. Accurate data was obtained from the San Luis Obispo County Human Resources data system (from FY2007-08) and directly from each Community Based Organization (CBO). Language proficiency data was obtained by survey of staff or from current, existing human resources data. Data was obtained from Behavioral Health Services (BHS) and all of its organizational and network providers including those organizations serving diverse unserved, underserved and inappropriately served communities. San Luis Obispo County conducted a Workforce Needs Assessment Survey of all BHS Staff and all Network Providers in December of 2008. Through vigorous follow up, San Luis Obispo County was able to achieve a 100% response rate. The information was analyzed to prepare these remarks.

A. Shortages by occupational category:

● There is a need for additional bilingual/bicultural staff in all classifications, especially in our threshold language of Spanish, which we have found to be hard to recruit.
● Psychiatrist and Registered Nurses that work at the Psychiatric Health Facility (PHF) are very hard to recruit.
● Other employers in the county, such as the State University, California Men's Colony and Atascadero State Hospital pays higher wages draws on the limited resources of the mental health workforce.
● Most of our positions are impacted greatly by the county's cost of living that limits the qualified pool of applicants.
● There is a small pool of graduate students looking for work, however the pay is minimal.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

● The table below displays FTE-to-client ratios by race and ethnicity for total and direct service staff. There is an overall shortfall in the mental health workforce in regards to meeting the prevalence needs within San Luis Obispo County. The county and its providers have indicated that it only provides services to 33% of the consumers who need mental health services.
● As indicated in the chart below, direct service providers for the County of San Luis Obispo do not represent target population in race/ethnicity and there is a specific shortage in bilingual staff.
● Contract providers and Behavioral Health Services need to hire more bilingual Spanish speaking employees as indicated below.
● It has been very difficult to find, hire, and train bilingual therapists skilled at working with individuals, families, and children.

	Number of Consumers who Identify as:	Direct Service Staff		Total Staff	
		Who Identify as	Ratio	Who Identify as	Ratio
White/Caucasian	3382 (77%)	108	31:1	280	12:1
Hispanic/Latino	684 (16%)	9	76:1	48	14:1
African-American	131 (3%)	2.5	52:1	9.5	14:1
Asian/Pacific Islander	50 (1%)	2	25:1	4	12:1
Native American	49 (1%)	0	0:1	1	49:1
Multi/Other	113 (2%)	2	56:1	5	23:1

C. Positions designated for individuals with consumer and/or family member experience:

●There is a significant shortfall in the mental health workforce in regard to the employment of consumer and family staff throughout the system though some CBO contractors have been more successful than others in recruiting consumer staff.
●There is a need to employ consumer staff in regular benefited positions vs. relying on volunteers, stipends, personal service contracts, ect.
●We need a significant increase in bilingual Spanish-speaking direct service consumer and family member staff in order to meet service demands.

D. Language proficiency:

●There is a great demand for bilingual (English/Spanish) clinicians.
●There is a strong need to improve the training and recruitment of language proficient and bicultural individuals.
●There is a need for bilingual (English/Spanish) consumer and family member staff.

E. Other, miscellaneous:

The geographic size and rural location of San Luis Obispo County makes the provision of services to all those in need of mental health services a challenge. For those individuals that do enter the mental health field, they seek higher paying positions with the State Hospital, Men's Colony Prison, or Cal Poly State University. Due to a high cost of living, it is particularly challenging to recruit professional staff into relocating to this area.

2.00 Culturally Competent, Multi-lingual Services

I. PURPOSE

To describe the way we provide multilingual and culturally appropriate services to the diverse populations in the County, as detailed in the Cultural Competence Plan

II. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) continues to develop a system of care that serves an increasing, changing, and diverse population in the County. SLOBHD will follow the guidelines in the Cultural Competence Plan to become a more culturally competent organization and to ensure that each person receives Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) that are culturally and linguistically appropriate.

SLOBHD will value diversity, reduce disparities, and will not discriminate against or deny admission or services to any person based on age, ethnicity, marital status, medical condition, national origin, physical or mental disability, pregnancy, race, religion, sex, sexual orientation, gender expression or identity, socio-economic status, literacy level, or any other legally protected status.

III. REFERENCE

- Code of Federal Regulations, Title 45, Part 80
- Code of Federal Regulations, Title 42, §438.6(f)(1), §438.10, §438.100, §438.206
- Welfare & Institutions Code §5600.2(g)
- California Code of Regulations, Title 9, §1810.410
- California Code of Regulations, Title 9, §3200.100, §3200.210, §3320
- Mental Health Plan Contract with DHCS
- Drug Medi-Cal Organized Delivery System contract with DHCS
- SLOBHD Cultural Competence Plan and Updates
- SLO Health Agency Non-discrimination and Language Access Plan

IV. PROCEDURE

A. Language Needs/Informing:

1. Upon initial contact to request services, individuals are informed in a language they understand that they have a right to free language assistance. An offer of free interpretation services is documented on the BH Service Request form and on the Demographic form.

2. Informing materials, including the Beneficiary Handbook, Notice of Privacy Practices, Consent for Treatment and other relevant documents are available in English and Spanish (SLOBHD's threshold language). Large print (72-point font) and audio CD versions of the Beneficiary Handbook are also available. See Policy 4.20, Information Process for Beneficiaries, for more detail.

3. When SLOBHD staff translate written materials into Spanish, every effort is made to provide review by two bilingual staff members to ensure that the translation is clear and culturally appropriate. See the SLO Health Agency Non-discrimination and Language Access Plan for additional detail.

B. Language Capacity:

1. SLOBHD is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations so that beneficiaries are provided with culture-specific and linguistically appropriate services. Our goal is to provide services by, in order of preference:

   - Bilingual/bicultural providers
   - Bilingual providers
   - Bilingual/bicultural interpreters
   - Language Line Solutions

2. SLOBHD will make key hiring and contracting decisions to grow our language capacity in all geographic regions of SLO County.

3. Particular emphasis will be placed on making sure that key points of contact, such as Central Access and SLOBHD afterhours 24/7 Access Line contractor employ staff who are bilingual (English and Spanish).

4. Language Line Solutions will be used to ensure oral interpretation capacity in Spanish if a more preferred option is not available.

5. Language Line Solutions will be used to accommodate consumers who speak non-threshold languages. Information and training in the use of the Language Line Solutions will be provided for all staff.

6. A specialized MHSA program, (Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP)) will offer culturally appropriate psychotherapy services to monolingual, low-income Spanish speakers and their bilingual children. LOP staff will be bilingual/bicultural.

7. Each clinic site will have the capacity to provide services in Spanish using bilingual staff.

Appendix 24

A

8. Additionally, SLOBHD contracts project with a community agency, Center for Family Strengthening, to provide in-person translation by "Promotores". Promotores are bilingual/bicultural community members who will receive training to provide translation services.

9. SLOBHD will maintain an open purchase order with Independent Living Resource Center for the provision of American Sign Language (ASL) services.

C. Translation and interpretation services will be provided in a confidential manner.

D. Family members will not be relied on as interpreters due to the extreme difficulty this often creates in treatment and familial relationships. However, upon documented request of the beneficiary, a family member may provide interpretation after the beneficiary is informed of the availability of free interpreter services. Minor children will not be used as interpreters except in exceedingly rare circumstances; justification for such action must be well documented in the record.

E. Bilingual Certification: Bilingual Certification Committee or designee will evaluate language competence. The committee will determine whether oral and/or written language skills are adequate for the staff member's role. See the SLO Health Agency Non-discrimination and Language Access Plan for additional detail

F. In addition to ethnic and language considerations, SLOBHD will expand capacity and expertise in dealing with other underserved populations, including, but not limited to, the LGBTQ community, hard to reach veterans, homeless residents, transitional aged youth, and children aged 0-5.

G. Cultural Competence Committee and Cultural Competence Training:

1. The Cultural Competence Committee will meet regularly to address issues related to reducing disparities and increasing staff awareness and competence.

2. Cultural Competence Training will include the following:

a. Mandatory annual e Learning cultural competence training
b. Periodic live cultural competence trainings
c. A Cultural Competence newsletter, which will be published periodically to highlight key issues affecting beneficiaries in SLO County

H. When culturally appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.

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Appendix 24

V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
10/1/2015	All	Reformatted and expanded
3/15/2018	All	Added references to the SLO Health Agency Non-discrimination and Language Access Plan
Prior Approval dates:		
02/27/2009		

		3/15/18
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 24

Dear Consumers,

Informational materials are available in alternative formats. Please ask the receptionist for assistance.

Estimado Consumidores,
Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda.

Gracias.

Appendix 25

Dear Consumers,

Free language assistance services are available upon request. Please ask the receptionist or any staff person for assistance.

Si usted busca servicion de salud mentales y necesita ayuda en Espanol por favor de informarle a la recepcionista.

Gracias

Appendix 25

Free language assistance available upon request.

Assistencia gratuita disponible en español si la requiere.

Appendix 25

Policy

Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services.

Procedure:

1. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).

2. The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members at least one of whom is a native speaker of the threshold languages in the county.

3. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a total of 100. The checklist will include, but not be limited to:

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

4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.

5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

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

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6. Following the departure of the candidate the BCC members separately score their evaluation of the candidate's performance. The evaluators' score is then averaged. A passing score will be 60 or greater. The candidate is notified by a memo issued from the committee as to the outcome of the evaluation, with copy given to Mental Health Human Resources.

7. A candidate who has failed to be certified may appeal to the Bilingual Certification Committee and request to be retested by two other committee members who will repeat the process.

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

Appendix 26

CSS Work Plan	CSS Sub Plan	Program	Program Description
1. FSP Child/Youth	1	Children and Youth Full Service Partnership (FSP)	The Children and Youth Full Service Partnership program serves children and youth ages 0-15 of all races and ethnicities with severe emotional disturbance or serious mental illnesses. Behavioral Health partners with Family Care Network to provide a wide array of culturally and linguistically appropriate services. All services are family driven and may include: individual and family therapy; rehabilitation services focusing on activities for daily living, social skill development, case management; crisis services; and medication supports.
2. FSP TAY	2	Transitional Aged Youth (TAY) Full Service Partnership (and Housing)	The Transitional Age Youth Full Service Partnership program serves youth between the ages of 16-25 of all races and ethnicities. Young adults served include those with serious emotional disturbances/serious mental illness and a chronic history of psychiatric hospitalizations; law enforcement involvement; co-occurring disorders. Behavioral Health and Family Care Network collaborate to provide wrap-like services and includes 24/7 crisis availability, intensive case management, housing, employment linkages and supports, independent living skill development and specialized services for those with a co-occurring disorder.

3. FSP Adult	3	Adult Full Service Partnership	The Adult Full Service Partnership team is a community and wellness approach to engage persons at risk and targets adults 26-59 years of age with serious mental illness. The participants are usually unserved, inappropriately served or underserved and are at risk of institutional care because their needs are difficult to meet using traditional methods. They may be frequent users of hospital or emergency room services, involved with the justice system or suffering with a co-occurring substance abuse disorder. Behavioral Health partners with Transitions Mental Health Association to provide a full range of services including assessment, individualized treatment planning, case management, integrated co-occurring treatment, medication supports, housing, and integrated vocational services to enable individuals to remain in the community, and live full, productive, self-directed lives.
	3	Adult Full Service Partnership: Homeless Outreach Team	The team focuses on outreach to unserved, difficult-to-reach homeless population, and seeks to engage clients in health care, mental health treatment, and housing. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence.
	3	Adult Full Service Partnership: AOT	The Adults in Assisted Outpatient Treatment includes AOT outreach and treatment services provided by a FSP team comprised of TMHA staff. SLOBHD staff provide assessment, program support and coordination with the court. The services offered to AOT clients include co-occurring treatment to address both mental health and substance use disorder needs, rehabilitation services to assist clients in learning and utilizing skills to improve self-care, social support system, and health, and intensive case management to support clients in accessing housing, financial, vocational, health care, and social support services, including voluntary mental health services.
	3	FSP AOT Intensive Residential Housing	This program provides supported housing with Intensive Residential Case Management services for adults with mental illness and operates in conjunction with Adult Assisted Outpatient Full Service Partnership Team services. Intensive Residential Services consists of independent living with external supports and includes evening and weekend (40 hours/week) case management coverage
	3	FSP Adult Intensive Residential Housing	This program provides supported housing with Intensive Residential Case Management services for adults with mental illness and operates in conjunction with FSP program services. Intensive Residential Services consists

			of independent living with external supports and includes evening and weekend (40 hours/week) case management coverage
	3	FSP Adult Intensive Residential Case Management Services	Program provides intensive residential management services to the 33 bed FSP Adult Intensive Residential Housing Program and 8 units at the Nipomo Street Studios. This program provides intensive case management services to assist the clients in developing problem solving skills related to daily living, housing, managing chronic symptoms of illness, decreasing psychiatric hospitalizations and employment. Case management activities also include assisting residents with cooking, cleaning, conflict resolution, budgeting, socialization and community integration
	3	FSP Homeless Housing Component	FSP Homeless Housing Component shall provide stable, supportive housing for individuals participating in the FSP program dedicated to homeless individuals. TMHA operates a 4-bed housing program in the city of San Luis Obispo for clients in the Homeless FSP program.
4. FSP Older Adult	4	Older Adult Full Service Partnership	The goal of the Older Adult Full Service Partnership team is to offer intensive, individualized interventions to older adults ages 60+ to ensure that participants remain in the least restrictive setting possible. Behavioral Health partners with Wilshire to provide client driven services to Older Adults who are at risk of inappropriate or premature out-of-home placement due to a serious mental illness and, in many instances, co-occurring medical conditions that impact their ability to remain in home/community environments.
Housing	Housing	Nelson St Studios	Studios were constructed and continue to be administered by Transitions Mental Health Association. Studios were constructed and continue to be administered by Transitions Mental Health Association. These five studio units are in South San Luis Obispo County adjacent to a peer-lead wellness center. The studio apartments provide stable and affordable housing with supports to assist low and very low-income clients in promoting whole life wellness. Crisis services are available as needed.
		Nipomo St Studios	Studios were constructed and continue to be administered by Transitions Mental Health Association. This MHSA housing project provides 8 units to serve adults who are homeless or at risk of homelessness and have a diagnosis of severe mental illness, consistent with the CSS Plan and the MHSA definition of target population. Those with co-occurring disorders are also considered for residency in a unit.

