COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due July 28, 2010 to:

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

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CHECKLIST OF THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

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Purpose

The Cultural Competence Plan Requirements (CCPR) establish new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). "CCPR" in this document shall mean the county's completed cultural competence plan submission inclusive of all requirements. The original CCPR (2002), Department of Mental Health (DMH) Information Notice 02-03, addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) is designed to address all mental health services and programs throughout the County Mental Health System. This CCPR seeks to support full system planning and integration. This revised CCPR (2010) includes the most current resources and standards available in the field of cultural and linguistic competence, and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The revised CCPR (2010) works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California's diverse racial, ethnic, and cultural communities in the mental health system of care.

Background

The CCPR (2002) revised addendum indicated that "future CCP requirements will evolve as more experience through plan development and implementation progresses. While efforts are being made on an ongoing basis to achieve cultural competence, as our competence improves, our standards will need to improve." This revised CCPR (2010) serves as an outcome of these advances in the field of cultural competence. DMH seeks to keep the County Mental Health System updated with the latest studies and applications in the field of cultural and linguistic competence, so that the mental health system functions as a highly efficient organization with the ability to provide effective and integrated services to its ethnic/racial and cultural communities. The revised CCPR (2010) serves to operationalize cultural competence at both the organizational and contractor level.

The basis for the revised CCPR (2010) criteria is the U.S. Department of Health and Human Services, Office of Minority Health (2001) *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (CLAS) (See Federal Standards, page 33 of this CCPR). The revised CCPR (2010) criteria were developed from a compilation of the CCPR (2002), CLAS, and other current cultural competence organizational assessment tools (see attached references). Combined, these documents incorporate eight domains that cover a system in its entirety:

Domain 1. Organizational Values;
Domain 2. Policies/Procedures/Governance;
Domain 3. Planning/Monitoring/Evaluation;
Domain 4. Communication;
Domain 5. Human Resource Development;
Domain 6. Community and Consumer Participation;
Domain 7. Facilitation of a Broad Service Array; and
Domain 8. Organizational Resources.

(Source: University of South Florida, 2006. *Organizational Cultural Competence: A Review of Assessment Protocols)*

Research on the above eight domains included review and analysis of 17 organizational level cultural competence assessment tools being used in the field today. The research yielded a compilation of the eight significant assessment domains as focus areas for assessing and integrating cultural competence into mental health programs. The domains work to create an organizational model for operationalizing cultural competence into systems. The inclusion of these eight domains is necessary for a County Mental Health System to effect change and progress towards a culturally competent mental health system of care in California.

From the above eight *domains*, eight *criteria* were developed to encompass the revised CCPR (2010) and assist counties in identifying and addressing disparities across the entire mental health system. Those eight criteria are as follows:

Criterion I: Commitment to Cultural Competence
Criterion II: Updated Assessment of Service Needs
Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
Criterion IV: Client/Family Member/Community Committee: Integration of the Committee Within The County Mental Health System
Criterion V: Culturally Competent Training Activities
Criterion VI: County's Commitment To Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
Criterion VII: Language Capacity
Criterion VIII: Adaptation of Services

These eight criteria are a mechanism to examine where counties lie on the scale of cultural competence. Having used the criteria to form a logic model, the CCPR's development and inclusion of the eight criteria allow counties to implement cultural and linguistic competence in a variety of settings and move toward operationalizing the concept of cultural competence. The assessment portion of the CCPR will identify areas the county may need resources, supports, and leverage to support its efforts in operationalizing cultural competence.

The County Mental Health System in California has changed greatly with the passage of the MHSA. MHSA has opened many doors for unserved/underserved individuals and

works toward increasing the county workforce. As MHSA expands and increases services, DMH recognizes that county reporting requirements have also increased. The revised CCPR (2010) takes this into consideration and has focused on omitting reporting redundancies by developing one, single plan that will be applied to all programs throughout the system. Where applicable, the revised CCPR (2010) requires copies or updates of areas already addressed in other reports or plans. Some areas will apply to Medi-Cal only, while other areas will apply to the entire system; these are delineated throughout the revised CCPR (2010).

Current State and Federal statutory, regulatory, and authority provisions related to cultural and linguistic competence and other policies, statutes, and standards.

This revised CCPR (2010) includes listings of required Federal and *S*tate statutes, regulations, and DMH policy letters related to cultural and linguistic competence in the delivery of mental health services. These provisions are in addition to other Federal or State laws that prohibit discrimination based on race, color, or national origin (for more information see page 32).

Timeframes

The revised CCPR (2010) shall be submitted by each county to DMH on a staggered three year cycle (a comprehensive CCPR is submitted every three years and an Annual Update is submitted in the interim years). Annual updates will be required and DMH will select specific criteria for counties to report on for each update. The first revised CCPR (2010) will be due in July 2010; subsequent CCPRs will be due in 2013 and 2016. Annual updates will be due in 2011, 2012, 2014, and 2015. Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty MHS, Article 4., Section 1810.410 (c)-(d) states each Mental Health Plan (MHP) shall submit an annual CCPR update consistent with the requirements of this revised CCPR document, consistent with the plan reporting requirements, including the population assessment and organizational and service provider assessments.

Counties may direct all inquiries about this CCPR (2010) to the California Department of Mental Health, Office of Multicultural Services at 916-651-9524.

Directions for completing the revised CCPR (2010)

The DMH expects this revised CCPR (2010) to be completed by the county Department of Mental Health (referred in document as county). The county will provide the plan to all county contractor(s) providing mental health services and hold the contractor(s) accountable for reporting the information to be inserted into the CCPR. The CCPR must reflect the activities of the MHP (county and contractor) and both county and contractor are required to adhere to the plan. Throughout the revised CCPR (2010) are fields to be completed by the county, with recommendations for data to be submitted by both the county and the contractor.

The revised CCPR (2010) requires counties to include an analysis and tabulation of the contractors' deficiencies, strategies to address the deficiencies, and timeframes for

implementing the strategies. This must be included in the overall county response to DMH, with timeframes for when the deficiencies will be addressed.

The DMH will review the revised CCPR (2010) submission and will provide a score and feedback to the counties.

An original, three copies, and a compact disc of this CCPR saved in PDF format (preferred) or Microsoft Word format 1997-2003 is due by July 28, 2010.

The CCPR's Cover Sheet shall be the first sheet of the submitted document. Submissions should follow the assigned format identifying each criterion by number, criterion title, and page numbers. Sections of the CCPR should be complete; however, if a section is incomplete (such as data is unavailable), identify the section and briefly explain when the section will be submitted to DMH. Counties must meet the submission deadlines. If submission timelines cannot be met, counties shall notify DMH ahead of time. Please call the Office of Multicultural Services at 916-651-9524 to discuss new CCPR deadline submissions.

CRITERION 1

COUNTY MENTAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE

Rationale: An organizational and service provider assessment is necessary to determine the readiness of the service delivery system to meet the cultural and linguistic needs of the target population. Individuals from racial, ethnic, cultural, and linguistically diverse backgrounds frequently require different and individual Mental Health Service System responses.

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.

Stanislaus County Behavioral Health and Recovery Services (BHRS) mission statement, policies, procedures and organizational culture demonstrate, on a daily basis, the importance of involvement with diverse communities. The BHRS Mission statement ("In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.") stresses partnership with our community and includes organizational values specifically related to the importance of acknowledging, supporting, and incorporating culture at all levels within the organization as well as external to BHRS. As an example, a contractor, Sierra Vista Child and Family Services (SVCFS) mandates that all new employees attend orientation training, and an overview of cultural competence is part of this. SVCFS also follows policies, procedures and practice established by BHRS, as noted in contracts. The BHRS Code of Ethics describes staff's primary responsibility to serve, respect and support the client. The "Non Discrimination" policy (40.2.108) clearly states BHRS shall not discriminate in the provision of services and employment based on the basis of race, ethnicity, ancestry, color, national origin, religion, physical or mental disability, or medical condition, pregnancy related condition, marital status, sex, sexual orientation, age, or political affiliation or belief.

The following organizational policies and procedures included in the Appendix assist BHRS in providing culturally appropriate services: 90.1.106 (Language Assistance Services to Limited English Speaking Clients and Family Members); 90.1.112 (Language Translators); 90.1.113 (Services to Consumers with Visual Impairments); 90.1.114 (Use of Contract Cultural Interpreters); 30.2.116 Forms for Limited English Speaking Clients).

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).

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.

Stanislaus County Behavioral Health and Recovery Services (BHRS) recognizes the value of and demonstrates involvement with diverse communities. BHRS leadership is committed to ongoing efforts to shift organizational culture, develop community strengths, establish supportive strategies, provide advocacy, and develop trust through engagement of individuals in racially, ethnically, culturally, and linguistically diverse communities. Through efforts to increase community capacity building in the areas of emotional health and wellness for all ages, all communities and constituents benefit. Following are examples of the various practices and activities BHRS currently has in place.

Outreach, engagement and involvement are enhanced and access to services is increased when staff is welcoming, culturally well-informed and able to communicate in the same language as the consumer. Stanislaus County has only one threshold language, i.e. Spanish. BHRS and its contracted programs employ bilingual/bicultural Spanish-speaking staff and interpreters. Staff or contract interpreters are also available for the variety of other languages spoken within the County. BHRS uses the Language Line if bilingual staff or an interpreter is not available. In addition to Spanish, staff interpreters/ translators are available in the following languages: Afghani, Assyrian, Cambodian, Farsi, Japanese, Laotian, Tagalog, Thai, and Vietnamese. Contract interpreters are available in Arabic, Armenian, Cantonese, Filipino, Hakka, Hindi, Hmong, Khmer, Mandarin, Portuguese, Pushto, Russian, Turkish, and Ukrainian. In addition, Sign Language providers for the hearing impaired are also available. A comprehensive and up-to-date list of interpreters/translators is posted on the BHRS Intranet/Extranet site, readily available to all BHRS and contract staff. BHRS Policy 90.1.106, Language Assistance Services to Limited English Speaking Clients and Family Members (included in Appendix), sets forth the expectation that language assistance will be provided through bilingual staff, certified interpreters or the Language Line, free of charge, twenty-four hours a day, seven days a week depending on the business hours of the facility/program. BHRS policy 90.1.112, Language Translators (included in Appendix) details departmental expectations regarding service provision to clients in their primary language, preferably through bilingual staff, secondarily through qualified translators. Use of Contract Cultural Interpreters is explained in BHRS policy 90.1.114 (included in Appendix).

Services to Consumers with Visual Impairments, BHRS policy 90.1.113 (included in Appendix), describes access to services and to Mental Health Plan informational materials for all consumers with visual impairments. BHRS policy 30.2.116 (included in Appendix) explains that clinical forms, education materials and documents are to be provided in the threshold language, and assistance is to be provided to complete and understand forms/materials in the client's primary language if that language is other than a threshold language.

BHRS programs are committed to engaging and sustaining clients in a therapeutic milieu. Program lobbies are welcoming and create healing environments that clients can translate to their own homes. As much as possible, furnishings are new and well-maintained. Culturally sensitive information and magazines are displayed on resource tables/racks, and wall art depicting nature and/or the major cultural groups served decorate the walls. As an example, staff diversity, posters and magazines at Josie's Place Drop-In Center create a culturally rich environment that provides comfort to clients and enhances engagement with them. Program staff representative of a variety of ethnicities and cultural groups, including individuals in recovery, are available at Josie's Place to provide opportunities for socialization with peers in a safe, non-judgmental environment. Staff recently led an outing to the Museum of Tolerance in Los Angeles and held a successful family barbecue at the beginning of summer. Family Partnership Center recently started an innovative movie group for Spanish-speaking families. Outside of the program setting, art and music festivals are held at the BHRS main campus as well as many other venues throughout the community to encourage participation of artists of all ages and are not restricted to mental health clients. Such participation builds support in the community that is not based upon having a mental illness and that fosters emotional wellness.

BHRS acknowledges Stanislaus County's imperfect transportation system and its negative impact on access to services. Programs attempt to eliminate transportation barriers and improve access to services by providing outreach and engagement and, at times, treatment in community settings. For example, Children's System of Care Juvenile Justice staff provide the preponderance of mental health services in the community, in clients' homes and neighborhoods. Child Welfare Services staff are also mobile and provide intensive service wherever the client is. Leaps and Bounds staff perform initial screenings in families' homes and provide mental health services in the home as well as in family-familiar community settings. In addition, staff provide consultation services at early education centers, Family Resource Centers and Healthy Birth Outcomes groups. Also, a pair of Advocates have conducted Consumer and Family Orientation meetings that are open to the public after hours at Turlock Recovery Services. Josie's Place staff conduct outreach at parks, bus stations and at the local acute psychiatric hospital.

BHRS cannot provide all the services clients may need so program staff work closely with other agencies. For example, School-Based Services/SED (a Children's System of Care program) partners with Stanislaus County school districts, and all team members become stewards at Individual Education Plan meetings for disabled students and their families, providing mental health services as well as other advocacy and legal resources. Within Adult and Older Adult Systems of Care programs, strong linkages have been forged with numerous public, community- and faith-based agencies to improve access to all types of services. For example, Modesto Recovery Services' (MRS) relationship with The Bridge Community Center, which provides information and referral for services to Cambodian, Hmong, Laotian and other members of the Asian community. MRS also has contact with the Cambodian and Lao Temples. Another example is MRS' connection with the Stanislaus PRIDE Center that provides resources to strengthen and support gay, lesbian, bisexual and transgendered persons in Stanislaus and surrounding counties. Turlock Regional Services (TRS) formed an invaluable partnership with the International Rescue Committee to serve the increasing number of refugees from the Middle East who have settled in the Turlock/South County area. BHS/StanWORKS is a multi-disciplinary team that provides mental health counseling and substance abuse services to recipients of Temporary Aid to Needy Families (TANF). BHS/StanWORKS' major partners are the Community Services Agency that administers the TANF program and Stanislaus Women's Haven that provides Domestic Violence services.

All MHSA-funded programs target unserved and underserved individuals from diverse communities. Two MHSA Community Services and Supports Work Plans for Full Service Partnership programs specifically require service to 40 participants per year at least 50% of whom are people of color. This target for Integrated Forensic Team and Westside SHOP is monitored on a regular, ongoing basis and is always successfully achieved or exceeded. The Forensic System of Care's direct referral process from Probation, Superior Court, the Sheriff's Office and the Modesto Police Department speeds access to Integrated Forensic Team services (IFT). IFT staff regularly provide outreach to the Public Safety Center/Jail and keep all collaborative partners informed about available services.

BHRS has long-established contracts with several community-based organizations to serve specific diverse populations (e.g., AspiraNet, Center for Human Services, El Concilio, Parents United, Sierra Vista Child and Family Services, Telecare Corporation, Turning Point Community Programs, and West Modesto King Kennedy Neighborhood Collaborative). Contract providers adhere to BHRS policies and procedures with regard to cultural competence, actively participate in the BHRS Cultural Competence Oversight Committee, attend BHRS trainings, and provide services in threshold and other languages through staff and/or contract interpreters. Contractors often develop their own internal cultural competence programs and locate services within diverse communities to enhance their ability to provide resources. For example, all Telecare staff members are required to have contact with an organization in the community where they maintain an ongoing relationship. Telecare's outreach is focused on maintaining a presence in key locations where the homeless and underserved might be found, including but not limited to parks, shelters and other community settings. Like other contractors, Telecare staff provide mental health assessments and services in community locations easily accessible to culturally and ethnically diverse populations (King-Kennedy Center, Alano Club, Salvation Army, and Golden Valley Health Clinic are a few examples). Turning Point Community Program's Integrated Services Agency (ISA) Modesto focuses on serving individuals in their preferred environment, engaging families in and reducing barriers to treatment. Turning Point's Respite at Garden Gate, an MHSA Outreach and Engagement program, reaches out to members of the homeless community to provide linkages to housing and treatment alternatives. Turning Point's innovative Community Activities and Rehabilitation Transport (CART) program provides transportation to increase access to community resources and recovery and the Consumer Empowerment Center utilizes the strengths of mental health consumers and their families to staff an activity center that welcomes diversity, offers linkages to resources, hosts social and educational activities, and provides group meeting space. A local community based organization (CBO), The Center for Human Services, provides a variety of prevention, intervention and treatment programming through Family Resource Centers, located in individual communities, eliminating transportation and other challenging barriers to access to services. SVCFS adopted a "promotora-like" model in which staff goes out to underserved communities to educate and provide information about services through community group presentations, health fairs, discussion panels, training and other events. Hughson Family Resource Center is a part of SVCFS that serves the southeast side of Stanislaus County. The Center has been very successful in reaching out to that community's ethnic groups. They collaborate with El Concilio, Haven Women's Center, United Samaritan and other local CBO's to bring services to this rural community. SVCFS also promotes education among consumers. They provide ESL classes at The Bridge for Southeast Asian clients and GED classes at the North Modesto Resource Center. SVCFS also has after school services for the children being served by The Bridge and their foster family division. El Concilio, expert in providing resource and referral to Hispanic/Latino populations, provides MHSA Outreach and Engagement services in the west side cities of Stanislaus County including Crows Landing, Westley and Grayson so residents do not have to travel forty-plus miles to Modesto. West Modesto King Kennedy Neighborhood Collaborative, another MHSA Outreach and Engagement contractor, provides community-based resource/referral on the west side of the City of Modesto and operates a weekend drop-in center for those ages 18 and over to socialize and connect with others.

BHRS solicits diverse input to local mental health planning processes, decision-making and development of services in participative and transparent processes that encourage broad-based community participation. The demonstrated track record of BHRS in utilizing this type of diverse countywide stakeholder process dates back to 1999 with the implementation of AB 34. With the advent of MHSA planning, the Representative Stakeholder Steering Committee was formed,

comprised of all MHSA-required and recommended stakeholder groups. Stakeholders are responsible for sharing information with other members of the stakeholder group they represent. Information is posted on the BHRS MHSA website for general stakeholder (and public) access. Contact information is included in materials and on the local website. From 2005 to date, BHRS has conducted extensive community and stakeholder input gathering processes to guide selection and prioritization of issues and populations initially addressed under its Mental Health Services Act Community Services and Supports Plan, to make decisions about MHSA Augmentation and Growth funds, Workforce Education and Training, Prevention/Early Intervention, Technological Needs and Innovations proposals and plan updates. Additionally, this stakeholder group process has been utilized to address housing, employment and service access issues, and is currently being used to help make other strategic business decisions such as budget reductions, program improvement, and implementation of a results based accountability system of measuring community outcomes.

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.

Clients and Family Members

Stanislaus County Behavioral Health and Recovery Services (BHRS) is committed to the fullest possible involvement of clients and family members in planning, developing, providing and evaluating services for consumers of all ages. Consumers and family members reflecting the diversity of our community have partnered with BHRS in planning processes related to MHSA programs, housing, employment, and access to services. BHRS encourages and appreciates participation of consumers and family members and benefits from their meaningful and significant involvement. The Community Activities and Rehabilitation Transport Program (CART) is designed to help consumers/family members access venues so the consumer voice can be heard. BHRS Policy 10.4.100, Compensation and/or Reimbursement of Time and Travel for Consumers and Family Members (included in the Appendix), describes the system for compensating consumers, family members, and parents or caregivers of minor children who receive behavioral health services related to activities as stakeholders in BHRS committees and stakeholder meetings or as participants in other planning efforts. BHRS has consumer- and family-driven programs wherein consumers identify their needs and preferences, which drive the services, policy and financing decisions that affect them. A prime example of this is Josie's Place Drop-In Center and its Young Adult Advisory Committee (YAAC) whose members made a written request to the CSOC Chief in mid-2009 for installation of Wi-Fi at the Drop-In Center, addressing the pertinent pros and cons. After careful consideration, the group's request was granted. The same group regularly provides input into the outings and activities conducted by the Drop-In Center, to the STAY Youth Leadership Conference programming, and to a Regional Workforce Education and Training focus group on clinical competencies. BHRS Parent Partners (called "parent mentors" in contract programs) are Behavioral Health Advocates who support and speak for families in service planning.

Advisory Committees

A senior management level position for Consumer and Family Affairs originated as a result of the BHRS MHSA-CSS Planning in 2005. This Manager is responsible for convening a Consumer and Family Steering Committee, the purpose of which is to advance consumer and family participation and involvement. The Committee's charge is to provide input into planning efforts and quality management activities, to assist the Manager by suggesting needed policy, and participate in the development of guidelines for consumer and family activities in all BHRS Systems of Care. It is comprised of representatives from all consumer and family organizations active with BHRS and provides outreach and engagement to other consumer and family members.

Since 2009, the Committee has given input to the Department's Workforce Development Council Training Plan Draft about training for consumers, family members and volunteers; provided feedback

to the draft BHRS Workforce Education Training Plan; taken part in vendor presentations about the future electronic health record system as well as providing input to the Technological Needs Planning – Consumer and Family Member Empowerment Projects; submitted feedback to the California Mental Health Planning Council in regard to how complaints about MHSA should be handled; and were well-represented in a lengthy Consumer Empowerment Center improvement project

Other advisory activities occur at The Consumer Empowerment Center, an MHSA program operated under contract with Turning Point Community Programs, which has an advisory committee made up of consumers who discuss the direction of the Center and make suggestions for activities and upcoming events. In addition, youth/young adult and adult advisory committees are in place at the Family Partnership Center and Josie's Place Drop-In Center. The Family Partnership Center Consulting Committee (FPCCC) is the adult advisory committee, composed of parents or caretakers of children with mental health, learning and/or physical disabilities. The composition of the committee includes various races and ethnicities, i.e., Hispanic, African-American, Native American and Caucasian, as well as mental health consumers. Josie's Place Young Adult Advisory Committee (YAAC), guided by contract staff from the Center for Human Services, is working to increase participation, develop organizational structure (including governance and accountability), learn leadership skills, and form linkages with other similar groups within the county.

Local Mental Health Board

Stanislaus County's Mental Health Board (MHB) exceeds statutory requirements that at least 20% of its members are consumers, at least 20% are family members, and the two categories combined comprise at least 50% of the board. Four members report they are both consumers and family members. Additionally, the MHB has four Hispanic members (31%), one African American member (8%), and one Asian member (8%); the remaining seven members are White/Caucasian (53%). There is a standing agenda item on the monthly MHB agenda for a staff report and updates/discussion of cultural competence. Each MHB member receives a hard copy of the BHRS Cultural Competence Newsletter and Cultural Competence Oversight Committee minutes in his/her agenda packet. A Mental Health Board member is designated as a standing member of the BHRS Cultural Competence Oversight Committee. MHB members have been involved in MHSA planning since August 2004, prior to passage of the Act. Each new MHSA component's draft plan and every annual update were considered by the MHB as they held public hearings as part of their agenda.

To facilitate effective participation in meetings and enhance communication skills, MHB members are provided periodic training regarding roles and responsibilities of membership. These trainings are initiated by the MHB Executive Committee on an as-needed basis. Past trainings have been facilitated by Board Chairs who were consumers and family members. Members have also participated in regional and Statewide trainings and conferences provided by the California Association of Local Mental Health Boards and Commissions.

MHB members have also been very effective at reaching out to consumers and family members to begin participation by serving on Committees. Committee meetings are smaller, less formal and a way to learn about how MHB works. Several consumers who began by participating on Committees and later became very effective MHB members. The MHB Chair increased recruitment of ethnically diverse populations by sending letters to leaders of ethnic communities, inviting a representative to attend MHB meetings to discuss whether mental health needs of their communities were being met. The letter described the Board's commitment to achieving cultural diversity and invited a representative to participate as a member. The Board has purposefully scheduled meetings in outlying communities each year so that not only consumers but community members are able to attend and discuss issues before the Board. The Board has been most successful in recruiting a "critical mass" of Latino community members. Currently four members (31%) of the MHB are Latino. The MHB Chair, who is just ending her term as Chair, is African American and has been a member of the Board since 2004. She is an instructor at the local junior college and has created a pool of potential MHB members by encouraging students to attend Mental Health Board meetings. There have been many robust discussions between members and students.

Community Organizations

Three large consumer/family groups participate regularly in BHRS community planning processes. The Stanislaus Chapter of Mental Health Consumers (SCMHC) have worked in partnership with BHRS on many planning and advocacy efforts over the past six years. SCMHC officers and members have facilitated targeted focus groups, participated in the MHB/MHRS Planning Committee and/or System of Care work groups, and have been members of the MHSA Representative Stakeholder Committee. SCMHC members were very active in the Statewide MHSA implementation process.

Officers and members of the National Alliance for the Mentally Ill (NAMI) Stanislaus also participate actively in local planning processes. They work closely with BHRS leadership and the MHSA Coordinator during the planning of each MHSA component.

The third large consumer/family group, Parent Partnership Program, is part of the BHRS Children's System of Care. Paid or volunteer staff, each Parent Partner is a parent and/or family member of a child who has received services in the public mental health system. Parent Partners have a significant history of providing effective support and advocacy to other parents and family members whose children and transition age youth currently receive services. During local planning processes for MHSA, Parent Partners worked with BHRS leadership to ensure that the voices of parents and family members are heard.

Efforts to engage diverse community members, create transparency and understanding in all community planning processes are ongoing in Stanislaus County. BHRS has partnered with community based organizations serving diverse cultural communities to support these efforts, each time building more capacity to reach more deeply into underserved cultural communities. During community program planning for MHSA-CSS, outreach to diverse populations was accomplished through presentations in five cities throughout Stanislaus County, at local NAACP in West Modesto, a community meeting with El Concilio – Council for the Spanish Speaking, with leaders of a Laotian Temple in Ceres and with members of the local chapter of Parents and Friends of Lesbians and Gays (PFLAG). During PEI planning, BHRS contracted with three community based organizations serving diverse communities: El Concilio – Council for the Spanish Speaking, West Modesto King-Kennedy Neighborhood Collaborative serving primarily African American, The Bridge Community Center serving South East Asian communities and with the Pride Center serving LGBTQ communities to actually do the outreach and gain input from communities. Many of these community based organizations are central to the success of CSS and PEI implementation as well.

Contractors are also involved in this engagement of diverse communities in mental health planning efforts. For instance, SVCFS acknowledges the importance of maintaining a close relationship with consumers and their families. They specifically reach out to ethnic consumers to become involve in expressing and sharing any concerns regarding delivery of services. Engaging clients/consumers is vital in developing responsive services that will meet their needs and lessen their marginal status. SVCFS utilizes cultural brokers, consultants and community providers who have experience in working with the various multicultural groups in the planning process of engaging multicultural communities. Through surveys, focus groups and satisfaction questionnaires, they are able to collect consumer input that may steer changes in service delivery and/or policy changes.

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.

Inspired by the BHRS Mission Statement, "In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes," BHRS is focused on creating, with our community, a different approach to behavioral health and emotional wellness in Stanislaus County. BHRS is permanently shifting away from the traditional approach to communities

based on what's "wrong" or "at-risk" and building a "help first" system where mental health professionals are primarily focused on mental health and wellness and there is genuine partnership with communities. The ultimate outcome will be a community that supports emotional wellness and resiliency, public awareness of stigma and discrimination as real issues to be eliminated, and easy early access to appropriate help when needed.

Community capacity building is a smart and sustainable strategic initiative. BHRS leverages MHSA Prevention/Early Intervention (PEI) and other funds to identify, catalyze, mobilize and support the strengths, assets and resources that exist within communities to meet these needs. These strengths and assets include leaders, individuals, groups, organizations, facilities, knowledge, and other sources of funding. As part of an upcoming CiMH Learning Collaborative Project on Community Capacity Building (CCB), BHRS intends to invite diverse community leadership to participate with the organization. In this way, there will be a shared understanding of CCB principles and we will have an opportunity to network with community leadership to further strengthen relationships among all of us.

A specific Community Capacity Building project, funded in Stanislaus County in 2009 with MHSA PEI dollars, involves supporting strategies to increase targeted communities' behavioral health capacity in the areas of (1) leadership development, (2) organizational capacity, and (3) community capacity by utilizing Asset-Based Community Development strategies and approaches. The project also expands community capacity using the Promotores/community health worker model by training and employing community behavioral health workers from targeted communities. A results-based accountability method is employed to establish community-selected outcome measures to monitor and report success within the project. Prior to PEI implementation, BHRS had well-developed relationships with local partners and participated in a number of major collaborative projects to develop skills and strengthen community organizations involved in providing essential services.

Another effort at skill development is our Crisis Intervention Training (CIT) that is provided twice annually to law enforcement personnel from throughout Stanislaus and nearby counties via a collaborative effort of BHRS, the Modesto Police Department and the National Alliance on Mental Illness (NAMI). This training is based upon a nationally recognized 40-hour curriculum for law enforcement Goals of CIT are to reduce use-of-force incidents by officers when encountering emotionally disturbed individuals; reduce related injuries to officers and citizens; reduce misdemeanor arrests among the SMI population; decrease the frequency and amount of time officers spend responding to calls for service with this population; reduce involuntary psychiatric hospitalizations, and improve relationships between law enforcement, local behavioral health and other service providers, consumers and family members.

In addition to BHRS efforts, contract providers play a major role in skills development and strengthening of community organizations that provide essential services. Telecare Corporation, for example, has an extremely active outreach team comprised of bilingual/bicultural (Hispanic, Cambodian) staff members. This team has ongoing contact with community organizations to educate about mental health and to provide support in meeting community needs. Another BHRS contractor, Turning Point Community Programs, has established a relationship with CSU Stanislaus for placement of interns as a venue for and means of creating awareness in future service providers. Turning Point ISA/Respite staff established collaborative relationships with key individuals in medical facilities and participate in monthly Restorative Policing meetings to advocate for awareness of issues requiring special consideration when working with mental health consumers. Respite Staff work closely with the Modesto Police Department to offer support to individuals who may have mental health issues. SVCFS acknowledges and understands that ethnic specific communities and religious organizations are usually the first contact ethnically diverse families make toward seeking and/or receiving services. SVCFS works with local community-based organizations and reaches out to local religious institutions. SVCFS partners with community organizations to promote cultural understanding and meet the needs of diverse populations.

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

When polled for input on this item, BHRS and contractor staff enumerated a variety of crucial lessons learned through their efforts to outreach to, engage with and strengthen the community:

- Collaborative efforts are critical to community capacity building and ensuring a continuum of care to sustain recovery from mental illness. Due to past negative experiences and new legal reforms, however, trust-building requires patience, time and reassurance that things are different.
- Up-to-date information about existing community resources must be widely available to providers as well as consumers.
- Seamless services are vitally important to engagement and retention of clients.
- Lack of transportation is a major impediment to accessing services, especially in rural areas and for the elderly in any part of Stanislaus County. Thus, building capacity in diverse communities is helpful to address this issue.
- The persistent poverty associated with mental illness is a continuing challenge to achieving mental health, wellness and independence.
- The simple fact that a Forensic System of Care exists is acknowledgement of the additional stigma and hurdles, even within BHRS, that clients involved in the criminal justice system or who have a record must face.
- In person interpreter services for those who speak other than threshold languages is preferred over the telephone-based interpreter services.
- The community educates us in ways to address their needs, simultaneously honoring diversity and respecting cultures. Sometimes unorthodox approaches are necessary to successful engagement.
- Hiring peers works! Integrated into teams, those with lived experience impact clinical work in very positive ways, increasing staff sensitivity, knowledge and understanding.
- Do not assume anything. Listen carefully, continually clarify meaning, attempt to understand each person as an individual, and maintain flexibility in treatment planning.

E. Identify county technical assistance needs.

BHRS program and contractor staff identified the following technical assistance/training needs:

- Training on effective outreach strategies
- Information regarding how to work with and provide culturally appropriate services to the increasingly diverse populations served in Stanislaus County
- Up-to-date tools to measure client satisfaction that are reliable and valid
- Enhancing collaboration among all contracting agencies/programs
- Working with consumers and families to improve computer skills for educational and employment purposes
- Effective recruitment strategies for multilingual, contract interpreters, particularly Middle Eastern languages

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

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

The county shall include the following in the CCPR:

A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of

appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Stanislaus County BHRS has designated two management level staff as CC/ESM. They co-facilitate the Cultural Competence Oversight Committee, which was established in 1997. At that time, BHRS completed a Five-Year Cultural Competence and Strategic Plan. To ensure the plan remained a "living document" and that the requirements of the State Department of Mental Health regarding Cultural Competence were adhered to, BHRS established its Cultural Competence Oversight Committee (CCOC) to monitor implementation of the Plan. This committee continues to function in this role.

For CC/ESM purposes, the two managers report to a Senior Leader sponsor, currently the Associate Director for Operations, who in turn reports to the Behavioral Health Director. See organization chart included in the Appendix. The co-facilitators and Associate Director meet on a regular monthly basis to plan Cultural Competence Oversight Committee meetings and to discuss related issues. The CCOC chairs regularly report to the BHRS Quality Management Team (QMT) that is responsible for overseeing and monitoring BHRS quality of care issues. In addition, the chairs report at the monthly departmental meetings of coordinators and managers. Minutes of the CCOC and the QMT are available to demonstrate that these reports occur.

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

A BHRS internal document entitled, "CCOC Purpose, Membership, Duties and Responsibilities Document" outlines the duties and responsibilities of the BHRS Cultural Competence Oversight Committee co-facilitators as follows:

The Chairpersons of the CCOC are responsible for the following duties:

- Distribution of the agendas and minutes to Sr. Leadership staff, CCOC members, Advisory Board on Substance Abuse Programs (ABSAP) MHB, and other identified stakeholder representatives
- Development and distribution of the Cultural Competency Update Newsletter
- Distribution of the New Member Orientation binder
- Monthly committee reports to the Quality Management Team and at the Monthly Leadership Meeting

In addition, CC/ESM has the following responsibilities:

- Participate in the regional and state level ESC meetings.
- Ensure that discussions of cultural competence include all types of culture. BHRS is consciously making a shift from cultural competence being only about race and ethnicity to encompassing all types of culture, including homelessness, sexual orientation, impoverishment, youth, and others.
- Are charged with bringing forward cultural competence issue/concerns during discussions about any topic so that this aspect is not overlooked in any planning or policy level work.
- Have the lead responsibility for the development of the CCPR
- Monitor county staff and contractors to ensure culturally competent delivery of services
- Ensure that race and ethnicity data is presented quarterly
- Ensure that cultural and linguistic diversity is taken into account in hiring decisions

BHRS contract providers manage cultural competence programs within their respective agencies. Typically, the contract staff person fulfilling the role of "Cultural Competence/Ethnic Service Manager" actively serves on the BHRS Cultural Competence Oversight Committee, oversees integration of the County's Cultural Competence Plan standards with the contract agency's standards, serves as internal liaison, and assesses need and identifies curriculum/training for staff. In this way, knowledge and skills are relayed back and forth between BHRS and its contract providers. One large contract provider,

SVCFS, hired its own Cultural Competence Director over ten years ago to assist in the process of developing a cultural competence plan and to ensure it was enforced in all areas of the agency.

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.

BHRS does not have a budget dedicated to cultural competence activities per se. However, instead considers cultural competence an over-arching value and embeds cultural competence activities throughout the department, in all programs. This is reflected in our organizational values (included in the Appendix) and in the mission statement of the CCOC (included in the Appendix).

BHRS contract providers manage time and resources for cultural competence differently but all are dedicated to cultural competence as an essential core value. Aspiranet provides training and allocates staff time to regular committee meetings and training that offer increased multicultural awareness, to translation of documents into Spanish and development of a resource library. Center for Human Services consistently allocates funds for interpreter/translation services and cultural competence training. El Concilio relies on sponsorships and donations to support its cultural competence efforts. Sierra Vista Child and Family Services dedicates a percentage of its budget to cultural competence activities, funds stipends for bilingual staff, cultural training and the salary of the Cultural Director. Turning Point Community Programs uses funds from their "Member Recreation" budget category to host activities and celebrations to engage individuals from diverse backgrounds.

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.

As noted above, BHRS does not have a specific budget set aside for culturally competent activities. It is possible to identify budget information on several of the five items listed above. We do have a list of interpreters that are utilized when bilingual staff are not available. For FY 2009/2010, BHRS spent $7,877.00 on this item**.** BHRS has allocated $87,000.00 in interpreter contracts for FY 2010/2011. Bilingual staff receive a $0.69/hour differential for their linguistic expertise. Informational and clinical materials are translated into our one threshold language. BHRS has MHSA Outreach and Engagement contracts directed at providing outreach, engagement, and information/referral to individuals reluctant to seek services in traditional mental health settings. These contractors target various diverse groups in the community, including but not limited to, African-American, Hispanic, Southeast Asian, and homeless individuals. These contracts amount to approximately $ 2.4 million since FY 06/07 and, over the last four years, contractors have been able to measurably impact some of the racial, ethnic, cultural, and linguistic disparities as evidenced in MHSA data. In addition, approximately $1.5 million has been spent on a program that provides services to target populations such as unserved, underserved individuals whose race includes Latino, African American, Southeast Asian Transitional Age Young Adults, Adults and Older Adults. This housing program is a short term (1-7day) stay. This program links individuals to appropriate resources in the community as well as referrals to county mental health programs. As BHRS develops the community's capacity to support emotional health and wellness, it is expected that more culturally appropriate mental health services will be available in various communities. Currently, service delivery includes a variety of groups

(depression, grief support, parenting skills, peer support, LGBT support, anger management, psycho-education, and co-occuring mental illness-substance abuse), a weekend Drop-In Center, and local area transportation. Almost all activities are provided in non-traditional service settings. The BHRS training and education budget for FY10/11 is approximately $332,948.00. In addition, approximately $108,000 has been allocated for a Fulltime Training Coordinator. The budget includes funding to send staff, consumers, and family members to the annual Cultural Competence/Mental Health Summit. In addition, BHRS has made a significant effort to purchase and train trainers in the California Brief Multi-Cultural Skills curriculum. This was done in collaboration with a community based organization, Center for Human Services, and trainers began to train staff in the summer of 2010. In addition, the training budget covers all staff (BHRS and contract providers) training in Clinical and Administrative Standards (CLAS) and other cultural competence topics selected to increase staff awareness and knowledge of disparities and how to reduce them. Some of BHRS PEI projects involve activities directed at cultural groups. For example, some funding is directed at Spanish language services for child sexual abuse services. Other projects place special focus on youth from diverse cultural groups, particularly Latino and African American; youth at risk for school failure, for experiencing early onset of serious mental illness. Many have been exposed to trauma and live in stressed families.

CRITERION 2

COUNTY MENTAL HEALTH SYSTEM

UPDATED ASSESSMENT OF SERVICE NEEDS

Rationale: A population assessment is necessary to identify the cultural and linguistic needs of the target population and is critical in designing, and planning for, the provision of appropriate and effective mental health services.

Note: All counties may access 2007 200% of poverty data at the DMH website on the following page: http://www.dmh.ca.gov/News/Reports_and_Data/default.asp within the link titled "Severe Mental Illness (SMI) Prevalence Rates".

Counties shall utilize the most current data offered by DMH.

Only small counties, as defined by California Code of Regulations 3200.260, may request Medi-Cal utilization data from DMH by submitting the appropriate form to DMH, no later than five calendar months before plan submissions are due. To complete the Data Request Form, counties must contact the Office of Multicultural Services at 916-651-9524 to have a DMH staff person assist in the completion of the proper form. Eligible counties may be provided data within thirty calendar days from the data request deadline; however, all requests are first-come first-serve and provided according to DMH staff availability and resources.

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).

Stanislaus County is a located in the Central Valley of California. The County seat is Modesto. With over 530,000 people currently calling this area home, its communities reflect a region rich in diversity and a strong sense of community. Stanislaus County is within 90 minutes of the San Francisco Bay Area, the Silicon Valley, Sacramento, the Sierra Mountains and California's Central Coast. It is also within a five-hour drive to Los Angeles. Two of California's north-south routes intersect the area, Interstate 5 and Highway 99. The mild Mediterranean climate makes this County one of the best agricultural areas in the world, positioning it as a global center for agribusiness. Established in 1854, its total land area is 1,494 square miles. The County averages 12 inches of rainfall each year and experiences a full spectrum of the seasons. Temperatures range from an average low of 38 degrees Fahrenheit in the winter, to an average high of 85 degrees Fahrenheit during the spring and fall, and to an average high in the 90's during the warm summer months.

POPULATION

Stanislaus County has seen tremendous population growth. This trend is expected to continue well into the future. From 194,506 residents as recently as 1970, to 451,190 in 2000 and 511, 263 in FY 2008/2009, Stanislaus is projected to be home to 1,191,344 people by the year 2050. This continuing growth trend, (164% from 2000 to 2050) represents an ongoing challenge for our area. A few of the major issues include job availability, farmland preservation, air quality, road and water infrastructure, and school capacity.

According to estimates prepared by Dr. Charles Holzer, Ph.D., University of Texas, Medical Branch, entitled, "CPES Estimates of Need for Mental Health Services For California, Stanislaus County for 2007," provided by DMH, Stanislaus County's population was 511,263 in FY 2008/2009. Holzer's estimated prevalence rate for Stanislaus County was 5.77%. The following Mental Health Services Utilization, General Population Based on Prevalence charts describe the County population, estimate of need based on prevalence and number of unduplicated clients served by BHRS by race/ethnicity, age and gender in FY 2008/2009.

By Race/Ethnicity

Region	**Estimated Population** (1)	**Incidence in the Population**	**Need 5.77% Prevalence**	**Unduplicated Clients Served** (2)	**% of Need Met**	**% Total Clients Served**
White	256,569	50.18%	14,804	3,941	26.62%	41.69%
Hispanic	199,543	39.03%	11,514	4,319	37.51%	45.68%
Asian/Pacific	26,667	5.22%	1.539	472	30.68%	4.99%
African American	13,942	2.73%	804	401	49.85%	4.24%
Other *	10,699	2.09%	617	262	42.44%	2.77%
Native American	3,843	0.75%	222	59	26.61%	.062%
Total:	511,263	100.00%	29,500†	9,454	32.05%	100.00%†

* *Amerasian, Hmong, Mien, Multiple, Other Non White, Other Pacific Islander, Unknown*

By Age

Region	**Estimated Population** (1)	**Incidence in the Population**	**Need 5.77% Prevalence**	**Unduplicated Clients Served** (2)	**% of Need Met**	**% Total Clients Served**
Under 18 years	145,874	28.53%	8,417	4,614	54.82%	48.80%
18 to 64 years	313,163	61.25%	18,070	4,629	25.62%	48.96%
65 years and older	52,226	10.22%	3,013	211	7.00%	2.23%
Total:	511,263	100.00% †	29,500†	9,454	32.05%	100.00%†

By Gender

Region	**Estimated Population** (1)	**Incidence in the Population**	**Need 5.77% Prevalence**	**Unduplicated Clients Served** (2)	**% of Need Met**	**% Total Clients Served**
Female	258,249	50.51%	14,901	4,685	31.44%	49.56%
Male	253,014	49.49%	14,599	4,763	32.63%	50.38%
Total:	511,263	100.00%	29,500†	9,454	32.05%	100.00%†

† D*ue to rounding, the sum may not equal 100%*

(1) Source: California Department of Mental Health – Statistics & Data Analysis: Prevalence Rates of Mental Disorders (http://www.dmh.ca.gov/statistics_and_data_analysis/Prevalence_Rates_Mental_Disorders.asp)

(2) Includes all BHRS and contractor services recorded in CSI/Insyst and all clients reported via the Initial Contacts teleforms or database, regardless of county of residence

Race/Ethnicity

Almost 90% of Stanislaus County's population falls into one of two ethnic categories, White/Caucasian or Hispanic/Latino. Comparing 2000 U.S. Census data with estimated FY 2008/2009 data, the White/Caucasian segment of the population decreased dramatically from 312,065 (69% of the County population) to 256,569 (50% of the County's population). Simultaneously, the growth trend in the Hispanic/Latino population continued from 142,165 in 2000 (32% of the County's population) to 199,543 (39% of the County's population) in FY 2008/2009. This growth trend is expected to continue. The Asian/Pacific Islander population group has grown in number since 2000, but very little in its proportion of the total County population, from 20,459 (5% of the County population) to 26,667 (approximately 5.22%) in FY 2008/209. The African American population has grown even more slowly from 11,533 in 2000 to 13,942 in FY 2008/2009 and continues to make up only about 3% of the total County population. The Native American segment also remains about the same as it was at the time of the 2000 Census, approximately 1% of the population.

Looking at charts in I.A., approximately 32% of the Holzer-estimated need for services was met by BHRS programs in FY 2008/2009. Conversely, 68% of the estimated need was not met. It is our belief that many of the individuals not being served by BHRS are getting their needs met in other, more appropriate ways by family members, community groups, general healthcare delivery systems, and others.

In comparing the Incidence in the Population with the Percentage of Total Clients served, the following conclusions may be drawn:

- The African American group made up 2.73% of the County population, had the largest proportion (49.85%) of estimated need met and comprised 4.24% of the total number of clients served by BHRS in FY 2008/2009.

- The Hispanic/Latino group made up 39.03% of the County population, had 37.51% of estimated need met but comprised the greatest proportion (45.68%) of the total number of clients served by BHRS in FY 2008/2009.

- The "Other" group (Amerasian, Hmong, Mien, Multiple, Other Non White, Other Pacific Islander and Unknown) made up 2.09% of the County population, had 42.44% of estimated need met but comprised 2.77% of the total number of clients served by BHRS in FY 2008/2009.

- The White/Caucasian group made up just over half (50.18%) of the County population, had 26.62% of estimated need met but comprised less than half (41.69%) of the total number of clients served by BHRS in FY 2008/2009. Perhaps this population group has other resources upon which to rely for mental health services.

- The Asian/Pacific Islander group made up 5.22% of the County population, had 30.68% of estimated need met but comprised 4.99% of the total number of clients served by BHRS in FY 2008/2009. Though this population group may seek non-traditional mental health services and may meet mental health needs through natural healers and other community resources, their utilization of BHRS services is not significantly disparate from their representation in the community.

- The Native American group made up 0.75% of the County population, had 26.61% of estimated need met but comprised 0.62% of the total number of clients served by BHRS in FY 2008/2009. There are no official tribes or Rancherias in Stanislaus County. It is possible the Native American population looks elsewhere for services. It is also possible this group is not correctly identified in the CSI coding system as they could be counted in White, Hispanic, African American or other groups.

Age

Stanislaus County's largest growing population group is the 18-59 year old range. This age group grew from 241,827 (54% of the County population) in 2000 to 313,163 (over 61% of the County population) in FY 2008/2009. Concomitantly, the Under 18 group grew in numbers but declined in proportionate size from 31% to about 29% of the population as did the older adult (60+) group that dropped from 14% to 10% of the County population.

- The Under 18 years group made up 28.53% of the County population, had the largest proportion (54.82%) of estimated need met and comprised 48.8% of the total number of clients served by BHRS in FY 2008/2009. These figures suggest that while a significant number of individuals in this group receive services, the estimated need is still not met. .

- The 18 to 64 years group made up the largest percentage of the County population (61.25%), had 25.62% of its estimated need met and comprised the largest percentage (48.96%) of the total number of clients served by BHRS in FY 2008/2009.

- The 65 years and older group made up the smallest percentage of the County population (10.22%), had the smallest portion (7%) of its estimated need met and comprised the smallest percentage (2.23%) of clients served by BHRS in FY 2008/2009. Clearly, there is significant disparity among this group between need and persons served.

Gender

Although the numeric counts increased, distribution of Stanislaus County population by gender remains the same since the 2000 Census: 49% males and 51% females.

- Males made up 49.49% of the County population, had 32.63% of estimated need met and comprised 50.38% of the total number of clients served by BHRS in FY 2008/09.

Possible Service Disparities:

Females made up just over half (50.51%) of the County population, had 31.44% of estimated need met and comprised 49.56% of the total number of clients served by BHRS in FY 2008/2009.

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).

According to the California Department of Health Care Services website, Stanislaus County had a Medi-Cal beneficiary population of 123,574 (24% of the County population) in FY 2008/2009. The following charts describe the County's Medi-Cal population and provide utilization (number served) and penetration rate data for specialty mental health services in FY 2008/2009 by Medi-Cal beneficiary race/ethnicity, preferred language, age and gender. Utilization and penetration rate in these charts are based on all services entered into CSI/INSYST by BHRS and BHRS contract providers, for clients on Medi-Cal at any time during the report year, regardless of county of residence.

Medi-Cal: FY 2008/2009 By Race/Ethnicity (in descending order by number of Medi-Cal beneficiaries)

Race/Ethnicity	Medi-Cal Beneficiaries (1)	% of MC Beneficiaries (1/Total of 1)	Unduplicated Medi-Cal Clients Served (2)	% of Total Clients Served (2/Total of 2)	Penetration Rate * (2/1)
Hispanic	63,542	51.42%	2,476	44.10%	3.90%
White	41,016	33.19%	2,392	42.60%	5.83%
Unknown	6,926	5.60%	38	0.68%	0.55%
Asian/Pacific	6,793	5.50%	299	5.33%	4.40%
Black	4,898	3.96%	242	4.31%	4.94%
Native American	398	0.32%	42	0.75%	10.55%
Amerasian	1	0.00%	2	0.04%	0.00%
Other			124	2.21%	0.00%
Total:	123,574	100.00%†	5,615	100.00%†	4.54%
Analysis of Asian/Pacific					
Asian/Pacific Islander ◦	2,687	2.17%	23	0.41%	0.86%
Cambodian ◦	1,241	1.00%	36	0.64%	2.90%
Asian Indian ◦	825	0.67%	4	0.07%	0.48%
Laotian ◦	644	0.52%	21	0.37%	3.26%
Vietnamese ◦	449	0.36%	4	0.07%	0.89%
Filipino ◦	414	0.34%	193	3.44%	46.62%
Samoan ◦	159	0.13%	1	0.02%	0.63%
Chinese ◦	158	0.13%	8	0.14%	5.06%
Hawaiian Native ◦	127	0.10%	3	0.05%	2.36%
Korean ◦	33	0.03%	1	0.02%	3.03%
Guamanian ◦	32	0.03%	2	0.04%	6.25%
Japanese ◦	24	0.02%	3	0.05%	12.50%
Total:	7192	5.82%	343	100.00%†	4.54%

◦ *These race/ethnicity groups roll-up to "Asian/Pacific" on the Mental Health Services Utilization, General Population Based on Prevalence report presented in I.A. When aggregated together, the sum number of Asian/Pacific Medi-Cal beneficiaries is 6,793 (5.5% of Medi-Cal beneficiaries. The number of unduplicated Asian/Pacific Medi-Cal clients served is 299 (5.335% of the total clients served).*

Medi-Cal: FY 2008/2009 By Preferred Language

Preferred Language	Medi-Cal Beneficiaries (1)	% of MC Beneficiaries (1/Total of 1)	Unduplicated Medi-Ca; Clients Served (2)	% of Total Clients Served (2/Total of 2)	Penetration Rate* (2/1)
English	77,037	62.34%	4,883	86.96%	6.34%
Spanish	35,844	29.01%	530	9.44%	1.48%
Other	10,693	8.65%	202	3.60%	1.89%
Total:	123,574	100.00%	5,615	100.00%	4.54%

Medi-Cal: FY 2008/2009 By Age

Age	Medi-Cal Beneficiaries (1)	% of MC Beneficiaries (1/Total of 1)	Unduplicated Medi-Cal Clients Served (2)	% of Total Clients Served (2/Total of 2)	Penetration Rate * (2/1)
Under 18 years	60,448	48.92%	2,995	52.63%	4.89%
18 to 64 years	51,529	41.70%	2,518	44.84%	4.89%
65 years and older	11,597	9.38%	142	2.53%	1.22%
Total:	123,574	100.00%	5,615	100.00%	4.54%

Medi-Cal: FY 2008/09 By Gender

Gender	Medi-Cal Beneficiaries (1)	% of MC Beneficiaries (1/Total of 1)	Unduplicated Medi-Cal Clients Served (2)	% of Total Clients Served (2/Total of 2)	Penetration Rate * (2/1)
Female	69,331	56.10%	2,783	49.56%	4.01%
Male	54,243	43.90%	2,829	50.38%	5.22%
Unknown			3	0.05%	
Total:	123,574	100.00%	5,615	100.00%	4.54%

(1) Medi-Cal Beneficiary Source: CA Dept. of Health Care Services website, http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Age_Demographics.aspx, as of January 2009.

(2) Includes all BHRS and Contractors services recorded in INSYST (BHRS Information System), for clients on Medi-Cal at any time during the year, regardless of county of residence.

† Due to rounding, the sum may not equal 100%.

* The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the number of eligibles for the month provided as indicated in footnote (1) [CAEQRO].

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.

Race/Ethnicity

Since 2000, the Medi-Cal population has grown from 21% to 24% of the total County population most likely due to the economic downturn, lay-offs, increasing unemployment and other factors. As the charts in II. A.show, the ethnicity of Medi-Cal beneficiaries in Stanislaus County is quite diverse. Fifty percent of the County population is White/Caucasian but only 33% of the County's Medi-Cal beneficiaries are White. Approximately 43% of Medi-Cal beneficiaries receiving specialty mental health services in FY 2008/2009 were White/Caucasian. Thirty-nine percent of the County population is Hispanic but over 51% of the County's Medi-Cal beneficiaries are Hispanic. Forty-four percent of Medi-Cal beneficiaries receiving specialty mental health services in FY 2008/2009 were Hispanic. In FY 2008/2009, Asian/Pacific Islanders made up a little over 5% of the County population and 5% of the County's Medi-Cal beneficiaries. Five percent of Medi-Cal beneficiaries utilizing specialty mental health services in FY 2008/2009 were Asian/Pacific Islanders. African Americans make up almost

3% of the County population and about 4% of its Medi-Cal beneficiaries. A little over 4% of Medi-Cal beneficiaries utilizing specialty mental health services in FY 2008/2009 were African American. There are very few Native Americans in Stanislaus County (0.75% of the population). Only 0.32% of

Native Americans in the County are Medi-Cal beneficiaries. Approximately 0.75% of Medi-Cal beneficiaries utilizing specialty mental health services in FY 2008/2009 were Native American. In sum, based solely on the ratio of the percentage of Medi-Cal beneficiaries served to total percentage of Medi-Cal beneficiaries in Stanislaus County, the only significant disparity is among the Hispanic population. However, based on the prevalence data presented in the previous section, the Hispanic population is much closer to having their estimated need met than White/Caucasian. Thus, it is difficult to decide how to interpret this data. There are many factors that contribute to the high percentage of Medi-Cal beneficiaries in the Hispanic population, but clearly one cannot assume that the estimated need changes.

Preferred Language

The primary language of Stanislaus County's Medi-Cal population has always been and continues to be English. The percentage of English speaking Medi-Cal beneficiaries in the County has grown from 51.5% in 2000 to 62.34% in FY 2008/2009. Spanish is the single threshold language in Stanislaus County. Medi-Cal beneficiaries whose preferred language is Spanish account for 29% of the population (an increase from 26% in 2000) and a composite of "Other" languages make up the remaining 8.65% of the Medi-Cal population. The majority of Medi-Cal beneficiaries who received specialty mental health services (87%) in FY 2008/2009 speak English. A little over 9% indicate that Spanish is the preferred language. Given that BHRS has bilingual, Spanish-speaking staff in all classifications with representation in most programs and contract interpreters available if bilingual staff are not available, the disparity is likely due to individuals receiving services/supports in other ways. Primary care, faith-based options, and family are most likely the resources for this group. Certainly, this has been substantiated in presentations by NAMI volunteers as they discuss their experiences. This same argument could be made for the "Other" group.

Age

In FY 2008/2009 almost half of the County's Medi-Cal beneficiaries (48.92%) were under 18 years of age. The next largest age group was adults, age 18 to 64, comprising 41.7% of the Medi-Cal population. A little over 9% of Medi-Cal beneficiaries were 65 years of age or older. By comparison, in 2000 Census data, 47% were under 18 and 10% were over 65 years of age, neither of which are statistically significant changes. The most disparate penetration rate in comparison to the percentage of Medi-Cal beneficiaries is among those 65 years and older. Generational biases against mental health treatment, social isolation, and mobility issues are likely factors in this discrepancy.

Gender

Females make up a greater proportion of the Medi-Cal population (56.1%) than their incidence in the general population of Stanislaus County (50.5%). Males comprise the remaining 43.9% of Medi-Cal beneficiaries. However, males on Medi-Cal have a higher penetration rate for specialty mental health services than females. Perhaps males with Medi-Cal coverage are receiving this coverage as a result of being disabled and, therefore, more like to have greater need for mental health services; whereas females may have Medi-Cal coverage because they have children in their care. Based on estimated need from the previous section, both genders have approximately the same percentage of need met.

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).

Stanislaus County BHRS tracks and reports service utilization by payor source and administers the Uniform Method of Determining Ability to Pay (UMDAP), mandated by Section 5718 of the California Welfare and Institutions Code. The UMDAP sliding scale charge schedule determines an annual fee for a family, regardless of the type of service or the number of visits, and is based on family size, assets and income. All clients are liable for this annual amount unless they are a Medi-Cal beneficiary with no Share-of-Cost (SOC). UMDAP calculations are based on client self-report. 200% of poverty income is not verified, tracked or reported, but the self report is all that is available in our county. Thus, the data may not be representative of the actual income levels.

Following the method recommended by DMH, 200% of poverty can be estimated by subtracting Medi-Cal beneficiary data from Charles Holzer's 200% of poverty population data supplied by DMH. Following are the resultant figures.

Mental Health Services Utilization
200% of Federal Poverty Guidelines
FY 2008-2009 (Jul 2008 – Jun 2009)

By Race/Ethnicity

Race/Ethnicity	Estimated Population (1)	Incidence in the Population	200% Clients Served (2)	% of Need Met (Served/Need)	% of Total Clients Served
African American	6,266	3.20%	64	17.68%	3.83%
Asian/Pacific	11,777	6.02%	66	9.71%	3.95%
Hispanic	106,156	54.28%	810	13.22%	48.50%
Native American	1,396	0.71%	4	4.93%	0.24%
White	65,895	33.69%	685	18.01%	41.02%
Other	4,083	2.09%	41	17.37%	2.46%
Total	195,573	100%†	1,670	14.80%	100%†

By Age Group

Age	Estimated Population (1)	Incidence in the Population	200% Clients Served (2)	% of Need Met (Served/Need)	% of Total Clients Served
Under 18 years	69,402	35.49%	505	12.61%	30.24%
18 to 64 years	109,628	56.05%	1,144	18.08%	68.50%
65 years and older	16,543	8.46%	21	2.20%	1.26%
Total	195,573	100%†	1,670	14.80%	100%†

By Gender

Gender	Estimated Population (1)	Incidence in the Population	200% Clients Served (2)	% of Need Met (Served/Need)	% of Total Clients Served
Male	93,606	47.86%	952	17.63%	57.01%
Female	101,968	52.14%	716	12.17%	42.87%
Unknown			2		0.12%
Total	195,574	100%†	1,670	14.80%	100%†

(1) Source: California Department of Mental Health – Statistics & Data Analysis: Prevalence Rates of Mental Disorders (http://www.dmh.ca.gov/statistics_and_data_analysis/Prevalence_Rates_Mental_Disorders.asp)

(2) Includes all BHRS and Contractors services recorded in INSYST, regardless of county of residence, where the client-reported information determines that they are 200% of poverty level according to the Federal Poverty Guidelines of 2008.

† Due to rounding, the sum may not equal 100%.

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 individuals who are in this 200% of federal poverty guidelines are mostly uninsured or underinsured. Unless these individuals are in crisis, possibly requiring psychiatric inpatient evaluation and treatment, BHRS is able to serve them to the extent that resources are available. Thus, it is not unusual that the overall percent of need met is quite low.

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).

Following is a copy of the population assessment extracted from Stanislaus County's approved CSS plan. It should be noted that at the time that this analysis was completed in 2005, the prevalence rate provided by Holzer was 7.09%. Since then, he has revised the estimated prevalence rate to 5.77%. This revision was due to a number of actuarial revisions to the factors that contribute to the prevalence rate development. Thus, the estimates presented in the previous sections of this document are a more accurate reflection of need than that established in the early CCS plan documents. The penetration rates used for the CSS planning are provided in an attachment to this document.

Children and Youth	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
African American	42	14	127	89	272	6.9	1872	59.8	3943	3.0
Asian Pacific Islander	6	1	15	12	34	0.9	3148	54.9	5697	4.4
Latino	139	73	841	537	1590	40.4	32048	61.9	61218	47.2
Native American	9	0	11	10	30	0.8	258	35.5	1416	1.0
White	333	148	816	671	1968	50.0	18411	33.6	53276	41.1
Other	3	3	18	17	41	1.0	2384	42.6	4161	3.2
TOTAL	532	239	1828	1336	3935		58121	46.9	129711	26.0

Transition Age Youth	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
African American	16	11	50	51	128	5.5	959	72.0	2784	3.4
Asian Pacific Islander	4	1	35	31	71	3.1	1856	58.2	4808	5.9
Latino	27	29	328	362	746	32.3	14208	57.8	34579	42.6
Native American	1	2	6	2	11	0.5	200	51.7	943	1.2
White	79	82	523	633	1317	56.9	9652	33.3	36279	44.6
Other	3	2	19	16	40	1.7	1133	42.8	1870	2.3
TOTAL	130	127	961	1095	2313		28008	43.1	81263	16.3

Adults	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
African American	8	12	91	151	262	4.5	1533	38.0	5873	2.7
Asian Pacific Islander	12	8	56	85	161	2.8	2967	36.8	10409	4.7
Latino	60	47	451	697	1255	21.7	25494	49.2	74434	33.9
Native American	1	4	13	26	44	0.8	550	32.3	3126	1.4
White	234	203	1395	2073	3905	67.4	27056	23.7	121925	55.6
Other	8	11	59	91	169	12.9	2460	34.9	3594	1.6
TOTAL	323	285	2065	3123	5796		60060	30.5	219361	44.0

Older Adults	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
African American	0	1	5	11	17	2.2	358	53.7	3041	4.4
Asian Pacific Islander	0	0	5	12	17	2.2	797	46.1	3490	5.1
Latino	3	3	41	42	89	11.5	3094	46.5	9750	14.2
Native American	0	0	0	2	2	0.3	147	43.8	728	1.1
White	16	25	198	364	603	77.9	14797	31.8	50544	73.6
Other	1	2	21	22	46	15.9	689	44.8	1099	1.6
TOTAL	20	31	270	453	774		19882	32.4	68652	13.8

Stanislaus County has one threshold language, Spanish. However, there are significant populations of Asian/Pacific Islander groups of various languages and cultures (Cambodian, Laotian and Hmong) that reside in Stanislaus County. There are other linguistic and cultural groups that are included in the "other ethnicity" category which require special attention. These include individuals whose primary language and cultural affiliation is Assyrian, as well as Portuguese Americans.

Information for this analysis was drawn from Stanislaus County Behavioral Health and Recovery Services databases for Fiscal Year 2003-2004, prevalence data developed by Holzer, 2004 State of California Department of Finance race/ethnic population data, and 2000 federal census data for Stanislaus County. Unduplicated clients were compared with prevalence of Seriously Mentally Ill (SMI) by race and ethnicity, age and gender to determine penetration rates for fiscal year 2003-2004. These comparisons do not include comparisons by age, gender or ethnicity by region due to the lack of available prevalence data by regions with which to compare penetration. Overall penetration rates by region are noted.

The data indicated that the lowest penetration rates for individuals with serious mental illness by race and ethnicity for public mental health services are for Asian/Pacific Islander, Native American and Latino groups. The highest penetration rates are for African Americans, followed by Caucasians.

Females have a higher penetration rate than males. (There are a significant number of clients whose gender is not identified resulting in less than 100%). However, the highest penetration rates by gender and age were for male children. The lowest penetration rates by gender and age were for older adult men.

By age, the greatest penetration rates are for children birth to 15, followed by transitional aged youth. As noted above, significantly lower penetration rates exist for older adults of all races and ethnicities. For children, the highest penetration rates are for African Americans, while the lowest penetration rates are for Asian/Pacific Islanders.

Penetration rates for all ethnic minorities, except African Americans remain low, especially for Asian/Pacific Islanders and Native Americans. Recent strategies to improve access for Latino

individuals and African Americans appear to have been successful, although Latino access still is below their representation in the overall County population.

