Cultural Competency Plan
2010

Alameda County the most diverse and colorful county in the State
# Alameda County Behavioral Health Care Services
## Cultural Competence Plan Requirements

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### Attachments:

| Criterion 1: | Attachment 1 IA-1; Attachment 1 I A-2; Attachment 1 I B-1; Attachment 1 I B-3; Attachment 1 I B-4; Attachment 1 I B-5; Attachment 1 I B-6; Attachment 1 I B 7-1; Attachment 1 I B 7-2; Attachment 1 I B 7-3; Attachment 1 II A-1; Attachment 1 II A-2; Attachment 1 II A-3; Attachment 1 II A-4; Attachment 1 II C; Attachment 1 III B-1; Attachment 1 IV A-1; Attachment 1 IV B-1; Attachment 1 IV B-2; Attachment 1 IV B-3; Attachment 1 IV B-4 |
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| Criterion 6: | Attachment 6 I A-1; Attachment 6 I A-2; Attachment 6 I C-1; Attachment 6 I D-1; Attachment 6 I D-2 |
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A Letter From The Director:

For more than forty years, Alameda County Behavioral Health Care Services (BHCS) and its provider partners have been committed to improving the quality of life among mental health and substance abuse consumers and their families. Through more than 900 mental health and substance abuse programs, BHCS treats more than 42,000 Alameda County residents each year.

Over the last six years, BHCS has become a national leader in many areas relating to the transformation of the mental health system, recognizing that we must identify and address ways in which we can improve our services, specifically as they apply to the needs of our community.

The attached Cultural Competence Plan presents our strategies for delivering culturally effective behavioral health care services to the individuals and their families who make up the multi-ethnic, multi-cultural communities in Alameda County. I would like to thank both staff and members of the Cultural Responsiveness Committee for their commitment and partnership in making these advancements possible.

Sincerely,

Marye L. Thomas, M.D.
Director, Alameda County Behavioral Health Care Services
Alameda County home to 1.5 million people
Mural displaying Native American culture, spirits and pride
Lake Merritt, Oakland, CA
CRITERIA 1: COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

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.

Alameda County Behavioral Health Care Services (BHCS) is committed to promoting a system of care that is both culturally responsive and socially just. BHCS understands the importance of reflecting this philosophy through our day to day operations, and holds our contracted providers equally accountable. We have made every attempt to fully incorporate our policies, procedures and practices to be reflective of a system of care that recognizes and values the racial, ethnic, linguistic and cultural diversity of our county. Alameda County is arguably one of the most ethnically and culturally diverse counties in the state, and this is another reason that BHCS has embraced this process. BHCS recognizes the added benefits our clients/consumers, their family members and loved ones, providers and other stakeholders will receive upon full execution and implementation of this plan.

BHCS has enhanced its Quality Improvement (QI) Department by hiring a QI Director and restructuring this department in an effort to cluster key system transformative initiatives/mandates in order to more intentionally support their success. Please see Attachment -1 I A-1, the Administrative Organizational Chart for more information. By placing the Cultural Responsiveness Office under QI, BHCS is able to better support and infuse Cultural Responsiveness through out our entire system of care. Under QI, there is a plan to have the Cultural Competence/Ethnic Services Manager (CC/ESM) work even more directly with the Directors of each of the four age-based Systems of Care. This approach ensures a more in-depth consultation with the CC/ESM around the planning and implementation of new and restructured programs, and that these programs incorporate the core principles of cultural responsiveness to the greatest extent possible.

In this plan you will find a strategic approach to address issues of disparities; further our efforts to identify root causes; and develop practices to effectively address and move toward the elimination of racial, ethnic, cultural and linguistic disparities. Specific efforts are underway in many of our unserved, underserved and inappropriately served communities. As an example, please see Attachment – 1 I A-2, the Power Point Presentation developed for the African American Utilization Study which focused on identifying recommendations to reduce the disparities in the African American Community.

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

We have attached the following documents and will make copies of each readily available to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. BHCS Mission, Vision and Values Statement (Attachments -1 I B-1);
2. Strategic Plans from the County of Alameda (Attachment 1 I B-2: http://www.acgov.org/strategic.htm); the BHCS Transition-Age Youth (TAY) System of Care (Attachment 1 I B-3: http://www.acbhcs.org/TAY/docs/tay_report_final_check.pdf); the BHCS Children’s System of Care/Early Childhood Connections (excerpt on section about Cultural and Linguistic Competence - Attachment 1 I B-4);
3. Diversity Program Policy Statement (Attachment -1 I B-5)
4. Contract Requirements; and Letter from the BHCS Director and CC/ESM (Attachment -1 I B-6)
5. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence) (Attachments -1 I B-7-1; Attachments -1 I B-7-2; Attachments -1 I B-7-3)

ACBHCS Transitional Age Youth Advisory Committee members
II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system

A. Description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Understanding the diversity within our system, it was important to take a snapshot of the county’s population and design an inclusive and collaborative system to improve our stakeholder input process. We recognized the value of capitalizing on the richness of our county’s diversity. We wanted to be as reflective of the community as possible yet honor the fact that not all communities may want to engage in our county process. The CC/ESM participated in a cultural broker stakeholder training offered by CiMH in 2008. The training offered insights to what is essential to ensure input and inclusion from all community interest. The knowledge gained at the training was rich and put to good use. The CC/ESM gave support and provided critical advice to our system as we developed advisory committees/boards/planning committees and other stakeholder processes.

Our BHCS Cultural Responsiveness Committee (CRC) worked with our MHSA Ongoing Planning Council Steering Committee to adopt guidelines to ensure a full representation of our diverse county, where more than 70% of the residents are people of color, on BHCS community decision making bodies. These guidelines compliment earlier established policies such as having a designated slot for a faith/spiritual representative as well as building committees with 1/3 clients/consumer, 1/3 family (using a broad definition for family - see Attachments – 1 II A-1 & 1 II A-2) and 1/3 provider and other stakeholder participants. (CCC recommendations Attachment –1 II A-3) OPC membership roster (Attachments 1 II A-4).

Early in the MHSA community planning processes, BHCS found that some stakeholders were anxiously waiting for more opportunities to speak out and share the needs of their communities with BHCS. These included representatives from the Hispanic/Latino, Asian/Pacific Islander (API) and Native American communities, as well as consumers, family members and representatives from age-based, faith-based and other cultural groups. They wanted to provide input that could result in better services as well as more funding to their communities under the banner of MHSA. Many of their leaders were already attending meeting or had been invited to the processes, but may not have had the supports in place to attend regularly or in high enough numbers to influence change.

To address this issue, BHCS staff identified potential linguistic, cultural, social and environmental barriers that make it difficult for some communities to effectively participate. These barriers were poor staffing capacities at ethnic specific organizations that prohibited attendance; language barriers; childcare; time of scheduled meetings; transportation issues; and anxieties and lack of understanding about how to participate in these types of groups. The following list includes strategies that BHCS has found helpful in addressing these identified barriers:

- Holding the meetings later in the work day;
- Offering interpretation services;
- Financial reimbursements and others incentives; and
- Providing new members with orientation and a mentor/buddy prior to their first meeting.

The Afghan, South Asian and Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex (LGBTQQI) communities, and those with complex issues, needed additional assistance in order to meaningfully participate. These groups experienced the already identified barriers as well as others systemic issues; and therefore needed individualized outreach, technical assistance (TA) and support before they could be engaged to feel comfortable involving themselves with the BHCS’ community planning efforts. Most of this early engagement was done by the
CC/ESM. For example, the CC/ESM attended monthly meetings and provided TA to the Afghan Community leaders for over a year in order to build relationships and an understanding of how the Afghan Community could participate in BHCS planning processes in order to improve mental health outcomes within this group. These meetings were hosted by a Board of Supervisor Member and held in the southern region of the county to best accommodate the attendees.

Noticeably missing from these initial processes were representatives of the African American community. Although the African American consumers/clients receive a disproportionately high amount of services, this group was not initially well engaged in the MHSA planning process. The State DMH recognized the need to address underserved populations but did not prioritize the needs of African Americans as an inappropriately served group.

Since the passage of the MHSA, all of the BHCS community outreach, engagement and involvement efforts have emphasized the inclusion of diverse stakeholders, and the participation of consumers and family members. Through a Continuous Quality Improvement (CQI) model, BHCS is continually seeking to enhance the meaningful participation of diverse groups in our stakeholder processes; to identify gaps in previous planning processes; and to address these gaps in future planning efforts. For example, BHCS received input from community stakeholders that African Americans and the LGBTQQI community may not have been sufficiently addressed through the MHSA Planning Processes for CSS, WET and PEI. In response to this feedback, the CC/ESM has convened specific Cultural Responsiveness Committee (CRC) subcommittees to heighten awareness on improving mental health outcomes among these groups.

More information specific to the MHSA Planning processes for Community Services and Supports (CSS); Workforce Education and Training (WET); and Prevention and Early Intervention (PEI) is included under Criteria III: Items I and II.

**B. Narrative description addressing the county’s current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system’s planning process for services.**

After almost four years of implementing MHSA programs, BHCS now has planning committees and boards that are both culturally and ethnically reflective of the diverse community it serves. For examples, please see the OPC roster and demographics (Attachments – 1 II B-1) and the MHB roster and demographics (Attachment -1 II B-2).

BHCS is most proud of the progress that was made to engage consumers. Under the leadership of our nationally recognized Consumer Relationship Manager and his team of consumer support staff, we have built a strong and empowered body of consumers who are called the Pool of Consumer Champions (POOC). They are a culturally and ethnically diverse group of more then 400 individuals with personal histories of behavioral health issues. There are informal translators among the POCC members to promote the inclusion of consumers with limited English proficiency.

The POCC has more then 13 committees of their own, with several focused on ethnic specific issues such as the API Committee, the Latino/Hispanic Committee and the Black Male Issues Committee. There is also a Transition-Age Youth (TAY) Committee to address issues specific to TAY and a BHCS TAY Advisory Board which is very ethnically reflective of the TAY receiving services in Alameda County. The group embraces Wellness and Recovery values and principles and works closely with the staff of the county operated Wellness and Recovery Hub which provides technical assistance to our system of care.
Recognizing that not all consumers would be interested in joining the POCC, for cultural and other personal reasons, the CC/ESM provides additional opportunities for input and participation. For example, the CC/ESM has found that working with spiritual and faith communities to do outreach and engagement with some ethnic, linguistic and cultural groups to be a mutually beneficial strategy. These clients/consumers are offered the same opportunities to sit on boards attend trainings and conferences and have their voices heard. Translation services are available for individuals with limited English proficiency.

Many consumers are seated on BHCS community decision making bodies such as the MHSA Ongoing Planning Council; the Mental Health Board; the Cultural Responsiveness Committee (CRC); the Budget Committee; the Spirituality Work Group; the CBO - Providers Board of Directors; and the Contract Procurement RFP processes to name a few.

The voices of the family members are also empowered, serving in the same BHCS decision making bodies as the consumers. For more then 10 years many family representatives have held a monthly meeting with the BHCS Director to address specific family concerns as they arise. Two years ago, with MHSA funding, a well informed and knowledgeable Family Relations Manager was hired and works closely with family members and organizations such as our three Alameda County NAMI affiliates. She also works closely and monitors our Family Education Resource Center which was the first of its kind in California. The strong background of the Family Relations Manager spans the age groups, which positions BHCS well to address issues of concerns for family members and loved ones with clients/consumers in all four of our age-based systems of care.

Both the Consumer Relations Manager and the Family Relations Manager work closely with the CC/ESM to ensure the voice of linguistically diverse, unserved, underserved and inappropriately served groups are represented. Both the Consumer Relations Manager and the Family Relations Manager have seats on the BHCS Executive team where they can best inform our agency about the needs of their constituents and set policies to ensure inclusion of the highly valued lived experience voice. The consumer and family member Financial Reimbursement Policy mentioned above helps ensure that barriers to participation are reduced or removed. An enhanced reimbursement rate is offered to consumers and family members who assist with interpretation.
BHCS Leadership recognizes the complexity involved with underserved communities engaging with county processes that may be unfamiliar to them. Prior to implementing the PEI planning process, BHCS received a request from the Ethnic Languages and Disparities Committee (ELDC), which is a subcommittee of the CRC focused on serving the needs of the API, Latino/Hispanic, Native American and Afghan communities. The ELDC’s request was for there to be two separate planning panels to ensure the underserved communities’ voices and concerns would be addressed. This request was granted by BHCS leadership. This resulted in the five known as the Underserved, Ethnic Language Programs (UELP’s) receiving significant MHSA PEI funding.

The planning process for the UELP Planning Panel was staffed by the CC/ESM who identified and suggested a facilitator from the API community who was then interviewed by representatives of all the participating communities. Once approved for hire, the facilitator designed an innovative approach, thus building a team that worked well and resulted in long lasting collaborative relationships between the ethnic communities involved. Each group received valuable insights about the other UELP groups and a shared commitment to supporting each other when funding decisions were made in the MHSA Ongoing Planning Council.

This unity was evident when a decision was made to separate funding for the Afghan Community and to designate specific funding for the South Asian Community. Instead of four UELP Prevention programs receiving funding, five communities received MHSA PEI dollars. Because Alameda County’s City of Fremont has the largest population of Afghan people outside of Afghanistan, this decision received strong community support.

C. Narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

The CC/ESM stays abreast of all local and statewide opportunities to better engage and strengthen cultural communities with limited or no existing capacity to deliver essential services, such as those related to behavioral health. The goal is to build up the skills of providers who offer essentials services, but need additional support to work successfully with larger public entities, such as the BHCS system of care.