5. Client and Family Wellness	5.1	Client & Family Partners Adult Family Advocates and Youth Family Partners (TMHA)	Conducted in partnership with Transitions Mental Health Association (TMHA), Adult Family Advocates and Youth Family Partners is a liaison with family members, care givers, consumers, local NAMI groups, and other service providers in San Luis Obispo County. This program provides support, education, information and referral, and community outreach for families of adults with psychiatric disabilities and children in care. Assist in orientation of new families entering the mental health system and develop programs that strengthen parent to parent support.
	5.2	Dual Diagnosis	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Located in every adult outpatient clinic, caseload reduction therapists and co-occurring specialists facilitate a “no wrong door” approach and ensure that every participant receives appropriate services regardless of how they enter the system.
	5.3	Family Education Program	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Trained family members provide education and support and orientation class that provides information regarding services available in our community including housing and supported employment, promoting self-care and help with navigating through the mental health system.
	5.4	Service Enhancement Team	Conducted in partnership with Transitions Mental Health Association (TMHA), Behavioral health navigators will help clients, their families, loved ones, and caregivers navigate through the first steps of receiving services, help assess needs, and engage services for basic necessities within the clinic setting.
	5.4	Martha's Place SET	Behavioral health navigators will help clients, their families, loved ones, and caregivers navigate through the first steps of receiving services, help assess needs, and engage services for basic necessities within the clinic setting. This clinician is housed at Martha's Place.
	5.5	Peer Support & Education Peer to Peer Program (TMHA)	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA provide peer mentoring, peer and family educational and support groups focused on wellness, recovery and resilience. Peer to Peer and Family to Family education coursed are delivered throughout the County

	5.6	Supportive Employment and Vocational Training	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA partners with Department of Rehabilitation to provide employment readiness classes, on the job training, and job placement.
	5.6	Growing Grounds Retail	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA provides vocational training, support and direct work experience in their retail outlet store. The program offers job coaching, assessment, vocational support and work experience.
	5.7	Integrated Case Management	These integrated access therapists allow clinic staff to spend more time with outpatient clients, providing more resources and referrals, groups, system navigation, and wellness activities within the traditional structure of mental health services.
	5.7	Integrated Case Management: Martha's Place	This integrated access therapist allows clinic staff to spend more time with outpatient clients, providing more resources and referrals, groups, system navigation, and wellness activities within the traditional structure of mental health services. The position will continue to serve the community, to increase access and triage those clients with needs outside of the child's assessment center.
	5	Wellness Centers	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Peer driven wellness centers offer support groups, socialization activities and sponsored educational activities in comfortable, welcoming settings throughout the county.
6. Latino Outreach Program	6	Latino Outreach and Engagement (LOP: Therapy Services)	Bilingual and bicultural therapists to provide culturally appropriate treatment services offered in both community and clinic settings. The target population is the unserved and underserved Latino community, particularly those in identified pockets of poverty in the north and south county areas and rural residents.
7. Enhanced Crisis and Aftercare	7.1	Mental Health Evaluation Team (MHET) & Crisis Response Team (CRT)	The Enhanced Crisis Response and Aftercare work plan features the Mobile Crisis team, and the new clinic-based Crisis Resolution Team (**funded as part of an SB 82 grant**), to increase the county's capacity to meet the needs of individuals requiring specialized, critical intervention and aftercare. The goal and objectives of the work plan include the aim to increase access to emergency care, prevent further exacerbation of mental illness, and be available to all county residents, across all age, ethnic and

			language groups. Additional to this work plan is a Crisis Mental Health Therapist assigned to coordinate efforts between emergency rooms, law enforcement, jails, the local Hotline, and inpatient psychiatric health facility.
	7.2	Crisis Stabilization Unit (CSU)	The Crisis Stabilization is a 23 hr. stay unit that is in place for crisis intervention, assessment, evaluation, collateral, medication support services, therapy, peer support, etc. to avoids unnecessary hospitalization and incarceration while improving wellness for individuals with mental health disorders and their families.
8. School and Family Empowerment	8.1	Community Schools	Behavioral Health and the San Luis Obispo County Office of Education have partnered with the community schools in the county to provide mental health services to seriously emotionally disturbed youth, engaging these youths and their families in services that enable them to stay in school. A separate team concentrates on students within the county's largest school district (Lucia Mar Unified) in the diverse, southern region of the county. This team provides an intense-but-brief engagement, focusing on family, school, and socialization outcomes.
	8.2	Family Empowerment (SAFE)	Behavioral Health and the San Luis Obispo County Office of Education have partnered with the community schools in the county to provide mental health services to seriously emotionally disturbed youth, engaging these youths and their families in services that enable them to stay in school. A separate team concentrates on students within the county's largest school district (Lucia Mar Unified) in the diverse, southern region of the county. This team provides an intense-but-brief engagement, focusing on family, school, and socialization outcomes.
9. Froensic Mental Health Services	9.1	Behavioral Health Treatment Court (BHTC)	The BHTC team serves adults, ages 18 and older, with a serious and persistent mental illness, who are on formal probation for a minimum of two years, and who have had chronic use of mental health treatment observed as a factor in their legal difficulties. BHTC clients volunteer for the program forming a contractual agreement as part of their probation orders. These individuals have been previously underserved or inappropriately served because of lack of effective identification by all systems, may be newly diagnosed, or may have been missed upon discharge from jail or Atascadero State Hospital. BHTC clients, in many cases, have little insight or understanding about having a mental illness or how enhanced collaborative services could meet their needs.
	9.2	Forensic Re-Entry Services (FRS)	A Forensic Re-entry Services (FRS) team, comprised of community-provided Personal Services Specialists (PSS) provides a "reach-in" strategy in the County Jail, adding capacity for providing aftercare needs for persons exiting from incarceration. The Forensic PSS is provided in partnership with TMHA and is responsible for providing a

			"bridge" for individuals leaving the jail in the form of assessment and referral to all appropriate health and community services and supports in addition to short-term case management during this transition.
	9.3a	Veterans Treatment Court (VTC)	Behavioral Health has a Mental Health Therapist located in the Veterans Services Office to serve veterans referred directly from the and those participating in the Veterans Treatment Court. The placement of the Therapist on-site at the VSO provides a culturally competent environment for veterans and their families to seek support and engage in behavioral health services.
	9.3b	Veterans Program	Behavioral Health has a Mental Health Therapist that provides individual, couple, family and group treatment services to veterans and their families during participation in the veterans' outreach program as well as monitors progress with other treatment providers.
	9.4	Forensic Coordination Therapist (FCT)	The FCT, in partnership with a Sheriff's Deputy assigned to the team, assists law enforcement with difficult, mental illness-related cases. The team works closely with all local law enforcement and court personnel in training and case management issues to reduce crisis.
	9.5	Community Action Team (CAT)	A behavioral health care professional shall be embedded within a municipal police department to respond directly to individuals experiencing behavioral health crises who are or in need of outreach and engagement. The behavioral health professional (CAT Community Liaison) shall work closely with highly trained officers establishing a new behavioral health unit within the SLO police department (SLOPD) focused on homeless, transient, and other high-risk individuals.

Last Name	First Name
Anaya	Rocio
Bautista	Susie
Bega	Arisa
Berg	Steve
Campos	Benjamin
Cantu	Humberto
Cosgrove	Lucero
Delgado	Abril
Dietz	Elaine
Hernandez	Alexandra
Jordison	Rita
Llamas Meza	Jakelyn
Lopez	Ricardo
Lopez	Gloria
Lopez	Mayra
Lopez	Claudia
Martin	Diana
McSpadden Tarver	Rachel
Mendoza	Conrad
Mendoza	Gricel
Mora	Yesenia
Pearce	James
Ponce Alvarez	Fatima
Real	Irma
Ruvalcaba	Angelica
Santiago	Esther
Sommers	Allison
Soto	Melissa
Vargas	M
Vasquez	Elba
Velasquez	Connie
Zarate	Laura

Servicios de Drogas & Alcohol

Evaluación / Evaluación
Los servicios de tratamiento comienzan con una evaluación seguida de una evaluación. Esto nos ayuda a determinar el programa correcto y el nivel de atención según sus necesidades. Tratamiento Ambulatorio Ambulatorio e Intensivo disponible.

Tratamiento / recuperación en curso
Una vez que se haya determinado su programa apropiado, trabajaremos con usted a través de varios servicios de asesoramiento para ayudarlo en su recuperación.

- **Tratamiento individual**
  Trabajaremos con usted individualmente para ayudarlo a encontrar formas de enfrentar y crecer.
- **Tratamiento grupal**
  Ofrecemos grupos para ayudarlo a aprender sobre su uso de sustancias y formas de recuperación.
- **Gestión de retiros**
  Brindamos asistencia médica y evaluación de medicamentos para reducir y manejar los síntomas de abstinencia de los trastornos por consumo de sustancias de opiáceos, alcohol y metanfetaminas.
- **Gestión de casos**
  Podemos ayudarlo a trabajar con agencias locales para obtener los servicios que necesita, como Tratamiento residencial o Residencia de recuperación.
- **Trastornos coocurrentes Tratamiento**
  Ofrecemos servicios especializados para personas con un trastorno de salud mental y uso de sustancias.
- **Prevención, intervención temprana y alcance**

Recursos Importantes y Números de teléfono

SLO Hotline/Línea Directa: (800) 783-0607

Admin. Del Dept. de Salud Mental:
(805) 781-4719

Defensor de los Derechos de los Pacientes:
(805) 781-4738

Otros Servicios en la Communidad

AEGIS Centro de Tratamiento: (805) 461-5212

Consejería de Cal Poly: (805) 756-2511

Community Counseling Center: (805) 543-7969

Grupo Holman: (800) 321-2843

Hospice/Hospicio: (805) 544-2266

Transitions Mental Health Association (TMHA): (805) 540-6500

Veterans Affairs: (805) 543-1233

Victim/Witness/Testigo/Víctima: (805) 781-5821

Wilshire Health & Community: (805) 547-7025

Servicios para Niños/Familia

Child Development Resource Center:
(805) 544-0801

Family Care Network, Inc.: (805) 781-3535

Kinship Center: (805) 434-2449

Tri-Counties Regional Center (805) 543-2833

Asistencia Financiera/Vivienda

Dept. of Social Services: (805) 781-1600

Community Action Partnership of
San Luis Obispo (CAPSLO): (805) 544-4355

Servicios de Salud

Community Health Centers (CHC): (805) 269-1500

Long Term Care Ombudsman: (805) 785-0132

Public Health Department: (805) 781-5500

Información General

National Alliance on Mental Illness (NAMI): (805) 236-1007

COUNTY of SAN LUIS OBISPO

AGENCIA DE SALUD

Departamento de Salud Mental

www.slobehavioralhealth.org

Estamos aquí para ayudarlo!

Para servicios de salud mental ó de drogas y alcohol,

Por favor llame:

(800) 838-1381

June, 2018

Servicios de Salud Mental

Evaluación
Los servicios para pacientes ambulatorios comienzan con una evaluación que nos ayuda a comprender sus necesidades, fortalezas y objetivos. Hablaremos sobre los servicios que pueden ayudarlo mejor y es posible que proporcionemos referencias a otras agencias.

Tratemiento/recuperación en curso:
Trabajaremos con usted para encontrar los servicios adecuados para ayudarlo en su recuperación. Por ejemplo, los servicios pueden incluir, pero no están limitados a:

- **Terapia individual**
  Podemos trabajar con usted individualmente para ayudarlo a encontrar maneras de sobrellevar y crecer.
- **Rehabilitación grupal**
  Ofrecemos grupos para ayudarlo a aprender sobre su enfermedad y formas de recuperación.
- **Manejo de medicamentos**
  Incluye una reunión con un psiquiatra para analizar si los medicamentos lo ayudarán.
- **Gestión de casos**
  Podemos ayudarlo a trabajar con agencias locales para obtener los servicios que necesita.
- **Trastornos coocurrentes Tratamiento**
  Ofrecemos servicios especializados para personas con un trastorno de salud mental y uso de sustancias.
- **Evaluación de crisis y respuesta**
- **Prevención, intervención temprana y alcance**

Llame 1-800-838-1381

Servicios de Salud Mental

PARA CONTACTO DE SERVICIO:

Servicio de Salud Mental
Servicios de Atención &
24/7 Servicios de Crisis
(800) 838-1381

Sitio Web:
www.slomentalhealth.org

Defensor de los Derechos de los Pacientes
(805) 781-4738

Servicios para Adultos y Jóvenes

- Servicios ambulatorios para adultos y jóvenes
- Servicios de tratamiento concurrenteServicios para pacientes internados
- Programas forenses
- Manejo de medicamentos
- Servicios de evaluación de salud mental
- Servicios de terapia

Prevención y Alcance

- Alcance de Veteranos
- Consejería de intervención temprana
- Alcance y educación

Servicios de Drogas & Alcohol

PARA CONTACTO DE SERVICIO:

Servicios de Drogas & Alcohol
(800) 838-1381

Sitio Web:
www.slodas.org

Conducir Bajo los Programs de Influencia
(805) 781-4746

- Servicios de tratamiento para adultos
- Tribunal de drogas para adultos (ADC)
- Tribunal de Tratamiento de Salud Conductual (BHTC)
- Tribunal concurrente (ATCC)
- Tribunal de Tratamiento Familiar (FTC
- Tratamiento ambulatorio
- Tratamiento de mujeres y niños de grupo extendido ambulatorio perinatal (POEG)
- Desvío previo al juicio (DPT)
- Programa Prop 36

Prevención y Alcance

- Asesoramiento de apoyo estudiantil
- Friday Night Live
- Tratamiento de uso de sustancias juveniles

Si está experimentando una emergencia, llame al 911
24/7 SLO Hotline/Línea Directa: (805) 783-0607
Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística.

Encuentre una Clínica cerca a usted:

Arroyo Grande Mental Health (Adultos)
1350 E. Grand Ave , Arroyo Grande, CA 93420
(805) 474-2154

Arroyo Grande Mental Health (Menores)
354 S. Halcyon , Arroyo Grande, CA 93420
(805) 473-7060

Atascadero Drug & Alcohol (Adultos y Menores)
3556 El Camino Real , Atascadero, CA 93422
(805) 461-6080

Atascadero Mental Health (Adultos y Menores)
5575 Hospital Drive , Atascadero, CA 93422
(805) 461-6060

Grover Beach Drug & Alcohol (Adultos y Menores)
1523 Longbranch Avenue , Grover Beach, CA 93433
(805) 473-7080

Paso Robles Drug & Alcohol (Adultos y Menores)
1763 Ramada Dr. , Paso Robles, CA 93446
(805) 226-3200

San Luis Obispo Drug & Alcohol (Adultos)
2180 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4275

San Luis Obispo Drug & Alcohol (Menores)
277 South St., Ste. T , San Luis Obispo, CA 93401
(805) 781-4754

San Luis Obispo Mental Health (Adultos)
2178 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4700

San Luis Obispo Mental Health (Menores)
1989 Vicente , San Luis Obispo, CA 93405
(805) 781-4179

San Luis Obispo Mental Health (Niños 0-5)
Martha's Place Children's Center
2925 McMillan Ave, Ste. 108, San Luis Obispo, CA 93401
(805) 781-4948

San Luis Obispo Prevention & Outreach
277 South St., Ste. T , San Luis Obispo, CA 93401
(805) 781-4754

San Luis Obispo Psychiatric Health Facility
2178 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4711

Services Affirming Family Empowerment (SAFE)
1086 Grand Ave., Arroyo Grande, CA 93420
(805) 474-2105

La Agencia de Salud comple con las leyes federales de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, sexo ó cualquier otra clase protegida.

4.24 Provider List Availability

I. PURPOSE

To describe the contents of and beneficiary access to the Provider List

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will maintain and make available a list of providers that will enable beneficiaries to make decisions about services. SLOBHD will update the Provider Lists monthly and within 30 days of any changes to the list or more often as needed to reflect the services available to beneficiaries.

III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.360, 1810.110, 1810.235
- Code of Federal Regulations, Title 42, §438.10
- MHP Contract, Exhibit A, Attachment 1, Section 7
- SLOBHD Policy 4.20 Beneficiary Rights and Informing Practices
- SLOBHD Policy 4.03 Change of Provider Request
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals

IV. PROCEDURE

A. Availability:

1. The Provider List will be:
   a. Given to each beneficiary at the beginning of services
   b. Available at any time upon request at all service sites or by contacting Central Access at 800-838-1381
   c. Included in the Client Information Centers in all clinic sites
   d. Available electronically on the SLOBHD website

B. Documentation

1. Beneficiaries will confirm receipt of the Provider List by signature in the Consent For Treatment
2. SLOBHD clinical staff will check the box labeled “Provider List Given” on the Assessment Progress Note

C. Content

1. The Provider List will:
   a. Be written in English and Spanish

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b. Contain the following elements:

i. Category or categories of services available from each provider
ii. Names, locations, and telephone numbers of current contracted providers by category
iii. Options for services in languages other than English and services that are designed to address cultural differences

c. Detailed provider specialty information will be available to beneficiaries by request from Managed Care Staff and electronically on the SLOBHD website

D. Network Provider availability:

1. Managed Care staff will contact Network Providers to determine availability to provide services in a timely manner

2. Beneficiaries will be informed in person which beneficiaries are accepting new clients upon referral

###

V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
11/01/2015	All	Added Purpose, reformatted
08/17/2017	All	Formatting
Prior Approval dates:		
05/30/2010		

Signature on file		*08/29/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 30

BEHAVIORAL HEALTH SERVICES

COUNTY OF SAN LUIS OBISPO

COMMUNITY MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535
(800) 838-1381
(805) 781-4176 (FAX)

July 17, 2019

Client name and address

Respecto a Sus Servicios de Psicoterapia:

Sus Servicios de psicoterapia han sido arreglado para usted con el sigueinte consejero:

Network Provider Name, Office Address, and phone number

Por favor ponerse en contacto con el consejero para hace una cita para servicios.