Asian Indians are the largest group of Asian/Pacific Islanders in the County, followed by Filipinos and Cambodians. While there are similarities with regard to immigration patterns, there are differences between these groups as to language, religion and other cultural factors. There is a need to differentiate strategies among each of the targeted groups to achieve the most effective outreach and engagement. Previous strategies have been to hire, train and promote linguistically and racially and ethnically diverse staff. This has been partially successful in improving access. However, the analysis of this data clearly indicates other additional strategies are necessary.

It is possible that the data regarding Native Americans is not reliable due to the failure of staff in accurately identifying Native American clients. Stanislaus County has no reservations, no rancherias, nor any Native American human service organizations based in the County. Neighboring counties have rancherias and Native American organizations whose expertise can be utilized to increase the understanding and cultural competency of BHRS leadership and staff.

By far, the largest ethnic group in Stanislaus County other than non-Hispanic Caucasians is Latinos. There is much less variation in penetration rates by age for this ethnic group, although the penetration rate for Latino children is somewhat higher than other Latino age groups. Overall penetration rates for Latinos are higher than for other ethnic groups other than non-Hispanic Caucasians and African Americans. Latinos represent about 36% of the County population, but only 29% of the service population. Various strategies such as increased and strategic deployment of bilingual and bicultural staff, cultural competency training and targeted programming have been effective in increasing access to services. It is known that many Latinos seek services for mental health problems from primary care health care providers rather than mental health providers. New strategies such as contracting with Latino-serving organizations for outreach and engagement and providing behavioral health services in collaboration with primary care providers offer promise for better access.

It is difficult to determine if the high penetration rates for African Americans, especially male children, are the result of over identification because of stereotypes or improved ease of access. Stanislaus County Behavioral Health and Recovery Services has an extensive school-based service system that targets schools that tend to have greater racial and ethnic diversity and higher levels of poverty. The highest numbers of African American children are in the BHRS early behavioral intervention programs for children tends to support the idea that the high numbers are a result of purposeful strategies. The second highest number of African American male children is in inpatient services. This fits national patterns of over utilization of high-end services by African Americans, most likely resulting from a lack of access to culturally competent interventions at lower levels as well as general discriminatory and social conditions. In either case, it appears that targeting school-based early intervention is appropriate, but perhaps with increased emphasis on employing and deploying African American service providers to minimize stereotyping that may be occurring.

Finally, there is a pattern of lower penetration rates in outlying areas. The Modesto region and the Ceres region have the highest rates, while the Turlock region, the Eastside and Westside regions of the County (those farthest from the central population centers of Modesto and Ceres) have lower rates. While not specific to the population of individuals with serious mental illness, these overall rates are likely indicative of lower penetration rates for individuals with serious mental illness in the outlying areas of the County.

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

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

Following is the section from the county's approved CSS plan analysis of the disparities at the time that the plan was written.

Stanislaus County has been a pioneer in what are now called Full Service Partnership programs beginning with the AB3777 Integrated Services Agency in 1989. A Children's System of Care grant (AB 3015) was received in 1993 and AB 34/AB2034 programs followed in 2000 and 2001. These programs continue to the present although some have gone through various changes over the years.

For the purposes of this analysis, individuals who are fully served are defined as those transition age youth, adults and older adults in AB34/AB2034 programs, the Stanislaus Integrated Services Agency, and some individuals who are receiving wellness recovery services and have completed their planned service. Children and Transition Age Youth who are receiving services under AB3632 and those who are in the enrollee-based portion of our federally funded Children's System of Care are the only children/youth defined as currently fully served.

Other individuals who receive services from Stanislaus County Behavioral Health and Recovery Services are not considered to be fully served due to the lack of a full and comprehensive array of services outside of the above programs. Key elements missing from other programs include the lack of 24 hour a day, 7 day a week access to a team or service coordinators, limited access to employment and housing supports and the lack of wrap around services for children. Persons who are uninsured or underinsured receive even less of an array of services, often having access to only emergency care.

Children and Youth

Children and youth are the most ethnically diverse of the four age groups. Only 41.1% of the group is in the White category. In adults, 55.6% are White and in older adults the number increases to 73.6%. Latinos are the largest ethnic group at 47.2% of children and youth, with 42.6% transition aged, 33.9% adult and 14.2% older adults. The prevalence rate for Latino children (7.91%) suggests there are 4,842 children in this category with serious mental illness. Service records show a total of 1,590 Latino children and youth received services or approximately 40.4%. This means that 3,252 children and youth in need went without service. Only 212 (4.4%) Latino children and youth were in fully served programs. This unserved/underserved group is larger than the entire Native American population, over half the entire African American population and over 1/3 of the entire Asian/Pacific Islander population. The challenge for this group will be to work with the Latino community to identify and focus on those children and youth in the greatest need and develop partnerships and practices that can be expanded as MHSA grows.

While Latino children and youth are the largest unserved/underserved population, the greatest disparity is for that of individuals who are Asian/Pacific Islanders. While the percentage of Latino consumers served vs. the percentage in the community is 85.6%, the percentage of Asian/Pacific Islanders served represents only 20.4% of their percentage of the community overall. The total number of Asian/Pacific Islander children and youth served was only 34 persons, with only 7 being fully served. Only 1% of fully served children and youth are Asian/Pacific Islander, while they make up 4.4% of the population. Clearly this disparity needs to be addressed.

Transition Age Youth

Racial/Ethnic patterns for Transition Age Youth (TAY) are much like those outlined for Children and Youth. The White group is overrepresented in the treatment group, (56.9% of served vs. 44.6% of population) as well as African Americans (5.5% served vs. 3.4% of population). Latinos are again the largest unserved/underserved group. Asian/Pacific Islanders and Native Americans are the most unserved/underserved when comparing the percent served vs. the percentage in the community (52.5 for Asian/Pacific Islanders and 45.4% for Native Americans). While this Asian/Pacific Islander disparity is not as pronounced as with Children and Youth, it is still considerable and in need of attention.

Adults

The adult group is the largest population group in Stanislaus County making up approximately 44% of the overall population. Adults are 55.6% White, 33.9% Latino, 4.7% Asian/Pacific Islander, 2.7% African American, 1.4% Native American and 1.6% some Other Ethnicity. While 55.6% of the population, Whites make up 67.4% of persons served. The percentage served vs. the percentage in the community for
Latinos (64%) is less for Adults than for TAY (76%) and Children and Youth (85.6). Of adults served, 41.2 percent were male. Of those in the fully served category, 53.1% were male suggesting males are possibly overrepresented in that category. For children and youth 69% of the fully served are males, for TAY 50.6%, for adults 53.1% and for older adults only 39.2%.

Older Adults

Older Adults have the lowest overall penetration of all groups in this study. Only 774 Older Adults were served of a population of 68,652, or about 1.1%. The overall County percentage is 13.8%. General Race/Ethnic patterns hold true for Older Adults with Whites overrepresented in the service population. In Older Adults the "Other" category is also overrepresented. The Latino population is much smaller in the Older Adult group at only 14.2% and with considerable efforts to reach this group in the past the percentage served is 81.0% of the percentage in the population. This rate is much better than in the transitional aged youth and adult groups and demonstrates that the disparity can be addressed and corrected with focused effort.

The Older Adult population as a whole is clearly underserved in Stanislaus County. They are underserved by ethnicity/race, gender and location. While the lack of service is more acute in some populations, the need for services for older adults, in all areas needs to be addressed.

As mentioned above, males make up only 37.5% of the service population and 39.2% of the fully served population. This may seem a disparity, however there is a lower percentage of males in this population and a considerable difference in the prevalence rates (older adult male prevalence rate is 2.22% and the older adult female rate is 4.9%).

In reviewing this data, the following comments can be made about the changes that have occurred since the original plan was written.

Stanislaus County BHRS reports quarterly and annual data to the Department of Mental Health via the required Exhibit 6 report. In addition, BHRS developed an internal report, "BHRS MHSA Demographic Report" for local monitoring of client demographics in MHSA-CSS Full Service Partnership, General System Development and Outreach and Engagement programs. Demographic data tracked and reported with this report includes number of clients, gender, age, ethnicity, preferred language and geographic area of residence. Programs are monitored month-to-month; quarterly reports are posted on the department's Intranet and Extranet sites, accessible by BHRS and contractor staff.

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

Stanislaus County developed eight PEI projects, identifying from one to six of the PEI priority populations in each project. The following summarizes the County's PEI projects by priority population.

PEI PROJECT NAME	**Underserved Cultural Population**	**Individuals Experiencing Onset of Serious Psychiatric Illness**	**Children /Youth in Stressed Families**	**Trauma-exposed**	**Children/ Youth At Risk of School Failure**	**Children/ Youth At Risk or Experiencing Juvenile Justice Involvement**
Community Capacity Building	X All ages					
Emotional Wellness Education/ Communication Support	X All ages	X All ages	X Children/ Youth TAY	X Children/Youth TAY	X Children/ Youth TAY	X Children/ Youth TAY
Adverse Childhood Experience Interventions	X All ages	X Children/ Youth TAY		X Children/Youth TAY		X Children/ Youth TAY
Children & Youth Resiliency & Development	X Children/ Youth TAY		X Children/ Youth TAY		X Children/ Youth TAY	X Children/ Youth TAY
Adult Resiliency & Social Connectedness	X Adult Older Adult			X Adult Older Adult		
Older Adult Resiliency & Social Connectedness	X Older Adult	X Older Adult		X Older Adult		
Health/ Behavioral Health Integration	X All ages					
School/ Behavioral Health Integration	X Children/ Youth TAY	X Children/ Youth TAY	X Children/ Youth TAY		X Children/ Youth TAY	X Children/ Youth TAY

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

The local community planning process was guided by a commitment to be inclusive, representative, and to elicit meaningful participation of diverse communities, including but not limited to underserved cultural populations, consumers, family members, potential consumers/family members, non-traditional providers of service, and people of all ages. The entire planning process spanned seven months, emphasized methods to promote inclusion and participation of people who had not

participated in MHSA planning process in the past. Its goal was to establish an authentic picture of community-wide needs, existing assets, and opportunities to build new and leverage existing communities of support.

Informed by the logic model provided in the PEI Program Plan Guidelines and with input from stakeholders, the planning process involved three phases:

- Broad stakeholder phase: education, outreach and identification of community need
- Representative stakeholder phase: analysis, recommendations and consensus
- Development of plan, public review and hearing phase: community-wide review prior to plan submission

The methods and assessment tools used are described below.

a. Inclusion of representatives of unserved and/or underserved populations and family members of unserved/underserved populations

All members of the community were welcomed to participate throughout all phases of the community planning process as actively as they desired. Many opportunities were available from July 2008 through March 2009.To ensure members of underserved and unserved populations had access to the planning process, BHRS partnered with the following organizations to conduct targeted focus groups and provide reports on community needs assessment information from specific diverse populations. An additional 200 individuals gave input through these reports. The communities engaged included: Hispanic, African American, Southeast Asian and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). The four community-based organizations were as follows:

- El Concilio: Council for the Spanish-Speaking
- West Modesto King Kennedy Neighborhood Collaborative
- Stanislaus PRIDE Center
- The Bridge Community Center

An example of an approach used to ensure participation by individuals who would not otherwise be heard from occurred at West Modesto King Kennedy Community Center when a focus group was conducted with a group of seniors at a weekly social group meeting.

b. Provision of opportunities to participate for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language.

To ensure inclusion of diverse and underserved/unserved populations throughout Stanislaus County, BHRS partnered with the following organizations to co-sponsor community stakeholder meetings in nine communities in Stanislaus County.

- Family Resource Center, Community Collaboratives and School Resource/Health Centers in Hughson, Ceres, Turlock, Newman, Grayson, Oakdale, Riverbank, Patterson, and Modesto
- Area Agency on Aging and Veteran's Affairs - Modesto
- National Alliance on Mental Illness (NAMI-Stanislaus) - Modesto
- Consumers -Modesto
- Child and Youth Service Providers & Family Members - Modesto
- Stanislaus County Health Services Agency/Public Health - Modesto
- Turlock Community Collaborative - Turlock/South County
- Parents United – Modesto

(The PEI Planning Team conducted the stakeholder meetings. In one case, a Spanish-speaking member of the community–based organization requested to co-present with the Spanish-speaking member of the PEI Team.)

Through this effort, over 500 people attended twenty-five community stakeholder meetings in nine communities throughout Stanislaus County. Detailed demographic information was not collected describing all participants at these workgroups. However, nine additional meetings were conducted for Spanish-speaking community members throughout the County and four additional meetings were conducted in strategic locations with youth and transition age youth. The PEI Planning Team developed an overview of who participated, illustrated in the following table.

Overview of Stakeholder Targeted Focus Group Participants

Location Stakeholders · Focus Group	English	Spanish	Children /TAY	Adult	Older Adult	African-American	Asian	Latino	White	Family Member	Consumer	Homeless	LGBTQ
Ceres · English · Spanish	X	X		X				X	X	X	X		
Hughson · English · Spanish · Youth	X	X	X	X	X			X	X	X	X		
Modesto · English · Spanish	*X*	X	X	X	X	X	X	X	X	X	X	X	X
Newman · Community	X			X					X	X	X		
Oakdale · School · Spanish	X	X		X				X	X	X	X		
Patterson · English · Spanish	X	X		X				X	X	X	X		
Riverbank · English · Youth	X		X	X				X	X	X	X		
Turlock · English · Spanish · Homeless	X	X		X	X			X	X	X	X	X	X
Westley /Grayson · Community · Youth	X	X	X	X				X	X	X	X		
Modesto · Aging Services	X			X	X			X	X	X	X		X

Location Stakeholders · Focus Group	English	Spanish	Children /TAY	Adult	Older Adult	African-American	Asian	Latino	White	Family Member	Consumer	Homeless	LGBTQ
Ceres · Alcohol and Drug Providers and Clients · Co-occurring Issues	X			X		X	X	X	X	X	X	X	X
Modesto · Parents United	X		X	X	X				X	X	X		X
Modesto · NAMI-Family Members	X			X	X	X		X	X	X	X		X
Modesto · Healthcare Providers	X			X	X	X		X	X				
Modesto · Child and Youth Providers	X	X	X	X		X		X	X	X	X		X
Modesto · Stigma and Discrimination Workgroup · Consumers	X			X		X	X	X	X	X	X	X	X

c. Inclusion of outreach to clients with serious mental illness and/or serious emotional disturbance and their family members to ensure the opportunity to participate.

BHRS partnered with the following organizations to co-sponsor two community stakeholder meetings with invitations specifically extended to consumers/family members:

- National Alliance on Mental Illness (NAMI) - Stanislaus Chapter
- Stanislaus Chapter of Mental Health Consumers, Peer Recovery Network members, BHRS Peer Recovery Advocate and BHRS Family Advocate co-sponsored a stakeholder meeting devoted to stigma and discrimination prevention strategies

Consumers/family members attended virtually all stakeholder meetings/targeted focus groups held throughout the county.

d. Assessment tools used were as follows.

Two types of community surveys were utilized:

- Approximately 328 Emotional Health in the Community surveys were returned through stakeholder meetings, postal service, and other methods.
- Asset Assessment surveys asked key partners to assist in identifying various types of prevention programs that already exist in the County: 49 existing programs were identified.

Additional community needs assessment data obtained from local stakeholders came from other sources that include input from underserved/unserved individuals including:

- MHSA planning processes conducted in 2005 and 2007 for Community Services & Supports (CSS) and Workforce Education & Training (WET)
- Stanislaus County Health Services Agency's Community Health Assessment 2008, and
- BHRS Substance Abuse Prevention Plan 2006

e. The County ensured that the Community Program Planning Process included the following required stakeholders and training:

a. Participation of stakeholders as defined in Title 9, California Code of Regulations (CCR), Chapter 14, Article 2, Section 3200.270, including, but not limited to:

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families
- Providers of mental health and/or related services such as physical health care and/or social services
- Educators and/or representatives of education
- Representatives of law enforcement
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families

b. Broad Stakeholder Phase: Education, Outreach and Identification of Community Need:

The PEI planning process was built upon knowledge gained from lessons learned and partnerships established during the Community Services and Supports and Workforce Education and Training components of MHSA. Stanislaus County BHRS conducted an extensive planning process that included many opportunities for stakeholders to participate:

- The community planning process took place from July 2008 through March 2009
- Over 500 unique individuals representing one hundred fifty-nine (159) community organizations attended twenty-five focus group meetings in nine cities throughout Stanislaus County (September 16 through October 15, 2008)
- Nineteen (19) agencies/community-based organizations partnered with BHRS to co-sponsor targeted focus groups throughout the county (September 16 through October 15, 2008)
- Over 200 culturally/ethnically diverse individuals gave input through reports submitted by four community-based organizations serving Latino, African American, South East Asian and LGBTQ communities/neighborhoods
- Approximately 328 community members completed our Emotional Health in the Community survey
- Approximately 25 key partners participated in the Asset Assessment survey to identify existing prevention programs in the County: 49 programs were identified. (August 2008 through September 2008)

- Additional stakeholder input was incorporated from previous MHSA planning processes: Community Services & Supports (CSS) over 1500 stakeholders gave input and Workforce Education & Training (WET) approximately 400 stakeholders gave input
- Data from Stanislaus County Health Services Agency's Community Health Assessment 2008 included 2,800 face-to-face interviews
- BHRS Substance Abuse Prevention Plan included key stakeholder input

Additional opportunities for stakeholder participation:

- BHRS MHSA Newsletter included articles about PEI Planning in the following issues; May, June, July, September, November, December 2008, and January and February 2009
- The MHSA Planning Coordinator (or other members of PEI Planning Team) were available for contact by phone, email or in person for individual concerns or input to be expressed
- Four Representative Stakeholder Steering Committee meetings were conducted (December 2, 17, 30, 2008; February, 24 2009)
- Seven PEI workshops were conducted to propose program selections for PEI Projects (January 16 – 22, 2009)
- The PEI Plan was available during 30-day public review and comment period, (February 25 through March 26, 2009)
- Informational Meeting was conducted during 30 day review (March 11, 2009)
- MHSA Planning Coordinator spoke about MHSA - PEI to a group of Modesto Jr. College students (Human Services Department – CASRA students) (March 16, 2009)
- Public Hearing was held by the Mental Health Board (March 26, 2009)
- Individuals representing one hundred fifty-nine (159) different organizations and community groups from throughout Stanislaus County participated in the local PEI Planning Process.

c. Representative Stakeholder Phase: Analysis, Recommendations and Consensus:

The Representative Stakeholder Steering Committee (RSSC) is currently comprised of 43 individuals representing many diverse stakeholder groups throughout the County. Approximately 50% of the individuals involved in the Representative Stakeholder Steering Committee have been partners in MHSA planning since the beginning and also faithfully participated in earlier phases of planning processes.

Throughout the years, the RSSC has grown in its diversity and its power to participate in the process. This is a crucial point to keep in mind when considering the importance of what is being asked of the representative members of the committee. Each time a new MHSA component is introduced and an initial plan is being developed, a variety of methods are used to engage deeper levels of community input and ownership of the process. There are always more needs identified than can be addressed in the plan that is ultimately developed. As a result, there is a need to make tough decisions about where to start with each initial plan.

During the PEI planning process the RSSC members participated fully, voluntarily and more extensively on behalf of their communities than ever before. They took the time to attend three meetings in the month of December when many other demands competed for time and energy. The scope of the discussions necessarily included the current budget reality of decreasing public mental health services. Given the budget reality of shrinking services, less people served each year and the need for more natural community supports, three strategic initiatives emerged from the planning process. The RSSC was asked to consider the possibility that the Stanislaus PEI plan could be smart and sustainable in design with these strategic initiatives as the framework:

- Community Capacity Building,
- Mental Health Promotion and
- Prevention & Early Intervention Projects

The committee was further asked to consider the possibility that rather than depending on an increasingly and inadequately funded public mental health system to take care of mental health needs, community capacity building would strategically leverage PEI funds to identify, catalyze, mobilize and support the strengths, assets and resources that exist within communities to meet these needs. The capital for leveraging PEI funds would come in the form of the community's many strengths, assets and resources including leaders, individuals, groups, organizations, facilities, knowledge, and other sources of funding. Key elements of community capacity building would include PEI Projects that would be established, mental health promotion campaigns to be integrated with existing community assets, such as networks of social support, healthcare systems, school systems, and community-based organizations. Expected outcomes would be a community that supports emotional wellness and resiliency, public awareness of stigma and discrimination as real issues to be eliminated, and easy early access to appropriate help when needed.

Above all, the focus on community capacity building would empower various cultural communities to develop supports appropriate to their cultural standards to sustain the emotional health and wellness in their communities. Stakeholders supported this in suggesting that investment in local communities is more powerful than putting programs in traditional mental health or human service organizations. Further, that access to underserved cultural populations could be strengthened by expanding resources that sustain natural supports in local communities; e.g., individuals, faith-based organizations, community health centers and collaborative organizations such as Family Resource Centers and School Resource/Health Centers.

The RSSC embraced and fully utilized the strategic initiatives and shared vision for the future throughout the consensus process and adopted community themes, project proposal ideas and "rough" resource allocation. The result is that each project in the plan and its programs is designed to uniquely address a key issue related to community capacity building that was identified in the stakeholder input process. All the programs are linked to one another with intent to achieve the overall goal expressed in the vision described above.

A variety of methods were used to ensure that the PEI planning process included required and recommended stakeholders. Key strategies included, but were not limited to the following:

- Specifically encouraging and inviting required and recommended stakeholder participation using a variety of methods (e.g., BHRS Director phone calls to other County Department Heads, use of the MHSA website and newsletter)
- Co-sponsoring targeted focus groups with community based organizations
- Ensuring that stakeholder meetings were offered at times of day and locations that were accessible to required and recommended stakeholders
- Offer incentives to consumers and family members to participate

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

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

Rationale: "Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services, these communities are less likely to receive needed mental health services, and when they get treatment they often receive poorer quality of mental health care. Although they have similar mental health needs as other populations they continue to experience significant disparities, if these disparities go unchecked they will continue to grow and their needs continue to be unmet..." (U.S. Department of Health and Human Services, Surgeon General Report, 2001).

Note: As counties continue to use this CCPR as a logic model, counties will use their analyses from Criterion 2, to respond to the following:

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).

Medi-Cal:

- Hispanic
- Preferred Language - Spanish
- 65 years and older

CSS:

- Hispanic
- Native American
- Asian/Pacific
- Older Adults
- Individuals living in outlying areas

As noted in the CSS plan, the data on Native Americans may not be reliable due to challenges in accurately identifying this group. Anecdotally, many of these individuals are of mixed race and ethnicity and identify themselves as White/Caucasian. Thus, there may be less disparity than the data suggest.

With respect to the Asian/Pacific group, efforts made in the years since the data was gathered for the CSS plan appear to have resulted in an improved penetration rate for this group. The percentage served by BHRS closely reflects their representation in the general population.

WET:

- Bilingual, bicultural staff, especially Spanish-speaking, in all classifications
- African-American direct service staff
- Bilingual, bicultural licensed staff who are able to provide clinical supervision
- Bilingual clinicians trained to work with children
- Individuals with lived experience, both consumers and family members, especially Spanish-speaking and Assyrian

PEI priority populations:

- Underserved cultural populations
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma-exposed
- Children/youth at risk of school failure
- Children/youth at risk or experiencing juvenile justice involvement

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).

As mentioned in the discussion in Criterion 2 regarding the PEI process, three strategic initiatives emerged from the extensive, broad-based, inclusive stakeholder planning process, i.e., community capacity building, mental health promotion, and prevention and early intervention projects. From all of the feedback gathered in the process, county staff and consultants more fully developed each of these initiatives to address disparities. The RSSC group then considered the analysis of these initiatives as they related to the priority populations targeted and the disparities addressed. This is illustrated in the chart on page 31.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

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

Medi-Cal:

Data indicate that Hispanic Medi-Cal beneficiaries comprise approximately 51% of the Medi-Cal population in Stanislaus County, but they represent only 44% of the individuals served. In addition, 29% of the Medi-Cal beneficiaries indicate that their preferred language is Spanish, yet BHRS serves approximately 9.44% of these individuals. When we compare Medi-Cal utilization from FY2007/2008 to FY2008/2009, we see improvement in access for Hispanic individuals. For both years, they represented 51% of Medi-Cal beneficiaries. In FY2007/2008, 43% of our clients identified themselves

as Hispanic. In FY2008/2009 this increased to 44%. Still, their representation in the clients served is significantly below their representation in the Medi-Cal population.

The Asian/Pacific group are served slightly less than their representation in the Medi-Cal population, i.e., 5.50% in Medi-Cal population and 5.33% served.

The individuals who are 65 years and older are significantly underserved. They represent 9.38% of the Medi-Cal population but only 2.53% receive services from BHRS.

CSS:

At the time that the CSS plan was done, Hispanics represented about 36% of the County population, but only 29% of the service population. According to the FY2008/2009 data, Hispanics represent 39% of the population in the county and represent 46% of the individuals served. Thus there has been a significant improvement in the numbers served. Considering the prevalence of Severe Mental Illness in the population, 38% of the need is met for Hispanics, second only to African-Americans. Thus, as far as target populations are concerned, there is no longer a disparity in this group.

Similarly, the original CSS data suggested a significant disparity in the Asian/Pacific group. However, the FY2008/2009 data indicate that they represent 5.22% of the population and 4.99% of the clients served. Again, considering the target populations the department must serve, the disparity noted here is close to insignificant.

As noted in the section describing the CSS plan, the data on Native Americans is likely to be unreliable given that they may not be accurately identified at the time that they seek services. From the experience of our Assessment Teams, many individuals with Native American heritage identify themselves as Caucasian or other race.

The CSS plan indicated that older adults had the lowest overall penetration rate of all age groups. At that time, they represented 13.8 % of the population, but they were only about1.1% of the population served. By FY2008/2009, they were 10.22% of the population and 2.23% of the clients served. Thus, the disparity while somewhat ameliorated, was still significant.

According to the CSS plan, individuals in outlying areas had lower penetration rates.

WET:

Identified disparities/shortages when the BHRS WET Plan was written included:

- Need for additional bilingual/bicultural in all classifications, especially in our threshold language of Spanish
- Shortage of Black/African American Direct Service Staff in some programs
- Need for more of a diverse pool of clinical supervisors, bicultural/bilingual staff who are eligible and trained to be clinical supervisors
- Shortage of bilingual clincicians trained to work with children and families
- The need to hire individuals with lived experience, both consumers and family members, especially Spanish –speaking and Assyrian

PEI:

Specific numerical information on the disparities for the priority populations outlined above has not been captured. However, stakeholder input was used to select the priority populations pertinent to our county from the list developed by the MHSOAC PEI Committee.

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.

CSS Strategies:

- Increased penetration for Asian/Pacific Islanders with special emphasis on children ages birth to 15 using new strategies for outreach and engagement to Asian/Pacific Islanders by making use of natural leaders (e.g. Buddhist Temple) and existing helping processes in those communities.

- Increased penetration for older adults of all ethnicities utilizing new outreach and engagement strategies capitalizing on collaboration with existing support networks, including primary care and ethnic organizations.

- Increased overall access for Latinos by contracting with existing Latino-serving organizations and primary care providers. Strategies that have deployed bilingual staff and cultural competency training throughout the organization have been successful to a point. It is now necessary to take the next step and contract directly with organizations in whom there is increased trust by Latinos, including primary care providers.

- Increase Native American access through staff education and training. There are no reservations or rancherias within Stanislaus County, and no Native American human service organizations are based in Stanislaus County. Strategies that utilize the expertise that exists in neighboring Counties who have rancherias and Native American organizations for staff training and education should be incorporated into the BHRS Cultural Competency Training Plan.

- Increase linguistically competent staff in Spanish, Cambodian, Laotian, Portuguese and Assyrian languages.

- Focus new and expanded Full Service Partnership programs on improving access for unserved ethnic populations by partnering with ethnic service organizations, primary care providers and deploying services to specific neighborhoods.

- Increase focus on client culture throughout the system by increasing consumer participation (as consumers as well as increasingly as staff) in all programs at all levels, and by expanded training opportunities on client culture for all staff. Identification and expansion of culturally competent services can only be truly accomplished with considerable consumer participation at all levels.

- Appointment of a Manager for Consumer and Family Affairs at the senior management level. This Manager will have accountability for continuity, development and promotion of programs that are consumer and family run. The Manager would have a shared accountability, with other BHRS leadership staff, to ensure that BHRS continues to evolve into a consumer and family member driven mental health system.

- Focus new and expanded services on outlying areas with a current disparity of service penetration. In the Latino population, for example, not only is there a disparity in penetration, but also the disparity is much greater for those living in outlying areas. BHRS needs to provide services that are not only culturally and linguistically competent, but are also easily accessible to consumers regardless of where they live in the County.

WET Plan Strategies/Objectives:

- Work in collaboration with BHRS Human Resources Manager to review and revise existing job descriptions including minimum qualifications to reduce barriers to hiring consumers, family members including those from diverse communities.
- Conduct a focused needs assessment of training and support needs necessary to increase the number of consumer and family members entering and remaining in the workforce.
- Develop a training and technical assistance plan for consumers and family members that will prepare them for successful employment in the Public Mental Health system.
- Implement training and technical assistance plan for consumers and family members.
- Participate in at least 6 community events annually (health fairs, cultural celebrations, community events) and provide information about mental health career pathways.
- By September 2008, implement psychosocial rehabilitation curriculum in collaboration with the community college.
- Convene system-wide training committee (Mental Health Workforce Development Council) with broad representation inclusive of organizational providers, consumer and family members and culturally diverse members.
- Conduct assessment and analysis of training and technical assistance necessary to transform system to MHSA goals.
- Identify evidence-based curriculum and models to be considered by the Mental Health Workforce Development Council.
- Develop a system-wide, comprehensive training plan based on MHSA transformation.
- Expand existing volunteer opportunities to establish a consumer- and family member-oriented volunteer program within the Public Mental Health system.
- Provide resources within BHRS and organizational providers for supervision and support of volunteers.
- Provide training for supervisors of volunteers.
- Develop a contract with at least one school district with the outcome of starting a Mental Health Professions Academy or similar program by September 2008.
- Conduct a minimum of 12 speaking engagements annually to youth and their families from and within diverse communities.
- Offer up to 6 stipends per year for junior high school age students.
- Provide opportunities for high school age volunteers in at least four agencies within the public mental health system.
- Provide at least 10 additional internship slots annually for master's level MSW/MFT students.
- Develop a plan for establishing 10 internship/service learning slots annually for students pursuing undergraduate degrees.

- Provide 1500 hours of clinical supervision and/or cultural consultation to existing workforce focused on development of skills.

- Implement supervision structure to ensure supervision of interns, students and pre-licensed candidates.

- Coordinate practicum opportunities within the public mental health system for undergraduate nursing and LVN students from Modesto Junior College and CSU Stanislaus.

- Explore development of internships with educational entities (CSU Stanislaus, UCSF and UC Davis) for physician assistants and graduate nursing students including mental health nurse practitioners.

- Establish contracts with CSU Stanislaus and other educational entities who wish to enter into a contractual agreement with BHRS consistent with MHSA Essential Elements for graduate stipends for MSW and MFT students in FY2008/2009 with a focus on hard-to-fill positions.

- Grant a minimum of 3 educational stipends and/or scholarships annually to existing or potential employees.

PEI Projects/Programs/Strategies:

- Community Capacity Building (CCB) utilizing:
  Asset Based Community Development
  Promotores and Community Health Workers

- Emotional Wellness Education/Community Support utilizing:
  Mental Health Promotion Campaign
  Friends Are Good Medicine – an online directory providing information on available support groups throughout the county as well as a central phone number to call for information about support groups.

- Adverse Childhood Experience Interventions utilizing:
  Teaching Pro-Social Skills (TPS)
  Expanded Child Sexual Abuse Prevention and Early Intervention
  Early Psychosis Intervention (PIER Model)

- Child and Youth Resiliency and Development utilizing:
  Youth Leadership and Resiliency
  Children Are People

- Adult Resiliency and Social Connectedness utilizing:
  In Our Own Voice – Anti-Stigma Program
  Arts for Adult Resiliency and Social Connectedness
  Faith/Spirituality-Based Resiliency and Social Connectedness

- Older Adult Resiliency and Social Connectedness utilizing:
  Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
  Senior Peer Counseling
  Senior Center Without Walls

- Health/ Behavioral Health Integration utilizing:
  Embedded Mental Health Clinicians within Community Health Centers

- School-Behavioral Health Integration utilizing:
  Student Assistance and School-Based Consultation Program
  Parents and Teachers as Allies (PTASA)

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

Medi-Cal population:

It is our belief that the strategies being utilized by our current CSS and PEI plans are working to reduce the disparities among Hispanics, including those with a preferred language of Spanish. We believe that the public mental health system is not, and cannot be, solely responsible for the behavioral health and emotional well-being of all county residents, The efforts at Community Capacity Building as well as the outreach and engagement activities of the CSS plan are enabling and empowering the community to design options to meet the needs of their own cultural groups. We believe that this is beginning to show results in that the FY2008/2009 population data show that the Hispanic group, while 39% of the population, comprises 46% of the treatment population. The fact that this is not the case for the Medi-Cal population has more to do with the composition of that group. We could find no data that would support that the prevalence need in the Medi-Cal population is similar to that of the general population. In fact, in these difficult economic times, more individuals may qualify for Medi-Cal but not necessarily be a member of the priority target population of persons with serious mental illnesses. In fact, many may have situational mental health issues. It is our intention to continue to expand community-based options, e.g., embedded services in primary care clinics, faith-based options, services in Family Resource Centers, which are likely to be better suited to various cultural groups as well as those who are less seriously impacted by their mental illness.

With respect to the older adult population, there may be a generational bias against admitting to and/or getting treatment for mental illness. As noted above for the Hispanic population, we do not believe that the public mental health system is the answer for the needs of the older adult population with mental illness. However, we do have a Full Service Partnership (FSP) which targets older adults with serious mental illness. We believe that this effort, along with some of the outreach and engagement efforts, is having an impact. At the inception of CSS, 1.1% of this group received services county-wide and now 2.23% are served. Of the older adult Medi-Cal beneficiaries, 2.53% are served. In addition, the PEI strategy to increase resiliency and social connectedness among this group should have an even greater impact.

200% of poverty population:

As noted in Criterion 2, many of this population are uninsured or underinsured and our department is able to mainly serve those in crisis. The strategies for this group include:

- Screen referrals from the local psychiatric hospitals to determine eligibility for a FSP
- Encourage community to develop resources for individuals in their communities
- Promote PEI strategies

MHSA/CSS population:

The strategies for this population are noted above in Section A.

PEI priority populations:

The strategies discussed Section A are the current strategies for these populations. The PEI plan implementation is in start up phase and data to measure effectiveness is not yet available.

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.

At this point, the strategies listed above are the ones currently in use.

1. 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.

A multiple decade leadership commitment in Stanislaus County to community collaboration, wellness recovery approach and inclusion of diverse perspectives is the cornerstone of what works well. Lessons learned related to this commitment crystallized in recent years with MHSA planning requirements. With each successive planning process for MHSA components important lessons were learned. As a result, new levels of inclusiveness, transparency, and consensus are becoming the gold standard for large organizational changes at BHRS. These new levels contribute to the development of strategies, objectives, actions and timelines that work to reduce disparities

Brief examples of lessons learned:

"We can always be more inclusive" Initially during planning for CSS and WE&T, we learned that attendance at Town Hall meetings is pretty light. Flyers posted in BHRS clinics and ads in local newspapers do not extend a strong enough invitation to ensure community participation, Focus groups based in service sites don't reach far enough. As a result future community planning included significant collaboration with community-based organizations that have strong roots in neighborhoods and diverse communities. From applying this lesson learned a more robust community response is achieved.

"Transparency takes time" Related to the lesson learned about inclusiveness, we have found that once community members trust enough to come to the table it is important to share information clearly and fully and to an extent that supports plan development and recommendations for funding levels. During planning for PEI, new levels of transparency were achieved by including funding decisions in the discussion.

"Consensus is possible" Prior to MHSA planning, BHRS had done input processes with diverse communities, consumers and family members but none with the scale or depth asked for by MHSA guidelines. The major lesson learned in 2005 and in every subsequent planning process is that a diverse group of community stakeholders, many with competing interests, and, in a spirit of cooperation, will work together to achieve consensus…because we all care about making things better.

These lessons learned will be built upon with the implementation of our first Innovation Project. The intent of this project is to develop stakeholder processes that enable community and county partners to join with BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results. Though the involvement of community representatives has been working well and has become an integral part of organizational culture at BHRS there are additional lessons to be learned through the Innovation Project.

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.).

CSS Update:

Increased penetration for Asian/Pacific Islanders with special emphasis on children ages birth to 15 using new strategies for outreach and engagement to Asian/Pacific Islanders by making use of natural leaders (e.g. Buddhist Temple) and existing helping processes in those communities.

Outreach and Engagement (O/E) programs reduced disparities in access to service for diverse cultural/ethnic populations by developing more community-based supports. In FY 2008/2009, O/E programs connected with individuals from more than 15 different ethnic/racial groups providing services to 76% non-Whites. Specifically, the number of Asian/Pacific Islanders served increased by 26% from FY2006/2007 to FY2008/2009. This represents an increase from 5.0% to 5.2%. This occurred while the percentage in the county population for Asian/Pacific Islanders decreased 0.2%.

Increased penetration for older adults of all ethnicities.

Older adults served has increased from 1.1% to 2.23%. It is expected that some of the PEI initiatives will increase this percentage.

Increased overall access for Hispanics.

The number of Hispanics served increased by 39% from FY2006/2007 to FY2008/2009. This represents and increase from 32.5% to 37.1%.

Increase Native American access through staff education and training.

There was no change in the access for Native Americans.

Increase linguistically competent staff in Spanish, Cambodian, Laotian, Portuguese and Assyrian languages.

Cultural interpreters have been increased/maintained in Spanish, Cambodian, Laotian, Portuguese and Assyrian.

Josie's Place: TAY Drop-in Center (GSD-01) has a diverse group of staff and volunteers represented by the following cultures, races and ethnicities: East Indian, Laotian, African American, Hispanic, Caucasian, LGBTQ, consumers, and family members which has contributed to a multi-cultural approach to this membership-driven center for transition age youth with serious mental illness.

Focus new and expanded Full Service Partnership programs on improving access for unserved ethnic populations by partnering with ethnic service organizations, primary care providers and deploying services to specific neighborhoods.

Westside Stanislaus Homeless Outreach Program (FSP-01) operated by Telecare Corporation has served twelve monolingual Spanish-speaking clients. These service recipients are entirely Spanish speaking, an unprecedented trend in local FSP service to Hispanic community members and a significant increase in service levels for the program.

Senior Access and Resource Team (FSP-03) has, through partnership with an Outreach and Engagement Program community-based contractor, increased services to African American consumers from zero to 5% of the total caseload of the program. Anecdotally, the significance of this increase is reflected in the community collaboration that provided advocacy and increased access to people who would not normally seek agency-based services.

Health/Mental Health Team (FSP-04) has since its inception served a diverse client population. Over 58% of the consumers served are from diverse racial/ethnic groups; primarily Hispanic and African American. This team works collaboratively with primary health care clinics as the participants in this FSP must have a serious general health problem, e.g., diabetes, hypertension.

Integrated Forensic Team (FSP-05) has focused on service to adults and transition age youth with co-occurring issues of mental illness and substance abuse. Through their carefully nurtured, long-time partnership with the criminal justice system (law enforcement, District Attorney, Public Defender, judges, Probation, Drug Court, and Restorative Policing), IFT has been successful in serving a large proportion of ethnically and racially diverse clients. These clients are predominantly Hispanic and African-American, and are over-represented in the jail population as compared to the county population.

Increase focus on client culture throughout the system by increasing consumer participation (as consumers as well as increasingly as staff) in all programs at all levels, and by expanded training opportunities on client culture for all staff. Identification and expansion of culturally competent services can only be truly accomplished with considerable consumer participation at all levels.
Added the following to the “Desirable Qualifications” section of BHRS job descriptions:
Lived experience as a consumer or family member.

Developed a training plan for consumer and family members to work in mental health settings.

Offered or will offer training on topics related to this objective, i.e., Creating a Welcoming Workplace for Staff with Lived Experience as Consumers and Family Members, Partnering with the Customer, Families …The Rest of the Story.

Offering stipends to consumers to participate in department/program planning activities.

Appointment of a Manager for Consumer and Family Affairs at the senior management level.

This objective has been accomplished.

Focus new and expanded services on outlying areas with a current disparity of service penetration.

A very successful partnership between Community Emergency Response Team/Warm Line Peer Support (GSD-02) and Modesto Police Department is established. Every day this team works together to provide increased mobile emergency and non-emergency services on the phone and in the community to residents throughout Stanislaus County.

Family Partnership Center/Families Together (FPC/FT)(GSD-04) has worked to fill needs identified during initial planning for CSS that indicated outreach into racially and ethnically diverse communities was needed. Many families are unaware of services for families with youth who have serious emotional disturbance (SED) or how to access the services. The outreach by FPC/FT has resulted in an increase in Hispanic women (Spanish-speaking and bi-lingual) participating in events and groups. A few of the women’s husbands or extended family members noticed the benefit of new support to

their families and have also begun to participate in FPC events. This type of networking is one of the intended outcomes in expanding system capacity and building service connections with diverse communities.

Outreach and Engagement Programs have worked to develop community capacity to support individuals and families in their neighborhoods, churches and other communities of support. In FY2007/2008 three O&E programs contacted a total of 1646 individuals. BHRS contracts with two community-based organizations: West Modesto King Kennedy Neighborhood Collaborative and El Concilio. In collaboration with Family Resource Centers and Healthy Start programs, outreach and engagement services are available in Modesto and the outlying areas of Stanislaus County's Westside.

WET Update:

Work in collaboration with BHRS Human Resources Manager to review and revise existing job descriptions including minimum qualifications to reduce barriers to hiring consumers, family members including those from diverse communities.

As noted above, BHRS recruitment flyers/job descriptions were reviewed and revised. "Lived experience as a consumer or family member" was added as a desirable qualification. Unique cultural experience and linguistic competence are also desirable.

Conduct a focused needs assessment of training and support needs necessary to increase the number of consumer and family members entering and remaining in the workforce.

The Workforce Development Council created a list of training topics to support and prepare consumers and family members for employment. From this process, as assessment tool for consumer and family member training needs was developed.

Develop a training and technical assistance plan for consumers and family members that will prepare them for successful employment in the Public Mental Health system.

A three-year system-wide Training Plan (FY2009/2012) has been completed which includes a training plan for consumer and family members to work in mental health settings.

Implement training and technical assistance plan for consumers and family members.

Stanislaus County Workforce Education and Training held its first eight week series of trainings for volunteers, consumers and family members from January 13 – March 3, 2010. The training, developed from stakeholder input including consumer and family members, contract agencies and BHRS Staff, served as an orientation for consumers and family member volunteerism and /or future employment in public mental health. Presenters included the Behavioral Health Director, Medical Director, and Manager of Human Resources as well as other BHRS staff. Topics included Community Capacity Building, wellness, recovery and resilience, resources and supports for individuals and families, the role of culture and impact of stigma, an overview of psychiatry and treatment, patient rights, job roles for volunteers and providers, self help facilitation, and how to apply for entry level employment within BHRS and at BHRS contract agencies. 108 individuals participated in the 8 week series of trainings. Eleven individuals participated in all eight trainings.

Participate in at least 6 community events annually (health fairs, cultural celebrations, community events) and provide information about mental health career pathways.

- Three freshman academy health classes at Davis High School (120 students)
- One psychology academy class at Davis High School (25 students)
- Two Wellness Recovery Center Milestones in Recovery Events (50 participants)

By September 2008, implement psychosocial rehabilitation curriculum in collaboration with the community college.

The California Association of Social Rehabilitation Agencies (CASRA) Certificate program has been adopted by Modesto Junior College. In FY2008/2009, 16 students received financial stipends for school costs. Fourteen students completed the semester. All students who enrolled in the class had lived experience as consumers and/or family members.

Convene system-wide training committee (Mental Health Workforce Development Council) with broad representation inclusive of organizational providers, consumer and family members and culturally diverse members.

The Workforce Development Council has been convened and includes individuals with lived experience as consumers or family members, culturally and ethnically diverse community members, and community partners delivering public mental health services.

Conduct assessment and analysis of training and technical assistance necessary to transform system to MHSA goals.

As noted above, a three-year system-wide Training Plan has been developed to support transformation of all systems of care, ensuring that the essential elements of MHSA are included.

Identify evidence-based curriculum and models to be considered by the Mental Health Workforce Development Council.

Examples below:

- The California Brief MultiCultural Scale (CBMCS) curriculum was considered and adopted. Trainings began in mid-2010.
- Early Psychosis Assessment and Support
- Multifamily Groups in the Treatment of Severe Psychiatric Disorders

Develop a system-wide, comprehensive training plan based on MHSA transformation.

This has been completed.

Expand existing volunteer opportunities to establish a consumer- and family member-oriented volunteer program within the Public Mental Health system.

A WET Volunteer Coordinator was hired in November 2008.

Volunteers offered supports to fellow students at Modesto Junior College (MJC) and facilitated two support groups on a weekly basis for individuals receiving services in the Co-occurring Treatment track at Stanislaus Recovery Center.

Volunteers, many with lived experience assisted other individuals with registration for CASRA program at MJC and conducted a weekly CASRA study group.

Provide resources within BHRS and organizational providers for supervision and support of volunteers.

In FY 2009/2010, with input from consumers and family members, a training was launched and designed to help supervisors and managers learn how to create welcoming workplaces for newly hired staff with lived experience as consumers or family members. Twenty-two program managers and coordinators from BHRS completed the first training entitled “Supervision of Staff with Lived Experience”

Provide training for supervisors of volunteers.

Included in the above training that was provided for BHRS program managers and coordinators to assist them creating a welcoming workplace for newly hired staff with lived experience as consumers or family members, this training also included strategies on how to work with volunteers.

Develop a contract with at least one school district with the outcome of starting a Mental Health Professions Academy or similar program by September 2008.

An agreement was developed with a local high school (Davis High School) to add a behavioral health component to the existing Health Academy curriculum. The WET Manager did presentations in the classrooms to promote interest in this area.

Conduct a minimum of 12 speaking engagements annually to youth and their families from and within diverse communities.

The following presentations were provided with the number of participants included:

- King Kennedy Presentation about WET/Wellness Project to prospective youth and families (15)
- Day of Hope hosted by West Modesto King Kennedy Neighborhood Collaborative (80)
- Occupational Olympics- All High School Seniors County Wide Occupational Fair Stanislaus County Fair Grounds (300)
- Davis High School Annual Academy Dinner for parents and students (30)
- Regional MH Board and Commissions Training day- Modesto Junior College (45)
- Modesto Junior College Recovery Day (100)
- Mark Twain Junior High- Back to school night (120)
- Homeless Vigil- longest day of the year (75)
- Two undergraduate psychology classes at CSU, Stanislaus (80)
- Rotarian Service Club- Ceres (15)
- Persephony Service Club- Ceres (12)

Offer up to six stipends per year for junior high school age students.

West Modesto King Kennedy Neighborhood Collaborative, a local community-based organization serving individuals in diverse ethnic/racial neighborhoods, implemented the first “Wellness Project” designed to identify junior high school students to receive stipends. Six African-American students were selected. They set up and managed an anti-stigma information table at an annual “Day of Hope” community event in May 2010.

Provide opportunities for high school age volunteers in at least four agencies within the public mental health system.

In FY 2009/2010 volunteer opportunities were provided, however none of the students from the Davis High School Health Academy selected a volunteer opportunity. We anticipate in FY 2010/2011 that there will be students placed with the public mental health system.

Provide at least 10 additional internship slots annually for master’s level MSW/MFT students.

BHRS developed a community-wide clinical supervision plan to add 10 additional internship slots annually for MSW/MFT students and pre-licensed interns.

Develop a plan for establishing 10 internship/service learning slots annually for students pursuing undergraduate degrees.

In FY 2009/2010 BHRS convened meetings with community-based organizations, community partners, and BHRS staff regarding opportunities and procedures. As a result of these discussions,

volunteer opportunities were developed for fifteen California Association of Social Rehabilitation Agencies (CASRA) students from Modesto Junior College. The placement opportunities were located in BHRS programs as well as non-profit community based organizations.

Provide 1500 hours of clinical supervision and/or cultural consultation to existing workforce focused on development of skills.

- BHRS and community contract partners devised a strategy in the Workforce Council to add clinical supervision hours for MSW/MFT students. Discussions led to a contract with four agencies to offer 16 additional internship slots.
- The structure agreed upon also included education/training of clinical supervisors in the essential elements of MHSA.
- The contract began in November 2009, five months into the fiscal year. 277 clinical supervision hours were completed in the remaining seven months. If fully executed, this contract would allow for up to 1600 total hours.

Implement supervision structure to ensure supervision of interns, students and pre-licensed candidates.

Implementation of an expanded clinical supervision for students and interns from CSU Stanislaus was delayed due to budget issues that educational partners were having. Thus, a plan was developed with community-based organizational partners to provide this supervision, and implementation is in process as noted in the objective above.

Coordinate practicum opportunities within the public mental health system for undergraduate nursing and LVN students from Modesto Junior College and CSU Stanislaus.

In June 2010, BHRS coordinated and secured a contract for practicum opportunities with CSU Stanislaus undergraduate nursing students (RN) to complete their psychiatric clinical field practicum at BHRS

Explore development of internships with educational entities (CSU Stanislaus, UCSF and UC Davis) for physician assistants and graduate nursing students including mental health nurse practitioners.

In FY 2009/2010 there was a series of meetings with CSU Stanislaus and Fresno State to explore opportunities for Nurse Practitioners. Ultimately, a contract was secured with Fresno State and a Nurse Practitioner preceptorship has been established at Turlock Recovery Services.

Establish contracts with CSU Stanislaus and other educational entities who wish to enter into a contractual agreement with BHRS consistent with MHSA Essential Elements for graduate stipends for MSW and MFT students in FY2008-09 with a focus on hard-to-fill positions.

A contract was successfully negotiated between BHRS and CSU Stanislaus to offer stipends to MSW students in the Master of Social Work program. Individuals from racial/ethnic communities and individuals with lived experience as consumers and family members were included among graduate students receiving stipends in the Career/Educational Pathways program.

Grant a minimum of 3 educational stipends and/or scholarships annually to existing or potential employees.

Among the four MSW students awarded stipends in FY2008/2009, three identified themselves as Latina, two were bilingual Spanish-speaking, and two self-identified as a consumer or family member. In FY 2009/2010 four MSW students two Latina's, one African-American and one consumer received financial stipends.

PEI Update:

Stanislaus County's PEI plan was approved at the end of FY08-09 in May 2009. Implementation began in FY 2009/2010 with a BHRS leadership decision to assign overall administrative supervision of PEI to the Children's System of Care Chief; over 50% of PEI program funding is dedicated to ages 0 to 25 year old individuals. BHRS has had no mental health prevention programs for over 25 years and an entirely new PEI Team was needed to ensure effective support of the new PEI programs and services and to fulfill on the strategic initiatives of the PEI plan: community capacity building, mental health promotion, and PEI projects. Significant effort and progress in FY 2009/2010 also focused on intensively working to develop requests for proposals (RFP) and identifying diverse community partners/agencies that would contract with BHRS to deliver PEI services. The overarching focus is to serve the priority population of underserved cultural populations and address the key community need of reducing disparities in access to service.

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.

A Research and Outcomes Specialist has been hired with expertise in statistical analysis.

We also routinely track client penetration and retention to identify disparities, establish goals and monitor improvement. Because of their importance, these indicators are always included in our annual Quality Management Work Plan. Our penetration indicator is an index score that measures the percentage to which we are successful in meeting our goal. For example, if our goal is to provide services to 1.7% of a specific population and our score was 50%, we would have provided services to 0.8% of that population. The penetration score helps us identify disparities in access to services. Given our intention to focus upon and leverage community resources, we are also evaluating alternative methods of calculating penetration to more accurately reflect our experience. In addition, we also track client retention by ethnicity and include this indicator in our annual Quality Management Plan. To measure retention, we look at clients who receive more than two visits within six months after episode opening. Our data shows very consistent results across groups and over time. In FY2007/2008 retention rates across groups varied from 75% to 84%, with Hispanic clients having the highest retention rate and Asian-Pacific Islanders the lowest rate. In FY2008/2009, the range was 77% for Caucasians to 84% for Native Americans. The retention rate for Hispanic clients was 80%.

Importantly, we have embarked upon an endeavor with our community-based partners and our own county-operated programs to use Results Based Accountability (RBA) to effectively measure outcomes. No longer are the amount and quality of services provided in and of themselves sufficient measures of the effect of our strategies. With our community we are going to develop measures to determine if anyone is better off as a result of our efforts.

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

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

C. Identify county technical assistance needs.

No technical assistance is requested at this time.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

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

Rationale: A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).

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).

Stanislaus County Behavioral Health and Recovery Services established its Cultural Competence Oversight Committee (CCOC) in 1997 as a way to ensure the department's Five-Year Cultural Competence and Strategic Plan remained a "living document" and to ensure that the requirements of the State DMH Cultural Competence Plan requirements were met. Through the use of the BHRS Cultural Competence Oversight Committee, the organization ensures that every system of care addresses cultural competency issues in its programming and service provision.

The department's Quality Management Team (QMT), which is the governance group of the CCOC, compiled a matrix detailing activities of each BHRS work group and ad hoc committee to eliminate duplication of effort and reduce confusion about what each group does. In 1999, QMT determined the overall role/purpose of the CCOC would be to monitor the cultural competence aspects of the department's Strategic Plan, including DMH Cultural Competence requirements. The CCOC uses four documents as guiding frameworks to provide technical assistance and ongoing monitoring of cultural competence integration to fulfill the BHRS Mission and Vision:

- DMH Managed Care Cultural Competence requirements
- Stanislaus County Cultural Competence Administrative and Clinical Standards
- BHRS Strategic Plan
- MHSA Essential Elements

Details about the CCOC are summarized in "Cultural Competence Oversight Committee Purpose, Membership, Duties and Responsibilities Document" .

Membership of the Cultural Competence Oversight Committee includes the following designated stakeholders as agreed by the BHRS Senior Leadership Team:

- Adult System of Care (ASOC)
- Older Adult System of Care (OASOC)
- Children System of Care (CSOC)
- Forensics Services/Public Guardian
- Data Management Systems (DMS)
- Fiscal/Administrative Services
- Senior Leadership
- Consumer and Family Affairs
- Consumer and Family Member Representatives.
- Organizational Contract Providers
- Executive Assistant to the Director
- Advisory Board on Substance Abuse (ABSAP)
- Mental Health Board (MHB)
- Managed Care
- Stanislaus Recovery Center (SRC)
- Quality Services
- Human Resources/Training Services
- Patients' Right's
- Community Emergency Response Team (CERT)

The CCOC is co-chaired by the department's Ethnic Services Manager and the Executive Assistant to the Director. The CCOC Chairs conduct regular monthly meetings. A typical CCOC meeting agenda includes standing items such as:

- Welcome and introductions
- Review and approval of minutes of the previous meeting
- Follow up on action items from the previous meeting
- Distribution and description of the monthly Cultural Competence newsletter
- Training updates/announcements
- Advocate/consumer/family member updates
- Informational presentation and/or focused discussion (e.g., annual accomplishments, annual goals/targets, topics relevant to cultural competence)
- Data review and discussion (e.g., utilization and penetration rates, MHSA statistics)

CCOC Chairs summarize meeting highlights at the monthly Leadership Meeting of BHRS managers and program coordinators as well as at bi-monthly Quality Management Team meetings. The Senior Leader sponsor of the CCOC is responsible for reporting to the Mental Health Board at regular monthly meetings, to the Advisory Board on Substance Abuse Programs, and to BHRS Senior Leadership as needed. Copies of the Cultural Competence Update, a monthly newsletter, are distributed at all of these meetings, are emailed to all BHRS and contractor staff and are posted on the BHRS internal website, accessible by staff and contract providers alike.

Members of the CCOC are responsible for attending and actively participating in monthly meetings (or arranging to send a substitute who is prepared with meeting materials and responses to any "homework" from the previous meeting). Attendance is recorded and monitored.

CCOC members are provided a comprehensive binder of informational documents with which they are to become familiar. These include but are not limited to the BHRS Vision, Mission, and Values; an organizational chart; the CCOC membership roster; the "Cultural Competence Oversight Committee – Purpose, Membership, Duties and Responsibilities Document"; Cultural Competence Administrative and Clinical Standards and Guidelines; copies of BHRS policies and procedures pertinent to cultural competence; and the CMHDA "Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities". In January of each year, informational documents are updated and distributed to CCOC members.

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;

Composition of the BHRS Cultural Competence Oversight Committee was determined by Senior Leadership after the original Five-Year Cultural competence and Strategic Plan was completed in 1997. The Committee includes several stakeholder members to represent each System of Care, each BHRS division, BHRS contractors, the Mental Health Board and the Advisory Board on Substance Abuse, Patient's Rights, consumers and family members. County management level and line staff represent their programs, clients and family members from ethnic, racial, and cultural groups, providers, community partners, and contract agency representatives serve on the CCOC. Designated stakeholder members are listed in the table found in I.A. and current program/contractor representatives are listed in I.D.

C. Organizational chart; and

See Behavioral Health and Recovery Services organizational chart and Organizational Quality Improvement Structure chart attached in Appendix.

D. Committee membership roster listing member affiliation if any.

The CCOC Sign-In Sheet, utilized at every meeting, is a list of all regular members and their program/agency affiliation. The January 2011 CCOC Sign-In Sheet is attached

BEHAVIORAL HEALTH AND RECOVERY SERVICES
CULTURAL COMPETENCE OVERSIGHT COMMITTEE (CCOC)
SIGN-IN SHEET

Meeting Date:	January 10, 2011	***Meeting Time:***	9:00 am – 10:30 am
Facilitators:	Pete Duenas & Linda Torres	***Place/Room:***	800 Scenic Drive – Redwood Room

Name	Program/Division	If Alternate Attending Print Name Here	Phone	Email	Signature
Alcala, Connie	Forensics/PG		525-7403	calcala@stanbhrs.org	
Alvarez, Teresa	Patients' Rights		525-7423	talvarez@stanbhrs.org	
Anderson, Jean	Senior Leadership		525-6225	janderson@stanbhrs.org	
Black, John	C & F Affairs		525-7368	jblack@stanbhrs.org	
Buckles, Debra	Senior Leadership		525-6225	dbuckles@stanbhrs.org	
Canelo, Mariana	Patients' Rights		525-7423	mcanelo@stanbhrs.org	
Carroll, Adrian	Senior Leadership		525-7442	acarroll@stanbhrs.org	
Cary, Dorbea	HR/Training/WET		525-6274	dcary@stanbhrs.org	
Catzalco, Hermille	CSOC/TAY		541-2910	hcatzalco@stanbhrs.org	

BEHAVIORAL HEALTH AND RECOVERY SERVICES CULTURAL COMPETENCE OVERSIGHT COMMITTEE (CCOC) SIGN-IN SHEET	
Meeting Date: January 10, 2011	***Meeting Time:*** 9:00 am – 10:30 am
Facilitators: Pete Duenas & Linda Torres	***Place/Room:*** 800 Scenic Drive – Redwood Room

Name	Program/Division	If Alternate Attending Print Name Here	Phone	Email	Signature
Clark, Lillie	CSOC/TAY		558-7494	lclark@stanbhrs.org	
Della, Stacey	Fiscal/Admin Services		525-6268	sldella@stanbhrs.org	
Duenas, Pete	CCOC Co-Chairs		525-6223	pduenas@stanbhrs.org	
Escobar, Lucy	CSOC/TAY		525-7494	lescobar@stanbhrs.com	
Gibson, Paul	DMS			pgibson@stanbhrs.org	
Golden, Christi	HR/Training/WET		525-7339	cgolden@stanbhrs.org	
Huntley, Ken	HMHT/SATT		558-4600	khuntley@stanbhrs.org	
Hurley, Jim	HR/Training/WET		525-5324	jhurley@stanbhrs.org	
Hutsell, Glenn	Senior Leadership		525-6225	ghutsell@stanbhrs.org	
Jameson, Janette	CSOC/TAY		558-4595	jjameson@stanbhrs.org	
Looney, Vickie	Quality Services		525-6046	vlooney@stanbhrs.org	
Martinez, Sofia B.	Juvenile Justice		525-5401	smartinez@stanbhrs.org	
Oakes, Elizabeth	Senior Leadership		525-6225	eoakes@stanbhrs.org	
Panyanouvong, Tommy	CSOC/TAY		558-4464	tpanyanouvong@stanbhrs.org	
Peitz, Vicki	Fiscal/Admin Services		525-7446	vpeitz@stanbhrs.org	
Preston, Stephen	Genesis/SRC		525-6146	spreston@stanbhrs.org	
Schlaepfer, Madelyn	Senior Leadership		525-6225	mschlaepfer@stanbhrs.org	
Tamraz, Alice	ASOC/OASOC		664-8044	atamraz@stanbhrs.org	
Torres, Linda	CCOC Co-Chair		525-6205	ltorres@stanbhrs.org	

BEHAVIORAL HEALTH AND RECOVERY SERVICES CULTURAL COMPETENCE OVERSIGHT COMMITTEE (CCOC) SIGN-IN SHEET	
Meeting Date: January 10, 2011	***Meeting Time:*** 9:00 am – 10:30 am
Facilitators: Pete Duenas & Linda Torres	***Place/Room:*** 800 Scenic Drive – Redwood Room

Name	Program/Division	If Alternate Attending Print Name Here	Phone	Email	Signature
Velarde, Vanessa	CSOC/TAY		525-2352	vvelarde@stanbhrs.org	
Vera, Elizabeth	NAMI		609-2188	elizabeth.vera@att.net	
White, Tim	C & F Affairs		525-7369	twhite@stanbhrs.org	
Consumers/Family Members					
Contractors					
Anderson, Barbara	WMKKNC		522-6902	banderson@westmodestocollaborative.com	
	WMKKNC				
Ellsmore, Al	Aspira		669-2583	aellsmore@aspiranet.org	
	Aspira		669-2583		
Gallardo, Marcos	El Concilio		523-2860	mgal@elconcilio.org	
Ruben Sanchez	El Concilio		558-5715	rsan@elconcilio.org	
Maxine Souza	El Concilio		558-5715	msou@elconcilio.org	
Granados, Fernando	SVCFS		523-4573	FGranados@sierravistacares.org	
Wood Hiatt, Kim	SVCFS		523-4573		
Riley, Jim	EMRS/Telecare		341-1804	jriley@telecarecorp.com	
Sanders, Linda	EMRS/Telecare		341-1804	lkwiatkowski@telecarecorp.com	
Trudell, Susan	Turning Point		341-0718	susantrudell@tpcp.org	

BEHAVIORAL HEALTH AND RECOVERY SERVICES CULTURAL COMPETENCE OVERSIGHT COMMITTEE (CCOC) SIGN-IN SHEET	
Meeting Date: January 10, 2011	***Meeting Time:*** 9:00 am – 10:30 am
Facilitators: Pete Duenas & Linda Torres	***Place/Room:*** 800 Scenic Drive – Redwood Room

Name	Program/Division	If Alternate Attending Print Name Here	Phone	Email	Signature
June Newman	Turning Point		341-0718	junenewman@tpcp.org	
Fernandez, Jorge	CHS		526-1440	jfernandez@centerforhumanservices.org	
Guests/Others					

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.

The Cultural Competence Oversight Committee developed a Vision Statement and a Mission Statement in FY 2008/2009. These statements reflect the intent of the CCOC to actualize the activities noted above. The Vision Statement is as follows:

- To be a leader in providing culturally competent services and to be recognized for our excellence in this by our community, state and nation.

The Mission Statement is as follows:

In partnership with our providers and community, our mission is to transform our entire system by:

- Ensuring that culture is acknowledged and incorporated throughout BHRS in a measurable and substantive way
- Educating our workforce about the meaning of cultural competence and about how to actually implement the concepts
- Ensuring our Cultural Competence Plan remains effective and responsive to change
- Empowering consumers, family members, and communities representing all cultures

The Vision and Mission Statements are printed on every CCOC agenda as a guide to the purpose of this committee.