In this current year, the ESM identified twelve ethnic specific providers and supported them to get involved with a capacity building project CiMH is facilitating through a contract with DMH. Please see Attachment 11 C for more information about the CiMH CBO Building Capacity Project. These providers were encouraged to attend by the CC/ESM because the target populations they desire to serve are those with limited English proficiency, or from unserved underserved or inappropriately served populations. The providers have either no, or limited resources to move their efforts forward and had previously contacted the CC/ESM seeking technical support and advice. By participating in this project, each provider had an opportunity to develop a work plan and receive technical assistance from a consultant to help them achieve their prescribed goal to be better positioned to get funding from counties and other funding entities. For some of these providers, their needs are support getting their 501c status or building their boards. For other more established agencies, it is more concrete support to build up their infrastructure and identify and eliminate gaps in services.

Most recently the CC/ESM has been supporting the BHCS MHSA planning team to spread the word about the new Innovative Grants Program. These funding dollars provides an excellent opportunity for agencies such as those mentioned above to submit a proposal and teach our system how to work more effectively with these communities. They can suggest using “practiced based strategies” that may be traditional for their community but new to our system of care. To promote learning about creative ideas that are new to the field of mental health, the vendor minimum requirements are much less stringent for the Innovative Grants Program than for traditional BHCS Requests for Proposals (RFPs).

D. Share lessons learned on efforts made on the items A, B, and C above.
Some of the strategies put in place to increase the participation of unserved, underserved and inappropriately served groups had to be rethought and modified in order to achieve the desired results. For example, although it is generally a good idea to ensure voices from all communities are heard, joining a committee can be very frightening and anxiety provoking – especially for consumers and family members that are expected to represent a diverse community alone and who have only recently been invited to the table. Rather than inviting one representative from each community, BHCS now tries to ensure that: more then one representative from a specific community gets seated; and that a culturally similar provider is paired up to support the consumer or family member from that same group. Providers typically have more experience with speaking up and can model and support this for consumers and family members. Often the process is too intimidating for a solo voice to have an impact; and there is strength and security in numbers.

As was mentioned earlier, the voice from some linguistically, culturally and ethnically diverse communities may not have been adequate earlier on in the process; and that this may have resulted in a lack of planning and recommendations to specifically address the needs of that community. For example, as the CC/ESM worked with the UELP PEI Planning Panel, the General PEI Planning Panel had very little advocacy supporting funding for the over, or inappropriately served African American Community. In Alameda County, the PEI guidelines were a barrier to serving the African American population by their emphasis on serving underserved cultural groups, which didn’t at that time include the African American community. Instead, African Americans receive a disproportionately high rate of behavioral health services, which is incongruent with the poor mental health outcomes among this population.

Many of the programs funded from the general PEI planning efforts will serve the African American Community. The CC/ESM is working with the System of Care Directors, the procurement staff and the contract monitors to implement these new PEI programs in a culturally responsive manner as demonstrated in their hiring practices, training plans and plans for engaging individuals with or at risk for serious mental health issues and their families. In hiring we have learned that it is important that programs ask more than: “Do you have experience working with people of color?” In Alameda County, most clinicians can easily answer yes to that question because the African American population is so disproportionately served. However, a more informing question is; “Have you had demonstrated success using culturally relevant approaches working with people of color?”

Despite several strong individual advocates, a cohesive voice advocating for strategies and funding to address the needs of the LGBTQQI community and individuals with multiple/complex issues (such as co-occurring physical disabilities) was also missing from the initial stakeholder processes.

Over the past two years, the CC/ESM has spearheaded efforts to convene stakeholders from the African American and LGBTQQI communities to raise awareness about mental health issues among these populations. The CC/ESM has initiated Cultural Responsiveness Committee (CRC) subcommittees to better address the needs of each of these groups. Over the next year, the CC/ESM will work with the CRC to also convene stakeholders around the issue of co-occurring physical disabilities.

The CC/ESM has learned to employ addition stakeholder strategies to promote more effective advocacy. The CC/ESM will continue to utilize the skills of the CRC members and colleagues in the QI Unit and BHCS managers as well as seek out additional supports and allies. These and other resources should help to address identified gaps to ensure the most inclusive and effective process in future planning efforts.

E. Identify county technical assistance needs.

At this time there are no specific identified technical assistance needs out side of an acknowledgement of the need for increased staff capacity. The CC/ESM will continue to collaborate with others in her networks to ensure that she is meeting the needs of all communities as effectively as possible in this difficult fiscal climate.
III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

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.*

In May 2008, Gigi R. Crowder was hired into the role of Cultural Competency/Ethnic Services Manager (CC/ESM). She brought with her 20 years of experience in public community health, working closely with ethnic, cultural and limited English proficiency communities. She identifies as a family member and is a dedicated client/consumer advocate.

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

**CC/ESM Job Expectations and Responsibilities:**

- Providing leadership in the area of promoting culturally responsive services. The CC/ESM is required to be knowledgeable in the principles of cultural competence and also demonstrate the ability to work effectively with culturally diverse staff and communities within the county.

- Chairing the Cultural Responsiveness Committee (CRC). The Cultural Competence Committee for BHCS is called the Cultural Responsiveness Committee (CRC) and has several sub committees and two workgroups. The CC/ESM is responsible for making sure the efforts of the committees and workgroups reflect the activities outlined in the Cultural Competency Plan approved by the DMH.

- Coordinating key individuals to promote the infusion of cultural competence into each respective area of service planning and delivery. This includes ensuring that either the CC/ESM or another CRC member participate in all BHCS planning committees.

- Promoting language access through the identification of competent behavioral health interpreters and translators; as well as other resources to promote access among individuals with limited English proficiency. Supporting all staff, including contractors and all other system partners, to utilize culturally responsive practices in their work with BHCS clients, family members and other staff.

- Providing guidance towards achieving and maintaining culturally responsive Policies and Procedures throughout the BHCS network of care.

- Providing consultation and technical assistance to staff members and community stakeholders in the area of cultural responsiveness and assist in the development and dissemination of culturally and linguistically appropriate literature and educational materials. The CC/ESM provides leadership to address the biases, prejudices, stereotypes and related “isms.”

- Serving as a bridge between cultural communities, families and age specific providers, community agencies and other stakeholders. This includes developing connections and formal/informal agreements with racial, ethnic, cultural and other diverse groups in the community.

- Advocating on behalf of cultural communities within the system of care and partner agencies.
• Assisting in the coordination of trainings. This position further assists in the development of a training plan and training performance standards to enhance the ability of staff to provide culturally responsive services.

• Participating in the resource mapping process, to identify key stakeholder groups for representation on committees. This includes ethnic, racial, and cultural groups.

Cultural Competency Coordinator/Ethnic Services Manager, Attachment 1 III B-1 Budgeted Position, Senior Program Specialist Classification.
IV. Identify budget resources targeted for culturally competent activities

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

Attachment 1 IV A-1 provides evidence of monies that were spent in the last year on BHCS Trainings and sending staff, consumers/clients and family members to external trainings that enhance our ability to responsively serve a diverse community.

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.

BHCS allocated more than $500,000 over the past two years to advance efforts to enhance services for unserved, underserved and inappropriately served communities. Included in this was a survey we conducted to ascertain how faith and spiritual practices support consumers and family members as they work toward mental wellness. This survey was instrumental in helping us better engage underrepresented cultural and linguistic communities. Please see the attachments listed below for more information about the BHCS funding allocations to support this work.

- Attachment 1 IV B-1 ION Invoice for Translations for MH Spirituality Surveys
- Attachment 1 IV B-2 CIMH Consultant Contract-Dr. Morrow
- Attachment 1 IV B-3 Draft-Consumer Family Reimbursement Policy
- Attachment 1 IV B-4 African-American Utilization Study Contract
I. General Population

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.

The total population for Alameda County is estimated at 1,457,169. The below tables describe the proportional breakdown of Alameda County’s population by race, ethnicity, age and gender. This data is from the American Community Survey Demographic and Housing Estimates: 2006-2008 (website: http://www.census.gov/).

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<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Latino</td>
<td>21%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>3%</td>
</tr>
<tr>
<td>All Other</td>
<td>2%*</td>
</tr>
<tr>
<td>Black</td>
<td>13%</td>
</tr>
<tr>
<td>Asian</td>
<td>24%</td>
</tr>
<tr>
<td>White</td>
<td>37%</td>
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<table>
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<tr>
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<tbody>
<tr>
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<td>7%</td>
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<tr>
<td>5-9 yrs</td>
<td>6%</td>
</tr>
<tr>
<td>10-14 yrs</td>
<td>6%</td>
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<td>15-19 yrs</td>
<td>7%</td>
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<td>7%</td>
</tr>
<tr>
<td>25-44 yrs</td>
<td>30%</td>
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<tr>
<td>45-54 yrs</td>
<td>15%</td>
</tr>
<tr>
<td>55-59 yrs</td>
<td>6%</td>
</tr>
<tr>
<td>60-64 yrs</td>
<td>5%</td>
</tr>
<tr>
<td>65+ yrs</td>
<td>11%</td>
</tr>
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* Other includes Native American (0.3%) and Some Other Race (0.5%).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>51%</td>
</tr>
<tr>
<td>Male</td>
<td>49%</td>
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II. Medi-Cal population service needs (Use current CAEQRO data if available.)

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).

In 2009, there were a total of 258,231 full-scope Medi-Cal beneficiaries in Alameda County. There were a total of 23,409 unique Medi-Cal clients who received any type of mental health services, and the utilization rate among full-scope Medi-Cal beneficiaries for any type of mental health service was 9.1%.

The reported EQRO data included only “selected mental health services” and excluded those provided in the hospital, Guidance Clinic, jail, crisis stabilization, and subacute settings. For consistency, the “selected mental health services” were used to calculate Medi-Cal utilization for the remainder of this report. In Alameda County, the total unique Medi-Cal clients for “selected mental health services” was slightly lower (20,787) than for any type of mental health service (23,409). The utilization rate was also lower for “selected mental health services” (8.0%) than for any type of mental health service (9.1%).

The following sub-sections provide further details on Medi-Cal beneficiaries compared with Medi-Cal clients who have received select mental health services by ethnicity, age, language, and gender. For the remainder of this section, the term “Medi-Cal clients” will refer to Medi-Cal clients that have received select mental health services.

Ethnicity

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Medi-Cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
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<tbody>
<tr>
<td>African American</td>
<td>76,295</td>
<td>8,443</td>
<td>11.1%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>59,690</td>
<td>2,292</td>
<td>3.8%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>33,833</td>
<td>4,520</td>
<td>13.4%</td>
</tr>
<tr>
<td>Latino</td>
<td>65,538</td>
<td>3,592</td>
<td>5.5%</td>
</tr>
<tr>
<td>Native American</td>
<td>943</td>
<td>106</td>
<td>11.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>21,932</td>
<td>1,834</td>
<td>8.4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>258,231</strong></td>
<td><strong>20,787</strong></td>
<td><strong>8.0%</strong></td>
</tr>
</tbody>
</table>

Since 2006, African Americans have been the largest ethnic group among both Medi-Cal beneficiaries and Medi-Cal clients. The number of African American beneficiaries increased 10% between 2006 and 2009, so did the number of unduplicated African American clients. The percentage of African Americans seen (i.e. the penetration rate) was 11% in both 2006 and 2009.

Since 2006, Native Americans have been the smallest ethnic group in both Medi-Cal beneficiaries and Medi-Cal clients. Nevertheless, the numbers among Native Americans have increased steadily, with a 31% increase in Medi-Cal beneficiaries and 39% increase in Medi-Cal clients between 2006 and 2009. The penetration rate for Native Americans increased from 10.5% in 2006 to 11.2% in 2009.

Caucasians have had the highest penetration rate and the lowest population growth rate. Between 2006 and 2009, Caucasian Medi-Cal beneficiaries increased by 9% and Caucasian Medi-Cal clients went up 5%. Whereas only 13% of Medi-Cal beneficiaries were Caucasian, they made up 22% of the Medi-Cal clients.
Asian/Pacific Islanders (APIs), on the other hand, comprise 23% of the Medi-Cal beneficiaries but only 11% of the Medi-Cal clients. Between 2006 and 2009, the number of API Medi-Cal beneficiaries increased by 22% (or by 10,613 beneficiaries), but the number of API Medi-Cal clients increased by only 7% (or by 158 clients). In all, African Americans, Caucasians, and Native Americans were served about three times the rate of APIs, who had the lowest penetration rate for receiving the select mental health services.

Between 2006 and 2009, the largest growth in both Medi-Cal beneficiaries and Medi-Cal clients occurred in the Latino population. Between 2006 and 2009, the number of Latino Medi-Cal beneficiaries increased by 34% (or 16,565 beneficiaries) and the number of Latinos clients increased by 45% (or 1,116 clients). As a result, the percentage of Latino beneficiaries seen (i.e. penetration rate) went from 5.1% in 2006 to 5.5% in 2009, which was one of the largest increases among all ethnicities during those years. In 2007, Latinos became the second largest ethnic group among the Medi-Cal beneficiaries. In 2009, 1-in-4 (or 25%) of the Medi-Cal beneficiaries were Latino. If the strong growth trajectory continues, there will be an even greater need for mental health services for this population.