Gracias,

Lynette Kirkpatrick, RHIT
Medical Records Technician
Managed Care

Appendix 31

UR Status/Annual Dates ☐ **Annual Review** ☐ **Six Month Review**

Reporting Unit: Start Date: ______/______/______ Provider: ____________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: Start Date: ______/______/______ Provider: ____________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: Start Date: ______/______/______ Provider: ____________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: Start Date: ______/______/______ Provider: ____________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Authorization Date: From: ____/____/____ To: ____/____/____

Client Signature: _____ Date: ____/____/____

Parent / Guardian Signature: _____ Date: ____/____/____

____/____/____ _____ ____/____/____

Lead Coordinator / Therapist Date Co-Signature (When Required) Date

____/____/____

Program Supervisor/Approval/Authorization Date

Interpretation Service Utilized in (Language) _____ ☐ Yes ☐ No Culture Specific Service Utilized (Culture) _____ ☐ Yes ☐ No

		SERVICE PLAN
CLIENT NAME	CLIENT NUMBER	Cd651 Service Plan Rev 10//07

4.20 Beneficiary Rights and Informing Process

I. PURPOSE

To describe beneficiary rights and beneficiary informing practices

II. POLICY

- County of San Luis Obispo Behavioral Health Department (SLOBHD) will comply with all Federal and State laws that pertain to beneficiary rights, and will ensure that all staff and providers take those rights into account when furnishing services.

- SLOBHD will ensure that each beneficiary is informed, in a language and format that the beneficiary can understand, of available services and the benefits, requirements and protections (rights) afforded to them.

- SLOBHD will ensure written materials are produced in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and for those who have auditory limitations.

- SLOBHD will ensure that written materials are readily accessible on the SLOBHD website, which is compliant with Web Content Accessibility Guidelines (WCAG) 2.0 guidelines in a machine readable and printable format.

- SLOBHD will ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights will not adversely affect treatment.

III. REFERENCE

- California Code of Regulations, Title 9, § 1810.360
- Code of Federal Regulations, Title 42, §§ 438.10 and 438.100
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 04-05
- SLOBHD Policy 2.00 Culturally Competent, Multilingual Services
- SLOBHD Policy 4.00 Patient's Rights Advocate
- SLOBHD Policy 4.03 Change of Provider
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 4.09 Fair Hearing Process
- SLOBHD Policy 4.23 Advanced Medical Directives
- SLOBHD Policy 4.24 Provider List Availability

Appendix 33

IV. PROCEDURE

A. SLOBHD will inform beneficiaries of their rights, protections and processes in the following ways:

1. The Beneficiary Handbooks, *Guide to Mental Health Services and Guide to Substance Use Disorders Services*, will contain detailed information about rights, protections and access. It will be available in English and Spanish in regular, large print (minimum 18 point font) and audio versions.

   i. The handbook will be:

   - Given to each beneficiary at the beginning of services and upon request thereafter
   - Available at all sites and by request through the 24/7 Central Access line at: 800-838-1381 within 5 business days
   - Posted in the lobby at each site
   - Available on the SLOBHD website

   ii. The handbook content will comply with contract requirements for informing beneficiaries about their rights

2. Client Information Centers at each site will make information readily available to both beneficiaries and staff, in English and Spanish. Beneficiaries will be able to obtain, complete and return a Consumer Request Form without having to make a verbal or written request to anyone. Client Information Centers will contain:

   i. "What are my Rights?" poster
   ii. Crisis Services poster
   iii. Provider List
   iv. Notice of Privacy Practices
   v. Notification that:
   - Alternative formats are available
   - Free language assistance is available
   - Assistance with forms is available

   vi. Consumer Request Form, which will describe problem solving processes, and:
   - Instructions
   - Patient's Rights Advocate contact information
   - Postage paid/addressed envelopes

   vii. Consumer Request Drop Box (locked)

3. Informing materials regarding Advance Medical Directives will be given to each adult consumer at the beginning of services.

4. The Consent for Treatment form will be explained to, signed by and given to each beneficiary at the start of treatment. It will further describe rights, responsibilities and payment processes.

Appendix 33

5. The Notice of Privacy Practices will explain the manner in which SLOBHD will maintain and use the beneficiary's medical record. An acknowledgement of receipt will be signed by each beneficiary.
6. Beneficiaries will also be inform of rights and benefits verbally by:
   i. Clinical and administrative staff
   ii. Patients' Rights Advocate (PRA)
7. The PRA will make informing materials, including the handbook titled, "Rights for Individuals in Mental Health Facilities" available to consumers.
8. The Patient's Rights Advocate will regularly train staff regarding beneficiary rights, including how to assist a beneficiary with completing the Consumer Request Form.

B. Documentation of Informing:

1. Distribution of the Beneficiary Handbooks and Provider lists will be documented by:
   - Client signature on the Behavioral Health Consent for Treatment form indicating receipt
   - Clinician attestation on the Assessment Progress Note
2. Right to Change Providers/limits on freedom of choice will be documented by clinician attestation on the Assessment Progress Note
3. Beneficiary signature on Consent for Treatment and Acknowledgement of Notice of Privacy Practices will be maintained in the medical record.

I. Definition

1. Each beneficiary has the right to:
   - Be treated with personal respect, dignity and with respect for privacy
   - Receive information on available treatment options and alternatives
   - Have treatment options resented in an understandable manner
   - Obtain services in a language of choice, without cost for interpretation services
   - Participate in decisions regarding care, including the right to refuse treatment
   - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
   - Request and receive a copy of his/her medical records
   - Request that medical records be amended or corrected
   - Receive appropriate, available and accessible services
   - Access other community services regardless of participation in treatment
   - Access other government supported services and providers regardless of participation in treatment
   - Request a change of provider

Appendix 33

- Access the problem resolution processes, including the Grievance, Appeal, Expedited Appeal and Fair Hearing processes, without fear of any punitive action as a result

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V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
11/18/2015	All	Added purpose, reformatted, added F
08/17/2017	All	Reformatted, New CRF Language
01/02/2018	All	Reformatting
Prior Approval dates:		
02/27/2009, 08/08/2011, 1/20/2012		

Signature on file		*08/29/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 33

PEI COMMUNITY PROGRAM PLANNING PROCESS
County: San Luis Obispo (SLO County) Date: November 17, 2008

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

The San Luis Obispo County Behavioral Health Department Administrator, Karen Baylor, Ph.D., MFT in conjunction with Nancy Mancha-Whitcomb, Mental Health Services Act Division Manager, had the overall responsibility for ensuring that the Community Program Planning Process was carried out as required by statute.

Ms. Mancha-Whitcomb was responsible for participating in statewide discussions and ensuring that DMH Notices and communications were followed, and that a compliant, feasible proposed PEI plan was submitted to DMH for approval.

A County Mental Health Services Accountant II, Lisa Anderson, is dedicated to MHSA and had the overall fiscal responsibility during the planning process.

Frank Warren, Program Supervisor within Drug and Alcohol Services, was the lead for writing the plan document, and will work with the MHSA Oversight and Accountably Commission to obtain approval of the plan. Mr. Warren will be responsible for PEI program implementation.

A 34-member Community Planning Team of diverse public and private stakeholders was responsible for guiding the planning process, analyzing community input, and selecting projects in accordance with community priorities. That membership is described further in Section 1c below.

An independent planning consultant, Dale Magee, was contracted to design and manage the planning process resulting in project selection and assist Mr. Warren in writing the plan document. Ms. Magee was also responsible for the 2005 CSS Community Program Planning Process.

b. Coordination and management of the Community Program Planning Process

From January through October 2008, the planning consultant coordinated and managed all components necessary to conduct a comprehensive community input and program planning process, including: the recruitment and coordination of the Community Planning Team and age specific workgroups; a publicity campaign; develop and distribute surveys, create informational materials; conduct focus groups and stakeholder interviews; synthesize and analyze input data; create data reports; identify community priorities; research program options and details, and facilitate the Planning Team's project selection process.

A mental health therapist experienced in community partnerships and integrated systems of care was dedicated half time from February through June 2008, to assist with outreach and input efforts, especially to reach underserved rural communities, age groups, and cultural populations.

From March through May 2008, the bilingual/bicultural psychologist who directs the CSS Latino Services Program and chairs County Mental Health's Cultural Competency Committee conducted extensive

outreach to low-acculturated Latino communities and other Latino groups, and conducted focus groups, interviews and PEI presentations. She also served an advisory role to the planning consultant.

An internal SLOBHD work team met at least monthly beginning September 2007 to review the PEI Guidelines, formulate the overall planning process, refine survey and input instruments, track the state and local planning process, and develop program and projects details. Those members included:

• Karen Baylor, Ph.D, MFT Behavioral Health Administrator
• Nancy Mancha-Whitcomb, MHSA Division Manager (joined January 2008)
• Frank Warren, Drug and Alcohol Services (DAS) Program Supervisor
• Lisa Anderson, MHSA Accountant
• Rhea Liiamaa, Systems Affirming Family Empowerment (SAFE) Coordinator (January - June 2008)
• Brad Sunseri, Youth Services Division Manager (September - December 2007)
• Janet Amanzio, Adult Services Division Manager (September - December 2007)
• Dale Magee, planning consultant

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The comprehensive Community Program Planning Process began in August 2007 and consisted of four phases:

1. "Plan to Plan." August 2007 through January 2008.
2. Community Outreach and Input. February through April 2008.
3. Data Analysis; Priorities and Strategy Identification. May through August 2008.
4. Project Selection and Design. August 2008 through October 2008.

More than 3,000 individuals were involved in the Community Program Planning Process throughout the phases. Stakeholders were involved from the beginning and will continue once PEI projects are operating.

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Phase I: Plan to Plan (August 2007 - January 2008)

This phase was for educating the work team on the PEI guidelines and DMH's approach, for strategy development for the community input process, and to gather resources to ensure a successful Community Program Planning Process. This was primarily an internal effort yet key stakeholders provided valuable input and guidance.

The existing MHSA CSS Community Planning Team, whose membership includes most of the representatives required for the PEI planning process, was consulted in December 2007 to provide recommendations on outreach strategies and stakeholder groups to include during the forthcoming PEI community input process. More than 25 people, including consumers, family members and Latino community representatives, contributed.

Recruitment for the PEI Community Planning Team began during this phase. Both "required" and "recommended" stakeholders were enlisted.

The 34-member PEI Community Planning Team first convened in January 2008 for a PEI component orientation and training. The Planning Team represents most of the required and recommended PEI groups, and serves as the oversight body for the Community Program Planning Process, and ensured a comprehensive and inclusive input process and that the resulting proposed PEI Plan reflected the spirit of the community's wishes.

The **Community Planning Team** membership includes representatives from the following groups (some members represent more than one group):

• Individuals with mental illness (at least 4)
• Consumers (at least 2)
• Family members (at least 7)
• Family Advocates
• Behavioral Health Department Administrator
• California Polytechnic University (Cal Poly), Counseling Services
• Community Members at Large
• County Jail / Custody
• County Office of Education
• Department of Social Services
• Drug and Alcohol Services
• Economic Opportunity Commission
• Family Care Network
• Law Enforcement
• Mental Health Board
• Mental Health Adult and Youth Services (MHS)

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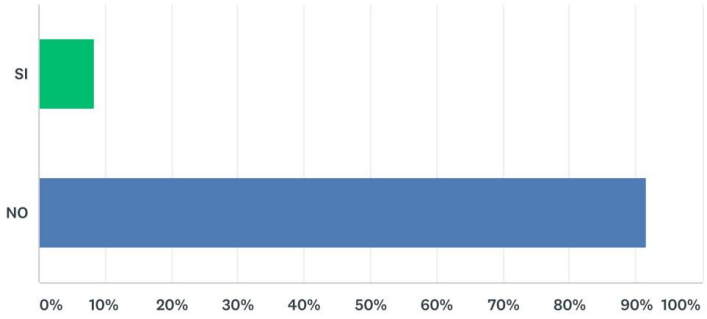
• Mental Health Services Cultural Competency Committee
• MHSA Administrative Staff
• MHSA Latino Outreach and Services
• National Alliance on Mental Illness (NAMI)
• Older Adult Full Service Partnership (FSP)
• Probation Department
• Psychotherapists, private practice (active and retired)
• Public Health Department
• SAFE System of Care
• Family Resource Centers
• San Luis Obispo County Community Foundation
• Special Education Local Plan Area
• Transitions-Mental Health Association (THMA)
• Tri-Counties Regional Center

Appendix 34

FY 2017-2018 LOP Survey - Spanish

Q1 Prefiero no contestar la encuesta

Answered: 12 Skipped: 0

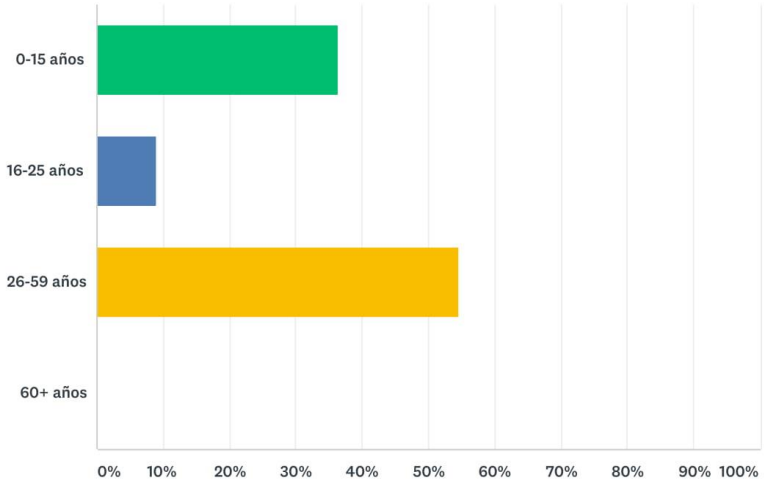


ANSWER CHOICES	RESPONSES	
SI	8.33%	1
NO	91.67%	11
Total Respondents: 12		

Appendix 35

Q2 Grupo de Edad

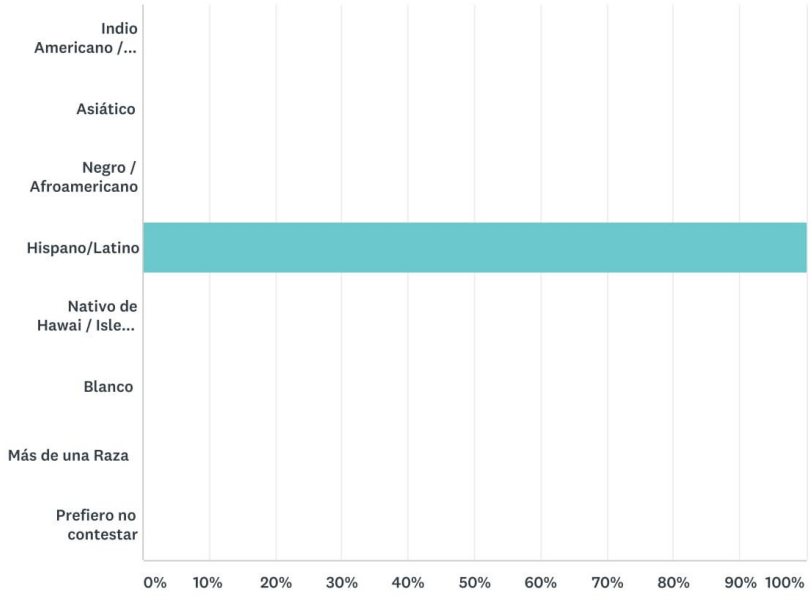
Answered: 11 Skipped: 1



ANSWER CHOICES	RESPONSES	
0-15 años	36.36%	4
16-25 años	9.09%	1
26-59 años	54.55%	6
60+ años	0.00%	0
Total Respondents: 11		

Q3 Raza

Answered: 12 Skipped: 0



ANSWER CHOICES	RESPONSES	
Indio Americano / Nativo de Alaska	0.00%	0
Asiático	0.00%	0
Negro / Afroamericano	0.00%	0
Hispano/Latino	100.00%	12
Nativo de Hawai / Isleño del Pacífico	0.00%	0
Blanco	0.00%	0
Más de una Raza	0.00%	0
Prefiero no contestar	0.00%	0
Total Respondents: 12		

FY 2017-2018 LOP Survey - Spanish

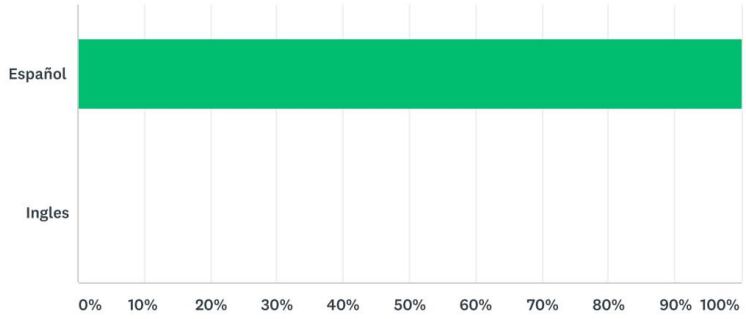
ANSWER CHOICES	RESPONSES	
Caribeño	0.00%	0

Appendix 35

Centralamericano	9.09%	1
Mexicano/Mexicano Americano/Chicanx	90.91%	10
Puertorriqueño	0.00%	0
Sudamericano	0.00%	0
Africano	0.00%	0
Asiático Hindú /Sur Asiático	0.00%	0
Camboyano	0.00%	0
Chino	0.00%	0
Europeo Oriental	0.00%	0
Europeo	0.00%	0
Filipino	0.00%	0
Japonés	0.00%	0
Coreano	0.00%	0
Medio Este	0.00%	0
Vietnamita	0.00%	0
Más de un grupo étnico	0.00%	0
Prefiero no contestar	0.00%	0
Total Respondents: 11		

Q6 ¿Cuál es su idioma principal?