Listed below are each months CCOC Minutes highlights for 2010. (See 2010 CCOC Minutes attached in Appendix)

January

- Staff who attended the Cultural Competence Mental Health Summit, November 2009, provided the CCOC information on each of their learning experiences at the Summit
- Discussion as to how to make CCOC information available to all BHRS Staff.
- CCOC co-chairs provided information on the Central Valley Ethic Services Manager Face to Face meeting held on 1/8/10
- Reviewed the 09/10 CCOC Goals- which includes having a role in determining how the California Brief Multicultural Scale (CMBS) Training Curriculum will be rolled out in BHRS - Stanislaus County

February

- Mental Health Plan Administrator provided data from the Quality Management Team Work Plan. The reports take a look at the ethnicity data, client retention, and penetration scores.
- Peer Recovery Specialist reported on Celebrate Recovery Conference he attended in San Jose
- BHRS Training Coordinator announced that some of the existing trainings will be folded into the CBMCS
- PEI Manager reported out on a Promotores workshop he attended at the CC MH Summit,
- Discussion on best ways to disseminate information to all staff
- CCOC co-chair announced that the CCPR are now available

March

- Training Coordinator proposed for CCOC to make recommendation to Sr. Leadership regarding the CBMCS Curriculum
- CCPR Proposed Timeline distributed to CCOC
- WET Manager announced that a workgroup will be discussing how Spirituality fits into services
- PEI Manager announced the Behavioral Health Summit will be on May, 10, 2010 with the focus being Community Capacity Building

- BHRS Associate Director reviewed the Alcohol and Other Drug date
- Discussed the Mental Health Utilization Data

April

- Training Coordinator announced that the Supervising Staff with Lived Experience is rescheduled for June 8
- Family Advocate reported that the Consumer/Family Steering Committee Meeting is being held on April 13. In addition, he announced several activities occurring in May and June
- ESM reported that they attended the DMH Technical Assistance Training for the CCPR
- Announcement that the NAMI Provider Education Course went well
- CCOC co-chair reported that the CCOC Minutes are now posted on the BHRS Intranet

June

- Training Coordinator announced that the initial CBMCS trainings have been scheduled
- Family Advocate announced that Stanislaus Transitional Age Youth (STAY) Leadership Conference will be on June 19
- NAMI Member shared that the in Our Own Voice training is scheduled for July 16 and 17th
- Training Coordinator announced the Demographic Data training is scheduled for June 21, 23, and 25
- Family Advocate announced that Families the Rest of Story training is scheduled for October 27

July

- PEI Manager provided update on efforts regarding Community Capacity Building
- Discussion regarding the Demographic Data Project
- Discussed 09/10 Accomplishments

August

- Discussion on a new CCOC co-chair
- Associate Director provided overview of MHSA Innovation Project
- NAMI Member announced a new Spanish Family to Family course
- Continued Discussion of Demographic Data Project
- Discussed CCOC 10/11 Goals
- Discussion on expectation of CCOC Members communicating to own areas

September

- Discussed the Friends are Good Medicine Website
- Housing Manager presented information regarding the Housing Program
- August Central Valley ESM Meeting Update
- PEI Activities Update
- WET Activities Update

October

- Reviewed Mental Health Prevalence Data
- Update on the Joint ESM/Social Justice Meeting
- CCPR Extension discussion

November

- MHSA Innovation Project Presentation
- Associate Director provided update on Innovation AOD Stakeholder Process
- Discussion on Cultural Competence Newsletter
- Follow up discussion on Mental Health Prevalence Report

The CCOC reviews all services/programs/cultural competence plans with respect to cultural competence issues at the county. In January 2009, staff from Josie's Place Drop-In Center, TAY Services Team and Telecare Josie's TRAC gave a presentation on transition age youth culture. In May and June 2009, the BHRS Cultural Competence Oversight Committee received comprehensive oral reports and supporting handouts regarding types of services provided, populations served, results of training, cultural competence data and other culturally relevant activities in Children's and Adult Systems of Care, respectively. **(See January 12, 2009, CCOC Minutes in Appendix Section for evidence of this information)**

The CCOC provides reports to Quality Assurance/Quality Improvement Program in the county. "Cultural Competence Report" is a standing agenda item on the department's Quality Management Team (QMT) meeting agenda. At each QMT meeting, the CCOC co-facilitators summarize the most recent CCOC meeting as well as other activities pertinent to cultural competence such as information received via CC/ESM teleconferences and meetings. Similarly, "Cultural Competence Updates" is a standing agenda item for each of the department's Quality Improvement Councils (QICs). One of the CCOC co-facilitators actively participates in the Administrative Services QIC and reports there about CCOC activities on a regular basis. (**See 2010 Quality Management Team Minutes located in the Appendix Section for evidence of this information**)

The CCOC participates in overall planning and implementation of services at the county. BHRS is a data-driven department. In its role as an oversight committee, the CCOC received statistical reports on a regular basis throughout FY 2008/09 to increase understanding and aid in making recommendations about cultural competence related issues. CCOC members reviewed and compared "Mental Health Service Utilization Based on Prevalence" for fiscal years 2006/2007, 2007/2008, and 2008/2009. Data for these reports reflected mental health services entered in the CSI/Insyst sytem and was provided in geographic region, race/ethnicity, and age categories. Quarterly data from the "MHSA Demographic Report" was also reviewed. This BHRS internal report was divided into Full Service Partnership, General System Development and Outreach/Engagement program sections and contained number of unduplicated clients served by program with breakdowns of numeric data by gender, age, ethnicity, primary language and geographic area of residence. The "BHRS Alcohol and Drug Treatment Admissions" report contained information categorized by gender, age, race, ethnicity, employment, level of education, legal status, and special needs**. (See March 9, 2009 CCOC Minutes and the MHSA Demographic Reports located in the Appendix Section for evidence of this information)**

In addition to statistical reports, in FY 2008/2009 the CCOC received presentations on a wide variety of subjects such as CLAS and WICHE Standards, California Alcohol and Drug Programs Conference, the statewide Spirituality initiative, quarterly local Refugee Committee meetings and how PTSD affects the Refugee community, diabetes and mental health, improving Stanislaus Recovery Center access and services for African Americans, CMHDA's statewide reducing disparities projects, CIMH's inclusion of CC/ESMs at MHSA and Full Service Partnership Coordinators' meetings, Central Region CC/ESM meetings and progress reports on development of the final 2010 Cultural Competence Plan Requirements by DMH Office of Multicultural Services. In addition, time was spent hearing from members about how their programs connect with culturally diverse communities, reduce stigma for clients in the LGBTQ population, and incorporate clients' spirituality in treatment. In December 2008, the "First Annual Taste of Culture" was conducted at the regular CCOC meeting. Members brought food items from their respective cultures and shared how culture influenced them and their family members during the holiday season. (**See CCOC Minutes for February 8, 2010, March 8, 2010, August 11, 2008, , April 12, 2010, May 11, 2009, June 8, 2009 located in Appendix Section for evidence of this information)**

CCOC reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director. The two BHRS managers responsible for co-facilitating CCOC meetings report to a Senior Leader sponsor (currently the Associate Director) who helps plan and coordinate as well as attends the CCOC meetings. The Associate Director reports to the Behavioral Health Director and, jointly with other executive management, develops the agenda for the weekly Senior Leadership meeting. All recommendations and concerns are brought to this meeting at which the Behavioral Health Director is in attendance.

The CCOC participates in and reviews county MHSA plans for all MHSA components. CCOC involvement in MHSA planning began in January 2005 with formation of the MHB/BHRS MHSA Planning Committee. This committee included the Cultural Competency Managers and met to develop strategies for a comprehensive community outreach plan. The Cultural Competence Oversight Committee reviewed and provided input to the BHRS MHSA-CSS Plan submitted to DMH for approval in October 2005. Members of the CCOC also serve on the MHSA Representative Stakeholder Committee on a regular basis. These include personnel from contract agencies providing services in Children's and Adult Systems of Care, MHSA Outreach and Engagement contractors, Senior Leaders, Fiscal/Administrative Services, Stanislaus Recovery Center, and the Executive Assistant to the Director. Managers of each MHSA component report to the CCOC on a regular basis. During the FY 08/09 reporting period, in August 2008, the Workforce Education and Training Manager shared a detailed and informative PowerPoint presentation regarding implementation of the Workforce Education and Training (WET) component in Stanislaus County. All BHRS staff was invited to respond to the MHSA Prevention/Early Intervention survey on community needs, take part in community feedback forums, and participate in Stakeholder meetings. PEI Workgroups were held in January 2009. The PEI Plan was available on-line for public review and comment in March 2009. CCOC members were asked to review the document, particularly the Project Descriptions, plans, and goals in order to compile an aggregated response from CCOC members. (See CCOC Minutes for September 12, 2005, August 11, 2008, November 8, 2010, March 2009, August 9, 2010, and December 13, 2010, located in Appendix Section for evidence of this information)

The CCOC participates in and reviews county MHSA stakeholder process. CCOC members participate in the county MHSA stakeholder process through direct participation in MHSA Representative Stakeholder meetings, as described above, or by reviewing and providing input on each proposed MHSA Plan which includes a section describing that Plan's stakeholder process.

The CCOC participates in and reviews client developed programs (wellness, recovery, and peer support programs). These programs were included as part of the Adult System of Care's report to the CCOC in June 2009. **(See CCOC Minutes June 8, 2009 in Appendix for evidence of this information)**

The CCOC participates in revised CCPR (2010) development. From July 2008 through January 2010, BHRS watched the progress of CCPR development at DMH, CMHDA and the state level Medi-Cal Policy committee. BHRS staff and the local Mental Health Board provided input to the process. At each monthly CCOC meeting from February 8, 2010 on, a CCPR status report was provided and/or input gathered from attendees. All BHRS Senior Leaders, managers, program coordinators and representatives of every BHRS contract agency were included as key informants to Plan development and asked to provide material for the BHRS new Cultural Competence Plan. (**See CCOC Minutes February 8, 20010 in Appendix for evidence of this information.)**

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

Included in the Appendix are the CCOC and Quality Management Minutes that reflect CCOC participation in the above activities.

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.

For FY 2009/2010, the CCOC Accomplishments were discussed at the 7/12/10 CCOC Meeting. These accomplishments included publishing the CCOC newsletter every month and posting the newsletter, meeting minutes, and 2010 CCPR on a new "Cultural Competence" BHRS Intranet page. In addition, the 2nd annual Taste of Culture was conducted. A third "Training in a Tube" module (LGBQ) was rolled out. Training was provided to staff on new demographic data collection codes. The evidence-based CBMCS curriculum was adopted, Information to meet 2010 Cultural Competence Plan Requirements was collected. Contract language to incorporate CCPR was developed. Quarterly service utilization reports were presented and reviewed. The CCOC's role as an oversight committee was redefined/clarified. Representatives were sent to the 2009 Cultural Competence/Mental Health Summit. CCOC member binders were updated. Lived experience was added as a Desirable Qualification on BHRS job flyers.

In regard to FY 2008/2009 goals and objectives: At its October 13, 2008 meeting, members of the BHRS Cultural Competence Oversight Committee suggested the following topics for the CCOC to look at for FY 2008/2009:

- Cultural Competency Plan
- Anti-Stigma Related Activities
- Consumer and Family Member Culture
- Children's System of Care – more attention to 0-18 years of age
- Understanding Consumer/Family Member – focus on 18-21 age group – Transition Age Youth
- Recovery Model
- Continue monitoring Cultural Competency Action Plans
- Monitor Multicultural Supervision Evaluations
- Focus on Recovery, Resiliency and Wellness
- Spirituality –provide a Spirituality Training

One year later, at the November 9, 2009 Cultural Competence Oversight Committee meeting, accomplishment of FY 2008/2009 goals and objectives was discussed. The following goals were met:

- Anti-Stigma Related Activities – A representative of Sierra Vista Child and Family Services (SVCFS) reported development of anti-stigma training with Continuing Education Units for staff. The BHRS StanWORKS coordinator provided customized "Labels are for Jars" training for about 60 Community Service Agency FSS staff. Her program also presents the Stanislaus County Aids Project (SCAP) information to AOD and dual diagnosis groups. El Concilio, an MHSA Outreach and Engagement contractor, reported collaborating with the Latino Business Roundtable and efforts to increase cultural sensitivity in relationship to the stigma of the Latino population in receiving services.

- Consumer and Family Member Culture - in July 2008, the local National Alliance on Mental Illness (NAMI) chapter began its first 10-week "Provider Education" series. The Public Guardian/Estate

Management Office (PG/EMO) Manager described resiliency and consumer and family member culture. One client was taken advantage of by a predatory lender. Turlock Regional Services staff is working with California Rural Legal Assistance to compensate the client and help find housing, furnishings and clothing to improve her quality of life, live independently and reduce stress. PG/EMO respects people's culture, neighborhood and way of life.

- Children's System of Care – focus to 0-18 years of age - The CSOC/TAY Family Partnership Center staff took more time to introduce TAY clients to Josie's Drop-In Center, connect with primary care physicians and BHRS services at 9th Street as well as Center for Human Services' Life Skills program. Also, Family Partnership Center (FPC) staff did outreach to Turlock and Oakdale by conducting age-appropriate support groups to help youth deal with peer issues. FPC also looked at 6-year-olds aging out of Leaps & Bounds and provided Tiny Tot Respite for families with children 0-5. FPC's Youth Advisory Council increased its involvement in sponsoring events for younger kids. The Leaps and Bounds (0 to 5) program coordinator reported the majority of referred females had significant history of trauma and AOD issues.

- Understanding Consumer/Family Member – focus on 18 to 21 age group – Transition Age Youth - Josie's Place Drop-In Center co-located a non-clinical team with two clinical service teams (Josie's TRAC, a Full Service Partnership, and Josie's Service Team). These teams increased collaboration with CSOC to serve 16 to 17 year olds, helping youth transition to adulthood and increasing family involvement. An article entitled "Client Culture" – Is There Such a Thing? Was published in the August 2008 edition of the department's Cultural Competency Update.

- Recovery Model - The representative from Stanislaus Recovery Center (SRC) said a large percentage of the population SRC served does not know how to live in society. SRC takes a holistic approach and depends heavily upon outside agencies and organizations (e.g., Soroptomists). Family groups were conducted in English and Spanish. Tai Chi and meditation were available and there was a clothes closet (to provide appropriate dress and enhance image). Volunteers developed a book of resources including clean and sober housing and basic needs.

- Continue monitoring Cultural Competency Action Plans - Anticipating receipt of Cultural Competence Plan Requirements from DMH, the CCOC continued to review data on a regular basis and to provide members with information about various cultures through guest presentations, sharing of learning from the Cultural Competence/Mental Health Summit, and discussion.

- Monitor Multicultural Supervision Evaluations - the BHRS Training Coordinator focused on multicultural supervision evaluations. She provided a handbook for cultural competence supervision, pilot training and two additional trainings to supervisors but was not successful obtaining evaluations. She attended a group supervision session where only four (4) individuals attended and two (2) completed evaluations. The Training Coordinator is moving forward to ask others who may be interested. She asked if the CCOC wants to continue to see if she can get more feedback from supervisors. This topic will be included in the new CBMCS curriculum. Our goal is to ensure supervisors address cultural competence.

- Focus on Recovery, Resiliency and Wellness - The Center for Human Services (CHS) representative announced purchase of the California Brief Multicultural Skills (CBMCS) curriculum. CHS has its own Cultural Competence committee. Training was provided on "The Culture of Poverty". The Consumer Network respondent described the comfortable, "coffee house" environment created in the NAMI/Consumer Network office on 9th Street. This is a place where people sit, relax, meet others and socialize. Observation was made that the stigma problem is sometimes within one's self. The Network is looking at ways to help correct this attitude. BHRS Quality Services described the "Documentation and Client Care Plan" training that was given. She advocated research on how clients view recovery and how they know they are getting better. SATT/SART focused on skills, strengths and abilities; recovery, resiliency and wellness. This program helped give individuals the skills necessary to function. They helped clients access information in the community and helped

them realize they have strengths. West Modesto King Kennedy Neighborhood Center (WMKKNC) reported two peer groups for depression and substance abuse. A second substance abuse group was added on Wednesday evenings because the Sunday group became too large. The Drop-In Center was opened to senior citizens to play cards whenever they want to. A "Growing for Health" garden would be planted in the Drop-In Center backyard.

- Spirituality –provide a Spirituality Training - The MHSA Workforce Education & Training Manager discussed "Spirituality and Wisdom" training that shows us how to talk about faith, how to ask questions and how to increase our comfort level with the topic.

  Cultural Competency Plan - DMH/Office of Multicultural Services did not release the final Plan Requirements until January 25, 2010.

Sources of Information:

Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department

CRITERION 5

COUNTY MENTAL HEALTH SYSTEM

CULTURALLY COMPETENT TRAINING ACTIVITIES

Rationale: Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).

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

The Department of Behavioral Health and Recovery Services established a training program as part of the overall strategic plan for the year 1998-1999 and developed specific goals related to staff training. One element of the training program was to establish specific training on cultural competencies required for culturally proficient staff.

In September 2001, BHRS approved a core competency training policy that identified core competencies for employees in various job classifications. This policy requires BHRS employees to complete specific training on core competencies necessary for their job. The core competencies vary based on the employee's classification, job and licensure requirements. Cultural Competency courses have been integrated into the core competencies policy. Since 1997, a faculty member in the Master of Social Work Program at CSU, Stanislaus has supervised the training program.

(See Policy 60.3.103, Core Competency Training in Appendix.)

In addition to the above core competency training, BHRS has developed a three year training plan in collaboration with the Training Advisory Committee.

WORKFORCE EDUCATION AND TRAINING PLAN

	New Curriculum Training Topic	Children & Youth System of Care	Transitional Age Youth	Adult System of Care (includes IFT)	Older Adult System of Care*	Managers & Supervisors
FY 2009-2010	Best Practices with Youth with Co-occurring AOD & MH	x				
	Working with Trauma within Transitional Age Youth		x			
	Application of Psychosocial Rehabilitation Techniques with Older Adults				x	
	Effective Strategies for Integration of Peer Staff in Mental Health Settings: Addressing stigma, dual relationships, role conflicts and other issues	x	x	x	x	x
	Mentoring and supervising peer staff employed in public mental health settings					x
FY 2010-2011	EBP or Promising Practice for Families and Family Systems	x				
	EBP or Promising Practice for Youth with first episode of mental illness		x			
	Suicide Prevention and Interventions for Older Adults				x	
	In depth Culturally Specific Engagement and Treatment Strategies: Asian Americans, African Americans, Latino, etc.	x	x	x	x	x
	Resources in Stanislaus County Public Mental Health: How to Collaborate and Integrate Services	x	x	x	x	x
	Stigma reduction strategies for all populations*	x	x	x	x	x
FY 2011-2012	EBP or Promising Practice Interventions with Youth involved in Gangs	x				
	In depth Culturally Specific Engagement and Treatment Strategies: Asian Americans, African Americans, Latinos, etc	x	x	x	x	x
	EBP or Promising Practice on Treatment Strategies for specific illness categories: depression, anxiety, psychosis, etc. for children and youth	x				
	Blending Harm Reduction and Recovery Strategies		x	x	x	
	Incorporating the concepts of Wellness Resilience & Client /Family Directed Services	x	x	x	x	
	Culturally Competent Services to Blended and non-traditional Families	x				

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

Cultural Competency Training Report
Stanislaus County Behavioral Health & Recovery Services
Fiscal Year: July 1, 2009 to June 30, 2010

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
Crossing Cultural Bridges	Introductory Workshop on Culture, Disparities and Sensitivity	4 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 10 3 0 9 Total= 22	8/27/09	Dorbea Cary
Cultural Competence Clinical Standards	Become familiar w BHRS Clinical Standard and Identify practices to improve services to diverse clients	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 14 0 0 4 Total= 18	10/29/09	Dorbea Cary
Partnering with the Customer	Includes topics of stigma, client culture, recovery and client directed services	4 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 8 3 0 18 Total= 29	8/18/09	Dorbea Cary, Tim White
Spirituality and Wisdom in Behavioral Health	Exploratory workshop on the meaning of spirituality and religion for clients	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	6 24 4 0 9 Total= 43	12/2/09	Jasbir Dhami, Kimberlee Hamilton, Jim Hurley, Marcus Martinez, Pauline Nou
Principles and Practices of Interpreting	Learn the role of interpreters and professional standards for use of interpreters	3 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 5 1 0 6 Total= 12	3/24/10	Marcus Martinez
Transition Aged Youth Dealing with	Learn effective engagement	6 hours	Management Direct Service Support Staff	4 31 1	3/16/10	Wayne Munchel

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
Trauma	tools and strategies for dealing w trauma		Interpreter Direct Service Contract Staff	0 51 Total= 87		
Families… the rest of the story	Learn how to partner with family members in providing mh services	3 hours 2x a year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	1 11 3 0 5 Total= 20	10/20/09	John Black
NAMI Provider Education 10 week Course	Overview of the experiences of mental illness from the perspective of the consumer & family member	30 hours 2x per year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	2 8 2 0 14 4 Total= 30	9/16/09 12/23/09	
Seeking Safety Day 1	Hands on skill building workshop on identifying, assessing & treating clients with dual diagnosis of PTSD and Substance abuse	12 hours annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	4 43 2 0 6 9 Total= 64	3/4/10	Kevin Reeder
Seeking Safety Day 2	Hands on skill building workshop on identifying, assessing & treating clients with dual diagnosis of PTSD and Substance abuse	12 hours annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	3 39 2 0 9 8 Total= 61	3/5/10	Kevin Reeder
Toward Effective Self Help Group Facilitator Training	Intro to self help group facilitation. Learn how to set up self help groups and plan successful meetings	12 hours 2x per year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	0 9 3 0 17 9 Total= 38	11/4/09 3/10/10	Ron Gilbert Sabrina Marquardt
Consumer & Family member	Introduction to volunteering in behavioral	16 hours 8 session workshop	Management Direct Service Support Staff	0 0 2	1/13/10 Eight-Week	BHRS Staff

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
Training Series	health services Overview of services & treatment	Annually	Interpreter Direct Service Contract Staff Community Members	0 0 13 Total= 15	Series	
Motivational Interviewing (6 week course)	Learn how to implement Motivational interviewing with clients	21 hours In 6 sessions Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 19 2 0 0 Total= 21	4/22/10 Six-Week Series	Elizabeth Oakes, Michael Wilson
IDDT Training	Overview of using IDDT tools in working with dually diagnosed clients	6 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 19 0 0 3 Total= 22	8/18/09	Elizabeth Oakes
The Asset Approach-40 Elements of Healthy Development	Learn how to use the 40 developmental assets to build resiliency with children and youth	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	1 17 4 0 9 Total= 31	12/9/09	Ruben Imperial, Kim Bull, Carla Skiles, Shanette Williams
Basic M.I. for Engaging Youth and Families	Learn how to use motivational interviewing to engage with children and families	5 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	4 13 0 0 1 Total= 18	2/18/10	Jenny Bates
Advanced M.I. for Engaging Youth and Families	Learn more advanced skills in using MI to engage youth and families	5 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 12 0 0 1 Total= 16	3/26/10	Jenny Bates
Working with Youth & Families with Co-Occurring AOD/MH Issues	Learn current substances youth are abusing & a curriculum for address co-occurring AOD/MH issues	12 hours 3module Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 22 0 0 9 Total= 34	4/21/10	Michael Brewer, Michael Greenlee
Supervising Staff with Lived Experience: What's different &	A dialogue w Supervisors to address stigma & create a welcoming	6 hour training annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	20 0 1 0 1	6/8/10	Jim Hurley June Newman Ron Gilbert Dorbea Cary

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
what's not.	environment for staff w lived experience			Total=22		
Behavioral Health & Prevention Summit	History and emerging promise of community capacity building in Stanislaus County; Introduction to Results Based Accountability	7 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	Total= 276	5/10/10	Mark Friedman John Ott

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

This fiscal year BHRS, in partnership with the Center for Human Services (CHS), will be utilizing a new evidence based cultural competency curriculum, the California Brief Multicultural Competence Scale (CBMCS) Training Program. This 32-hour training curriculum uses a 21–item scale developed to measure self-reported multicultural competencies of mental health practitioners. The scale consists of four subscales each corresponding to a training module. The curriculum provides an expanded definition of cultural competency to include content on oppressed groups of racial/ethnic minorities and content of other oppressed groups including women, gays and lesbians, individuals with disabilities, the elderly and content on sensitivity and responsiveness to consumers.

Two trainers from BHRS and one from CHS, have completed a Train-The-Trainer process developed by several of the master trainers who originally developed the curriculum. The first CBMCS training for Stanislaus County occurred on July 15 and 16 and August 10 and 11, 2010. At this time, it is expected that the CBMCS training will be repeated twice a year for the next three years. Given budget concerns and programs operating with few staff, discussions are in progress regarding the method to train the most staff within the next three years.

The CBMCS training will replace and update three existing BHRS cultural competency workshops, i.e., Crossing Cultural Bridges, Cultural Dialogues and the Cultural Competency Clinical Standards developed by WICHE. The BHRS core competency training policy will be revised to reflect these changes. All BHRS staff will be required to take between one and four modules depending on their

job classification. The new core competency training requirements for the CBMCS Training are the following:

- BHRS administrative and support staff will be required to take one module each year and complete all modules within four years.
- BHRS alcohol and drug staff in residential and outpatient programs will be required to take at least two modules within three years.
- BHRS direct service staff including Behavioral Health Specialists, Behavioral Health Advocates, Clinicians, Nurses, Psychologists, Supervisors, Managers will be required to take all four modules within three years.

Use the following format to report the above requirements:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Example: *Cultural Competence Introduction*	*Overview of cultural competence issues in mental health treatment settings.*	*Four hours annually*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	*15* *20* *4* *2* *Total: 41*	*1/24/10*	

Cultural Competency Training Report
Stanislaus County Behavioral Health & Recovery Services
Fiscal Year: July 1, 2009 to June 30, 2010

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
Crossing Cultural Bridges	Introductory Workshop on Culture, Disparities and Sensitivity	4 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 10 3 0 9 Total= 22	8/27/09	Dorbea Cary
Cultural Competence Clinical Standards	Become familiar w BHRS Clinical Standard and Identify practices to improve services to diverse clients	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 14 0 0 4 Total= 18	10/29/09	Dorbea Cary
Partnering with the Customer	Includes topics of stigma, client culture,	4 hours Annually	Management Direct Service Support Staff	0 8 3	8/18/09	Dorbea Cary, Tim White

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
	recovery and client directed services		Interpreter Direct Service Contract Staff	0 18 Total= 29		
Spirituality and Wisdom in Behavioral Health	Exploratory workshop on the meaning of spirituality and religion for clients	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	6 24 4 0 9 Total= 43	12/2/09	Jasbir Dhami, Kimberlee Hamilton, Jim Hurley, Marcus Martinez, Pauline Nou
Principles and Practices of Interpreting	Learn the role of interpreters and professional standards for use of interpreters	3 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 5 1 0 6 Total= 12	3/24/10	Marcus Martinez
Transition Aged Youth Dealing with Trauma	Learn effective engagement tools and strategies for dealing w trauma	6 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	4 31 1 0 51 Total= 87	3/16/10	Wayne Munchel
Families… the rest of the story	Learn how to partner with family members in providing mh services	3 hours 2x a year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	1 11 3 0 5 Total= 20	10/20/09	John Black
NAMI Provider Education 10 week Course	Overview of the experiences of mental illness from the perspective of the consumer & family member	30 hours 2x per year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	2 8 2 0 14 4 Total= 30	9/16/09 12/23/09	
Seeking Safety Day 1	Hands on skill building workshop on identifying, assessing & treating clients with dual diagnosis of PTSD and Substance abuse	12 hours annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	4 43 2 0 6 9 Total= 64	3/4/10	Kevin Reeder

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
Seeking Safety Day 2	Hands on skill building workshop on identifying, assessing & treating clients with dual diagnosis of PTSD and Substance abuse	12 hours annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	3 39 2 0 9 8 Total= 61	3/5/10	Kevin Reeder
Toward Effective Self Help Group Facilitator Training	Intro to self help group facilitation. Learn how to set up self help groups and plan successful meetings	12 hours 2x per year	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	0 9 3 0 17 9 Total= 38	11/4/09 3/10/10	Ron Gilbert Sabrina Marquardt
Consumer & Family member Training Series	Introduction to volunteering in behavioral health services Overview of services & treatment	16 hours 8 session workshop Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff Community Members	0 0 2 0 0 13 Total= 15	1/13/10 Eight-Week Series	BHRS Staff
Motivational Interviewing (6 week course)	Learn how to implement Motivational interviewing with clients	21 hours In 6 sessions Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 19 2 0 0 Total= 21	4/22/10 Six-Week Series	Elizabeth Oakes, Michael Wilson
IDDT Training	Overview of using IDDT tools in working with dually diagnosed clients	6 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	0 19 0 0 3 Total= 22	8/18/09	Elizabeth Oakes
The Asset Approach-40 Elements of Healthy Development	Learn how to use the 40 developmental assets to build resiliency with children and youth	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	1 17 4 0 9 Total= 31	12/9/09	Ruben Imperial, Kim Bull, Carla Skiles, Shanette Williams
Basic M.I. for Engaging Youth and Families	Learn how to use motivational interviewing to	5 hours	Management Direct Service Support Staff Interpreter	4 13 0 0	2/18/10	Jenny Bates

Training Event or Workshop Title	Description of Training	Number of Hours and How often	Attendance by Function	# of Attendees & Total	Date Training Held	Trainer or Presenter
	engage with children and families		Direct Service Contract Staff	1 Total= 18		
Advanced M.I. for Engaging Youth and Families	Learn more advanced skills in using MI to engage youth and families	5 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 12 0 0 1 Total= 16	3/26/10	Jenny Bates
Working with Youth & Families with Co-Occurring AOD/MH Issues	Learn current substances youth are abusing & a curriculum for address co-occurring AOD/MH issues	12 hours 3module Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 22 0 0 9 Total= 34	4/21/10	Michael Brewer, Michael Greenlee
Supervising Staff with Lived Experience: What's different & what's not.	A dialogue w Supervisors to address stigma & create a welcoming environment for staff w lived experience	6 hour training annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	20 0 1 0 1 Total=22	6/8/10	Jim Hurley June Newman Ron Gilbert Dorbea Cary
Behavioral Health & Prevention Summit	History and emerging promise of community capacity building in Stanislaus County; Introduction to Results Based Accountability	7 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	Total= 276	5/10/10	Mark Friedman John Ott

CBMCS Multicultural Training Program

Module One- Multicultural Knowledge. This training module is a review of the demographic, historical and cultural context of four major minority groups as well as other groups in the U.S., documentation of unmet mental health needs, deficiencies in research, cultural competency defined, awareness of cultural factors and one's cultural self, and DSM IV cultural formulation.

Module Two-Awareness of Cultural Barriers. This module focuses on cultural values and beliefs, definitions of prejudice, discrimination, racism, white privilege, and heterosexism. Participants are introduced to racial Identity development models and white identity models and the clinical implications for working with multicultural clients and families.

Module Three- Sensitivity and Responsiveness to Consumers. This modules covers communication styles, stereotyping of groups, the effects of racism on consumers, use of active engagement and guiding principles for sensitive and responsive practice.

Module Four- Sociocultural Diversities. This module focuses on other diversities including older adults, gender and culture, sexual orientation, socioeconomic status and person with disabilities.

Principles and Practices of Interpreting

Principles and Practices of Interpreting is required for all direct-service providers, including clinicians, behavioral health specialists, nurses, psychologists, psychiatrists, clinical services technicians and staff and contract agency staff who provide interpreter services. Participants learn the importance of briefing and debriefing and managing the triad between the client, professional and interpreter. Legal and ethical issues are presented along with the limitations and benefits of using interpreters. Participants practice their skills doing a role play. This training is a core requirement for all direct service staff. This workshop was cancelled this year due to low attendance.

Client Culture- Partnering with the Customer

Partnering with the Customer is a very successful training developed and by consumers and family members and staff. The workshop trainers consist of consumer/family members, staff and volunteers who are or have been consumers. The learning objectives are the following: a) Learn key concepts for developing partnerships with clients and families, b) understand how stigma, language, hierarchical relationships can negatively impact clients and families, c) Learn how rights and responsibilities increase client's sense of strength and self-confidence, d) develop a plan of action to partner with clients and families.

Family Class for Providers

John Black, Family Advocate, recently revised the training on family members experiences. Family members participate on a panel and on videotape to share their stories. The workshop is called "Families: The Rest of the Story". This workshop is required of all direct-service providers and management staff. Participants learn what it is like to experience mental illness from a family member's perspective. They learn how to interact with families and build a collaborative relationship with families. This training is a core competency for direct service staff. Results: 39 staff and contract staff attended this training in 2009.

National Alliance for Mentally Ill Provider Education Course

NAMI continues to offer a ten week Provider Education Course this year to BHRS staff, contract staff and other community providers. This course is taught by a team consisting of family members, consumers and providers. Both staff and community members are encouraged to attend. The training focuses on current research on mental illness, the experience of mental illness from the consumer and family perspective and a model of collaborative treatment. Staff feedback from those who took the course found the information and discussions to be informative and useful to their jobs.

Lesbian, Gay, Bisexual and Transgender Training for Service Providers

BHRS offers an introductory and advanced workshop in LGBT training. The objectives for the introductory workshop are the include the following: a) Understand the issues and importance of accessibility, b) Identify the myths/stereotypes vs. the facts related to LGBT populations, c) Understand the impact of cultural victimization, d) learn how to create a safe & welcoming environment for this population. The advanced training is specifically for clinicians and direct services providers. The learning objectives for this workshop are the following; a) to increase knowledge of the

transgender population, b) To understand the coming out process, c) To learn how to address cultural victimization, d) to identify effective clinical strategies with this population.

Spirituality & Wisdom in Behavioral Health

The purpose of this training is to provide an opportunity for participants to openly explore issues of faith/spirituality/religion in their work with consumers and families. The training engages participants in an exploratory dialogue, an examination of spiritual beliefs and practices, and provides basic information about engagement and how to respond to the issue of faith/spirituality/religion with people we serve. The learning objectives for this training include the following: a) Create dialogue, encourage curiosity, and enhance provider's exploration about faith, spirituality or religious beliefs, b) Share the richness and differences of various beliefs and traditions, c) Discover the shared meaning and experience among individuals with different beliefs, e) Explore concerns and benefits of engaging in faith/spiritual/religious conversations with consumers and families who receive services, Increase participant's comfort in discussing spiritual issues with consumers and families, and f) Learn new ways to work with consumers and families related to spirituality

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

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

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

Trainings help to ensure that BHRS has a well trained workforce where each employee has the minimum competencies necessary to do their job in a culturally competent manner. The trainings provide the necessary job training to employees in an ever-changing environment in order to provide quality services to consumers served by the Department.

Emphasizing MHSA, specific training content and course design were reviewed and updated to ensure that the essential elements of MHSA were included. To ensure a quality approach to content and design, course evaluations were revised for all trainings to track whether consumer/family member expertise, cultural competency, and recovery and resiliency were included in these trainings. The following questions were added to the course evaluation and instructor evaluations:

- This training includes content on family/consumer perspective
- This training includes content on diversity issues.
- The instructor includes content on diversity, includes family/consumer perspective and the concepts of recovery and resiliency.

Some of the ways that we have included the family/consumer perspective has been to invite consumers and family members to share their stories as part of a panel presentation or as a guest speaker or presenter as part of the training. Efforts are made to include diversity in these panels. Some of the trainings using consumer/family member panels and presenters include the following: Partnering with the Customer, Spirituality and Wisdom, Families: The Rest of the Story, Supervising Staff with Lived Experience: What's different and what not, Milestones in Recovery from Mental Illness, and Asset Approach to 40 Elements of Health Development. In addition, staff with lived experience were trained in how to be a trainer so that they can participate as trainers for the Department.

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

All workshops offered at BHRS have an evaluation that employees complete at the end of the workshop. Both the instructors and the course content are evaluated. The Training Program has a goal of 80% satisfaction with workshops and instructors. The Training Coordinator reviews all evaluations and meets with instructors as needed. All instructors are sent a copy of their training evaluation. Instructors review evaluations and feedback, and improvements are made to the curriculum when necessary for all core competency workshops. In addition, there are several opportunities to use the CBMCS training for outcome evaluations. The scale may be administered before and after training to evaluate the impact of the training.

3. Summary report of evaluations; and

Training evaluations support MHSA transformation The BHRS Training Department tracks the evaluation ratings and reviews and notes what additional content needs to be included in training. Results from for the FY2009/2010 training evaluations are the following:

- Over 91% of training participants indicated that the trainings they attended included content on diversity.
- Over 93% of training participants indicated that consumer and family perspective was included.

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

The CBMCS curriculum also includes content mastery exams to evaluate the extent to which participants are able to retain the material covered for a particular module. The Cultural Competency Oversight Committee will be developing a method of monitoring these curriculum outcomes. Furthermore, BHRS has made a commitment to the development of leadership in culturally competent practices by training managers and coordinators to be role models of cultural competency for their programs. This is accomplished by training them to facilitate brief discussions/trainings on specific cultural competency topics during a staff or program meeting. These trainings are referred to as "Training-in-a-Box" since all materials are provided to the trainers in a box or tube. Four discussion topics were identified by the Cultural Competency Oversight Committee for this project:

- Stigma and language in the workplace
- Cultural humility with the Latino population
- Education about the Lesbian, Bisexual, Gay, and Questioning (LBGQ) population
- Promoting Recovery and Resilience

To date, 288 staff have participated and 35 program managers have facilitated the anti-stigma training called "Labels are for Jars: Using Person First Language in the Workplace". Comments include: *"This information makes you think before speaking"* and *"Group participation is a great way to learn and understand ideas".* This training and the "Training-in-a-Box" idea were identified as best practices and presented by the Training Coordinator to the Stanislaus County Equal Rights Commission in April 2009.

The following trainings entitled "Engaging the Latino Community through Cultural Humility" and "The Invisible Diversity: Gay, Lesbian, Bisexually Oriented and Questioning Persons" have been presented at the monthly Leadership Meetings. The latter training included four objectives, i.e., a) staff will identify myths and misconceptions about lesbian, gay or bi-sexual youth, adults, and older adults that are unfounded, b) staff will increase their sensitivity and awareness of some issues that lesbian, gay, bi-sexual families face regarding their health and mental health care, c) staff will survey their own attitudes about this population and reflect on them, and d) staff will identify several strategies they can use to provide a safe and non-judgmental work environment that treats everyone with the utmost

respect. The intent was for managers and coordinators to subsequently deliver the two trainings to their teams. Due to the current economic crisis resulting in program reductions, implementation has been slower than anticipated. So far, "Engaging the Latino Community" module has been presented to 56 staff and 11 programs have completed this training. "The Invisible Diversity: module has been presented to 41 staff and four programs have completed this training.

The last module is projected to roll out in this fiscal year.

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

The BHRS Core Competency Training Policy requires immediate supervisors to ensure employees attend all required training. Annual performance evaluations reviews will indicate progress toward completion of the required core competency workshops and employees will be evaluated on their progress to complete training within the required time frames. The Trainings in a Box also provide a means of onsite training that can be reviewed and discussed in the context of the actual treatment or prevention venue.

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.

Note: The following explanation is offered to assist counties in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in

a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer. Clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system, and their own ethnic culture. These personal experiences and beliefs can be used to empower clients to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

As noted above, the following trainings deal with Client Culture: Partnering with the Customer, Spirituality and Wisdom, Families - The Rest of the Story, Supervising Staff with Lived Experience: What's different and what not, Milestones in Recovery from Mental Illness, and Asset Approach to 40 Elements of Health Development. Following is a brief explanation of several of the courses.

Client Culture- Partnering with the Customer

Partnering with the Customer is a very successful training developed and by consumers and family members and staff. The workshop trainers consist of consumer/family members, staff and volunteers who are or have been consumers. The learning objectives are the following: a) Learn key concepts for developing partnerships with clients and families, b) understand how stigma, language, hierarchical relationships can negatively impact clients and families, c) Learn how rights and responsibilities increase client's sense of strength and self-confidence, d) develop a plan of action to partner with clients and families.

Families – The Rest of the Story

The BHRS Family Advocate recently revised the training on family members experiences. Family members participate on a panel and on videotape to share their stories. This workshop is required of all direct-service providers and management staff. Participants learn what it is like to experience mental illness from a family member's perspective. They learn how to interact with families and build a collaborative relationship with families.

National Alliance for Mentally Ill - Provider Education Course

NAMI continues to offer a ten week Provider Education Course to BHRS staff, contract staff and other community providers. This course is taught by a diverse team consisting of family members, consumers and providers. Both staff and community members are encouraged to attend. The training focuses on current research on mental illness, the experience of mental illness from the consumer and family perspective and a model of collaborative treatment. Staff feedback from those who took the course found the information and discussions to be informative and useful to their jobs.

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

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

Use the following format to report the above requirements:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Example *Cultural Competence Introduction*	*Overview of cultural competence issues in mental health treatment settings.*	*Four hours annually*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	*15* *20* *4* *2* *Total: 41*	*1/24/10*	

The Asset Approach-40 Elements of Healthy Development	Learn how to use the 40 developmental assets to build resiliency with children and youth	6 hours Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	1 17 4 0 9 Total= 31	12/9/09	Ruben Imperial, Kim Bull, Carla Skiles, Shanette Williams
Basic M.I. for Engaging Youth and Families	Learn how to use Motivational Interviewing to engage with children and families	5 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	4 13 0 0 1 Total= 18	2/18/10	Jenny Bates
Advanced M.I. for Engaging Youth and Families	Learn more advanced skills in using MI to engage youth and families	5 hours	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 12 0 0 1 Total= 16	3/26/10	Jenny Bates
Working with Youth & Families with Co-Occurring AOD/MH Issues	Learn current substances youth are abusing & a curriculum for address co-occurring AOD/MH issues	12 hours 3module Annually	Management Direct Service Support Staff Interpreter Direct Service Contract Staff	3 22 0 0 9 Total= 34	4/21/10	Michael Brewer, Michael Greenlee

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

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

Rationale: The diversity of an organization's staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring diverse and bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).

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

The county shall include the following in the CCPR:

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

See MHSA Workforce Needs Assessment in Appendix.

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

Stanislaus County's General population for 2007 was 511,263, according to estimates prepared by Dr. Charles Holzer, Ph.D, in the "CPES Estimates of Need for Mental Health Services Report of 2007) In the table below are WET Plan Assessment comparisons to the Stanislaus County General Population, Medi-Cal and 200% poverty data. The Stanislaus County WET Plan was approved in January 2008. The staffing levels in the WET Plan Assessment column are from 2007. These staffing levels include County, Community Based Organizations, independent contractors and volunteers.

Staff Race & Ethnicity	WET Plan Assessment/Staffing levels	General Population	Medi-Cal	200% of Poverty
Hispanic	19%	39.03%	51.42%	54.28
Caucasian	49%	50.18%	33.19 %	33.69%
African-American	6%	2.73%	3.96 %	3.20 %
Asian Pacific Islander	9 %	5.22%	5.50 %	6.02
Native American	1 %	.75%	.32%	.71%

Listed below in (D) are some of the objectives that BHRS has achieved in assisting to grow a multicultural workforce. Despite the hiring freeze, BHRS has made efforts to continue to recruit staff from diverse cultural backgrounds.

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.

There were no recommendations from the cultural consultant regarding our WET Plan.

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

The following objectives were met:

- In FY 2009/2010 Despite a hiring freeze and an emphasis placed on education and training, BHRS hired twenty (20) new part time staff. Of the twenty new hires, ten or 50% were staff from ethnically diverse backgrounds.

  50% Non Hispanic White
  30% Asian/Pacific Islander
  15% Hispanic
  5% African-American

- Forty-four (44) financial stipends were awarded to CASRA/Human Services students at Modesto Junior College.
  All 44 stipend students had lived experience as consumers or family members. In addition the students were from the following ethnic groups:

  52% Non Hispanic White (23)
  23% Hispanic (10)
  20% African- American (9)
  2% Native American (1)
  2% Asian/Pacific Islander (1)

- Twenty-two (22) program managers and coordinators from BHRS completed the first training entitled “Supervision of Staff with Lived Experience”.

- Four MSW students received financial stipends from CSU, Stanislaus. Three self identified as Latina, two were bi-lingual in Spanish and two identified as consumers or family members.

- In FY09/10, six African American junior high students completed the Wellness Project through West Modesto King Kennedy Neighborhood Collaborative.

- A contract was signed between Modesto City School District and BHRS to add a behavioral health component to the Health Academy at Davis High School. In March 2010, 12 Health Academy students had the opportunity to participate in BHRS service sites to fulfill their Academy Practicum requirement.

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

The value and necessity of building relationship community partnerships.

- The Workforce Education and Training plan included a multitude of partnerships in the community, including educational institutions. As an example, BHRS was able to add a behavioral health component to the existing Davis High School Health Academy.

- The securing of a contact with Davis High School was the end result of meetings, discussions, and the sharing of ideas, as could be expected. However, what made the biggest difference was creating a working relationship, based on trust, following through with commitments made, and the cultivation and alignment of a shared vision.

- For example, neither BHRS nor Davis High School wanted to administratively distribute stipends for academy seniors. This was a difficult contractual issue. It was resolved to both parties satisfaction because sufficient trust and partnership allowed for frank and open discussions to work it out.

- The lesson of trust and partnership was also true for other contracts BHRS gained with CSU, Stanislaus and West Modesto King Kennedy Neighborhood Collaborative.

F. Identify county technical assistance needs.

- Training entitled: *Job Accommodations* with Jane Kow, Esq. An excellent overview of employers' obligations, under federal and state disability laws to provide reasonable accommodations to employees with psychiatric disabilities.

- Training entitled: *Job descriptions* with Roberta Etcheverry. This training provides guidance on how to create effective job descriptions that clearly identify essential job functions when recruiting, hiring, retaining and accommodating consumers and their family member staff.

CRITERION 7

COUNTY MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

Rationale: Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the language of the client that includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). The DMH will provide threshold language data to each county.

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.

Standard language in all recruitment flyers and transfer memos include bilingual language skills as desirable. **(See copies of Recruitment flyers and transfer memo's in Appendix**). Language also includes a strong commitment to and demonstrated skills in provision of culturally competent services to diverse populations, consistently utilizing multicultural skills, knowledge and experience. Interpreter's list is kept and updated on interdepartmental intranet for all staff. Countywide listing is also available

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.

In FY 2009/2010, there were 29- bi-lingual staff in MHSA programs. Twenty three of these staff were bi-lingual Spanish speaking. The other six spoke Laotian, Cambodian, Punjabi and Hindi. Overall these twenty nine staff received $41,181.35 in bi-lingual pay for FY 09/10.

3. Total annual dedicated resources for interpreter services.

In FY 2009/2010, $7,877.00 was spent on contracted interpreter services. For FY 2010/2011 $87,000.00 has been allocated for contracted interpreter services

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.

BHRS has established policies and procedures for ensuring services to limited English-speaking clients and family members are in the individual's preferred language. The preference is for services to be provided by bilingual staff, followed by use of interpreters and finally through use of the language line. The policy expressly prohibits the use of children and adolescents as interpreters for family members and requires the presence of a trained interpreter even if the individual requests that an adult family member translate.

During regular business hours, employees who speak Spanish, Farsi and Assyrian staff the 24-hour access line. After hours, staff who answer the 24-hour access line are more likely to use the language line because there is access to fewer bilingual staff. All individuals who staff the access line receive training on BHRS language assistance policies, use of the language line and use of TDD.

See Policies 50.1.100 & 90.1.106, in Appendix

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

We are considering telemedicine options as part of our MHSA Technological Needs Component.

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

Embedded in the policy reference above (90.1.106) is the process for using the language line.

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.

All staff have the number for the 24-hour access line. It is part of the materials that they provide to the individuals seeking services. The employees who staff the 24-hour access line are specifically trained on meeting the client's linguistic needs.

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

BHRS expects all program sites, including contract providers, to post information regarding client rights to language assistance services. We monitor this through the Managed Care Quality Improvement Committee with a Medi-Cal key indicator, i.e., "Notices regarding free language assistance are posted at all sample sites". Quality Services staff routinely check for the presence of

the posting whenever they have occasion to visit a program site, such as during site certification visits. During FY09/10, 21 sites visited during the year and 97% complied with this requirement. When a program does not have the poster visible, Quality Services staff inform the coordinator of the requirement and return to the site to ensure it is posted. This information is also available in the materials that clients receive when they seek specialty mental health services.

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.

When scheduling an assessment for specialty mental health services, access line staff always ask the individual's preferred language and offer to arrange for an interpreter for the assessment if the preferred language is not English. Of 1,416 assessments scheduled in FY 2007/2008, 72 (5%) of callers accepted our offer of an interpreter. More than half of the 72 identified their primary language as Spanish, which is the only threshold language in Stanislaus County. In FY 2008/2009, 56 (4%) of 1,303 callers who scheduled assessments accepted the offer of an interpreter. Just under half of the 56 callers were primarily Spanish-speaking. For FY 09/10, 53 (5%) of 1073 individuals who were scheduled assessments accepted an offer of an interpreter. Of these 26 (49%) 53 were Spanish speaking

In general BHRS clinical staff have communicated that clients/family members are appreciative of having an option to have a male or female interpreter. In some cases, clients have communicated that they prefer using the same interpreter each time. We've also had clients request another interpreter because at times the interpreter may not speak the regional dialect as the client. Another anecdotal example is from one of our Access Line (800 number) staff who speaks Assyrian. This staff states her experience has been that Assyrian speaking clients get very excited and relieved when the clients are able to communicate in Assyrian.

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

Test calls by DMH staff during triennial system reviews have presented challenges, especially for limited English-speaking callers. In FY2008/2009, we implemented a protocol for routine test calls to the access line, which is supervised by the Quality Services Manager and monitored by the Managed Care QIC as a Medi-Cal key indicator. Each quarter a minimum of six test calls are placed, some of which are in languages other than English. The callers use a format similar to the one used by the DMH test callers. Each caller provides written and verbal feedback to the Quality Services Manager, who in turn shares the information with access line staff and supervisor and provides the data for the Medi-Cal key indicator, "Limited English-speaking callers to the access line were given information in their preferred language". During FY 2008/2009, the two limited English-speaking test callers said they were provided information in their preferred language. During FY2009/2010, 75% of the LEP test callers were provided information in their preferred language. We are increasing our efforts to recruit test callers who speak languages other than English.

E. Identify county technical assistance needs.

None identified at this time.

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.

BHRS understands the importance of having a work force that mirrors the population we serve. This is especially important with regard to our ability to recruit and retain Spanish-speaking staff. Our established expectation is that every "front door" or key point of contact will have Spanish-speaking staff (our threshold language), and we have designated bilingual positions at every program site. We monitor our ability to retain Spanish-speaking staff through our annual quality management action plan. In FY2007/2008, 24% of county population were Spanish-speaking and 23% of 467 BHRS staff were Spanish-speaking, which includes 22% of direct services staff and 30% of support service staff. Even with the reduction of more than 40 staff in FY2008/2009, we were successful in retaining 22% of direct services staff and 29% of support services staff who speak Spanish. For both years, 13% of our management staff were bilingual in Spanish. We did not have further staff reductions during FY09/10, but implemented a strategic hiring freeze, which resulted in decreased from 424 to 416. The diversity of our work force declined slightly, but continues to be generally reflective of our community. Overall, 21% of our staff are Spanish-speaking, including 20% who provide direct services and 31% who provide support services

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.

BHRS expects all program sites, including contract providers, to post information regarding client rights to language assistance services. We monitor this through the Managed Care QIC with a Medi-Cal key indicator, "Notices regarding free language assistance are posted at all sample sites". Quality Services staff routinely check for presence of the posting whenever they have occasion to visit a program site, such as during site certification visits. In addition to Spanish, we have staff and interpreters who speak Cambodian, Laotian, Assyrian, Tagalog, Vietnamese, Hmong, Hindi, Portuguese, Farsi, French, and American Sign Language. If neither a bilingual staff member or an interpreter is available, we use the Language Line or TTD

BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

Denise C. Hunt, RN, MFT
Behavioral Health Director
800 Scenic Drive, Modesto, CA 95350
Phone: 209.525.6225
Fax 209.525.6291

CULTURAL INTERPRETERS

This list is for employee use only. Please do not share with clients.

Interpreters may be contacted in the following order of priority:
1. BILINGUAL STAFF (for Spanish) 2. CONTRACTOR 3. EXTRA HELP 4. FULL-TIME STAFF 5. LANGUAGE LINE*

CONTRACT INTERPRETERS: (One-hour cancellation notice required)					
NAME (Male/Female)		LANGUAGE	CONTACT NUMBERS (Cell phone calls preferred) CELLPHONE	WORK	HOME
Mohsin Ibriahim	(M)	Arabic	324-8701		572-4595
John Daoud	(M)	Armenian/Arabic	535-7733		632-6377
Homer David	(M)	Assyrian/Arabic	277-9500		668-3684
Gladis Karam	(F)	Assyrian/Farsi/Afghani	352-0486		632-4606
Frank Khoubiar	(M)	Assyrian/Farsi/Turkish/ Armenian			669-3727
Linda Rith	(F)	Cambodian	499-1411		541-0766
Van Long Tun	(M)	Cambodian	872-0542	571-0349	521-6750
Marge Leopold *(The Bridge – SCVF)*		Cambodian/Khmer		595-9852	
Mei Xie-McGar	(F)	Cantonese, Mandarin, Hakka	556-3043		
Marcy Pena	(F)	Filipino	914-1087		839-8609
Kathleen Aguinaldo	(F)	Filipino/Tagalog	604-8395		
Teddy Alvarado	(M)	Hearing Impaired	312-3758		
Jorie Baltz	(F)	Hearing Impaired	620-4169		634-6775
NorCal *($125/hour base rate) (24 hr fax cancellation notice required – fax (916) 349-7578)*		Hearing Impaired	474-8996 (Voice/TTY)	(916) 349-7525 (877) 866-7225	(866) 658-8417 (Emergency/after hours)
Ritu Dutt	(F)	Hindi/Punjabi	985-8742		526-6430
Melanie Moua	(F)	Hmong			574-0796
Marge Leopold *(The Bridge – SVCF)*		Hmong		595-9852	
Say Sosongkham	(M)	Lao/Thai	996-4182		
Marge Leopold *(The Bridge – SVCF)*		Laotian		595-9852	
Suzanna Adamova	(F)	Russian/Ukrainian	535-3987		
Jossara Pires	(F)	Spanish/Portuguese	606-7771		527-3953
*Language Line *(Call Contracts for Acct. #)*		*Refer to BHRS Policy No. 90.1.106 for detailed instructions.*			(800) 523-1786
EXTRA HELP STAFF INTERPRETERS:					
Teresa Garza (SRC)	(F)	Spanish	761-6203	541-2155	726-1604
FULL TIME STAFF: (Contact Senior Leader In Advance for Overtime Approval)					
Alice Tamraz (TRS)	(F)	Assyrian/Farsi/Afghani	534-8422	664-8044	
Patrice Phengdy (BHS)	(M)	Cambodian/Lao/Thai	244-5993	558-3612	477-2385
Ath Kittiphane (TAYA)	(F)	Lao	614-0811	558-4464	
Keo Silim (FPC)	(F)	Lao	(562)453-9552	558-7494	531-0995

For help in reaching interpreters, please call the Contracts Office at 525-6268.
New information on interpreter contact numbers will be appreciated.
View this list on the BHRS Intranet, from the Homepage – Phone Lists, click on Cultural Interpreters Phone.

Rev 01/11/11
G:\WORDDATA\Contracts\Interpreters\Administration\InterpretersList_current.doc

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

When scheduling an assessment for specialty mental health services, access line staff always ask the individual's preferred language and offer to arrange for an interpreter for the assessment. Of 1,416 assessments scheduled in FY2007/2008, 72 (5%) of callers accepted our offer of an interpreter. More than half of the 72 identified their primary language as Spanish, which is the only threshold language in Stanislaus County. In FY08/09, 56 (4%) of 1,303 callers who scheduled assessments accepted the offer of an interpreter. Just under half of the 56 callers were primarily Spanish-speaking**.** For FY 2009/2010, 53 (5%) of 1073 who were scheduled assessments accepted an offer of an interpreter. Of these, 26 (49%) were Spanish speaking.

Quality Services staff coordinate routine chart review processes for all outpatient specialty mental health services. The review worksheet includes the question, "If the client is monolingual, non-English speaking, is there documentation that a translator was used?" In FY2008/2009, 295 charts were reviewed, of which 18 identified the client as monolingual, non-English speaking. Of the 18, only one did not clearly document use of translator. In FY 2009/2010 265 were reviewed, of which 19 identified the client as monolingual, non-English speaking. Of these 19, five charts did not clearly document of a translator.

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

Of nine major contractors, approximately 21% of all of the contract staff are Spanish-speaking. The contractors range from 11% of their staff who are Spanish-speaking to 100%.

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

It is the practice of Stanislaus County to provide a bilingual fluency examination for staff in languages other than English. The purpose of this examination is to certify that staff have been able to demonstrate communication skills in the areas of pronunciation, fluency, listening comprehension and resourcefulness in the language being tested in order to provide full-service delivery to County customers. This applies to Stanislaus County employees and Personal Service Contractors, excluding managers. In addition, Stanislaus County and Personal Service Contractors must attend the BHRS Principles and Practices of Interpreting Training. Bilingual pay of $0.69/hour is given to those who successfully pass this examination.

Below is the sample template that BHRS uses when contracting with interpreters

SAMPLE – EXHIBIT A – CULTURAL INTERPRETERS

A. SCOPE OF WORK

1. Contractor shall provide translation services for certain language spoken and speaking clients on an "as needed" basis.

2. Contractor is expected to attend all mandatory trainings for Interpreters within six (6) months from Agreement start date or as scheduled. BHRS shall notify Contractor of the date of the trainings.

3. Contractor shall perform translation services in a professional manner and in accordance with the following guidelines:

a. **Confidentiality:** In order to insure that all health care interactions are kept private and personal, Contractor shall not reveal information about any translation assignment or client outside the work site. Contractor shall not reveal to anyone outside the work site that the translation service was or is being performed, or in any other way identify or acknowledge the client. When the client is unaware of or has a question about the interpreter's role with regard to confidentiality, it is the Contractor's responsibility to explain it to the client.

b. **Accuracy:** To enable all parties to know precisely what each speaker has said, Contractor shall translate everything that is said by all parties present in a session. Contractor

shall accurately and completely convey the content and spirit of the original message of each speaker into the other language, without omitting, modifying, condensing or adding to that message. Contractor must transmit everything that is said in the same way it was intended, using language that is most readily understood by the other party. If Contractor cannot accurately and faithfully translate everything that is said, for any reason, Contractor must immediately advise all parties. Contractor must remember that he/she is not responsible for what is said, only for translating it accurately, and must refrain from interjecting the Contractor's personal opinions, beliefs, biases or issues into the translation. If the Contractor's personal feelings interfere with translating the message accurately, Contractor must discontinue working, immediately notify all parties, so another interpreter may be engaged to complete the assignment, and, note that end time on the Time Record.

c. **Conflict of Interest:** Contractor shall refrain from providing translation services in any situation that involves Contractor's family members, close personal friends or where other professional relationships exist between the client and Contractor. Contractor must be impartial in order to insure there is no interpreter bias, prejudice or preference. Contractor should avoid casual conversation with the client, before, during or after the actual interpreter task, in order to respect the client's personal privacy and to avoid tainting later translation duties. Contractor shall refrain from contact with the client outside the scope of the translation duties, including any personal or professional contact that could provide personal benefit to Contractor.

d. **Boundaries:** Contractor shall meet with client(s) at the BHRS site for translation services. The Contractor shall not provide transportation services or any functions or services that are not part of the interpreter role. Contractor shall refrain from getting personally involved and shall monitor his/her own personal feelings for signs of transference issues.

e. **Response Time:** When Contractor receives a call from County staff, whether or not Contractor is available for service, Contractor shall respond within twenty four (24) hours of the call. Contractor understands that County may continue to contact other interpreters until the assignment has been accepted.

f. **Appointments:** Contractor shall make every effort to keep all appointments at all times. In the event an emergency occurs that would prevent Contractor from keeping the appointment or fulfilling the assignment, Contractor is obligated to inform County staff within one (1) hour of the emergency.

4. Contractor shall perform the above services consistent with the BHRS Code of Ethics and Organizational Compliance Plan, copies of which have been provided to the Contractor on DATE.

5. Contractor agrees to ensure confidentiality and integrity of Protected Health Information (PHI) of clients served by County to comply with all Health Insurance Portability and Accountability (HIPAA) regulations. PHI consists of any identifiable health information that is transmitted by electronic media or maintained in any medium or form, which may be made available to Contractor. Contractor shall attend County sponsored HIPAA trainings as required.

Contractor shall attend County sponsored cultural competency trainings as required.

Supporting documentation includes:

- Stanislaus County Language Examination and Policy
- Bilingual Pay Policy (Personnel Manual; Tab4)

STANISLAUS COUNTY
LANGUAGE EXAMINATION POLICY

It is the practice of Stanislaus County to provide a bilingual fluency examination for staff in languages other than English. The purpose of this examination is to certify identified staff who demonstrate communication skills in the areas of pronunciation, fluency, listening comprehension and resourcefulness in the language being tested, I in order to provide full-service delivery to County customers. This applies to Stanislaus County employees and Personal Service Contractors.

RATIONALE

To identify and acknowledge specific department staff who are responsible for providing a full range of services to customers who are non-English speaking or speak limited English.

Please refer to Stanislaus County Policy and Procedure Manual, Section VII-11, 3.20.160 regarding bilingual pay.

PROCEDURE

1. This examination will be utilized for staff who provide translation services and is comprised of three (3) parts:
   A. Part I - Oral Interpretation
   B. Part II - Oral Interpretation of a Case Vignette
      **Pronunciation, Fluency, Listening Comprehension and Resourcefulness
   C. Part III- Overall Summary of Part I and Part II
      - Pronunciation – clarity of speech
      - Fluency – a smooth flow of speech with a minimum of hesitation.
      - Listening Comprehension – the ability to grasp the significance of statements and questions without having them repeated.
      - Resourcefulness – the ability to express an idea or term.

2. Testing instructions
   A. Testers will follow approved County guidelines and will refer candidate to the Department's Human Resources Unit for results.

3. Identification of Bilingual Testers

   3.1 Bilingual Testers will be Stanislaus County employees, or Personal Service Contractors. who have been recommended by the Department and have successfully completed a bilingual fluency examination, **or successfully demonstrated fluency in that language. Approval of the Department Director, or his/her designee, will be required.**

   3.2 Bilingual Testers will be identified for the following languages and additional languages as needed.

   - Spanish
   - Cambodian

- Laotian
- Hmong
- Assyrian
- Farsi
- Russian
- Vietnamese
- Portuguese
- Sign Language
- Other languages as identified by the Chief Executive Office.

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STANISLAUS COUNTY
PERSONNEL MANUAL
BILINGUAL PAY

3.20.160 **Bilingual Pay**

The Personnel Director will review a request by a department for bilingual pay for a position. The Personnel Director shall be authorized to approve bilingual pay. (Ordinance CS 373 § 1, 1990).

BILINGUAL PAY GUIDELINES FOR EXTRA-HELP
BOARD OF SUPERVISORS RESOLUTION
ADOPTED MAY 8, 2007/RESOLUTION #2007-350

Represented employees in the County have negotiated additional compensation for qualified bilingual employees required to utilize bilingual skills in the workplace. The Board approved that bilingual certification pay be made available for qualified Extra-Help employees consistent with the procedures and compensation ($.69 per hour) provided in the MOU between the County and AFSCME Local #10. This additional compensation will provide County Departments increased flexibility in recruiting bilingual Extra-Help employees to support the diverse needs of our community.