### Age

#### Table 2: Medi-Cal Beneficiaries and Clients by Age and Ethnicity (Alameda County, 2009 – Page 1 of 2)

<table>
<thead>
<tr>
<th>Age</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Ages</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>76,295</td>
<td>8,443</td>
<td>11.1%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>59,690</td>
<td>2,292</td>
<td>3.8%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>33,833</td>
<td>4,520</td>
<td>13.4%</td>
</tr>
<tr>
<td>Latino</td>
<td>65,538</td>
<td>3,592</td>
<td>5.5%</td>
</tr>
<tr>
<td>Native American</td>
<td>943</td>
<td>106</td>
<td>11.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>21,932</td>
<td>1,834</td>
<td>8.4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>258,231</td>
<td>20,787</td>
<td>8.0%</td>
</tr>
<tr>
<td><strong>Children 0-17 Years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>32,418</td>
<td>3,606</td>
<td>11.1%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>17,018</td>
<td>450</td>
<td>2.6%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>8,996</td>
<td>1,052</td>
<td>11.7%</td>
</tr>
<tr>
<td>Latino</td>
<td>44,246</td>
<td>2,263</td>
<td>5.1%</td>
</tr>
<tr>
<td>Native American</td>
<td>364</td>
<td>42</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>8,309</td>
<td>583</td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>111,351</td>
<td>7,996</td>
<td>7.2%</td>
</tr>
<tr>
<td><strong>TAY 18-24 Years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>9,559</td>
<td>829</td>
<td>8.7%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>4,323</td>
<td>154</td>
<td>3.6%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2,944</td>
<td>281</td>
<td>9.5%</td>
</tr>
<tr>
<td>Latino</td>
<td>5,210</td>
<td>299</td>
<td>5.7%</td>
</tr>
<tr>
<td>Native American</td>
<td>96</td>
<td>4</td>
<td>4.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>1,650</td>
<td>127</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>23,782</td>
<td>1,694</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
Table 2: Medi-Cal Beneficiaries and Clients by Age and Ethnicity (Alameda County, 2009 – Page 2 of 2)

<table>
<thead>
<tr>
<th>Transition-Age Youth (TAY) 18-24 Years</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>9,559</td>
<td>829</td>
<td>8.7%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>4,323</td>
<td>154</td>
<td>3.6%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2,944</td>
<td>281</td>
<td>9.5%</td>
</tr>
<tr>
<td>Latino</td>
<td>5,210</td>
<td>299</td>
<td>5.7%</td>
</tr>
<tr>
<td>Native American</td>
<td>96</td>
<td>4</td>
<td>4.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>1,650</td>
<td>127</td>
<td>7.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23,782</td>
<td>1,694</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults 25-59 Years</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>26,140</td>
<td>3,594</td>
<td>13.7%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>15,153</td>
<td>1,361</td>
<td>9.0%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>13,370</td>
<td>2,606</td>
<td>19.5%</td>
</tr>
<tr>
<td>Latino</td>
<td>10,715</td>
<td>945</td>
<td>8.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>379</td>
<td>54</td>
<td>14.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>6,040</td>
<td>904</td>
<td>15.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>71,797</td>
<td>9,464</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older Adults 60+ Years</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>8,178</td>
<td>414</td>
<td>5.1%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>23,196</td>
<td>327</td>
<td>1.4%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>8,523</td>
<td>581</td>
<td>6.8%</td>
</tr>
<tr>
<td>Latino</td>
<td>5,367</td>
<td>85</td>
<td>1.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>104</td>
<td>6</td>
<td>5.8%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5,933</td>
<td>220</td>
<td>3.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>51,301</td>
<td>1,633</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Between 2006 and 2009, the highest percentage increase in Medi-Cal beneficiaries (32%) was among Transition-Age Youth (TAY); however, children under 18 years had the largest absolute number of new Medi-Cal beneficiaries (17,150). This increase in new child beneficiaries made up over 40% of the overall growth among Medi-Cal beneficiaries, and two thirds (or 11,442) of these new child beneficiaries were Latino.

In 2009, both Children and TAY had the same penetration rate of 7%. Adults, who made up over 45% of the Medi-Cal clients, had the highest penetration rate of 13%, which was more than four times higher than the penetration rate among Older Adults (3%) and nearly twice as high as the rate among Children and TAY (7%).

The penetration rate among Older Adults has been the lowest of all age groups but it has been consistently increasing, despite a growing Older Adult Medi-Cal beneficiary population. In fact, between 2006 and 2009, the number of Older Adult Medi-Cal clients receiving selected mental health services increased by 33%, while the number of Older Adult Medi-Cal beneficiaries grew only 17%, increasing the penetration rate from 2.8% to 3.2%.

Gender

Table 3: Special Population Medi-Cal Beneficiaries and Clients by Gender (Alameda County, 2009)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>146,288</td>
<td>11,344</td>
<td>8%</td>
</tr>
<tr>
<td>Male</td>
<td>111,943</td>
<td>9,444</td>
<td>8%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>258,231</td>
<td>20,787</td>
<td>8.0%</td>
</tr>
</tbody>
</table>
Table 3 shows the County Medi-Cal beneficiaries and clients by gender. 57% of the Medi-Cal beneficiaries were female, and 43% were male. 55% of the Medi-Cal clients were female, and 45% were male. The gender ratio between males and females has remained consistent since 2006 for both Medi-Cal beneficiaries and Medi-Cal clients.

**Language**

<table>
<thead>
<tr>
<th>Language</th>
<th>Medi-cal Beneficiaries</th>
<th>Unique Medi-Cal Clients</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>154,578</td>
<td>14,697</td>
<td>10%</td>
</tr>
<tr>
<td>Spanish</td>
<td>42,696</td>
<td>1,698</td>
<td>4%</td>
</tr>
<tr>
<td>Chinese</td>
<td>18,413</td>
<td>333</td>
<td>2%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>8,263</td>
<td>342</td>
<td>4%</td>
</tr>
<tr>
<td>Farsi</td>
<td>3,314</td>
<td>371</td>
<td>11%</td>
</tr>
<tr>
<td>Missing/Other</td>
<td>22,736</td>
<td>2,984</td>
<td>13%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>258,231</strong></td>
<td><strong>20,787</strong></td>
<td><strong>8%</strong></td>
</tr>
</tbody>
</table>

Since 2006, English, Spanish, Chinese, Vietnamese, and Farsi have been the top five language groups within Alameda County. English has had the largest number of primary speakers among both Medi-Cal beneficiaries and Medi-Cal clients. Spanish has been the second largest language group, followed by Chinese (including Cantonese, Chinese and Other Chinese), Vietnamese, and Farsi.

In 2009, 60% (or 154,578) of the Medi-Cal beneficiaries and 71% (or 14,697) of the Medi-Cal clients in Alameda County listed English as their primary language. 17% (or 42,696) of the Medi-Cal beneficiaries reported being primary speakers of Spanish; however, only 8% of the Medi-Cal clients listed Spanish as their primary language.

Between 2006 and 2009, the number of Spanish-speaking Medi-Cal beneficiaries increased by 37%, which was the largest increase of all languages. The number of English- and Chinese-speaking Medi-Cal beneficiaries increased by 20% each, while Vietnamese and Farsi decreased by nearly 8% and 5% respectively.

The increase in Spanish-speaking Medi-Cal clients was even greater than the increase among Medi-Cal beneficiaries. Between 2006 and 2009, the number of Spanish-speaking Medi-Cal clients increased from 1,038 to 1,698, a 64% increase.

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

In addition to the information in this section, a more structured description of the selection process, rationale and analysis of identified disparities for the PEI priority populations is included under Criterion 3: Items I and II. Objectives for these defined disparities will be identified in Criterion 3, Section III.

As mentioned in Section A, the largest growth in both Medi-Cal beneficiaries and Medi-Cal clients came from the Latino ethnic group, yet Latinos were among the least served. Although the Latino penetration rate increased from 5.1% in 2006 to 5.5% in 2009, it was still second to lowest among the ethnic groups and considerably lower than the 8% County average.

The API Medi-Cal beneficiaries have the lowest penetration rate across all of the ethnic groups. In 2009, 1-in-5 Medi-Cal beneficiaries was Asian/Pacific Islander, but only 1-in-10 Medi-Cal clients was API. The API penetration rate of 3.8% was well below the Latino penetration rate of 5.5% and a very long way from the 8% County average.
The rate of full-scope Medi-Cal beneficiaries receiving mental health services varied greatly by ethnicity in part due to the different levels of eligibility characteristics in the Medi-Cal population. When we took a closer look at the Medi-Cal beneficiary population in Alameda County, we found that in 2009, about 29% of African-Americans and Native Americans had Medi-Cal related to a disability or foster care. The rate was 37% for Caucasians, 12% for Asian/Pacific Islanders, and 8% for Latinos.

The adjustment – the calculation of penetration rates for the disability or foster care related Medi-Cal “Special Population” – shows that the penetration rate (21%) was two and a half times higher among the disabled and foster care Medi-Cal population, compared to the penetration rates among the general population of Medi-Cal beneficiaries (8%).

Ethnicity: Special Populations

For this Special Population that has Medi-Cal due to a disability or foster care, the disparity in penetration rates was quite insignificant between the ethnic groups. For example, as shown in the table below, APIs were served at about the same rate as African Americans, Caucasians, and Native Americans. Also, the difference in penetration rate between Latinos (18%, the lowest) and Caucasians (23%, the highest) was considerably smaller than the difference among the general population of Medi-Cal beneficiaries, where APIs had the lowest penetration rate of 3.8% and Caucasians had the highest penetration rate of 13.4%.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Medi-Cal Beneficiaries (Special Population)</th>
<th>Medi-Cal Clients (Special Population)</th>
<th>Penetration Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>22,085</td>
<td>4,588</td>
<td>21%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>7,310</td>
<td>1,480</td>
<td>20%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>12,642</td>
<td>2,890</td>
<td>23%</td>
</tr>
<tr>
<td>Latino</td>
<td>4,977</td>
<td>876</td>
<td>18%</td>
</tr>
<tr>
<td>Native American</td>
<td>274</td>
<td>63</td>
<td>23%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>7,064</td>
<td>1,387</td>
<td>20%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>54,352</strong></td>
<td><strong>11,284</strong></td>
<td><strong>21%</strong></td>
</tr>
</tbody>
</table>

Age and Ethnicity: Special Populations

Before the adjustment (i.e. calculation of penetration rates for the disability or foster care related Medi-Cal “Special Population”), API adult Medi-Cal beneficiaries had one of the lowest penetration rates of 9%. With adjustment, the Medi-Cal Special Population data shows that API adult beneficiaries had the highest penetration rate of 31%.

The data on the disabled and foster care Special Population revealed the important fact that those who were on Medi-Cal because they were financially disadvantaged and receiving cash aid (such as CalWORKs benefits) but not necessarily in need of medical or mental health care services have kept the County’s Medi-Cal penetration rate low and have also widened the gap between ethnicities. The result of the adjustment shows that mental health services were provided not only at a much higher rate but also more uniformly across ethnicities for those who received Medi-Cal related to a disability or foster care.

Nevertheless, disparities in penetration rates for this adjusted Special Population still exist. In 2009 among the Special Population, African-American, Caucasian, and Native American Children were served at over twice the rate of API Children (20%); and the rates for Latino Children are in-between (30%). In fact, Older Adults have had the lowest penetration rate (10%) among all age groups since 2006. Latino and API Older Adults were
especially underserved – they had the very lowest penetration rates (5% and 8% respectively) and were the least served compared to all other ethnicities in all age groups.

Language: Special Populations

The Special Population that had Medi-Cal related to disabilities or foster care, showed a much higher penetration rate across language groups, and the disparity was less significant between language groups. For example, the rate of Chinese-speaking Medi-Cal beneficiaries receiving mental health services was 2% for all beneficiaries and 14% for beneficiaries within this Special Population. Among the Special Population, the penetration rate was 21% for English-speaking Medi-Cal beneficiaries, 21% for Vietnamese-speaking beneficiaries, and 31% for Farsi-speaking beneficiaries, while the average penetration rate was 21%.
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).**

The narrative and tables below show the County population living below 200% of the Federal Poverty Level (FPL) (minus the Medi-Cal population) by race, ethnicity, age and gender. Please note that the data on individuals living below 200% of the FPL is not currently available at the local level for language. Alameda County will include updated poverty data based upon Census 2010 when that data is released, including the breakdown of the poverty population by language if available at the local level.

The BHCS Decision Support Unit recommends that BHCS first focus reducing disparities within the Medi-Cal population and then, later, on reducing disparities within the 200% of poverty (minus Medi-Cal) population, as:

1. The Medi-Cal population is already extremely underserved;
2. The poverty data is from Census 2000 and is not an accurate snapshot of the current poverty population; and
3. The Medi-Cal data is newer, from 2009, but does not match the time period of the poverty data – due to population growth, particularly in the poverty population, it may even appear, incorrectly, that the Medi-Cal population is bigger than the poverty population for some groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>200% of Poverty Pop</th>
<th>Medi-Cal Pop</th>
<th>200% of Poverty (minus Medi-Cal) Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>78,151</td>
<td>23%</td>
<td>33,833</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>93,935</td>
<td>28%</td>
<td>65,538</td>
</tr>
<tr>
<td>Non-Hispanic Asian/Native Hawaiian/Other Pacific Islander</td>
<td>69,374</td>
<td>20%</td>
<td>59,690</td>
</tr>
<tr>
<td>Non-Hispanic Black/African American</td>
<td>80,039</td>
<td>23%</td>
<td>76,295</td>
</tr>
<tr>
<td>Non-Hispanic American Indian/Alaska Native</td>
<td>1,848</td>
<td>1%</td>
<td>943</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>17,370</td>
<td>5%</td>
<td>21,932</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>340,717</td>
<td>100%</td>
<td>258,231</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Male</td>
<td>155,503</td>
<td>46%</td>
<td>111,943</td>
</tr>
<tr>
<td>Female</td>
<td>185,180</td>
<td>54%</td>
<td>146,288</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>340,683</td>
<td>100%</td>
<td>258,231</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Children and Youth (&lt;18 years)</td>
<td>117,647</td>
<td>33%</td>
<td>111,351</td>
</tr>
<tr>
<td>Transition-Age Youth (18-24 years)</td>
<td>51,007</td>
<td>14%</td>
<td>23,782</td>
</tr>
<tr>
<td>Adults (25-59 years)</td>
<td>141,043</td>
<td>40%</td>
<td>71,797</td>
</tr>
<tr>
<td>Older Adults (60 years and over)</td>
<td>47,254</td>
<td>13%</td>
<td>51,301</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>356,950</td>
<td>100%</td>
<td>258,231</td>
</tr>
</tbody>
</table>

1 Other/Unknown includes Multiracial for the poverty data, but not for the Medi-Cal population.
B. Provide an analysis of disparities as identified in the above summary.