Answered: 6 Skipped: 6

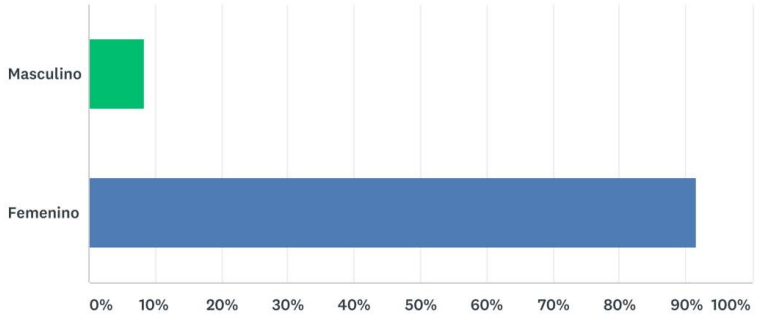


ANSWER CHOICES	RESPONSES	
Español	100.00%	6
Ingles	0.00%	0
TOTAL		6

Appendix 35

Q7 ¿Cuál es su sexo?

Answered: 12 Skipped: 0

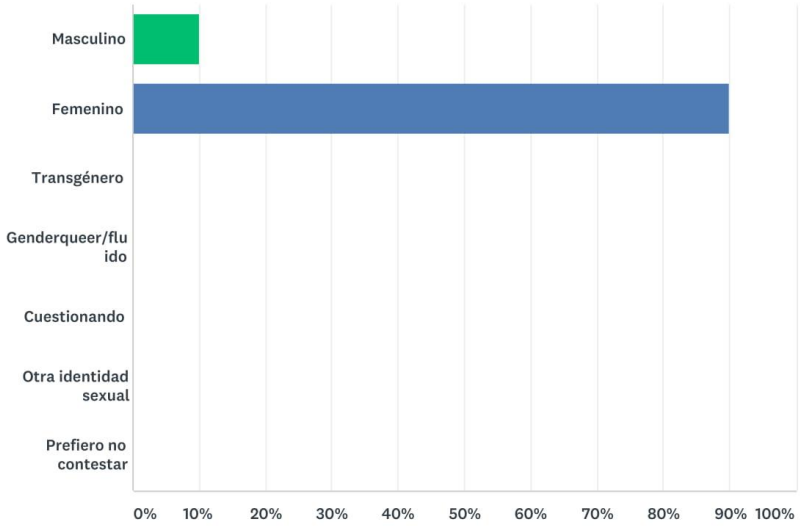


ANSWER CHOICES	RESPONSES	
Masculino	8.33%	1
Femenino	91.67%	11
TOTAL		12

Appendix 35

Q8 ¿Cuál es su género?

Answered: 10 Skipped: 2

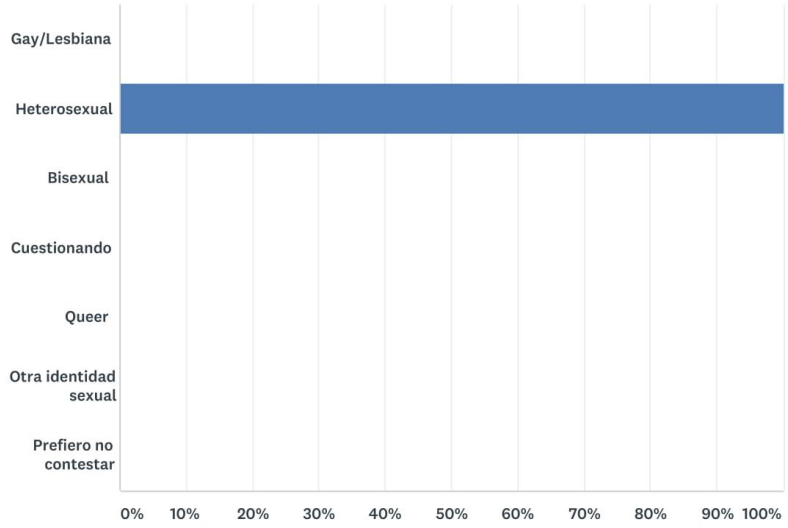


ANSWER CHOICES	RESPONSES	
Masculino	10.00%	1
Femenino	90.00%	9
Transgénero	0.00%	0
Genderqueer/fluido	0.00%	0
Cuestionando	0.00%	0
Otra identidad sexual	0.00%	0
Prefiero no contestar	0.00%	0
TOTAL		10

Appendix 35

Q9 ¿Cuál es su orientación sexual?

Answered: 6 Skipped: 6

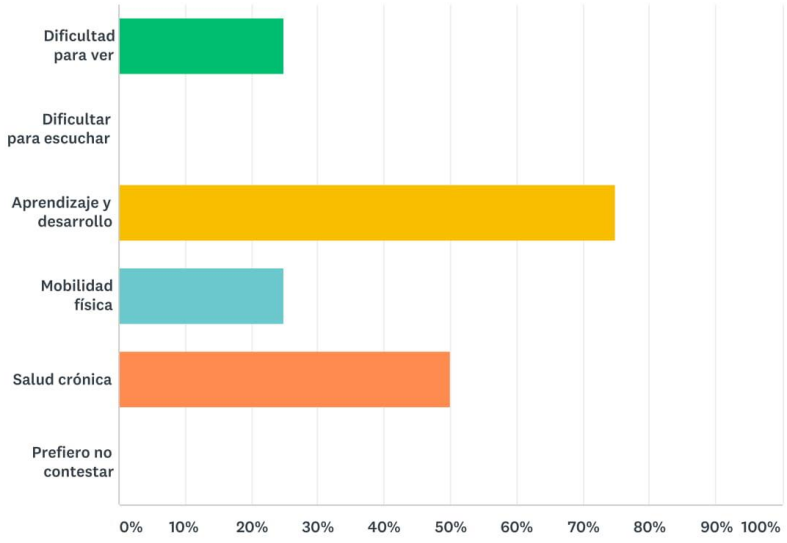


ANSWER CHOICES	RESPONSES	
Gay/Lesbiana	0.00%	0
Heterosexual	100.00%	6
Bisexual	0.00%	0
Cuestionando	0.00%	0
Queer	0.00%	0
Otra identidad sexual	0.00%	0
Prefiero no contestar	0.00%	0
TOTAL		6

Appendix 35

Q10 ¿Tiene alguna de las siguientes desabilidades?

Answered: 4 Skipped: 8

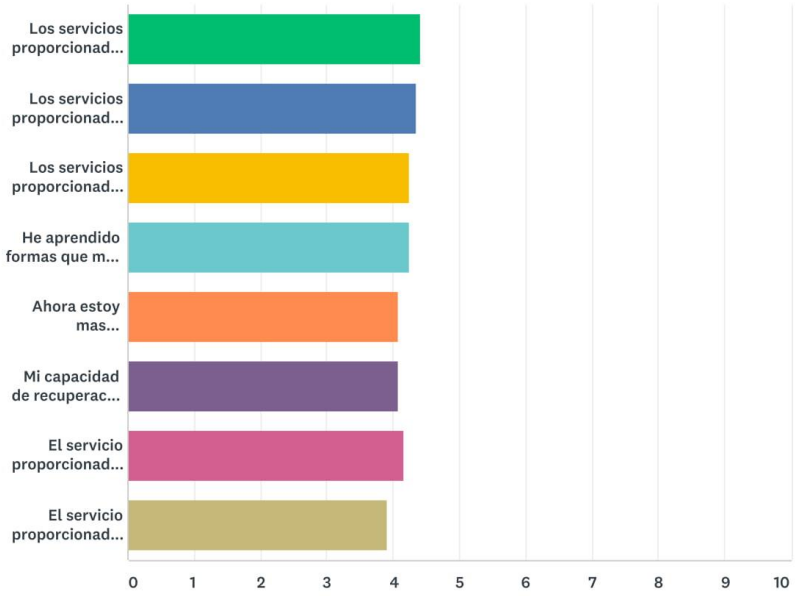


ANSWER CHOICES	RESPONSES	
Dificultad para ver	25.00%	1
Dificultar para escuchar	0.00%	0
Aprendizaje y desarrollo	75.00%	3
Mobilidad física	25.00%	1
Salud crónica	50.00%	2
Prefiero no contestar	0.00%	0
Total Respondents: 4		

Appendix 35

Q11 Por favor califique su experiencia con los servicios proporcionados:

Answered: 12 Skipped: 0



	N/A	TOTALMENTE EN DESACUERDO	EN DESACUERDO	NEUTRAL	DE ACUERDO	TOTALMENTE EN ACUERDO	TOTAL	WEIGHTED AVERAGE
Los servicios proporcionados abarcaron la cultura y el idioma latino.	0.00% 0	0.00% 0	0.00% 0	8.33% 1	41.67% 5	50.00% 6	12	4.42
Los servicios proporcionados ayudaron a entender y resolver mis necesidades de salud mental.	0.00% 0	0.00% 0	0.00% 0	18.18% 2	27.27% 3	54.55% 6	11	4.36
Los servicios proporcionados me ayudaron a obtener fortaleza interna y me siento mejor acerca de la vida.	0.00% 0	0.00% 0	0.00% 0	16.67% 2	41.67% 5	41.67% 5	12	4.25
He aprendido formas que me ayudan a calmarme y sentirme mejor.	0.00% 0	0.00% 0	0.00% 0	25.00% 3	25.00% 3	50.00% 6	12	4.25

Appendix 35

Ahora estoy mas familiarizado con los recursos de salud mental.	0.00% 0	0.00% 0	8.33% 1	8.33% 1	50.00% 6	33.33% 4	12	4.08
Mi capacidad de recuperación y mi actitud positiva en la vida han mejorado.	0.00% 0	0.00% 0	8.33% 1	16.67% 2	33.33% 4	41.67% 5	12	4.08
El servicio proporcionado me ha ayudado a mejorar cuando me siento nervioso, ansioso, ó asustado.	0.00% 0	0.00% 0	8.33% 1	8.33% 1	41.67% 5	41.67% 5	12	4.17
El servicio proporcionado ha mejorado mi calidad al dormir.	0.00% 0	8.33% 1	8.33% 1	8.33% 1	33.33% 4	41.67% 5	12	3.92

Appendix 35

SAN LUIS OBISPO COUNTY
MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535

PLEASE READ THIS FORM CAREFULLY. IF YOU HAVE PROBLEMS READING IT, ASK TO HAVE IT READ TO YOU.

Dr. _____ has met with me and we talked about the following items.

1) We discussed my illness or condition for which my doctor is recommending medication.

2) The doctor told me of medications, and other reasonable alternatives, if any, which are known to be of help in treating problems such as mine.

3) The doctor also informed me why such medications are important or necessary in the treatment of my illness or condition and discussed with me the likelihood of my improving or not improving without such medication(s). I understand the medication will be from the group that follows:

MEDICATIONS AND DOSAGE/RANGE

Neuroleptic/	**Hypnotics/**
Major Tranquilizer_____	**Antianxiety**_____
_____	_____
Mood Stabilizer _____	**Stimulants**_____
_____	_____
Antidepressant _____	**Other** _____
_____	_____

We also discussed:

a) the type, frequency, and amount of each medication, as well as the method (by mouth, injection, etc.), and how long I will need to take them.

b) the side effects of these medications which commonly occur and ones which may particularly affect me.

I understand that I have the right to accept, to refuse, or to discontinue medication(s) ordered for me by telling my physician or a member of the treatment staff at any time.

I understand that if I have any further questions or want to know more about my medications I can ask for further information.

I HAVE READ THIS FORM, I UNDERSTAND IT, AND I CONSENT TO TAKE THE MEDICATION(S) PRESCRIBED BY THE DOCTOR. I HAVE RECEIVED EDUCATIONAL MATERIAL(S) WHICH DISCUSSES THE ABOVE MEDICATIONS AND POSSIBLE SIDE EFFECTS.

Patient's Signature:_____ / / Date

Physician's Signature:_____ / / Date

CLIENT NAME:_____ **RECORD NUMBER:**_____

Original: Client Record
Copy: Client

12/99 CD-601

MEDICATION CONSENT FORM

Appendix 36

SAN LUIS OBISPO COUNTY
MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535

PHOTOCOPY FOR CLIENT

POR FAVOR, LEA ESTE DOCUMENTO CUIDADOSAMENTE. SI TIENE ALGUNA DIFICULTAD PARA LEER LO, PIDA QUE ALGUIEN LE AYUDE.

El Doctor _____ me ha comunicado personalmente lo siguiente:

1) Hemos hablado de mi condición o enfermedad por lo cual el me ha recomendado medicamento(s).

2) El doctor me ha explicado acerca de los medicamentos y otras alternativas razonables conocídas, si las hay, efectivas en el tratamiento de problemas como el mío.

3) También el doctor me ha informado acerca de la importancia o necesidad de este(os) medicamentos en el tratamiento de mi enfermedad o condición. Además, el doctor me explicó acerca de las posibilidades de mejorar, o no mejorar, sin tomar este(os) medicamentos. Yo entiendo que los medicamentos serán de las siguientes categorias:

MEDICAMENTOS Y SU DOSIS/AMPLITUD

Neurolépticos/
Tranquilizante Mayor _____
_____

Hipnóticos/
Anti-Ansiedad _____
_____

Estabilizante de Humor _____
_____

Estimulantes _____
_____

Anti-Depresivo _____
_____

Otro _____
_____

Nosotros también placticamos de lo siguiente:

a) el típo, la frecuencia, y la cantidad de cada medicamento y el método de tomarlo (por la boca, por inyección) y por cuanto tiempo necesitaré tomarlo(s).

b) las contraindicaciones de este(os) medicamento(s) que son comunes, y los que me pueden afectar a mí en particular.

En cualquier momento, retengo el derecho de aceptar, rechazar, o descontinuar este(os) medicamento(s) ordenados para mi solamente con decirle a mi médico o uno de los trabajadores de tratamiento.

Yo entiendo que si tengo más preguntas o quiero saber más acerca de mis medicamentos, puedo pedir más información.

DESPUES DE HABER LEIDO Y ENTENDIDO ESTE DOCUMENTO, DOY MI CONSENTIMIENTO PARA TOMAR EL (LOS) MEDICAMENTO(S) QUE HAN SIDO RECETADOS POR EL DOCTOR. TAMBIEN HE RECIBIDO MATERIALES EDUCATIVOS QUE INFORMAN SOBRE LOS MEDICAMIENTOS MENCIONADOS Y LOS EFECTOS NEGATIVOS POSIBLES DE ELLOS.