Bilingual pay provisions do not apply to management employees as well as to certain represented bargaining units.

The Chief Executive Officer will review the request and may require qualifying language tests. In recommending positions, it is important to remember that a position need not be designated simply because the incumbent is bilingual and occasionally uses their skills in the normal course of work. Positions approved for bilingual pay will generally be those rendering services linking the County with clients who are largely monolingual in a language other than English. Employees who use bilingual skills will be expected to continue to perform other assigned job duties in a manner acceptable to department management whether or not their positions receive bilingual pay.

Persons certified and receiving bilingual compensation may be subject to serve a seven-day period of on-call status per month to serve as interpreters without additional compensation unless called back to work. The parties agree that designation of such positions shall not be subject to the grievance procedure.

Stanislaus County Personnel Manual can be viewed at: www.co.stanislaus.ca.us

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.

As noted above, BHRS has established policies and procedures for ensuring services to limited English-speaking clients and family members are in the individual's preferred language. The preference is for services to be provided by bilingual staff, followed by use of interpreters and finally through use of the language line. Embedded in the policy is the process for using the language line. The policy expressly prohibits the use of children and adolescents as interpreters for family members and requires the presence of a trained interpreter even if the individual requests that an adult family member translate.

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.

Per policy (90.1.106), all clients are served in the preferred language. Bicultural staff may be used for consultation, regarding cultural issues. Training for all staff on cultural competency has enhanced skills of all staff.

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;

See Policy and Procedure 90.1.106.

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

See Policy and Procedure 90.1.106. Even if clients insist on using a friend or family member as an interpreter, we still require an interpreter to be present.

3. Minor children should not be used as interpreters

See Policy and Procedure 90.1.106.

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.

Quality Services staff coordinate routine chart review processes for all outpatient specialty mental health services. The review worksheet includes the question, "If the client is monolingual, non-English speaking, is there documentation that a translator was used?" In FY2008/2009, 295 charts were reviewed, of which 18 identified the client as monolingual, non-English speaking. Of the 18, only one did not clearly document use of translator. In FY 09/10 265 were reviewed, of which 19 identified the client as monolingual, non-English speaking. Of these 19, 5 charts did not clearly document of a translator.

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

BHRS provides the MHSIP, YSS and YSSF in Spanish and monitors overall consumer satisfaction for the Spanish language surveys separately as a Medi-Cal key indicator. In FY08/09, of 3,002 consumer surveys submitted, 242 (8%) were in Spanish. Overall satisfaction for clients and family members who submitted surveys in Spanish was 90% as compared with 84% for all clients and family members who submitted surveys. In FY09/10, of 1,757 consumer surveys submitted, 144 (8%) were in Spanish. Overall satisfaction for clients and family members who submitted surveys in Spanish was 96% as compared with 84% for all clients and family members who submitted surveys. Historically, the Spanish language surveys have shown higher levels of overall satisfaction. The number of surveys was reduced due to surveys only being administered once during the FY 2009/2010.

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

BHRS uses contractors and bilingual staff who have passed the County's examination for proficiency in Spanish to translate materials into Spanish, the threshold language for Stanislaus County.

Translated materials are then vetted through a core group of staff who check for accuracy and consistency in the translations.

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

This requirement is written into agreements with contractors. The requirement is also made clear to staff who translate and vet translated materials.

CRITERION 8

COUNTY MENTAL HEALTH SYSTEM

ADAPTATION OF SERVICES

Rationale: Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).

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.

One example is Josie's Place, which is designed for transition age youth and offers both a Drop In Center and a service team. Staff provide outreach to a broad spectrum of racial, ethnic, and cultural groups, including but not limited to Southeast Asian youth, foster youth, LBGT individuals, and faith communities. Staff are racially, ethnically, and culturally diverse. The Young Adults Advisory Committee is composed of a diverse cultural group of consumers that act as partners and advocates for the need of the young adults at the center. Peer support counselors at the center regularly participate in planning of activities, outings and programming that will work with all cultures.

Modesto Recovery Services (MRS) makes every attempt to ensure that the clients we serve, receive services that are culturally, linguistically, age and gender appropriate. We meet with clients and when available, meet with their family members or support system to involve them in completing the Client Care plan and include them in the treatment planning. Staff also has on going discussion with clients about the Recovery Milestones and work with clients closely to help them identify their goals and objectives. Staff also discussed treatment limitations and challenges. As a team, we coordinate and match clients with program staff where language, cultural, age, and genders are concerned so that we are able to provide the most competent and appropriate services to our clients. We have a diverse team of Cambodian, Laotian, Thai, Vietnamese, and Spanish speaking staff as well as LGBT, AOD and dual specialty staff on board. We are also able to utilize interpreters for Hmong, Hindi, Punjabi, Farsi and other languages as needed. When permitted by our clients, we work closely with family members and peers for consultations and assistance to help us better serve and understand the situations of our clients.

At MRS, we are able to integrate our AOD and mental health services. We have a Co-Occurring Track, consisting of AOD and mental health groups. In addition, we offer Seeking Safety, Anger Management and Skills Building group, Dual Diagnosis group, Women's Intensive Outpatient AOD

group, Arts and Crafts and AOD Aftercare group. In the past, we were able to provide extensive AOD treatment groups, including an LGBT group but due to constraints of resources and budget cuts, we were not able to continue those services. Staff participates in the NAMI provider class, and are involved with the monthly Celebration of Recovery. We continue to work in partnership with community agencies for consultations and referral purposes. Staff are highly encouraged to participate in cultural competency trainings and trainings that will enhance and improve services to our consumers.

At the BHRS Wellness Recovery Center there are four Consumer Peer Recovery Specialists who provide groups and one on one services. These Peer Recovery Specialists provide outreach to the local Inpatient Psychiatric Hospital (Doctor's Behavioral Health Center) and to Board and Care Facilities. In addition our Peer Recovery Specialists provide home visits and provide transportation when needed.

Turlock Recovery Services has a full time Wellness Recovery Peer Specialist, who works independent of treatment service delivery, to provide Peer Recovery. She supports her peers to find what recovery means for them. Wellness Programming includes: engagement, individual and group support across a variety of recovery activities and topics, education, linkage and social skills. The services calendar is offered monthly and any current or former TRS/BHRS clients are welcome. It is our goal in FY 2010/2011 to provide Peer Recovery services to monolingual populations through the use of BHRS' contract interpreters.

Turning Point, BHRS Contract Provider, has core values of empowering individuals and family members of individuals with psychiatric disabilities through employment and welcoming diversity. The Consumer Employment Empowerment Center (CEEC) staffed by behavioral health consumers and/or family members of consumers, is an activity and resource center open to mental health consumers from all walks of life. This center responds to the community's diversity by honoring the specific consumer requests to incorporate various facets of culture into the provision of services, and offering meeting space for consumer and family organizations, as well as a variety of self-help groups.

The Warm Line, another Turning Point Program, is also staffed by mental health consumers and family members of mental health consumers. This program provides non-crisis peer support for any individual or family member of an individual in the community who may be struggling with a psychiatric disability. Referrals to other community resources are provided, and an outreach component is incorporated into their work through follow-up calls based on preference of the individual being served.

Turning Point Respite at Garden Gate is a consumer staffed program. Garden Gate offers respite to individuals with psychiatric disabilities, who may be dually diagnosed, who are also members of the homeless community, engaging individuals and linking them to community resources with the goal of increasing the individual's awareness of the array of services, housing, and other resources. Similarly, the Turning Point Supportive Housing Programs I and II further address the needs of individuals from the homeless community with psychiatric disabilities, or those who may be dually diagnosed, and for whom poverty constitutes an additional barrier to recovery.

Telecare Corporation, BHRS Contract Provider, has implemented the Shared Decision Making process which is lead by Peer Staff to empower client's in working with the program Psychiatrist. Peer Staff facilitate the following groups Living Skills, Communication, Medication and Art Therapy groups. In addition the Telecare Recovery Access Center is staffed by peers

One of the Core values for the BHRS Children System of Care (CSOC) is to provide client and family driven services that promote Wellness and Resilience.

The BHRS Children System of Care the School Based Services/ SED Program has Interagency MOU Agreements with SELPA's to include provisions that emphasize client driven and family strength based interventions.

In the Family Partnership Center (FPC) clients drive most services on an ongoing basis. FPC utilizes feedback from families through Suggestion Boxes, FPC Advisory Committee and the Youth Advisory Committee (YAC).

The Children's System of Care has a Provider Agreement with Aspiranet Corporation to provide a Wraparound Program for high risk youth. The Wraparound Program principles are: Family Voice and Choice, Team-Based, Natural Supports, Collaboration, Community Based, Culturally Competent, Individualized, Strength-Based, Persistance, and Outcome Based. This agreement stipulates that clients and families are fully engaged, and are active participants in case/service planning.

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

Programming at these sites incorporate activities and treatment that is appropriate for a variety of cultural groups, but none of them limit themselves to one specific group.

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).

BHRS has developed and on-line resource group information source called Friends Are Good Medicine. The concept of self-help is promoted in both the general and professional community. We provide leadership training, consultation and assistance to groups, and information sheets on topics of interest to self-helpers. A peer leads any group that is described as a self-help group. A professional or paraprofessional in the field leads any group that is described as a support group. The resource does not endorse any particular group. Individuals who visit the website are encouraged to visit a group to see if it is for them. The website can be accessed at www.friendsaregoodmedicine.com .

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

This resource is part of our Prevention and Early Intervention Plan and has been widely promoted to a variety of groups, including but not limited to, consumer groups, family members, and staff. We will be working on adding this to our member services brochure.

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.)

At meetings with partners, e.g., law enforcement, child welfare, schools, available services and instructions for accessing the services are provided. In addition, the Stanislaus County Community Service Agency (CSA) provides Medi-Cal beneficiaries, during the application process, an Access Line Information Card, English and Spanish, for specialty mental health services (**See Access Line Card, English and Spanish, attached in Appendix)**

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;

Services are often co-located with other partners, e.g., schools, juvenile justice, child welfare and Family Resource Centers. Many of our contractors took location into consideration when siting their services. For instance, Telecare, in choosing a new facility site in 2008, believed it was important to have a location that was in proximity to Westside Modesto as well as is centrally located, since most of their programs serve the entire county. Another contractor, Sierra Vista Child and Family Services, when leasing or purchasing an office, takes into consideration the location. When possible, offices are located in the community of service or in a location that is accessible. At one of the county sites, the Department and partners advocated for a bus stop adjacent to the site and was successful in getting this to happen. Many programs give out bus passes to clients. One of our contractors operates a transportation service (CART) that assist individuals in getting to community resources. CART's goal is meant to foster a better quality of life for consumers by offering transportation services, this includes transporting consumers from rural areas to Modesto to access resources. Hours are flexible and usually include both day and evening hours. CART follows a less traditional schedule, from 5 a.m. to 11 p.m., to allow greater access to a wider range of and/or nontraditional resources that foster recovery.

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

Both county-operated sites and contractor-operated sites provide magazines, brochures, and other printed materials in the reception areas that are of interest to and reflect the different cultures of clients served. The pictures, posters, artwork and other décor reflect the cultures and ethnic backgrounds of clients being served. Our local Peer Recovery Art Project, which supports local artists including consumer artists, provides original artwork for offices on a rotating basis. Contractors have also taken environment into consideration. For example, Telecare took great care in designing offices that incorporated client framed art in lobby and hallways, along with posters and a board featuring current activities. BHRS also has an Accessibility Plan designed to ensure that the organization's various settings are accessible for persons served, for personnel, and for other stakeholders.

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.)

BHRS has been co-locating services in a variety of settings for many years. Some of our Children's System of Care programs are co-located, e.g., child welfare and juvenile justice programs. We have co-located staff in primary care clinics, welfare to work agencies, and substance use treatment facilities. Contractors are in Family Resource Centers.

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.

Below are sample Request For Proposal (RFP) evaluation tools that assist in selecting contract proposers. The first sample includes in Phase II (7) the MHSA General Standards, which includes Cultural Competence as an essential element. The second sample scoring tool in Phase II (C) includes staff are culturally and linguistically competent as one of the evaluation criteria.

EVALUATION CATEGORIES - THREE PHASES	POINTS	BONUS POINTS POSSIBLE	MAXIMUM POINTS INCLUDING BONUS POINTS
PHASE I – Review Proposal for Completeness			**Pass/Fail**
PHASE II			
1. Focus of the Project	5	0	5
2. How does the Project proposed contribute to learning	5	0	5
3. Project Proposal(s) Description	20	5	25
4. Expected mental health goal/outcomes of the Project	15	0	15
5. Timeline proposed for desired learning to occur	10	5	15
6. Project Measurements proposed for assessing the expected contribution to learning of the Project	10	0	10
7. MHSA General Standards (aka Essential Elements)	5	0	5
8. Experience and Strengths	5	0	5
9. Population to be served (if applicable)	10	0	10
11. Statement of Commitment	5	0	5

PHASE III			
10. Proposed budget and narrative	10	0	10
TOTAL POSSIBLE WEIGHT OR POINTS:	100	10	110

EVALUATION CATEGORIES	MAXIMUM POINTS
Phase I – Review and Evaluate Financials	Pass / Fail
PHASE II	**MAXIMUM POINTS**
Capacity and Experience a. Demonstrates experience providing strength-based, family centered services. b. Has experience with the target population. c. Staff are culturally and linguistically competent. d. Ability to develop or identify a survey to measure collaboration and customer satisfaction. e. Demonstrate a history of strong community partnerships. f. Has the capacity to start a program immediately and the ability to expand. g. Demonstrate the ability to apply State training and technical assistance**.**	20
Program Operations a. Demonstrate the ability to meet the 18 criteria listed in the Operations/Program section of the Wraparound Services RFP scope of work. b. Demonstrate the ability to hire and train staff to deliver Wraparound Program services effectively and efficiently to manage the program described in the RFP. c. Clearly defines an implementation plan.	20
Budget Justification and Level of Service a. Budgeted items will be used to achieve outcomes. b. Cost of the program relates to the expected outcomes. c. Be a Medi-Cal certified provider with experience in administrative billing, technical assistance and reporting support for Medi-Cal billing for SB163.	25
Outcomes/Impact of Wraparound Services a. Stated activities directly result in achievement of outcomes. b. Measurement tools accurately measure actual outcomes. c. Ongoing assessment process that evaluates outcomes to actual outcomes. d. Program goal/outcome(s) are **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**imely. e. Develop and clearly define discharge plans. f. Demonstrate understanding and experience in utilizing Wraparound Fidelity Index	35
TOTAL POSSIBLE POINTS:	100

In addition, below is the Contract Language Section that is included in BHRS Provider Agreements. Also, as part of the Contract Monitoring Meetings we review how Contractors are integrating Cultural Competence into the service delivery system, whether the contractor is participating in the monthly BHRS Cultural Competence Oversight Committee and whether Contractor Staff have participated in Cultural Competence Training.

a. CONTRACTOR shall ensure that cultural competency is integrated into the provision of services. The terms of this section of the Agreement shall be reviewed during contract monitoring meetings.

b. COUNTY will provide the Cultural Competence Plan (CCP) to CONTRACTOR when submitted to the California Department of Mental Health and as updated annually.

c. CONTRACTOR shall adhere to the provisions of the COUNTY CCP, as submitted and updated, and provide information as required for submitting and updating the CCP.

d. CONTRACTOR shall document evidence that interpreter services are offered and provided for threshold languages at all points of contact. CONTRACTOR shall also document the response to the offer of interpreter services.

e. CONTRACTOR shall regularly have a representative participate in the COUNTY Cultural Competence Oversight Committee.

f. CONTRACTOR staff shall attend the COUNTY Clinical and Administrative Cultural Competency Standards training.

IV. Quality Assurance

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

The county shall include the following in the CCPR:

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

We monitor on a quarterly basis a variety of Medi-Cal Key Indicators, several of which have to do with access, follow up care, and beneficiary satisfaction with services for LEP clients.

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

Our last formal staff satisfaction survey was completed in 2005.This survey was performed by an outside firm specializing in this. Findings were aggregated. Funding restrictions have prevented a continuation of this practice. Overall, in comparison to "High Performing Companies", BHRS scored well with respect o overall job satisfaction. Over 75% or our employees at the time indicated that we

provided quality services to our customers. Recommendations that were related to diversity included training supervisors to be more effective at managing diversity. This has occurred. Classes to learn Spanish were also suggested, but the logistics of the request were difficult to accomplish during work hours. A staff satisfaction committee was formed to track progress on all recommendations. Over time, this group decided that staff support was a better focus than satisfaction, especially in view of the reductions in force that were occurring. The BHRS Cultural Competence Oversight Committee (CCOC) is a current forum for staff to endorse our organization's ability to value diversity or to voice concerns. This will be offered as one of the CCOC's goals to consider for FY 2010/2011.

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.

For more than five years, BHRS has used complaint-tracking software to manage complaints and grievances and to produce reports for analysis and process improvement. Only written complaints/grievances are entered in the system. Data, including demographic data, is routinely reported to the Managed Care QIC and the Quality Management Team. We do not routinely analyze the data with regard to ethnicity because the number of complaints/grievances is so small that it does not have any statistical significance. Historically, the majority of our complaints/grievances were from patients of our inpatient psychiatric hospital, which we sold on November 1, 2007. During the last year we operated the hospital, we received 62 written complaints/grievances. Of those, 55% were from Caucasian clients, 34% from Hispanic clients, 6% from African-American clients and 4% from Asian clients. These percentages are very similar to Stanislaus County 2000 census population. In FY2008/2009, we received only 28 written complaints/grievances of which 75% were from Caucasian clients, 18% from Hispanic clients, 4% from African-American clients and 4% from Native American clients. For FY 09/10 we received 31 written Grievances /Complaints, of which 65% (20) were from Caucasian clients, 26% (8) were from Hispanic clients, 3% (1) were from African-American clients, 3% (1) from Southeast Asian clients and 3% (1) from Native Americans.

California State Statute

Welfare and Institutions Code (WIC), Section 4341 -- relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: "Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state."

WIC, Section 5600.2 -- relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable…"

WIC, Section 5600.2(g) -- "Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (2) Recognize that culture

implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups. (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

WIC, Section 5600.3—Relates to populations targeted for services. This section details the target populations that shall be served by mental health funds. Target populations include the following: Seriously emotionally disturbed children and adolescents, adults and older adults who have serious mental disorders, adults or older adults who require or are at risk of requiring acute treatment, and those persons who need brief treatment as a result of natural disaster or severe local emergency.

WIC, Section 5600.9(a) -- "Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs."

WIC, Section 5802. (a)(4) -- relates to Adult and Older Adult Mental Health System of Care. "System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes."

WIC, Section 5807. – relates to Human Resources, Education, and Training Programs. Requires counties to work in an interagency collaboration (and public and private collaborative programs) to effectively serve target populations to assure service effectiveness and continuity and help set priorities for services.

California State Statute Cont.

WIC, Section 5813.5 (d)(3) – relates to distribution of funds, services to adults and seniors, funding, and planning for services. "Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers…to reflect the cultural, ethnic and racial diversity of mental health consumers."

WIC, Section 5820. – relates to Human Resources, Education, and Training Programs. This section details "the intent to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses." A needs assessment is required of the mental health programs in each county that detail anticipated staff shortages where the county will need to fill positions in order to meet requirements in reducing discrimination and improving services for underserved populations as detailed in WIC, Section 5840.

WIC, Section 5822 (d) and (i) – relates to Human Resources, Education, and Training Programs. Relates to the State Department of Mental Health. Section 5822 (d) requires an establishment of regional partnerships among mental health and educational systems to expand outreach to multicultural communities and increase the diversity of the mental health workforce. Section 5822 (i) requires promotion of the inclusion of cultural competency in training and educational programs.

WIC, Section 5840 (b) and (b)(4) and (e)– relates to Prevention and Early Intervention Programs. This section requires programs to reduce discrimination and improve services for underserved populations. Additionally, this section requires the department to revise elements of the program to reflect lessons learned. "The program shall emphasize improving timely access to services for underserved populations." "Reduction in discrimination against people with mental illness." "In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors."

WIC, Section 5848– relates to the development of prevention and early intervention plans with local stakeholders. This section requires stakeholder participation in the development of the PEI plan.

WIC, Section 5855. (f) -- relates to Children's Mental Health System of Care. "Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery."

California State Statute Cont.

WIC. Section 5865. (b) -- relates to the county System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. "(b) A method to screen and identify children in the target population including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent."

WIC Section 5878.1—relates to establishing programs that assure services are culturally competent. "It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family."

WIC. Section 5880. (b)(6) -- relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. "To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation."

WIC, Section 14683 (b) -- requires the department establish minimum standards of quality and access for managed mental health care plans. This section sets forth a requirement that managed mental health care plans include a system of "outreach to enable beneficiaries and providers to participate in and access mental health services under the plans, consistent with existing law."

WIC, Section 14684 (h) -- "Each plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate."

California Government Code (CGC) Section 7290-7299.8 – "This chapter may be known and cited as the Dymally-Alatorre Bilingual Services Act." Relates to the Legislature's findings and declarations regarding rights and benefits to those precluded from utilizing public services because of language barriers. This section details the need for effective community between the government and its citizens and describes legislative intention to provide for effective communication to those that either do not speak or write English at all or their primary language is other than English.

California Code of Regulations

California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 10, Medi-Cal Psychiatric Inpatient Hospital Services, Article 1, Section 1704 "Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings."

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.310 1(a-b) Implementation Plan. This section discusses how an MHP must submit an Implementation Plan with procedure details for screening, referral and coordination with other necessary services and "Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP."

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410 (a-e), Cultural and Linguistic Requirements. This section provides an in-depth listing of cultural and linguistic requirements. "Each MHP shall develop and implement a Cultural Competence Plan that includes…" provisions of the CCPR that work to improve cultural and linguistic competence. "The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. "The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually."

Cultural Competence Plan provisions in this section include but are not limited to the following: strategies and objectives, cultural and linguistic assessments, resource listing of linguistically appropriate services, and cultural and linguistic training for mental health workers. MHPs shall have a statewide, toll-free number, oral interpreters available, referrals for linguistic and cultural services the MHP does not provide, policies and procedures to assist beneficiaries who need interpreters in non-threshold languages, and general program literature in threshold languages

CCR, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2: Definitions, Section 3200.100. Cultural Competence. This section provides an in depth definition of "Cultural Competence". It identifies nine goals to incorporate in all aspects of policy-making, program design, administration and service delivery and assist in the development of an infrastructure of a service, program or system, as necessary in achieving these goals.

California State Statute Cont.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2, Definitions, Section 3200.210. "Linguistic Competence" means organizations and individuals working within the system are able to communicate effectively and covey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures, and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy needs of the populations being served.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 3, General Requirements, Section 3300. Community Program Planning Process. This section provides requirements related to designated positions for community planning processes and details minimum Community Program Planning Process requirements. The planning process shall include opportunities for stakeholder participation of "unserved and/or underserved populations" and their family members as well as to "stakeholders who reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity."

California Code of Regulations Cont.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 6, General Requirements, Section 3610 (b)(1). General Community Services and Supports. "The County shall conduct outreach to provide equal opportunities for peers who share the diverse race/ethnic, cultural, and linguistic characteristics of the individuals/clients served."

MHSA Component Guidelines

Prevention and Early Intervention: Cultural Competence
"Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore cultural competence must be emphasized in PEI programs."
Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, and administration and service delivery. (Source: PEI, 2007, p. 2).

Workforce Education and Training: Cultural Competence
Guides counties for the "development and implementation of recruitment, retention and promotion strategies for providing equal employment opportunities to administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic cultural and linguistic characteristics of individuals with severe mental illness/emotional disturbance in the community." "Staff, contractors and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and /or linguistic population or community they serve." (Source: WET, 2007, p.4-5)

Workforce Education and Training: Objectives in the Five Year Plan
Guides counties in the "development of strategies for the meaningful inclusion of individuals with mental health client and family member experience, and incorporate their viewpoints and experiences in all training and education programs." (Source: WET, 2007, p.6)

Workforce Education and Training: Workforce Needs Assessment
Guides counties to "establish a current, standardized baseline set of workforce data that depicts personnel shortages and the needs of ethnic/racial and culturally underrepresented populations." (Source: WET, 2007, p.11)

Federal Statute

Title VI of the Civil Rights Act of 1964-"No person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (42 U.S.C. 2000d).

As pertains to language access: Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, all MHPs must ensure that all Medi-Cal LEP members have equal access to all mental health care.

Federal Statute (Cont.)

Executive Order 13160 of June 23, 2000. Nondiscrimination on the Basis of Race, Sex, Color, National Origin, Disability, Religion, Age, Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs. To ensure that persons with limited English skills can effectively access critical health and social services, the Office of Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills. As pertains to language assistance to persons with limited English proficiency (LEP). The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of

1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law.

Title 42 – The Public Health and Welfare, Chapter 126, Equal Opportunity For Individuals with Disabilities Section 12101. Findings and Purpose. [Section 2} -- to provide a clear and comprehensive national mandate, and a strong, consistent, enforceable standard, for the elimination of and addressing discrimination against individuals with disabilities. The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.

Federal Standards/Guidelines

U. S. Department of Health and Human Services, Office of Minority Health (OMH), National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. These national standards were to respond to: 1) the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, and 2) a means to correct inequities that currently exist in the provision of health service and to make these services more responsive to the individual needs of all consumers. CLAS mandates (Standards 4, 5, 6, and 7) are current federal requirements for all recipients of Federal funds. Standards 1,2,3,8,9,10,11,12, and 13 are CLAS guidelines and are recommended by OMH for adoption as mandates for Federal, State, and national accrediting agencies. OMH recommends CLAS Standard 14 for adoption by healthcare organizations.

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/underrepresented Racial/Ethnic Groups –Final report from working groups on cultural competence in managed Mental Health Care Services. Prepared by Western Interstate Commission for Higher Education. (These standards have not been mandated by CMHS.)

DMH Letter

DMH Information Notice: 94-17 issued on December 7, 1994 -- requests all counties applying to become a Mental Health Plan to submit a written Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation by January 1, 1995. Counties were required to describe the process they would implement to improve cultural competence and age-appropriate services to Medi-Cal beneficiaries.

Federal Waiver Request

DMH Waiver Request Submission to Health Care Financing Administration (HCFA) states: MHPs will be required to develop and implement a plan for the provision of culturally competent and age appropriate services to beneficiaries. At a minimum this plan must include maintaining a statewide 800 number with linguistic capability that is available 24 hours a day, and must include goals for improving cultural competence. DMH will establish a task force to address linguistic and cultural competence issues and may set additional statewide requirements for MHPs as a result of task force findings and recommendations.

DEFINITIONS

BILINGUAL STAFF
Bilingual staff members have language capacity in both English and the specific non-English languages used by cultural groups in the target community.

CLIENT/CONSUMER
Client/consumer is a person with lived experience of mental health issues. (*Source: California Network of Mental Health Clients*, 2002).

COMMUNITY-DEFINED EVIDENCE
"Community-defined evidence" is a "set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community." *(Source: Martinez (2008), The Newsletter of the National Latina/o Psychological Association, page 9).*

COMMUNITY ENGAGEMENT
Community engagement has been defined over the last two decades in multiple, evolving ways (1). One definition of community engagement is "the process of working collaboratively with relevant partners who share common goals and interests" (2). It involves "building authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the 'win-win' possibility" in the collaborative project (3). The emphasis on community engagement promotes a focus on common ground and recognizes that communities have important knowledge and valuable experience to add to the public stakeholder input debate.

CULTURAL BROKERS
Cultural brokers may be State and county officials working within county Mental Health Departments (such as Cultural Competence/Ethnic Service Managers) or outside county Mental Health Departments (such as public health, social services, and education) who have prior knowledge and trusting relationships with particular communities. In addition, cultural brokers may be community activists, advocates working at the State or county level, as well as county or State level non-governmental organizations (with established trust and credibility in particular communities). For Native American communities in particular, contact with appropriate tribal organization leaders is a critical first-step (*Source:* University of California, Davis, Center for Reducing Health Disparities and CA Department of Mental Health (2007). *Building Partnerships: Key Considerations When Engaging Underserved Communities Under the MHSA, UC Davis CRHD and DMH,* Page 3).

CULTURAL COMPETENCE
Cultural competence is a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations (Adapted from Cross et al, 1989). (See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.100, Cultural Competence)

ENGLISH PROFICIENCY
Level at which a person can understand English and respond in English to explain their behavioral healthcare problems, express their treatment preferences and understand the treatment plan.

ETHNIC DISPARITY
The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

EVIDENCE BASED PRACTICE
Evidence based practice is a prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

FAMILY MEMBER
A family member is a parent or caretaker of a child, youth, adult, or older adult, who is currently utilizing, or has previously, utilized mental health services. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

GATEKEEPER
“Gatekeeper” means those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk for mental health problems or suicide and refer them to treatment or supporting services as appropriate.

HISTORICAL DISPARITIES
Historical disparities have been consistently found in and continue to exist among California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American. Any other population group(s) targeted in a county plan must be clearly defined with demonstrated evidence and supporting data to target them as having historical disparities in unserved, underserved and inappropriately served in mental health services. (Source: MHSOAC, (2008). *Cultural & Linguistic Competence Technical Resource Group Workplan*.)

INTERPRETERS
Interpreters are individuals with specific language skills and knowledge of health care terminology who are trained to communicate effectively with persons with limited proficiency with the English language.

INTERPRETER SERVICES
Interpreter services are methods in place to assist persons with limited English proficiency. This includes telephone interpreter services ("language lines"), interpreters obtained from a central listing maintained by agency or other source, trained volunteers from a target community with identified language skills.

KEY POINTS OF CONTACT (MANDATED/NON-MANDATED)
"Common points of access to Specialty Mental Health Services from the MHP, including, but not limited to, the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP." (Source: CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410, Cultural and Linguistic Requirements)

LIMITED ENGLISH PROFICIENT (LEP)
A diminished level of English language skills that calls into question the person's ability to understand and respond to issues related to their treatment.

LINGUISTIC COMPETENCE
The capacity of an organization and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of LEP, those who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that the structures, policies, procedures and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy and language needs of the population being served. *(*See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.210, Linguistic Competence.)

LINGUISTICALLY PROFICIENT
A linguistically proficient person is a person who meets the level of proficiency in the threshold languages as determined by the MHP.

MEDI-CAL BENEFICIARIES
Any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001.

NON-TRADITIONAL MENTAL HEALTH SETTINGS
"Non traditional mental health settings" means systems and organizations not traditionally defined as mental health; i.e., school and early childhood settings, primary health care systems including community clinics and health centers, and community settings with demonstrated track records of effectively serving ethnically diverse and unserved or underserved populations.

PENETRATION RATE
The total number of persons served divided by the number of persons eligible.

PREVALENCE
The number of cases of the condition present in a defined population at a specified time or in a specified time interval (e.g., the total number of cases with a specific disease or condition, such as ischemic heart disease, at a given time divided by the total population at that time) (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

PRIMARY LANGUAGE
That language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

PROMISING PRACTICE
"Promising Practice" means programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. It has an evaluation design in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

RECOVERY
Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

RESILIENCE
Resilience means the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school, and in the community, mental health programs, and interventions that teach good problem solving skills, optimism, and hope can build and enhance resilience in children. *(Source: California Family Partnership Association, (2005).* (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

RETENTION RATE
A retention rate is the percent of new clients who receive 2, 3, 4, etc. follow-up day or outpatient services following an initial non-crisis contact with the mental health system. This measures the rate at which new clients in general are retained in the system for treatment.

SMALL COUNTY
Per California Code of Regulations Section 3200.260, "'Small County' means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance data."

SPECIALTY MENTAL HEALTH SERVICES
Includes the following: rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

STAFF DIVERSITY
Staff who are representative of the diverse demographic population of the service area and including the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. (*Source: CLAS, Final Report, Page 8*).

TARGET POPULATION
That part of the general population designated as the population to be served by the administrative or service delivery entity. (*Source: Chambers, Final Report: 2008: Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care, Page 42)* **Note**: DMH recognizes each MHSA component has its own identified target population(s).

THRESHOLD LANGUAGE
The annual numeric identification on a countywide basis, of 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

TRANSLATION SERVICES
Translation services are those services that require "The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language. **Note:** Translation refers to written conversions from one language into a second language, while interpreting refers to the conversion of spoken or verbal communication from one language into a second language.)" (Source: California Healthcare Interpreters Association, 2002)

UNDERSERVED
Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences (Source: Department of Mental Health *(2002) Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

UNSERVED
Persons who may have serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of underserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth existing the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian Rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

WELLNESS
A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

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APPENDIX

BHRS VISION, MISSION, and VALUES

Confirmed by Senior Leadership Team September, 2006

BHRS Vision

Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.

BHRS Mission

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

BHRS Values

ORGANIZATIONAL VALUES

Clients are the Focus

- Our clients and their families drive the development of our services

Excellence

- We are continuously improving to provide the highest quality of services, which exceeds the expectations of our customers.

Respect

- We believe that respect for all individuals and their cultures is fundamental. We demonstrate this in our daily interactions by treating every individual with dignity.

Cultural Competence

- Our organization acknowledges and incorporates the importance of culture at all levels.

Proactive and Accountable Community Participation

We actively work together with the community to identify its Diverse needs and we are willing to respond, deliver and support what we have agreed to do. We take responsibility for results with our community partners.

Integrity and Compliance

- We conduct our operations with the highest standards of honesty, fairness, and personal responsibility in our interactions with each other and the community. Our work also requires a high standard of ethical behavior and compliance with legal statues, regulatory requirements and contractual obligations. We are committed to compliance and to ensuring that all services are provided in a professional ethical manner.

Competitive and Efficient Service Delivery

- Stanislaus County Behavioral Health and Recovery Services provides the highest quality, easiest to access, most affordable and best integrated behavioral health service of its kind.

Responsive and Creative in a Changing Environment

- We listen and respond to our customers. We are innovative, flexible and socially responsible in our efforts to overcome challenges. We are always open to change through continuous learning.

LEADERSHIP VALUES

Empower Others to make decisions

- We provide clear information on project background, context and parameters of participation. We actively delegate authority, share responsibility, set direction, acknowledge progress and provide assistance when needed.

Encourage Initiative and Innovation

- We show interest in new ideas by soliciting them, celebrating them and exploring ways to implement them.

Individuals Working Together to Achieve Results

- We foster teamwork by encouraging:
  - ♦ Diversity
  - ♦ Diversity
  - ♦ Partnership
  - ♦ Collaboration
  - ♦ Cooperation
  - ♦ Joint decision making

  with peers, colleagues, consumers, families and the community to achieve a superior product.

Influence by Example

- We demonstrate congruency between our words and behavior and take every opportunity to educate others about our organizational and leadership values and confront behavior which is inconsistent with those values.

Shape the Organization's Character and Climate

- We take responsibility to educate others abut our organizational and leadership values and confront behavior which is inconsistent with those values.

Stimulate Right Things

- We acknowledge and encourage ideas and activities that will further the accomplishment of the Organization's mission and vision.

Value Individual Contributions

- We value the importance of individual contributions as essential to the success of our organization. It is through individual creativity, pride, dedication and personal responsibility for achieving results that our mission is accomplished. We recognize and reward individuals for their efforts.

STANISLAUS COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES

CULTURAL COMPETENCE OVERSIGHT COMMITTEE

Vision

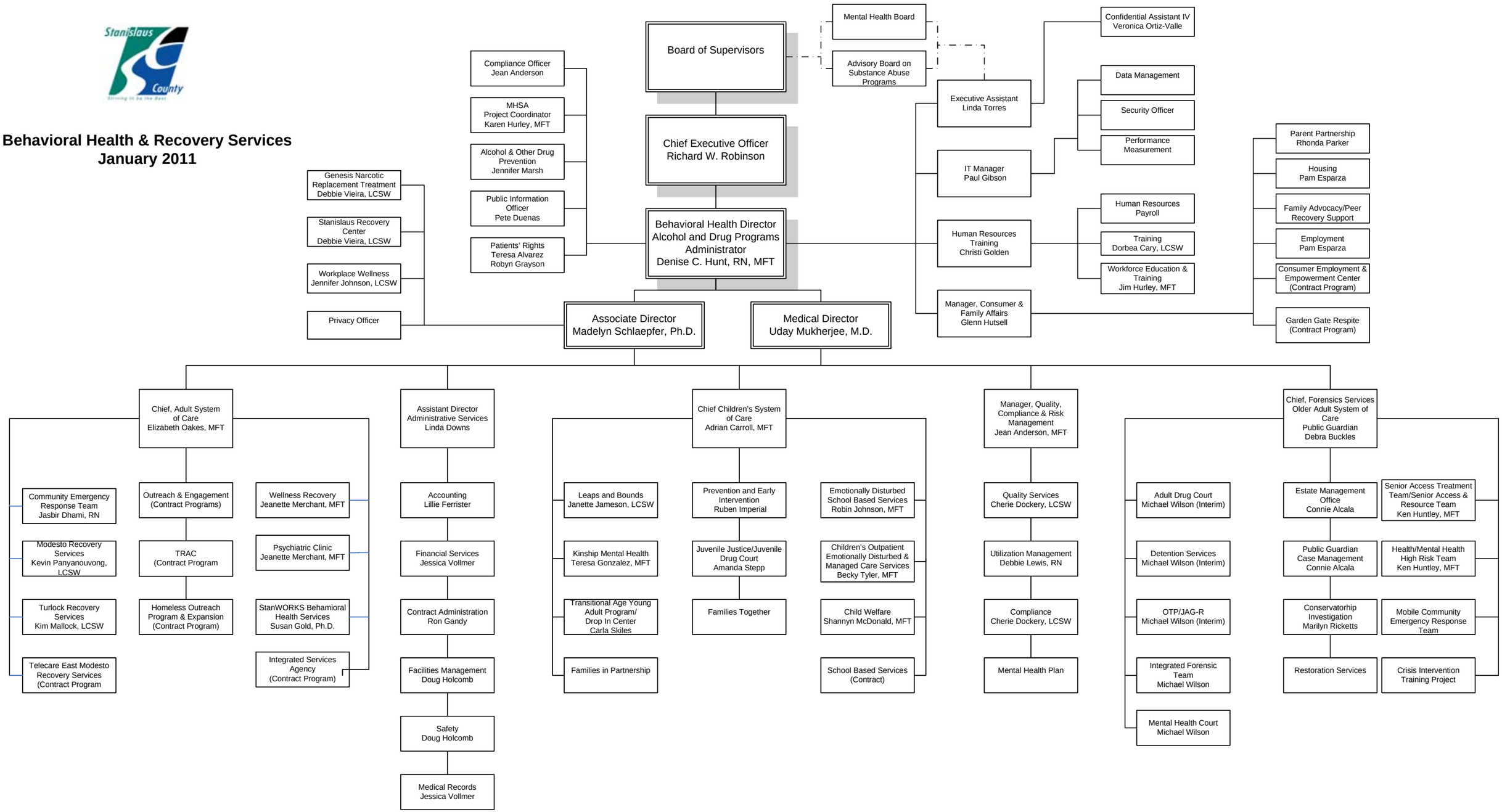
Our Vision is to be a leader in providing culturally competent services and to be recognized for our excellence in this by our community, state and nation.

Mission

In partnership with our providers and community, our mission is to transform our entire system by:

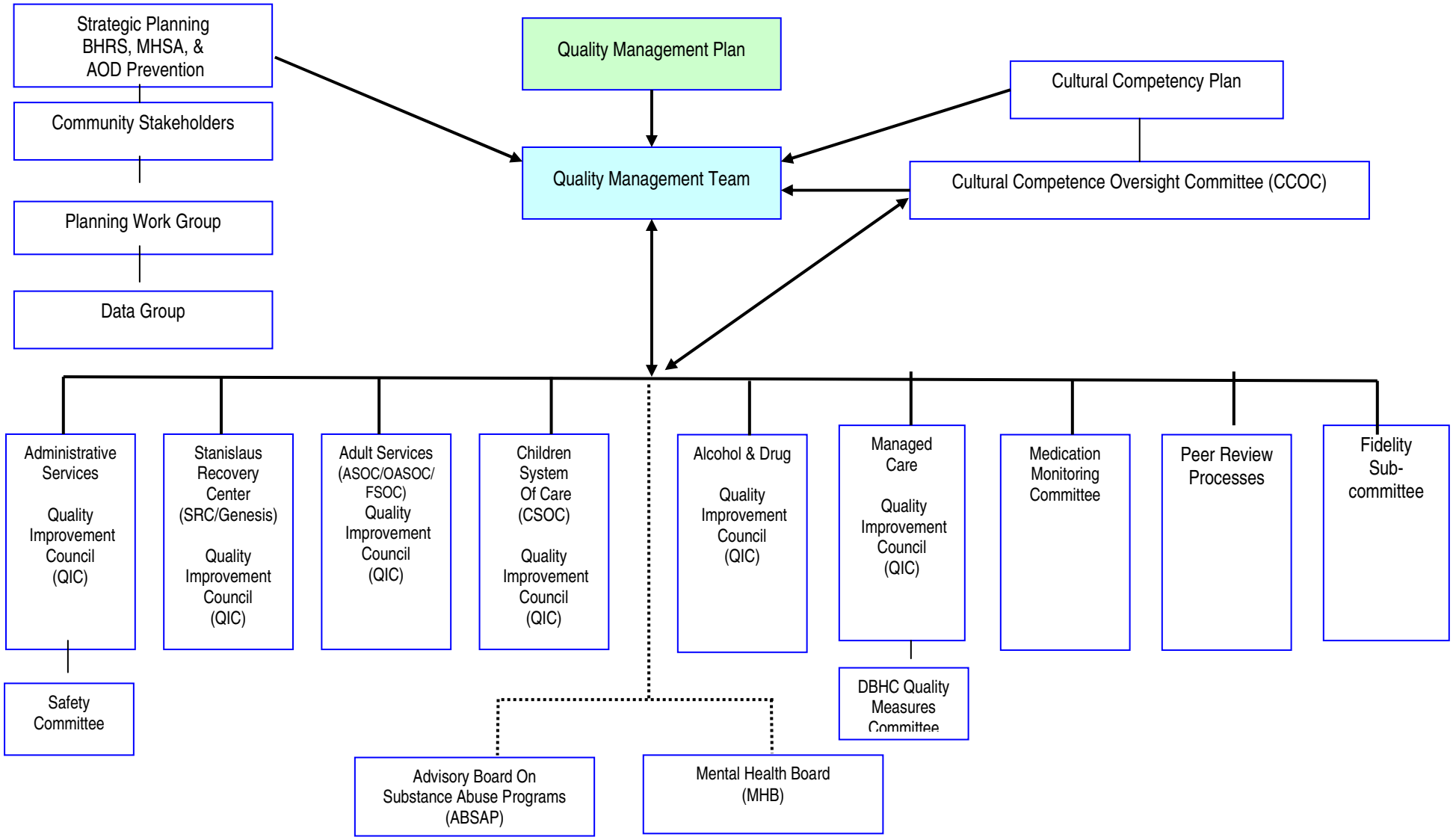
- Ensuring that culture is acknowledged and incorporated throughout BHRS in a measurable and substantive way.
- Educating our workforce about the meaning of cultural competence and about how to actually implement the concepts
- Ensuring our Cultural Competence Plan remains effective and responsive to change
- Empowering consumers, family members, and communities representing all cultures

Behavioral Health & Recovery Services
January 2011



BEHAVIORAL HEALTH AND RECOVERY SERVICES

Organizational Quality Improvement Structure – January 2010



BHRS Policies

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Dan Souza, LCSW	**Page:** 1 of 1	**Number:** 30.2.116
			Subject: INFORMATION SYSTEMS
	Reviewed by/Revised Date: Madelyn Schlaepfer, Ph.D. 2/26/01	**Replaces:**	**Distribution:** All Programs
Title: **FORMS FOR LIMITED ENGLISH SPEAKING CLIENTS**			**Approved:**

POLICY

It is the policy of Stanislaus Behavioral Health and Recovery Services to provide departmental clinical forms, educational materials and documents in the threshold language(s) and to provide assistance in completing and understanding forms/materials in the client's primary language if that language is other than a threshold language.

PURPOSE

Effective communication with clients and California Code of Regulations, Title 9, Chapter 11, Section 1810.410 (d) (3).

PROCEDURE

A. Clinical forms, which the client must read and sign, shall be available in the threshold language(s). Forms in languages other than the threshold language will be made available as feasible.

B. In the event that forms and/or educational materials are not available in the primary language, efforts shall be made on the part of program staff to provide explanations and assistance in completing clinical forms, reading educational material or other documents. This assistance shall be provided in the primary language of the client.

C. A list of translated forms and educational materials will be available in all programs. The office of the Cultural Competence Coordinator will routinely update this list. A copy of all newly translated materials will be sent to all programs as they become available.

D. Clinical forms may be ordered from Purchasing, utilizing the appropriate forms ordering protocol. Educational materials may be requested from Quality Services staff by telephone.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Dan Souza, LCSW 10/3/02	**Page:** 1 of 1	**Number:** 40.2.108
			Subject: ETHICS AND LEGAL ISSUES
	Reviewed by/Revised Date: Denise Hunt, RN, MFT 7/15/04	**Replaces:** 3/03, 01/02, 06/01	**Distribution:** All Programs
Title: **NON DISCRIMINATION**			**Approved:**

POLICY

Behavioral Health and Recovery Services shall not discriminate in the provision of services and employment on the basis of race, ethnicity, ancestry, color, national origin, religion, physical or mental disability (including individuals with AIDS or those with a record of or regarded as having a substantially limiting impairment), or medical condition (cancer related), pregnancy related condition, marital status, sex, sexual orientation, age (over 40), or political affiliation or belief.

REFERENCE

Title VI of the Civil Rights Act of 1964 (Section 2000d, Title-24, United States Code), the Rehabilitation Act of 1990 (Section 12132, Title 42, United States Code); the Americans with Disabilities Act of 1990 (Section 12132, Title 42, United States Code); Section 11135 of the California Government Code; and Chapter 6 (commencing with Section 10800), Division 4, Title 9 of the California Code of Regulations; California Alcohol and Drug Certification Standards Section 23000, and City/County Performance Contract Between California Department of Mental Health and Stanislaus County Behavioral Health, (Article III, D (1).

PURPOSE

To provide services to individuals requiring behavioral health and recovery services without discrimination.

PROCEDURE

A. Education shall be provided for staff regarding personal rights of clients, the program philosophy, cultural sensitivity and the non discrimination policy.

B. Where required by law and regulation, clients shall be informed of their rights on admission.

C. The program supervisor shall monitor program activities to assure that the non discrimination policy is upheld.

Cross/Reference: SBHC 100.1.114

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Madelyn Schlaepfer, PhD 2/26/01	**Page:** 1 of 3	**Number:** 50.1.100
			Subject: MANAGED CARE FUNCTIONS
	Reviewed by/Revised Date: Madelyn Schlaepfer, PhD 10/25/04	**Replaces:**	**Distribution:** All Programs
Title: ACCESS TO SERVICES FOR MEDI-CAL BENEFICIARIES			**Approved:**

POLICY

It is the policy of Stanislaus County Mental Health Plan (MHP) to ensure access to specialty mental health services for all eligible Stanislaus County Medi-Cal beneficiaries.

PURPOSE

According to the contract between the California Department of Mental Health and the Stanislaus County Mental Health Plan as well as CCR, Title 9, Chapter 11, Section 1810.405 (a), the MHP must ensure access for all Medi-Cal beneficiaries who are eligible for specialty mental health services.

DEFINITIONS

A. "Key points of contact" means common points of access to specialty mental health services from the MHP, including the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

B. "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

C. "Threshold language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

PROCEDURE

A. Any Medi-Cal beneficiary who wishes to access specialty mental health services may call the state-wide, toll free number, i.e., 888-376-6246, or present at any Stanislaus County Behavioral Health and Recovery Services site to begin the process to access to services.

B. If the beneficiary presents at a service site, personnel at that site will assist the beneficiary in contacting the state-wide, toll free number.

C. The state-wide, toll free number shall be answered by an individual who will:

1. be able to access appropriate linguistic support,

2. perform a brief screening procedure to determine the nature of the problem and appropriate referral,

3. immediately transfer the call to Emergency Services for emergent and urgent situations,

4. schedule or arrange for the scheduling of a thorough face-to-face assessment, and

5. be able to provide information on the use of the beneficiary problem resolution and fair hearing processes.

6. inform beneficiaries that free language assistance is available.

D. Initial assessments for services will be performed by licensed or wavered/registered professionals. Beneficiaries who have special needs, e.g., linguistic, age, cultural, will be assessed by individuals who have experience in dealing with these special populations. Staff who are bilingual, interpreters, and/or staff trained to use the Language Line will be available at all mandated key points of contact. Beneficiaries will again be informed through signs posted in service sites and verbally, if necessary, that free language assistance is available.

E. Upon first accessing services, beneficiaries will be given a copy of the Medi-Cal Member Guide, which outlines benefits, grievance and appeal processes, and beneficiary rights and responsibilities. In addition, beneficiaries will receive information on Advance Medical Directives and Notices of Privacy Practices. Beneficiaries who are visually limited will be offered informing materials in large print or on audiotape. Beneficiaries who have limited reading proficiency will be offered assistance in reviewing the materials or an audiotape version Lastly, beneficiaries will be given a list of providers. At any time after the initial assessment, a beneficiary may request a copy of this list. . These materials will be available in threshold language(s).

F. Beneficiaries who meet the medical necessity criteria for specialty mental health services will be authorized to receive services in their primary language, regardless of whether the language is a threshold language or not. Beneficiaries will be referred to the most appropriate level of care as determined by the individual performing the assessment. At each level of care, bilingual staff, interpreters, or the Language Line will be used, if needed; to provide services in the primary language.

G. Beneficiaries who do not meet the medical necessity criteria for specialty mental health services will be assisted in locating self-help and treatment resources in the community. Beneficiaries will also be informed of their right to challenge the denial for services as part of the Notice of Action procedure. If a beneficiary disputes the denial for services, a psychiatrist or licensed clinician will be contacted for a second opinion. The psychiatrist or licensed clinician will be an individual who was not involved in any way in the original decision to deny services to the beneficiary. The second opinion will not necessarily involve a face-to-face assessment of the beneficiary but will, in most cases, involve a review of the records.

H. Beneficiaries with emergent conditions will be seen as quickly as possible. If several beneficiaries are waiting with emergent concerns, beneficiaries will be triaged according to the seriousness of the condition. Emergency services will be available 24 hours a day, seven days a week.

I. Beneficiaries with urgent concerns will be able to receive services 24 hours a day, seven days a week. These services must be pre-authorized by contacting the state-wide, toll free number or the local Emergency Services Unit. Services will be authorized within one hour of notification of the need for urgent services. Services will be provided within 24 to 48 hours of the initial contact and determination of need for urgent services.

J. Stanislaus County Medi-Cal beneficiaries who reside or are traveling out-of-county will be able to access services by contacting the toll free number.

1. If the condition is urgent, the beneficiary will be directed to a local mental health facility where an urgent assessment can be performed. Services can then be authorized for the beneficiary in the area in which they are located.

2. If the request is for routine services, arrangements will be made by the Utilization Management Unit to have an assessment performed in the area in which the beneficiary is located. If the beneficiary is eligible for specialty mental health services, providers in the area in which the beneficiary is located will be contacted to provide services for the beneficiary. If the beneficiary is a minor, information will be given regarding contact with Value Options for service authorization. If the level of service required is beyond the scope of Value Options, e.g., day treatment, Utilization Management and Manage Care Services will arrange for services at the appropriate level of care.

3. If the beneficiary intends to return to Stanislaus County shortly, only services necessary to stabilize the condition and allow the beneficiary to return will be authorized.

4. To the extent possible, all children in foster care or other residential placements out-of-county and adults in residential placements out-of-county will be assessed before they leave the county to ensure timeliness and continuity of care in arranging for services out-of-county.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	Developed by/Date: Dan Souza, LCSW / 9/19/01	Page: 1 of 1	Number: 60.3.103
			Subject: HUMAN RESOURCES
	Reviewed by/Revised Date: Dorbea Cary 04/28/08	Replaces: 09/01	Distribution: All Programs
Title: CORE COMPETENCY TRAINING			Approved:

POLICY

Employees will be required to complete specified training courses and other activities related to the development of specified core competencies necessary for their job. These courses and activities will be made available to employees, including release time from regular duties. Time frames for completion will be established for each employee and communicated to them at the time of appointment and at each annual performance review. Core competencies will vary based on employee's classifications, job and licensure requirements. These core competencies are required for all full-time employees and may be required for part-time staff by senior managers depending on job requirements.

PURPOSE

To ensure a well trained workforce where each employee has the minimum competencies necessary to do their job. To provide the necessary job training to employees in an ever-changing environment and to provide quality services to consumers served by the Department.

PROCEDURE

A. Senior Leadership, in consultation with the BHRS Training Committee, will establish core competency courses and activities for all groups of employees. *(See Attachment A for Leadership Staff) (See Attachment B for Administrative and Clerical Staff) (See Attachment C for All Services Staff) (See Attachment D for SRC and AOD Services Staff)* These will be communicated in writing to all employees.

B. The BHRS Training Coordinator will be responsible for insuring that the required courses and activities are available to employees. Senior Leadership will be responsible for ensuring that adequate resources are available.

C. New employees' immediate supervisors will provide staff a list of required core competency courses, activities and the timeframes for completion.

D. Immediate supervisors will be responsible for providing newly promoted or transferred employees a list of required core competency courses and activities for their new positions. The employee and his/her manager are responsible for ensuring that the employee attends all required training in the allotted time.

E. Annual performance reviews will indicate progress toward completion of the required core competency courses and activities and corrective action plans if not completed.

F. Senior Leadership and the BHRS Training Committee will review the required core competency courses and activities annually and make adjustments as needed.

G. Attendance records for BHRS sponsored trainings will be maintained jointly by the Training Department, Data Management Services and Human Resources and entered into People Soft.

H. Supervisory staff will have access to training attendance reports for each employee through the Training Coordinator.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Connie Moreno-Peraza, LCSW Dan Souza, LCSW/ 10/20/00	**Page:** 1 of 6	**Number:** 90.1.106
			Subject: CLIENT SERVICES
	Reviewed by/Revised Date: Madelyn Schlaepfer, Ph.D./ 6/19/01	**Replaces:** 10/20/00	**Distribution:** All Programs
Title: **LANGUAGE ASSISTANCE SERVICES TO LIMITED ENGLISH SPEAKING CLIENTS AND FAMILY MEMBERS**			**Approved:**

POLICY

It is the policy of Stanislaus County Behavioral Health and Recovery Services to provide language assistance to clients and families who are limited English proficient. Assistance will be provided though bilingual staff, certified interpreters and the Language Line. Such assistance will be available free of charge, twenty-four hours a day, seven days a week depending on the business hours of the facility or program.

PURPOSE

Culturally competent services will be provided by this Department as identified in the Mission Statement, Welfare & Institutions Code Section 5600 (g), and Title VI of the Civil Rights Act of 1964; Limited English Proficient (LEP) clients/customers will have meaningful and equal access to benefits and services.

The following procedures will be used in order to access the different resources available to assist limited English proficient and culturally diverse clients and their family members to receive services and benefits of this Department.

PROCEDURE

A. General Information

1. Bilingual staff and service providers are the preferred and expected method of providing language assistance to persons who are limited English proficient, especially those languages identified as threshold languages. After attempts to locate bilingual staff have not been successful, the use of trained interpreters is the next preferred method of providing language assistance. If the language needed is one available from the list of trained interpreters or no bilingual staff or trained interpreters are available, staff should implement the procedure below for use of the Language Line.

2. A list of interpreters on independent contract is maintained by the Contracts Unit and updated as necessary (see Policy and Procedure 90.1.112). When it is updated, each program receives multiple copies through interdepartmental mail. These copies are intended for posting and notifying staff.

3. Children and adolescents are prohibited from being used as interpreters for their families. Generally, adults should not be used as interpreters for members of their family. It is recognized there may be occasions when an adult family

member prefers and requests that another adult family member be used as an interpreter. If such a request is made, the Department's policy on the use of trained interpreters to provide language assistance is to be explained to the client or family member. If the request is still to use an adult family member, then a trained interpreter is to be obtained to monitor the accuracy of the translation.

4. Staff are to document the need for interpreters, the use of interpreters and the name of interpreters whenever used. In addition, the individual's response to the offer of an interpreter shall be noted.

5. Assessments, including current episode intakes and crisis sheets, are to identify the need for department certified and trained interpreters if such a need is identified.

6. Whenever an interpreter is used, a progress note (or the crisis sheet) of that contact is to include documentation of the use of an interpreter and the name of the interpreter.

7. Interpreters should be instructed to provide literal translation. The role of interpreter is to be explained prior to each episode of translation by the service delivery staff.

8. Staff using interpreters should be aware of the following limitations in using interpreters:

    a. The nature of the client/therapist relationship is altered with the presence of a third party. Bonding with the therapist by a client may be altered or different because of a third party interpreter.

    b. Feelings of distress may arise on the part of all participants regarding the accuracy of the translation or the ability to convey what is intended. This is because neither the client nor the therapist can totally verify the accuracy of what is being translated. There may always be an element of doubt on the part of all parties because they are not able to speak and communicate directly.

    c. There are limitations to the use of interpreters compared to direct communication. These include the fact that there is a third party, feelings cannot always be conveyed effectively, eye contact may not be direct between the therapist and the client, and therapist and client may not be positioned in the session as they would if they did not have a third party interpreter.

9. Following each episode of translation, staff are to provide a period of time for debriefing with the interpreter. This time should be used to respond to any issues related to the translation, problems noted during the session related to translation, and any feelings the interpreter may have that could not be expressed during the session. Staff can also use this time to raise any questions they may have about this translation with the interpreter.

10. Quality Services Training Unit will regularly calendar training for interpreters. All linguistically proficient bilingual staff and contract interpreters are required to attend and successfully demonstrate competency in translation. Training will also be periodically scheduled for persons using interpreters. All service delivery staff will be expected to attend.

11. All organizational providers who operate as key points of contact will also provide language assistance to clients and families who are limited English proficient in order to link them to appropriate services. This language assistance will be provided for all languages, including those that are not considered threshold languages.

B. Bilingual Staff

1. All key points of contact will have bilingual staff who is linguistically proficient in Spanish available during business hours to insure ease of access and quality services to persons who are limited English proficient and who speak Spanish. Key points of contact will be defined by Department Leadership. All linguistically proficient bilingual staff are to provide, when needed, language assistance to persons who are limited English proficient.

2. All linguistically proficient bilingual staff will be trained and have passed the county-approved competency for language interpreters.

3. Twenty-four (24) hour programs will make every effort to ensure that bilingual staff are assigned on all shifts and that on-call replacement staff for these positions are also bilingual.

4. Annually the Cultural Competency Manager and System of Care leaders will assess the language assistance needs, including the need for linguistically proficient bilingual staff at all work-sites. This assessment will include an analysis of the community that the system and program serve, demand for interpretation by linguistically proficient bilingual staff, the need for bilingual staff to deliver culturally competent services and the amount of usage of contract interpreters by language. The assessment will result in the identification and recruitment of linguistically proficient bilingual staff necessary to meet the language assistance needs of those systems and programs.

C. Language Interpreters

1. When linguistically proficient staff and bilingual service delivery staff are not available to someone who is limited English proficient, staff will provide language assistance through a Department trained interpreter. The Department trained interpreter could be someone on staff other than the service delivery person or someone from the Department's list of Department trained contract interpreters.

2. All linguistically proficient interpreters will be trained and have passed the county-approved competency for language interpreters.

3. The Contracts Unit of Behavioral Health and Recovery Services will maintain a list of Department trained linguistically competent bilingual interpreters whose skills are in the following languages:

- Spanish
- Hmong
- Vietnamese
- Lao
- Cambodian
- Assyrian
- Portuguese
- American Sign Language

The list will be continuously and sufficiently large enough to ensure 24-hour availability of these interpreters. The Contracts Unit will provide orientation and will schedule training prior to interpreters being placed in the list.

4. When a limited English proficient client or family member's primary language is a language other than English or those listed above, supervisory service delivery staff will authorize the Contracts Unit to recruit an interpreter for that language and add that person to the interpreter list.

5. At the end of each month in which the interpreter provided service, the interpreter will attach the Authorization for Service form to the time card or monthly Blue Claim. The Authorization for Service form will be used to verify service to Department clients and charge the appropriate program.

6. The Department will not reimburse charges by contract interpreters for services that are not documented as authorized by Department staff.

D. The Language Line

1. When no bilingual staff or trained interpreters are available, the Language Line may be used until such time as bilingual staff or an interpreter is available. It is recognized that the Language Line is not the first choice in providing services to persons who are limited English proficient, but it is available when no other resource can be obtained. Staff must first attempt to locate Department certified and trained bilingual staff or a Department certified and trained interpreter.

2. When receiving a call from or when with a client who is limited English proficient first try and locate an interpreter in-house before calling the Language Line.

3. When using the Language Line, maintain a log which includes the following information:

   a. Program

   b. Client's Name and/or Medical Record Number

   c. Staff Name

   d. Language Needed

   e. Time Call Began

f. Interpreter's Number

g. Time Call Ended

4. Ensure that the client/customer is near a telephone. If a client is calling on a phone, ask the client to hold while you connect to the interpreter.

5. On same line, dial interpreter service (do not conference until interpreter comes on line).

   a. Dial:

      - 9-1-800-523-1786

   b. They will answer:

      - Language Line (The Answer Point Person)

   c. Give language needed:

      - Be specific if language of the client/customer is known or, if guessing, let the Answer Point know we are not sure of the client's/customer's language but think it may be . . .

   d. Give client ID number:

      - 201277

   e. Give Organization Name:

      - Stanislaus County Behavioral Health and Recovery Services

   f. Give Personal Code:

      - Department 809004

6. Connect the caller or client to the line with you and the Answer Point letting them know we are waiting for the interpreter. If the client is present, use second phone to connect client to you and Answer Point person.

7. Stay on the line to direct and control communication between the Language Line interpreter and the client.

   NOTE: If, for some reason, the client hangs up his/her telephone while you are waiting to connect to Language Line, the Language Line Answer Point can place a "dial-out" call to the client to reconnect. Have the client's number handy.

8. When the interpreter joins the line he/she will say, “This is (language) interpreter number “(#)”.

9. Introduce yourself to the interpreter. Explain what you would like to accomplish. For example, if you want to obtain a Consent for Treatment, tell the interpreter and request word-for-word translation. If you are not sure what the client has called about, tell the interpreter you do not know and ask him/her to find out what the client needs.

10. The interpreter will relay information back and forth between you and the client.

11. Tips for a successful call:

    a. Use easily understood words and simple sentence structure. Avoid using jargon.

    b. Keep the call as brief as possible by preparing in advance, being concise and specific.

    c. Take the lead. The interpreter will repeat what you say.

    d. Some questions can be grouped effectively, such as demographic information, questions that can be answered “yes” or “no”, and questions that cover only one thought/concept.

    e. To ensure information is correct, confirm as you go instead of asking for the information again.

12. Continue to direct and control the exchange until you have all of the information you need and the call is completed. When the call is completed, ask the interpreter to “end the call.” The interpreter will say, “end of call.” Write down the approximate time services ended. Charges will stop accruing.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Connie Moreno-Pereza, LCSW 2/7/94	**Page:** 1 of 2	**Number:** 90.1.112
			Subject: CLIENT SERVICES
	Reviewed by/Revised Date: Connie Moreno-Peraza, LCSW / 9/30/01	**Replaces:** 6/6/94	**Distribution:** All Programs
Title: **LANGUAGE TRANSLATORS**			**Approved:**

POLICY

Services (including those of contract agencies) will be provided to clients, in their primary language, primarily and preferably through bilingual staff. Qualified translators may be used on occasions where preferred bilingual staffs are unavailable.

PURPOSE

Provision of culturally competent services as identified in the Department's Mission Statement. W & I Code, Section 5600(g).

PROCEDURE

A. Whenever possible, services should be provided in the client's primary language by staff fluent in that language. All programs will identify, designate and recruit bilingual staff for languages, which are primarily spoken by specific populations in the community. Twenty-four hour programs will ensure that bilingual staffs are designated on all shifts and that on-call replacement staff for these positions are also bilingual. The principal goal is to provide services directly to clients by staffs who are fluent in the client's primary language and to only use translators when staff are not available.