In terms of race/ethnicity, it appears that Non-Hispanic Whites comprise the largest proportion of the 200% of poverty (minus Medi-Cal) population (54%), followed by Hispanic/Latinos (34%). In terms of age, it appears that adults comprise the largest proportion of the 200% of poverty (minus Medi-Cal) population (70%), followed by transition-age youth (28%). In terms of gender, males comprise just over half (53%) of the 200% of poverty (minus Medi-Cal) population.

Individuals living below 200% of the Federal Poverty Level, who do not have Medi-Cal, are particularly at risk for delayed treatment due to their lack of health insurance and lack of connection with health care providers. This has significant impact on behavioral health needs, as research shows that there is a strong correlation between early treatment and reduced impact of serious behavioral health issues.
IV. MHSA Community Services and Supports (CSS) population assessment and service needs

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).

The following is a copy of the population assessment from Alameda County’s approved CSS Plan, which summarizes population and client utilization data by race, ethnicity, language, age, gender and other factors. This section includes information about prevalence rates and service utilization among different groups. This is a long and detailed population assessment; please note that Item IV.B begins on page 25.

EXCERPT FROM THE CSS PLAN
PART II: PROGRAM EXPENDITURE AND PLAN REQUIREMENTS
SECTION II: ANALYZING MENTAL HEALTH NEEDS IN THE COMMUNITY

Please note that this section was informed by census data given to us by the State Department of Mental Health in addition to utilization data from Alameda County. See Chart B, located at the end of this section, to review the data set used by planning panels to understand mental health needs in the community.

Answers to 2.1, 2.2 and 2.3 present the combined analysis of Alameda County and the City of Berkeley. However, the answer to 2.4 “Objectives ...Related to the Need for Services” is presented first for Alameda County, and then for the City of Berkeley.

2.1 Narrative analysis of the unserved populations by age group, with specific explanations of racial ethnic disparities. Use county population data and any available estimates of unserved populations.

Note: A narrative that explains racial ethnic disparities within the Native American population is included at the end of Question 2.1.

(i) Unserved Children and Youth

Of all children and youth, the youngest (ages 0-5) are the most dramatically unserved population. The first part of the question focuses on a narrative analysis focused on this age group. The question goes on to address ethnic disparities for children and youth ages 0-16.

Young Children

In Alameda County in 2000, comparing the total population of children who are living in households earning <200% Federal Poverty level and estimated to have Serious Emotional Disorders (SED), the children receiving mental health services account for only 31%, the lowest amongst all children 0-17. In assessing the unserved and underserved populations of children aged 0-6 it is necessary to include both the children and the primary caregiver for two reasons. First, the quality of the caregiver/child attachment is a well documented predictor for an individual’s mental health, which makes the 0-6 population key for early intervention and the prevention of future impairment due to mental illness. Second, very young children are completely dependent on an adult for achievement of social and emotional milestones, which places the children of parents with mental illness, including alcohol and drug problems, at very high risk for mental health disorders. The National Academy of State Health Policy reported in 2002 that infants and toddlers of depressed parents are 6-8 times more likely to develop conduct disorders.

Thus, children age 0-6 of parents with mental health disorders, including co-occurring substance abuse, who face peer and family problems, are at risk of out of home placement, school failure and serious emotional disorders. Data related to the issues of homelessness, school failure, out of home placement, peer and family problems and involvement in the child welfare system characterize the unmet needs of the 0-6 child/primary caregiver population in Alameda County bear this out:

- Forty seven percent (47%) of first entries to foster care were between the ages 0-5. (Center for Social Services Research, UC Berkeley, 2005.) Young children who have been removed from the home often experience post traumatic stress symptoms that frequently manifest as behavioral difficulties.
- In 2000, there were 17, 273 allegations of child abuse or neglect with 28% involving children ages 0-5 (Alameda County Child Abuse Council.) Abuse and neglect takes a tremendous toll on young children’s social adjustment and relationships often resulting in multiple symptoms and serious emotional disorders.
- In 2003, the daily count of homeless individuals was 6,215 people – 28% of them were children. (Source: Alameda Countywide Homeless Continuum of Care Council)
2,571, that is 46%, of all primary caregivers were screened for depression by Alameda County First Five Intensive Family Support programs; 1,180 (7%) screened positive. (Source: First Five Alameda County 2003-2004 Annual Report)

- Of the Asian/Pacific Islander and Latino children aged 0-6 living in poverty and estimated to have SED, only 13% and 15%, respectively, were frequent users of mental health services compared with 42% of Caucasian children and 39% of African American children.

- In California, for every 133 pre-kindergarten students, one is expelled. Pre-kindergarten students are expelled at a rate more than three times that of their older peers in the K-12 classes in all but three states in the United States. (Source: National Pre-kindergarten Study, Yale University Child Study Center)

**Ethnic Disparities Among Children and Youth Who Are Unserved and Asian/Pacific Islander or Latino**

Uninsured APIs and Latinos include the working poor whose income is too high to qualify for Medi-Cal but cannot afford private insurance. In addition, many Asians & Pacific Islanders and Latinos do not qualify for, or are fearful of applying for Medi-Cal because of their legal status. (Source: Ponse, N. et al, Advancing Universal Health Insurance Coverage in Alameda County: Results of the County of Alameda Uninsured Survey, UCLA Center for Health Policy Research and Community Voices Project, 2001; Mental Health Needs of APIs Survey/Asian Community Mental Health Services & Asian Pacific Psychological Services, June 2005).

Of the 421 Latinos surveyed (day laborers, seniors, and general public, people needing mental health services) by La Clinica staff and health promoters, 36% said lack of health insurance make it difficult to find help (Source: Mental Needs in the Latino Survey, July 2005).

The ethnic disparity of mental health service utilization is most glaring for children and youth. Nearly 3 out of every 4 (73%) of API children and youth are uninsured and 3 out of every 5 (62%) of Latino children and youth are uninsured, compared with one out of every 4 (25%) of all children and youth. Among API and Latino children and youth, the largest percentage of the prevalence population is served in outpatient services (16% and 21% respectively), while much smaller percentages are served in school (6% and 9% respectively), Level 3 (8% and 14% respectively) and day treatment (2% and 3% respectively). Very few API and Latino children and youth received wraparound and residential services (0% and 1% respectively).

API and Latinos often use the primary health care system for issues that are related to behavioral health needs [Source: Mental Health Needs of Latinos and APIs-La Clinicas; ACMHS & APPS].

Sixty-three percent (63%) of Asians and 43% of Latinos in Alameda County are foreign-born. Latino and Asian immigrants and refugees are at high risk for severe mental illness and serious emotional disturbance due to trauma experienced from war and political strife in their homelands, the stress and loss in leaving their homelands and the adjustment in adapting to a new cultural and social environment. They often experience loss of status and power and intergenerational cultural conflicts between older and younger generations. Older adults experience social isolation, loss of status and dependence on their children. Mental health issues common in immigrant and refugee communities include post-traumatic stress disorder (PTSD), depression, bipolar disorder, anxiety disorder, schizophrenia, alcohol and drugs, domestic violence and suicidal ideation.

There are a number of barriers to accessing services specific to these ethnic communities including:

- Communication style and language: a tendency to towards indirect, non-verbal communication and a lack of bilingual providers
- Cultural stigma and shame associated with mental health issues
- Lack of integration of mental health services with other types of care (e.g. primary health and social services)
- Lack of insurance coverage
- Cultural dissonance

APIs and Latinos are the two fastest growing population groups in California. In Alameda County API’s grew by 60% and Latinos by 37%. API and Latino have the highest % of linguistically isolated households (25% and 22% respectively). Thirty-eight percent (38%) of APIs and 40% of Latinos in Alameda County population speak limited English, and 78% of APIs and 72% of Latinos speak a language other than English at home [Source: US 1990 Census Data].

The language barrier contributes to social and linguistic isolation. All APIs and Latinos that speak a primary language other than English have difficulty accessing care, because there is a lack of bilingual/bicultural services throughout most of the mental health system. Children of immigrant parents also have difficulty accessing care because the system lacks capacity to communicate with their parents.

There is a shortage of mental health professionals who speak API and Latino languages. The greatest unmet need is among those API ethnic/language groups for whom there is the most severe shortage of mental health professionals and paraprofessionals. Some of these groups have immigrated to the country within the last five years and are not counted in 2000 census data. These groups include: Southeast Asian (Burmese, Khmu, Mien, Thai); Pacific Islander (Tongan and Samoan); South Asian (Hindi, Punjabi); Middle Eastern including refugees from Afghanistan (Pashtu, Dari); and East Asian (Mongolian, Tibetan).

In two consumer surveys conducted by Asian Community Mental Health Services (ACMHS), Asian Pacific Psychological Services (APPS) and La Clinica de la Raza, 72% of APIs did not seek help due to language and cultural barriers and 51% of Latinos did not seek help due to lack of knowledge about services. Language and cultural capacity of service providers was also the most frequently mentioned issue in focus groups and interviews conducted with providers [Source: Mental Health Needs of Latinos and APIs, ACMHS, APPS, La Clinica de la Raza].

Uninsured APIs and Latinos includes the working poor whose income is too high to qualify for MediCal but cannot afford private insurance. In addition, many APIs (ranging from 6%-27% by country of origin) and Latinos do not qualify for, or are fearful of applying for MediCal for immigration reasons (Source: Ponse, N. et al, Advancing Universal Health Insurance Coverage in Alameda County: Results of the County of Alameda Uninsured Survey, UCLA Center for Health Policy Research and Community Voices Project, 2001; Mental Health Needs of APIs Survey/ACMHS & APPS, June 2005).
the 421 Latinos surveyed (day laborers, seniors, and general public, people needing mental health services) by La Clinica staff and health promoters, 36% said lack of health insurance makes it difficult to find help (Source: Mental Health Needs in the Latino Community Survey, July 2005).

There is extreme cultural dissonance between systems and community concepts of mental health. An overarching concern that came up in all consumer focus groups is that the conceptualization, language and structure of mental health in the U.S. are in conflict with the ways that many API and Latino cultures think about, talk about and address these issues. The language of mental health is completely foreign to some communities, and may be a deterrent for seeking care. In addition, there is a profound stigma attached to people with mental health problems in many communities. In the API Consumer and Caregiver survey, 62% of responses indicated that reasons for not seeking care are culturally motivated, including religious beliefs, feeling that their problem is not serious enough to warrant seeking mental health support, or fear of evil that is associated with mental illness. [Source: Mental Health Needs of Latinos and APIs-La Clinica; ACMHS & APPS].

(ii) Unserved Transition Age Youth (TAY)

This section begins with a narrative analysis of unserved Transition Age Youth and ends with the recommendations of the Transition Age Youth planning panel regarding ethnic disparities in the unserved TAY population.

The majority of TAY with SED in Alameda County are unserved. According to the DMH prevalence rates and County data on TAY served, at least seventy percent of 16-24 year olds with SED are unserved in Alameda County. Moreover, within this age group there is a significant drop off in services after youth turn 18. Over 80% of 18-24 year olds in Alameda County are unserved. Asian/ Pacific Islanders and Latinos are the most significantly unserved at 92% and 86% respectively. When youth turn 18 they are legally considered adults and lose eligibility for many services; however many youth with SED who turn 18, particularly those without the support of their families are not ready take on the full responsibilities of adulthood.

The problems facing TAY are all interconnected. Twenty-five to 35 percent of youth with serious mental health issues experience an alcohol or other drug dependence or abuse disorder. Youth leaving foster care or the juvenile justice system are more likely to become homeless than other youth and are also more likely to be severely emotionally disturbed. All of these factors make it difficult for these youth to pursue education, become successfully employed, or in turn, find and afford permanent housing.

In addition, psychosis is a particularly relevant topic for TAY because the typical onset of schizophrenia is between the ages of 16 and 25. Although the incidence is low compared to other disorders, it is one of the most disabling mental conditions.

Transition age youth with SED are at an important juncture between childhood and adulthood and it is critical time to provide appropriate mental health services to facilitate this transition.

Specific issues facing TAY include:

Homelessness. There are an estimated 990 community-defined homeless youth in Alameda County. Of those approximately 24%, or 238, are likely to have a mental illness (Alameda Countywide Homeless and Special Needs Housing Plan). Approximately 260 youth are discharged from foster care annually in Alameda County.

School Failure. In 2004-05 there were 322 16-22 year olds in Alameda County public schools diagnosed with emotional disturbance (DataQuest). The Individual with Disabilities Education Act (IDEA) requires that the planning for each special education student's needs happen at an individual education plan (IEP) meeting. In addition an individual transition plan (ITP) there must be developed by the time a youth turns 16. However parents of TAY say this is not happening.

Employment. After leaving foster care only half of youth are regularly employed (Wald, 2003). Homeless youth are unlikely to become employed because of lack of address and contact information required for an effective job search. (Focus Group at Homeless Shelter Dreamcatcher).

Involvement in the Criminal Justice System. The National Health Policy Forum estimates 20% of all children in Juvenile Hall have a serious mental disorder (SED). Approximately 25-32% have a history of physical or sexual abuse, and 80% have a some kind of psychiatric disorder, including those disorders falling short of SED. In 2003 the Federal General Accounting Office reported that 12,700 families nationwide relinquished custody of their children to juvenile justice or the child welfare system for the sole purpose of trying to gain mental health services for them. A study carried out by Linda Teplin and her colleagues at Northwestern University (2002) found that, among teens in juvenile detention, nearly three quarters of the girls and 65 percent of the boys had at least one psychiatric disorder (Marsenich, Lynne, A Roadmap to Mental Health Services for Transition Age Young Women: A Research Review).