Firma del paciente: _____ *Fecha*: _____

Firma del doctor: _____ *Fecha:* _____

CLIENT NAME:_____ **RECORD NUMBER:**_____

07-97 ***CD-601 Spanish/la***

CONSENTIMIENTO PARA TOMAR MEDICAMENTOS
MEDICATION CONSENT FORM

Appendix 36

San Luis Obispo County Behavioral Health Services
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535

Phone: (805) 781-4700
Fax: (805) 781-4271

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Last Name	First	Middle	AKA:
Street Number/Name	City	State	Zip Code
Home Telephone: ( )	DOB:	Last four digits of SSN#: XXX – XX - _____	

San Luis Obispo County Behavioral Health Services is authorized to:

☐ Receive/Obtain information from **AND/OR** ☐ Release information to:

Contact Person Name/Organization:

Street Address:

City/State/Zip Code

Telephone: ( ) Fax:( )

_____ **I authorize the use and/or disclosure of the entire behavioral health record.**
(Initials)

OR*

I only authorize the use and/or disclosure of the following (initial):

_____ Mental Health Diagnosis/Diagnostic Information
_____ Initial Evaluation/Assessment
_____ Psychiatric Evaluation
_____ Medication History _____ Discharge Summary _____ Transfer Summary
_____ Labs _____ Nursing Assessment _____ Treatment Summary
_____ Other: _____
_____

*Psychotherapy notes require a separate authorization

I additionally specifically authorize the use and/or disclosure of the following health information (initial):

_____ Alcohol and/or Drug Abuse Treatment Program
_____ HIV/AIDS Testing, Diagnosis and/or Treatment

PURPOSE: I authorize San Luis Obispo County Behavioral Health Services to use or disclose my health information, during the term of this authorization for the following specific purpose:

☐ Evaluation ☐ Treatment Planning/Course/Delivery
☐ Other (Specify): _____
_____

Client Name:_____ **Record Number:**_____

Appendix 37

I understand the following about this authorization:

- I can revoke this authorization in writing. Requests to revoke authorizations must be made in writing at the Medical Records Office where this form originated. For additional information see our Notice of Privacy Practices. Revocation is effective upon receipt, except to the extent that others have previously acted in reliance upon this authorization
- Treatment cannot be denied to you if you refuse to sign this authorization. However, outside agencies, that require protected health information to provide various services to, or for, you may not be able to do so.
- If the recipient of this information is subject to California or federal confidentiality laws, it is possible that it may be redisclosed.
- This authorization includes written, electronic, and/or verbal disclosure.
- I have a right to receive and I will be offered a copy of this authorization. _____ _____
  Please Initial Received Offered copy
- A copy of this authorization is as valid as an original.

I may contact San Luis Obispo County Behavioral Health Services Privacy Officer by mail at:
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, or by calling (805) 781-4700.

TERM: This authorization will remain in effect from the date of this authorization until the _____ day of _____, 20 _____ .

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize San Luis Obispo County Behavioral Health Services to use and/or disclose my health information in the manner described above.

Client Signature : _____ Date:_____

A minor client's signature (12-17) is required in order to release information concerning care for mental health conditions and/or alcohol drug abuse issues.

Signature of Parent/Guardian/Conservator and Authorized Representative and Description of Authority**

_____ Date:_____

**(with copy of court papers/letters of conservatorship)

Signature of Staff:_____ Date: _____
(MD, PhD, LCSW, LMFT)

Client Name:_____ Record Number:_____

Appendix 37

San Luis Obispo County Mental Health
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535

Teléfono: (805) 781-4700
Fax: (805) 781-4271

AUTORIZACIÓN PARA USAR Y/O REVELAR INFORMACIÓN SANITARIA PROTEGIDA
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Apellido	Primer nombre	Segundo nombre	También conocido como:

Calle/Número	Ciudad	Estado	Código postal

Teléfono particular: ( )	Fecha nac.:	Últimos cuatro dígitos del Nro. de seguro social: XXX – XX - _____ _____ ____ ____

El servicio de salud conductual del condado de San Luis Obispo está autorizado a:

☐ Recibir / Obtener información de **Y/O** ☐ Brindar información a:

Nombre de la persona/organización de contacto:

Domicilio:

Ciudad/Estado/Código postal

Teléfono: ( ) Fax:( )

_____ **Autorizo el uso y/o la publicación de <u>toda</u> la historia clínica conductual.**
(Firmas)

<u>O*</u>

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):

_____ Diagnóstico de enfermedad mental/Información del diagnóstico
_____ Evaluación inicial/Diagnóstico
_____ Evaluación psiquiátrica
_____ Historial de medicación _____ Resumen del alta médica _____ Resumen para transferencia
_____ Laboratorio _____ Evaluación de las enfermeras _____ Resumen del tratamiento
_____ Otros: _____
_____

*Las anotaciones de psicoterapia requieren una autorización por separado.

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):

_____ Programa de tratamiento para el abuso de alcohol /drogas
_____ Pruebas para VIH, su diagnóstico y/o tratamiento

<u>PROPÓSITO:</u> Autorizo al Servicio de salud conductual del condado de San Luis Obispo a usar y publicar información sobre mi salud durante el término de esta autorización para los siguientes propósitos específicos:

☐ Evaluación ☐ Planificación del tratamiento/Curso/Entrega
☐ Otro (especificar) _____
_____

Client Name: _____ **Client Number:** _____

Appendix 37

Entiendo lo siguiente acerca de esta autorización:

- Puedo revocar esta autorización por escrito. Las solicitudes para revocar autorizaciones pueden hacerse por escrito en la oficina de registros médicos donde se emitió este formulario. Para más información, vea nuestra notificación sobre prácticas de privacidad. La revocación tiene vigencia a partir de su recepción, excepto en la medida en que otros hayan actuado en base a la autorización.
- No se le pueden negar tratamientos sobre la base de haberse negado a firmar esta autorización. Sin embargo, es probable que agencias externas, que requieran información protegida de salud para brindarle varios servicios, no estén en condiciones de brindarle el tratamiento.
- Si quien recibe esta información está sujeto a las leyes de California o a las federales de confidencialidad, es posible que la pueda volver a publicar.
- Esta autorización incluye la revelación por escrito, en forma electrónica y/o oral.
- Tengo derecho a recibir y se me debe ofrecer una copia de esta autorización. _____ _____
  Firme Recibido Copia ofrecida
- La copia de esta autorización es tan válida como el original.

Puedo ponerme en contacto con la oficina de privacidad del Servicio de salud conductual del condado de San Luis Obispo por correo escribiendo a:
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, o llamando por teléfono al (805) 781-4700.

PLAZO: La presente autorización tendrá vigencia a partir de la fecha de la presente autorización hasta el _____ día de _____ de 20 _____ .

He leído y entiendo los términos de la presente Autorización y he tenido la oportunidad de hacer preguntas acerca del uso y/o la publicación de información relativa a mi salud. Por medio de mi firma, que aparece más abajo, en forma voluntaria y con conocimiento, autorizo por la presente al Servicio de salud conductual del condado de San Luis Obispo a usar y/ o revelar la información sobre mi salud en la forma descripta más arriba.

Firma del paciente: _____ Fecha:_____

En caso de un paciente menor de edad (12-17 años), se requiere su firma para revelar información relativa a su estado de salud mental y/o temas relacionados con el abuso de drogas y alcohol.

Firma del padre/tutor/protector, representante autorizado y descripción de autoridad**

_____ Fecha:_____

**(con copia de documentos del tribunal/documentos de tutela o curaduría)

Signature of Staff
Firma del personal:_____ Fecha(Date): _____
(Doctor en medicina, PhD., asistente social clínico matriculado, terapeuta familiar matriculado)
(MD, PhD, LCSW, LMFT)

Client Name: _____ **Client Number:** _____

Appendix 37

Services

- Increase access to other community services / Acceso a otros servicios comunitarios.
- Services available at clinics, schools, and community resource centers / Los servicios están disponibles en clínicas, escuelas, y centros de recursos comunitarios.
- Services will help you improve your coping and social skills / Los servicios te ayudarán a mejorar tus habilidades sociales y para enfrontar problemas.

Mental Health Services Act
Ley de Servicios de Salud Mental

The services provide culturally competent behavioral health services.
Funding for this program is provided by Community Services and Supports, and Prevention and Early Intervention.

Los servicios proveen servicios de salud conductal culturalmente competentes.
El financiamiento para éste programa es propocionado por Servicios Comunitarios y Apoyos, y Prevención e Intervención Temprana.

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY

WELLNESS • RECOVERY • RESILIENCE

Latino Outreach Program

COUNTY OF
SAN LUIS OBISPO
BEHAVIORAL HEALTH
DEPARTMENT

EMOTIONAL
WELLNESS SERVICES FOR
THE LATINO COMMUNITY

SERVICIOS DE BIENESTAR
EMOCIONAL PARA LA
COMUNIDAD LATINA

TELEPHONE
TELÉFONO
1-800-838-1381

We can help you if you are experiencing / Le podemos ayudar si esta experimentado:

1. Emotions and behaviors which you cannot understand / Emociones y comportamientos que no puedes entender.

2. Anger that you cannot control / Cólera que no puedes controlar.

3. Uncontrollable crying and prolonged periods of sadness / Llanto incontrolable y períodos prolongados de tristeza.

4. Excessive worry / Preocupación excesiva.

5. Painful and fearful memories / Recuerdos que traen dolor y temor.

6. Irrational thoughts / Pensamientos irracionales.

7. Decreased functioning at school, work, or home / Disminución del funcionamiento en la escuela, el trabajo, ó el hogar.

8. Suicidal and/or self-harm thoughts / Pensamientos suicidas.

9. Great difficulty adjusting to and coping with the American culture / Dificultad para adaptarse a la cultura Americana.

Services Offered

- Therapy for children, youth, adults, and families offered by bilingual and bicultural therapists.

Servicios Ofrecidos

- Terapia para niños, jóvenes, adultos, y familias ofrecidos por terapeutas bilingües y biculturales.

Information About the Services / Información Acerca de los Servicios

- Services are offered to Latinos who are low income and to those covered by MediCal. / Los servicios son ofrecidos a los Latinos que tengan poco ingreso y a aquellos que sean cubiertos por MediCal.

- Services are provided by bilingual and bicultural counselors. / Los servicios son proporcionados por terapeutas bilingües y biculturales.

LOBBY CHECKLIST

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH LOBBIES:
North County MH Clinic/Atascadero, Kinship Center, SLO Adult MH Clinic (CON REP), SLO Youth Services, MHSA, Martha's Place, Family Care Network, Juvenile Services Center, Transitions Mental Health Admin Office, South County Clinic/Arroyo Grande, SAFE Family Resource Center - South County

LOCATION: _____ AUDIT DATE: _____

___ Consumer Request Form ENGLISH, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)

___ Consumer Request Form SPANISH, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)

___ GUIDE TO Medi-Cal Mental Health Services, ENGLISH booklet
(Beneficiary Handbook)

___ GUIDE TO Medi-Cal Mental Health Services, SPANISH booklet
(Beneficiary Handbook)

___ Notice of Privacy Practices (May 10, 2010) ENGLISH (HIPAA)

___ Notice of Privacy Practices (10/1/2009) SPANISH (HIPAA)

___ Medi-Cal Ombudsman Services (tri-fold brochure), ENGLISH

___ Medi-Cal Ombudsman Services (tri-fold brochure), SPANISH

___ SIGN (font 48): "Dear Consumers, Informational materials are available in alternative formats. Please ask the receptionist for assistance."

___ SIGN (font 48): "Dear Consumers, Free language assistance services are available upon request. Please ask the receptionist for assistance."

___ SIGN (font 48): "Estimado Consumidores, Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda."

___ SIGN (font 48): "Si usted busca servicion de salud mentales y necesita ayuda en espanol por favor de informarle a la recepcionista. Gracias."

___ SIGN (font 72): "Free language assistance available upon request."

___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO ENGLISH

___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO SPANISH

Appendix 39

___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided.) On M-Drive, each Program Supervisor has access/copy.

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH FACILITIES:
PSYCHIATRIC HEALTH FACILITY (PHF), SLO COUNTY MENTAL HEALTH; YOUTH TREATMENT PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA); SOCIALIZATION PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA); AMERICAN CARE HOME, ATASCADERO

LOCATION: _____ AUDIT DATE: _____

___ MENTAL HEALTH PATIENTS RIGHTS poster (CA Dept. M Health, 1999)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. HANDBOOK ENGLISH: (CA Dept. of Mental Health)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. HANDBOOK/MANUAL SPANISH: (CA Dept. of M. Health)

___ Consumer Request Form ENGLISH, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ Consumer Request Form SPANISH, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ GUIDE TO Medi-Cal Mental Health Services ENGLISH booklet
(Beneficiary Handbook)

___ GUIDE TO Medi-Cal Mental Health Services SPANISH booklet
(Beneficiary Handbook)

___ Notice of Privacy Practices (May 10, 2010) ENGLISH

___ Notice of Privacy Practices (10/1/2009) SPANISH

___ Medi-Cal Ombudsman Services (tri-fold brochure) ENGLISH

___ Medi-Cal Ombudsman Services (tri-fold brochure) SPANISH

___ SIGN (font 48): "Dear Consumers, Informational materials are available in alternative formats. Please ask the receptionist for assistance."

___ SIGN (font 48): "Dear Consumers, Free language assistance services are available upon request. Please ask the receptionist for assistance."

___ SIGN (font 48): "Estimado Consumidores, Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda."

Appendix 39

___ SIGN (font 48): “Si usted busca servicion de salud mentales y necesita ayuda en espanol por favor de informarle a la recepcionista. Gracias.”

___ SIGN (font 72): “Free language assistance available upon request.”

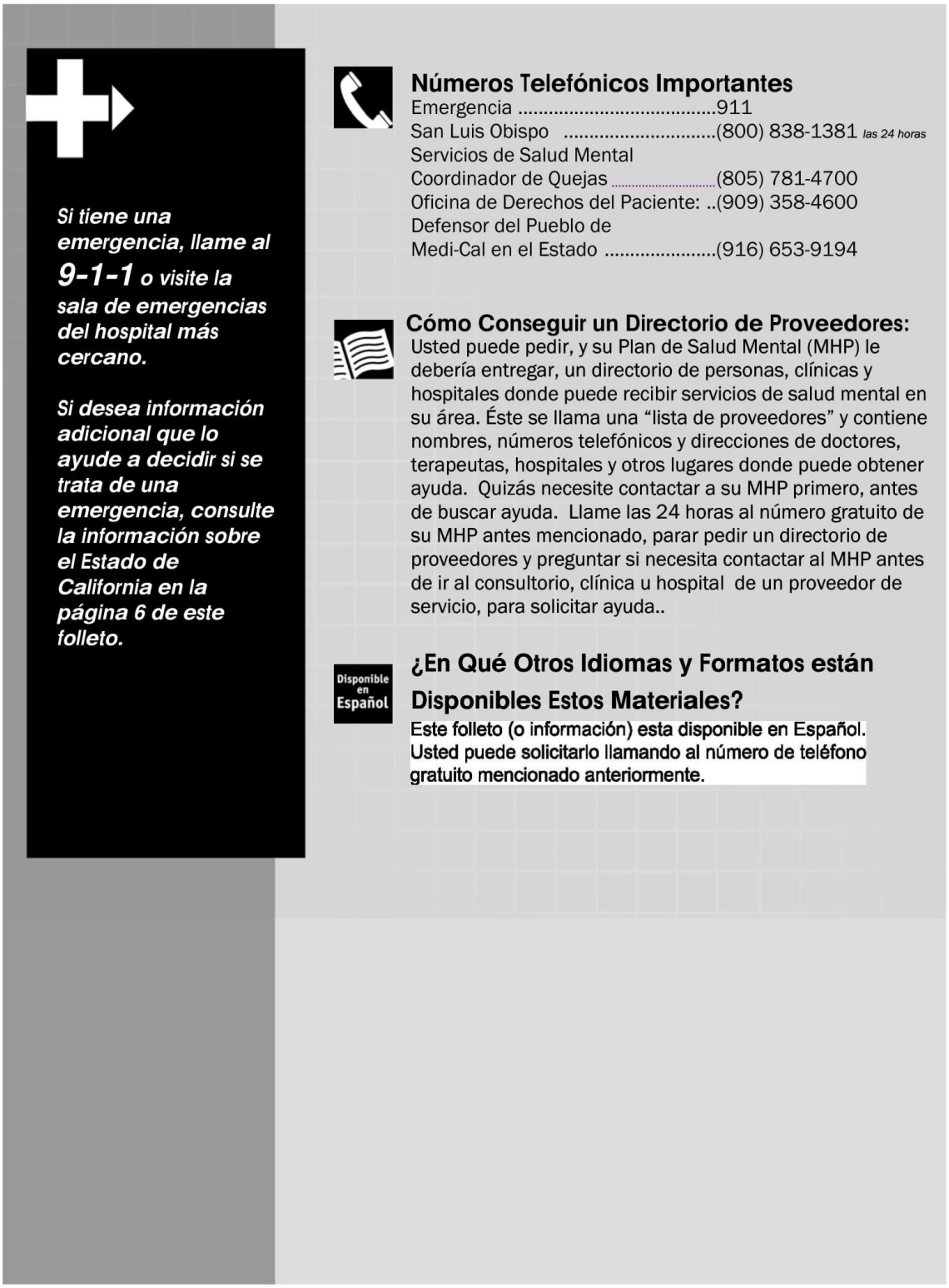
___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided.) This document is on the SLO County M-Drive