B. When bilingual service delivery staff are not available to someone whose primary language is other than English, staff will provide assessment and other direct services through a qualified translator. The qualified translator could be someone on staff other than the service delivery person or someone designated by the client except as noted below.

C. The personnel unit of Stanislaus County Behavioral Health and Recovery Services will maintain a list of qualified bilingual translators whose skills are in the following languages:

Spanish	Cambodian
Hmong	Assyrian
Vietnamese	Portuguese
Lao	American Sign Language

The list will be continuously and sufficiently large enough to ensure 24-hour availability of these translators. The personnel unit will provide orientation and training to translators who are listed.

D. When identification of a client's primary language is made and is other than English or those listed above, service delivery staff will request the personnel unit to recruit a translator for that language, and add that person to the translator list.

E. When no bilingual staff or translator are available, the AT&T Language Line (see attached) may be used until such time as bilingual staff or a translator is available. It is recognized that the AT&T Language Line is not the first choice in providing services to persons whose primary language is other than English, but it is available when no other resource can be obtained. Staff are first to attempt to locate bilingual staff or a qualified translator.

F. Children and adolescents are not to be used as translators for their families. Generally, adults should not be used as translators for members of their families. It is recognized there may be occasions when an adult family members prefers and requests that another adult family member be used as a translator.

G. Translators should be instructed to provide literal translation. The role is to be explained prior to each episode of translation by the service delivery staff.

H. Following each episode of translation, staff are to provide a period of time for debriefing with the translator. This time should be used to respond to any issues related to the translation, problems noted during the session related to translation, and any feelings the translator may have that could not be expressed during the session. Staff can also use this time to raise any questions they may have about this translation with the translator.

I. Staff using translators should be aware of the following limitations in using translators:

1. The nature of the client/therapist relationship is altered with the presence of a third party. Bonding with the therapist by a client may be altered or different because of a third party translator.

2. Feelings of distress may arise on the part of all participants regarding the accuracy of the translation or the ability to convey what is intended. This is because neither the client nor the therapist can totally verify the accuracy of what is being translated. There may always be an element of doubt on the part of all parties, because they are not able to speak and communicate directly.

3. There are limitations to the use of translators compared to direct communication. These include the fact that there is a third party, feelings cannot always be conveyed effectively, eye contact may not be direct between the therapist and client, may not be positioned in the sessions as they would if they did not have a third party translator.

J. Staff are to document the need for translators, the use of translators and the name of translators whenever used.

1. Assessments, including current episode intakes and crisis sheets, are to identify the need for translators if such a need is identified.

2. Whenever a translator is used, a progress note (or the crisis sheet) of that contact is to include documentation of the use of a translator and the name of the translator.

K. This policy will be an attachment to all Department agency provider contracts. (Contracts utilizing the Department's contract translators will be billed for the cost of the translator if not otherwise negotiated in the contract.)

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Madelyn Schlaepfer, Ph.D. 2/26/01	**Page:** 1 of 1	**Number:** 90.1.113
			Subject: CLIENT SERVICES
	Reviewed by/Revised Date:	**Replaces:**	**Distribution:** ALL PROGRAMS
Title: **SERVICES TO CONSUMERS W ITH VISUAL IMPAIRMENTS**			**Approved:**

POLICY

It is the policy of Stanislaus County Behavioral Health and Recovery Services (BHRS) that all consumers with visual impairments will have access to services and to Mental Health Plan (MHP) informational materials, e.g., Member Guide, in an oral format.

PURPOSE

California Code of Regulations, Title 9 and Title 22. Federal laws and regulations. Visually impaired individuals have a right to services as well as information regarding services that is provided in a manner that ensures optimal communication between the visually impaired person and the provider.

PROCEDURE

A. Upon contact with BHRS at any location, it will be determined if an individual has any visual impairments.

B. If visual impairments are present, staff providing the initial face-to-face assessment will be notified of the impairment prior to the assessment.

C. Staff who performs the initial assessment will ensure that informational materials are available on an audio tape, which can be given to the applicant for services.

D. Once appropriate referrals have been identified, staff performing the initial assessment will ensure that the referral sources are made aware of the individual's impairment and the expectation that informational materials will be provided in an oral format.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Cathleen St. Martin / 10/4/93	**Page:** 1 of 1	**Number:** 90.1.114
			Subject: CLIENT SERVICES
	Reviewed by/Revised Date: Cathy St. Martin / 9/30/01	**Replaces:** 4/28/97	**Distribution:** ALL PROGRAMS
Title: **USE OF CONTRACT CULTURAL INTERPRETERS**			**Approved:**

POLICY

Each Department staff who requests a contract Cultural Interpreter must sign the Authorization for Services form which documents they have authorized the service (Attachment A).

PURPOSE

Contract Cultural Interpreters are limited to translating for Department clients only. A staff signature is one way of monitoring this. Costs are applied to the program requesting the services. The determination of which program to charge is made according to which program staff authorized the service.

PROCEDURE

A. Each Cultural Interpreter will bring to the session an Authorization for Service form. At the end of the session, the Department staff person who requested the service shall sign the Authorization for Service form on the line where the Cultural Interpreter has indicated the date and hours of service.

B. At the end of each month in which the Cultural Interpreter provided service, he/she will attach the Authorization for Service form to the monthly blue claim. The Authorization for Service form will be used to verify service to Department clients and charge the appropriate program.

C. Charges by contract Cultural Interpreters for services which are not documented as authorized by Department staff will not be reimbursed.

D. A list of Cultural Interpreters on independent contract is maintained by Contracts and updated as necessary. The Cultural Interpreters List can be located at the BHRS Intranet under “Our Teams”, “Contracts”. When it is updated, each program receives and e-mail update intended for posting and notifying staff.

FROM: _____
(Translator)

RE: TRANSLATING SERVICES FOR _____
(Month)

DATE	HOURS OF SERVICE	SIGNATURE OF STAFF AUTHORIZING SERVICE	PROGRAM LOCATION

90.1.114 Attachment A

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES	**Developed by/Date:** Maria Maceira-Lessley, 4/2/07	**Page:** 1 of 4	**Number:** 10.4.100
			Subject: LEADERSHIP FUNCTIONS
	Reviewed by/Revised Date: Glenn Hutsell 1/11	**Replaces:**	**Distribution:** All Programs
Title: **COMPENSATION AND/OR REIMBURSEMENT OF TIME AND TRAVEL FOR CONSUMERS AND FAMILY MEMBERS**			**Approved:** Denise C Hunt

POLICY

It is the policy of Stanislaus County Behavioral Health and Recovery Services (BHRS) to compensate consumers, family members, and parents or caregivers of minor children who receive behavioral health services related to activities as stakeholders in BHRS committees and stakeholder meetings, and when assisting BHRS by completing special project tasks related to program planning and policy development. BHRS encourages and appreciates consumer and family member participation in any activity.

An elemental concept in the Mental Health Services Act (MHSA) is that community mental health programs develop consumer and family-driven systems of care. Under this model, consumers identify their needs and preferences, which lead to the programs and providers that will help them most. Their needs and preferences drive the policy and financing decisions that affect them.

Stanislaus County Behavioral Health and Recovery Services is committed to the fullest possible involvement of consumers and family members in planning, developing, providing and evaluating services for consumers of all ages. BHRS values the participation of consumers and family members and benefits from the meaningful and significant involvement of consumers and family members.

PURPOSE

This policy is intended to provide a mechanism to promote participation and fairly compensate consumers and family members for their participation in BHRS activities, including participation on committees, stakeholder meetings, consultations, focus groups, special projects, program review activities and hiring panels.

This process must be culturally competent and ensure that monolingual consumers and family members and consumers and family members with disabilities have opportunities to contribute.

Standards established by the California Department of Mental Health for the MHSA state that, “Community Program Planning must include meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.” Welfare and Institutions Code Section 5892(c) states that, “The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process,” which means that counties are funded to pay for these costs.

ELIGIBILITY

A. Consumers and family members who participate in the following approved activities as stakeholders are eligible to be compensated with prior approval from the Manager of Consumer and Family Affairs or other managers designated by the Behavioral Health Director:

1. Participation in BHRS approved committees;
2. Participation in BHRS approved stakeholder meetings;
3. Participation in other BHRS approved planning, program review, and policy development workgroups, focus groups or meetings;
4. Assisting BHRS by completing special projects related to planning and policy development; and
5. Participation in hiring panels.

B. Exclusions: Attendance at a public meeting designed to offer opportunities for general input or for attendees to gain general knowledge will not qualify for compensation or reimbursement (e.g., attendance at a Mental Health Board meeting, or at a large community forum concerning BHRS services or planning).

C. Consistent with Section 5604.3 of the Welfare and Institutions Code, Mental Health Board members may be reimbursed for actual and necessary expenses incurred incident to the performance of their official duties and functions. Expenses may include travel, lodging, childcare and meals for members while on official business as approved by the Director of Behavioral Health and Recovery Services.

D. A Social Security Number is required to qualify for a stipend.

PROCEDURE

A. If a consumer or family member meets the eligibility requirements, previously approved compensation will be provided in one of three ways, and/or meals and travel expense reimbursement(s) as agreed upon by the consumer, the facilitator (who may be staff, consumer or family member) of the committee, meeting, or project, and the BHRS Manager of Consumer and Family Affairs or other manager designated by the Behavioral Health Director.

1. No compensation will be provided if the consumer or family member prefers to participate as an unpaid volunteer.
2. Consumers and Family members who participate in approved meetings and/or activities are eligible for a stipend. Participants are allowed to submit up to eight (8) stipend invoices per month. The stipend amount for any meeting regardless of length is $25.00. See **Attachment A and B.**
3. A Personal Services Contract between the consumer or family member and BHRS may be developed for time limited special projects. Compensation will be consistent with the current stipend amount.

AND/OR:

BHRS will provide meals and/or compensation for transportation (e.g., mileage for own vehicle, bus passes, or BHRS may arrange and provide transportation). Mileage and

other expenses (e.g., meals, parking, etc.) will be compensated at the same rate currently paid to staff for mileage on travel expense claims. Mileage and meals shall not exceed limits established in the Board of Supervisors approved County Travel Policy.

B. To receive a stipend, consumers and family members must:
   1. Sign-in when arriving at a meeting
   2. Cannot arrive more than 30 minutes late to any meeting
   3. Need to present at each meeting for a minimum of:
      - If meeting is 6-8 hours long, need to be at meeting for 5-7 hours
      - If meeting is 4-6 hours long, need to be at meeting for 3-5 hours
      - If meeting is 1-3 hours long, need to be at meeting for 1-2 hours

C. No additional compensation will be available if participation by a consumer or family member is considered paid work time, either through Stanislaus County or another employer.

D. If a meeting is canceled, the meeting facilitator should make attempts to contact all expected and regular participants to inform them of the cancellation by using the last known telephone number, last known email address, and by personal communication. Consumers and family members should ensure that current phone numbers and e-mail addresses are provided to BHRS.

E. For compensation of travel expenses, the consumer or family member will submit a County Blue Claim form. Any out of town travel expenses must have prior approval through the use of a County Trip Authorization Form.

INVOICE

For compensation through a stipend, the consumer or family member will submit an Invoice for Consumer/Family Member Stipend (attached).

PROCESSING CLAIMS

Procedures for processing claims for compensation are as follows:

A. The meeting facilitator should complete the following steps:
   1. Confirm that the consumer or family member had prior approval for attendance at the meeting through notation on the meeting sign-in sheet.
   2. Confirm that the hours stated on the Invoice for Consumer/Family Member Stipend or Blue Claim are correct by verifying signatures on sign in sheet.
   3. Confirm that the consumer/family member completes all sections of the form, i.e. mailing address, telephone number name of the meeting, number of hours, date of meeting and signature have been entered on the forms submitted.
   4. Ensure all necessary BHRS documentation to obtain stipend or Blue Claim compensation is completed based on the information from the Blue Claim or Invoice for Consumer/Family Member Stipend. The facilitator will approve by signing and dating the forms.
   5. Submit completed forms to the Consumer/Family Manager.

B. A designated BHRS staff person should complete the following steps:
   1. Confirm that all sections of the form have been completed.

2. Route to the Manager of Consumer and Family Affairs Manager or the Behavioral Health Director/designee for authorization to pay.
3. Make copy of the Consumer/Family Member Stipend form for reference.
4. Submit the approved documents to BHRS Accounting to process payment for the Blue Claim or the Invoice for Consumer/Family Member Stipend.

C. BHRS Accounting staff should complete the following steps:

1. Inform the Manager of Consumer and Family Affairs Manager if any problems arise that may prevent or delay the processing of the compensation.
2. Mail check to the address on the form.

IMPACT ON BENEFITS AND IRS REPORTING REQUIREMENTS

A. BHRS will abide by all IRS reporting requirements as directed by County Counsel. If an individual receives SSI and/or SSDI benefits, it is the individual's responsibility to contact Social Security to determine how the compensation may affect benefits.

B. BHRS will issue 1099 tax-reporting forms to anyone who receives $600 or more in a calendar year.

BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

800 Scenic Drive, Modesto, CA 95350
Phone: 209-525-6225 Fax: 209-525-6291

NOTE: Check will be mailed to the address indicated below (allow approximately 30 days to process)

☐ Pick up from BHRS Administration

INVOICE

Consumer/Family Member Stipend

(To receive the stipend and/or meals and travel expense reimbursement(s), this invoice must be signed by the recipient submitting this invoice and the meeting facilitator or a Senior Leader.)

Name:_____

Address:_____

City:_____ Zip:_____

Telephone:_____

I attended/participated in (indicate meeting name and/or describe event): _____

_____

_____

Number of Hours:_____On date(s):_____

I hereby declare that the above information is true and correct. I understand that the above information may be verified by the facilitator and/or my signature from the sign-in-sheet(s) of the meeting(s) or event(s) that I attended/participated in.

_____ _____
Consumer/Family Member Signature Date

_____ _____
Meeting Facilitator/Senior Leader Signature Date
Print Name:

Please return this completed and signed form to:

Behavioral Health & Recovery Services
Administration
800 Scenic Drive
Modesto, CA 95350

Reporting Stipends as Income to Social Security:
If you receive SSDI or SSI benefits, the law requires that you report any earned income to Social Security. The stipends you receive from Stanislaus County when you participate in meetings or other activities count as earned income and should be reported. For more information, please contact the BHRS Office of Consumer and Family Affairs at (209) 525-6225.

FOR BHRS OFFICE USE ONLY

Date:_____

Amount to be paid: $_____ Approval Signature:_____

All invoices must be approved by the Manager for Consumer and Family Affairs or the Behavioral Health & Recovery Services Director. ☐ Paid _____(←Accounting initial)

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3. Participation in other BHRS approved planning, program review, and policy development workgroups, focus groups or meetings;
4. Assisting BHRS by completing special projects related to planning and policy development; and
5. Participation in hiring panels

Exclusions: Attendance at a public meeting designed to offer opportunities for general input or for attendees to gain general knowledge will not qualify for compensation or reimbursement (e.g., attendance at a Mental Health Board meeting, or at a large community forum concerning BHRS services or planning).

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PROCEDURE - If a consumer or family member meets the eligibility requirements, previously approved compensation will be provided in one of three ways, and/or meals and travel expense reimbursement(s) as agreed upon by the consumer, the facilitator (who may be staff, consumer or family member) of the committee, meeting, or project, and the BHRS Manager of Consumer and Family Affairs or other manager designated by the Behavioral Health Director.

1. **No compensation** will be provided if the consumer or family member prefers to participate as an unpaid volunteer.
2. **Stipend:** Consumers and Family members who participate in approved meetings and/or activities are eligible for a stipend. Participants are allowed to submit up to eight (8) stipend invoices per month. The stipend amount for any meeting regardless of length is $25.00.
    a. To receive a stipend, consumers and family members must:
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        3. Need to be present at each meeting for a minimum of:
            - If meeting is 6-8 hours long, need to be at meeting for 5-7 hours
            - If meeting is 4-6 hours long, need to be at meeting for 3-5 hours
            - If meeting is 1-3 hours long, need to be at meeting for 1-2 hours
3. A **Personal Services Contract** between the consumer or family member and BHRS may be developed for time limited special projects. Compensation will be consistent with the current stipend amount.

AND/OR

Meals & Travel Expense: BHRS will provide meals and/or compensation for transportation (e.g., mileage for own vehicle, bus passes, or BHRS may arrange and provide transportation). Mileage and other expenses (e.g., meals, parking, etc.) will be compensated at the same rate currently paid to staff for mileage on travel expense claims. Mileage and meals shall not exceed limits established in the Board of Supervisors approved County Travel Policy.

a. For compensation of travel expenses, the consumer or family member will submit a County Blue Claim form. Any out of town travel expenses must have prior approval through the use of a County Trip Authorization Form.

Exclusions: *No additional compensation will be available if* participation by a consumer or family member is considered paid work time, either through Stanislaus County or another employer.

If a meeting is canceled, the meeting facilitator should make attempts to contact all expected and regular participants to inform them of the cancellation by using the last known telephone number, last known email address, and by personal communication. *Consumers and family members should ensure that current phone numbers and e-mail addresses are provided to BHRS.*

(See BHRS Policy #10.4.100 Compensation and/or Reimbursement of Time and Travel for Consumers and Family Members for details.)

Cultural Competence Oversight Committee
Minutes

Stanislaus County Minutes

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	September 12, 2005
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Cherie Dockery	**Ending Time:**	11:00 am

Attendees:

Administration
Marisela Cantu

Patients' Rights
Teresa Alvarez

Training
Dorbea Cary

DMS/Performance Outcomes
Mark Morrison

CSOC
Lillie Clark-YFS
Jeanine Serpa

Consumer/ Community Rep.
Tricia Nugent
Diana Lynn Kaysen

ASOC
Cherie Dockery-AOD
Brian Barker

SRC
Ruben Imperial

Admin Services
Martha Escutia

Quality Services
Pat Hitch

Human Resources
Christi Golden

OASOC
Connie Alcala-EMO

SBHC
Jennifer Johnson

Absent:

Administration
Nancy Millberry-VAC
Khani Gustafson
Madelyn Schlaepfer-VAC
Linda Torres

Managed Care
Pete Duenas-VAC

ASOC
Pat Mireles

Common Ground
Bernard Green

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Everyone introduced him/herself.			
Approval of Minutes – August 8, 2005	All	Approved			
Approval of Agenda – September 12, 2005	All	Approved			
Cultural Competence Assessment Tool	Dorbea Cary	Dorbea Cary stated she would contact Khani Gustafson and Pete Duenas regarding the status of the Cultural Competence Assessment Tool.			
Mental Health Services Act Review	All	Cherie distributed Part II: Program and Expenditure Plan Requirements of the Mental Health Services Act. CCOC members were asked to critically review and comment on the Mental Health Services Act. CCOC members were asked to break into small groups and go over only the Cultural Competence portion. CCOC members spent the majority of the meeting reviewing the eleven activities and each group			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Mental Health Services Act Review Continued	All	submitted their comments during the meeting. A summary of committee comments will be forwarded to Khani Gustafson.			
Announcements	All	A packet regarding the Eleventh Annual Latino Behavioral Health Institute scheduled for September 20-22, 2005 in Universal City, CA was distributed to CCOC members who were interested in attending. An article printed in the Modesto Bee titled 'Minority' Label Criticized as Outdated, Inaccurate was distributed for informational purposes. Lillie Clark announced September is Native American and Hispanic Heritage Month. Teresa Alvarez and Trisha Nugent volunteered to bring food to the next meeting.			

Next Meeting: **October 10, 2005** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 11:00 am, unless otherwise indicated.**
Respectfully Submitted by:	Marisela Cantu

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	August 11, 2008
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

Administration
Linda Torres

Administrative Services
Nancy Riggs

Training/WET
Marisela Cantu
Jim Hurley

ASOC
Alice Tamraz

CSOC
Lillie Clark
Blanca Medina

Managed Care
Pete Duenas

Consumer & Fam. Rep.
Jamie Hoover
Jesus Gutierrez

Human Resources
Christi Golden

MHSA
Carol Jo Hargreaves

Quality Services
Cherie Dockery

EMO
Connie Alcala

AOD Ed. & Prevention
Ruben Imperial

DMS
David White

Contract Providers
Susan Trudell
Barbara Anderson
Jim Riley
Al Ellsmore

CERT
Tanya Mangum *for Ken Huntley*

Formatted

Formatted

Absent:

Administration
Jean Anderson
Debra Buckles-Vac
Adrian Carroll
Glenn Hutsell
Madelyn Schlaepfer

Training
Dorbea Cary-Vac

Health/Mental Health Team
Mary Aguirre

Genesis
Robert Broom

CSOC
Janette Jameson
Shereen Reid

MHB
Robert Angell

ASOC
Rose Mitchell-M. Leave

Administrative Services
Stacey Della-Vac

SATT/SART
Demi Laughlin-Leave

Quality Services
Vickie Looney-Vac

Patients' Rights
Teresa Alvarez

Family Advocate
John Black

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Attendees shared their name, program(s) representing and reported on two cultural groups their program serves.			
Approval of Minutes – July 14, 2008	All	Cherie Dockery motioned to approve the 7/14/08 meeting minutes, Ruben Imperial seconded. The minutes were approved as submitted.			
Additions/Changes to Agenda Items	All	None			
Action Items from July 14, 2008 Meeting	P. Duenas	Pete reminded CCOC Members to review the Strategic Action Plan 1, Major Action #2, "Assessment of Supervisor's Inclusion of Diversity Content" and send any feedback to Dorbea Cary.	Submit feedback to Dorbea Cary on the "Assessment of Supervisor's Inclusion of	CCOC Members	ASAP

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
			Diversity Content"		
CCOC Newsletter, August 2008 Edition	C. Hargreaves	Carol Jo distributed the August CCOC Newsletter. Carol Jo discussed the article on Client Culture and invited members to write a comment and submit to the CCOC for discussion. Carol Jo also asked that members share the August CCOC Newsletter in their team meetings. September Newsletter contributors were asked to submit articles regarding recovery stories or culturally competent program activities. Deadline to submit an article is Monday, August 18th.	Submit September Newsletter articles to Carol Jo	September Contributors	8/18/08
Consumer/Family Member Input	All	None.			
Training Update/Training Announcements	D. Cary	The BHRS Training Calendar for August – October 2008 was distributed. David White reported the "Labels Are For Jars" presentation to Senior Leadership by Dorbea Cary and Ruben Imperial was very good and he can't wait to provide this at his program staff meeting. Linda Torres reported Senior Leadership brought up the need for suggestions of ways to address someone who is using inappropriate, stigmatizing language. Jim Hurley reported the Spirituality Training will be offered again in the future and asked that anyone interested in being a presenter contact him.			
Quarterly Refugee Meeting (7/16/08) Report; Model for Community Supports	A. Tamraz	Alice Tamraz reported she attended the Quarterly Refugee Meeting on July 16, 2008 and stated funding for the "Unanticipated Arrival Program" will end February 2009. Alice reported the program is currently submitting letters requesting more funding. This program helps refugees connect with programs or resources in the County such as transportation, housing, the school system, Food Stamps and MediCal, immunizations, etc. Refugees may receive services for 9 months and can be sponsored by anyone in the community. There was much discussion regarding BHRS staff being properly trained to provide services to the Refugee population. Pete Duenas and Alice Tamraz will contact Jean Anderson regarding discussion and concerns.	Contact Jean Anderson regarding staff training for Refugee population	P. Duenas A. Tamraz	9/8/08

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Cultural Competence Aspects of WET Plan Implementation	J. Hurley	Jim shared a very detailed and informative PowerPoint presentation regarding Workforce Education and Training (WET). The presentation included what Workforce Education and Training is about, transformation, the BHRS WET planning process, shortages within the workforce, workforce needs assessment, etc. A system-wide Training Committee will be convened, to include 50% consumers and family members. Notify Jim or Marisela if you would like a copy of today's PowerPoint.			
Strategic Plan 2007/2008 Status Summary; Ideas for 2008/2009	All	The CCOC was scheduled to review the Cultural Competence Strategic Action Plans but were not able to review the Status Summary for each of these Action Plans due to running out of time. Pete stated the plan is to continue some of these Action Plans into FY 08/09 given that some of the Action Plans are partially completed. Pete will e-mail the two Cultural Competence Strategic Action Plans to all CCOC members and ask members to read the Status Summary column then provide ideas/suggestions for revision. Pete stated, because we've completed Action Plan # 2-1 he would like ideas for FY 08/09. Please send your ideas to Pete Duenas via e-mail by August 25, 2008.	E-mail Strategic Plan ideas to P. Duenas	CCOC Members	8/25/08
Other Business	All	Ruben Imperial reported that MHSA Prevention and Early Intervention (PEI) invites BHRS staff to respond to the survey on community needs and take part in upcoming community feedback forums.			
Next Meeting: **September 8, 2008** **Redwood Room, 800 Scenic Drive**		**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**			
Respectfully submitted by: Marisela Cantu					

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	January 12, 2009
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

Administration
Linda Torres

Training/WET
Marisela Cantu

MHSA
Carol Jo Hargreaves

Health/Mental Health Team
Mary Aguirre

ASOC
Alice Tamraz
Rose Mitchell

CSOC
Lillie Clark
Carolyn Warren-Smith for Janette Jameson
Lucy Escobar

EMO
Connie Alcala

Consumer & Fam. Rep.
Reg Gilbert

Family Advocate
John Black

Administrative Services
Stacey Della

Peer Advocate
Tim White

Quality Services
Vickie Looney

DMS
David White

CERT
Ken Huntley

Managed Care
Pete Duenas

Human Resources
Christi Golden

Contract Providers
Barbara Anderson
Al Ellsmore
Ana Perez
Jim Riley
Fernando Granados
Susan Trudell
Jorge Fernandez

SRC
Michael Toomey

Absent:

Administration
Jean Anderson
Glenn Hutsell
Debra Buckles
Adrian Carroll
Elizabeth Oakes
Madelyn Schlaepfer

Patients' Rights
Teresa Alvarez

Genesis
Robert Broom

AOD Ed. & Prevention
Ruben Imperial

MHB
Robert Angell

CSOC
Shereen Reid
Blanca Medina

SATT/SART

Quality Services
Cherie Dockery

Administrative Services
Nancy Riggs

Training/WET/HR
Dorbea Cary
Jim Hurley

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome, Introductions	All	Each attendee shared his/her name and program(s) representing.			
Approval of Minutes – December 8, 2008	All	David White motioned to approve the 12/8/08 meeting minutes, Ken Huntley seconded. The minutes were approved as submitted.			
Action Items from December 8, 2008	All	None.			
CCOC Newsletter, January 2009 Edition	M. Cantu	Marisela distributed the January 2009 CCOC Newsletter. Carol Jo reminded February 2009 Newsletter contributors that the deadline to submit their articles is Tuesday, January 20, 2009.	Submit February 2009 Newsletter articles to Carol Jo	February 2009 Contributors	1/20/09

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
CCOC Orientation Materials Binder Update	C. Hargreaves	Carol Jo went over the purpose of the CCOC Orientation Binder and drew member's attention to the purpose and duties of the CCOC. The binder includes the BHRS Mission, Vision and Values. The CCOC monthly agenda includes the CCOC Mission. Carol Jo read aloud the CCOC Mission to remind members of the Committee's purpose.			
Anti-Stigma Committee Report	L. Clark	Lillie requested this item be moved to the April 2009 CCOC agenda.			
State MHSA Workgroup Report	L. Clark	Lillie reported she was asked to participate in the CIMH MHSA Workshop as a Cultural Competency Panel Member. Lillie participated in mock community meetings, reviewed materials, participated in activities and provided feedback. Lillie co-facilitated a workshop in December. She participated in developing a booklet on how to engage with Cultural Competency for coordinators and managers. Lillie reported she might also be participating as a Cultural Competency Panel Member in 2009.			
Presentation: Training In A Box #2 – "Working with Latino/Hispanic Populations"	H. Ramirez	Hugo Ramirez gave a status report on the next Training In A Box - Model of Engagement for Providing Services to Latino/Hispanic Populations." Hugo reported the model would be finalized next week. The concept of cultural humility, as distinguished from cultural competence, refers to a lifelong process of self-reflection and self-critique and development of self-awareness and a respectful attitude toward diverse viewpoints. Through the concept of a Venn Diagram, Hugo explained that where formal, traditional training intersects with information/understanding gained through interaction, a richer learning occurs. Hugo will e-mail an article on Cultural Humility to all CCOC members. Hugo reported Prevention and Early Intervention (PEI) Workgroups would be held in January 2009. Space is limited and RSVP's are strongly encouraged. To RSVP call 525-6247. Hugo will e-mail the schedule to all CCOC members.	E-mail article on Cultural Humility to all CCOC members E-mail schedule of PEI Workgroups to CCOC members	H. Ramirez H. Ramirez	2/9/09 2/9/09
TAY Culture	T. Panyanouvong, M. Boucher M. Hibdon	Tommy Panyanouvong (Josie's Place Drop-In Center), Mark Boucher (TAY Services Team) and Mike Hibdon (Telecare Josie's TRAC) gave a presentation on TAY Culture. The three represent a program serving young adults 16-25 years old, co-located at 1208 9th Street, Modesto. Each presenter gave further explanation about their program and the types of services they provide. They also distributed a brochure on Josie's TRAC and flyers on Josie's Place Drop-In Center and Young Adult Advisory Council.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Ken Huntley asked if they work with youth that will be turning 18 years of age to help in the transition to adulthood? Presenters stated that they do. Lillie Clark reported she takes TAY to the Drop-In Center to introduce them to staff. John Black asked about family involvement? Tommy stated they encourage youth to bring in their parents and other family members. John asked that the wording that states young adult diagnosed with mental illness on the Josie's Place Drop-In Center flyer be made to sound more positive.			
Consumer/Family Member Input	All	None.			
Training Update/Training Announcements	All	BHRS Training Calendar was distributed to all CCOC members. Tim White reported he would be providing "Partnering With The Customer Training" at SRC on January 21, 2009. John announced the next "Families…The Rest Of The Story Training" is scheduled for February 12, 2009 from 9-12 in the Redwood Room.			
Announcements; Other Business	All	Carol Jo stated the February meeting would be review of the MHSA Demographics Report and a BHRS Penetration/Service Report. Lillie announced "Educate, Equip and Support" would be offered every Wednesday from 6:00 pm to 8:00 pm at the Family Partnership Center (FPC). For more information contact Regina or Sabrina at FPC. The class is open and free of charge. John announced the next NAMI Provider Education 10-Week course would begin Thursday, February 5, 2009 from 2:00 pm to 5:00 pm at the Jana Lynn Community Room. Christi reported the CASRA curriculum course at MJC is full and has 8 students on the waiting list.			

Next Meeting: **February 9, 2009** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Marisela Cantu	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	March 9, 2009
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Rose Mitchell

CSOC/TAY
Lucy Escobar
Janette Jameson

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della

Sr. Leadership
Madelyn Schlaepfer

C & F Affairs
John Black
Tim White

C & FM Rep.
Rose Peterson
Reggie Gilbert
Jesse

Mgd Care/CERT
Daljit Grewal for Ken Huntley

SRC/Genesis
Robert Broom
Michael Toomey

Quality Services
Vickie Looney

HR/Training/WET
Jim Hurley

Patients' Rights
Mariana Canelo

CCOC Co-Chairs
Pete Duenas
Carol Jo Hargreaves

Contract Providers
Barbara Anderson
Al Ellsmore
Ana Perez
Jim Riley
Fernando Granados
Susan Trudell

Absent:

ASOC/OASOC
Mary Aguirre
Alice Tamraz

CSOC/TAY
Lillie Clark
Blanca Medina
Shereen Reid
Tommy Panyanouvong

DMS/PM
David White

Fiscal/Admin Services
Nancy Riggs

Sr. Leadership
Jean Anderson
Glenn Hutsell
Debra Buckles
Adrian Carroll
Elizabeth Oakes

Executive Asst. to Director
Linda Torres

ABSAP

MHB

Quality Services
Cherie Dockery

HR/Training/WET
Christi Golden

Patients' Rights
Teresa Alvarez

Other
Ruben Imperial

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome, Introductions	C. Hargreaves/All	Each attendee shared his/her name and program(s) representing and one thing their program does to connect with culturally diverse communities. All members introduced themselves. Some highlights include: Michael Toomey, SRC, brought examples of the Serenity Prayer translated into different languages and framed to hang on group room walls. Ana Perez from El Concillio shared that she provides presentations in both Spanish and English and distributed a recent article from Vida en Valle entitled, "Students find a place for their art." John Black shared that he forgets differences, looks for similarities and treats everybody *right*. Barbara Anderson shared that her program makes sure there is cultural representation in			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		WMKKNC's staffing. Tim White keeps an open mind and learns from others.			
Appoint Timer	C. Hargreaves	Today's full Agenda necessitated staying on time as allocated. Rose P. volunteered to serve as Timer for the meeting.			
Approval of Minutes – February 9, 2009	All	Stacey Della motioned to approve the 2/9/09 meeting minutes, Rose P. seconded. The minutes were approved as submitted.			
Action Items from February 9, 2009 Meeting	All	Ruben Imperial and Dorbea Cary presented "Training in a Tube" at the Monthly Leadership Meeting on Monday, 3/2. This training is now available to staff via their Coordinators.			
CCOC Newsletter, March 2009 Edition	M. Canelo	Mariana distributed the March 2009 CCOC Newsletter. Carol Jo thanked April 2009 Newsletter contributor, Michael Toomey for submitting his article before the deadline.			
Consumer/Family Member Input	All	Tim White asked for a moment of silence for the passing of a consumer this weekend.			
Training Update/Training Announcements; Clinical Supervision Survey Results	D.Cary	Dorbea announced that the Seeking Safety training is full. Currently working on another training "40 Developmental Assets," a resiliency-based model. There are still openings for the "Spirituality and Wisdom Training in Behavioral Health" on 3/26/09. CSU, Stanislaus is providing training entitled, "Addressing the Complexity of Homelessness Through Community Engagement" on 3/20/09. Cost is $65. For additional information call 667-3091. Jim Hurley will present at the Spirituality Conference in Oakland, June 1-2. He will report back to the CCOC. Any feedback or questions regarding the handout, "Assessment of Supervisor's Inclusion of Key diversity Criteria Supervision," distributed in last month's meeting may be directed to Dorbea by 3/20/09.			
PEI Plan Input from CCOC	P. Duenas	The PEI Plan is available on-line for public review and comment. Pete asked members to review the document, particularly the Project Descriptions, plans, and goals. He would like to send a response from CCOC members as a group. Public review ends March 26.	Review PEI Plan and provide input to Pete Duenas.	All	3/23/09
CCOC Member Feedback on Reports: Mental Health Service Utilization Based on Prevalence Report. MHSA Demographics Report, other oversight/monitoring reports	All	Carol Jo asked for comments and feedback on reports presented last month and ideas for additional reports to assist the CCOC with its monitoring and oversight functions. Pete shared that EQRO reviewed our Prevalence Reports and liked the easy to read, understandable format. Stacey Della mentioned that the MHSA Demographic Report is very			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
needed		useful for contract monitoring. Barbara Anderson questioned if quality of services could be reported (are people really getting services?). Pete announced that, beginning at next month's meeting, each System of Care would present to the Committee about types of service, results of training and other cultural competence-related topics. CSOC will report in April. Janette Jameson suggested reporting how well each program serves its particular demographic in relationship to that population's incidence in the County. Dorbea Cary suggested Retention Rate reports.			
AOD Statistics	M. Schlaepfer	Madelyn distributed the "BHRS Alcohol and Drug Treatment Admissions" report. The information is categorized by gender, age, race, ethnicity, employment, level of education, legal status, and special needs. It was asked if there could be a disability breakdown. Madelyn stated anything beyond these categories is not possible as this is a "canned report", however reports can be run by gender and/or race/ethnic group.			
Evaluation/Feedback – Labels Are For Jars	P. Duenas	Overall, the training was rated excellent. Out of 168 surveys returned, 91% agree or strongly agree the training would improve their ability to be culturally competent with clients and family members. (Five percent were neutral and 4% disagreed or strongly disagreed.) Some comments from the surveys were that this training will help staff be more aware, think before speaking, and show how others might interpret the language we use. Most liked the role-playing, sharing of ideas, hands-on and the visual props. Some suggestions for improvement were to allow more time for the training and include testimonials of people who have experienced stigmatization. It is important for all staff to understand about stigma, including support staff. Dorbea announced the training is now available to contractors.			
ESM Report	P. Duenas	Pete and Carol Jo attended a face-to-face Ethnic Services Managers (ESM) meeting last Friday in Stockton. The County Mental Health Directors' Association (CMHDA) is currently developing strategies to reduce disparity throughout the state through contracts with five different groups (Latino, African American, Native American, Asian/Pacific Islander and LGBTQ). The CCOC will be kept posted as this project develops. The California Institute for Mental Health (CiMH) will include ESMs in MHSA Full Service Partnership meetings and MHSA Coordinators' meetings. Not sure how it will be implemented			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		but will keep members updated. There is still no timeline for the annual Cultural Competence Plan Update. DHM is currently redrafting the guidelines to include feedback received.			
Announcements; Other Business	All	Tim White shared that the presentation and panel for the CIT recovery presentation were revised to be more conversational and personal. Response was excellent. John Black stated it was an interactive and good group.			

Next Meeting: **May 11, 2009** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	May 11, 2009
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Rose Mitchell
Alice Tamraz

CSOC/TAY
Lillie Clark
Shannyn McDonald
Janette Jameson
Robin Johnson
Rachel Acosta
Carolyn Warren Smith

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Nancy Riggs

Sr. Leadership
Madelyn Schlaepfer
Adrian Carroll

C & F Affairs
John Black
Tim White

C & FM Rep.
Jesse Gutierrez

Executive Asst. to Director
Linda Torres

Mgd Care/CERT
Daljit Grewal for Ken Huntley

SRC/Genesis
Michael Toomey

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden

Patients' Rights
Mariana Canelo

CCOC Co-Chairs
Pete Duenas
Carol Jo Hargreaves

Contract Providers
Fernando Granados
Susan Trudell
Jorge Fernandez

Absent:

ASOC/OASOC
Mary Aguirre

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Lucy Escobar

DMS/PM
David White

Fiscal/Admin Services
Stacey Della

Sr. Leadership
Jean Anderson
Glenn Hutsell
Debra Buckles
Elizabeth Oakes

ABSAP

MHB

SRC/Genesis
Robert Broom

Quality Services
Cherie Dockery

HR/Training/WET
Dorbea Cary
Jim Hurley

Patients' Rights
Teresa Alvarez

Other
Ruben Imperial

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome, Introductions	C. Hargreaves/All	Each attendee shared his/her name and program(s) representing and described the efforts their program makes to reduce stigma for clients who are LGBT. Some highlights include: Madelyn Schlaepfer shared that she values diversity. Tim white is willing to work with everyone, listens and learns, and doesn't judge anyone. John Black pretends stigma doesn't exist. Alice Tamraz shared that her program treats everyone with respect, makes the clients feel comfortable, shakes hands or gives a hug to reduce stigma. Rose Mitchell states that her programs have signs and posters, invites her staff to participate in LGBT trainings and makes sure that staff knows about resources. Michael Toomey tries to create an atmosphere of open mind. Rachel Acosta treats everyone equally and offers			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		resources. Shannyn McDonald avoids labeling and makes sure staff knows about trainings. Robin Johnson makes sure all kids are treated with unconditional positive regard. Pete Duenas tries to create awareness.			
Appoint Timer	C. Hargreaves	Today's full Agenda necessitated staying on time as allocated. Vickie Looney volunteered to serve as Timer for the meeting.			
Approval of Minutes – March 9, 2009	All	Madelyn Schlaepfer motioned to approve the 3/9/09 meeting minutes, Nancy Riggs seconded. The minutes were approved as submitted.			
Action Items from March 9, 2009 Meeting	All	The only action item was to review the PEI Plan and provide input to Pete Duenas. No one from this group sent any comments.			
CCOC Newsletter, May 2009 Edition	M. Canelo	Mariana distributed the May 2009 CCOC Newsletter. Carol Jo mentioned this edition had two great articles. Lillie Clark is the contributor for June 2009 Newsletter.			
Consumer/Family Member Input	All	John Black shared that "The Soloist" showing went well at Brenden Theatres. The Peer Recovery Art Project is on CIMH website. Art Music Festival went well and there was a lot of participation. Day of Hope is scheduled for May 29 at WMKKNC. NAMI Walk is June 20th. John was selected to serve on DMH Planning Council. Tim White announced that he and John will be moving to 9th Street in July.			
Training Update/Training Announcements; Clinical Supervision Survey Results	D. Cary	Dorbea not present to report. Prevention Summit is May 12th. NAMI started a new Spanish-speaking Family to Family group but no one attended. Spirituality Training is June 1st and 2nd in Oakland. Pete will bring back information to CCOC.			
Anti Stigma Committee Update	L. Clark	Lillie shared there is a two-sided "SOS" bookmark in process. When ready the first draft will be brought back to CCOC members. Any comments may be directed to Lillie.			
Ethnic Services Manager Report	P. Duenas, C. Hargreaves	On May 8th, Pete and Carol Jo took part in a telephone conference with other regional Ethnic Services Managers. CIMH is developing e-training modules to be available on-line regarding mental health topics. A report is being prepared on the Latino Access Study.			
Mental Health Service Utilization Based on Prevalence Report.	P. Duenas	An updated Prevalence Report was distributed for fiscal year 08/09 (Jul/08 – Apr/09). Pete asked how frequently members want this report distributed. Members would like to have the report provided on a quarterly basis.			
CSOC Cultural Competence-Related Efforts and Outcomes	CSOC Coordinators	CSOC Coordinators presented cultural competence data and activities from their System of Care. Janette Jameson distributed a Client Demographic Report for all CSOC clients receiving services between July 1, 2008 and Jan 31, 2009.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Janette shared that only 38% of the time CSOC staff can be found in their offices; the remaining time they are working in the field. CSOC is a diverse team which includes 75 clinicians and case managers. Some of the statistics are: 62% of children are in the system due to abuse and trauma, 50% are Hispanic, 40% are White, and 59% are males. CSOC programs provide a safety net for children at risk that always involves partnering with others. For Leaps and Bounds, 57% are females, 55% are Hispanic, and 31% are undocumented. Carolyn Warren Smith collaborates with three Healthy Birth Outcome programs. If a relationship is developed with the facilitator then it makes it easier to develop a relationship with participants. She found she received better response from Hispanic consumers by using the terminology "Behavioral Health & Recovery Services" instead of "Mental Health". Robin Johnson oversees SED – School Based Services. Their "Parent's Guide" was distributed. The program serves 77% males. Southeast Asian population is underrepresented. No program staff speaks an Asian language but 1/4 speaks Spanish. Shannyn McDonald oversees CAIRE Center and Child Welfare Services. There is 22 staff in the program, 13 of whom are clinicians. They serve 200 of the 500 youth in placement. Each clinician carries 13-18 children on their caseload. 90% of their work is done in the field. Rachel Acosta oversees Juvenile Justice. 60% of children served have previously been in the system and have experienced a lot of trauma. There are now only two staff persons assigned to Juvenile Hall. 70-80% of youth coming into the Hall are males. Many Asian Americans do not enter the system but when they do they are there for a very serious crime or severe mental illness. Only 3-7% of CSOC children enter the Adult System of Care due to the work CSOC staff does. More community/outreach programs like The Bridge are needed.			
Announcements; Other Business	All	Next month ASOC will present their cultural competence related efforts and outcomes.			

Next Meeting: **June 8, 2009** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	June 8, 2009
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Rose Mitchell
Jasbir Dhami
Kevin Panyanouvang
Ken Huntley

CSOC/TAY
Lillie Clark
Janette Jameson

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Nancy Riggs
Stacey Della

Sr. Leadership
Madelyn Schlaepfer
Elizabeth Oakes

C & F Affairs
Tim White

C & FM Rep.
Jesse Gutierrez

Executive Asst. to Director
Linda Torres

Mgd Care/CERT

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden

Patients' Rights
Mariana Canelo

CCOC Co-Chairs
Pete Duenas
Carol Jo Hargreaves

Contract Providers
Barbara Anderson
Marcos Gallardo
Jim Riley
Pam Frymire
Maxine Sousa

Absent:

ASOC/OASOC
Mary Aguirre
Alice Tamraz

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Lucy Escobar
Hermille Catzalco

DMS/PM
David White

Sr. Leadership
Jean Anderson
Glenn Hutsell
Debra Buckles
Adrian Carroll

C & F Affairs
John Black

ABSAP

MHB

SRC/Genesis
Robert Broom
Michael Toomey

Quality Services
Cherie Dockery

HR/Training/WET
Dorbea Cary
Jim Hurley

Patients' Rights
Teresa Alvarez

Other
Ruben Imperial

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome, Introductions	P.Duenas/All	Each attendee shared his/her name and program(s) representing and described the efforts their program makes to incorporate clients' spirituality in treatment. Some highlights include: Janette Jameson, Leaps & Bounds, doesn't ask the question but will work with the client if s/he brings it up. Lillie Clark says Family Partnership Center tries to be as general as possible so as not to offend anyone or negatively impact services. Barbara Anderson says WMKKNC represents all cultures through staffing and has discussions in staff meetings about cultures and their respective beliefs. Jim Riley, Telecare, doesn't address spirituality upfront but if it comes up they will help link clients with community resources. Tim White, Peer			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Advocate, talks to clients about their spiritual beliefs. Pam Frymire said Garden Gate Respite encourages consumers to explore their spirituality but sometimes must discourage this during groups to avoid problems. Connie Alcala, EMO, mentioned that her program assists in what they can and does not impose beliefs. Rose Mitchell, StanWORKS, will explore the issue if it is one of the client's strengths. Christi Golden, HR, makes sure no one is being discriminated against because of their religious beliefs.			
Appoint Timer	C. Hargreaves	Today's full Agenda necessitated staying on time as allocated. Vickie Looney volunteered to serve as Timer for the meeting.			
Approval of Minutes – May 11, 2009	All	Madelyn Schlaepfer motioned to approve the 5/11/09 meeting minutes, Lillie Clark seconded. The minutes were approved as submitted.			
Action Items from May 11, 2009 Meeting	All	There were no action items to be discussed.			
CCOC Newsletter, June 2009 Edition	M. Canelo	Mariana distributed the June 2009 CCOC Newsletter. Carol Jo thanked Marcos Gallardo and Lillie Clark for their articles.			
Consumer/Family Member Input	All	Tim White shared that the Day of Hope went well. There were great speakers and compliments were received.			
Training Update/Training Announcements	D. Cary	Dorbea not present to report. Carol Jo distributed the Training Calendar for June and July. Principles and Practices of Interpreting will be held June 16. Milestones In Recovery is scheduled for June 30. NAMI Provider Education, a 10-week series, begins July 15.			
Ethnic Services Manager Report	C. Hargreaves	On 6/5, Carol Jo took part in a telephone conference call with other regional Ethnic Services Managers. Cultural Competence guidelines should be released sometime in July or August. The Mental Health CC Summit is coming up on November 17th. There is no money for this conference for next year. On May 21-22, Carol Jo attended "Mapping Progress in Mental Health Disparities in a Transformed California Mental Health System", sponsored by UC Davis Health System. Carol Jo distributed important highlights from this meeting.			
ASOC Cultural Competence-Related Efforts and Outcomes	ASOC Coordinators	ASOC Coordinators presented cultural competence data and activities from their System of Care. Rose Mitchell oversees BHS/StanWORKS at CSA. She distributed a brochure describing the program. The program provides services to clients receiving Temporary Assistance to Needy Families. They reduce barriers for clients unable to work. The program has diverse staff members that speak			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		English, Spanish, Cambodian and Laotian. They provide a variety of mental health and substance abuse groups. Assessments and crisis interventions are offered. The program works with Haven, Families in Partnership and First Step. Most referrals come from MAT and others from case managers and CSA. Kevin Panyanouvong oversees Modesto Recovery Services (MRS), a bilingual, bicultural multi-disciplinary team. Demographic information (MHS705) was distributed for MRS and Turlock Regional Services. Intensive, Wellness, and Med Clinic are the three levels offered. MRS partners with many agencies such at Stanislaus Recovery Center, Leaps & Bounds, Turning Point and Housing/Shelter Plus Care. MRS tries to match consumers with staff in order to provide the best services. Referrals come from Doctors Behavioral Health Center (DBHC), MAT, and BHS. Jasbir Dhami oversees Wellness Recovery Center and Wellness Recovery Psychiatric Clinic. Brochures for both programs were distributed. Staff is diverse. Wellness offers three medication groups, groups at Board and Care Homes, quit smoking groups for consumers and staff, and movie groups. The Psychiatric Clinic is a one-time 2-hour consultation followed by referral to a primary care physician. A recommendation is given by the psychiatrist to the client's PCP to prescribe medications. Referrals come from MAT. Wellness Recovery Center will host the monthly Recovery Celebration June 19. It will be a carnival for staff and peers. Games and raffles will be available for children and adults.			
Announcements; Other Business	All	Next month Forensics/OASOC will present their cultural competence related efforts and outcomes.			

Next Meeting: **July 13, 2009** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	January 11, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley
Rose Mitchell

CSOC/TAY
Lillie Clark
Hermille Catzalco
Carolyn Warren-Smith
Sofia Martinez

Forensics/PG

Fiscal/Admin Services
Stacey Della

DMS/PM
Hector Ayala

Sr. Leadership
Jean Anderson
Elizabeth Oakes
Madelyn Schlaepfer

C & F Affairs
John Black
Tim White

C & FM Rep.

Executive Asst. to Director
Linda Torres

Mgd Care/CERT

SRC/Genesis

Quality Services

HR/Training/WET
Christi Golden
Dorbea Cary

Patients' Rights
Mariana Canelo

CCOC Co-Chairs
Pete Duenas
Carol Jo Hargreaves

Contract Providers
Barbara Anderson
Ruben Sanchez

Other
Elizabeth Vera

Absent:

ASOC/OASOC
Mary Aguirre
Alice Tamraz

CSOC/TAY
Blanca Medina
Shereen Reid
Lucy Escobar
Tommy Panyanouvong
Janette Jameson

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Nancy Riggs

Sr. Leadership
Debra Buckles
Adrian Carroll
Glenn Hutsell

C & FM Rep.
Jesse Gutierrez
Reginald Gilbert

SRC/Genesis
Michael Toomey

Quality Services
Vickie Looney

HR/Training/WET
Jim Hurley

Patients' Rights
Teresa Alvarez

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Everyone was welcomed to the meeting.			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Christi Golden volunteered to serve as Timer for this meeting.			
Approval of Minutes – December 14, 2009	All	Christi Golden motioned to approve the 12/14/09 meeting minutes, Ken Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	P. Duenas	Articles for the CCOC Newsletter were submitted by those who attended the Mental Health Summit.			
CCOC Newsletter, January	M. Canelo, All	Mariana distributed the January 2010 CCOC Newsletter. Carol	Submit article	Stacey Della	1/18/2010

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
2010 Edition		Jo thanked those who contributed articles. The Newsletter Sign-up Sheet for 2010 was circulated.	for CCOC Newsletter		
CCOC Binder Updates	M. Canelo	Mariana distributed several updated documents to be included in each CCOC member's binder. The Member Roster was circulated for all to update. A current Roster will be distributed at February's meeting.			
Consumer/Family Member Input	All	Dorbea announced that the Mental Health Services Act (MHSA) is sponsoring a new series of 8 workshops targeted for volunteers and anyone in the community interested in learning about mental health. The first workshop of the series will be conducted 1/13, 1-3 pm in the Redwood Room. In this workshop Jim Hurley and Ruben Imperial will address concepts of wellness, recovery and resilience. On 1/27, Pete Duenas will present on cultural competency and Tim White will present a stigma video. On 2/1, Dr. Mukhurjee will present on psychiatry. Patients' Rights will also give a presentation on 2/3. Each workshop is 2 hours. They are open to everyone and you may attend as many of them as you wish. Register at the door. John Black announced that the 10-week NAMI Provider Education series will be held on Thursday mornings, beginning 2/11. If interested, call 558-4555. Tim White suggested starting a training regarding the dos and don'ts when approached by a police officer. Rose Mitchell requested that CIT-trained officers be included. Ken Huntley reported there was a training in San Francisco regarding police officers from which valuable resources could be obtained. John Black shared that the memorial for a client killed by police officers was overwhelmingly attended and positive. Her family was appreciative. Pete welcomed new member, Elizabeth Vera, a NAMI volunteer.			
Training Update/Training Announcements	D. Cary	The January-March 2010 Training Calendar is now out. There is a free training 1/15 in Merced presented by Bruce Anderson. This training is offered by Central Region and is about building hope at work. If interested in attending, email Marisela Cantu by 1/12. Carol Jo shared information regarding Immersion Training, a free 3-day workshop presented by Turning Point Community Programs for MHSA funded organizations. Staff who attended in December found it valuable and validating. A session will be offered every month through this fiscal year. The schedule has been sent to Senior Leadership and program coordinators. If interested, let Carol Jo know.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Cultural Competency Mental Health Summit	Vickie Looney, Ruben Imperial, Elizabeth Vera	Vickie and Ruben were absent. Elizabeth Vera shared her learning experience from the Summit. She found most interesting the approach used to help women with a background of trauma break out of the victim/failure mode. Elizabeth explained that Hispanics may see things as interrelational ("we"), not individual ("I"). Latinos may see everything as a whole and feel the health of the whole family must be put into perspective, not simply that of only one individual family member. Elizabeth applied this technique in her NAMI class and found that it worked.	Report CCMH Summit learning experience to group and in newsletter article	R. Imperial, V. Looney	2/8/2010
ESM Update	P. Duenas, C. Hargreaves	Pete and Carol Jo attended the Ethnic Services Manager face-to-face meeting Friday, 1/8. Beginning in February this meeting will be held on the 4th Friday of the month so DMH representatives are able to attend. Cultural Competence Plan Requirements are still not out. Dorbea Cary, Rose Mitchell and Rosemary McFadden (CHS) attended California Basic Multicultural Skills (CBMCS) training for trainers in December and will attend follow-up in February. When training is complete we will discuss how the new curriculum will be rolled out. The Framework for Eliminating Cultural, Linguistic, Racial & Ethnic Behavioral Health Disparities document is found in the CCOC binder. Its related Checklist was distributed for review. Once the Cultural Competence Plan Requirements are available, suggestions may be made for updating the Framework and Checklist. These documents help lay out the structure and activities we do. Concern was expressed about the short timeframe in which our CC Plan is due. John Black offered to provide input at the 1/19 Planning Council meeting.	Submit suggestions for updating the Framework and Checklist Provide CCOC input re CC Plan requirements to Planning Council	CCOC members J. Black	Upon receipt and analysis of CCOC Plan require-ments 1/19/2010
Best Way to Disseminate CCOC Information to All?	All	Discussed how to make CCOC information available to all BHRS staff. Suggestions included: (1) Send meeting materials to delegates unable to attend. (2) CCOC delegates report back to their team(s) after each meeting. (3) Put cultural competence on every meeting agenda including Senior Leadership, QICs, System of Care team, Coordinators' and Clerical. (4) Add list of "hot topics" to CCOC newsletter. (5) Embed cultural competence in how we do our business. (6) Continue homework questions that are relevant to both direct and indirect staff for delegates to obtain team's feedback. (7) Post CCOC Minutes on BHRS Intranet and email them to all BHRS staff.	Add list of "hot topics" to CCOC newsletter Post CCOC Minutes on BHRS Intranet	C. Hargreaves P. Duenas	2/8/2010 2/8/2010
FY 09/10 Goals and Objectives	All	Members suggested the following goals for the CCOC to accomplish in FY 09/10: (1) Complete and submit the Cultural			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Competence Plan. (2) Have a role in determining how CBMCS curriculum will be rolled out in BHRS. (3) Report progress and results of the four CC modules - "Labels are for Jars", "Cultural Humility", "LGBQ-Invisible Diversity", and "Recovery & Resilience." (4) Add new training about myths in regard to older adults. (5) Continue to report demographics, penetration and utilization rates. (6) Become involved in the community by participating in the Stanislaus County Occupational Olympics. (7) Further integrate WET and PEI into CCOC. (8) Ensure cultural competence is embedded in all evidence-based practices employed by BHRS. Madelyn reminded members to maintain a broad focus including other ethnicities, other cultures and their diversity.			
Announcements; Other Business	All	John Black announced that Black History Month Celebration will occur in Patterson 2/27. There will be a talent and fashion show.			

Next Meeting: **February 8, 2010** **Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	February 8, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves and Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Rose Mitchell

CSOC/TAY
Carolyn Warren-Smith
Sofia Martinez
Lucy Escobar
Janette Jameson
Sandra Portillo

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della

DMS/PM

Sr. Leadership
Jean Anderson
Madelyn Schlaepfer

C & F Affairs
John Black
Tim White

C & FM Rep.
Jamie Hoover

Executive Asst. to Director

Mgd Care
Debbie Lewis

SRC/Genesis
Scott Roberts
Michael Toomey

Quality Services

HR/Training/WET
Christi Golden
Dorbea Cary
Kimberlee Hamilton

Patients' Rights
Mariana Canelo

PEI
Ruben Imperial

CCOC Co-Chairs
Pete Duenas
Carol Jo Hargreaves

Contract Providers
Barbara Anderson
Al Ellsmore
Fernando Granados
June Newman
Xochitl Magallon

Other
Elizabeth Vera

Absent:

ASOC/OASOC
Mary Aguirre
Alice Tamraz
Ken Huntley

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Hermille Catzalco
Lillie Clark

Forensics/PG

Fiscal/Admin Services
Nancy Riggs

DMS/PM
Hector Ayala

Sr. Leadership
Debra Buckles
Adrian Carroll
Glenn Hutsell
Elizabeth Oakes

C & FM Rep.
Jesse Gutierrez
Reginald Gilbert

Executive Asst. to Director
Linda Torres

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Jim Hurley

Patients' Rights
Teresa Alvarez

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Connie Alcala volunteered to serve as Timer for this meeting.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Approval of Minutes – January 11, 2010	All	Elizabeth Vera motioned to approve the 1/11/10 meeting minutes, Connie Alcala seconded. The minutes were approved as submitted.			
Follow Up on Action Items	P. Duenas	An article for the CCOC Newsletter was submitted by Stacey Della. Ruben Imperial will report about his CC/MH Summit experience today. Vickey Looney is on LOA; her report has been postponed. Submission of suggestions for updating the Framework and related Checklist postponed since CC Plan Requirements received. John Black provided this committee's input regarding CC Plan Requirements at the 1/19 Planning Council meeting but did not get any substantial information. "Hot Topics/Highlights" was added to the January CCOC Newsletter. Pete spoke with Shellie Smith, DMS regarding posting CCOC Minutes on the BHRS Intranet.	Continue to include Hot Topics/Highlights in the CCOC Newsletter Post CCOC Minutes on BHRS Intranet	C.Hargreaves, M. Canelo P. Duenas, M. Canelo	Ongoing 3/8/2010 (ongoing)
CCOC Newsletter, February 2010 Edition	M. Canelo, All	Mariana distributed the February 2010 CCOC Newsletter. Carol Jo thanked those who contributed articles. The Newsletter Sign-up Sheet for 2010 was circulated.	Submit article for CCOC Newsletter	Ruben Imperial, Michael Toomey	2/15/2010
QMT Workplan Data	J. Anderson	Jean Anderson, MHP Administrator, distributed statistical reports from the FY 08/09 QMT Work Plan. The reports look at ethnicity data, client retention, and penetration scores. Reports include direct services data only. The department met its goal of obtaining 85% General Client Satisfaction. The Staff Ethnicity and Language Report shows a high level of diversity in percentage of Hispanic employees, however not the equivalent of this ethnic group in the County's population. The Mental Health Client Retention By Ethnicity report shows the retention rate across ethnic groups is similar to FY 07/08 even though there were staff reductions. In the Mental Health Penetration Scores report the penetration for African Americans is highest; more were served than expected based on incidence in the community. Again, numbers are similar to FY 07/08. Mental Health Penetration Scores by geographic area show the Westside increased penetration from 29% in FY 07/08 to 31.1% in FY 08/09. Modesto has the highest penetration rate. Once QMT has reviewed and approved these reports they will be posted on the Intranet.	Provide FY 07/08 report for comparison purposes	J. Anderson	3/8/2010
Consumer/Family Member Input	All	Tim White attended the Celebrate Recovery Conference in San Jose and distributed the following handouts: "Twelve Steps of Alcoholics Anonymous", "The Road to Recovery", and "The Twelve Steps for Physical/Sexual/Emotional Abuse". Celebrate Recovery covers issues other than substance abuse, such as overeating and sexual addiction. Ruben Imperial explained that Tim attended this conference to improve linkages with the faith-based community, increase			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		mental health resources and identify staff training needs. Kimberlee Hamilton shared that the culture or recovery really wants to have a voice and be seen. She asked if it would be possible to add to CCOC agenda a section on client culture input. Pete stated this could be part of the Consumer/Family Member Input. Elizabeth Vera, a NAMI volunteer, attended NAMI's "In Our Own Voice", a combination of video clips and personal sharing of dark days, coping skills, goals and dreams. She facilitates a family support group in Spanish the first Monday of each month, 6:30 – 8:00 p.m. This support group will now also be offered Thursdays, 6:30 – 9:00 p.m. There is a 12- week course offered for those who want to be trained to lead a support group. Contact Lynn Padlo, NAMI if interested.			
Training Update/Training Announcements	D. Cary	Dorbea Cary announced that trainings are open to all staff and contractors. Principles and Practices of Interpreting will be offered 3/24. With roll-out of CBMCS this summer, it is recommended to fold in trainings such as Clinical Standards, Crossing Cultural Bridges, and Cultural Dialogue. Senior Leaders must determine the amount of staff time available for training. Dorbea would like feedback as to what works best for staff schedules. Toward Effective Self-Help, A Group Facilitator Six-Week Training will begin 2/10 from 10-12p.m., facilitated by Ron Gilbert. John Black announced the 10-week NAMI Provider Education course is open to contract providers. Elizabeth announced a new NAMI training called "Friends in Recovery" beginning 2/9. Contact NAMI for more information.	Provide feedback about available training time for staff to Dorbea Cary	All supervisors	3/8/2010
February is Black History Month (handout)	C. Hargreaves	A Fact Sheet from the Surgeon General's website was distributed addressing African Americans and mental health services.			
Cultural Competence Mental Health Summit	Ruben Imperial	Ruben described a workshop on Promotores in mental health and prevention/early intervention. The workshop focused on public health outreach in the Latino community. It was emphasized that counties wanting to use the Promotores model must stay true to the model and not turn the program into something else. Ruben will email CCOC members a link to a recent CIMH article about the Promotores model.	Provide link to CIMH article on Promotores model	R. Imperial	3/8/2010
Best Way to Disseminate CCOC Information to All?	All	At our 1/11/2010 meeting we discussed recommendations to better disseminate CCOC information to all BHRS staff. We would like to develop a cultural competence website through the BHRS Intranet and need CCOC members to volunteer to help with this project. Pete stated he reminded staff at the	Need volunteers to form subcommittee to develop	CCOC members	3/8/2010

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Monthly Leadership meeting that cultural competence needs to be part of agendas for all meetings.	CCOC website		
Framework and Implementation Checklist	All	Postponed to a future agenda.			
Cultural Competence Plan Requirements	All	Carol Jo announced that the Cultural Competence Plan Requirements (CCPR) are now available. Our Plan is due 7/28. CCOC members will be asked to help compile BHRS' Plan. The CCPR include 8 Domains and 8 Criterion and will be a combination of narrative and data about access, retention, and services. Pete stated there is a specific area that asks what the CCOC does. There will be an Ethnic Service Managers meeting on 2/10 in Riverside that Carol Jo will attend. We intend to have our Plan ready for review by the June CCOC meeting. Carol Jo would like input from everyone. Fernando Granados asked if contract agencies are required to have their own Plan. Pete and Stacey Della answered affirmatively.	Review Cultural Competence Plan Requirements and come to the March CCOC meeting with ideas about how you can contribute	CCOC members	3/8/2010
Announcements; Other Business	All	John Black announced February is Healthy Heart Month. "Women of the Arts for Healthy Hearts" will be held 2/12 from 4-7p.m. at the DoubleTree Hotel. (Poster available at jbpresents.com). Sofia Martinez announced Juvenile Justice will take youth to the Young Masters art exhibit. Ruben announced PEI RFPs are now posted on the MHSA website. Dorbea shared that Seeking Safety training will be provided in March for two days by a trainer whose specialty is PTSD and substance abuse.			