Treatment services for youth exiting the hall are few. In Alameda County, during 2004, only 55 18-24 years olds with previous criminal justice system experience were receiving outpatient mental health services (Use of Forensic Services by Ethnicity and Age Group, BHCS, 2004).

Dual Diagnosis. Substance use issues have been estimated to affect 35% of people with serious mental illness nationally (Alameda Countywide Homeless and Special Needs Housing Plan). There are a total of 5,302 low-income 18-24 year olds estimated to have mental health needs in Alameda County (ACBHCS). Assuming a rate of 35% with a dual diagnosis, there are approximately 855 transition age youth needing dual diagnosis services.

Out-of-Home Placement. Approximately 260 youth emancipate from foster care every year in Alameda County, and it is estimated that 40 percent of these youth become homeless within 18 months. More than one-third of youth emancipating
from foster care have emotional disorders or developmental disorders (Richards, Amanda, “Housing, Services, and Support: A Comprehensive Housing Continuum for Youth Aging Out of Foster Care in Alameda County” A report prepared for the Forging the Links: Housing Working Group, May 2004). More than 80 additional long-term supported housing units must be developed each year in Alameda County to address the needs of emotionally and developmentally disabled youth who are also foster care youth (Richards, 2004). “Youth who have had more than 5 placements are 6 times more likely to need mental health services; this is 1/3 of the foster care youth in California.” California Family Impact Seminars “Helping Those Who Need It Most: Meeting the Mental Health Care Needs of Youth in Foster Care and the Juvenile Justice Systems” Nell Bernstein, 2005.

Ethnic Disparities Among Transition Age Youth

The Transition Age Youth Planning Panel recommends that the MHSA planning process offer services to youth coming out of the justice system, the foster care system and residential treatment.

The numbers of unserved are so high across gender and ethnicities that the Planning Panel feels that it is important to serve all unserved ethnic groups. However, the Planning Panel feels that it is important to provide culturally competent services and provide additional outreach to the most unserved ethnicities particularly to Asian/PI and Latino youth. In addition, Gay-Lesbian-Bisexual-Transgender-Queer-Intergender (GLBTQI) youth report little or no culturally sensitive mental health services for gay and lesbian, bisexual or transgender questioning and inter-sexed youth. They report a lack of health insurance and stigma associated with their already marginalized status (focus group at the Sexual Minority Alliance of Alameda County). African-American youth are disproportionately represented in the foster care, juvenile justice and special education population and are also included in this population.

(iii) Unserved Adults

This section presents a narrative analysis and review of ethnic disparities for unserved adult populations studied by our Adult Planning Panel Workgroups: adults in crisis; homeless adults; incarcerated adults; and adults in need of wellness recovery services.

Ethnic Disparities Among Unserved Adults in Crisis

Compared to a total of 4,344 API adults estimated to need services is Alameda County, only 1,515 received ongoing outpatient services in 2004. While a total of 4,862 Latinos are estimated to need services in Alameda County, only 1,092 Latinos received ongoing outpatient services.

Members of the Latino and API populations with mental health service needs are significantly at risk of being unserved in Alameda County. Comparing the number who receive ongoing outpatient services and the number estimated to need such services, the chart below provides a graphic presentation:

![Prevalence and Number of Service Users](image)

The unserved individuals in this population are often invisible, frequently isolated, unable to work, and unable to manage independence. They are often cared for by family members, but this is non-optimal, for at least two reasons. First, the family members themselves are subject to great stress and, after a while, may “burn out” and cease being effective caregivers. Secondly, untreated mental illness contributes to a risk of periodic crises, which may result in institutionalization. Untreated mental illness, even when the affected individual is in the care of a responsible family member, leads to unnecessary suffering.

Ethnic Disparities Among Unserved Homeless Adults
The following data come from the Alameda County-wide Shelter and Service Survey (conducted in 2003) and are all point-in-time numbers (the annual numbers are expected to be two to 2.5 time the point in time numbers). While some of these homeless adults with mental illness may have limited contact with the Alameda County service system, the majority of them are currently unserved:

- Homeless adults: 3,603
- Homeless adults with serious mental illness: 866 (24% of all homeless adults)
- Chronically homeless adults: 1,280
- Chronically homeless adults with serious mental illness: 377 (30% of all chronically homeless)

Regional Distribution of Chronically Homeless Persons (persons homeless for a year or more and with a disability which may serious include mental illness):

<table>
<thead>
<tr>
<th></th>
<th>Oakland</th>
<th>Berkeley</th>
<th>Other Mid &amp; North County</th>
<th>South and East County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless adults</td>
<td>1,921</td>
<td>773</td>
<td>436</td>
<td>474</td>
</tr>
<tr>
<td>(53%)</td>
<td>(21%)</td>
<td>(12%)</td>
<td>(13%)</td>
<td></td>
</tr>
<tr>
<td>Chronically homeless</td>
<td>627</td>
<td>529</td>
<td>45</td>
<td>79</td>
</tr>
<tr>
<td>(49.5%)</td>
<td>(41%)</td>
<td>(3.5%)</td>
<td>(6%)</td>
<td></td>
</tr>
</tbody>
</table>

Unlike the mental health system, in which APIs and Latinos appear to be the most unserved, among the homeless population the vast majority of persons needing additional services are African-American and Caucasian. The racial/ethnic breakdown of chronically homeless persons in Alameda County is:

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Native-American</th>
<th>API</th>
<th>African-American</th>
<th>Latino</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.3%</td>
<td>1.8%</td>
<td>56.7%</td>
<td>3.2%</td>
<td>33.7%</td>
</tr>
</tbody>
</table>

Those figures generally hold true for Berkeley, Oakland and other North and Mid County but the ethnic breakdown of the chronically homeless is very different in South and East County:

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Native-American</th>
<th>API</th>
<th>African-American</th>
<th>Latino</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.1%</td>
<td>29.3%</td>
<td>11.4%</td>
<td>28%</td>
<td>26.3%</td>
</tr>
</tbody>
</table>

Ethnic Disparities Among Unserved Incarcerated Adults

Most adults with SMI who are incarcerated are not engaged in outpatient mental health treatment. Moreover, a relatively high proportion of the African-American prevalence population is incarcerated – 53%. Few of these inmates are engaged users of outpatient services. The disparity between the incarceration rate and the engagement rate is far higher for African American inmates than it is for other ethnic groups.

Alameda County has no specialized programs in the community or in the courts to assist the SMI who enter the criminal justice system. Mental health staff are needed to assist with the court process, develop an individual service plan that includes families, and facilitate return to community treatment as
soon as possible. Reducing the length of incarceration is an important issue as the jail environment is harsh for individuals with SMI (Director, Alameda County Jail Mental Health Services).

There is no mental health court and no mental health staff in courtrooms to assist the SMI and their families to get treatment outcomes instead of incarceration. (Alameda County courts – Judge Thomas Reardon)

There is not dedicated team within the jail to engage individuals with SMI to proactively work with the courts and the community to expedite discharge and facilitate connections to community treatment. (Jail mental health services and the sheriff’s department)

There is no service to assist families of the individuals with SMI in navigating and understanding the criminal justice system and the jail mental health system (Family member of incarcerated SMI adults (Denise Ronay, Ana Rojas)

There is no special housing or residential services for individuals with SMI when they leave incarceration. This contributes to relapse (Community housing providers and residential programs.)

There is no transportation services for individuals with SMI released from jail to get to treatment programs (Consumers’ reports.)

There is no system in place to coordinate time of release from jail. Individuals with SMI are released without transportation at all times of the night and day. (Alameda County Sheriff's Dept Lt. Ayala, family member Ana Rojas, public defenders Byron Brown and Sheri Schoenberg

Ethnic Disparities Among Unserved Adults in Need of Wellness Recovery Services

Homeless individuals with SMI are least likely to access treatment in the system. They lack the basics of housing, health care, food and social supports. Without these essential needs met, they have no opportunity to begin addressing their wellness and recovery goals through mental health services.

The system does not give social service supports to ex-felons. There are no existing supports built into transition plans within prison systems, so individuals are not connected to needed services upon release. These additional barriers prevent ex-offenders from addressing their wellness and recovery goals as well as basic needs.

Early release of hospitalized individuals in the unserved group goes without transition plans which connect them to health monitoring as well as recovery and wellness resources.

With the lack of services to the Asian and Latino communities there is also a lack of language appropriate services and understanding of the unique issues inherent of those cultures. Wellness and recovery outreach will need to be culturally.

(iv) Unserved Older Adults

This section begins with an overview of ethnic disparities in the unserved older adult population. It proceeds with narrative analysis and ethnic disparity summaries for older adults residing in each of Alameda County’s four regions.

Overview: Ethnic Disparities in the Unserved Older Adult Population

The most unserved populations in Alameda County include API and Latino older adults.

There are many indications that older API and Latino are not being reached by current mental health programs. Alameda County’s year 2000 estimate of prevalence of persons with SMI who are Alameda County residents, and whose age is 65+, indicates that within the population with SMI only 35% of API and 26% of Latino persons who are below 200% of the poverty level are served.

Compared with the Surgeon General’s 1999 Mental Health Report which estimates about one in five Americans experiences a mental disorder in course of a year, using prevalence rate of 8.69% and excluding the high risk population such as the incarcerated and homeless, this prevalence population (SED/SMI) greatly underestimates the actual need for mental health services.

A report by the U.S. Dept. of Health & Human Services (Mental Health: Culture, Race, and Ethnicity) states that there are striking disparities in mental health care for racial and ethnic minorities and that:

- Minorities have less access to, and availability of, mental health services
- Minorities are less likely to receive needed mental health services
- Minorities in treatment often receive a poorer quality of mental health care
- Minorities are underrepresented in mental health research

The Latino Population. There are approximately 277,596 Latino Alameda County residents per US Census 2000. Twenty-six percent of Alameda Central County population is Hispanic.

According to California Mexican Health Initiative Mental Health Fact Sheet 2005:

- Emotional problems like depression or anxiety impair the daily activities of 11.5% of California’s elders. One-quarter of California’s Elder population reports that they do not feel calm and peaceful most of the time. Those most likely to report mental health problems include elders of color, those with limited-English abilities and Medi-Cal recipients.
- Among Latino Americans with a mental disorder, fewer than 1 in 11 contact mental health specialists, and less than 1 in 5 contact general health care providers. Among Latino immigrants with mental disorders, fewer than 1 in 20 use services from mental health specialists, and less than 1 in 10 use services from general health care providers.
- While the percentage of mental health professionals who speak Spanish is not known, only about1% of licensed psychologists who are also
members of the American Psychological Association identify themselves as Latino. Moreover, there are only 29 Latino Mental Health professionals for every 100,000 Latinos in the United States, compared to 173 non-Latino white providers per 100,000 non-Latino whites.

- Non-Latino providers may have trouble diagnosing certain symptoms due to cultural barriers. Latino’s may report symptoms differently than non-Latinos, such as susto (panic attacks), nervios (nerves), mal de ojo (evil eye), and ataque de nervios.
- Mexican immigrants who have lived in the United States less than 13 years have lower rates of mental disorders than Mexican Americans born in the United States, and adult Puerto Ricans living on the island tend to have lower rates of depressions than Puerto Ricans living on the mainland. This information suggests that factors associated with living in the United States are related to an increased risk of mental health disorders. Thus older adults are more likely to be affected.
- Studies have consistently shown that people in the lowest strata of income, education, and occupation are about two to three times more likely than those in the highest strata to have a mental disorder and have higher levels of psychological distress. Latinos are almost three times as likely to live in poverty as whites. In 1999, the per capita income of Latinos was less than half that of whites ($11,621 compared with $24,109).

The Asian & Pacific-Islander Population.

- According to U.S. Census Bureau statistics from the year 2000, Chinese-Americans are the largest Asian American ethnic group, comprising 22.6% (2.8 million) of all Asian Americans.
- Total API (Asian and Pacific Islander) population is 306,816 in Alameda County (US Census 2000.)
- Over 1/3 of API households in Alameda County are linguistically isolated.

Mental Health is the aspect of an Asian American’s health and wellness that gets the least attention for API’s (Le, 2005). Asian Americans, as a group, rarely use or seek traditional mental health services (Fugita, 1990) and terminate treatment earlier (Lin & Cheung, 1999; Sue, 1994). These findings may not necessarily reflect the absence of psychopathology or psychological distress but rather point out probable reasons for not seeking mental health services. These reasons include the level of enculturation and acculturation, non-availability of culturally sensitive forms of treatment, the degree of knowledge or understanding about available mental health services, or a previous encounter with inappropriate Western mental health services that may have been a negative experience (Sue, 1994). The tendency to manage and maintain mental illness or familial conflict with the exception of severely disruptive family dynamics also leads to decreased rates of utilization of services (Fugita, 1990).

While Asian Americans share many of the same cultural values, their degrees of adherence or assimilation vary. A client’s degree of assimilation is a significant factor in the counseling process and greatly affects outcomes. Li and Kim (2004) posit that clients who strongly adhere to Asian values may experience stigma or hesitate to seek mental health services and may be less forthcoming and willing to communicate their personal problems than a client with lesser adherence to Asian values. Older Asians may be less adaptable to the new American culture and adhere more to traditional values.

According to the Surgeon general’s report, 2001:

- Nearly half of APIs have problems with availability of mental health services because of limited English proficiency and lack of providers who have appropriate language skills.
- About 21 percent of APIs lack health insurance, but again there is much variability. The rate of public health insurance for API’s with low income, who are likely to qualify for Medicaid, is well below that of whites from the same income bracket.
- API’s have lower rates of utilization compared to whites. This under-representation in care is characteristic of most API groups, regardless of gender, age, and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until problems become very serious. Stigma and shame are major deterrents to their utilization of services, particularly for Older Adult APIs.