Appendix 39

GUÍA PARA

Servicios de Salud Mental de Medi-Cal

Appendix 40


Si tiene una emergencia, llame al 9-1-1 o visite la sala de emergencias del hospital más cercano.
Si desea información adicional que lo ayude a decidir si se trata de una emergencia, consulte la información sobre el Estado de California en la página 6 de este folleto.
Números Telefónicos Importantes
Emergencia 911
San Luis Obispo .....(800) 838-1381 las 24 horas
Servicios de Salud Mental
Coordinador de Quejas .....(805) 781-4700
Oficina de Derechos del Paciente: ..(909) 358-4600
Defensor del Pueblo de
Medi-Cal en el Estado .....(916) 653-9194
Cómo Conseguir un Directorio de Proveedores:
Usted puede pedir, y su Plan de Salud Mental (MHP) le debería entregar, un directorio de personas, clínicas y hospitales donde puede recibir servicios de salud mental en su área. Éste se llama una "lista de proveedores" y contiene nombres, números telefónicos y direcciones de doctores, terapeutas, hospitales y otros lugares donde puede obtener ayuda. Quizás necesite contactar a su MHP primero, antes de buscar ayuda. Llame las 24 horas al número gratuito de su MHP antes mencionado, parar pedir un directorio de proveedores y preguntar si necesita contactar al MHP antes de ir al consultorio, clínica u hospital de un proveedor de servicio, para solicitar ayuda..
Disponible en Español
¿En Qué Otros Idiomas y Formatos están Disponibles Estos Materiales?
Este folleto (o información) esta disponible en Español. Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

Appendix 40

GUIDE TO

Medi-Cal Mental Health Services

Appendix 40

*If you are having an emergency, please call **9-1-1** or visit the nearest hospital emergency room.*

If you would like additional information to help you decide if this is an emergency, please see the information on State of California page 6 in this booklet.

Important Telephone Numbers

Emergency 911

San Luis Obispo .....(800) 838-1381 *24-hours*
Mental Health Services
Grievence Coordinator..... (805) 781-4700
State Patient's Rights Office .....(909) 358-4600
Medi-Cal State Ombudsman .....(800) 896-4042
.....(916) 653-9194

How to Get a Provider List:

You may ask for, and your Mental Health Plan (MHP) should give to you, a directory of people, clinics and hospitals where you can get mental health services in your area. This is called a 'provider list' and contains names, phone numbers and addresses of doctors, therapists, hospitals and other places where you may be able to get help. You may need to contact your MHP first, before you go to seek help. Call your MHP's 24-hour toll-free number above to request a provider directory and to ask if you need to contact the MHP before going to a service provider's office, clinic or hospital for help.

Disponible en Español

In What Other Languages And Formats Are These Materials Available?

Este folleto (o información) esta disponible en Español. Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

Appendix 40

COUNTY OF SAN LUIS OBISPO BEHAVIORAL HEALTH DEPARTMENT

You are cordially invite to
Participate in a discussion about
Therapeutic Behavioral Services (TBS)
In San Luis Obispo

Who: County of San Luis Obispo Mental Health; Public defenders; CASA; Family Court Judge; San Lis Obispo Probation; San Luis Obispo Child Welfare Services; Foster Family Agencies, TMHA; Mr. Baily; CAPSLO; Child Development Center; County Office of Education; SELPA.

Who is eligible for TBS under the Emily Q settlement?
Children and youth under age 21 receiving EPSDT mental health services who:

1. Are placed in or are being considered for RCL 12 or higher; or
2. Have received psychiatric hospitalization in the past 24 months; or
3. Are being considered for psychiatric hospitalization.

Agenda topics:
Introduction – Welcome and Purpose of the Meeting
TBS Overview
TBS A Case Presentation
Discussion regarding the following questions:

1. Are the children and youth in your county wo are Emily Q class members and who benefit for TBS, getting TBS?
2. Are the children and youth who get TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in your county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in your county?
5. What are the other issues or concerns do you have?

When: October 30, 2009 from 10-12 noon
Where: San Luis Obispo County Library
Why: Assure that TBS services are accessible to those that need

RSVP – Patty Ford, LMFT at pford@co.slo.ca.us | 805.781.4209

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EXHIBIT E
CONTRACT FOR BEHAVIORAL HEALTH SERVICES

SPECIAL CONDITIONS

1. Compliance with Health Care Laws.

Contractor agrees to abide by all applicable local, State and Federal laws, rules, regulations, guidelines, and directives for the provision of services hereunder, including without limitation, the applicable provisions of the Civil Code, Welfare and Institutions Code, the Health and Safety Code, the Family Code, the California Code of Regulations, the Code of Federal Regulations, and the Health Insurance Portability and Accountability Act. This obligation includes, without limitation, meeting delivery of service requirements, guaranteeing all client's rights provisions are satisfied, and maintaining the confidentiality of patient records.

2. No Discrimination In Level Of Services.

As a condition for reimbursement, Contractor shall provide to and ensure that clients served under this Contract receive the same level of services as provided to all other clients served regardless of status or source of funding.

3. Nondiscrimination.

Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human services, effective June 2, 1977, and found in the Federal Register, Volume 42, No.86 dated May 4, 1977.

Contractor shall comply with the provisions of the Americans with Disabilities Act of 1990, the Fair Employment and Housing Act (Government Code section 12900 et seq.) and the applicable regulation promulgated thereunder (Title 2 Section 7285 et seq.) The Contractor shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap.

4. Quality Assurance.

Contractor agrees to conduct a program of quality assurance and program review that meets all requirements of the State Department of Mental Health. Contractor agrees to cooperate fully with program monitoring or other programs that may be established by County to promote high standards of mental health care to clients at economical costs.

5. Compliance Plan.

Contractor and its employees, contractors and agents shall read, acknowledge receipt, and comply with all provisions of the latest edition of the County Mental Health Compliance Plan and Code of Ethics ("Compliance Plan"). The Compliance Plan

includes policies and procedures that are designed to prevent and detect fraud, waste and abuse in federal health care programs, as required by Section 6032 of the Deficit Reduction Act ("DRA"). Failure to comply with any Compliance Plan provision, including without limitation, DRA compliance provisions is a material breach of this Contract and grounds for termination for cause.

Contractor will certify, on an annual basis, that it and all of its employees, contractors and agents have read and received a copy of the Compliance Plan and agree to abide by its provisions. In addition, at the time Contractor hires a new employee, contractor or agent, Contractor will certify that the individual has read and received a copy of the Compliance Plan and agrees to abide by its provisions.

6. Compliance with County Cultural Competence Plan.

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

7. Training Program.

Contractor will participate in training programs as provided in Title 22 of the California Code of Regulations, Health Information Portability and Accountability Act, and other appropriate regulations, and as required by County.

8. Record keeping and reporting of services.

Contractor shall:

a. Keep complete and accurate records for each client treated pursuant to this Contract, which shall include, but not be limited to, diagnostic and evaluation studies, treatment plans, progress notes, program compliance, outcome measurement and records of services provided in sufficient detail to permit an evaluation of services without prior notice. Such records shall comply with all applicable Federal, State, and County record maintenance requirements.

b. Submit informational reports as required by County on forms provided by or acceptable to County with respect to Contractor's program, major incidents, and fiscal activities of the program.

c. Collect and provide County with all data and information County deems necessary for County to satisfy State reporting requirements, which shall include, without limitation, Medi-Cal Cost reports in accordance with Welfare and Institutions Code 5651(a)(4), 5664(a) and (b), 5705(b)(3), 5718(c) and guidelines established by DMH.

9. State Audits.

Pursuant to California Code of Regulations section 1810.380, Contractor shall be subject to State oversight, including site visits and monitoring of data reports and claims processing; and reviews of program and fiscal operations to verify that medically necessary services are provide in compliance with said code and the contract between the State and County. If the Contractor is determined to be out of compliance with State or

Print Form

California Brief Multicultural Competence Scale

Below is a list of statements dealing with multicultural issues within a mental health context.

Please indicate the degree to which you agree with each statement choosing from the drop down list.

1.	I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1.	1 Strongly Disagree
2.	I am aware of how my own values might affect my client.	2.	1 Strongly Disagree
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	3.	1 Strongly Disagree
4.	I am aware of institutional barriers that affect the client.	4.	1 Strongly Disagree
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	5.	1 Strongly Disagree
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	6.	1 Strongly Disagree
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	7.	1 Strongly Disagree
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	8.	1 Strongly Disagree
9.	My communication skills are appropriate for my clients.	9.	1 Strongly Disagree
10.	I am aware that being born a White person in this society carries with it certain advantages.	10.	1 Strongly Disagree
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	11.	1 Strongly Disagree
12.	I have an excellent ability to critique multicultural research.	12.	1 Strongly Disagree
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	13.	1 Strongly Disagree
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	14.	1 Strongly Disagree
15.	I can discuss, within a group, the differences among ethnic groups socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	15.	1 Strongly Disagree
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	16.	1 Strongly Disagree
17.	I can discuss research regarding mental health issues and culturally different populations.	17.	1 Strongly Disagree
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	18.	1 Strongly Disagree
19.	I am knowledgeable of acculturation models for various ethnic minority groups.	19.	1 Strongly Disagree
20.	I have an excellent ability to assess, accurately, the mental health needs of women.	20.	1 Strongly Disagree
21.	I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	21.	1 Strongly Disagree

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (In Press, 2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. Measurement and Evaluation in Counseling and Development, 37, 3.

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Research Questions

1. Does the staff's level of comfortability/understanding of cultural competence with their clients differ by the division in which they work? By their gender? By their race?
2. How does the staff of the Behavioral Health Department feel about connecting with different cultural groups?
3. How does the staff feel about their division serving its targeted populations?
4. How does the staff feel about cultural competency trainings preparing them for their job? What topics would they like to see in future trainings?
5. Overall, how does the staff of the Behavioral Health Department feel about their level of cultural competency?

Broken Down

Agreement Scale

Disagree | Somewhat Disagree | Somewhat Agree | Agree

- Agree
- Somewhat Agree

→ Agree

- Somewhat Disagree
- Disagree
- Neutral / Don't Know

→ Do Not Agree

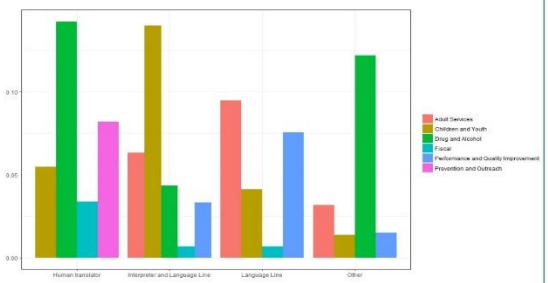
Frequency Scale

Never | Seldom | Sometimes | Often | Always

Ex) Grouping together Similar Answers

How would you address a situation where a client speaks a language other than your own?

Coded Responses	Number in this category	Percent
Human translator	24	31%
Interpreter and Language Line	22	29%
Language Line	15	22%
Other	10	18%



Question: "Which race do you primarily identify with?"		
Response	Number of People	Percent
White	54	73.6%
Latino	12	17.6%
Other	5	8.8%

→ Hispanic/Latinx, White, Other

Division	Sample Size	Population Size	# of respondents
Fiscal	7	15	7
Prevention and Outreach	13	27	8
Performance and Quality Improvement	16	45	9
Adult Services	24	67	13
Child and Youth	23	73	18
Drug and Alcohol	27	109	16
			71

Response Rate = 64%
Cooperation Rate = 100%

Of all the trainings you have received, which topic(s) did you find most relevant to your work?

Coded Responses	Number in this category	Percent
Issues of Mental Health, Access and/or Attitudes	12	18%
Issues of culture, race and/or language barriers	19	25%
Issues pertaining to gender and orientation	6	9%
Issues relating to trauma, poverty and/or substance abuse	6	8%
N/A or No Answer	12	16%
None	5	8%
Other (answers which strongly overlapped or themes not contained in other categories)	11	13%

Identify the subgroup(s) you believe are inadequately served by your division.

Coded Responses	Number in this category	Percent
Impoverished	3	6%
LGBTQ+	4	9%
Latinos and the spanish speaking community	18	39%
Mentally ill and/or Homeless population	9	23%
Non-Latino ethnic groups	6	10%
Other	5	10%

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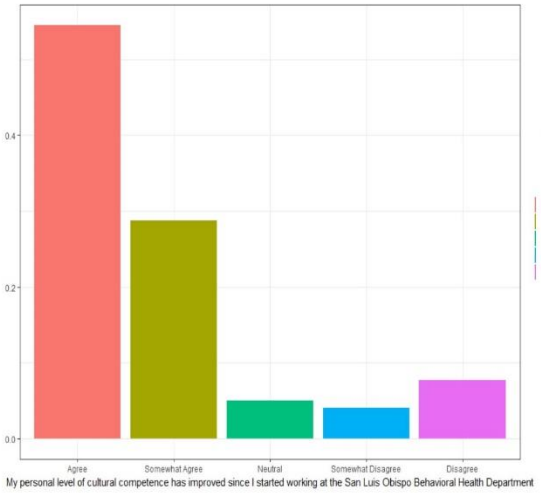
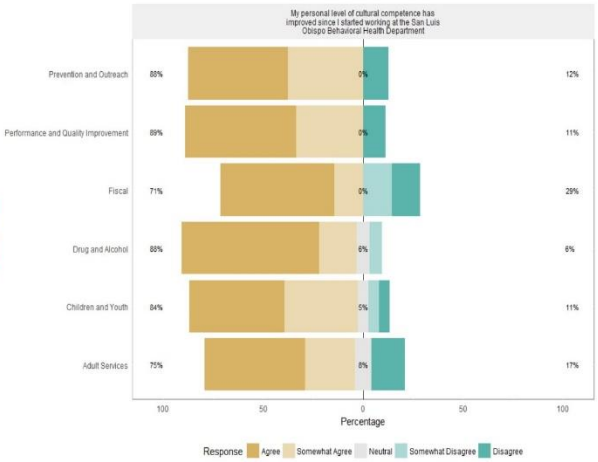
Example Analysis for Each Question

"My personal level of cultural competence has improved since I started working at the San Luis Obispo Behavioral Health Department"

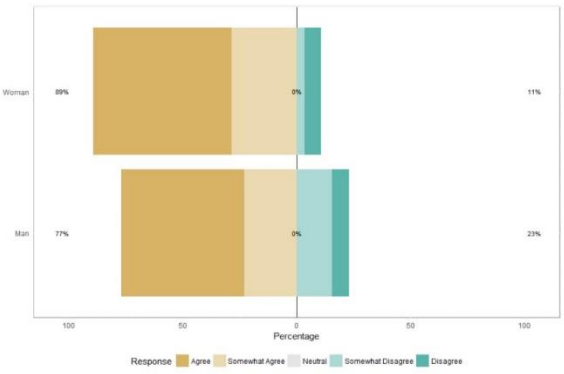
OVERALL



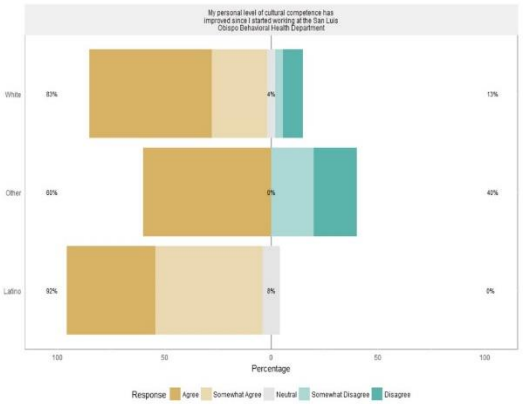
BY DEPARTMENT



BY GENDER



BY RACE



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4.07 Beneficiary Grievances, Appeals & Expedited Appeals

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes.