Next Meeting: **March 8, 2010** **Martin Conference Room, 830 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	March 8, 2010
Place:	830 Scenic Drive, HSA Martin Conference Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Janette Jameson
Robin Johnson for Hermille Catzalco
Lillie Clark

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della
April Sanchez for Nancy Riggs

DMS/PM

Sr. Leadership
Madelyn Schlaepfer

C & F Affairs
John Black
Tim White

C & FM Rep.
Jamie Hoover
Reginald Gilbert

Executive Asst. to Director
Linda Torres

Mgd Care
Debbie Lewis

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden
Dorbea Cary
Kimberlee Hamilton
Jim Hurley
Maria Ontiveros

Patients' Rights
Mariana Canelo

PEI
Ruben Imperial
John Alvarado

CCOC Co-Chairs
Carol Jo Hargreaves

Contract Providers
Barbara Anderson
Fernando Granados
June Newman
Jorge Fernandez
Ruben Sanchez

Other
Elizabeth Vera

Absent:

ASOC/OASOC
Mary Aguirre
Alice Tamraz
Rose Mitchell

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Sofia Martinez
Carolyn Warren-Smith
Lucy Escobar
Sandra Portillo

Forensics/PG

Fiscal/Admin Services

DMS/PM
Hector Ayala

Sr. Leadership
Debra Buckles
Adrian Carroll
Glenn Hutsell
Elizabeth Oakes
Jean Anderson

C & FM Rep.
Jesse Gutierrez
Reginald Gilbert

Executive Asst. to Director

SRC/Genesis
Scott Roberts
Michael Toomey

Quality Services

HR/Training/WET

Patients' Rights
Teresa Alvarez

CCOC Co-Chairs
Pete Duenas

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	C. Hargreaves	Today's Agenda necessitated staying on time as allocated. Kimberlee Hamilton volunteered to serve as Timer for this meeting.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Approval of Minutes – February 8, 2010	All	Connie Alcala motioned to approve the 2/8/10 meeting minutes, Kent Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	C. Hargreaves	Hot Topics/Highlights were included in February's Newsletter. CCOC minutes are now available on the BHRS Intranet. For now they may be found under the Newsletter link but will be moved to a different link in the future. An article for the CCOC Newsletter was submitted by Michael Toomey. Jean Anderson was not available to provide the FY 07/08 report QMT Work Plan. Ruben Imperial has not yet provided the link to CIMH article on Promotores model but states he will.	Provide link to CIMH article on Promotores model	R. Imperial	4/12/2010
CCOC Newsletter, March 2010 Edition	M. Canelo	Mariana distributed the March 2010 CCOC Newsletter. Carol Jo thanked those who contributed articles.	Submit article for CCOC Newsletter	K. Huntley	3/15/2010
Cultural Competence/Mental Health Summit	V. Looney	Vickie Looney reported that the keynote speakers at the Summit were excellent. Vickie attended the workshop "Cyberbullying: No Rules, No Limits, No Safety". She shared that the prevalence of cyberbullying has increased. Texting, Instant Messaging, Youtube, MySpace, and Twitter are some of the methods used for cyberbullying. Vickie also attended "Building Bridges between the Hearing and the Deaf". There is a lot of discrimination due to ignorance. This is referred to as "audism". People who are hearing impaired are categorized in three groups: the hard of hearing, the deafened, and the deaf.			
Training Update, CBMCS	D. Cary	Dorbea Cary distributed a handout entitled, "Comparison of Current Cultural Core Competency Training with the CBMCS Training". Dorbea would like to make the following recommendations to Senior Leadership: Replace Crossing Cultural Bridges, Cultural Competency Clinical Standards, and Cultural Dialogues with the new CBMCS training. All direct service staff, supervisors and managers will be required to take all four 8-hour modules, AOD staff will be required to take 2 modules, and administrative and support staff will be required to take one module. Each module stands alone. Pre- and post-tests identify a person's strengths and weaknesses in a module and could help decide which module(s) to take. Reginald Gilbert asked if volunteers may take this training. Dorbea answered that it is open to volunteers. Linda Torres recommended that support and administrative staff take all four modules, one per year. Janette Jameson suggested looking at training's impact on Productivity and consider providing only one module per month or decreasing time to four hours. Forty students will be trained in each session.	Present CCOC recommenda-tions to Senior Leadership	D. Cary	4/12/2010

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Fridays are not good due to possible furlough days. Summer is good for school-based staff, however summer is vacation time for others. Dorbea asked if all agree to make these recommendations to Senior Leadership. Everyone accepted.			
Proposed Cultural Competence Plan Timeline	C. Hargreaves	Carol Jo distributed "Proposed BHRS Cultural Competence Plan Timeline." On 1/25 DMH issued Cultural Competence Plan Requirements in Information Notice 10-02. In February the CCPR's were announced at Monthly Leadership and Carol Jo attended the CC/ESM meeting to ask questions. On 3/9 a meeting will be held with key BHRS informants. Subsequent meetings will be held with partner agencies and community advocates. Follow-up meetings will be held with all groups. Deadline for submission of all reports and evidence is April 30. In May data/information will be compiled into a draft CC Plan and status updates will be given to various groups. The final Plan will be submitted to DMH on or before 7/28. Kimberlee Hamilton questioned if any peer advocates or consumer reps will be asked to participate in any of the key informant meetings. Dorbea mentioned that Glenn Hutsell previously set up a process to decide as to who would be selected to attend. Carol Jo will consult with Glenn Hutsell. Stacey Della asked how contractors will be involved. Carol Jo will research and report back.	Attend meetings as invited and submit data/ evidence as requested. Investigate consumer rep selection process with Glenn Hutsell. Determine how contractors will be involved and report to S. Della	All C. Hargreaves C. Hargreaves	4/30/2010 Immediately Immediately
Spirituality	J. Hurley	Jim Hurley announced that Stanislaus County received the outcome of the Survey of Individuals Receiving Mental Health Services and Their Families conducted by CIMH. Jim, Ruben Imperial, John Alvarado, Carol Jo Hargreaves, Pete Duenas, and Dorbea Cary are involved in a work group to discuss how spirituality fits into our work through community capacity building, training, direct services and a strength-based approach. At their first meeting Ruben reported on work being done with the faith community, Jim talked about Spirituality and Wisdom training, and Dorbea agreed to check CBMCS curriculum. Ultimately a set of recommendations will be developed for CCOC to consider and forward to Senior Leadership. Consumer/family member involvement is needed. If interested in being a part of this work group, contact Jim. The next meeting will be 3/22 at 8:30am in the BHRS Training Room, Building A.	Continue to report	J. Hurley	4/12/2010
MHSA Prevention/Early Intervention	R. Imperial	Ruben Imperial announced the Behavioral Health Summit will be 5/10 at the Doubletree Hotel. The Summit will cover community capacity building, results based accountability and	Continue to report	R. Imperial	As scheduled

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		leadership. Mark Friedman, author of Trying Hard is Not Good Enough, will speak. Ruben provided an update of the strategic initiatives and projects within our PEI Plan. Some sole source contracts have been developed (Parents United, NAMI). Information is posted on the MHSA website. Madelyn Schlaepfer asked how co-occurring is being addressed. Ruben said Prevention addresses both mental health and AOD.			
AOD Statistics	M. Schlaepfer	Reports on AOD statistics for 3/1/08-2/28/09 and 1/1/09-12/31/09 were distributed. Madelyn stated there were no major changes since the previous report and no outstanding differences between the two reports. There was a slight decrease in the number of clients with criminal justice involvement. A small percentage had parental rights terminated. A new section, Parent and Child Status, was added to the report. 57.8% of clients have minor children. The percentage of homeless stayed the same.	Continue to report	M. Schlaepfer	As scheduled
Mental Health Service Utilization Based on Prevalence Report –Quarter 2, FY 09/10	C. Hargreaves	Carol Jo distributed a revised report of the Utilization Based on Prevalence Report for FY 09/10. The prevalence rate for our county has decreased from 7.09% to 5.77%. Carol Jo will investigate reasons for this decrease.	Research reasons for decrease in prevalence rate	C. Hargreaves	4/12/2010
Peer Advocate and Family Advocate Report	J. Black, T. White	This is a new section being added to the CCOC agenda. Tim White shared that the Friends Are Good Medicine Guide (to Stanislaus County support groups) is being updated. If you have information, email Tim. John Black made no report.	Send support group information to Tim White	All	As soon as possible
Consumer/Family Member Input	All	There was none.			
Announcements; Other Business	All	There was none.			

Next Meeting: **April 12, 2010** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	April 12, 2010
Place:	830 Scenic Drive, HSA Martin Conference Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves, Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley
Rose Mitchell

CSOC/TAY
Janette Jameson
Robin Johnson for Hermille Catzalco
Lillie Clark
Sofia Martinez

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della

DMS/PM

Sr. Leadership
Madelyn Schlaepfer
Jean Anderson
Elizabeth Oakes

C & F Affairs
John Black
Tim White

C & FM Rep.
Reginald Gilbert

Executive Asst. to Director
Linda Torres

Mgd Care
Debbie Lewis

SRC/Genesis
Michael Toomey

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden
Dorbea Cary
Kimberlee Hamilton

Patients' Rights
Mariana Canelo

PEI

CCOC Co-Chairs
Carol Jo Hargreaves
Pete Duenas

Contract Providers
Barbara Anderson
Fernando Granados
Jorge Fernandez
Ruben Sanchez
Jim Riley

Other
Elizabeth Vera
Michael Atinsky

Absent:

ASOC/OASOC
Alice Tamraz

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Carolyn Warren-Smith
Lucy Escobar
Sandra Portillo

Forensics/PG

Fiscal/Admin Services

DMS/PM
Hector Ayala

Sr. Leadership
Debra Buckles
Adrian Carroll
Glenn Hutsell

C & F Affairs

C & FM Rep.
Jesse Gutierrez

Executive Asst. to Director

Mgd Care

SRC/Genesis
Scott Roberts

Quality Services

HR/Training/WET
Jim Hurley

Patients' Rights
Teresa Alvarez

PEI
Ruben Imperial

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	C. Hargreaves	Today's Agenda necessitated staying on time as allocated. Ken Huntley volunteered to serve as Timer for this meeting.			
Approval of Minutes – March 12, 2010	All	Lillie Clark motioned to approve the 3/12/10 meeting minutes, Ken Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	C. Hargreaves	Ruben Imperial provided the link to the CIMH article on			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Promotores model. An article for the CCOC Newsletter was submitted by Ken Huntley. Dorbea Cary will share CCOC recommendations regarding CBMCS to Senior Leadership at the end of the year. Carol Jo Hargreaves met with Glenn Hutsell to investigate consumer rep selection process. She also provided information to Stacey Della about how contractors will be involved in CCRP.			
CCOC Newsletter, April 2010 Edition	M. Canelo	Mariana distributed the April 2010 CCOC Newsletter. Carol Jo thanked Ken Huntley for contributing an article. Ken thanked Mary Aguirre (H/MHT) for the idea of writing an article about being sensitive to the deaf culture. Dorbea mentioned that MJC offers a sign language course in the evenings.	Submit article for CCOC Newsletter	K. Hamilton	4/19 /2010
Training Update, CBMCS	D. Cary	The CBMCS is moving forward. Training dates are currently being identified for July and August. Two-day trainings will be offered back to back each month as a "trial run". After trainings have been completed, Dorbea will ask for feedback and the trainings will be offered again in the Fall. It was previously recommended to offer the trainings once a month but this might not be effective. Dorbea announced that Supervising Staff with Lived Experiences has been rescheduled to June 8th. A six-week Motivational Interviewing series with Elizabeth Oakes and Mike Wilson starts April 22nd. The April-June Training Calendar is available on the Intranet. Fernando Granados mentioned he attended Mental Health First Aid training in Florida. Dorbea explained to our guest, Mike Atinsky, Jail Chaplain, that training is open to County staff and to volunteers on a space-available basis.			
Consumer/Family Member Input	All	John Black announced the Consumer/Family Steering Committee Meeting will be held 4/13 at 3pm in the Redwood Room. He also shared that he attended the CIMH & Stan State Masters Program Wellness conference and the Spring into Mental Health conference at Modesto Junior College. The Behavioral Health Summit will be 5/10 at the Doubletree, Day of Hope will be 5/14 at West Modesto King Kennedy Center and Tuolumne River Trust's "Green on the Stream" will be 5/22 at Tuolumne River Regional Park. The STAY Partnership Youth Conference will be Saturday, June 19. Kimberlee Hamilton shared that a vegetable garden is being planted near the Consumer Empowerment Center. Michael Atinsky invited us all to attend the Project Inter-Face Summit to be held 5/7, 8:30am-4pm, at the Gospel Mission. Breakfast and lunch will be provided at no cost. Email chaplainatinsky@yahoo.com to register for this event. Tim White mentioned that he and			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Dorbea are revamping Partnership with the Customer training. Elizabeth Vera, NAMI, reported the new Friends in Recovery program is going well. Heather Walton is the contact for pairing people up.			
Cultural Competence Plan Requirements Status Report	C. Hargreaves, P. Duenas	Pete Duenas shared that Carol Jo and he attended DMH Technical Assistance Training 3/29. Cultural Competence Plan development is on track, as planned. To date there have been meetings with BHRS key informants, contractors and consumer advocates. April 30th is the deadline for submission of all requested data and information. The CCPR and timeline are posted on the BHRS intranet. There is still a lot of work to be completed in a short amount of time. Carol Jo stated a follow-up meeting will be held with contractors 4/15. If you haven't been invited to a meeting and would like to be involved, talk to your supervisor/coordinator.	Submit data and information for the CC Plan	Key informants, contractor agencies and consumer advocates	4/30/2010
Mental Health Service Utilization Based on Prevalence Report – Quarter 2, FY 09/10	C. Hargreaves	Carol Jo explained that prevalence is how many people in our community need mental health services. Two Prevalence Reports were provided. The report using "original" Charles Holzer data, showed a prevalence rate for Stanislaus County of 7.09% and the new Holzer report showed 5.77%. Carol Jo researched the reason for this decrease with DMH and found it is due to use of a more conservative methodology for calculating prevalence. All CA county's prevalence rates decreased. Data in the two reports is from CSI/Insyst.			
Peer Advocate and Family Advocate Report	J. Black, T. White	John announced the current 10-week NAMI Provider Education training went well and will end 4/15. This training is for providers; there is also a 9-week Family to Family course offered. Pete shared that the passion brought into the Provider Education training is interesting and he encouraged everyone to take the course. Tim White made no report.			
Results Based Accountability	Ruben Imperial	Ruben was not available to present.	Reschedule presentation	C. Hargreaves	6/14/2010
Announcements; Other Business	All	Dorbea Cary announced there will be a Workforce Council meeting 4/21 from 3-4:30pm in the Redwood Room. Carol Jo shared that the Cultural Competence section of the BHRS intranet was reorganized. Agenda and minutes are posted as well as the CCPR document and Timeline. A separate website for CC is not necessary. Reminder that the May 10th CCOC meeting has been cancelled to encourage attendance at the Behavioral Health Summit 2010 to be held at the Doubletree Hotel, 8-5pm.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Next Meeting: **June 14, 2010** **BHRS Redwood Room, 800 Scenic Drive**		**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**			
Respectfully submitted by: Mariana Canelo					

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	June 14, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves, Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Rose Mitchell

CSOC/TAY
Carolyn Warren-Smith for Janette Jameson
Sofia Martinez
Lucy Escobar

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della
Lillie Farriester

DMS/PM
Brenda Kachel

Sr. Leadership
Madelyn Schlaepfer
Elizabeth Oakes

C & F Affairs
John Black

C & FM Rep.

Executive Asst. to Director
Linda Torres

Mgd Care

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden
Dorbea Cary

Patients' Rights

PEI
Jennifer Marsh
Karen Reid

CCOC Co-Chairs
Carol Jo Hargreaves
Pete Duenas

Contract Providers
Ruben Sanchez
June Newman

Other
Elizabeth Vera
Teresa Garibay

Absent:

ASOC/OASOC
Alice Tamraz
Ken Huntley

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Lillie Clark
Hermille Catzalco
Sandra Portillo

Forensics/PG

Fiscal/Admin Services

DMS/PM

Sr. Leadership
Debra Buckles
Adrian Carroll
Glenn Hutsell
Jean Anderson

C & F Affairs
Tim White

C & FM Rep.

Executive Asst. to Director

Mgd Care
Debbie Lewis

SRC/Genesis
Scott Roberts
Michael Toomey

Quality Services

HR/Training/WET
Jim Hurley
Kimberlee Hamilton

Patients' Rights
Teresa Alvarez
Mariana Canelo

PEI
Ruben Imperial

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	C. Hargreaves	Today's Agenda necessitated staying on time as allocated. Stacey Della volunteered to serve as Timer for this meeting.			
Approval of Minutes – April 12, 2010	All	Stacey Della motioned to approve the 4/12/10 meeting minutes, Ken Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	C. Hargreaves	Kimberlee Hamilton submitted an article for the May			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Newsletter. Data and information for the CC Plan was submitted by almost everyone. All the time and effort it took to compile this information is appreciated. The Results Based Accountability presentation has yet to be rescheduled due to Ruben Imperial not being available for this particular meeting time.			
CCOC Newsletter, June 2010 Edition	T. Garibay	Teresa distributed the June 2010 CCOC Newsletter. Carol Jo shared that she had a really fun time interviewing Jai Gullatt for the "Juneteenth" article.	Submit article for CCOC Newsletter	C.Alcala	6/21/10
Training Update, CBMCS & CC Training. Modules Status Report	D. Cary	In collaboration with the Center for Human Services, dates for the California Brief MultiCultural Scales (CBMCS), our new cultural competence modules, have been scheduled for 7/15-16 and 8/10-11 at Harvest Hall. BHRS Core Competencies have been revised accordingly. It was decided that clerical staff would need to take only one module, AOD staff need to take 2 modules, and all other staff need to take all 4 modules. Flyers should be sent out this week. Demographic Data training will be held 6/21 from 9-11am, 6/23 from 1-3pm, and 6/25 from 9-11am. All who collect and enter data into Insyst or the MHSA Initial Contact Database need to attend. Revamped LPS training is on 7/23. The 10-week NAMI Provider Education training begins Wednesday, 7/28, 8:30-11:30, at the Jana Lynn Center. Toward Effective Self Help will be facilitated by Ron Gilbert and Tim White, 8/4-8/8, from 10-2pm. CSOC will begin using CANS (Child/Adolescent Needs and Strengths), an assessment tool to take the place of CAFAS. There will be a series of trainings in August and September.			
Consumer/Family Member Input	All	John Black shared that El Concilio is hosting a special dinner on Thursday, 6/17 from 4:30-5:30pm, at which Keena Wells and Mark Bixty will display their artwork. "Touching Home" will be shown at the State Theatre 6/22, 6:30pm. Tickets are $10. Part of the proceeds will go to Peer Recovery Art Project, Inc. Edwin Rivera, Education and Prevention, will introduce the show in Spanish and John will do the English introduction. The Stanislaus Transitional Age Youth (STAY) Youth Leadership Conference will be held Saturday, 6/19 at MJC West Campus. Elizabeth Vera shared the "In Our Own Voice" trains consumers to go out into our community to share their story of dark days, acceptance and how they learned to cope with mental illness. The intention of this training is to educate and raise awareness. There are currently 6 people doing			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		presentations and 6 more to be trained. Next training dates are 7/16-7/17. Call NAMI with names of those interested. There is a $50 per presentation compensation. Spanish Family to Family will be 8/17 and will now be held twice a year. Connie Alcala mentioned that Public Guardian/Public Administration/Public Conservator will be having their annual conference at the Doubletree in September. John mentioned that Ruben Imperial provided a PEI update at the Consumer/Family Member Steering Committee and new members from NAMI and CASRA joined the committee. Day of Hope went well; 200 attended. There was a huge art show and food. Peer Recovery Art Project and the Modesto Art Co-Op completed a mural at Ceres Partnership for Healthy Children. A ribbon cutting ceremony will be held 6/22.at 1pm.			
Cultural Competence Plan Requirements Status Report	C. Hargreaves, P. Duenas	The due date for the CC Plan has been extended to 8/31 and the timeline is being adjusted. This task has been complex and more difficult than originally anticipated. An update will by provided at the CCOC meeting, 8/9.			
Demographic Data Project Update	C. Hargreaves	As Dorbea already mentioned, the Demographic Data training will be on 6/21, 6/23, and 6/25. Carol Jo provided a summary of how this project originated. In next week's training attendees will learn new ethnicity/language codes, veterans' status and sexual orientation codes. There will be group work so people can learn about the topics and how to handle them in their day to day jobs doing assessments and entering data.			
Peer Advocate and Family Advocate Reports	J. Black, T. White	John announced that "Families….the Rest of the Story" will be held 10/27. "Partnering with the Customer" training was held two weeks ago. Results Based Accountability (RBA) training is 6/16. Mental Health Planning Council will be in Oakland, 6/15-6/16. Bruce Anderson is providing a special training 6/17-6/18 at Harvest Hall. The MHSA Oversight and Accountability Commission plans to do a feature story in their newsletter for September. The revised "Friends Are Good Medicine" directory of support groups will be available to print online on 7/1. The Barkin' Dog Grill will feature artwork from Franklin Elementary School 5th graders all summer. Elizabeth mentioned there is a new "Friends in Recovery" mentoring program where pairs receive a weekly stipend to provide support and encourage participation in activities, resulting in reduced social isolation.			
Senior Prevention Service Activities	J. Marsh, K. Reid	Karen Reid, BHS and Jennifer Marsh, Coordinator from Education and Prevention Services presented highlights about			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		services for seniors from the Stanislaus Prevention Plan. California has the largest older adult population of any state in the United States. Older Adult is the fastest growing segment of population with the baby boomer cohort the first generation where the majority has used illicit drugs. Seniors are broken down into two categories: "Hardy Survivors," those who have used substances for may years, and "Late Onset," the ones using drugs later in life because of stressors and life changes. Alcohol absorption is higher in older adults so blood alcohol levels increase more rapidly. This population tends to be prideful, wary of strangers, and want interactive education and support. Provider education training is available for staff. Services are provided at senior centers, church senior groups, senior apartment complexes and service organizations. Older adult concerns include falling, poor sleep, memory lapses. Often doctors do not consider substance abuse when working with senior patients. Partnerships have been established with Patterson Hammond /senior center, Area Agency on Aging, Fall Prevention Coalition, and the Stanislaus Pride Center. The federal government defines a senior as 55 years old and above. John Black suggested train some seniors to provide "In Our Own Voice." Pete Duenas asked if older adults are diverse in background. Karen answered that in certain communities they are diverse but there are problems reaching the Assyrian population. Karen distributed a flyer about free older adult community education. Call Karen Reid to schedule a presentation or workshop: 525-4614.			
Announcements; Other Business	All	Dorbea asked if all programs had completed the LGB training module. Pete asked members to remind their program coordinators to complete this training with staff. At the 7/12 CCOC meeting we will discuss FY 09/10 accomplishments and begin to establish FY 10/11 goals in concert with the 2010 Cultural Competence Plan.			

Next Meeting: **July 12, 2010** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	July 12, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Carol Jo Hargreaves, Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Carolyn Warren-Smith for Janette Jameson
Amanda Stepp for Sofia Martinez
Hermille Catzalco
Lillie Clark
Shannyn McDonald
Carrie Becker
Jeanette Merchant
Carla Skiles

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Vicki Peitz for Lillie Farriester

DMS/PM
Brenda Kachel

Sr. Leadership
Madelyn Schlaepfer
Adrian Carroll

C & F Affairs
John Black

C & FM Rep.
Reginald Gilbert

Executive Asst. to Director
Linda Torres

Mgd Care
Debbie Lewis

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden
Dorbea Cary

Patients' Rights
Mariana Canelo

PEI
Ruben Imperial

CCOC Co-Chairs
Carol Jo Hargreaves
Pete Duenas

Contract Providers
Ruben Sanchez
June Newman
Barbara Anderson
Fernando Granados
Jorge Fernandez
Mike DeRose
Kim Wood Hiatt

Other

Absent:

ASOC/OASOC
Alice Tamraz

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Sandra Portillo
Lucy Escobar

Forensics/PG

Fiscal/Admin Services
Stacey Della

DMS/PM

Sr. Leadership
Debra Buckles
Glenn Hutsell
Jean Anderson
Elizabeth Oakes

C & F Affairs
Tim White

C & FM Rep.

Executive Asst. to Director

Mgd Care

SRC/Genesis
Scott Roberts
Michael Toomey

Quality Services

HR/Training/WET
Jim Hurley

Patients' Rights
Teresa Alvarez

PEI

Other
Elizabeth Vera

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing. A Certificate of Appreciation was presented to Carol Jo in recognition of her excellent leadership as a co-chair for CCOC. Members shared food and beverages in celebration of Carol Jo's 7/30 retirement.			
Appoint Timer	C. Hargreaves	Today's Agenda necessitated staying on time as allocated. Ken Huntley volunteered to serve as Timer for this meeting.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Approval of Minutes – June 14, 2010	All	Lillie Clark motioned to approve the 6/14/10 meeting minutes, Ken Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	C. Hargreaves	Connie Alcala submitted an article for the June Newsletter.			
CCOC Newsletter, July 2010 Edition	M.Canelo	Mariana distributed the June 2010 CCOC Newsletter. Carol Jo thanked Connie Tipton for the positive article submitted. The 2nd article is regarding the "First Annual Youth Leadership Conference" put on by the Stanislaus County Transitional Age Youth (STAY) Partnership Group. Planning has begun for the second conference to be held in May 2011.	Submit article for CCOC Newsletter	T.White	7/19/2010
Training Update	D. Cary	"How to be a LPS Deputy" sponsored by Connie Alcala, Suzanne Herron, Kevin Panyanouvong, and Marilyn Ricketts will be held 7/23 at the Jana Lynn Community Room, 500 N. 9th Street. CSOC is replacing CAFAS with the Child Adolescent Needs and Strengths (CANS) tool. Mandatory training will begin in August. CANS organizes clinical information collected during a behavioral health assessment in a consistent manner, to improve communication among those involved in planning care for a child or adolescent. It is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. BHRS, in partnership with CHS, will provide the first two modules of California Brief Multicultural Competency Scale (CBMCS) training 6/17-6/18. The second two modules will be provided in February/March 2011. Fernando Granados asked if this training is mandatory for contract agencies. Dorbea replied it depends upon the agency's contract requirements.			
Results Based Accountability	R. Imperial	Ruben Imperial, PEI Manager, reported that on 4/29/10, Denise Hunt and Leadership convened with a group of community partners to discuss Community Capacity Building. This movement began with AOD Prevention/Education, is now being deployed in PEI and will then be used through the rest of BHRS. "Community" is defined as a group of people who know each other well enough that they can act together and support each other. "Capacity building" is strengthening the ability of communities to act on their own behalf to promote the well being of their members. Results, community-defined indicators, and strategies to improve communities are RBA concepts embedded in PEI. Pete Duenas mentioned that RBA is targeting diverse communities. CMASA, Promotores, and Vision y Compromiso are being used to engage with Spanish speaking individuals. The department currently has 26 PEI contracts, 8 community efforts and 8 BHRS efforts.	If interested in taking Results Based Accountability 101, contact Ruben Imperial	All	

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Advocate/Consumer/Family Member Input	All	Carol Jo mentioned that this section of the agenda was modified, combining the Advocate/Consumer/Family Member Input sections. John Black distributed the July edition of "Renaissance", the Peer Recovery Art Project newsletter. The NAMI Walk and Modesto Blues Art & Music Festival held at Mellis Park, West Modesto King Kennedy Neighborhood Center, 7/10, were well-attended and fun. An article and photo were published in The Modesto Bee, 7/11.	If you know an artist who is interested in showing their art, let John Black know	All	
Demographic Data Project Update	P. Duenas	Pete reminded members information about the Demographic Data Project, spearheaded by Denise Hunt and sponsored by the CCOC, was presented at Monthly Leadership 6/7 and the coding changes were implemented in BHRS, 7/1/10. Challenges and concerns were discussed. Shannyn McDonald, CWS, expressed concern about asking children about sexual orientation without hindering relationships, labeling or planting a seed. She wondered how the new process is bettering demographic information and treatment. Amanda Stepp, JJ, thought it inappropriate to ask about sexual orientation. Carol Jo explained Adrian Carroll and CSOC Coordinators discussed concerns and on 6/28 a "Deferred" category was added to the coding system which may be used with an established timeline for resolution. Madelyn Schlaepfer asked how else this data could be collected and emphasized we need to know if the LGBTQ group is being served and be careful there is no stigma toward them. Dorbea Cary mentioned there have been trainings offered related to the subject that no BHRS staff attended. Madelyn clarified that this question does not need to be asked in the first assessment. Brenda Kachel reported she attended Dr. Davina Kotulski's training whereat consumers expressed a strong desire to be asked about and have a free environment in which to discuss their sexual orientation. Brenda reminded members that data can change over time and CSI should be updated. In order to continue discussion, Pete will add this topic to next month's meeting agenda. Madelyn reminded members that part of the CCOC Mission Statement is to collect measurable data. Adrian thanked Carol Jo for her willingness to add the Deferred code and requested inclusion of additional CSOC perspective. Dorbea said training would be developed and encouraged everyone to move forward. Pete reminded members of their responsibility to report CCOC information			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		back to their programs. Carol Jo thanked the group for thinking, talking and learning.			
FY 2009/10 CCOC Accomplishments	All	Began to compile a list of FY 09/10 CCOC accomplishments: Published the CCOC newsletter every month and posted the newsletter, meeting minutes and 2010 CCPR on a new "Cultural Competence" BHRS Intranet page, conducted the 2nd annual Taste of Culture, rolled out the third "Training in a Tube" module (LGBQ), provided staff training on new demographic data collection codes, adopted the evidence-based CBMCS curriculum, collected and began compiling information to meet 2010 Cultural Competence Plan Requirements, revised contract language to incorporate CCPR, presented quarterly service utilization reports, redefined/clarified the CCOC's role as an oversight committee, sent representatives to the 2009 Cultural Competence/Mental Health Summit, updated CCOC member binders, and added lived experience as a Desirable Qualification on BHRS job flyers.	Be prepared to continue discussion of FY 09/10 accomplishments	All	8/9/2010
Announcements; Other Business	All	Reminder that cultural competence should be on every QIC agenda.			
Next Meeting: **August 9, 2010 BHRS Redwood Room, 800 Scenic Drive**		**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**			
Respectfully submitted by: Mariana Canelo					

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	August 9, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC

CSOC/TAY
Sofia Martinez
Lillie Clark

Forensics/PG

Fiscal/Admin Services
Vicki Peitz for Lillie Farriester
Stacey Della

DMS/PM

Sr. Leadership
Madelyn Schlaepfer
Adrian Carroll

C & F Affairs
John Black
Tim White

C & FM Rep.
Reginald Gilbert

Executive Asst. to Director
Linda Torres

Mgd Care

SRC/Genesis
Stephen Preston

Quality Services

HR/Training/WET
Dorbea Cary

Patients' Rights
Mariana Canelo
Teresa Alvarez

PEI

CCOC Co-Chairs
Pete Duenas

Contract Providers
Ruben Sanchez
June Newman
Fernando Granados
Al Ellsmore

Other
Elizabeth Vera
Cathee Vaughn

Absent:

ASOC/OASOC
Alice Tamraz
Ken Huntley

CSOC/TAY
Blanca Medina
Shereen Reid
Tommy Panyanouvong
Sandra Portillo
Lucy Escobar
Janette Jameson
Hermille Catzalco

Forensics/PG
Connie Alcala

Fiscal/Admin Services

DMS/PM
Brenda Kachel

Sr. Leadership
Debra Buckles
Glenn Hutsell
Jean Anderson
Elizabeth Oakes

C & F Affairs

C & FM Rep.

Executive Asst. to Director

Mgd Care
Debbie Lewis

SRC/Genesis
Scott Roberts
Michael Toomey

Quality Services
Vickie Looney

HR/Training/WET
Jim Hurley
Christi Golden

Patients' Rights

PEI
Ruben Imperial

Other

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Vicki Peitz volunteered to serve as Timer for this meeting.			
Approval of Minutes – July 12, 2010	All	Madelyn Schlaepfer motioned to approve the 7/12/10 meeting minutes, Lillie Clarke seconded. The minutes were approved as submitted.			
Follow Up on Action Items	P. Duenas	Tim White submitted an article for the Newsletter. Dorbea			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		shared that once the train the trainer has been completed there will be multiple training dates available for those interested in taking Results Based Accountability 101. There will be 20 trainers trained. Pete mentioned that Ruben Imperial gave a presentation in the July CC meeting and it is a very worth while training. John Black is always looking for artists who want to show their art. Today we will be discussing FY 2010/11 CCOC Goals.			
CCOC Newsletter, August 2010 Edition	M.Canelo	Mariana distributed the August 2010 CCOC Newsletter. Mariana thanked Marcos Gallardo for the article on "El Concilio Update". There was also an article on CCOC Highlights from the July meeting and an article in recognition of National Senior Citizen's Day, August 21st.	Submit article for CCOC Newsletter	June Newman	8/16/10
CCOC Co-Chair	M. Schlaepfer	We would like to have a new co-chair, possibly a BHRS staff member from this group. Madelyn asked if anyone in this group would be interested in taking this responsibility. Pete gave a description of what being a co-chair would entail. The co-chair would look at how this committee helps drive cultural competence throughout the organization, attends meetings at the state level, helps develop the monthly agenda, presents at the monthly Leadership meeting and reviews what activities are occurring within the department. Tim White asked if the co-chair could be a consumer/family member. Madelyn answered it could be but should be a BHRS staff person because of the time requirements.	If interested in becoming CCOC Co-chair, email Madelyn Schlaepfer and Pete Duenas	All	9/13/10
Training Update	D. Cary	"Friends are Good Medicine" has been cancelled due to low enrollment and will be rescheduled to October. Dorbea emphasized the importance of signing up for trainings. Tim shared that there may be some confusion as to registering for trainings. On flyers a time is indicated for registration, so some may be led to believe you can register on the day of the training and do not need to email Marisela Cantu to sign up. Rosemary McFadden, Jorge Fernandez, and Dorbea Cary are finishing up on the training preparation for the California Brief Multicultural Competency Scale (CBMCS) training. "Engaging and Helping Children with Autism Spectrum Disorder" will be on 9/16. Gwen Gnapp is doing Medical Records 101 on 9/14. Clinical Supervision training is coming soon. Training calendar will be posted to the intranet.			
MHSA Innovation Project	M. Schlaepfer	The proposal on the Stanislaus County Behavioral Health and Recovery Services Innovation Project was distributed. At the end of the packet is a 30-day public comment form and everyone is encouraged to contribute any comments. Madelyn	Submit Public Comment Form for Innovation	All	8/26/10

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		explained that innovation is about trying something new and learning from it. The purpose needs to be about increasing access to underserved populations, increasing the quality of services, promoting inner agency collaborations and/or general increases in access to services. This process will officially begin in FY 2011/12. This year in FY 2010/11 we will be looking at the Community Services and Supports MHSA budget. This will involve meetings with key informants. There will also be a trial run with AOD, which will be a stakeholder process held between now and March 2011. This will be an effort to collaborate with the community in the budget process. Dorbea Cary asked how we are going to ensure that diverse communities are getting involved in terms of input. Madelyn stated choosing stakeholders is one way. June Newman asked what criteria is needed to be a stakeholder. A stakeholder is usually someone who is representing a group, agency, or community. Pete Duenas added that there is an existing mental health stakeholder steering committee that comprises of 44 stakeholders within the community. Lillie Clark questioned as to how a stakeholder will learn the needed information that is expected from them. There will be an education process given. It will take time to learn the material and the only way we will know if people understand is with the reflections that come out. Lillie asked if any CC members will be participating in this process on a regular basis and if they will be reporting back to this committee. Madelyn informed that she will be participating on a regular basis and will give updates and reports to this committee. Contract agencies will be participating as well. Anyone wanting more information about the proposal project can attend an informational meeting on Tuesday, 8/17 from 4 – 5 pm in the Redwood Room. The 30-day public review and comment period will conclude with a public hearing on Thursday, 8/26 beginning at 5 pm in the Redwood Room.	Project		
Advocate/Consumer/Family Member Input	All	Elizabeth Vera shared information about some upcoming training. A 12-week course for “Family to Family” in Spanish will begin on 8/17. If interested let Elizabeth know or call 558-4555. This training is also offered in English on 9/2 in Modesto and on 9/7 in Turlock. There are also two support groups being offered in Turlock. June Newman shared that if transportation is needed for clients call 238-9436. John Black shared that the Multi-agency Food Fest event last Friday was great. For the first time he has seen a concerted effort to			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		transport many people throughout the county who have struggled with getting transportation in the past. The Alumni Association had a Drug Court Celebration at Harvest Hall which was beautiful. Madelyn thought John did a great job emceeing the event and we must appreciate the energy and endorse it. It was amazing how many people said art helped them bridge to recovery. Tim White shared that he presented "Friends are Good Medicine" to the quality management team and received blessing to move forward. He would like to give a presentation of this to this committee.			
Demographic Data Project Update	P. Duenas	CSOC Coordinators were unable to be present, so Adrian Carroll reported information on their behalf. There is definitely an acknowledgement of the need for data collection concerning sexual orientation for children. Staff have different comfort levels when it comes to discussing this topic. There are concerns of privacy, meaning this information may be shared with schools and with parents. Parents may also be offended if asked this question about their child. Staff feel this is important to ask, but there are risks and there needs to be more conversation on the topic. Having the deferred category is a short term solution and not long term. Coordinators recommend there be training for staff who are uncomfortable with this topic or some type of work group be convened. It was noted that some ASOC staff have also come out to say that this topic is also uncomfortable for them. Madelyn clarified that this does not need to be asked in the first assessment and that the deferred category is an option at the opening but not at the end. The timing of when to ask this is up to the clinician at this point. Adrian stated that staff need to feel that their expertise is being heard and currently they don't feel they are being heard by BHRS. Dorbea suggested taking this discussion back to Senior Leadership, since there was previous agreement to move forward with collecting this data.			
FY 2010/11 CCOC Goals	All	Some of the CCOC goals for FY 2010/11 will include the following: Come up with a process decision as to how to collect data, complete the Cultural Competence Plan, begin the CBMCS curriculum and monitor and encourage all to take training, encourage all to take Results Based Accountability 101 training, participate in work group involving the electronic health record which is coming soon, maintain oversight on PEI, assign a new co-chair, and monitor diversity of current program staffing.			
CCOC Member Sharing to	M. Schlaepfer	Madelyn emphasized that each representative in this			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Systems of Care		committee needs to go back to their program and share the information provided from each meeting. Reminder that cultural competence should be in staff meetings. Stacey Della shared that she emails the highlights of the meeting to staff in Contracts.			
Announcements; Other Business	All	Pete announced that an extension for the CC Plan Requirements will be requested to the state. Hoping to extend to October 31st, 2010.			
Next Meeting: **September 13, 2010** **BHRS Redwood Room, 800 Scenic Drive**		**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**			
Respectfully submitted by: Mariana Canelo					

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	September 13, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Pete Duenas	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Lillie Clark
Janette Jameson
Carla Skiles
Shannyn McDonald
Vanessa Velarde

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della

DMS/PM
Brenda Kachel

Sr. Leadership
Jean Anderson
Glenn Hutsell

C & F Affairs
John Black
Tim White

C & FM Rep.
Reginald Gilbert

Mgd Care

SRC/Genesis
Stephen Preston

Quality Services
Vickie Looney

HR/Training/WET
Dorbea Cary
Jim Hurley
Christi Golden

Patients' Rights
Mariana Canelo

PEI
Ruben Imperial

CCOC Co-Chairs
Pete Duenas
Linda Torres

Contract Providers
Ruben Sanchez
June Newman
Fernando Granados
Al Ellsmore
Susan Trudell
Jorge Fernandez

Other
Elizabeth Vera
Pam Esparza
Jamie Hoover

Absent:

ASOC/OASOC
Alice Tamraz
Sofia Martinez

CSOC/TAY
Blanca Medina
Tommy Panyanouvong
Sandra Portillo
Lucy Escobar

Forensics/PG

Fiscal/Admin Services
Vicki Peitz

DMS/PM

Sr. Leadership
Debra Buckles
Elizabeth Oakes
Adrian Carroll
Madelyn Schlaepfer

C & F Affairs

C & FM Rep.

Mgd Care
Debbie Lewis

SRC/Genesis

Quality Services

HR/Training/WET

Patients' Rights
Teresa Alvarez

PEI

Other

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	We welcomed Linda Torres as the new co-chair for this committee. Each attendee shared his/her name and program(s) representing			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Ken Huntley volunteered to serve as Timer for this meeting.			
Approval of Minutes – August 9 2010	All	Ken Huntley motioned to approve the 8/9/10 meeting minutes, Elizabeth Vera seconded. The minutes were approved as submitted.			
Follow Up on Action Items	P. Duenas	June Newman submitted an article for the newsletter. A new co-chair was selected. The public comment forms were			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		submitted for the Innovation Project.			
CCOC Newsletter, September 2010 Edition	M.Canelo	Mariana distributed the September 2010 CCOC Newsletter. Mariana thanked June Newman for the article on "My Grandmother", written by Barbara Gibson. Also included in this edition are the CCOC Highlights from the August meeting, "Bicentennial of Mexican Independence", and "Living with a Recovery Drug Addict."	Submit article for CCOC Newsletter	Elizabeth Vera, NAMI & Fernando Granados, SVCFS	9/20/10
Training Update	D. Cary	Close Encounters of the Joyous Kind: Engaging and Helping Children with ASD" with Karen Mitchell is full. "Child and Adolescent Needs and Strengths" is on 9/29 and 9/30. Clinical Supervisor Training is on 9/22 and Dorbea asked each contract agency to send at least one person to this training. Also, getting ready to put together the selection criteria for train the trainers for Results Based Accountability 101 which will begin in November. 20 people will be selected. More information will be sent out soon to staff.			
Friends Are Good Medicine	T. White	Tim White introduced the Friends Are Good Medicine Community Support Group Website. The website is now up and running. Tim thanked Shellie Smith for designing the website. This website is a directory to publicize support groups. Jean Anderson asked if the information gets updated. Tim checks periodically to make necessary updates. There is a section in the search tab that includes faith/spirituality based category. Ruben Imperial asked if this was appropriate to include. Everyone agreed this is a great category because many people want faith based support groups. The website will also be available in Spanish in the future. There will be an advertising campaign in order to promote the website. Pete shared that if anyone has any input to please provide that information. Brenda Kachel suggested it would be a good idea to train the WARM line staff to use this website. Janette Jameson mentioned there is a new version of the HSA Family Resource Directory available at www.hsahealth.org/publichealth. Also, Promotores is sponsoring a free vaccination clinic on 9/18-9/19 from 10-4 at El Remate Flea Market located on Crowslanding.	Email Family Resource Directory to All BHRS Staff	L. Torres	9/20/10
Advocate/Consumer/Family Member Input	All, G. Hutsell, P. Esparza	Pam Esparza, Housing & Support Services Coordinator, presented information regarding housing program. BHRS currently has transitional and permanent housing. This ties into cultural competence because the majority of the population served is referred through the MHSA program. 29% of referrals are homeless individuals. Housing Services provides independent living skills training, cooking, childcare.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		A new 40-unit housing development will be built in partnership with the City of Modesto and Housing Authority. This is a $6 million project that will be funded with federal funds through the Neighborhood Stabilization Project. Will also be submitting applications to the state for the Coolidge and Lincoln Housing Projects. The Coolidge Project will be 32 units of which 8 units will be for transitional housing. Lincoln will be 18 units for older adults. Currently, there are 33 units with individuals or families in transitional living and 84 units of permanent housing. There are 27 on the waitlist for transitional housing and 56 on waitlist for permanent housing. Jean Anderson stressed the importance of money going into the construction in order to make affordable housing. Glenn Hutsell shared that a portion of MHSA funding allocated for the electronic record system will be used to make computers available for consumers and family members in order for them to have access to information. Glenn will be working with the Consumer Steering Committee on this project and as it gets further along will provide this committee with updates. John Black announced that the Art & Music Festival will be every Tuesday, starting 9/14/10 till 10/26/10 from 11am-2pm at 1010 10th Street Plaza. There will be live entertainment, art, poetry, jewelry, health, and wellness information. PEI is having an open house on 9/14/10 from 10am-2pm.			
Central Valley – ESM Update	P. Duenas	Pete reported on the August 26th ESM conference call. An extension for CCPR was approved for 10/31/10. The small counties cultural competence plan requirements also came out this past month, which had been delayed for almost 8 months. The State Office of Multicultural Services is developing a strategic plan around cultural competence in their departments. Also, a scoring tool has been developed to rate and provide feedback on the CCPR. 45 WET plans have been approved, 52 PEI plans have been approved, and 20 innovation plans have been approved. An annual conference for improving services for children and families for reducing stigma is scheduled for February 2011. If interested in presenting at this conference contact Pete. The CBMCS leadership group will be having a meeting to discuss developing a component for supervisors. California Institute for Mental Health (CIMH) provided some community capacity building trainings recently and is developing a wellness guide. Pete and Linda are planning to attend the joint between ESM's			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		and Social Justice committee on 9/27/10.			
PEI Activities Update	R. Imperial	Ruben distributed a handout on Community Capacity Building Initiative. Promotores is the key strategy in the intervention plan for the Spanish community. 9 promotores within the community will be hired. These promotores will be hired because of their extensive history with the community, their language, their culture, and their overall relationships that they have with their neighborhood. Pete suggested having one of these promotores give the committee a presentation in the near future.			
WET Activities	J. Hurley	Jim announced that a total of 44 stipends were given to students during the FY 09/10 for the CASRA curriculum at Modesto Junior College. For the Fall 2010 semester, 33 stipends were given out. As CASRA enters its 4th semester, there are students completing the 9 unit certificate and are now requesting stipends for Human Services and working on AA degrees. BHRS partnership with Davis High School resulted in a contract to add a Behavioral Health component to the Davis High School Health Academy. For the first time, on 3/22/10, Academy Seniors rotated through BHRS offering students a behavioral health option as a career choice. Four students have successfully completed their Master of Social Work. The current MSW contract between BHRS and CSU, Stanislaus was used as a model for a contract expansion to include Masters of Science for the MFT track. The contract was just completed and stipends will be offered for MS students in the fall of 2010. Upcoming Spirituality and Wisdom training is on 10/19.			
CCPR Extension	P. Duenas	Information was provided in the ESM Update.			
Announcements; Other Business	All	Christi Golden announced that Stanislaus County has identified the last week of September as Diversity Week. We would like people to start thinking of ideas as to how to celebrate this week for next year. Denise Hunt is being awarded the Stanislaus County Equal Rights Award. The award ceremony will be on 10/27/10 from 3:30-5pm at 1010 10th Street.	Email award ceremony information to All BHRS Staff	L. Torres	10/11/10

Next Meeting: **October 11, 2010** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	October 11, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Pete Duenas, Linda Torres	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Janette Jameson
Carla Skiles
Lucy Escobar

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della
Vicki Peitz

DMS/PM

Sr. Leadership
Adrian Carroll
Elizabeth Oakes

C & F Affairs
Tim White

C & FM Rep.
Reginald Gilbert

Mgd Care

SRC/Genesis

Quality Services

HR/Training/WET
Dorbea Cary
Christi Golden

Patients' Rights
Mariana Canelo
Teresa Alvarez

PEI

CCOC Co-Chairs
Pete Duenas
Linda Torres

Contract Providers
Ruben Sanchez
Fernando Granados
Jorge Fernandez
Barbara Anderson

Other
Elizabeth Vera
Debbie Lewis

Absent:

ASOC/OASOC
Alice Tamraz
Sofia Martinez

CSOC/TAY
Blanca Medina
Tommy Panyanouvong
Sandra Portillo
Lillie Clark

Forensics/PG

Fiscal/Admin Services

DMS/PM
Brenda Kachel

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Debra Buckles
Madelyn Schlaepfer
Jean Anderson
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SRC/Genesis
Stephen Preston

Quality Services
Vickie Looney

HR/Training/WET
Jim Hurley

Patients' Rights

PEI
Ruben Imperial

Other

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Adrian Carroll volunteered to serve as Timer for this meeting.			
Approval of Minutes – September 13, 2010	All	A correction was requested to be made in the Friends Are Good Medicine section. Stacey Della motioned to approve the 9/13/10 meeting minutes as corrected. Fernando Granados seconded. The minutes were approved as corrected.			
Follow Up on Action Items	P. Duenas	Elizabeth Vera and Fernando Granados submitted an article for the newsletter. The Family Resource Directory was emailed to all BHRS staff. Linda Torres requested that staff notify her if there are any changes to the Resource Directory.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Information regarding award ceremony for Denise Hunt was emailed to all BHRS staff.			
CCOC Newsletter, October 2010 Edition	M.Canelo	Mariana distributed the October 2010 CCOC Newsletter. Included in this edition is "A Culture of survivors" written by Tim White and Highlights of the 9/13/10 CCOC Meeting. Pete Duenas and Linda Torres both commended Tim for such a powerful article.	Submit article for CCOC Newsletter	Jorge Fernandez, CHS	10/18/10
Training Update	D. Cary	Tim White and Ron Gilbert began Friends Are Good Medicine training. 41 people registered for the training and 40 attended. The Asset Approach…40 Elements of Healthy Development is full. Spirituality and Wisdom training is cancelled and will be rescheduled in the spring. 5150 Certification training will be on 10/20/10. There is still space for Families…the Rest of the Story on 10/27/10. Six trainers will be sent to train the trainer for Mental Health First Aid. One person from Sierra Vista, one from King Kennedy, two from PEI, one from Training, and one from Aspiranet will be attending. There will also be train the trainer for Results Based Accountability on 11/9/10 and 11/10/10, which is by invitation only. Per Denise Hunt a letter went out to all the contract agencies. Up to 24 people may attend. Pete and Tim mentioned a date is yet to be selected to train the WARM line staff on the Friends Are Good Medicine website. Linda asked Tim to give a presentation of Friends Are Good Medicine at a clerical meeting.	Schedule Friends are Good Medicine Training for WARM line staff	P. Duenas/ T. White	
MHS 718 Prevalence Report	P. Duenas	The Mental Health Service Utilization Based on Prevalence report for FY 09-10 (Jul/09 – Sep/09) and FY 10-11 (Jul/10 – Sep/10) was distributed. Pete provided an overview of how the data is determined. The data is reported by region, race/ethnicity, and age group. Ken Huntley asked what the goal is. Pete responded that the role of this committee is to look at the disparities. Are there disparities in relation to the services we are providing within BHRS. There is not a huge difference in terms of services provided during the first quarter of each of the past two years. Between the reports there is about a 1% difference in the total percentage of Need Met for each category. Carla Skiles thought it was unusual that there are no differences in the numbers of estimated population for race/ethnicity for the two years. It was explained that the numbers used are based on the census. Vicki Pietz noticed that for Balance of County in the region category there are 110,628 of population, yet there are 0 unduplicated clients being served. Pete mentioned that in the age group, clients under 18 years dropped from 30% to 27%. Not sure what factors lead to this. Maybe there were program closures or	Invite DMS staff to CCOC meeting.	Pete Duenas	11/8/10

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		services reduced. Carla will be comparing these numbers to the numbers on TBS, Janette Jameson stated that children who are uninsured are not reported on this report because they are not entered in Insyst. It was clarified that only services entered into Insyst are reflected on the prevalence report. Pete stated he would invite DMS to a CCOC meeting to help interpret this report.			
Advocate/Consumer/Family Member Input	All	Tim shared it was Disability Awareness Week last week at Modesto Junior College. On 10/19/10, Friends Are Good Medicine will be advertised on 1010 10th Street. Elizabeth Vera shared that the Spanish Family to Family training is going well. There are 13-15 people attending. NAMI is actively recruiting peers who are doing well and recovering to help and educate bilingual peers. In Our Own Voice had more than 700 people attend last year. Connie Alcala attended the Public Guardian/Public Administrator/Public Conservator annual conference last month and shared that she enjoyed the presentation given by NAMI. Christi Golden congratulated the CSOC for coordinating the Fall Festival.			
ESM/Social Justice Update	P. Duenas, L. Torres	Linda reported information from the Joint Ethnic Services Manager's/Social Justice Advisory Committee meeting on 9/27/10. Eleven counties have submitted their CCPR to DMH and 15 extensions to the submission deadline have been approved. A scoring tool for CCPR is in draft form and is being vetted internally at DMH. A motion was passed to not score the plans, but instead feedback be provided related to process improvement, and not post scores for counties. There was a presentation on California Reducing Disparities Project (CRDP). A statewide policy initiative was implemented to improve access, quality of care, and increase positive outcomes to racial, ethnic and cultural communities. The Mental Health Services Oversight and Accountability Commission approved a statewide project for ethnic and Cultural specific Programs and Interventions of $60 million over four years, which will focus on five populations: African American, Asian/Pacific Islanders, Latinos, LGBTQ, and native American. DMH will use $1.5 million of MHSA funds to fund the CDRP. Contracts were developed for Strategic Planning Workgroups for the five populations, for a facilitator/writer and for the MHSA Multicultural Coalition. There was also a discussion on Health Care Reform. The Social Justice Advisory Committee has established a workgroup to review Health Care Reform from a social justice lens to develop recommended actions at federal, state, and local levels.	Send email regarding the five contract organizations that received contracts for the five targeted Ethnic Groups.	Pete Duenas	11/8/10

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		Some information provided is that 74% of California's uninsured are from communities of color and one-fifth to one-third of uninsured are people with mental and substance abuse disorders. 2.78 million low income, uninsured individuals of color will be newly eligible for coverage through Medicaid or subsides in the Exchange. In 2014, Medi-Cal will be expanded to all individuals and families under 133% of poverty, including childless adults with mental illness who may not have qualified before.			
CCPR Extension	All	Pete continues to work on the plan requirements. The intention is to have it ready within a week for CCOC members and QMT representatives to review. The goal is to have it sent electronically to CCOC members and present to the MHB on 10/27/10.			
Announcements; Other Business	All	Ken stated the Healthy Aging Summit will be this Friday at downtown center plaza from 8am-2pm. Adrian stated that the Department is starting a full year project for the new computer system. There will a place for this committee to give some feedback in regards to race/ethnicity tables. Pete asked members if they would like to continue the Taste of Culture in December. Members agreed to do so.			

Next Meeting: **November 8, 2010** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	November 8, 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Pete Duenas, Linda Torres	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Janette Jameson
Carla Skiles
Lillie Clark
Shannyn McDonald

Forensics/PG

Fiscal/Admin Services
Stacey Della
Vicki Peitz

DMS/PM
Brenda Kachel

Sr. Leadership
Adrian Carroll
Madelyn Schlaepfer

C & F Affairs

C & FM Rep.
Jamie Hoover

Mgd Care
Debbie Lewis

SRC/Genesis
Stephen Preston

Quality Services
Vickie Looney

HR/Training/WET
Dorbea Cary
Christi Golden
Jim Hurley

Patients' Rights
Mariana Canelo

PEI

CCOC Co-Chairs
Linda Torres

Contract Providers
Ruben Sanchez
Fernando Granados
Barbara Anderson
June Newman

Other
Elizabeth Vera
Karen Hurley

Absent:

ASOC/OASOC
Alice Tamraz
Sofia Martinez

CSOC/TAY
Blanca Medina
Tommy Panyanouvong
Sandra Portillo
Lucy Escobar

Forensics/PG
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Reginald Gilbert

Mgd Care

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Quality Services

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Patients' Rights
Teresa Alvarez

PEI
Ruben Imperial

CCOC Co-Chairs
Pete Duenas

Other

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Welcome and Introductions	All	Each attendee shared his/her name and program(s) representing.			
Appoint Timer	L. Torres	Today's Agenda necessitated staying on time as allocated. Vickie Looney volunteered to serve as Timer for this meeting.			
Approval of Minutes – October 11, 2010	All	Ken Huntley motioned to approve the 10/11/10 meeting minutes as submitted. Elizabeth Vera seconded. The minutes were approved as submitted.			
Follow Up on Action Items	L. Torres	Jorge Fernandez submitted an article for CCOC Newsletter. Not sure if Friends Are Good Medicine training was scheduled for WARM line staff. DMS staff is not present, but Linda Torres will report on their behalf. Email was sent regarding the			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		five contract organization that received contracts for the five targeted Ethnic Groups.			
CCOC Newsletter, November 2010 Edition	M.Canelo	Mariana distributed the November 2010 CCOC Newsletter. Included in this edition is "Dale Butler Equal Rights Award" written by Linda Torres and "Dia De Todos Los Santos Y Dia De Muertos" submitted by Jorge Fernandez. The 2011 Newsletter Article Sign-up Sheet was passed around.	Submit article for CCOC Newsletter	Jim Riley, Telecare	11/15/10
Innovation Project	K. Hurley	Karen Hurley distributed a handout regarding the Mental Health Services Act – Innovation Project Planning. Behavioral Health & Recovery Services is preparing to release a Request for Proposals (RFP) for MHSA Innovation Projects. Funds for these projects are from the MHSA Innovation Component and can only be used for projects that contribute to learning in mental health/behavioral health. Orientation workshops have been held in five locations: Modesto, Riverbank, Ceres, Patterson, and Turlock. Approximately three dozen people attended the workshops. All materials from the outreach workshops are available at www.stanislausmhsa.com. The primary purpose of projects is to contribute to learning rather than provide services to address unmet needs. The potential focus of the project is to increase access to undeserved groups, increase the quality of services, promote interagency collaboration, and/or increase access to services. There are two working definitions. Community, which is a group of individuals who have sufficiently strong relationship to be able to provide tangible support to each other and act together. Learning edge, which is a place where focused learning can significantly advance the transformation of the system. The amount available for projects is $1,834,555. Funds not used by a specific date will revert back to the state. The anticipated release of RFP is early December 2010. Close of RFP is anticipated to be in late January 2011. A 30 day review/comment period is anticipated to be in March 2011. Approval of projects is anticipated to be in July 2011. Lillie Clark questioned as to how the funds will be distributed. If there are four projects, will the funds be distributed equally? Karen explained that when people respond to the RFP they will need to state how much funding is needed for the project. Janette Jameson mentioned that this is not a training that is being provided; instead people are going to be engaging in a learning process. Karen clarified that the goal of the project is forward learning for emotional health/behavioral health. BHRS staff may also initiate project ideas. There will be a deadline set to submit project ideas. Also, ideas submitted by staff			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		would come up the chain of command. BHRS staff that develop and submit projects will be excluded from the scoring and decision-making process.			
Innovation AOD Stakeholder Process	M. Schlaepfer	Beginning in Fiscal Year 2011/2012 it is expected that the Innovation Project for BHRS will involve a group of community stakeholders who will be meeting with regard to the BHRS budget that includes the core budget for Medi-Cal, MHSA, Public Guardian, and AOD. November 30th is the first AOD Stakeholder meeting, which will begin that process. Currently, we are putting together the stakeholder group. Madelyn asked if a subcommittee of the CCOC would be interested in looking at the diversity of the stakeholder panel. Elizabeth Vera, June Newman, and Vicki Peitz volunteered to be part of the subcommittee who will ensure there is diversity (culturally and ethnically) and also give recommendations. Linda Torres and Pete Duenas will also be part of the subcommittee. Once a meeting date is set an email will be sent to invite those who wish to participate in this process. Jim Hurley asked how long the stakeholder group will meet. The expectation is that the process will be from November 2010 to March 2011. There needs to be a commitment from those who participate in the stakeholder process because they will need to learn a lot about our budget and the department.			
Cultural Competence Newsletter Discussion	L. Torres	There was a meeting held to look at developing a department wide newsletter which would be produced quarterly. This quarterly newsletter would be a combination of both the CCOC and MHSA Newsletters. The focus of the newsletter would be the four change initiatives which are fiscal sustainability, leadership development, community-capacity building, and results based accountability. Linda asked the group for input regarding if this was a good idea or do we want to keep Cultural Competence Newsletter as is. Fernando Granados stated that the CC newsletter works well how it is. He distributes it to other staff and feels that if more information is added that staff may not review it. Jim Hurley asked if the quarterly newsletter would include more contexts. Karen Hurley responded that the format that was discussed was keeping it to 1-2 pages, front and back. Elizabeth Vera suggested keeping the monthly CC newsletter and maybe doing one quarterly newsletter in combination with the MHSA newsletter. Dorbea Cary mentioned that the CC newsletter is part of our strategic plan and there is collaborative with contractors. It was the consensus of CCOC members that the CC Newsletter will continue as is.			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
MHS 718 Report Follow Up	C. Skiles, L. Torres	Carla Skiles reported that this report focused on individuals who are 17 years and under versus 21 years and under. Brenda Kachel noted that the report for FY 10/11 was run on 10/5/10 and the report for FY 09/10 was run on 10/6/10, a year later. So late changes had not been included. When run later there was a 1% increase change for the number of clients served. It was indicated that Kim Berg provided information that the number used for balance of county comes from the state database. Kim is going to discuss this further with Patricia Ortega-Ruiz.			
Training Update	D. Cary	Dorbea just completed a 5-day training for Mental Health First Aid. Suicide: Risk Assessment and Intervention with Jim Hurley and John Yost is on 12/1/10. Psychological First Aid is on 12/15/10.			
Advocate/Consumer/Family Member Input	All	Elizabeth Vera shared that In Our Own Voice (IOOV) will be presenting at Modesto Junior College West campus on 11/10/10, 6pm. Linda also mentioned that IOOV will be presenting at the Leadership meeting in December.			
Announcements; Other Business	All	Linda distributed handout regarding the ESM conference call on 10/22/10. Some highlights are that DMH is moving forward with posting scores for CCPR submissions from counties and Ethnic service Managers are being asked to volunteer to be on review teams as peer reviewers.			