The Chinese American Psychiatric Epidemiological Survey (CAPES) is a survey that was conducted during 1993 and 1994 with a sample size of 1,503 Chinese-Americans in Los Angeles. It showed that only 17% of those who had problems with emotion, anxiety, drugs, alcohol, or mental illness in the past 6 months sought care, fewer than 6% saw a mental health professional, only 4% saw a medical doctor, and 8% visited with a minister or priest (Young, 1998).

In conclusion, there seems to be compelling evidence that API’s and Latinos are being unserved, especially in the realm of Psychiatric and Mental Health services. Delivering linguistically, culturally and geographically accessible Mental Health services are the keys to reducing the suffering of the SMI API and Latino older adults and their families.
North Alameda County: Narrative and Ethnic Disparities

Estimates of Persons with Severe Mental Illness in North County

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income seniors in Alameda (CHIS estimate)</td>
<td>81,000</td>
</tr>
<tr>
<td>Proportion of population living in north county (proportion of total county population in north county area)</td>
<td>43%</td>
</tr>
<tr>
<td>North county low income seniors</td>
<td>34,830</td>
</tr>
<tr>
<td>Low Mental Health prevalence estimate - 15%</td>
<td>5,225</td>
</tr>
<tr>
<td>High Mental Health Prevalence estimate - 25%</td>
<td>8,708</td>
</tr>
<tr>
<td>ACBHCS estimate of seriously mentally ill in North County (age 60+)²</td>
<td>1,600</td>
</tr>
<tr>
<td>Unserved SMI seniors in north county (including homebound and homeless)</td>
<td>1,200</td>
</tr>
</tbody>
</table>

The workgroup estimates between 5,225 and 8,700 seniors with mental illness (55+) reside in the north county area, of which 1,600 are deemed seriously mentally ill by the prevalence data. Of these, just over 400 individuals are currently receiving outpatient services or via the Strides Toward Acquiring Geriatric Empowerment and Success program (STAGES),³ which leaves a minimum of 1,200 unserved individuals (including homebound and homeless).

Homebound and homeless seniors who also experience barriers to care due to culture, ethnicity and/or sexual orientation are also specifically targeted.

**Homeless senior population:** Based on information provided by the Alameda Countywide Homeless Continuum of Care Council⁴:
- Oakland has an estimated 460 homeless seniors (Age 55+),⁵ of whom an estimated 138 are mentally ill.⁶
- In Oakland, seniors (age 55+) comprise 15% of the homeless population, 5% higher than the national average.
- Nearly three-quarters of Oakland homeless are African American (74%). The remainder are Caucasian (13%), 6.8% Hispanic (7%), and American Indian (6%).

Culture, ethnicity and sexual orientation are additional barriers to care:
- Although all seniors often fail to recognize that their symptoms are related to mental illness, the inability to recognize that they need help is most prevalent among Asians (73%) and Whites (67%). Latino and African American elders (59% and 57%) are also affected.
- Oakland is home to the largest lesbian community in the US, and the third-largest gay population.⁷ This suggests that Oakland is home to nearly 3,500 LGBT senior residents. LGBT community is one of the communities identified by the North County Work Group as being of particular concern along with other cultural and ethnic groups.

Central Alameda County: Narrative Analysis and Ethnic Disparities

Latinos and Asians have the lowest rates of hospital and crisis services use in the county as a whole. (3% of Asian/Pacific Islanders were served in the crisis sector and 1% in hospitals. 7% of Latinos in the crisis sector and 3% in hospitals.) This was true despite the fact that in Central County Asians (311) are as well represented in the estimated SED/SMI prevalence population as are Caucasians (304) and African Americans (284) and Latinos (967) are over three times as numerous in this population. This disparity persists in community settings. Only 37% of Pacific/Islanders and 24% of Latinos who are below 200% of the poverty level are served in community settings as compared to 60% of Caucasians and 91% of African Americans. This data indicate that any community based program that is geared toward reducing ER use and hospitalization must have an outreach component to these ethnic groups.

The data also indicate that those over age 65 who have SMI and are below 200% of the Federal Poverty level have by far the lowest rate of utilization of community programs (13%). There are 140 transition age adults in the 55-59 age range, 150 adults 60-64, 229 adults 65-74 and 367 adults 75 years old or older in Central Alameda County that are SED/SMI. The total number of adults over 55 with SED/SMI is 786. It is evident that the capacity of the present community-based system specifically targeted to older adults through the STAGES program which serves 38 individuals with SMI, is not adequate to meet the need for a significant number of these individuals. Examining the data on older adults by age group and service type, it is evident that the inpatient programs are serving a larger percentage of those with the greatest problems due to SMI (11% of the prevalence population for those 55-59 and 18% of those over 60) while assertive community treatment programs serve 0% of those 55-59 and 6% of those over 60. This is of particular note since traditionally consumers that are discharged from MHRC/sub-acute facilities are those who transition into an assertive community treatment program because they require this level of care in order to remain in the community.

South Alameda County: Narrative Analysis and Ethnic Disparities

**Isolation.** Mental illness prevalence data estimated by Alameda County suggest that 12% of clients with SMI/SED who are over age 60 in South County are served by the Alameda County mental health system. This percentage served is the lowest of any region in the County. The low % served is due to a combination of cultural, linguistic, and geographic (i.e. travel distance to reach services) causes.

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² ACBHCS data, July 2005
³ Strides currently serves 38 individuals. ACBHCS serves an additional 400 individuals (outpatient services) from the north county area.
⁴ Homelessness in Alameda County...the people, THE FACTS, the solutions, November 6, 2003
⁵ 3,506 homeless individuals, of whom 15%, or 460 are seniors.
⁶ National statistics suggest that 30% of the homeless population suffers from mental illness.
⁷ Oakland's 2004 Senior Needs Assessment
ACBHCS estimates that only 13% (19 out of 143) of South County A/PI seniors needing mental health services are actually receiving services, compared to 31% in North County and 35% in Central County.

Among the unmet needs identified of older adults, many Asian older adults who have SMI do not utilize the mental health system. Because mental illness is highly stigmatizing in the Asian Community, Chinese families tend to discourage the use of mental health facilities among family members until disturbed members become unmanageable and their illness severe. According to the Chinese American Psychiatric Epidemiological Study (CAPES), only 17% of those experiencing mental health problems sought care.

Even where Chinese older adults and their families are willing to acknowledge mental illness, language barriers make it difficult for them to access services: according to the Surgeon General, approximately 70 Asian/Pacific Islander providers are available for every 100,000 A/PIs in the US, as opposed to 173 per 100,000 whites (http://www.surgeongeneral.gov/library/mentalhealth/cre/fact2.asp). In a survey of A/PI clients conducted by ACBHCS, 72% of respondents had difficulty finding appropriate mental health providers due to language barriers (Mental Health Services Act, Asian & Pacific Islanders, June 2, 2005).

There is also an unmet need among Afghan senior immigrants who suffer from post traumatic stress in large numbers due to the loss of family members during the 1980 Soviet war in Afghanistan.

Southern Alameda County, California is home to the largest community of Afghan refugees in the United States. Afghans are not tracked as a separate ethnic group by the census, so population estimates vary. However, local community groups and city officials estimate that there are approximately 10,000 Afghans in Southern Alameda County with the largest concentration living in the city of Fremont. In a community survey conducted by UCSF of 196 Afghan families, participants reported a large majority of family members do not speak, read or write English (Lipson, Omidian, & Paul, 1995).

Mental health issues were identified as one of the most significant problems in the community (Lipson, 1993). Community meetings and ethnographic data also reveal many barriers to services such as language translation, finding doctors who accept Medicaid, and transportation. Affordable mental health services for this group are almost non-existent. Furthermore, many of the elders live in poverty, lack transportation and are unable to access basic services such as housing and medical support.

**Inability to manage independence.** Alameda County BHCSA estimates that only 12% of seniors in South County who need mental health services are receiving them, the lowest percentage of any region in the county.

Cultural and language barriers are one impediment for South County seniors who might need services. However, a larger issue is the utter lack of geriatric mental health services in South County. There are currently only two psychiatrists in the County's mental health network located in South County that indicate a specialty in geriatric psychiatry. South County is also a large geographic area with spotty public transit, which adds an additional barrier to seniors trying to access mental health services.

The City of Fremont's Senior Support Services Division estimates that half (125) of the 250 clients it serves through its case management programs in the Tri-Cities have unmet mental health needs.

**Cultural stigma and shame amongst API older adult population.** Research has shown that Asian-American women over 65 have the highest suicide rate among women in the United States; eighty-nine percent of the Asian-American women who committed suicide were immigrants. Among all the ethnic groups, Chinese-American women have the highest suicide death rate. Some recent studies show that more than 75% of the older adults 60 and over seen by primary care physicians have mental health related issues.

Only 3% of Asian/Pacific Islanders were served in the crisis sector and 1% in hospitals. 61% of the total population with SED and SMI is served, only 32% of the API population with SED and SMI is served.

Isolation, cultural stigma, and shame are major issues for seniors with mental illness, which will further aggravate the low utilization rate of mental health services and increase the underserved population.

**East Alameda County: Narrative Analysis and Ethnic Disparities**

**Isolation.** This includes seniors living alone with no family support. Isolation is a major issue for seniors with SMI. Aging can be isolating due to death of spouses, friends, family and health problems which limit mobility. Depression and anxiety, often caused by losses, can create more isolation and lead to a downward spiral and loss of independence. There is a general failure to acknowledge problems, often lack of information about mental illness available to older adults or their families. Because of the stigma associated with mental health problems, older individuals may not seek out any service which openly advertises itself as a mental health service. The numbers of those over age 85 are the fastest growing segment of the senior population and are more likely to be isolated.

**Frequent Emergency Medical Care.** This includes seniors who request treatment for medical reasons when there may be an underlying undiagnosed/untreated mental illness. Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis proportions before they are dealt with and when they are, emergency medical care is required.

(v) **Summary of Data on the Native American Population in Alameda County**

Among the most underserved populations in the United States, Native Americans have the lowest per-capita incomes, the highest unemployment rates, highest school drop-out rates and the highest rates of infant mortality, teen suicide, diabetes, cancer, and alcoholism (Mail & Johnson, 1993; Denny et al, 2003). American Indian/Native Alaskan Demographics by Age Group in Alameda County is presented in the table below:
According to the Surgeon General’s Report on Mental Health: Culture, Race and Ethnicity (2001), American Indians / Alaskan Natives (AI/ANs) are over represented among people who are homeless, people who are incarcerated, and people with substance abuse problems. The estimated rate of alcohol-related deaths for AI/ANs as a whole is much higher than it is for the general population. Many AI/ANs suffer from historical trauma, a type of intergenerational post-traumatic stress disorder, attributed to a cultural history of oppression (Brave Heart, 2003; Duran & Duran, 1995). In the 2000 Census, 46% of urban AI/AN households were reported as being headed by a single parent. In 2002, nearly one in four AI/ANs reported having a disability (UIHI, 2004).

Co-occurring Mental Illness and Substance Abuse: While large-scale prevalence studies of mental disorders among AI/ANs are lacking, mental illness is a major problem for AI/ANs often accompanied by substance abuse and violence. Risk factors for co-occurring disorders among AI/ANs include poverty, unemployment, historical trauma, contemporaneous trauma, violence, child abuse and neglect, negative role models, and easy availability of alcohol and drugs.

The prevalence of suicide for AI/ANs is 1.5 times the national rate. Since 1979, suicide and homicide have been leading causes of death among young AI/ANs. The rate of violent victimization of AI/ANs is more than twice the national average. The higher rate of traumatic exposure results in a 22% rate of PTSD for AI/ANs, compared to 8% in the general U.S. population (Wallace et al, 1996; MMWR, 1998).

The California Mental Health Master Plan listed the following barriers to providing services for AI/ANs: the DSM-IV is limited in dealing with cultural issues; high unemployment rates among AI/ANs in California limit their ability to purchase insurance; and the long history of broken treaties has led to a feeling of mistrust of the mainstream culture (Hodge, 1997).

Resiliency factors include strong group affiliation, extended family, cultural respect, spirituality, community support, wisdom and strength of elders, and sense of humor (Clark et al, 2004).

In a pilot study funded by IHS, a review of clinical files from 200 clients who received outpatient treatment at the Native American Health Center (NAHC) Family & Child Guidance Clinic showed that 85% had a history of alcohol abuse and 73% had a history of drug abuse. Additionally, 64% of these clients were diagnosed with substance induced disorders, 58% with anxiety disorders, and 50% with mood disorders, indicating a significant number of clients with dual diagnoses of substance abuse and mental illness (Duran & Yellow Horse-Davis, 1996).

Violence Issues: Anger and violence are prolific within the Native American community. Among AI/AN admissions to substance abuse programs, 40% were referred from the criminal justice system (DASIS, 2005). In 1997, an estimated 1 out of every 25 AI/AN adults was involved in the criminal justice system (Surgeon General, 2001). AI/ANs experienced a per capita rate of violence twice that of the general U.S. population. During FY 2001, AI/ANs were 16% of all offenders entering federal prison for violent crimes.

Family violence accounts for 18% of all violent victimizations experienced by American Indians. Gender-based trauma has emerged as one of the most serious public health problems facing American Indian women today (Williams, 2002). In a study of lifetime exposure to trauma for Native American women, over half the sample experienced physical or sexual assault (Walters & Simoni, 1999). In a study of high-risk women at NAHC, 41% reported feeling afraid of being beaten or threatened by a sexual partner during the past 12 months (Klein et al, 1995).