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBHD's performance of its duties.

The Appeals and Expedited Appeals processes will ensure that beneficiaries have consistent and timely means to respond to any adverse benefit determination taken by SLOBHD. The Grievance process will ensure that beneficiaries have a consistent and timely means to resolve all other concerns about the care they receive at SLOBHD.

SLOBHD will ensure that all Medi-Cal beneficiaries are well informed about the appeals process.

SLOBHD will process Grievances, Appeals and Expedited Appeals within the periods established by law.

III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.200, 1810.375, 1810.203.5, 1810.216.2,1850.205 – 1850.208
- Code of Federal Regulations, Title 42, §§ 438.400 – 438.424, 438.3(h)
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMC-ODS Waiver Contract
- DMH Letter 05-03

IV. PROCEDURE

A. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to clients at the beginning of services and upon request thereafter. See *Beneficiary Rights and Informing Processes* for detail regarding availability of materials in alternative formats and electronic form on the SLOBHD website.

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2. The Beneficiary Handbooks, *Guide to Mental Health Services and Guide to Substance Use Disorder Services* contain detailed information about the processes and will be available at all certified sites, through the 24/7 Central Access line at: 800-838-1381, and posted on the SLOBHD website in a machine readable and downloadable format.
3. SLOBHD will post Client Information Centers at each certified site, which will contain notices explaining grievance, appeal, and expedited appeal processes to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

B. General Provisions

1. A beneficiary may authorize another person to act on the beneficiary's behalf, including the Behavioral Health care provider in an appeal or expedited appeal. The beneficiary's legal representative may use the grievance/appeal/expedited appeal processes on the beneficiary's behalf.
2. All grievances/appeals/expedited appeals will be directed to the Patients' Rights Advocate (PRA) for logging and assistance.
3. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive adverse benefit determination for filing a grievance/appeal/expedited appeal
4. All grievances/appeals/expedited appeals will be resolved in a confidential manner that respects the rights and dignity of the beneficiary.
5. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

C. Filing a Grievance/Appeal/Expedited Appeal

1. Appeals and expedited appeals must be filed within 60 days of the Notice of Adverse Benefit Determination (NOABD) that is being appealed.
2. Grievances can be filed orally or in writing at any time.
3. Appeals will be initially filed orally or in writing. An oral appeal must be followed up by a written, signed appeal.
4. Expedited appeals will be filed orally without requiring that the request be followed by a written appeal.
5. The Consumer Request Form will be available for written submission of grievances/appeals/expedited appeals.

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6. The PRA will, at the beneficiary's request, assist with these filing processes. Assistance will include, but not be limited to, help writing the grievance/appeal/expedited appeal on a Consumer Request Form, interpreter services, including ASL and TTY/TTD.
7. The date of the initial oral or written submission starts the disposition timeline.

8. If SLOBHD denies a beneficiary's request for expedited appeal resolution, the PRA will:

    a. Resolve the issue as a standard appeal
    b. Make reasonable efforts to promptly notify the beneficiary and/or representative of the denial of the request for an expedited appeal
    c. Provide written notice within two calendar days of the date of the denial

D. Grievance/Appeal Log and Confirmation of Receipt

1. The PRA will record each grievance/appeal/expedited appeal in a Grievance/Appeal Log within one working day of receipt. The log will contain all of the following:

    - Name of the beneficiary
    - A general description of the reason for the appeal or grievance
    - The date received
    - The date of each review or, if applicable, review meeting
    - Resolution at each level of the appeal or grievance, if applicable
    - Date of resolution at each level, if applicable
    - Persons responsible for resolution
    - Final resolution
    - Date the written decision is sent to the beneficiary

2. The PRA will report de-identified data to DHCS from the log on an annual basis that summarizes beneficiary grievances, appeals and expedited appeals. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas and by disposition.

3. The PRA will retain the log and records for a period of no less than 10 years.

4. The PRA will send written confirmation to the beneficiary within one working day of the receipt of the grievance/appeal/expedited appeal. The written notice of the resolution must include the following:

    a. The results of the resolution process and the date it was completed
    b. For appeals not resolved wholly in favor of the enrollees—
        I. Have the right to request a State fair hearing, and how to do so

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II. Have the right to request and receive benefits while the hearing is pending, and how to make the request
III. Know that the beneficiary, may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds SLOBHD's Notice of Adverse Benefit Determination (NOABD).

E. Timelines for Resolution

Resolution	Resolution and Notification Timeline
Grievance	90 calendar days
Appeal	30 calendar days
Expedited Appeal	72 hours

1. If the grievance/appeal/expedited appeal is not resolved in the allotted timeframe, the PRA will notify the beneficiary and issue a NOABD.
2. Timeframes may be extended by up to 14 calendar days if the beneficiary requests an extension or if SLOBHD determines that there is a need for additional information and that the delay is in the beneficiary's interest.
3. If SLOBHD extends the timeframes, the PRA shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing within (2) two calendar days. The notice must include the reason the decision to extend the timeframe was made and information of the right to file a grievance if he or she disagrees with that decision.

F. Review process

1. SLOBHD will allow the beneficiary and/or representative to examine, before and during the appeal process, the beneficiary's medical records, any other documents or records and any new or additional evidence considered, relied upon or generated by SLOBHD in connection with the appeal.
2. In an appeal or expedited appeal, SLOBHD will provide the beneficiary with a reasonable opportunity to present evidence in person or in writing and make legal and factual arguments.
3. SLOBHD will utilize staff who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
4. If an appeal or expedited appeal is about a clinical issue, SLOBHD will utilize staff with appropriate clinical expertise to review and make decisions on the appeal.
5. SLOBHD must take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
6. SLOBHD must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for

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the appeal) and must be confirmed in writing, unless the beneficiary or the provider requests expedited resolution.

7. SLOBHD must provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. SLOBHD must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals.
8. SLOBHD must provide the beneficiary and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by SLOBHD in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

G. Notification of Resolution

1. The PRA will notify providers involved in the grievance/appeal/expedited appeal of the final disposition of the process.

2. The PRA will notify the beneficiary and/or his or her representative of the resolution of the grievance or appeal in writing. The notice will contain:

    I. The results of the appeal resolution process
    II. The date that the appeal decision was made
    III. If an appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing after the appeal process has been exhausted

3. In addition to written notification following an expedited appeal, the PRA will make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

H. SLOBHD will promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

I. Aid Paid Pending

1. SLOBHD will provide “aid paid pending” (APP) services during the resolution of an appeal or expedited appeal to beneficiaries who have filed a timely appeal (10 days from the date the Notice Of Adverse Benefit Determination (NOABD) was mailed or 10 days from the date the NOABD was personally given to the beneficiary).

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2. The beneficiary must either have an existing service authorization, which has not lapsed, and the service is being terminated, reduced, or denied for renewal by SLOBHD.
3. This adverse benefit determination will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal is otherwise withdrawn or closed, whichever is earliest.
4. APP services will be provided at no cost to the beneficiary.

V. Definitions:

a. **Adverse benefit determination**:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by SLOBHD
- A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals

b. **Appeal**

- A review by **SLOBHD** of an adverse benefit determination when requested by a beneficiary or provider.
- A request by a beneficiary or a beneficiary's representative for review of an adverse benefit determination.
- A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for Specialty Mental Health Services (SMHS) and/or Substance Use Disorder Services (SUDS).
- A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a SMHS or SUDS when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs, whether or not SLOBHD has established a timeliness standard for the delivery of service.

c. **Expedited Appeal:** The accelerated resolution of an appeal when SLOBHD determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

d. **Grievance:** A beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an adverse benefit determination. Grievances

may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by SLOBHD to make an authorization decision.

VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	Purpose All	Added Purpose Combined Policies 4.02, 4.07, 4.08, 4.10
08/15/2017	All	Updated with CFR 42 language and timeliness
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2015		

Signature on file		*08/24/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

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Policy

Bilingual materials are distributed to all treatment sites.

Procedure

1. Behavioral Health Services maintains a list of bilingual material including, but not limited to:
    a. Outpatient medical records material on the list called Bilingual Forms
    b. Patient's Rights poster as contained in the medical records Forms Managed Care file
    c. Medi-Cal Beneficiary Member Handbook
    d. County of San Luis Obispo Health Agency Grievance Form
    e. Department of Behavioral Health Medi-Cal Ombudsman Services Brochure
    f. Consumer Satisfaction Survey

2. Bilingual materials are distributed on an as-needed basis by the Central Medical Records to sites.

3. Program Supervisors and Contract Provider Supervisors designate a contact employee for the inventory and distribution of bilingual materials at each service site.

4. The designated contact person replenishes the displayed bilingual materials from Patient's Rights Advocate and Medical Records.

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Policy

San Luis Obispo Behavioral Health Services periodically involved clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level.

Reference:
CFR, Title 42, Section 438.10(d)(1)(i)
CCR, Title 9, Chapter 11, Section 1810.110(a)

Procedure

1. The standardized review protocol is followed to assess the readability of the Beneficiary Handbook as well as other informing handouts.

2. The Patients' Rights Advocate periodically meets face-to-face with a representative sample of beneficiaries and follows these steps:

    a. The presenter introduces the process to a group of clients using wording such as the following: "We need your assistance in reviewing our Beneficiary Handbook and other informing materials. If you wish to participate you may do so voluntarily. You are not required to participate in this focus group. Each client of mental health should receive a Beneficiary Handbook when he or she signs up for services and at the time of the review of their client care plan. We want to ensure that the handbook is understandable to our clients. Clients also receive other informing materials, and we would like to know whether or not these materials are easy to understand."

    b. The presenter distributes the handbook and materials to the clients and reads selected portions out loud as clients follow along by reading their own copy.

    c. The presenter queries for questions or comments and records all responses.

    d. The presenter offers a summary of the client responses to the Performance and Quality Improvement/Quality Management Committee.

3. Tests of readability must happen with each significant revision of the Beneficiary Handbook or the informing materials.

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Policy:
The Mental Health Services Act (MHSA) of County of San Luis Obispo establishes Peer support and family education support services and expand these services to meet the needs and preferences of clients and/or family members.

Reference
Title 9, Chapter 14, Section 3610(b)

Procedure
A. Transitions Mental Health Association (T-MHA) is the leading local Community-Based Organization (CBO) responsible for consumer based activities in San Luis Obispo County. MHSA funds the following consumer-based activities run by T-MHA which aims at providing a forum for advocacy, education, promotion of Wellness and Recovery, and striving to eliminate stigma:

1. **Supportive employment and vocational training** is provided through employment readiness classes and job placement.

2. **Client and family-run support**, mentoring and educational groups is conducted through the following programs overseen by a community-based organization.

3. **Peer to Peer** is a 9-week experiential education course on recovery that is free to any person with a mental illness. It is taught by a team of 3 to 4 peer teachers who are experienced at living well with mental illness.

4. **Family to Family** is a 12-week educational course for families of individuals with severe mental illness. It provides up to date information on the diseases, causes and treatments, as well as coping tools for family members who are also caregivers. A team of 2 family members teach the class.

5. The **Peers Empowering Peers** (PEP) Center is a consumer driven Wellness Center in the northern region of the county. Support groups and socialization activities as well as NAMI –sponsored educational activities are conducted here.

6. **Client & Family Partners act as advocates**, to provide day-to-day, hands on assistance, link people to resources, provide support and help to "navigate the system." This strategy will also include a flexible fund that can be utilized for individual and family needs such as uncovered health care, food, short-term housing, transportation, education, and support services.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 05/30/2009
Review dates: 05/30/2009

Appendix 48

7. **Peer Advisory/Advocacy Team** (PAAT), Advocates and educates the community about mental health and recovery. Goals include: Eliminate the stigma attached to mental illness. Advocate and educate the mental health system about the valuable workforce contributions to be made by the individuals it serves. Educate individuals served and family members about their rights and responsibilities in the mental health system. Provide support to peer employees and other leaders of the peer movement to ensure that they have the tools they need to achieve and maintain success and job satisfaction. Promote the concept of wellness versus illness and focus attention on personal responsibility and a balanced life, grounded in wholeness.

B. Evidence that the County, in collaboration with T-MHA, has established ongoing peer support and family education support services, as well as expanded these services will be provided in the form of:

i. Announcements and flyers of the aforementioned programs.
ii. Agendas and sign-in sheets
iii. Brochures and newsletters
iv. Meeting minutes
v. Curricula or similar documents that reflect that peer support services and family education support services are available or offered.
vi. Records of statistics for required DMH reports will also be available.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 05/30/2009
Review dates: 05/30/2009

Appendix 48

MAC Stakeholder Meeting August 17, 2017 4:00-5:30 P.M.

	Last	First	Agency	Email	RSVP	Signature
1	Barnett	Cynthia	FCNL	cbarnett@fcnl.org	Y	
2	Kim	Genie	Cal Poly	gkim23@calpoly.edu		
3	Boaz-Alvarez	Meghan	TMHA	mboazalvarez@t-mha.org	Y	
4	Bolster-White	Jill	TMHA	jbw@t-mha.org		
5	Bragg	Marty	BH Board	mebragg49@gmail.com	Y	
6	Derickson	Dagmar	4-H	dderickson@ucanr.edu		
7	Derose	Tonya	SAFE	northcountysafe@linkslo.org		
8	Duffy	Joan	Cuesta	joan_duffy@gmail.com		
9	Fraser	Lisa	CFS	lfraser@linkslo.org	Y	
10	Gambs	Roger	Public	rgambs@sbcglobal.net		
11	Green	Matthew	Cuesta	mgreen@cuesta.edu	Y	
12	Haas	Mark	DSS	mhaas@co.slo.ca.us		
13	Heddleson	Joyce	BH Board	rahecreations@gmail.com	Y	
14	Hererra	Henry	TMHA	HHerrera@t-mha.org	Y	
15	Johnson	Barry	TMHA	bjohnson@t-mha.org	N	

16	Madsen	Joe	TMHA	jmadsen@t-mha.org	Y	
17	McIntosh	Grace	CAPSLO	gmcintosh@capslo.org		M Sokolowski for Grace
18	Mello	Traci	Wilshire	tmello@wilshirehcs.org		
19	Paric	Marcy	PAAT	MarcyParic@outlook.com	N	
20	Riester	David	NAMI	davidriester@sbcglobal.net	Y	
21	Roberts	Hannah	Cal Poly	hrober02@calpoly.edu		
22	Salio	Jim	Probation	JSalio@co.slo.ca.us		
23	Smith	Jeff	SLOPD	jsmith@slocity.org	Y	
24	Weatherspoon	Jena	tion for California Community (	jweatherspoon@foundationccc.org		
25	Cruse	Katie	FCNI	kcruse@fcni.org	Y	
26	Sturtz	Ellen	GALA	eosturtz@yahoo.com	Y	
27	Thomas	Bonita	PAAT	bonitatrio@sbcglobal.net		
28	Vasquez	Estella	Cuesta	evazquez@cuesta.edu		
29	Weirick	Clint	BH Board	clint.weirick.nonprofit@gmail.com	Y	
30	Young	Mike	Vet Center	Michael.Young3@va.gov		
31	Zweifel	Pam	NAMI	pmz5k@sbcglobal.net	Y	
32						

33				STAFF		
34	Hansen	Briana	Staff	bhansen@co.slo.ca.us	Y	
35	Ford	Patty	Staff	pford@co.slo.ca.us		
36	Graber	Star	Staff	sgraber@co.slo.ca.us		
37	Lopez	Raven	Staff	rclopez@co.slo.ca.us		
38	Veloz-Passalqua	Nestor	Staff	nvelozpassalacqua@co.slo.ca.us	Y	
39	Pietryzk-Jimenez	Luise	Staff	lpietrzyk-jimenez@co.slo.ca.us	Y	
40	Redman	Rebecca	Staff	rredman@co.slo.ca.us	Y	
41	Robin	Anne	Staff	arobin@co.slo.ca.us		
42	Tindula	Sarah	Staff	stindula@co.slo.ca.us		
43	Vick	Judy	Staff	jvick@co.slo.ca.us		
44	Warren	Frank	Staff	fwarren@co.slo.ca.us	Y	
45						
46						
47	Feld	Elissa	TMHA	efeld@t-mha.org	Y	
48	Leonard	Tonya	Cuesta	Tonya_leonard@cuesta.edu	Y	
49	Florez	Janet	Cuesta	jflorez@cuesta.edu	Y	