Next Meeting: **December 13, 2010** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**
Respectfully submitted by: Mariana Canelo	

Stanislaus County

Department: Behavioral Health and Recovery Services

MINUTES

Type of Meeting:	Cultural Competence Oversight Committee	**Date:**	December 13 , 2010
Place:	800 Scenic Drive, Redwood Room	**Starting Time:**	9:00 am
Facilitator:	Pete Duenas, Linda Torres	**Ending Time:**	10:30 am

Attendees:

ASOC/OASOC
Ken Huntley

CSOC/TAY
Janette Jameson
Lillie Clark
Lucy Escobar

Forensics/PG
Connie Alcala

Fiscal/Admin Services
Stacey Della
Vicki Peitz

DMS/PM
Brenda Kachel

Sr. Leadership

C & F Affairs
Tim White

C & FM Rep.
Jamie Hoover

Mgd Care
Debbie Lewis

SRC/Genesis
Stephen Preston

Quality Services

HR/Training/WET
Dorbea Cary
Jim Hurley

Patients' Rights
Mariana Canelo

PEI

CCOC Co-Chairs
Pete Duenas
Linda Torres

Contract Providers
Ruben Sanchez
Fernando Granados
Barbara Anderson
Mary Burton
Al Ellsmore
Jorge Fernandez

Other

Absent:

ASOC/OASOC
Alice Tamraz
Sofia Martinez

CSOC/TAY
Blanca Medina
Tommy Panyanouvong
Sandra Portillo

Forensics/PG

Fiscal/Admin Services

DMS/PM

Sr. Leadership
Debra Buckles
Jean Anderson
Glenn Hutsell
Elizabeth Oakes
Madelyn Schlaepfer
Adrian Carroll

C & F Affairs
John Black

C & FM Rep.
Reginald Gilbert

Mgd Care

SRC/Genesis

Quality Services
Vickie Looney

HR/Training/WET
Christi Golden

Patients' Rights
Teresa Alvarez

PEI
Ruben Imperial

CCOC Co-Chairs

Other

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Third Annual CCOC Taste of Culture (including welcome and introductions)	All	Each attendee shared his/her name and program(s) representing. CCOC members treated themselves to food samples of each other's cultures. Pete Duenas brought pan dulce and stated this was a treat to have growing up. Linda Torres also brought pan dulce and stated it was custom in her culture to have pan dulce after a midnight mass. Mary Burton made black-eyed peas and shared that this dish is something she makes for Sunday family dinners. Dorbea Cary shared a pumpkin pie. Tim White shared Russian tea cookies. Ken Huntley brought glazed donuts. Vicki Peitz baked danish Aebleskiver, which are pancake balls. Lillie Clark shared some ham cooked without seasoning. Lucy Escobar made pico de			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		gallo with chips, which is something she always has in her home. Everyone enjoyed sampling the variety of different foods.			
Appoint Timer	P. Duenas	Today's Agenda necessitated staying on time as allocated. Tim White volunteered to serve as Timer for this meeting.			
Approval of Minutes – November 8, 2010	All	Lillie Clark motioned to approve the 11/8/10 meeting minutes as submitted. Ken Huntley seconded. The minutes were approved as submitted.			
Follow Up on Action Items	L. Torres	Jim Riley submitted an article for the CCOC Newsletter. Tim provided the Friends are Good Medicine Training for WARM line staff on 12/7/10.			
CCOC Newsletter, December 2010 Edition	M.Canelo	Mariana distributed the December 2010 CCOC Newsletter. Thanks to Jim Riley and Elizabeth Vera for the articles used in this edition. The 2011 Newsletter Article Sign-up Sheet was passed around. Linda drew attention to a comment received concerning the article, "All Saints Day and Day of the Dead" from the November Newsletter. A reader disagreed with a statement made and the reader's opposing comments were printed in the newsletter.	Submit article for CCOC Newsletter	Janette Jameson, CSOC	12/20/10
AOD Stakeholder Recommendation Update	P. Duenas, L. Torres	A memo with the CCOC recommendations regarding the AOD Stakeholder Process was distributed. Linda Torres, Vicki Peitz, Pete Duenas, and Elizabeth Vera met with John Ott on 11/15/10 to discuss recommendations to give to Senior Leadership about the composition of the delegates to the AOD stakeholder process. Some recommendations were to increase the number of Spanish-speaking AA/NA representatives, to reach out particularly to Hispanics, and to have a delegate and alternate from Promotoras and from the Pride Center. Inviting Alice Tamraz as a representative of the interests and perspectives of the large Assyrian population in Turlock was suggested. Lastly, speak to NAMI regarding whether they would want to have a delegate and alternate involved in this process was suggested.. Next stakeholder meeting is scheduled to be on 12/15/10 at Harvest Hall from 5-9pm. Linda invited members as well and people in the community to attend this meeting as observers and to voice their opinion. Jim Hurley asked how stakeholders are selected. Is there a process we follow in determining this? Linda answered that Senior Leader selects them.			
Central Valley ESM Meeting Update – November 19	P. Duenas, L. Torres	In the Regional Ethnic Services Manager meeting on 11/19/10 there was discussion about the FSP toolkit. They have a steering committee that will ensure that there is culturally competent content and that the toolkit is culturally relevant. The Department of Mental Health reported that they are still working on their strategic plan. They have a contract for a cultural competency consultant to work with the work group to collect race and ethnicity data for scoring the cultural competency plans. 18 counties have submitted their plans,			

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
		17 asked for extensions, and 11 are pending submission. Scoring tool is being finalized. Regarding MHSA 48 Workforce and Education Training plans, 52 PEI plans, and 27 Innovation plans have been approved. Seven contracts were awarded for the Reducing Disparities Project. DMH has a translation contract executed and are asking as to what state documents should be translated. The Office of Multicultural Services has a training plan. Suicide Prevention training will be in the beginning of April. The Central Region needs a co-chair, so Pete Duenas volunteered to help until a co-chair is assigned. Last week in the State Ethnic Services manager meeting there was discussion around 2011 Cultural Competence Summit. Tentatively, they are looking at having a northern region summit and a southern region summit. The southern region summit would be in November 11 in San Bernardino and the northern region would be in June 11, 2011 in Santa Clara. May 3 is the Policy Forum in San Diego. There was a discussion whether or not there could be scholarships provided to community-based organizations, family members, and consumers. There was also discussion around involving ESM's in the tri-annual medical audit.			
Training Update	D. Cary	Dorbea has been in discussion with Adrian Carroll in regards to how to roll out the 4th module of Training in a Box. The 4th module will focus on resiliency. Psychological First aid is on 12/15/10. This training is only open to licensed people. Field Safety Training is on 1/12/11. Law and Ethics: A Workshop for Clerical, CST's and Support staff is on 1/26/11, 9-11am. Law, Ethics and Confidentiality Issues for AOD Treatment Program Providers is on 1/26/11, 1-5pm. Law and Ethics for Behavioral Healthcare Providers is on 1/27/10, 9am-4pm. Partnering with a Customer is on 2/3/11. NAMI will be having their 10-week provider course starting on 2/9/11. PEI is having Aggression Replacement training on 2/16-2/17/11. Tim White reported that on 2/16/11 there will be a Friends Are Good Medicine Conference at Harvest hall from 11-2pm. Information tables will be set up. All staff are invited to attend.			
Advocate/Consumer/Family Member Input	All	Tim reported that the last Consumer/Family Steering Committee was cancelled, however in the previous meeting there had been discussion around the electronic health record and putting computers in different sites in the community for consumers to use.			
Announcements; Other Business	All	None			

Next Meeting: **January 10, 2011** **BHRS Redwood Room, 800 Scenic Drive**	**The Cultural Competence Oversight Committee meets on the second Monday of each month from 9:00 am to 10:30 am, unless otherwise indicated.**

Order of Agenda Items	Presenter	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Respectfully submitted by: Mariana Canelo					

Quality Management Team Minutes

Stanislaus County
Behavioral Health and Recovery Services
QUALITY MANAGEMENT TEAM MINUTES

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California Evidence Code 1157

Type of Meeting:	Quality Management Team	**Date:**	January 11, 2010
Place:	800 Scenic Dr. – Redwood Room	**Starting Time:**	2:00 p.m.
Facilitator:	Jean Anderson	**Ending Time:**	4:00 p.m.
Attendees:	Jean Anderson, Cherie Dockery, Stacy Della, Adrian Carroll, Elizabeth Oakes, John Black, Pete Duenas, Madelyn Schlaepfer, Ph.D., Debbie Vieira, Dr. Uday Mukherjee, Christi Golden, Linda Torres, Robin Carol Johnson, Carol Jo Hargreaves, Linda Downs, Dawn Vercelli, Karen Cardoza		

Order of Agenda Items	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Call to Order & Approval of Meeting 11/16/09	Jean asked members to review the minutes for approval.	Members motioned to accept the minutes as written.		
Changes/Additional Agenda Items	Hold MC-Key Indicator Quarterly Report.	• Report item next meeting.	Jean Anderson	3/15/10
Timer	Christi Golden			
***Injury/Illness Prevention Program Report**	Approved.			
***Quality Council Reports**	Approved.			
Medication Monitoring Review	Held report to next meeting.	• Report item next meeting.	Uday Mukherjee	3/15/10
Follow-up on Action Items from Previous Meeting	Jean asked members to provide updates from the previous meeting's action items as follows: • C. J. reported she did not post fidelity reports to the QMT as the reports she had were not related to fidelity. • Jean reported she did not meet with Karen regarding QIC minute reporting and to provide a handout regarding Q.I. claiming. • Vickie was not present to provide documentation data. • Cherie reported she sent out an email regarding staff help for the 24-hour Hotline. • Jean reported the linkage between MHSA CSS/QMT would be discussed today. • Velinda was not present to report if AOD evidence-based practices are set up for AOD. • Adrian reported Karen was to send out the Fidelity	• Carol Jo will email report to Karen in order to send out to	C.J. Hargreaves K. Cardoza	

	Monitoring report to other QMT members not present at the last meeting.	members.		3/15/10
Complaint Tracking Quarterly Report	Cherie reported Complaint Tracking highlights for the 2nd Qtr. Oct/'09 through Dec/'09 as follows: • 3 complaints: 3 Medi-Cal grievances • Complaint category: 33% abuse, 33% practice/care problem, 33% medication concern • Complaints by SOC: 33% AOD, 33% ASOC, 33% DBHC • Complaints by disposition: 100% Unable to contact client. • Complaints resolved in timely manner: 1-10 days=33%, 16-30 days=33%, pending = 33%. • Severity of complaints: Appropriate practice/care = 100% Cherie reported the number of complaints was low, but explained that last quarter's complaints were high due to a telephone issue at SRC. Jean reported it might be helpful to see the data put into a yearly format that would track any trends over the last couple of years. Pete reported he and Jean have had discussions with DBHC about allowing clients better access to the complaint forms and reported DBHC has followed through with this request since November.	• Investigate combining complaint data into a yearly report format to track trends. Continue to report.	C. Dockery	3/15/10
Cultural Competence Update Report	Pete reported highlights from the CCOC meetings held in December and January as follows: • December meeting was a holiday celebration that involved members bringing in food from their cultural backgrounds. • Dorbea presented workshop information regarding the Public Mental Health System. Initial orientation on 1/13/10. • E. Barrett, a family member, presented a MH Summit report. • Information for updating and reviewing documents to include other disparities. • Members were asked to review a checklist tool and asked to provide feedback about how to roll it out to BHRS. • Discussion about how we disseminate discussion at CCOC to BHRS. • CCOC working on 09/10 goals and objectives. • CC Plan from the State will be coming out in the near future. • Seven CCOC members attended MH Summit and five of them have reported about their experiences and three have written articles for the newsletter. • ESMM Forum will meet in Riverside in March.			

	• Discussion about how to include CC in various meetings throughout BHRS.	Continue to report.	C. J. Hargreaves/ P. Duenas	03/15/10
Clinical Standards Update Report	John presented a handout reporting extensively on the Self-Help groups activities and progress in the following areas: • West Modesto King Kennedy Collaborative/King Kennedy Memorial Center • SRC • NAMI • Telecare • Consumer Network • Empowerment Center • WRC • TRS • Lessons from Reintegration Awards • WET Members expressed their appreciation of the activities that are being accomplished and asked questions regarding TEAM Solutions training. The training promotes healthy lifestyles and is a free program. Members suggested brainstorming ways in which it could be utilized throughout programs.	Continue to report.	John Black	5/17/10
MHSA Statistics Quarterly Report	Carol Jo presented a handout report that provided highlights from 7/1/09 through 11/13/09. The following areas were explained and discussed: • Data Capture Systems and Training • Recovery Training • Customer Satisfaction • Statistics • Exhibit 6 data for FSP, GSD, and O&E programs • BHRS Demographic Report for FSP, GSD, and O&E programs The reporting timeframe was questioned as to why it was not annualized in order to obtain a straight comparison that is in alignment with the State methodology. Carol Jo explained the decision was made by K. Hurley and DMS to report the data through the timeframe provided and she did not know why this methodology was chosen. She also explained our county is participating in a data group and will be extracting from the new system and have their own methodology that they're using. Carol Jo explained KETs do not always reflect the correct hospital data as clinicians sometimes forget to turn in the Teleforms. She explained the new on-line "live" system should help to improve the data results.			

	Madelyn inquired why the number of clients varied in the Exhibit 6 Report showing a differing amount of clients for SHOP in the FSP data. Carol Jo reported she would look into the discrepancies for her. Carol Jo reported the Exhibit 6 data is also available on the Intranet for members to review.	• Look into variances in the Exhibit 6 Report to determine accuracy. Continue to report.	C. J. Hargreaves C. J. Hargreaves	5/17/10 5/17/10
Fidelity Monitoring Update Report	Adrian reported he presented a written report from the Ad Hoc Subcommittee at the last meeting that provided recommendations to QMT from the committee. He reported the recommendations were to develop the QMT Fidelity Subcommittee that would start a process for fidelity reviews. He explained the standard for high-fidelity levels is expected to get tighter over the years. Adrian reported Liz brought forth an issue regarding cultural competence and evidence-based practice that the committee could look at and build in the flexibility for this aspect. Members of the Ad Hoc Committee consist of Adrian, Liz, Cherie, Carol Jo, Ken Huntley, and Mike Wilson. Adrian reported the recommendation was to start with the Ad Hoc Committee and then include additional members such as a family/consumer member. Jean reported the next step would be to approve the sub-committee to the QMT and then include the other members to establish the committee. Other members recommended other additions Members discussed the issue of CCOC representation on the sub-committee. After review, it was decided to keep Carol Jo as the attending member, but with the knowledge that fidelity-based ratings work to standards that may or may not have a cultural component.	• Members agreed and approved the addition of the Fidelity Subcommittee to the QMT. • Include members to the sub-committee: Family/consumer member, MD/RN, data analyst, clerical support • Contact G. Hutsell for consumer/family member. • Dr. Mukherjee will assign RN/MD member. • Decide meeting schedule, time frames and bring back information to QMT. • Send Q.I. Sign-in Sheet to C. J. Hargreaves to claim QI time for staff.	All Members Adrian Carroll C. J. Hargreaves A. Carroll U. Mukherjee K. Cardoza	1/11/10 1/11/10
QMT/MHSA Linkage Discussion	Jean reported in updating the QM Plan, she noticed there was a box that showed MHSA was connected to the QMT, but other than the statistical report that Carol Jo presents there is no direct link that she is aware of. She reported she and Carol Jo discussed the linkage for MHSA CSS, at a MHSA meeting and are now bringing it to QMT to ask members if it should be included on the org chart and if it is something we should be developing a relationship with. Carol Jo reported since 2006 no QIC has issued an invitation to report out anything regarding MHSA. She reported she only			

	reports data at CCOC and at QMT. She stated she is concerned that we have not had any ASOC/OASOC/Forensic QIC yet in place to report. Robin reported CSOC has integrated the programs into the overall QIC and the MHSA programs are not separated out. Others expressed that the MHSA programs should be integrated and incorporated into the QICs, not as a stand alone program. A question was also raised about what role the QMT would have in results-based accountability. Jean explained that she thought this would be a good place for it and if it is tied through the QICs would be claimable time for staff. She stated the decision has not been finalized, but stated that you cannot have good outcomes without quality and that they are intertwined. Members discussed the proposal and provided feedback. Jean asked if she should remove the box off of the chart even if no decision was reached today. Jean inquired from Liz if there was a proposed start date for the ASOC/OASOC/Forensic QIC. Liz reported she has scheduled a meeting with Pete at Coordinators on 1/14 to discuss this and the goal is to have an initial QIC running in March.			
"Hot Issues"	None reported.	Continue to report.	All Members	3/15/10
Other Business:	Jean reported the APS EQRO visit was originally scheduled for January 28-29, but we were recently notified, because we are in the top-ten of reporting counties, that we became eligible for a desk audit this year instead of the regular two-day visit. Jean explained we are waiting to receive clarification on the process for the teleconference review that will be set for sometime in March. More information will be sent out by Cherie regarding what is required to send to APS by the designated timeframe.	Continue to report.	All Members	3/15/10
Evaluation of meeting:	None reported.	Continue to report.	All Members	01/11/10
Agenda Items Next Meeting:	Cultural Competence Report Medication Monitoring Quarterly Report Medi-Cal Key Indicators Quarterly Report Fidelity Monitoring Updates EPSDT PIP Quarterly Update Report PCP Contact Quarterly Update Report Shared Decision Making PIP Update Report		Hargreaves/ Duenas Mukherjee Anderson Carroll Dockery Dockery Dockery	01/11/10
Next Meeting:	Next meeting: **March 15, 2009**, 2:00-4:00 p.m. 800 Scenic - Redwood Room			
Submitted by:	Karen Cardoza	Date: 01-13-2010		

Stanislaus County
Behavioral Health and Recovery Services
QUALITY MANAGEMENT TEAM MINUTES

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California Evidence Code 1157

Type of Meeting:	Quality Management Team	**Date:**	March 15, 2010
Place:	800 Scenic Dr. – Redwood Room	**Starting Time:**	2:00 p.m.
Facilitator:	Jean Anderson	**Ending Time:**	3:30 p.m.
Attendees:	Jean Anderson, Cherie Dockery, Adrian Carroll, Elizabeth Oakes, Debra Buckles, Madelyn Schlaepfer, Ph.D., Dr. Uday Mukherjee, Glenn Hutsell, Christi Golden, Linda Torres, Debbie Vieira, Stacey Della, Carol Jo Hargreaves, Linda Downs, Vickie Looney, Dawn Vercelli, Karen Cardoza		

Order of Agenda Items	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Call to Order & Approval of Meeting 01/11/10	Jean asked members to review the minutes for approval.	Members motioned to accept the minutes as written.		
Changes/Additional Agenda Items	None.			
Timer	Vickie Looney			
***Injury/Illness Prevention Program Report**	Approved.			
***Quality Council Reports**	Approved.			
Follow-up on Action Items from Previous Meeting	Jean asked members to provide updates from the previous meeting's action items as follows: • Karen reported the Fidelity Monitoring report was sent out to members though email last month. • Cherie reported she discussed the issue of combining complaint tracking data to a yearly report w/DMS. • Carol Jo reported she would follow up regarding the variances in the Exhibit 6 report. • Elizabeth Oakes reported the Fidelity Monitoring Subcommittee met with members from the SOCs involved in identifying evidence-based practices in the system. She reported they do not yet have a representative for AOD treatment. The subcommittee plans to meet once per month. • Jean reported she would add the Ad-HOC QMT Fidelity Monitoring Subcommittee to the QM Organization Chart and Matrix.	• Follow up with variances regarding Exhibit 6. • Recommend AOD staff member to attend the Subcommittee. • Add item to QM Org. Chart and Matrix.	C. J. Hargreaves L. Oakes J. Anderson	5/17/10 5/17/10 5/17/10

Medication Monitoring Review Report	Dr. Mukherjee reported the Med-Monitoring Review took place on 3/3/10. There was a communication problem with one program that did not submit their charts for review. Overall, he stated the review went well. They continue their efforts to improve and monitor diagnosis matching prescribed medications and the consents for medications and labs.	Continue to report.	Dr. Uday Mukherjee	7/19/10
Cultural Competency Oversight Committee Updates	Carol Jo reported highlights from the CCOC meeting held on 3/8/10 as follows: • V. Looney presented her report from the CC Summit regarding cyber-bullying and audism (hearing-impaired) communities and discrimination. • D. Cary presented a training crosswalk regarding the new curriculum for multi-cultural trainings for CBMCS and recommendations for proposed staff training requirements. • DMH issued the new CC Plan on 1/10/10 and BHRS must submit our plan to them by 7/10. She explained the handout of the Proposed BHRS CC Plan Timeline to members. • J. Hurley reported the results from the Spirituality Survey which mirrored the State's results. A workgroup will evaluate the results and recommend how to implement spirituality within our department. • R. Imperial reported updates on the implementation of PEI and reported the planning process with a summary of the initiatives and projects. These are posted on the MHSA website. • M. Schlaepfer presented CALOMS statistical data comparing this year and last year's data. • Discussion concerning the new prevalence report received through the CC Plan. The previous rate was 7.09 that was reduced to 5.77. Carol Jo is investigating the reason why this has happened and is in process of contacting DMH to address the issue.	Continue to report.	C. J. Hargreaves/ P. Duenas	05/17/10
Medi-Cal Key Indicators	Jean presented the Medi-Cal Key Indicator 2nd Qtr. report and highlighted areas as follows: • A-1 (a-c) – Jean gave kudos to ASOC with 99%. CSOC/OASOC are figuring out how to address this area for improved percentages. • A-2 – Not too many submissions, as they come from the MHSIP. • A-3 – 100%. Good results regarding the non-English speaking callers to the access line. • B-1 – 67% - Jean reported DBHC has been very prompt in responding but explained she does not always get them in on time. • B-2 – 100% • B-3 – 51% of DBHC clients have signed their tx. plan.			

	Good work by their staff as they have increased their percentage. • B-4 – 100%. • B-5 – 75% - TBS notifications sent out by DBHC are being done but it continues to be a documentation issue that they are addressing. • B-6 – 100% • C-1 – Met goal for PCP Contact. Adrian reported this area was discussed at the PCP Contact Steering Committee and recommended changing the indicator as it is under-reporting the capture of contacts that have been made. She and V. Looney will discuss this further and decide any changes to the indicator. • C-2 – 87%. • C-3 – 39%=ASOC, CSOC=87%, OASOC=50%. Jean reported it is hoped there will be a better way to capture this information once the EHR is in place. Liz reported the liaisons have contact with clients in DBHC and follow up by phone when they miss appointments. • D-1 = 83%. Good job with overall customer satisfaction. • D-2 = 96%. • D-3, Jean reported we have had very few change of provider requests. • D-4 = 100% • D-5 = No complaints were submitted by family members. • D-6 = No complaints were submitted by consumers. • D-7 = 60% of callers were satisfied with help and information they received. Jean asked members if they had suggestions for any staff or consumer members to make test calls to submit them to Cherie. • E-1 – 100%. Jean reported she is very pleased with most of the indicators and the work that staff are doing.	• Members to submit recommendations for test callers to Cherie Dockery. Continue to report.	All Members	5/17/10
EPSDT PIP Quarterly Update Report	Cherie reported the EQRO Teleconference Review was held this month on 3/5 and went well. She reported we would receive a written response within the next few months. Cherie reported the EPSDT PIP now has 78-80 clients in the study group. She explained the goal is to do interventions on all the clients during treatment team staff meetings and/or diagnostic revisions and the reasoning behind them. She reported she has been receiving copies of the staff meeting minutes and/or diagnostic revisions from the programs. She explained once this has been accomplished on all the clients within the next few weeks, the second intervention study will be done in two to three months to see if there was improvement in the amount of crisis contacts and need for services.			

	Jean stated the hypothesis; if we are coming together around the diagnosis we will see less unplanned or crisis services. Dr. Mukherjee brought up the idea of making the PIP broader for all clients in regard to the PCP Contact process. Vickie reported the current diagnostic protocol does not match the policy and procedure and we are currently in the process of doing a revision of the protocol to match the existing policy and procedure. We may discover ideas for process improvement during this process. Cherie reported the final data on the PIP will be ready soon but advised APS will be coming up with a new question for a new PIP in June.	Continue to report.	Cherie Dockery	7/19/10
Shared Decision Making PIP Update Report	Cherie reported the PIP was accomplished out of TRS and had 18 client participants. A survey was developed and also a questionnaire for clients to complete before their appointment with the MD/RN. Cherie reported she is in the process of trying to categorize the second tool as it required written answers and has made it more difficult to score. She has asked APS to help her with this task. Dr. Mukherjee reported TRS did a very good job with this effort and voiced appreciation for the good work they did. Jean shared the hope is what was learned can be applied in a broader context.	Continue to report.	Cherie Dockery	7/19/10
PCP Contact PIP Update Report	Cherie presented the PCP Contact Demographic Report and Contacts by Program Report sharing the following information: <u>By Program:</u> Open clients = 2539 With PCP = 1522, 59.9%, plus 417 clients (16.4%) with no contact within last year = 76.3% with PCP. W/O PCP = 538, 21.2% Refused PCP = 62, 2.4% Cherie reported most programs are doing well, but some percentages are still low regarding PCP contact. She reported a Supervisor's Questionnaire was sent out last quarter to ask them about what they are doing to improve percentages at their programs. The committee will be sending out another questionnaire this quarter for more feedback for comparison and analysis. <u>Demographic:</u> Age: 18-25 have the highest percentage w/o PCP at 43.6%. Ethnicity: Hispanic w/ PCP 66.4%, 30.4% w/o PCP. Gender: Both male and female are closely distributed. Dr. Mukherjee expressed the significant improvements are being			

	made from over one year ago. He asked that a baseline be established showing the amount of bounce back letters from doctors that have been received. Cherie explained contract programs (CHS and SVCFS) have not yet been trained and it would be best to wait until this has been accomplished by the end of the fiscal year. She also explained this report would have to be set up by DMS and she would discuss this with Patricia. Cherie also explained they are working on the data reports to reflect client totals as the same amount. She explained one report is a "snap-shot in time" and the other is run quarterly.	• Tentative start date 7/10 for starting a baseline of the amount of letters received back from doctors. • Discuss baseline report with P. Ortega-Ruiz/DMS. Continue to report.	C. Dockery	7/19/10
Fidelity Monitoring Update Report	See "Action Items".	• Change agenda to read Elizabeth Oakes.	K. Cardoza	5/17/10
QMT/MHSA Linkage Discussion	Jean reported it was decided at the last meeting that this was not a quality issue and would not be reported at QMT. She explained Carol Jo would be the link for this and would share quality issues to QMT as required.	• Remove item from agenda.	K. Cardoza	5/17/10
"Hot Issues"	1. Jean reported she and Liz Oakes had a conversation concerning the ASOC/OASOC QIC. It was reported the first meeting is scheduled for 4/7/10. 2. Cherie reported she would be attending the Cal-QIC 20th Annual Conference tomorrow. Jean explained Cherie is chairing the committee this year and has been involved in setting up the conference. Cherie reported they were surprised at the number of attendees that are attending, (about 70) due to the counties budget constraints. 3. Jean reported we hope to receive back the APS report soon.	Continue to report.	All Members	
Other Business:	None reported.			
Evaluation of meeting:	None reported.	Continue to report.	All Members	01/11/10
Agenda Items Next Meeting:	Cultural Competence Report – Status Report Fidelity Monitoring Updates QIC Chair Quarterly Reports Clinical Standards Update Report BHRS Strategic Training Plan		Hargreaves/ Duenas Oakes QIC Chairs Hutsell Cary	01/11/10
Next Meeting:	Next meeting: **May 17, 2009**, 2:00-4:00 p.m. 800 Scenic - Redwood Room			
Submitted by:	Karen Cardoza	Date: 03-23-10		

*Consent Items

Stanislaus County
Behavioral Health and Recovery Services
QUALITY MANAGEMENT TEAM MINUTES

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Type of Meeting:	Quality Management Team	**Date:**	May 17, 2010
Place:	800 Scenic Dr. – Redwood Room	**Starting Time:**	2:00 p.m.
Facilitator:	Jean Anderson	**Ending Time:**	3:45 p.m.
Attendees:	Jean Anderson, Cherie Dockery, Glenn Hutsell, Christi Golden, Linda Torres, Robin Carol Johnson, Stacey Della, Carol Jo Hargreaves, Dorbea Cary, Adrian Carroll, Vickie Looney, Karen Cardoza		

Order of Agenda Items	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Call to Order & Approval of Meeting 03/15/10	Jean asked members to review the minutes for approval.	Members motioned to accept the minutes as written.		
Changes/Additional Agenda Items	None.			
Timer	Christi Golden			
***Injury/Illness Prevention Program Report**	Approved.			
***Quality Council Reports**	Approved.			
Follow-up on Action Items from Previous Meeting	Jean asked members to provide updates from the previous meeting's action items as follows: • Carol Jo reported regarding the question raised from MHSA data reports regarding timeframes in the Exhibit 6 data reports. She reported she sent an email to clarify this for M. Schlaepfer and J. Anderson last month. • Carol Jo reported an AOD member, Jennifer Marsh, was included on the Ad-Hoc QMT Fidelity Monitoring Committee in March. • Jean reported she added included the Fidelity Monitoring Committee into the QM Org. Chart and Matrix. • Jean reported members were to submit any recommendations for test callers to the MC 800 # to C. Dockery. • Cherie was not present to report actions regarding PCP Contact letters baseline report concerning letters received back from doctors and discussion with DMS. • Karen reported she changed the agenda to read Elizabeth	• Follow up with C. Dockery concerning PCP Contact action items and report back next meeting.	K. Cardoza C. Dockery	7/19/10

	Oakes as chair for Ad-Hoc QMT Fidelity Monitoring Committee.	Continue to report.	All Members	
Cultural Competency Oversight Committee Updates	Carol Jo reported highlights from the CCOC meeting held on 4/12/10 as follows: • No May meeting due to Behavioral Health Summit held May 10. • D. Cary announced a trial run of the new CBMCS for BHRS in July and August. Dorbea reported it would be offered again in the Spring/2011. • Development of the new CC Plan is being worked on. Meetings are being held with BHRS key informants, contract agency representatives and consumer advocates. "Homework" assignments were due on 4/30 and most of what was requested has been sent back to the committee and formatted into the Plan. The CCOC plans to share the CC Plan with various groups (MHB, Leadership, etc) starting in June. • CC Plan posted the new prevalence rate that was reduced to 5.77%. Carol Jo explained she researched the reasons why they are applying a more conservative methodology to the data, which makes it appear like less population needs MH services in CA. Members reported the penetration rate was an index decided over 10 years ago a and felt it would be a good time to make a change in the methodology for penetration. Members recommended looking at the measures to see if they are still meaningful. • Orientation Training for BHRS staff will begin in the early fall regarding new Insyst coding for sexual orientation and ethnicity.	• Ask DMS to provide data by demographic and geographic information to help decide a new rate in the next fiscal year. Continue to report.	C. J. Hargreaves C. J. Hargreaves/ P. Duenas	07/19/10 7/19/10
BHRS Strategic Training Plan	Dorbea presented the proposed BHRS Strategic Training Plan and provided an overview of the changes that were made for QMT approval. She provided a handout with the trainings that were removed and/or replaced highlighted. Some of the changes noted were as follows: • CBMCS Multicultural Training (4 modules) has replaced Crossing Cultural Bridges, Clinical Standards and Cultural Dialogue. • Outlook Training has replaced Groupwise • Anasazi Electronic Record Training should be coming in Spring/2011. • Supervisor Training Academy Cert. Program is not new but was added onto the plan. • ICS NIMS/SEMS/ICS was added. Jean reported that the 40			

	hr. course is only for designated managers/leaders that have a role for declared disasters. • Introduction to FSP will become a ReadyGo training. • Psychological First Aid has been added. • IDDT is in process of being revised by Elizabeth Oakes. • LOCUS – Adrian reported this should be for OA/ASOC MH providers. He reported the counterpart for CSOC is CANS should be included. • AOD Documentation, Part I, II, and III added as new training. Members motioned to accept the BHRS Strategic Training Plan with the recommended changes.	• Include a qualifier for training only those managers who have a designated role in a disaster. • Include CANS/CSOC as counterpart for LOCUS training. • Reference CBMCS as four modules to be completed one per year for support staff and AOD staff. • QMT members motioned to approve the training plan with the recommended changes.	D. Cary All Members	7/19/10
Fidelity Monitoring Updates	Carol Jo provided a brief update from the last Ad-Hoc Fidelity Monitoring meeting held in March. She reported members collected extensive lists of evidence-based practices being used at BHRS and also lists obtained on web-sites. DMS has also provided data. Adrian reported CSOC evidence-based practices from the State regarding the ART fidelity model. Jean suggested that the Fidelity Subcommittee discuss how to encourage community/members/agencies providing Aggression Replacement Therapy (ART) to adhere to fidelity of the evidence-based practice and apply the appropriate fidelity scale(s).	• Bring ART fidelity discussion to subcommittee at this month's scheduled meeting. Continue to report.	A. Carroll	5/28/10
QIC Chair Quarterly Reports	Jean asked QIC Chairs to present their quarterly reports as follows: <u>CSOC QIC</u> – Robin reported the AOD integration has happened with the CRAFFT screen now embedded in the BHI. A recent compliance audit was accomplished that showed 90% compliance with the CRAFFT screen. She also reported DMS would provide assessment data for the 2nd part of the year to screen for teen ASI within the 10-day period. She reported D. Cary provided 3-day module AOD training available to CSOC that went very well. Training for CANS, the new functioning measurement that is replacing the CAFAS, are being attended, including contract agencies that have sent staff to the trainings. There are certified in-house trainers and an on-line certification test process to maintain fidelity is available. The implementation date for the CANS is October 1st. Adrian reported DMS is working to capture the information for CANS. Adrian also reported new State DMH TBS updates and expressed the QIC may want to monitor TBS data results.	• Ask CSOC QIC to consider monitoring TBS data results.	R. Johnson	7/19/10

	Admin. Services QIC – Stacey reported the QIC completed four projects out of the seven projects on the 09/10 Work Plan. She explained the following projects: • Request for Contract Form completed and the goal met. • Customer Service Survey – 45 responses showed 92% of the satisfaction goals were met. • Perf. Evaluation Form – It was determined this project is not viable due to constraints with CEO-HR and the Unions. • HIPAA – Due to budget constraints that will be discussed at the 5/18 meeting, it will be decided whether to continue project. • Office Supply Requisition Form was completed and process rolled out to all staff who order office supplies. • Service Deletion Process was determined to no longer be a project for the QIC as the Business Office reports the information to the Compliance Committee. • ID Mail Project was accomplished by posting mail sort codes at the Bldg. 4 mail boxes and a courier list was posted on the BHRS Intranet for assistance in coding ID mail envelopes. • In process of developing the FY 10/11 Action Plan. • Challenge has been the participation of volunteers and consumers. Carol Jo reported Stacey has ended her role as chair that is now being assumed by Kim Allmond. Jean expressed appreciation for her contributions to the QIC. Managed Care QIC – Jean reported she was not in attendance at the last meeting, but was told there were four consumer members in attendance. She reported the committee is working on the Action Plan for 09/10 and will be discussing at the next meeting if they want to extend the plan into the following year rather than taking on new projects. Jean explained this is something other QICs may want to consider in view of our limited resources. Jean reported the focus has been on tying in some areas from our PIPs with the action plan regarding Medi-Cal key indicators and what is meaningful to the QIC. She reported Cherie gave out assignments to members that they are bringing back to the next meeting. Jean reported it appears that meeting every other month has posed some difficulties in remembering what was accomplished in the last meeting. She suggested this may be an area to discuss for the next fiscal year and asked members to bring back their feedback regarding the timeframes of QMT/QIC meetings and if it worked well or not and what members would like to do in the future.	• Debrief regarding QMT/QIC timeframes next meeting.	J. Anderson	7/19/10
"Hot Issues"	None reported.	Continue to report	All Members	7/19/10

Other Business:	None reported.	Continue to report.	All Members	7/19/10
Evaluation of meeting:	None reported.	Continue to report.	All Members	07/19/10
Agenda Items Next Meeting:	Cultural Competence Report – Status Report Medi-Cal Key Indicators Fidelity Monitoring Updates EPSDT PIP Quarterly Report PCP Contact Update Report Clinical Standards Update Report BHRS Strategic Training Plan		Hargreaves/ Duenas Anderson Oakes Dockery Dockery Hutsell Cary	07/19/10
Next Meeting:	Next meeting: **July 19, 2009**, 2:00-4:00 p.m. 800 Scenic - Redwood Room			
Submitted by:	Karen Cardoza	Date: 05-18-10		

*Consent Items

Stanislaus County
Behavioral Health and Recovery Services
QUALITY MANAGEMENT TEAM MINUTES

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Type of Meeting:	Quality Management Team	**Date:**	September 27, 2010
Place:	800 Scenic Dr. – Redwood Room	**Starting Time:**	2:00 p.m.
Facilitator:	Jean Anderson	**Ending Time:**	3:00 p.m.
Attendees:	Jean Anderson, , Linda Downs, Kim Allmond, Cherie Dockery, Debbie Vieira, Dawn Vercelli, Elizabeth Oakes, Glenn Hutsell, Madelyn Schlaepfer, Vickie Looney, Christi Golden, Debra Buckles, Dr. Uday Mukherjee, Adrian Carroll, Karen Cardoza		

Order of Agenda Items	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Call to Order & Approval of Meeting 07/19/10	Jean asked members to review the minutes for approval.	Members motioned to accept the minutes as written.		
Changes/Additional Agenda Items	None.			
Timer	None.			
Follow-up on Action Items from Previous Meeting	Jean asked members to provide updates from the previous meeting's action items as follows: ▪ Cherie will present on baseline data related to the amount of letters received back from doctors at the meeting today. ▪ Jean reported the Managed Care QIC is monitoring the indicators. ▪ Karen removed the Clinical Standards Update Report from the agenda and Process Management Project List. ▪ Jean reported she did not poll the QIC chairs regarding their preference for reporting. Members reported the recommendation was to spread out the reports over the year rather than all at once. Assignments were made for each QIC to report twice per year. ▪ Madelyn reported there has been discussion about the demographic changes with CSOC. CCOC is waiting for a plan from CSOC on how they will document the data that they will take to Sr. Leadership. Currently they can use the deferred code to document. ▪ Madelyn reported the CC Plan has been given an extension until 10/31/10. She reported it will go the CCOC and Sr. Leadership for approval. She will bring	• Nov/10 – A.S. QIC/CSOC Jan/11 – SRC/Genesis, OA/A Forensics Mar/11 – AOD, Managed Care • Bring back the approved CC Plan to QMT for members to review in November.	M. Schlaepfer	11/15/10

	back the finalized plan in November for review at QMT.			
Medication Monitoring Quarterly Review	Dr. Mukherjee reported highlights from the 9/1/10 review as follows: • Improvement in compliance – 77%. • Major non-compliance issues are consents and AIMS. The consent form is being modified to reflect both benzo and other medications. • A workgroup is meeting to consider and review best practices from other counties. A revision of the worksheet will be implemented once the information is received and studied.	▪ Continue to report quarterly.	Dr. Mukherjee	1/10/11
Cultural Competency Oversight Committee Updates	Madelyn reported highlights from the 9/13/10 meeting as follows: • Linda Torres was chosen as the co-chair to the CCOC. • Tim White provided information about Friends Are Good Medicine. Warm-line staff have been trained and it has been posted to the Intranet. • G. Hutsell provided information about the IT project to provide computers for consumer access at programs and other sites. Two DMS technicians are being hired from consumer/family members to help develop and manage this project to be implemented next year. • Training updates regarding the CBMCS curriculum that replaces Crossing Cultural Bridges training. • Ruben Imperial reported updates on PEI activities: Working to expand the Promotores model for Assyrian community, Community Capacity Building activities and new contracts to expand for nine more Promotores. • Jim Hurley reported WET activities – 31 CASRA stipends this fall, MSW stipends and programs at Davis High School. • Pam Esparza gave a presentation on the housing project for TAY and foster youth. • Denise Hunt will be receiving the Dale Butler Equal Rights Award on 10/27 at BOS at 3:30 p.m.	Continue to report.	L. Torres/ P. Duenas	11/15/10
Documentation Competency Quarterly Report.	Cherie reported she had received the data report from DMS but noticed the dates she requested for the post data were not correct. She explained she would redo the report and present the data in November.	Continue to report data at November meeting.	C. Dockery	11/15/10
PCP Contact Update Report	Cherie handed out a data report showing the percentage of letters received by programs returned from the PCP. Cherie reported overall we have received back 47% of the letters we have sent out to PCPs. Members expressed it is an impressive amount considering some of the programs have recently begun the process in the last several months. The data shows PCPs do want to have contact with			

	BHRS programs. Cherie reported the committee is still meeting regularly as AOD programs still need to be trained and continue to monitor the progress of programs.	Continue to report.	C. Dockery	11/15/10
QIC Semi-Annual Chair Reports	AOD-QIC – Dawn reported the focus has been on implementing the AOD Peer Review. The first one was conducted on 9/12/10 and others have been scheduled. The committee is also reviewing MHSIP results and most AOD scores are 80% or higher, with the lowest percentages in the area of access. Managed Care QIC – Jean reported the committee has finalized the action plan for last year and were pleased with the results. No changes are being made for next year and the same indicators will be measured. The meetings timeframe has been changed to meet monthly except for two months.	Reports due next meeting: A.S. QIC and CSOC QIC.	K. Allmond R. Johnson	11/15/10
Fidelity Monitoring Update	Adrian reported the committee met last Friday and continues to work toward cataloging all EBPs we are using. It was determined to sort the categories into six areas: • AOD Prevention • Mental Health Prevention • AOD Treatment • Children Mental Health EBPs • Adult Mental Health EBPs • Medical EBPs Adrian reported the focus of the committee is not just fidelity but more of a mission about promoting the use of EBPs within our department with fidelity and effectiveness. The committee will take a look at building resources, promote the use of various EBPs and continue to develop processes to conduct fidelity reviews. Jean reported we need to determine what all the EBPs are and then to build a structure to accomplish them. Cherie reported what the committee agreed to do is to review the EBPs we currently have and build a structure to categorize them and eventually develop links for staff to access on the Intranet. Adrian reported the committee reviewed one EBP for TPS and determined it did not really fit as we have to pay for the training and outcome data is sent to the organization as they monitor the results as we respond to their feedback; which to them means fidelity has been met. The report is called a dashboard and it is something the committee will be reviewing at the next meeting. Adrian reported the mission statement will be constructed at the next meeting.	Continue to report.	Elizabeth Oakes	11/15/10
QMT/QIC Timeframe	Jean reported this was discussed at the last meeting and reported each QIC can determine what best suits them in regard to meeting scheduling; but must meet according to what they've stated, either	• Remove item from agenda.	K. Cardoza	11/15/10

	monthly or a minimum of six meetings per year.			
"Hot Issues"	1. CANS – Adrian reported the new CSOC assessment tool Child/Adolescent Needs and Strengths (CANS) has been rolled out and both BHRS and contract staff have been trained to begin on Oct. 1. The tool replaces the CAFAS and will be able to use for the SAMSHA report. DMS is working on the collection/measurement aspects and is not yet in place but will be similar to ASI and able to provide clinical and outcomes data. Comparison reports will also be provided for both clinicians and managers. CSOC QIC is helping to compile and develop the reports. Cherie reported the CANS would also be brought into the AOD Co-Occurring Training that is currently being developed. The plan is to have a brief overview and refresher course taught by a master trainer and how it fits into co-occurring treatment. She reported that they would also be incorporating it into the MH Documentation Training as well. 2. PEI/DMS – Adrian reported they are in process of recruiting for a Research/Outcomes Specialist. Interviews have been conducted and five have been selected for a second interview selection process. He expressed the candidates are very computer literate and have knowledge and experience in research and good at teaching and communicating. 3. Anasazi Training – Jean reported next week we will be starting the development of the IT system for the electronic health record with Anasazi representatives. We will be working with them to lay out the basic framework for our requirements. Many staff will be attending the whole week and other staff may be pulled in for various aspects of what we need. 4. Delete System – Linda reported meetings have been conducted concerning the delete process for void and replace. Cherie reported another meeting is being held in mid-October and no data has been changed yet. Linda reported the B.O. are not processing deletes and they are being held. Re-entries are being put on a spreadsheet for fiscal year '09/'10 and captured manually before 6/30/10. Jean reported we are in process of re-vamping the MH Peer Review and any deletes will not happen until January/2011. It was reported the AOD Peer Review has been launched this month and went well.	Continue to report	All Members	11/15/10

Other Business:	None reported.	Continue to report.	All Members	11/15/10
Agenda Items Next Meeting:	Cultural Competence Report Documentation Competency Update Report PCP Contact Update Report EPSDT PIP Quarterly Report Fidelity Monitoring Update Report MHSA Statistical Quarterly Report QIC Chair Semi-Annual Reports – Admin. Services, CSOC		Duenas/Torres Dockery Dockery Dockery Oakes Anderson Allmond/Johnson	11/15/10
Next Meeting:	Next meeting: **November 15, 2010**, 2:00-4:00 p.m. 800 Scenic - Redwood Room			
Submitted by:	Karen Cardoza	Date: 09/29/10		

*Consent Items

Stanislaus County
Behavioral Health and Recovery Services
QUALITY MANAGEMENT TEAM MINUTES

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Type of Meeting:	Quality Management Team	**Date:**	November 15, 2010
Place:	800 Scenic Dr. – Redwood Room	**Starting Time:**	2:00 p.m.
Facilitator:	Jean Anderson	**Ending Time:**	3:15 p.m.
Attendees:	Jean Anderson, , Kim Allmond, Elizabeth Oakes, Debra Buckles, Dr. Uday Mukherjee, Peter Duenas, Linda Torres, Robin Carol Johnson, Karen Cardoza		

Order of Agenda Items	Discussion	Scheduled Actions	Person(s) Responsible	Target Date
Call to Order & Approval of Meeting 09/27/10	Jean asked members to review the minutes for approval.	Members motioned to accept the minutes as written.		
Changes/Additional Agenda Items	Remove MHSA Statistics Report.	Report item next meeting.	J. Anderson	01/10/10
Timer	None.			
Follow-up on Action Items from Previous Meeting	Jean asked members to provide updates from the previous meeting's action items as follows: ▪ Jean reported the CC Plan has been postponed for review until December. ▪ Cherie was not present to report Documentation Competency follow-up report as requested last meeting. ▪ K. Allmond and R. Johnson will present QIC Chair reports this meeting per new QIC Chair reporting schedule.	• Advise C. Dockery to present the report in January.	K. Cardoza	1/10/11
***Consent Items**	Approved.			
Cultural Competency Oversight Committee Updates	Linda and Pete reported highlights from the November 8, 2010 meeting as follows: • Presentation by K. Hurley regarding Innovation Project. RFP process was discussed and some questions were clarified. • M. Schlaepfer provided updates on the AOD stakeholder process. CCOC asked to review the stakeholder group and provide recommendations on the makeup of that group regarding diversity. Pete explained a lot of people are involved and they gave some recommendations of who to involve. He reported they are more concerned about constituents from various communities with			

	diverse populations and how are they being connected with services. It is the hope each member is going back to their community to ensure all are represented including LGBT and Hispanic AA/NA groups. Pete reported the recommendations sent to Sr. Leaders would include a prioritized list based on diversity. • Linda reported another item discussed was a recommendation to merge the MHSA newsletter with the CCOC newsletter. She reported members discussed and felt the newsletters should not be merged and that the CCOC newsletter should continue on a monthly basis. • CCOC Plan was given an extension due date of December 31, 2010. Linda reported Madelyn has been working on it and the goal is to have the MHB and QMT review it.	Continue to report.	L. Torres/ P. Duenas	11/15/11
Medi-Cal Key Indicators Quarterly Report	Jean reported highlights from the 1st Qtr. Medi-Cal Key Indicator report as follows: • A-1 – ASOC doing well at 99%. Jean reported she and Liz would be looking at "no-show" data. V. Looney is analyzing data issues regarding CSOC and OA results. She will be also meeting with K. Huntley regarding OA screening and assessment issues. • A-2 – Jean reported she is not certain why surveys are being received, but the results are good. • A-3 – 100% for preferred language calls. Jean reported this is important over the next few months due to the upcoming MC Audit. Cherie and Vickie have been conducting staff training for this. • B-1 – 67% due to one delayed appeal not processed timely due to on-going investigation. • B-2 – 90%. Jean reported V. Looney is also doing site visits to prepare for the MC Audit and ensuring notices are posted. • B-4 – 100%. Jean reported the "n" is small due to hold on MH peer review process, but has given us the opportunity to implement the AOD peer review in the interim. • B-3 – 42%. Jean explained it is low due to DBHC audits that differ from ours. It has been brought to their attention. • B-5 – 77%. Jean reported DBHC is working on their processes to improve, but no consistent trends have been noted. • B-6 – Jean reported V. Looney is working with the two sites that did not have the notices posted. • C-1 – 40%. Jean reported everyone with the exception of AOD programs are now using the PCP Contact database.			

	The goal may be increased or to change the indicator to show the connection between the PCP and provider. She reported the Managed Care QIC would be looking at this. • C 3-4 – Jean reported the percentages vary and these indicators need a better way to capture the data. She reported there is discussion with Anasazi about this and wanting to capture the data through the pre-registered track. They are in process of figuring how to accomplish this information gathering process. • D-1 and 2 – Jean reported the surveys are being completed but do not know where they are coming from. Robin reported they are completed for IEBP purposes. • D-3 – Jean reported six change of provider requests. • D-4 – 100%. All those who completed the MHSIP had favorable responses to recommend our services. • D-5 – Jean reported the complaint involving DBHC was not satisfied. • D-6- 3 complaints from consumers, only one was satisfied. • D-7 – Only one of the test callers for 24-hr. access line was satisfied. Jean reported Cherie and Vickie are working with MAT/CERT teams to educate and train staff. • E-1 – 100%. All 57 appeals were completed.	Continue to report.	J. Anderson	01/10/11
Fidelity Monitoring Update Report	Liz reported the committee decided last month to prioritize and identify the goals and focus of the committee at the December meeting.	Continue to report.	L. Oakes	01/10/11
QIC Semi-Annual Chair Reports	Admin. Services QIC – Kim reported the committee has been working on the action plan. A sub-committee is revising the annual Customer Satisfaction Survey to 1) receive a better response rate and 2) to develop more department/program specific questions. Kim also reported she would like to bring a suggestion to the committee regarding going back to meeting monthly instead of bi-monthly to expedite improvement processes more timely. CSOC QIC – Robin passed out a data report regarding the primary focus on the action plan this year, the AOD/MH integration. She reported the CRAFFT and AOD screen was imbedded into the BHI last year and shared recent audit results as follows: - 638 assessments were completed with youths 12 years and older. • 22% - of charts were audited • 97% - of charts audited had CRAFFT screen completed • 25% - of the screened clients needed further assessment • 0% - of assessments were done on old BHI • <1% - of assessment were completed with assessment update of SB785 form			

	• 42% - of Teen ASI completed within 60 days Robin explained they would like to have uniformity of interventions between programs in order to have good customer service. Robin shared the notes of discussion regarding the Teen ASI and further assessment for parents use considered as a "risk" factor. There is a need for guidelines for auditing and implementation of T-ASI and also training for documentation of co-occurring disorders for youth. Robin shared that Amanda and Dorbea are working on the training for this area that should be ready by March/2011. She also reported DMS is working on a cumulative report for 2010. Members discussed the issues presented and provided their feedback. <u>AOD QICs</u> – Debra reported she met with the AOD Coordinators group to discuss putting together a joint QIC for both inpatient SRC/ Genesis and AOD outpatient programs. She reported the plan is to meet jointly in December to develop a new QIC that would meet the needs of both and to brainstorm what it would look like. Jean inquired if the end result would also hinge on what comes from the AOD stakeholders process. Debra reported this was discussed and the QIC would be responsible to monitor/review what comes out of the stakeholders group. Jean reported this would be an opportunity to develop some indicators that would come out of this group.	Reports due next meeting: SRC/Genesis and A/OA/Forensics.	D. Vieira S. Gold	01/10/11
"Hot Issues"	None reported.	Continue to report.	All Members	01/10/11
Other Business:	None reported.	Continue to report.	All Members	
Agenda Items Next Meeting:	Cultural Competence Report Medication Monitoring Quarterly Review Documentation Competency Update Report Complaint Tracking Quarterly Report PCP Contact Update Report EPSDT PIP Quarterly Report Fidelity Monitoring Update Report MHSA Statistical Quarterly Report QIC Chair Semi-Annual Reports – SRC/Genesis, A/OA/Forensics		Duenas/Torres Mukherjee Dockery Dockery Dockery Dockery Oakes Anderson Vieira/Gold	01/10/11
Next Meeting:	Next meeting: **January 10, 2011, 3:30-5:00 p.m.** 800 Scenic - Redwood Room			
Submitted by:	Karen Cardoza	Date: 11/16/10		

*Consent Items

Behavioral Health and Recovery Services
Recruitment Flyers

NOTES

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MENTAL HEALTH CLINICIAN I/II

COUNTY PROMOTION

BEHAVIORAL HEALTH &
RECOVERY SERVICES

HOURLY SALARY
$26.43 - $35.57

FINAL FILING DATE
June 18, 2010
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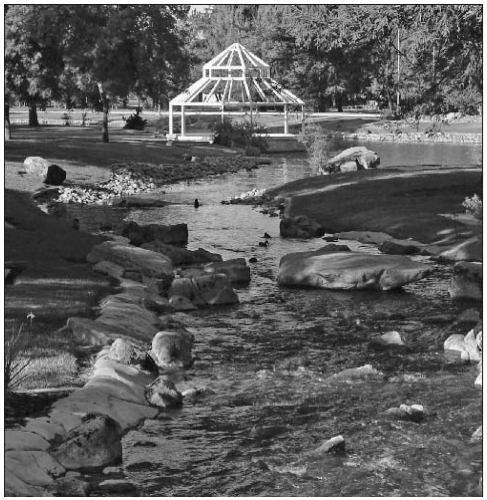


OUR COMMUNITY

Located in the heart of California's Central Valley, Stanislaus County is blessed with mild weather year-round and a strong agricultural economy.

With a population exceeding 500,000, Stanislaus County is proud of its vibrant citizenry, great traditions, educational opportunities, and multicultural lifestyles.

Modesto, the largest city and seat of Stanislaus County, offers the diversity and facilities of a metropolitan city while maintaining an atmosphere of old-fashioned hospitality.

West of the Valley and over the coastal mountains lies the San Francisco Bay Area, a 90-minute drive from Modesto. Eastward are the foothills of the famed Mother Lode gold country that leads to the majestic Sierra Nevada mountain range, Yosemite National Park, and Lake Tahoe.

Stanislaus County is home to California State University, Stanislaus and Modesto Junior College. Stanislaus County is a general law County established in 1854, governed by a five-member Board of Supervisors with assistance from the County Chief Executive Officer, elected officials and appointed department heads.

Stanislaus County has a current year total budget of $958 million and 3,990 full-time positions within 26 agencies and departments.

ABOUT THE DEPARTMENT

The Stanislaus County Behavioral Health & Recovery Services Department, under the administrative direction of the Chief Executive Officer and subject to the policy of the Board of Supervisors, is responsible for providing or arranging for the provision of an array of specialized behavioral health services for residents in and around Stanislaus County. The Department consists of over 300 allocated positions with an operational budget of $70 million.

JOB TASK ANALYSIS

The Job Task Analysis provides information detailing the physical and functional demands of the classification. For the complete job task analysis, visit the Risk Management website at www.co.stanislaus.ca.us/riskmgt under "Disability Management."

APPLICATION PROCEDURES/FINAL FILING DATE

Applications are to be submitted through the County online application system **no later than 5:00 p.m. on June 18, 2010**.

Make your application as complete as possible so a full and realistic appraisal may be made of your qualifications. Applicants are invited to submit a brief resume outlining paid or not-paid experience relevant to the position. **Resumes will not be accepted in lieu of a completed online application.**

EQUAL EMPLOYMENT OPPORTUNITY

The County of Stanislaus is an Equal Opportunity Employer. All qualified applicants are encouraged to apply for open positions.

TESTING ACCOMODATIONS

Arrangements may be made to accommodate disabilities or religious convictions. Describe the special test arrangements you require in the "Additional Information" section of the application form.

APPLICATION AND/OR EXAMINATION APPEALS RIGHTS

Application and/or examination results may be appealed by applicants presenting facts alleging irregularity, fraud and/or error in application screening or in exam scoring. Appeals must be in writing and submitted to the Chief Executive Office within seven (7) days after the results are mailed.

GENERAL QUALIFICATIONS

- Pass County-paid pre-employment drug screening and job-related background investigation.
- Perform job duties in a manner assuring a safe working environment for oneself and others.
- Establish and maintain effective working relationships with the general public, co-workers, supervisors, and members of diverse cultural and linguistic backgrounds regardless of race, color, national origin, ancestry, political affiliation, sex, sexual orientation, religion, marital status, age (over 40), pregnancy related condition, medical condition (cancer related), physical (including AIDS) or mental disability.
- Maintain confidential information according to the legal standards and/or County regulations as required.

NOTE: A Doctoral Degree in Clinical Psychology may be substituted for the above educational requirement.

Experience:

- Two years of experience in a Mental Health setting under clinical supervision as required to qualify for the State recognized license

MINIMUM QUALIFICATIONS (Continued)

Licensure:

- Incumbents must be licensed as either a Licensed Clinical Social Worker or Marriage and Family Therapist in the State of California

NOTE: A license as a Psychologist in the State of California may be substituted for the above licensure requirement.

Driver's License:

- Valid California Class C Driver's License or the ability to utilize adequate alternative method of transportation, when needed, to carry out essential job related functions in a timely manner

DESIRABLE QUALIFICATIONS

- Experience or willingness to learn and work with familial and developmental issues across a normal life span
- Experience in understanding the influence of cultural issues and providing services with appropriate cultural context
- Experience providing recovery resiliency/wellness informed treatment
- Lived experience as a consumer or a family member of a consumer of behavioral health services
- Familiarity with 12 Step and social model principles of AOD treatment
- Knowledge of Mental Health Services Act (MHSA) components and essential elements and how they inform the transformation of the public mental health system
- Experience in an Employee Assistance setting
- Experience in training and consultation
- Principles and practices of supervision, management and human resource development
- Multicultural skills, knowledge and experience
- Computer literacy
- Bilingual skills preferred

GENERAL INFORMATION

Stanislaus County is establishing an eligibility list for Extra-Help/On-Call Mental Health Clinician I/II for the Department of Behavioral Health & Recovery Services (BHRS). Mental Health Clinicians can be assigned, based on departmental needs, to our alcohol & drug treatment center, or one of our various outpatient/administrative program sites serving children, adults and older adults.

ABOUT THE POSITION

Clinician I is the non-licensed clinical classification. Under direction, and within the scope of their license (Clinician II), the Clinician works independently, providing diagnosis, prognosis, counseling, and psychotherapeutic treatment in a community mental health setting. The incumbents may provide supervision to professional and technical personnel; may provide education and consultation services to other staff, community agencies and the public; may administer and coordinate a program unit; and perform other related work as required.

Unless otherwise provided, this position is part of the Classified Service of the County and is assigned to the Community and Health Services Bargaining Unit for labor relations purposes. Mental Health Clinicians may be expected to meet with clients in the field, and are subject to overtime, standby, callback, and after-hour assignments.

Mental Health Services Act (MHSA) - Stanislaus County BHRS is in process of fully implementing all components of Mental Health Services Act (MHSA) with the intent to transform the public mental health system by expanding our capacity to be an effective integrated service system that delivers recovery/resiliency/wellness-oriented, culturally competent, consumer and family member driven services through collaboration with community.

Adult System of Care (ASOC) - Positions could be available (dependent on system need) working in the Adult System of Care with individuals who have a severe and persistent mental illness or have co-occurring disorders, Community Emergency Response Team, Children's System of Care working with children and families, StanWORKs working with individuals participating in Welfare to Work, Workplace Wellness (EAP) and Prevention & Early Intervention. Hours would vary depending on site.

Children's System of Care (CSOC) - Provides mental health services to children and families in multiple settings such as outpatient clinics, child welfare, public schools, residential treatment, and juvenile justice. The ages of children range from birth through eighteen and young adults. The focus is on improving social emotional health, increasing resilience in

ABOUT THE POSITION (Continued)
families and networking to the community.

TYPICAL TASKS

- In the appropriate therapeutic setting, meets with individuals and groups, including children and their families from diverse cultural backgrounds, to assist them in assessing social emotional health and challenges, strengths, and identifying barriers, and developing realistic plans to address them
- Advises clients on available community resources and acts in a liaison and advocate capacity between the client and persons or agencies in the client's psycho-social system, and makes referrals and other arrangements as assigned
- Works collaboratively with consumers and families in a recovery based model
- Participates in training programs including the teaching of diagnosis and treatment methods conducted for the benefit of the community, and may act as a consultant for other community agencies
- Prepares and presents cases for review of other staff
- Prepares and maintains complex treatment and progress reports on assigned cases, and may participate in matters relating to diagnosis and treatment recommendations, discharge and follow-up planning for clients and their families
- Works collaboratively with a wide range of disciplines in mutual treatment planning
- Ability to use effective and assertive communication, problem-solving and conflict resolution skills
- Engage in efforts to reduce stigma in individuals and community
- May be assigned the administrative, coordinative or supervisory responsibility for staff in a program or unit including scheduling, training, case allocation, clinical direction and performance evaluation
- Some evening and weekend work may be required.

MINIMUM QUALIFICATIONS

- Mental Health Services Act (MHSA) essential elements
- Principles, techniques and trends in counseling, psychotherapy, clinical case management, and various treatment modalities
- Biological, behavioral and environmental aspects of emotional disturbances, mental disability, retardation and substance abuse
- Culturally proficient practices with diverse service recipients
- The scope and activities of public and private health and welfare agencies and other available community collaborating and resources
- Principles and techniques of mental health education, prevention, recovery, and crisis intervention within the community
- Ability to provide assessment, treatment planning and treatment implementation to children, adults and families
- Ability to use conflict resolution skills in all aspects of your role
- Ability to provide education to reduce stigma

MENTAL HEALTH CLINICIAN I

Education:

- Graduation from an accredited two year graduate school of social work with the receipt of an ASW Degree which can lead to licensure as a Clinical Social Worker

OR

- Graduation from an accredited graduate program with receipt of a Master's Degree which can lead to acquisition of a LCSW or MFT License and meet qualifications to participate in a Short-Doyle program

Experience:

- No experience required but relevant clinical experience as a para-professional or an intern with multicultural skills, knowledge and experience is desirable

Licensure:

- Incumbents must be eligible to be licensed as either a Licensed Clinical Social Worker or a Marriage and Family Therapist in the State of California

MENTAL HEALTH CLINICIAN II

Education:

- Graduation from an accredited two year graduate school of social work with receipt of an MSW Degree and acquisition of the State recognized license
- Graduation from an accredited graduate program with receipt of a Master's Degree and acquisition of an LCSW or MFT License which meets qualifications to participate in a Short-Doyle program

BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

Denise C. Hunt, RN, MFT
Director

HUMAN RESOURCES
800 Scenic Drive, Modesto, CA 95350
Phone: 209-525-7339 Fax: 209-525-7338

DATE: May 03, 2010

TO: All Full Time Mental Health Clinicians I/II Staff

FROM: Mike Wilson
Program Coordinator
Integrated Forensic Team & Mental Health Treatment Court

SUBJECT: **Transfer Opportunity**

Due to the Departmental Budget considerations, if an employee is not selected through the internal departmental process, the position may be filled by reassignment of current staff within BHRS.

A transfer opportunity currently exists for a full-time Mental Health Clinician (MHC) in the Forensic System of Care. This position will be part of the Integrated Forensic Team (IFT). The MHC will work closely with the rest of the Integrated Forensic Team and provide an Intensive Community Supports and Services (ICCS) Level of Care. This is a lower level of care than the current IFT Full Service Partnership and will have an approximate caseload of 40.
This position will not be required to do on-call, though the position will have the option to participate in the on-call rotation.

WHY:
This transfer memo is being issued due to a vacated position at the Integrated Forensic Team.

WHAT:

Abilities:

- Ability to engage individuals and to work with them in achieving goals;
- Strategically build and maintain relationships with co-workers, probation and other community partners across the county, and participate in a wide range of community collaborative and capacity building efforts, and provide education to reduce stigma;
- Ability to see strengths in individuals and families;
- Knowledge of services related to BHRS;
- Ability to conduct groups;
- Knowledge of basic casework procedures, documentation, and outcomes;
- A strong commitment to and demonstrated skills in provision of culturally competent services to diverse populations, consistently utilizing multicultural skills, knowledge and experience;
- Ability to work independently, while maintaining team involvement is necessary; and,
- Excellent paperwork and communication skills.

Typical Tasks & Desirable Qualifications:

- Provide a range of clinical, case management and rehabilitative services, i.e., behavioral health assessments, assessment of needs, therapy, crisis management, linking with additional services, advocacy, etc.;
- Provide new and innovative approaches outside traditional mental health case management approaches;
- Attend regular team meetings;
- Provide culturally sensitive services;
- Complete a variety of paperwork and reports in a timely manner;
- Provide home visits and services at various locations, including the Public Safety Center and Jail;
- Bi-cultural/Bilingual, lived experience as a consumer of behavioral health services or as a family member of a consumer of behavioral health services;
- Able to participate as a positive contributing member within a collaborative team, utilizing conflict resolution techniques;
- Experience in working collaboratively with criminal justice agencies;
- Knowledge of and commitment to include, Mental Health Services Act essential elements; and,
- Knowledge of the court system and procedures.

HOW:
If you have questions about this position, please contact **Mike Wilson** at **558-4420**.