Factors for Native American Youth: Native American youth are high-risk for substance abuse, HIV/AIDS, mental illness, and delinquency. In the San Francisco Bay Area this at-risk population includes Indian youth who are: children of substance abusers; in reentry from the juvenile justice system; members of low-income families; those living in foster care; gay, lesbian, bisexual, and transgender (LGBT) youth; gangs, members, emotionally disturbed, and homeless youth (Nebelkopf & King, 2003). During the Circle of Care, the prevalence of severe emotional disturbance (excluding substance disorders) among AI/AN children in the Bay Area was estimated at 22.5% (Simmons, Novins et al, 2004).

Risk factors for AI/AN youth in the San Francisco Bay Area include school truancy, negative peer pressure to participate in risky behaviors, unsafe sex practices, gang membership, and economic pressure to participate in illicit behavior. Protective factors include connection and support by a caring adult, engagement in meaningful after school activities, culturally appropriate alternative activities, opportunities to develop life skills and employment, sports, and community events.

Homelessness: Homelessness is a significant issue. While representing less than 1% of the U.S. population, it is estimated that AI/ANs constitute 8% of Americans who are homeless (Surgeon General, 2001).

Lobo and Vaughn (2003) did an ethnographic study of homeless AI/ANs in the San Francisco Bay Area. The forms of homelessness included: staying with a rotating set of family or friends; living on the streets; living in a vehicle; staying in shelters; and cycling in and out of treatment centers or jails. The results indicated a strong association between homelessness, mental illness, and substance abuse.
2.2 Using the format in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/inappropriately served, by age group and race ethnicity. Also provide the total county and poverty population by age group and race ethnicity.

CHART A: Service Utilization by Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Fully Served</th>
<th>Underserved/Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Number</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>165</td>
<td>129</td>
<td>3,774</td>
<td>2,804</td>
<td>6,872</td>
</tr>
<tr>
<td>African American</td>
<td>127</td>
<td>90</td>
<td>1,863</td>
<td>1,320</td>
<td>3,400</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>1</td>
<td>3</td>
<td>229</td>
<td>219</td>
<td>452</td>
</tr>
<tr>
<td>Latino</td>
<td>8</td>
<td>10</td>
<td>692</td>
<td>528</td>
<td>1,238</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>1</td>
<td>40</td>
<td>20</td>
<td>61</td>
</tr>
<tr>
<td>Caucasian</td>
<td>26</td>
<td>24</td>
<td>727</td>
<td>552</td>
<td>1,329</td>
</tr>
<tr>
<td>Other</td>
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<td>0</td>
<td>57</td>
<td>44</td>
<td>101</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>1</td>
<td>166</td>
<td>121</td>
<td>291</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Fully Served</th>
<th>Underserved/Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Number</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>38</td>
<td>48</td>
<td>967</td>
<td>964</td>
<td>2,017</td>
</tr>
<tr>
<td>African American</td>
<td>25</td>
<td>32</td>
<td>403</td>
<td>371</td>
<td>831</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>0</td>
<td>1</td>
<td>102</td>
<td>94</td>
<td>197</td>
</tr>
<tr>
<td>Latino</td>
<td>0</td>
<td>7</td>
<td>153</td>
<td>192</td>
<td>352</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Caucasian</td>
<td>10</td>
<td>6</td>
<td>246</td>
<td>251</td>
<td>513</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>19</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>1</td>
<td>37</td>
<td>32</td>
<td>72</td>
</tr>
</tbody>
</table>
2.3 Narrative discussion/analysis of ethnic disparities in fully served, underserved and inappropriately served populations by age group as identified in Chart A. Include any available information about their age and situational characteristics as well as race, ethnicity, gender, primary language, sexual orientation, and special needs.

This section begins with an Alameda County MHSA staff summary of ethnic disparities in fully served, underserved and inappropriately served populations across age groups before presenting an analysis for each age group.

Ethnic Disparities in Fully Served, Underserved and Inappropriately Served Populations Across All Age Groups

- Who is poor by age?
  - 30% of poverty population: 0-17 Children/Youth
  - 15% of poverty population: 18-24 TAY
  - 15% of poverty population: 60+ Older Adults
  - 40% of poverty population: 18-59 Adults
- The ethnic composition of poverty population in Alameda County varies across age groups, for example 40% of the older adults in poverty are white and 5% are Hispanic while the poverty population under 18 is 15% White and 39% Hispanic.
- Caucasian and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos.
- Asians/Pacific Islanders and Latinos are much less likely to be served than African Americans and Caucasians.
- Latinos are four times less likely than African American and about two time less likely than Caucasians to receive mental health services.
- About 38% of the Asian/Pacific Islander prevalence population is served, while the rate for Caucasians is 68% and 102% for African Americans.
- Broadly, adults 18-59 are more underserved than children in Alameda County. Clients served compared to prevalence population in need of services produces a rate of only 58% for adults. The rate for children is 75%.
- Disparities for ethnic groups are similar for adults as for those that exist in the 0-17 population.
- There are more women in the prevalence population in men. (Prevalence population is 14,000 for adult women and 7,000 for adult men.) In order to answer the question of which gender is served more, you need to compare the absolute number to the prevalence population. Once this is done, it becomes clear that more men are more likely to be served than women in all four age groups.
(i) Underserved and/or Inappropriately-Served Children and Youth Populations

This section presents narrative analysis and situational characteristics of children and youth who are 0-6, in the school system, and the juvenile justice system. Ethnic disparities are included in this section in addition to the introductory paragraph of 2.3 - “Ethnic Disparities Across All Age Groups.”

Underserved Children, aged 0-6

African-American children are over-represented in school failure and in the Alameda County child welfare system. From March 2004 to April 2005, 357 children ages 0-5 were removed from the home and placed in foster care. Of the 357, children 138 were African-American. One of the many unmet needs in working with these communities is the need for community-based services that are both linguistically and culturally relevant. Additionally, there exists a dearth of bilingual/bicultural social work professionals who can provide services within a socio-culturally relevant model. As noted by the University of California, San Francisco, in the chart above, the expulsion rates for African-American children are disproportionate, and speak to the need for mental health services to help mitigate social/emotional difficulties that contribute to school failure.

African-Americans attending state-funded pre-kindergarten were about twice as likely to be expelled as Latino and Caucasian children, and over five times as likely to be expelled as Asian-American children. (Source: National Pre-Kindergarten Study, Yale University Child Study Center)

Underserved Children and Youth in the School System

School Failure. API and Latino students make up about 17% and 32% of Oakland Unified School District’s total enrollment. Asian students show a large increase in suspensions from grade 5 to grade 6 that reflects the trends for the district as a whole. Although Asian students in OUSD perform relatively well on the math portion of standardized tests, less than 50% of them met national standards in all other subjects. Latinos have the second highest dropout rate in 2000-01 school year and Pacific Islanders had the highest dropout rate in 1999-2001 (2.6% and [Community Response Plan, June 2003].

Anti-social behaviors. On average, depressed South East Asian (SEA) youth committed about 1.5 times more anti-social behaviors than non-depressed SEA youth.

Trauma. Many APIs and Latinos experience severe trauma before emigrating to the US or during the process of fleeing their homes. The rates of depression in primary health clinics are 20% and 50% in mental health clinics. The rate of Post Traumatic Stress Disorder in mental health clinics is 70%. There is strong co-morbidity of depression and PTSD in South East Asian refugees. Medical conditions may mimic or exacerbate psychiatric symptoms. There are chronic health problems from war injuries and torture including head trauma and musculoskeletal injuries. Medical illnesses include TB, anemia, hepatitis B, parasitic infections.

Underserved Children and Youth in the Juvenile Justice system

General national trends show that juvenile arrests have decreased in the last 20 years. However, when examined by ethnicity, API juveniles are the only group to show an increase in arrests (11.4%). [Community Response Plan, June 2003]

Data from 1991-2000 show that Latino youth have the second highest juvenile arrest rates. Compared to Caucasian, African American, and Hispanic youth, API youth in Oakland are arrested at a lower rate (2.4%) than the juvenile population (5.5%) in 2000. However, once arrested, API youth have the highest adjudication (conviction) rate (34.2%) of all races. They also have a higher likelihood of being placed outside of the home (e.g. boot camp, foster care, group homes, etc.) than most other groups. [Community Response Plan, June 2003]

While the arrest rates for all API youth in Oakland appear to be relatively low compared to other races, when the rates are broken down by API ethnicity, certain groups such as Samoans (8%) and Laotians (7%) reveal high arrest rates. Most arrests (68%) of API youth in Oakland in 2000 were felonies. Laotian, Chinese, Vietnamese, and Other Asian girls had the highest number of arrests among API females between 1991 and 2000.

<table>
<thead>
<tr>
<th>Race</th>
<th>From 2000-2003 the number of youth in Alameda County between the ages of 10 to 17 was 154,830. 51% of these youth were male and 48.9% were female. The ethnic break down of the youth is as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>17.2%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>29.4%</td>
</tr>
<tr>
<td>Latino</td>
<td>25.7%</td>
</tr>
<tr>
<td>Asian</td>
<td>22.0%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>5.0%</td>
</tr>
<tr>
<td>Native American</td>
<td>less than 1%</td>
</tr>
</tbody>
</table>

American youth represented 17.2% of the population in Alameda County in 2003; they represented 46.1% of all referrals during 1999-2003.

Youth involved with the juvenile justice system have higher rates of mental health disorders than youth in the general population. Some of the same factors that place children and adolescents at risk for delinquency also contribute to the emergence of mental health problems such as depression,

posttraumatic stress disorder, and attention deficit hyperactivity. Furthermore, mental health problems have been shown to be a risk factor for delinquency. (Juvenile Justice Evaluation Center Guidebook Series, Evaluation Issues in Mental Health Programming in the Juvenile Justice System, Ron Prinz, Ph.D., Mary E Poulin, M.A. August 2003. Juvenile Justice Evaluation Center, Justice Research and Statistics Association, Office of Juvenile Justice and Delinquency Prevention.)

The Huskey Report provides a profile of the youth in Alameda County and Alameda County Probation. The study surveyed youth confined to Juvenile Hall and reports that nearly two-thirds (62.2%) of the minors reported to have a psychiatric disorder sometime in their lifetime and 60.09% had two or more. These findings suggest a need for greater depth of screening for mental health problems at intake beyond the acute needs, for a comprehensive assessment for those identified at intake and for more youth having Mental Health Treatment Plans completed prior to release.

These findings are consistent with national studies completed in Cook County Juvenile Detention Center, 2002, Teplin, et al.,2002; Rochester, NY; Denver, CO and Pittsburgh, PA, Huizinag et al. 2000; Harris County, TX Detention Center, Domalanta et al. 2003. The rates of substance abuse among boys (81.7%) in Juvenile Hall and (74.1%) are significantly higher for Alameda County Juvenile Detention that what was found in the aforementioned studies.

(ii) Underserved and/or Inappropriately-Served Transition-Age Youth Populations

Fully served, underserved/inappropriately served situational characteristics as well as race, gender, primary language, sexual orientation, special needs:

- Fifteen percent (15%) of the County's poverty population are transition age youth between 18-24 years old.
- Transition age youth (16-24) (and older adults) are the least likely to receive services.
- Youth age 16-17 are served at a much higher rate than the 18-24 year old group.
- Ninety seven percent (975) of the African American TAY live northern and central regions of the county.
- Asian/Pacific Islanders are the least served among TAY; they are six times less likely to be served than African Americans and over twice less likely than Caucasians.
- A larger percentage of the prevalence population of males is served than the prevalence population of females.
- Caucasian and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos.
- African Americans are four times more likely to receive services than Asian/API. African Americans are two times more likely to receive services than Latinos.
- Men are more likely to receive services than women.

(iii) Underserved and/or Inappropriately-Served Adult Populations

This section begins with an overview of all adults and proceeds to discuss adults in the criminal justice system, those who are in crisis, and those in need of wellness recovery services. Homeless adults are understood to be unserved and are not included in this discussion.

Fully served, underserved/inappropriately served situational characteristics as well as race, gender, primary language, sexual orientation, special needs:

- Forty percent (40%) of the County’s poverty population are adults 18-59 years old.
- A larger percentage of the prevalence population of males is served than the prevalence population of females.
- Caucasian and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos.
- African Americans are two times more likely to receive mental health services than API. African Americans are three times more likely to receive mental health services as Latinos.
- Men are more likely to receive services than women.

Adults Involved With the Criminal Justice System

Twenty percent (20%) of SMI adults who are incarcerated and served by the jail-based mental health team are assigned to service teams (programs with single-point responsibility for needs of their caseloads) (BHCS stats). The fact that they are incarcerated indicates they may have been underserved, even though they were assigned to a service team, and certainly indicates these persons are ‘at risk of incarceration’.

26% of SMI adults who were incarcerated in 2004 were also hospitalized for mental disorders at least once in the period between January 2003 and July 2005. Of those who were hospitalized at least once, 42% were hospitalized at least 3 times in the 30-month period studied. (BHCS statistics)

Most adults with SMI who are incarcerated are not engaged in outpatient mental health treatment. Moreover, the African-American population estimated to suffer from serious mental illness is highly at risk of incarceration (number of jail mental health service users as percent of prevalence population = 53%). Few of these inmates are engaged users of outpatient services outside the jail. The disparity between the incarceration rate and the engagement rate of clients in services following release from jail is far higher for African American inmates than it is for other ethnic groups. This is a significant issue in our community.
Alameda County has no specialized programs in the community or in the courts to assist persons with SMI who enter the criminal justice system. Mental health staff is needed to assist with the court process, develop an individual service plan that includes families, and facilitate return to community treatment as soon as possible. Reducing the length of incarceration is an important issue, as the jail environment is particularly harsh for the persons with SMI.