50	Bettergarcia	Jay	CAL POLY	JBetterg@calpoly.edu		
51	Lawrence	Hillee	Prevention/Outreach	hlawrence@co.slo.ca.us		
52	Elfers	John	CCC 415	John Elfers		
53						
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MAC Stakeholder Meeting September 21, 2017 4:00-5:30 P.M.						
	Last	**First**	**Agency**	**Email**	**RSVP**	**Signature**
1	Barnett	Cynthia	FCNI	cbarnett@fcni.org		
2	Boaz-Alvarez	Meghan	TMHA	mboazalvarez@t-mha.org	YES	
3	Bolster-White	Jill	TMHA	jbw@t-mha.org		
4	Bragg	Marty	BH Board	mebragg49@gmail.com		
5	Cruse	Katie	FCNI	kcruse@fcni.org	NO	
6	Derickson	Dagmar	4-H	dderickson@ucanr.edu		
7	Derose	Tonya	SAFE	northcountysafe@linkslo.org		
8	Duffy	Joan	Cuesta	joanduffy@gmail.com		
9	Fraser	Lisa	CFS	lfraser@linkslo.org	YES	
10	Gambs	Roger	Public	rgambs@sbcglobal.net		
11	Green	Matthew	Cuesta	mgreen@cuesta.edu		
12	Haas	Mark	DSS	mhaas@co.slo.ca.us		
13	Heddleson	Joyce	BH Board	rahecreations@gmail.com	NO	
14	Hererra	Henry	TMHA	HHerrera@t-mha.org	YES	
15	Johnson	Barry	TMHA	bjohnson@t-mha.org	YES	

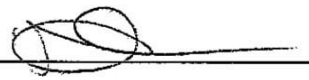
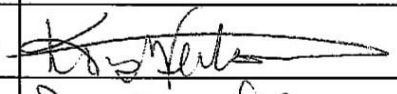
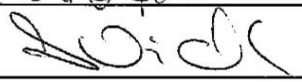
16	Kim	Genie	Cal Poly	gkim23@calpoly.edu	YES	
17	Madsen	Joe	TMHA	jmadsen@t-mha.org	YES	
18	McIntosh	Grace	CAPSLO	gmcintosh@capslo.org		
19	Mello	Traci	Wilshire	tmello@wilshirehcs.org		
20	Paric	Marcy	PAAT	MarcyParic@outlook.com	YES	
21	Riester	David	NAMI	davidriester@sbcglobal.net	YES	
22	Roberts	Hannah	Cal Poly	hrober02@calpoly.edu	NO	
23	Salio	Jim	Probation	JSalio@co.slo.ca.us		
24	Smith	Jeff	SLOPD	jsmith@slocity.org		
25	Sturtz	Ellen	GALA	eosturtz@yahoo.com	YES	
26	Thomas	Bonita	PAAT	bonitatrio@sbcglobal.net	YES	
27	Vasquez	Estella	Cuesta	evazquez@cuesta.edu		
28	Weatherspoon	Jena	tion for California Community	jweatherspoon@foundationccc.org		
29	Weirick	Clint	BH Board	clint.weirick.nonprofit@gmail.com		
30	Young	Mike	Vet Center	Michael.Young3@va.gov		
31	Zweifel	Pam	NAMI	pmz5k@sbcglobal.net	NO	
32	Kurtzman	Joseph	PAAT	Joseph@Paatslo.org	No	

				STAFF		
33	Hansen	Briana	Staff	bhansen@co.slo.ca.us	YES	
34	Ford	Patty	Staff	pford@co.slo.ca.us		
35	Graber	Star	Staff	sgraber@co.slo.ca.us		
36	Lopez	Raven	Staff	rclopez@co.slo.ca.us		
37	Veloz-Passalqua	Nestor	Staff	nvelozpassalacqua@co.slo.ca.us	YES	
38	Pietryzk-Jimenez	Luise	Staff	Lpietrzyk-jimenez@co.slo.ca.us	YES	
39	Redman	Rebecca	Staff	rredman@co.slo.ca.us	YES	
40	Robin	Anne	Staff	arobin@co.slo.ca.us		
41	Tindula	Sarah	Staff	stindula@co.slo.ca.us		
42	Vick	Judy	Staff	jvick@co.slo.ca.us		
43	Warren	Frank	Staff	fwarren@co.slo.ca.us		
44	Friedrich	Danielle	PAAT	dfriedrich@t-mha.org		
45	Sokolowski	Melinda	CAPSL	MSokolowski@capslo.org		
46	Leonard	Tonya	CuestaCollege	Tonya-Leonard@Cuesta.Edu		
47						
48						

RIETJENS JILL STAFF JRietjens@co.slo.ca.us

MAC Stakeholder Meeting February 27, 2018 3:30-5:00 P.M.						
	Last	**First**	**Agency**	**Email**	**RSVP**	**Signature**
1	Barnett	Cynthia	FCNI	cbarnett@fcni.org	YES	
2	Boaz-Alvarez	Meghan	TMHA	mboazalvarez@t-mha.org		
3	Bolster-White	Jill	TMHA	jbw@t-mha.org		
4	Bragg	Marty	BH Board	mebragg49@gmail.com	YES	
5	Cruse	Katie	FCNI	kcruse@fcni.org	YES	
6	Derickson	Dagmar	4-H	dderickson@ucanr.edu	YES	
7	Derose	Tonya	SAFE	northcountysafe@linkslo.org		
8	Fraser	Lisa	CFS	lfraser@linkslo.org	YES	
9	Green	Matthew	Cuesta	mgreen@cuesta.edu	YES	
10	Haas	Mark	DSS	mhaas@co.slo.ca.us	YES	
11	Heddleson	Joyce	BH Board	rahecreations@gmail.com	YES	
12	Johnson	Barry	TMHA	bjohnson@t-mha.org	YES	
13	~~Kim~~	~~Genie~~	~~Cal-Poly~~	gkim23@calpoly.edu	YES	
14	Leonard	Tonya	Cuesta	tonya_leonard@cuesta.edu		
15	Madsen	Joe	TMHA	jmadsen@t-mha.org	YES	

16	Mello	Traci	Wilshire	tmello@wilshirehcs.org	YES	
17	Paric	Marcy	PAAT	MarcyParic@outlook.com	YES	
18	Riester	David	NAMI	davidriester@sbcglobal.net	YES	
19	~~Roberts~~ Reynaga-Asiko	~~Hannah~~ Geneva	Cal Poly	~~hlober02@calpoly.edu~~ greynaga@calpoly.edu		
20	Salio	Jim	Probation	JSalio@co.slo.ca.us		
21	Smith	Jeff	SLOPD	jsmith@slocity.org	YES	
22	Sokolowski	Melinda	CAPSLO	msokolowski@capslo.org		
23	Sturtz	Ellen	GALA	eosturtz@yahoo.com	YES	
24	Thomas	Bonita	PAAT	bonitatrio@sbcglobal.net	YES	
25	Vasquez	Estella	Cuesta	evazquez@cuesta.edu		
26	Weirick	Clint	BH Board	clint.weirick.nonprofit@gmail.com		
27	Young	Mike	Vet Center	Michael.Young3@va.gov		
28	Zweifel	Pam	NAMI	pmz5k@sbcglobal.net	NO	
				STAFF		
29	Hansen	Briana	Staff	bhansen@co.slo.ca.us	YES	
30	Ford	Patty	Staff	pford@co.slo.ca.us	YES	

31	Graber	Star	Staff	sgraber@co.slo.ca.us		
32	Lopez	Raven	Staff	rclopez@co.slo.ca.us		
33	McCoy	Joni	Staff	Jmccoy@co.slo.ca.us	YES	
34	Redman	Rebecca	Staff	rredman@co.slo.ca.us	YES	
35	Robin	Anne	Staff	arobin@co.slo.ca.us	YES	
36	Veloz-Passalacqua	Nestor	Staff	nvelozpassalacqua@co.slo.ca.us	YES	
37	Ventresca	Kristin	Staff	kristinv142@gmail.com	YES	
38	Vick	Judy	Staff	jvick@co.slo.ca.us		
39	Warren	Frank	Staff	fwarren@co.slo.ca.us	YES	
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MAC Stakeholder Meeting April 24, 2018 4:00-5:30 P.M.						
	Last	**First**	**Agency**	**Email**	**RSVP**	**Signature**
1	Aparicio	John	Veterans	japaricio@co.slo.ca.us	YES	
2	Barnett	Cynthia	FCNI	cbarnett@fcni.org	YES	
3	Boaz-Alvarez	Meghan	TMHA	mboazalvarez@t-mha.org	YES	
4	Bolster-White	Jill	TMHA	jbw@t-mha.org		
5	Bragg	Marty	BH Board	mebragg49@gmail.com	NO	
6	Cruse	Katie	FCNI	kcruse@fcni.org	NO	
7	Derickson	Dagmar	4-H	dderickson@ucanr.edu	YES	
8	Derose	Tonya	SAFE	northcountysafe@linkslo.org		
9	Fraser	Lisa	CFS	lfraser@linkslo.org		
10	Green	Matthew	Cuesta	mgreen@cuesta.edu	YES	
11	Haas	Mark	DSS	mhaas@co.slo.ca.us	YES	
12	Heddleson	Joyce	BH Board	rahecreations@gmail.com	YES	
13	Johnson	Barry	TMHA	bjohnson@t-mha.org	YES	
14	Kim	Genie	Cal Poly	gkim23@calpoly.edu		
15	Leonard	Tonya	Cuesta	tonya_leonard@cuesta.edu		

Arthur athompson@t-mha.org

16	Madsen	Joe	TMHA	jmadsen@t-mha.org	NO	
17	Mello	Traci	Wilshire	tmello@wilshirehcs.org		
18	Paric	Marcy	PAAT	MarcyParic@outlook.com	YES	
19	Reynaga-Abiko	Geneva	Cal Poly	greynaga@calpoly.edu	YES	
20	Riester	David	NAMI	davidriester@sbcglobal.net	YES	
21	Salio	Jim	Probation	JSalio@co.slo.ca.us		
22	Smith	Jeff	SLOPD	jsmith@slocity.org	YES	
23	Sokolowski	Melinda	CAPSLO	msokolowski@capslo.org	YES	
24	Sturtz	Ellen	GALA	eosturtz@yahoo.com	YES	
25	Thomas	Bonita	PAAT	bonitatrio@sbcglobal.net	YES	
26	Vasquez	Estella	Cuesta	evazquez@cuesta.edu		
27	Weirick	Clint	BH Board	clint.weirick.nonprofit@gmail.com		
28	Young	Mike	Vet Center	Michael.Young3@va.gov		
29	Zweifel	Pam	NAMI	pmz5k@sbcglobal.net	YES	
30						
				STAFF		
30	Hansen	Briana	Staff	bhansen@co.slo.ca.us	YES	

31	Belch	Linda	Staff	lbelch@co.slo.ca.us	YES	
32	Ford	Patty	Staff	pford@co.slo.ca.us		
33	Graber	Star	Staff	sgraber@co.slo.ca.us	YES	
34	Lopez	Raven	Staff	rclopez@co.slo.ca.us		
35	McCoy	Joni	Staff	Jmccoy@co.slo.ca.us	YES	
36	Redman	Rebecca	Staff	rredman@co.slo.ca.us	YES	
37	Robin	Anne	Staff	arobin@co.slo.ca.us		
38	Veloz-Passalacqua	Nestor	Staff	nvelozpassalacqua@co.slo.ca.us	YES	
39	Ventresca	Kristin	Staff	kristinv142@gmail.com	YES	
40	Vick	Judy	Staff	jvick@co.slo.ca.us		
41	Warren	Frank	Staff	fwarren@co.slo.ca.us	YES	
42	Dragoo	David	Staff	DDragoo@t-mha.org		
43	Johnson	Nicole	Cuesta	nicole.johnson7@cuesta.edu	NO	
44	Ison	Shawn	TMHA	sison@t-mha.org	YES	
45	Brown	Ileara	TMHA	ibrown@t-mha.org	YES	
46	Lucas	Fernanda	promotor	ref0528@gmail.com		
47	Ruvalcaba Heredia	Erica	Promotores Director	erica.ruvalcaba05@gmail.com		

MAC Stakeholder Meeting June 26, 2018 4:00-5:30 P.M.						
	Last	**First**	**Agency**	**Email**	**RSVP**	**Signature**
1	Aparicio	John	Veterans	japaricio@co.slo.ca.us	Yes	
2	Barnett	Cynthia	FCNI	cbarnett@fcni.org		
3	Boaz-Alvarez	Meghan	TMHA	mboazalvarez@t-mha.org		
4	Bolster-White	Jill	TMHA	jbw@t-mha.org	NO	
5	Bragg	Marty	BH Board	mebragg49@gmail.com		
6	Cruse - Poe	Katie	FCNI	kcruse@fcni.org	YES	
7	Derickson	Dagmar	4-H	dderickson@ucanr.edu	YES	
8	Derose	Tonya	SAFE	northcountysafe@linkslo.org		
9	Fraser	Lisa	CFS	lfraser@linkslo.org		
10	Green	Matthew	Cuesta	mgreen@cuesta.edu	YES	
11	Haas	Mark	DSS	mhaas@co.slo.ca.us		
12	Heddleson	Joyce	BH Board	rahecreations@gmail.com	YES	
13	Johnson	Barry	TMHA	bjohnson@t-mha.org		
14	Kim	Genie	Cal Poly	gkim23@calpoly.edu		
15	Leonard	Tonya	Cuesta	tonya_leonard@cuesta.edu	NO	

16	Madsen	Joe	TMHA	jmadsen@t-mha.org	YES	
17	Mello	Traci	Wilshire	tmello@wilshirehcs.org		
18	Paric	Marcy	PAAT	MarcyParic@outlook.com	NO	
19	Reynaga-Abiko	Geneva	Cal Poly	greynaga@calpoly.edu	NO	
20	Riester	David	NAMI	davidriester@sbcglobal.net	YES	
21	Salio	Jim	Probation	JSalio@co.slo.ca.us	YES	
22	Smith	Jeff	SLOPD	jsmith@slocity.org	YES	
23	Sokolowski	Melinda	CAPSLO	msokolowski@capslo.org	YES	
24	Sturtz	Ellen	GALA	eosturtz@yahoo.com	YES	
25	Thomas	Bonita	PAAT	bonitatrio@sbcglobal.net	YES	
26	Weirick	Clint	BH Board	clint.weirick.nonprofit@gmail.com		
27	Young	Mike	Vet Center	Michael.Young3@va.gov		
28	Zweifel	Pam	NAMI	pmz5k@sbcglobal.net	YES	
				STAFF		
29	Hansen	Briana	Staff	bhansen@co.slo.ca.us	YES	
30	Ford	Patty	Staff	pford@co.slo.ca.us	NO	

31	Graber	Star	Staff	sgraber@co.slo.ca.us	NO	
32	Lopez	Raven	Staff	rclopez@co.slo.ca.us		
33	McCoy	Joni	Staff	Jmccoy@co.slo.ca.us	YES	
34	Redman	Rebecca	Staff	rredman@co.slo.ca.us	YES	
35	Robin	Anne	Staff	arobin@co.slo.ca.us		
36	Veloz-Passalacqua	Nestor	Staff	nvelozpassalacqua@co.slo.ca.us	YES	
37	Ventresca	Kristin	Staff	kristinv142@gmail.com	YES	
38	Vick	Judy	Staff	jvick@co.slo.ca.us		
39	Warren	Frank	Staff	fwarren@co.slo.ca.us	YES	
40	Cohen	Katie	Staff	kmcohen@co.slo.ca.us	NO	
41	ISON	SHAWN	STATE	SISON@T-MHA.ORG		
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