If you are interested in being considered for this position, please forward a written summary to the attention of **Erin Gregston, Human Resources, 800 Scenic**. This should include a summary of your skills and experience relative to this position, along with a brief summary of how this position would meet your career goals.

All requests must be made by 5:00 p.m. on May 10, 2010 and can be sent by fax at **525-7338**, interdepartmental mail or via Outlook.

WHAT IF:
Upon receipt of transfer memo responses, the Senior Leadership staff involved will review and evaluate. Candidates who submit a response will be notified of any additional steps and/or decisions.

cc: All Staff via Outlook
800 Scenic: Binder in Building B

BEHAVIORAL HEALTH SPECIALIST I/II

DEPARTMENT PROMOTIONAL

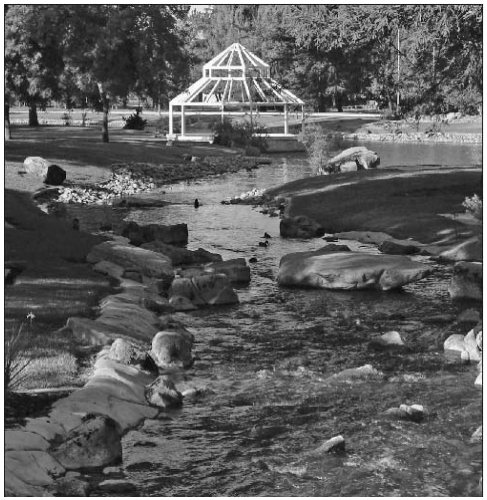
BEHAVIORAL HEALTH &
RECOVERY SERVICES

HOURLY SALARY
$19.54 - $27.14

FINAL FILING DATE
August 17, 2010

APPLY ONLINE AT: www.stanjobs.org

County Personnel: 209-525-6341
County Job Line: 209-525-4339



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Stanislaus County has a current year total budget of $946 million and 4,462 full-time positions within 26 agencies and departments.

ABOUT THE DEPARTMENT

The Stanislaus County Behavioral Health & Recovery Services Department, under the administrative direction of the Chief Executive Officer and subject to the policy of the Board of Supervisors, is responsible for providing or arranging for the provision of an array of specialized behavioral health services for residents in and around Stanislaus County. The Department consists of over 400 allocated positions with an operational budget of $73 million.

DISTINGUISHING CHARACTERISTICS CONT'D

experienced the wide variety of duties assigned, and would qualify for promotion consideration to the classification of Behavioral Health Specialist II.

TYPICAL TASKS

- Provide appropriate interventions to culturally diverse individuals or families
- Interview clients to determine their service needs, including evaluating risk factors
- Establish an individual client care plan based on clients stated goals, identified problems, relevant life circumstances, pertinent history and other issues expressed by the client and/or family
- Support clients to attain "quality of life" goals such as education, employment, job training, meaningful activity, etc.
- Participate in diagnostic and evaluative staff conferences for effective and client directed services and supports
- Provide direct services including individual counseling and group facilitation
- Facilitate referrals to appropriate professional and support services, community-based programs, or other specialized services
- According to department standards and policies, prepare daily records, summarize progress of recovery or service goals, and keep records current
- Consult and partner with other agencies and community service providers to exchange applicable information, identify services, and discuss referrals;
- Provide education and facilitate community collaboration that reduces stigma and addresses questions/concerns of the community (i.e., parent/family education, information regarding prevention and recovery services)
- May act as a lead-worker, or direct the work of others, and offer training when needed
- Respond to requests or calls from clients, family members, agencies, etc. at various locations in the community as needed
- Advocate for and assist individual clients (and if applicable, their families), in accessing and/or receiving services, i.e., medical care, housing, food and clothing
- Assist clients and encourage family involvement in their services;
- May accompany clients in court, as required
- Work closely with individuals to support the accomplishment of their recovery or service goals

TESTING ACCOMODATIONS

Arrangements may be made to accommodate disabilities or religious convictions. Describe the special test arrangements you require in section 13 of the application form.

APPLICATION AND/OR EXAMINATION APPEALS RIGHTS

Application and/or examination results may be appealed by applicants presenting facts alleging irregularity, fraud and/or error in application screening or in exam scoring.
Appeals must be in writing and submitted to the Chief Executive Office within seven days after the results are mailed.

GENERAL QUALIFICATIONS

- Pass County-paid pre-employment drug screening and job-related background investigation.
- Perform job duties in a manner assuring a safe working environment for oneself and others.
- Establish and maintain effective working relationships with the general public, co-workers, supervisors, and members of diverse cultural and linguistic backgrounds regardless of race, color, national origin, ancestry, political affiliation, sex, sexual orientation, religion, marital status, age (over 40), pregnancy related condition, medical condition (cancer related), physical (including AIDS) or mental disability.
- Maintain confidential information according to the legal standards and/or County regulations as required.

NOTES

Stanislaus County reserves the right to revise the examination plan described in this flyer to better meet the needs of County service. The provisions of this bulletin do not constitute an express or implied contract. Any provision contained in this bulletin may be modified or revoked without notice. The information contained in the bulletin is information, which sets forth a general summary of benefits for this respective position. This information is not legally binding. The benefits and other information regarding this position may be found in the Stanislaus County Code, the Stanislaus County Personnel Policies Manual, or in the applicable Memorandum of Understandings, and such information prevails over information contained in this flyer. Questions regarding this announcement may be directed to the Stanislaus County Chief Executive Office/Personnel.

ABOUT THE POSITION

Incumbents in the Behavioral Health Specialist (BHS) classification may be appointed to specialize in the Alcohol and Drug (AOD) area and/or the Mental Health (MH) area. While the primary focus of incumbents will be similar, both specialty areas will require unique typical tasks and specific abilities as indicated.

Under supervision, the Behavioral Health Specialist provides a variety of services to clients, recommends appropriate referrals, maintains community liaisons to ensure adequate services are made available to clients, and provides facilitation for a variety of client-focused specialty groups. As part of the treatment team, the incumbent will establish and implement client care plans that are client or family member driven, culturally competent, and promote wellness, recovery and resilience.

Behavioral Health Specialists may be assigned to residential facilities, regional teams, and various outpatient programs. Incumbents may perform field visits to those under care, may supervise subordinates and perform related duties as assigned. Incumbents are subject to overtime, weekend, shift-work, holiday, standby and call back assignments.

Due to Counselor Certification Standards required by the Department of Alcohol & Drug Programs (ADP), BHS's assigned to AOD programs will have a timeline, no later than 6 months from the date of hire, to register and initiate the certification process with one of the certifying organizations which meets the State ADP regulations. Please contact BHRS/HR for details at 209-525-7339.

DISTINGUISHING CHARACTERISTICS

The Behavioral Health Specialist I can be distinguished from the Clinical Services Technician by the advanced nature and full scope of responsibility. The Behavioral Health Specialist I is the entry-level position in the series. Incumbents will perform assigned duties under general supervision.

The Behavioral Health Specialist II classification is considered the experienced, journey-level in the series. Incumbents perform under general supervision and with much greater independence than BHS I's. After one year of satisfactory performance in the Behavioral Health Specialist I classification, it is expected that incumbents would have

DESIRABLE QUALIFICATIONS CONT'D

- Alcohol and Drug certification with one of the certifying organizations that meets the State ADP regulations
- Bilingual skills preferred

Due to Counselor Certification Standards required by the Department of Alcohol & Drug Programs (ADP), BHS's assigned to AOD programs will have a timeline, no later than 6 months from the date of hire, to register and initiate the certification process with one of the certifying organizations which meets the State ADP regulations. Please contact BHRS/HR for details at 209-525-7339.

CLASSIFICATION INFORMATION

Unless otherwise provided, this position is part of the Classified Service of the County and is assigned to the Community Health Services bargaining unit for labor relations purposes.

Individuals who are in a full-time classified position are required to serve a twelve-month probationary period, which may be extended an additional six months for a total of eighteen months. The probationary period does not apply to unclassified positions.

JOB TASK ANALYSIS

The Job Task Analysis provides information detailing the physical and functional demands of the classification. For the complete job task analysis, visit the Risk Management website at www.co.stanislaus.ca.us/riskmgt under "Disability Management."

EQUAL EMPLOYMENT OPPORTUNITY

The County of Stanislaus is an Equal Opportunity Employer. All qualified applicants are encouraged to apply for positions.

APPLICATION PROCEDURES/FINAL FILING DATE

Applications are to be submitted through the County online application system **no later than 5:00 p.m. on August 17, 2010**.

Make your application as complete as possible so a full and realistic appraisal may be made of your qualifications. Applicants are invited to submit a brief resume outlining paid or not-paid experience relevant to the position. **Resumes will not be accepted in lieu of a completed online application.**

TYPICAL TASKS CONT'D

- Assist in establishing eligibility for Medi-Cal or other benefits and advocate for continuation of benefits, when appropriate
- Provide transportation in County vehicles, as needed
- Facilitate admission or discharge to an acute facility or alcohol and drug residential program, when necessary
- Work productively as part of a multidisciplinary team in order to provide recovery oriented services to clients, and their families;
- Provide after hours, on-call coverage when requested
- Ability to work well in a culturally diverse team
- May, in conjunction with the Estate Management Office, assist with coordinating estate and personal management tasks (i.e., may assist with developing financial management plans for individuals who receive Representative Payee Services)

For AOD Specialty:

- Using recovery principles, provide a variety of highly skilled alcohol/drug services to varied individuals
- Interview to screen/access alcohol/drug use to determine service needs

For MH Specialty:

- Using wellness, recovery and resilience principles, provide highly skilled mental health services to individuals and/or families
- May provide Deputy Public Conservator services

MINIMUM QUALIFICATIONS

Ability to:

- Effectively interview and engage clients, develop and maintain the confidence and cooperation of individuals and their families
- Provide culturally relevant services to a diverse customer base
- Perform skilled services using a variety of wellness or recovery approaches
- Plan, organize and conduct structured groups, classes, etc.
- Assess individual's needs and develop effective care plans, constantly modeling compassion and respect
- Ability to provide an integrated service experience with individual clients and their families
- Ability to create and maintain partnerships with key stakeholders who provide services and supports in the community
- Respond appropriately to crisis situations, making accurate

MINIMUM QUALIFICATIONS CONT'D

interventions and taking effective action independently
- Relate directly with community organizations including law enforcement agencies, schools, parent groups, etc.
- Maintain confidentiality, HIPAA requirements and adhere to BHRS Code of Ethics
- Supervise others and/or delegate responsibilities, when assigned
- Write concise reports/evaluations, social histories, etc.; maintain record keeping and tracking systems of assigned clients
- Support individuals and their families with respect and compassion, utilizing a strength-based approach
- Using conflict resolution skills, function effectively as a member of a multidisciplinary team demonstrating flexibility and the ability to take direction
- Obtain and maintain a California Driver's License and remain free from preventable accidents
- Ability to communicate well verbally and in written form
- Hear and understand normal conversational tones
- Sit, lift, bend, stoop, & reach overhead as well as, push, pull, squat, twist & turn

For AOD Specialty:
- Prepare concise written alcohol/drug assessments and social histories
- Provide a variety of highly skilled alcohol/drug services, to individuals at multiple site locations (i.e., education, engagement, pretreatment, treatment planning services and crisis intervention, etc.)
- Provide services that facilitate clients in their transition to alcohol and drug-free living and facilitate the recovery process
- Assist Coordinator/Manager in oversight of program operations

For MH Specialty:
- Provide mental health services and crisis intervention to individuals with serious and persistent mental illness or youth who have a seriously emotional illness and their families
- Provide a variety of highly skilled mental health services to culturally diverse individuals or families at multiple site locations

Education/Experience:

Pattern #1

Fifteen (15) units of college credit* in a related field and four (4) years experience in:
- Crisis intervention, group/family/individual counseling or in a psychiatric inpatient setting, **or**
- Drug/alcohol treatment and recovery program.

Pattern #2

LVN or Psychiatric Technician license or 30 units of college credit* in a related field and three (3) years experience in:
- Crisis intervention, group/family/individual counseling, or a psychiatric inpatient setting, **or**
- Drug/alcohol treatment and recovery program.

Pattern #3

B.A. in a related field and two (2) years responsible experience in:
- Crisis intervention, group/family/individual counseling, or a psychiatric inpatient setting, **or**
- Drug/alcohol treatment and recovery program.

Pattern #4
- Master's degree in a related field (i.e., counseling, psychology, social work).

One year of experience as a BHS I, or the equivalent, is needed in order to qualify for the BHS II level.

DESIRABLE QUALIFICATIONS

Applicant screening, in addition to the minimum qualifications, will focus on the following desirable categories:
- Lived experience as a consumer or a family member of a consumer of behavioral health services
- Multicultural skills, knowledge and experience
- Demonstrated customer service orientation and skills
- Knowledge of Mental Health Services Act (MHSA) components and essential elements and how they inform the transformation of the public mental health system
- Recent, experience in providing Behavioral Health services, including AOD residential treatment experience

BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

Denise C. Hunt, RN, MFT
Director

HUMAN RESOURCES
800 Scenic Drive, Modesto, CA 95350
Phone: 209-525-7339 Fax: 209-525-7338

DATE: November 9, 2010

TO: All Full Time Behavioral Health Specialist I/II Staff

FROM: Debbie Vieira, LCSW
Site Administrator, Stanislaus Recovery Center

SUBJECT: **Transfer Opportunity**

Due to the Departmental Budget considerations, if an employee is not selected through the internal departmental process, the position may be filled by reassignment of current staff within BHRS.

A challenging transfer opportunity currently exists for a Behavioral Health Specialist (BHS) with mental health and alcohol and drug specialty in the Adult Treatment Program at Stanislaus Recovery Center (SRC). The position will be currently assigned to the SRC/Co-Occurring Treatment program, a program designed to serve adults and older adults who have co-occurring mental health and substance abuse disorders who are being served by MHSA funded programs. The Adult Treatment Program at SRC has a treatment structure that promotes recovery at every phase of the recovery process. This position may include intake, assessments, groups, and individual sessions with clients. The incumbent's schedule will involve shift work and may include P.M. shift, weekend assignments and applicable 5% residential and shift differentials.

Due to recent Counselor Certification Standards required by the Department of Alcohol & Drug Programs, the BHS assigned to this AOD position will be required to be registered to initiate the certification process with one of the certifying organizations specified in the regulations, or already certified.

WHY:

This transfer memo is being issued due to a vacancy within the SRC/Co-Occurring Treatment program, which is funded under the Mental Health Services Act (MHSA) that is assigned to Stanislaus Recovery Center.

WHAT:

Typical Tasks and Desirable Qualifications include:

- Ability to engage clientele to assess for the need for treatment services;
- Ability to provide efficient and accurate alcohol and drug assessments and treatment;
- Ability to provide efficient and accurate mental health assessments and treatment;
- Ability to demonstrate/utilize crisis intervention techniques;
- Ability to provide 1:1 and group counseling;
- Knowledge of, and ability to, provide training to new staff regarding phase-based and mental health treatment;
- Knowledge of treatment services available, including those in the community, and the ability to utilize placement criteria consistently;
- Knowledge of, and ability to, communicate and work effectively with community agencies and resources that provide services as appropriate;
- Strategically build and maintain relationships with community partners across the county, and participate in a wide range of community collaborative and capacity building efforts, and provide education to reduce stigma;
- Ability to use performance outcome processes and data in MHSA program planning;
- Knowledge of and commitment to utilize, Mental Health Services Act essential elements;
- Ability to supervise staff and complete performance evaluations;
- Ability to problem solve a myriad of daily questions that arise with both residential and outpatient client populations;
- Able to participate as a positive contributing member within a collaborative team, utilizing conflict resolution techniques.
- Use of County Insyst/Electronic Health Record system;
- Lived experience as a consumer of behavioral health services or as a family member of a consumer of behavioral health services;
- A strong commitment to and demonstrated skills in provision of culturally competent services to diverse populations, consistently utilizing multicultural skills, knowledge and experience; and,
- Bilingual/Spanish is highly desirable.

HOW:
If you have questions about this position, please contact **Debbie Vieira** at **541-2121**.

If you are interested in being considered for this position, please forward a written summary to the attention of **Erin Gregston, Human Resources, 800 Scenic Road**. This should include a summary of your skills and experience relative to this position, along with a brief summary of how this position would meet your career goals.

All requests must be made by 5:00 p.m. Tuesday, November 16, 2010 and can be sent by fax at 525-7338, interdepartmental mail or via GroupWise.

WHAT IF:
Upon receipt of transfer memo responses, the Senior Leadership staff involved will review and evaluate. Candidates who submit a response will be notified of any additional steps and/or decisions.

cc: All Staff via GroupWise
800 Scenic: Binders in Buildings B and C

ADMINISTRATIVE III

DEPARTMENT PROMTIONAL

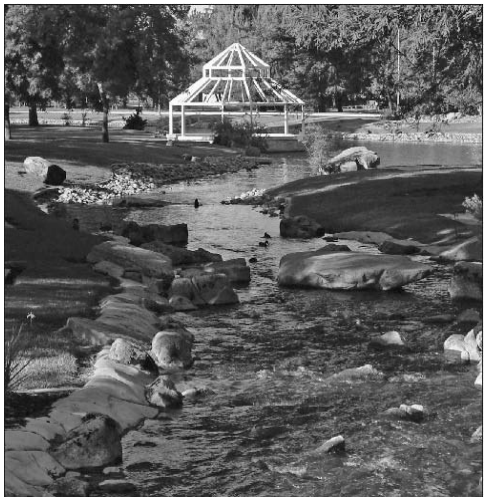
BEHAVIORAL HEALTH &
RECOVERY SERVICES

HOURLY SALARY
$16.58 - $20.15

FINAL FILING DATE
August 27, 2010

APPLY ONLINE AT: www.stanjobs.org

County Personnel:	209-525-6341
County Job Line:	209-525-4339



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With a population exceeding 500,000, Stanislaus County is proud of its vibrant citizenry, great traditions, educational opportunities, and multicultural lifestyles.

Modesto, the largest city and seat of Stanislaus County, offers the diversity and facilities of a metropolitan city while maintaining an atmosphere of old-fashioned hospitality.

West of the Valley and over the coastal mountains lies the San Francisco Bay Area, a 90-minute drive from Modesto. Eastward are the foothills of the famed Mother Lode gold country that leads to the majestic Sierra Nevada mountain range, Yosemite National Park, and Lake Tahoe.

Stanislaus County is home to California State University, Stanislaus and Modesto Junior College. Stanislaus County is a general law County established in 1854, governed by a five-member Board of Supervisors with assistance from the County Chief Executive Officer, elected officials and appointed department heads.

Stanislaus County has a current year total budget of $958 million and 3,990 full-time positions within 26 agencies and departments.

ABOUT THE DEPARTMENT

The Stanislaus County Behavioral Health & Recovery Services Department, under the administrative direction of the Chief Executive Officer and subject to the policy of the Board of Supervisors, is responsible for providing or arranging for the provision of an array of specialized behavioral health services for residents in and around Stanislaus County. The Department consists of over 300 allocated positions with an operational budget of $70 million.

GENERAL QUALIFICATIONS

- Pass County-paid pre-employment drug screening and job-related background investigation.
- Perform job duties in a manner assuring a safe working environment for oneself and others.
- Establish and maintain effective working relationships with the general public, co-workers, supervisors, and members of diverse cultural and linguistic backgrounds regardless of race, color, national origin, ancestry, political affiliation, sex, sexual orientation, religion, marital status, age (over 40), pregnancy related condition, medical condition (cancer related), physical (including AIDS) or mental disability.
- Maintain confidential information according to the legal standards and/or County regulations as required.

NOTES

Stanislaus County reserves the right to revise the examination plan described in this flyer to better meet the needs of County service. The provisions of this bulletin do not constitute an express or implied contract. Any provision contained in this bulletin may be modified or revoked without notice. The information contained in the bulletin is information, which sets forth a general summary of benefits for this respective position. This information is not legally binding. The benefits and other information regarding this position may be found in the Stanislaus County Code, the Stanislaus County Personnel Policies Manual, or in the applicable Memorandum of Understandings, and such information prevails over information contained in this flyer. Questions regarding this announcement may be directed to the Stanislaus County Chief Executive Office/Personnel.

Stanislaus County
Striving to be the Best

CLASSIFICATION INFORMATION

Unless otherwise provided, this position is part of the Classified Service of the County and is assigned to the Office Worker/Clerical Bargaining Unit for labor relations purposes. Incumbents are subject to overtime, standby and call-back assignments.

Individuals who are in a full-time classified position are required to serve a twelve-month probationary period, which may be extended an additional six months for a total of eighteen months.

JOB TASK ANALYSIS

The Job Task Analysis provides information detailing the physical and functional demands of the classification. For the complete job task analysis, visit the Risk Management website at www.co.stanislaus.ca.us/riskmgt under "Disability Management."

APPLICATION PROCEDURES/FINAL FILING DATE

Applications are to be submitted through the County online application system **no later than 5:00 p.m. on August 27, 2010**.

Make your application as complete as possible so a full and realistic appraisal may be made of your qualifications. Applicants are invited to submit a brief resume outlining paid or not-paid experience relevant to the position. **Resumes will not be accepted in lieu of a completed online application.**

EQUAL EMPLOYMENT OPPORTUNITY

The County of Stanislaus is an Equal Opportunity Employer. All qualified applicants are encouraged to apply for open positions.

TESTING ACCOMODATIONS

Arrangements may be made to accommodate disabilities or religious convictions. Describe the special test arrangements you require in the "Additional Information" section of the application form.

APPLICATION AND/OR EXAMINATION APPEALS RIGHTS

Application and/or examination results may be appealed by applicants presenting facts alleging irregularity, fraud and/or error in application screening or in exam scoring. Appeals must be in writing and submitted to the Chief Executive Office within seven (7) days after the results are mailed.

GENERAL INFORMATION

Stanislaus County is establishing an eligibility list for Full-Time Administrative Clerk III for the Department of Behavioral Health & Recovery Services (BHRS).

The Administrative Clerk III is the advanced journey-level class in the Administrative Clerk series. Incumbents are highly skilled and work independently, performing the more complex and responsible clerical assignments. These duties reflect a greater degree of responsibility than those found in the journey-level class in the series. Incumbents may also be assigned lead worker/supervisory duties.

ABOUT THE POSITION

The immediate vacancy is shared between the Mental Health Services Act Prevention and Early Intervention (PEI) program and the Alcohol and Drug Education and Prevention Services program. This Administrative Clerk III will work independently, providing support and collaborating with multiple staff, contract providers, consumers and family members, community leaders and other collaborative efforts. Some evening and weekend work may be required.

TYPICAL TASKS

- Work independently within a team structure
- Prioritize clerical tasks taking into consideration multiple, competing priorities
- Meet deadlines and specific time frames on a daily basis
- Work effectively and establish and maintain good working relationships with all levels of internal and external diverse customers
- Travel to attend meetings and take minutes
- Transcribe meeting minutes, complex reports, correspondence and standardized forms of a sensitive nature from written or recorded sources
- Ability to plan and coordinate all aspects of multiple community/program meetings (e.g. room reservations & logistics, AV equipment setup, catering, organization of meeting materials, and initiate meeting announcements/invites/reminders)
- Develop and maintain annual meeting calendars and schedules
- Demonstrate strong computer skills, including experience with Windows, Word, Excel, and Publisher
- Communicate effectively orally and in writing to individuals, groups, and the community of varying cultural, ethnic, social, economic and educational backgrounds
- Strategically build and maintain relationships with community partners across the county, and participate in a wide range of community

TYPICAL TASKS CONT'D

collaborative and capacity building efforts
- Participate as a positive contributing member within a collaborative team, utilizing conflict resolution techniques
- Work evenings and weekends, as required
- Other duties as needed and assigned

MINIMUM QUALIFICATIONS

Ability to:
- Type at a speed of 45 wpm or greater
- Accurately type correspondence and reports of a sensitive and/or complex nature
- Understand and apply policies, rules and procedures related to department operation
- Accurately maintain operational records and filing systems
- Deal with the public in a tactful and courteous manner
- Perform assigned tasks independently
- Carry and stack supplies, including full cartons of copy paper
- Handle frequent telephone interruptions
- Sit at a desk for extended amounts of time
- Travel to various sites when necessary
- Lift, bend, stoop and reach overhead
- Push, pull, squat, twist and turn

Knowledge of:
- Current office practices, procedures and organization
- Business letter writing
- Principles of supervision; and
- Office equipment and business forms

Education/Experience:
- Equivalent of two years full-time clerical experience, of which one year must be at the journey level
  OR
- Equivalent of one year of full-time, journey-level clerical experience **AND** the equivalent of one year of full-time schooling in relevant college course work or business school training (24 semester units or 36 quarter units)

DRIVERS LICENSE:
- Some positions in this classification may require possession of a valid California Driver's License

DESIRABLE QUALIFICATIONS:
- Excellent customer service skills
- Excellent personal computer skills, including experience with Windows, Word, PowerPoint, Outlook and Excel
- Proficiency in spreadsheet applications
- Ability to establish and maintain good working relationships with all levels of internal and external customers

Understanding of community collaborative and capacity building efforts
- Ability to type reports, correspondence, and standardized forms of a difficult and sensitive nature from written or recorded sources
- Must be willing to travel to attend meetings and take minutes
- Knowledge of stigma reduction
- Ability to communicate effectively orally and in writing to individuals, groups, and the community of varying cultural, ethnic, social, economic and educational backgrounds
- Knowledge of and commitment to include Mental Health Services Act essential elements
- Conflict resolution skills
- Multicultural skills, knowledge and experience
- Lived experience as a consumer of behavioral health services or as a family member of a behavioral health services
- Flexibility to work some evenings and weekends
- Bilingual Spanish/English

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

new 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	45.8	1	92.0							
Case Manager/Service Coordinator	0	0	0							
Employment Services Staff.....	0	0	0							
Housing Services Staff	8.0	0	16.0							
Consumer Support Staff	11.46	1	24.0							
Family Member Support Staff.....	8.56	1	17.0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	90.4	1	39.0							
Sub-total, A (County)	**164.22**	**4**	**188.0**	**68.81**	**35.43**	**9.96**	**19**	**4.03**	**0**	**137.23**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	19.0	1	35.0							
Case Manager/Service Coordinator	44.74	1	86.0							
Employment Services Staff.....	4.6	1	12.2							
Housing Services Staff	1.0	1	3.0							
Consumer Support Staff	12.0	1	28.0							
Family Member Support Staff.....	4.35	1	13.2							
**Benefits/Eligibility Specialist.....	0	1	3.0							
Other *Unlicensed* MH Direct Service Staff	14.0	1	30.0							
Sub-total, A (All Other)	**99.69**	**8**	**210.4**	**41.8**	**25.45**	**4.0**	**2.5**	**2.6**	**6.4**	**82.75**
Total, A (County & All Other):	**263.91**	**12**	**398.4**	**110.61**	**60.88**	**13.96**	**21.5**	**6.63**	**6.4**	**219.98**

(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

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	11.5	1	23.0							
Psychiatrist, child/adolescent	2.0	1	4.0							
Psychiatrist, geriatric	1.0	1	2.0							
Psychiatric or Family Nurse Practitioner	0	0	0							
Clinical Nurse Specialist	121.09	1	42.0							
Licensed Psychiatric Technician	17.0	0	34.0							
Licensed Clinical Psychologist	2.44	0	0							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	32.69	1	65.0							
MSW, registered intern (or waivered)	28.23	0	56.0							
Marriage and Family Therapist (MFT)	17.92	1	36.0							
MFT registered intern (or waivered)	20.8	0	42.0	(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Other *Licensed* MH Staff (direct service)	0.0	0	0							
Sub-total, B (County)	**254.67**	**6**	**304.0**	**131.12**	**32.26**	**17.8**	**33.1**	**0**	**0**	**214.28**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	1.3	1	5.0							
Psychiatrist, child/adolescent	1.1	1	2.0							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	1.4	1	4.0							
Clinical Nurse Specialist	1.0	1	2.0							
Licensed Psychiatric Technician	1.8	1	3.6							
Licensed Clinical Psychologist	1.25	1	3.5							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	3.43	1	8.0							
MSW, registered intern (or waivered)	14.4	1	24.0							
Marriage and Family Therapist (MFT)	20.07	1	34.0							
MFT registered intern (or waivered)	48.55	1	76.0	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Other *Licensed* MH Staff (direct service)	0.87	1	0							
Sub-total, B (All Other)	**95.17**	**11**	**162.1**	**61.93**	**20.8**	**5.4**	**3.0**	**1.0**	**1.53**	**93.66**
Total, B (County & All Other):	**349.84**	**17**	**466.1**	**193.05**	**53.06**	**23.2**	**36.1**	**1.0**	**1.53**	**307.94**

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	0	0	0							
Registered Nurse	0	0	0							
Licensed Vocational Nurse	2.37	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	2.0	0	4.0							
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)	**4.37**	**0**	**4.0**	**2.37**	**0**	**0**	**0**	**0**	**0**	**2.37**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0	0	0							
Registered Nurse	0	0	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)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total, C (County & All Other):	**4.37**	**0**	**4.0**	**2.37**	**0**	**0**	**0**	**0**	**0**	**2.37**

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/ Caucasian	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	14.0	1	28.0							
Supervising psychiatrist (or other physician)	0	0	0							
Licensed supervising clinician.....	15.26	1	32.0	(Managerial and Supervisory; Sub-Totals Only) ↓						
Other managers and supervisors.....	17.96	0	36.0							
Sub-total, D (County)	**47.22**	**2**	**96.0**	**30.22**	**5.0**	**3.0**	**1.0**	**0**	**0**	**39.22**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	7.04	1	11.51							
Supervising psychiatrist (or other physician)	0	0	0							
Licensed supervising clinician.....	7.53	1	13.5	(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Other managers and supervisors.....	10.4	1	12.5							
Sub-total, D (All Other)	**24.97**	**3**	**37.51**	**21.55**	**2.0**	**1.0**	**0**	**0**	**0.5**	**25.05**
Total, D (County & All Other):	**72.19**	**5**	**133.51**	**51.77**	**7.0**	**4.0**	**1.0**	**0**	**0.5**	**64.27**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	14.34	1	28.0							
Education, training, research	1	0	3							
Clerical, secretary, administrative assistants.....	58.59	0	118.0	(Support Staff; Sub-Totals Only) ↓						
Other support staff (non-direct services)	40.58	0	82.0							
Sub-total, E (County)	**114.51**	**1**	**231.0**	**64.55**	**27.62**	**1.98**	**7.8**	**1.0**	**1.0**	**103.95**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	6.75	1	13.0							
**Education, training, research	0	1	1.0							
Clerical, secretary, administrative assistants.....	24.96	1	45.5	(Support Staff; Sub-Totals and Total Only) ↓						
Other support staff (non-direct services)	10.25	1	14.0							
Sub-total, E (All Other)	**41.96**	**4**	**73.5**	**17.15**	**20.33**	**0**	**2.0**	**0**	**2.5**	**41.98**
Total, E (County & All Other):	**156.47**	**5**	**304.5**	**81.7**	**47.95**	**1.98**	**9.8**	**1.0**	**3.5**	**145.93**

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) .....**	**584.99**	**13.0**	**823.0**	**297.07**	**100.31**	**32.74**	**60.9**	**5.03**	**1.0**	**497.05**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E).....**	**261.79**	**26.0**	**483.51**	**142.43**	**68.58**	**10.4**	**7.5**	**3.6**	**10.93**	**243.44**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**846.78**	**39.0**	**1306.54**	**439.5**	**168.89**	**43.14**	**68.4**	**8.63**	**11.93**	**740.49**

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**			**6,599**	**2,176**	**680**	**563**	**106**	**784**	**10,908**

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.....	23.46	1	29.75
Family Member Support Staff	12.91	1	16.37
Other *Unlicensed* MH Direct Service Staff.....	104.4	1	132.37
Sub-Total, A:	**140.77**		**178.49**
B. *Licensed* Mental Health Staff (direct service).....	**0**	**0**	**0**
C. Other Health Care Staff (direct service)	**0**	**0**	**0**
D. Managerial and Supervisory.....	**1.5**	**1**	**1.90**
E. Support Staff (non-direct services).....	**0**	**0**	**0**
GRAND TOTAL (A+B+C+D+E)	**142.27**	**4**	**180.39**

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: 110.45 Others: 44.92	Direct Service Staff: 162.25 Others: 112.32	Direct Service Staff: 272.70 Others: 157.24
2. CAMBODIAN	Direct Service Staff: 16.0 Others: 0	Direct Service Staff: 0 Others: 5.33	Direct Service Staff: 16.0 Others: 5.33
3. LAOTIAN	Direct Service Staff: 5.93 Others: 0	Direct Service Staff: 0 Others: 2.57	Direct Service Staff: 5.93 Others: 2.57
4. ASSYRIAN	Direct Service Staff: 3.0 Others: 1.01	Direct Service Staff: 6.0 Others: 2.0	Direct Service Staff: 9.0 Others: 3.01
5. TAGALOG	Direct Service Staff: 3.0 Others: 0	Direct Service Staff: .6 Other: 2.1	Direct Service Staff: 3.6 Others: 2.1
6. VIETNAMESE	Direct Service Staff: 3.0 Others: 0	Direct Service Staff: .7 Others: 2.13	Direct Service Staff: 3.70 Others: 2.13
7. HMONG	Direct Service Staff: 2.0 Others: 0	Direct Service Staff: .44 Others: 1.40	Direct Service Staff: 2.44 Others: 1.40

8. AMERICAN SIGN (ASL)	Direct Service Staff: 2.0 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0
9. HINDI	Direct Service Staff: 1.06 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0
10. PORTUGUESE	Direct Service Staff: 1.0 Others: 2.0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0
11. FARSI	Direct Service Staff: 1.0 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0
12. FRENCH	Direct Service Staff: 1.0 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0
13. GURATI	Direct Service Staff: 0.05 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 0 Others: 0

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/orr 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 Stanislaus County with the proportion of that prevalence need currently being met by existing providers. In general, Stanislaus County needs to increase its current providers by three times the current level. There were some modifications for specific classifications, e.g., the closure of the local inpatient unit has decreased the need for registered nurses in the County workforce and some CBO's projected needs on factors other than prevalence.

This Needs Assessment attempted to capture, with close to 100% accuracy, the current workforce within the Stanislaus County Public Mental Health Service System. Accurate data was obtained from the Stanislaus County Human Resources data system (from FY 2007-08) and directly from each CBO. Language proficiency data was obtained by survey of staff or from current, existing human resources data. Data was obtained from BHRS and all of it's organizational and network providers including those organizations serving diverse underserved and inappropriately served communities.

** One of our CBOs contracted to provide Outreach and Engagement to ethic communities does not yet have a funded position. They plan to have one in the future and are anticipating difficulty in recruiting (based on recent experiences with recruitments) and feel strongly that it should be noted in the needs assessment.

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.
- There is a shortfall of licensed mental health clinicians.
- Psychiatrists are very hard to recruit when a vacancy occurs

- Finding candidates who have both employment development expertise and mental health expertise is nearly impossible.
- There is a shortage of Black/African American Direct Service Staff in some programs.
- There needs to be a more diverse pool of clinical supervisors, bicultural/bilingual licensed staff who are eligible and trained to be clinical supervisors.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

- There is an overall shortfall in the mental health workforce in regard to meeting the prevalence needs within Stanislaus County.
- Direct service providers do not represent target population in race/ethnicity and there is a specific shortage in bilingual English/Spanish staff.
- It is hard to find, hire, recruit and train bilingual therapists skilled at dealing with children and families e.g. child sexual abuse treatment.
- Contracting CBO's tend to have diverse staff that is more reflective of the population served but still have a need to recruit bilingual (English/Spanish and English/Cambodian) staff.

C. Positions designated for individuals with consumer and/or family member experience:

- There is a shortfall in the mental health workforce in regard to the employment and retention 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, etc.
- There is a need for Parent Mentors in children's programs.
- We need more bilingual Spanish-speaking direct service consumer and family member staff in order to proficiently provide services.
- There are group co-facilitator aides to assist with children's groups, but it has been hard to get volunteers who can be there consistently for group without a compensation source, as many need paid employment.

D. Language proficiency:

- There is a great need for bilingual (English/Spanish &/or English/Cambodian) clinicians.
- Improve ability to identify and hire language proficient and bicultural individuals.
- There is a need for bilingual (English/Spanish, English/Assyrian) consumer and family member staff.

E. Other, miscellaneous:

- BHRS is a behavioral health provider that has attempted to integrate Alcohol and Other Drug (AOD) and Mental Health services in many of its programs. While AOD-funded provider staff were not included in the Workforce Needs Assessment, BHRS plans to frequently include AOD service experience in requirements for the recruitment of staff.
- Address the need for both male/female staff for Southeast Asian population due to cultural traditions (i.e., gender discrimination for traditional members of the community).

Mental Health, Alcohol & Other Drug Services Access/Information Line

Mental Health Crisis,Treatment, Recovery and Peer Support Services

1-888-376-6246

Internet

For additional information, please visit us online:

www.stancounty.com/bhrs

Behavioral Health & Recovery Services

A Mental Health, Alcohol & Other Drug Services Organization
800 Scenic Drive Modesto, California

Sponsored by the Stanislaus County Board of Supervisors

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MHSA Demographic Report

BHRS MHSA FSP Demographic Report

Final

FY 2008/2009 as of 06/30/09

Clients (Includes Enrollments and Assessments)

Program Name	Program Start Date	Jul 08	Aug 08	Sep 08	Undup Clients Qtr 1	Oct 08	Nov 08	Dec 08	Undup Clients Qtr 2	Jan 09	Feb 09	Mar 09	Undup Clients Qtr 3	Apr 09	May 09	Jun 09	Undup Clients Qtr 4	Undup Clients FY To Date	FY Exhibit 6 or Contract Annual Target	Total Active Clients as of 06/30/09	Monthly % Target as of 06/30/09	% Annual Target Met as of 06/30/09
Westside SHOP	03/02/2006	35	3	0	38	32	8	6	46	41	3	3	47	47	1	2	50	**68**	40	44	110.0%	170.0%
Partnership TRAC	10/01/2007	75	2	7	84	73	0	7	80	72	7	11	90	85	6	3	94	**133**	60	74	123.3%	221.7%
Josie's TRAC	11/01/2007	31	0	2	33	31	3	5	39	38	0	2	40	32	1	5	38	**59**	28	32	114.3%	210.7%
Juvenile Justice	05/23/2006	28	1	5	34	27	3	0	30	26	5	4	35	24	3	2	29	**57**	25	22	88.0%	228.0%
SART	06/24/2006	39	3	1	43	43	2	1	46	43	3	2	48	48	2	1	51	**57**	50	46	92.0%	114.0%
HMHT	07/01/2006	49	1	0	50	46	0	2	48	44	3	3	50	47	1	2	50	**66**	50	46	92.0%	132.0%
IFT	01/24/2006	33	3	0	36	34	2	5	41	39	3	3	45	41	1	3	45	**58**	40	42	105.0%	145.0%
TOTAL		290	13	15	318	286	18	26	330	303	24	28	355	324	15	18	357	**498**	293	306	104.4%	170.0%

Exhibit 6 reporting may reflect fewer clients for FSP plans with multiple programs.

Gender of Clients Served Fiscal Year to Date

Program Name	*Male*	*Female*	*Unknown*	*Total Clients*
Westside SHOP (53011)	25 36.8%	43 63.2%	0 0.0%	**68** 100.0%
Partnership TRAC (53012)	58 43.6%	75 56.4%	0 0.0%	**133** 100.0%
Josie's TRAC (53015)	31 52.5%	28 47.5%	0 0.0%	**59** 100.0%
Juvenile Justice (53031)	35 61.4%	22 38.6%	0 0.0%	**57** 100.0%
SART (53041)	10 17.5%	47 82.5%	0 0.0%	**57** 100.0%
HMHT (53051, 53052)	37 56.1%	29 43.9%	0 0.0%	**66** 100.0%
IFT (53001)	36 62.1%	22 37.9%	0 0.0%	**58** 100.0%
TOTAL	232 46.6%	266 53.4%	0 0.0%	**498** 100.0%

Data not captured

Age of Clients Served Fiscal Year to Date

Program Name	*0-15*	*16-17*	*18-25*	*26-59*	*60+*	*Unknown*	*Total Clients*
Westside SHOP	0 0.0%	0 0.0%	6 8.8%	61 89.7%	1 1.5%	0 0.0%	**68** 100.0%
Partnership TRAC	0 0.0%	0 0.0%	10 7.5%	121 91.0%	2 1.5%	0 0.0%	**133** 100.0%
Josie's TRAC	0 0.0%	0 0.0%	59 100.0%	0 0.0%	0 0.0%	0 0.0%	**59** 100.0%
Juvenile Justice	21 36.8%	30 52.6%	6 10.5%	0 0.0%	0 0.0%	0 0.0%	**57** 100.0%
SART	0 0.0%	0 0.0%	0 0.0%	9 15.8%	48 84.2%	0 0.0%	**57** 100.0%
HMHT	0 0.0%	0 0.0%	0 0.0%	63 95.5%	3 4.5%	0 0.0%	**66** 100.0%
IFT	0 0.0%	0 0.0%	6 10.3%	51 87.9%	1 1.7%	0 0.0%	**58** 100.0%
TOTAL	21 4.2%	30 6.0%	87 17.5%	305 61.2%	55 11.0%	0 0.0%	**498** 100.0%

Not specified as a target in the MHSA Plan

Final

Ethnicity of Clients Served Fiscal Year to Date

Program Name	African American	Cambodian	Caucasian	Filipino	Hispanic	Japanese	Laotian	Native American	Other Asian	Other Non White	Other Southeast Asian	Unknown	Total Clients	Total Clients Excluding Caucasian, Other & Unknown	Contract / Workplan Requirement	% of Minority Target
Westside SHOP	12 17.6%	2 2.9%	34 50%	1 1.5%	18 26.5%				1 1.5%				**68**	34 50%	50% of 40 people (or 20) will be of color	34 170%
Partnership TRAC	12 9%		71 53.4%	3 2.3%	44 33.1%		1 0.8%				1 0.8%	1 0.8%	**133**	61 45.9%		
Josie's TRAC	5 8.5%	1 1.7%	27 45.8%	1 1.7%	22 37.3%			1 1.7%	1 1.7%	1 1.7%			**59**	32 54.2%		
Juvenile Justice	3 5.3%		15 26.3%	4 7%	34 59.6%					1 1.8%			**57**	42 73.7%		
SART	3 5.3%		41 71.9%	1 1.8%	10 17.5%					1 1.8%	1 1.8%		**57**	16 28.1%		
HMHT	5 7.6%		29 43.9%	1 1.5%	26 39.4%	1 1.5%		1 1.5%		3 4.5%			**66**	37 56.1%		
IFT	2 3.4%		32 55.2%		23 39.7%				1 1.7%				**58**	26 44.8%	50% of 40 people (or 20) will be of color	26 130%
TOTAL	42 8.4%	3 0.6%	249 50%	11 2.2%	177 35.5%	1 0.2%	1 0.2%	2 0.4%	3 0.6%	6 1.2%	2 0.4%	1 0.2%	**498**	248 49.8%		

Preferred Language of Clients Served Fiscal Year to Date

Program Name	Assyrian	Cambodian	English	Filipino	Other	Russian	Spanish	Thai	Unknown	Total Clients
Westside SHOP	1 1.5%	1 1.5%	65 95.6%				1 1.5%			**68**
Partnership TRAC			119 89.5%	1 0.8%	2 1.5%		7 5.3%	3 2.3%	1 0.8%	**133**
Josie's TRAC			57 96.6%			1 1.7%	1 1.7%			**59**
Juvenile Justice			49 86%		1 1.8%		5 8.8%	2 3.5%		**57**
SART	1 1.8%		51 89.5%	1 1.8%	1 1.8%		1 1.8%	2 3.5%		**57**
HMHT			54 81.8%		1 1.5%		10 15.2%	1 1.5%		**66**
IFT			57 98.3%					1 1.7%		**58**
TOTAL	2 0.4%	1 0.2%	452 90.8%	2 0.4%	5 1%	1 0.2%	25 5%	9 1.8%	1 0.2%	**498**

Final

Geographic Area (Residence) of Clients Served Fiscal Year to Date								
Program Name	*Ceres*	*Eastside*	*Modesto*	*Turlock*	*Westside*	*Unknown*	*Out of County*	*Total Clients*
Westside SHOP	7 10.3%	0 0.0%	53 77.9%	3 4.4%	0 0.0%	4 5.9%	1 1.5%	**68** 100.0%
Partnership TRAC	10 7.5%	15 11.3%	91 68.4%	9 6.8%	3 2.3%	4 3.0%	1 0.8%	**133** 100.0%
Josie's TRAC	6 10.2%	1 1.7%	43 72.9%	5 8.5%	1 1.7%	0 0.0%	3 5.1%	**59** 100.0%
Juvenile Justice	7 12.3%	6 10.5%	34 59.6%	4 7.0%	5 8.8%	0 0.0%	1 1.8%	**57** 100.0%
SART	3 5.3%	1 1.8%	41 71.9%	12 21.1%	0 0.0%	0 0.0%	0 0.0%	**57** 100.0%
HMHT	8 12.1%	4 6.1%	43 65.2%	8 12.1%	1 1.5%	0 0.0%	2 3.0%	**66** 100.0%
IFT	4 6.9%	4 6.9%	48 82.8%	1 1.7%	0 0.0%	0 0.0%	1 1.7%	**58** 100.0%
TOTAL	45 9.0%	31 6.2%	353 70.9%	42 8.4%	10 2.0%	8 1.6%	9 1.8%	**498** 100.0%

The contract for Westside SHOP states the areas of focus for service are western and southern Modesto.

Zipcode not provided.

Data Source/Definitions:

Data Source:	Episode and client information entered in Insyst.
Total Clients Served:	The sum of unique clients with an episode that was in "open status" during the fiscal year. This number does not account for discharges.
Total Active Clients:	Reflects episodes in "open status" as of 06/30/2009.
Ethnicity	Is based upon the Insyst fields "Hispanic Origin" and "Ethnicity".

BHRS MHSA GSD Demographic Report

Final

FY 2008/2009 as of 06/30/09

Clients Served

Program Name	Program Start Date	Jul 08	Aug 08	Sep 08	Undup Clients Qtr 1	Oct 08	Nov 08	Dec 08	Undup Clients Qtr 2	Jan 09	Feb 09	Mar 09	Undup Clients Qtr 3	Apr 09	May 09	Jun 09	Undup Clients Qtr 4	Undup Clients FY To Date	FY Exhibit 6 or Contract Annual Target	% Annual Target Met as of 06/30/09
Josie's Place Drop-in Cen	05/08/2006	2	6	2	10	1	4	6	11	6	2	62	70	5	91	26	122	**157**	150	104.7%
Josie's Place-ISS	11/01/2007	69	6	9	84	79	5	8	92	85	5	0	90	87	10	7	104	**144**	100	144.0%
CERT	10/01/2006	239	227	248	714	253	190	186	629	210	160	0	370	234	222	168	624	**2222**	3000	99.3%
Warm Line	06/15/2006	132	74	68	274	81	45	48	174	74	77	84	235	85	79	113	277	**879**	Included above	Incl. above *
Families Together	08/14/2006	61	13	39	113	81	21	19	121	57	42	48	147	67	13	20	100	**344**	80	430.0%
CE&E	07/01/2006	65	44	0	109	146	13	15	174	58	25	39	122	160	78	51	289	**503**	500	100.6%
Fast TRAC	10/01/2007	51	4	5	60	60	0	2	62	51	1	0	52	53	3	3	59	**87**	45	193.3%
SHOP Wellness	10/01/2007	54	4	1	59	57	0	3	60	56	2	0	58	55	7	6	68	**85**	60	141.7%
IFT GSD	01/01/2008	8	0	0	8	11	2	7	20	23	3	0	26	29	5	8	42	**44**	40	110.0%
TOTAL		681	378	372	1431	769	280	294	1343	620	317	233	1170	775	508	402	1685	**4465**	3975	112.3%

Gender of Clients Served Fiscal Year to Date

Program Name	*Male*	*Female*	*Unknown*	*Total Clients*
Josie's Place Drop-in Center (53021)	103 65.6%	48 30.6%	6 3.8%	**157** 100.0%
Josie's Place-ISS (53022)	74 51.4%	70 48.6%	0 0.0%	**144** 100.0%
CERT (53061, 53062)	1118 50.3%	1102 49.6%	2 0.1%	**2222** 100.0%
Warm Line (GS02)	329 37.4%	539 61.3%	11 1.3%	**879** 100.0%
Families Together (53071)	91 26.5%	240 69.8%	13 3.8%	**344** 100.0%
CE&E (GS05)	298 59.2%	199 39.6%	6 1.2%	**503** 100.0%
Fast TRAC (53013)	39 44.8%	48 55.2%	0 0.0%	**87** 100.0%
SHOP Wellness (53014)	39 45.9%	46 54.1%	0 0.0%	**85** 100.0%
IFT GSD (53002)	19 43.2%	25 56.8%	0 0.0%	**44** 100.0%
TOTAL	2110 47.3%	2317 51.9%	38 0.9%	**4465** 100.0%

Data not captured

Age of Clients Served Fiscal Year to Date

Program Name	*0-15*	*16-17*	*18-25*	*26-59*	*60+*	*Unknown*	*Total Clients*
Josie's Place Drop-in Center	1 0.6%	10 6.4%	143 91.1%	2 1.3%	0 0.0%	1 0.6%	**157** 100.0%
Josie's Place-ISS	0 0.0%	0 0.0%	144 100.0%	0 0.0%	0 0.0%	0 0.0%	**144** 100.0%
CERT	260 11.7%	191 8.6%	433 19.5%	1291 58.1%	47 2.1%	0 0.0%	**2222** 100.0%
Warm Line	30 3.4%	14 1.6%	125 14.2%	553 62.9%	38 4.3%	119 13.5%	**879** 100.0%
Families Together	69 20.1%	5 1.5%	6 1.7%	139 40.4%	23 6.7%	102 29.7%	**344** 100.0%
CE&E	0 0.0%	0 0.0%	42 8.3%	389 77.3%	25 5.0%	47 9.3%	**503** 100.0%
Fast TRAC	0 0.0%	0 0.0%	10 11.5%	74 85.1%	3 3.4%	0 0.0%	**87** 100.0%
SHOP Wellness	0 0.0%	0 0.0%	6 7.1%	76 89.4%	3 3.5%	0 0.0%	**85** 100.0%
IFT GSD	0 0.0%	0 0.0%	6 13.6%	38 86.4%	0 0.0%	0 0.0%	**44** 100.0%
TOTAL	360 8.1%	220 4.9%	915 20.5%	2562 57.4%	139 3.1%	269 6.0%	**4465** 100.0%

Not specified as a target in the MHSA Plan

* The % Annual Target is based on the combined unduplicated clients for the 2 programs.

Ethnicity of Clients Served Fiscal Year to Date

Final

Program Name	African American	Asian Indian	Cambodian	Caucasian	Chinese	Filipino	Guamanian	Hispanic	Hmong	Korean	Laotian	Native American	Other	Other Asian	Other Non White	Other Pacific Islander	Other Southeast Asian	Samoan	Unknown	Vietnamese	Total Clients	Total Clients Excluding Caucasian, Other & Unknown
Josie's Place Drop-in Center	22 14%	1 0.6%	1 0.6%	93 59.2%	2 1.3%			29 18.5%	1 0.6%		1 0.6%		2 1.3%			1 0.6%			3 1.9%		**157**	59 37.6%
Josie's Place-ISS	10 6.9%		1 0.7%	58 40.3%		4 2.8%	1 0.7%	63 43.8%	1 0.7%		1 0.7%				4 2.8%				1 0.7%		**144**	85 59%
CERT	84 3.8%	5 0.2%	10 0.5%	1043 46.9%	6 0.3%	53 2.4%	1 0%	941 42.3%		1 0%	4 0.2%	11 0.5%		7 0.3%	10 0.5%		1 0%	1 0%	37 1.7%	6 0.3%	**2222**	1142 51.4%
Warm Line	27 3.1%			436 49.6%		1 0.1%		146 16.6%			1 0.1%	3 0.3%	15 1.7%	3 0.3%		2 0.2%		1 0.1%	239 27.2%		**879**	189 21.5%
Families Together	23 6.7%		1 0.3%	182 52.9%				131 38.1%			1 0.3%	1 0.3%							5 1.5%		**344**	157 45.6%
CE&E	32 6.4%			284 56.5%		2 0.4%		90 17.9%			2 0.4%	7 1.4%	9 1.8%			1 0.2%		1 0.2%	73 14.5%		**503**	137 27.2%
Fast TRAC	6 6.9%		1 1.1%	45 51.7%		2 2.3%		31 35.6%									1 1.1%		1 1.1%		**87**	41 47.1%
SHOP Wellness	7 8.2%		1 1.2%	52 61.2%		1 1.2%		20 23.5%			1 1.2%						1 1.2%		2 2.4%		**85**	31 36.5%
IFT GSD	1 2.3%		1 2.3%	20 45.5%				19 43.2%			1 2.3%								1 2.3%	1 2.3%	**44**	23 52.3%
TOTAL	212 4.7%	6 0.1%	16 0.4%	2213 49.6%	8 0.2%	63 1.4%	2 0%	1470 32.9%	2 0%	1 0%	12 0.3%	22 0.5%	26 0.6%	10 0.2%	14 0.3%	4 0.1%	3 0.1%	3 0.1%	362 8.1%	7 0.2%	**4465**	1864 41.7%

Preferred Language of Clients Served Fiscal Year to Date

Program Name	Assyrian	Cambodian	Chinese	Eng Japan	Eng Span	English	Farsi	Filipino	Ilacano	Japanese	Laotian	Mandarin	Other	Portuguese	Sign ASL	Spanish	Thai	Unknown	Total Clients
Josie's Place Drop-in Center	1 0.6%					153 97.5%												3 1.9%	**157**
Josie's Place-ISS		1 0.7%				139 96.5%		1 0.7%								1 0.7%	2 1.4%		**144**
CERT	4 0.2%	5 0.2%	1 0%			1991 89.6%	4 0.2%	4 0.2%	2 0.1%	3 0.1%	1 0%	2 0.1%	35 1.6%		1 0%	77 3.5%	92 4.1%		**2222**
Warm Line				1 0.1%	1 0.1%	824 93.7%							1 0.1%			33 3.8%		19 2.2%	**879**
Families Together						285 82.8%					1 0.3%			1 0.3%		53 15.4%		4 1.2%	**344**
CE&E	1 0.2%					483 96%							2 0.4%			3 0.6%		14 2.8%	**503**
Fast TRAC		1 1.1%				75 86.2%		2 2.3%					1 1.1%		1 1.1%	7 8%			**87**
SHOP Wellness						76 89.4%		1 1.2%					3 3.5%			5 5.9%			**85**
IFT GSD		1 2.3%				38 86.4%		1 2.3%			1 2.3%		1 2.3%				2 4.5%		**44**
TOTAL	6 0.1%	8 0.2%	1 0%	1 0%	1 0%	4064 91%	4 0.1%	9 0.2%	2 0%	3 0.1%	3 0.1%	2 0%	43 1%	1 0%	2 0%	179 4%	96 2.2%	40 0.9%	**4465**

Final

Geographic Area (Residence) of Clients Served Fiscal Year to Date								
Program Name	**Ceres**	**Eastside**	**Modesto**	**Turlock**	**Westside**	**Unknown**	**Out of County**	**Total Clients**
Josie's Place Drop-in Center	5 3.2%	4 2.5%	97 61.8%	12 7.6%	2 1.3%	34 21.7%	3 1.9%	**157** 100.0%
Josie's Place-ISS	16 11.1%	11 7.6%	89 61.8%	21 14.6%	6 4.2%	0 0.0%	1 0.7%	**144** 100.0%
CERT	216 9.7%	212 9.5%	1404 63.2%	267 12.0%	50 2.3%	13 0.6%	60 2.7%	**2222** 100.0%
Warm Line	65 7.4%	61 6.9%	497 56.5%	65 7.4%	28 3.2%	105 11.9%	58 6.6%	**879** 100.0%
Families Together	30 8.7%	35 10.2%	196 57.0%	25 7.3%	5 1.5%	48 14.0%	5 1.5%	**344** 100.0%
CE&E	46 9.1%	26 5.2%	366 72.8%	32 6.4%	4 0.8%	13 2.6%	16 3.2%	**503** 100.0%
Fast TRAC	14 16.1%	8 9.2%	54 62.1%	7 8.0%	1 1.1%	3 3.4%	0 0.0%	**87** 100.0%
SHOP Wellness	8 9.4%	3 3.5%	61 71.8%	10 11.8%	2 2.4%	0 0.0%	1 1.2%	**85** 100.0%
IFT GSD	4 9.1%	3 6.8%	29 65.9%	6 13.6%	2 4.5%	0 0.0%	0 0.0%	**44** 100.0%
TOTAL	404 9.0%	363 8.1%	2793 62.6%	445 10.0%	100 2.2%	216 4.8%	144 3.2%	**4465** 100.0%

Zipcode not provided.

Data Source/Definitions:

Data Source:	
CERT and Families Together:	MHSA Initial Contacts Forms and Insyst
Josie's Place-ISS, Fast TRAC, SHOP Wellness, and IFT GSD:	Insyst
Josie's Place Drop-in Center, Warm Line, and CE & E:	MHSA Initial Contacts Forms
	Initial Contact forms for Josie's Place Drop-In Center are distributed at the program site.
	Initial Contact forms for Warm Line are completed via phone conversations with individuals who have made contact with the program.
	Initial Contact forms for Families Together are distributed at school committee meetings, contact with individuals who come into the program, and in the field.
Total Clients Served:	Reflects the # of unique clients who received service in a given month. If an initial contact form was submitted in a subsequent month for a client previously reported in the same fiscal year, the client was only counted in the first month of contact. If a client had an episode closed in Insyst and then re-opened at a later date in the same fiscal year, only the initial episode was counted.
Ethnicity for programs	For those reporting via Insyst, ethnicity is based upon the Insyst fields "Hispanic Origin" and "Ethnicity". Those reporting on initial contact forms are based upon the ethnicity selected.

BHRS MHSA O&E Demographic Report

Final

FY 2008/2009 as of 06/30/09

Clients Served

Program Name	Program Start Date	Jul 08	Aug 08	Sep 08	Undup Clients Qtr 1	Oct 08	Nov 08	Dec 08	Undup Clients Qtr 2	Jan 09	Feb 09	Mar 09	Undup Clients Qtr 3	Apr 09	May 09	Jun 09	Undup Clients Qtr 4	Undup Clients FY To Date	FY Exhibit 6 or Contract Annual Target	% Annual Target Met as of 06/30/09
El Concilio	08/01/2006	83	47	0	130	259	26	9	294	45	16	2	63	28	130	27	185	**667**	600	111.2%
WMKKNC	08/01/2006	77	188	7	272	230	78	70	378	59	10	9	78	23	9	39	71	**772**	600	128.7%
Garden Gate Respite	05/15/2006	60	33	19	112	61	26	18	105	32	28	27	87	39	24	38	101	**333**	150	222.0%
TOTAL		220	268	26	514	550	130	97	777	136	54	38	228	90	163	104	357	**1772**	1350	131.3%

Gender of Clients Served Fiscal Year to Date

Program Name	*Male*	*Female*	*Unknown*	*Total Clients*
El Concilio (OE01E)	150 22.5%	507 76.0%	10 1.5%	**667** 100.0%
WMKKNC (OE01K)	434 56.2%	336 43.5%	2 0.3%	**772** 100.0%
Garden Gate Respite (OE02R)	179 53.8%	147 44.1%	7 2.1%	**333** 100.0%
TOTAL	763 43.1%	990 55.9%	19 1.1%	**1772** 100.0%

Data not captured

Age of Clients Served Fiscal Year to Date

Program Name	*0-15*	*16-17*	*18-25*	*26-59*	*60+*	*Unknown*	*Total Clients*
El Concilio	49 7.3%	23 3.4%	82 12.3%	489 73.3%	20 3.0%	4 0.6%	**667** 100.0%
WMKKNC	1 0.1%	1 0.1%	147 19.0%	581 75.3%	42 5.4%	0 0.0%	**772** 100.0%
Garden Gate Respite	0 0.0%	0 0.0%	78 23.4%	233 70.0%	21 6.3%	1 0.3%	**333** 100.0%
TOTAL	50 2.8%	24 1.4%	307 17.3%	1303 73.5%	83 4.7%	5 0.3%	**1772** 100.0%

Not specified as a target in the MHSA Plan

Ethnicity of Clients Served Fiscal Year to Date

Final

Program Name	*African American*	*Asian Indian*	*Cambodian*	*Caucasian*	*Filipino*	*Hispanic*	*Hmong*	*Japanese*	*Korean*	*Laotian*	*Mien*	*Native American*	*Native Hawaiian*	*Other*	*Other Pacific Islander*	*Samoan*	*Unknown*	*Vietnamese*	*Total Clients*	*Total Clients Excluding Caucasian, Other & Unknown*
El Concilio	20 3%	2 0.3%		59 8.8%	5 0.7%	551 82.6%		1 0.1%	3 0.4%			7 1%		11 1.6%	1 0.1%	3 0.4%	3 0.4%		**667**	594 89.1%
WMKKNC	149 19.3%	3 0.4%	122 15.8%	137 17.7%	7 0.9%	236 30.6%	10 1.3%	2 0.3%		33 4.3%	7 0.9%	37 4.8%	1 0.1%	20 2.6%	2 0.3%	3 0.4%	1 0.1%	2 0.3%	**772**	614 79.5%
Garden Gate Respite	33 9.9%		1 0.3%	220 66.1%		63 18.9%				1 0.3%		2 0.6%		11 3.3%	1 0.3%			1 0.3%	**333**	102 30.6%
TOTAL	202 11.4%	5 0.3%	123 6.9%	416 23.5%	12 0.7%	850 48%	10 0.6%	3 0.2%	3 0.2%	34 1.9%	7 0.4%	46 2.6%	1 0.1%	42 2.4%	4 0.2%	6 0.3%	4 0.2%	3 0.2%	**1772**	1310 73.9%

Preferred Language of Clients Served Fiscal Year to Date

Program Name	Assyrian	Cambodian	Eng Span	English	Farsi	Filipino	Laotian	Other	Spanish	Unknown	Vietnamese	Total Clients
El Concilio			2 0.3%	169 25.3%		1 0.1%		1 0.1%	490 73.5%	4 0.6%		**667**
WMKKNC	1 0.1%	64 8.3%		587 76%	1 0.1%	1 0.1%	11 1.4%	5 0.6%	102 13.2%			**772**
Garden Gate Respite	1 0.3%			318 95.5%				2 0.6%	11 3.3%		1 0.3%	**333**
TOTAL	2 0.1%	64 3.6%	2 0.1%	1074 60.6%	1 0.1%	2 0.1%	11 0.6%	8 0.5%	603 34%	4 0.2%	1 0.1%	**1772**

Geographic Area (Residence) of Clients Served Fiscal Year to Date

Final

Program Name	Ceres	Eastside	Modesto	Turlock	Westside	Unknown	Out of County	Total Clients
El Concilio	83 12.4%	25 3.7%	387 58.0%	37 5.5%	111 16.6%	4 0.6%	20 3.0%	**667** 100.0%
WMKKNC	0 0.0%	0 0.0%	764 99.0%	0 0.0%	1 0.1%	6 0.8%	1 0.1%	**772** 100.0%
Garden Gate Respite	3 0.9%	1 0.3%	256 76.9%	5 1.5%	0 0.0%	65 19.5%	3 0.9%	**333** 100.0%
TOTAL	86 4.9%	26 1.5%	1407 79.4%	42 2.4%	112 6.3%	75 4.2%	24 1.4%	**1772** 100.0%

Zipcode not provided.

Data Source/Definitions:

Data Source:	MHSA Initial Contacts Forms
Total Clients Served:	Reflects the # of unique clients who received service in a given month. If an initial contact form was submitted in a subsequent month for a client previously reported in the same fiscal year, the client was only counted in the first month of contact.