Deficiencies in the current system of care for the criminal justice population include:

- According to the Alameda County Sheriff’s Department, there is no dedicated team within the jail to engaged the SMI and proactively work with the courts and the community to expedite discharge and facilitate connections to community treatment.
- According to family members of incarcerated adults, there is no service to assist families of the people with SMI in navigating and understanding the criminal justice system and the jail mental health system.
- According to community housing providers, there is no special housing or residential services for individuals with SMI when they leave incarceration.
- Consumer reports find that there are no transportation services for persons with SMI released from jail to get to treatment programs.
- According to the Alameda County Sheriff’s Department, the Public Defender’s Office and family members, there is no system in place to coordinate time of release from jail. Persons with SMI are released without transportation at all times of the night and day.

Adults Who Are In Crisis

Two thirds (67%) of the users of crisis services and 46% of the users of inpatient mental health hospital services in Alameda County during 2004 were not engaged in ongoing outpatient treatment in 2004. The disparity by ethnicity was relatively small, even though there are significant differences among ethnic groups in the use of mental health services. Thus, even though a significantly higher proportion of the African-American prevalence population was engaged in ongoing outpatient services than, for example, the Asian population, the same proportion of those populations who were engaged in ongoing outpatient services also had crisis services. This seems to imply that crisis services will continue to be needed even if services to unerved and underserved populations are expanded. North County, in particular, has a significant need for additional mobile and crisis services. Community representatives from families of severely mentally ill individuals were particularly insistent on the need for mobile and crisis services that were not necessarily accompanied by the police.
The chart below illustrates the need for services in North County:

![Prevalence of Mental Illness in the Poverty Population and Use of Mental Health Services by Region Adults Age 18+](chart.png)

The populations of the South and East planning regions are smaller than those of the other two regions. Their access to mental health services is also proportionately lower, due to the combined impact of smaller populations in poverty, fewer available resources in both areas and the geographic isolation of East County. This lack of access results in unnecessary hospitalization as well as other adverse affects.

The chart below illustrates the need for services in South and East County:

![Prevalence of Mental Illness in the Poverty Population and Use of Ongoing Outpatient Services in Alameda County by Region in Alameda County - Adults 18+](chart.png)

Representatives from all segments of the community – all ethnicities, all geographic regions, consumers, family members and providers – expressed a need for access to professional advice and counsel services beyond the current hours of the telephone-based Access availability. The lack of this service affects individuals with severe mental illness who are both unserved and underserved, and contributes to isolation, inability to manage independence and unnecessary hospitalization.
Adults in Need of Wellness Recovery Services

Clients who have been released from mental health treatment are often not transitioned to Wellness and Recovery options. Since long-term independent supports are limited, consumers are at risk of relapse, homelessness and incarceration – this includes consumers from Latino and Asian communities. These clients are from Board and Care and subsidized housing, many with substance abuse issues and incarceration histories. Without the needed supports from peers, skills training, and employment options, which encourage these adults to make independent decisions about their wellness, they are statistically inclined towards mental health crisis. Transitional Aged youth also have no specific Wellness and Recovery options available to them when transitioning from the children’s to the adult systems of care, also placing them at risk.

(iv) Underserved and/or Inappropriately-Served Older Adult Populations

The inability to manage independence, isolation, and frequent emergency room (ER) hospitalizations has been identified as risk factors for the older adults. Often these emergency room visit is for medical issues related to non-compliance with a prescribed medical regimen. This non-compliance is often secondary to mental health issues. However, these mental health issues, while chronic, are not so acute as to consider the individual to be a danger to self, or others, nor require involuntary hospitalization for mental health treatment under LPS conservatorship laws. The ER visit may or may not require general hospital admission, but whatever the outcome, discharge to the natural living setting usually follows. However, the underlying mental health concerns, when inadequately addressed, often leads to repetitive ER visits.

Statistics from Eden Medical Center, between January 1 through June 30, 2005, show 2,046 individuals over the age of 60 utilized emergency room visits at Eden Medical Center and at San Leandro Hospital.

Undiagnosed and untreated mental health conditions result in increased use of ERs by older adults. Furthermore, health care providers lack training in the area of managing behaviors related to mental health.

The elderly, in general, are underserved in the area of mental health needs for many reasons: language and cultural barriers, denial by the individuals and family members and the unavailability and/or accessibility of services.

It is well known that depression is a serious illness affecting approximately 15 out of every 100 adults over age 65 in the United States, regardless of income levels. When depression occurs for the first time in older adults, its onset often coincides with the emergence of another medical illness.

Many other factors can contribute to the development of depression. Often people describe one specific event that triggered their depression, such as the death of a partner or loved one, or the loss of health or the ability to perform activities of daily living. These factors contribute to an inability to adhere to a medical regimen, which leads to deteriorating health and repeat trips to the emergency room due to acute health emergencies, which may have been prevented.

The In-Home Supportive Services (IHSS) consumer population is an ideal target for interventions seeking to reduce ER visits. Many IHSS clients are elderly, have chronic illnesses, and experience social isolation, which is often accompanied by moderate depression or other affective disorders. These factors combined with a lack of resources for these Medi-Cal clients, stretches ER resources.

Recipients of Adult Protective Services with mental health issues and in medical self neglect are overusing or at risk of overusing emergency room services in Central Alameda County.

Based on 2000 estimates of prevalence of persons with SMI, persons >65 years of age with incomes <200% of the poverty level are significantly underserved. Of the expected 2200 persons in this category, only 497 (19%) are currently receiving services.

Homebound seniors with SMI who are not receiving needed services are enduring significant suffering and are at high risk of harm from inability to care for themselves, loss of social support, homelessness, and medical and psychiatric hospitalization. Frequent ER visits indicate that an individual has medical or emotional problems with which he/she is unable to cope. At Eden Hospital, there were 444 individuals who made three or more ER visits during the first six months of 2005. There were ten individuals who made nine visits, 27 who made ten visits and 11 who made 11 visits during the six month period.

2.4 ALAMEDA COUNTY: Identify objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the county’s threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in this Plan.

The global and operational objectives listed below were derived from Chart A above combined with Chart B, (found at the end of this question.) Chart A uses census data provided by the State Department of Mental Health. Chart B uses data that combines census data with Alameda County utilization data.

These objectives were developed after taking into consideration:

- The need for culturally and linguistically competent services based on our population assessment (see charts referenced in the paragraph above, and the data summary that precedes each global and operational objective);
- Alameda County's threshold languages (Mandarin, Spanish, Farsi and Vietnamese); and
- Disparities in access and service delivery that are addressed in our Community Services and Supports Plan (each operational objective is followed by the Program Work Plan code that links the objective with a specific Community Services and Supports Plan proposal).
**Children and Youth:**

*Data:* Caucasian and African American children and youth are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos. A larger percentage of the prevalence population of males is served than the prevalence population of females. Native American children and youth are high-risk for substance abuse, HIV/AIDS, mental illness, and juvenile delinquency.

*Global Objective:* Increase culturally competent outreach/engagement and service delivery to Asian/API and Latino children and youth. Ensure that females are adequately represented in the service population.

*Operational Objectives:*

- Increase number of mental health providers who are bi-lingual and culturally competent who care for indigent unserved Asian/API, Latino and Native American children and youth. *(OE/SD 6a,b,c)*
- Decrease recidivism of Latino, African American and Asian/API youth with the juvenile justice system through:
  - Staff training in how mental health staff can coordinate more closely with probation officers; effective use of MAYSi-2 that identifies youth with SMI or SED; and designing discharge strategies that focus on community integration; *(OE/SD 8)* and
  - Referrals to a specialized therapy team based on an evidence-based practice “Multisystemic Therapy” - this project will include Native American children and youth. *(OE-SD 9)*

**Transition Age Youth (ages 16-24):**

*Data:* The prevalence populations of TAY who are African American, Asian/PI and Latinos are roughly the same size (about 1,600). Yet there are great disparities of service provision to this age group. Asian/Asian Pacific Islanders are the most unserved. The 18-24 year olds are over 6 times less likely to be served than African Americans and over 2 times less likely than Caucasians. Native American TAY are high-risk for substance abuse, HIV/AIDS, mental illness and juvenile delinquency.

*Global Objective:* Increase culturally competent outreach/engagement and service delivery to Asian/Pacific Islanders who are 18-24 years old

*Operational Objectives:*

- Reduce homelessness and increase opportunities for recovery and successful growth into adulthood for ethnic minority TAY (which includes Asian/API, African American and Latinos) by:
  - Providing long-term supportive housing that has been especially designed to meet the unique needs of TAY *(FSP 3)*; and
  - Providing a multidisciplinary treatment team with a peer support component that has been designed to meet the unique needs of TAY *(FSP 6).*

**Adults (ages 18-59)**

*Data:* Asian/Pacific Islanders and Latino adults are much less likely to be served than African Americans and Caucasians. Countywide, Latinos are four times less likely than African American and about two times less likely than Caucasians to receive mental health services. Disparities in service provision are also quite marked in the API population. Compared to the prevalence population only they are 38% served while the rate for Caucasians is 68% and 102% for African Americans. Native American adults are at high risk for homelessness, incarceration, substance abuse and HIV/AIDS.

Among the homeless population with severe mental illness, the vast majority of persons needing additional services are African-American and Caucasian in the North and Mid County and Asian/API, Latino and Caucasian in the South and East.

Among those that are incarcerated and have severe mental illness, a relatively high proportion of the African-American population is incarcerated – 53%. Few of these inmates are engaged users of outpatient services. The disparity between the incarceration rate and the engagement rate is far higher for African American inmates than it is for other ethnic groups.

*Global Objective:* Increase culturally competent outreach/engagement and service delivery to Asian/Pacific Islanders and Latinos and to African Americans who are homeless and/or incarcerated.

*Operational Objectives:*

- Decrease homelessness by:
  - Providing supportive housing to ethnic minorities located in North and Mid-County (focus on African Americans) *(FSP 1)*; and South/East County (focus on Asian/API, Latino and Caucasian) *(FSP 4)*; and to Native Americans who enroll in either project cited above;
  - By increasing access to housing information and rental subsidies for FSP enrollees on service teams *(FSP 7).*
- Promote client/family driven mental health system that is recovery/resiliency oriented and culturally competent by:
  - Establishing a Wellness Recovery Resource Hub that will train an ethnically diverse MHSA peer support staff (including African Americans, Latinos, Asian/API and Native Americans); provide technical assistance to MHSA programs; and support wellness recovery strategic planning and peer support within the wider mental health system *(OE/SD 1)*;
  - Establishing a Family Education Center that will provide information and support services to families within the mental health system; and provide consultation to MHSA programs to improve staff/family/client relationships *(OE/SD 2).*
Decrease number of inappropriate and repeated incarcerations of adults with severe mental illness by funding a multidisciplinary team and community support center (FSP 5) and by placing mental health specialists in courts to work with judges and assess/advocate for defendants with severe mental illness (OE/SD 7).

Decrease ethnic disparities caused by:
- lack of language and cultural specific services by increasing staff in agencies providing services to Latino and Asian/API clients (OE/SD 3).
- lack of geographic access to services by expanding crisis response program in South and East Alameda County (OE/SD 5).

Older Adults

Data: The percentage of older adult clients served compared to the prevalence population is 15% for Asian/PI’s and Latinos and 20% for African Americans. The ethnic composition of this group is more heavily weighted toward Caucasians (41%) than any other age group. Also, compared to other age groups older adults are very unlikely to be Latino. White and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos.

Global Objective: Increase outreach and engagement and service delivery to Asian/Asian Pacific Islanders and Latinos.

Operational Objectives:
- Decrease homelessness and the inability to manage independence by creating a multidisciplinary team that engages homeless older adults and links them to a range of services with a focus on subsidies and supports for obtaining and retaining housing (FSP 2); and
- Increase collaboration between mental health and primary care and reduce frequent hospitalization and emergency care by training primary care staff in early detection and screening of mental illness in older adults; and by deploying four geriatric mental health teams to emergency rooms and primary care clinics to collaborate with existing primary care staff.

All Ages

Global Objective: Increase access to services appropriate to and sensitive of the needs of the LGBTQI community.

**Chart B: Estimates of Prevalence of Persons with Serious Emotional Disturbance and Serious Mental Illness**

Chart B, below, present staff analyses of prevalence and target populations within Alameda County. Included are comparisons of prevalence and utilization detailed by age group, gender, and ethnicity among persons living in households below 200% of the Federal Poverty Guidelines. This data was used as the basis for orienting Planning Panels, Workgroups, and administration on ethnic and age group disparities. The data used to produce this chart combines census data given to Alameda County by the State Department of Mental Health with Alameda County utilization data. This chart is followed by an additional section that contains Alameda County staff analysis of the data presented in Chart B.

<table>
<thead>
<tr>
<th>Estimates of Prevalence of Persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda County Persons &lt;200% Federal Poverty Level</td>
</tr>
<tr>
<td>All ages</td>
</tr>
<tr>
<td>Prevalence</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Youth total</td>
</tr>
<tr>
<td>Age 0-17</td>
</tr>
<tr>
<td>0-5</td>
</tr>
<tr>
<td>6-11</td>
</tr>
<tr>
<td>12-17</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Asian/PI</td>
</tr>
<tr>
<td>Native American</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Latino</td>
</tr>
</tbody>
</table>
Staff Analysis of Empirical Data Presented in “Chart B”

MHSA staff compared the ‘Intended Service Population’ to ‘Actual Service Population.’ We estimated the relative level of unmet need by comparing data describing actual utilization of community-based outpatient services to estimates of how many people experience severe mental illness in the population. Our comparison of population data from our county with these estimates of the prevalence of severe mental illness helped us conclude the following:

- Thirty percent (30%) of the County’s poverty population are under 18 years old. Adults (60+ years old) and transitional age adult (18-24) make up about 15% each. The balance of the poverty population (about 40%), are adults 18-59 years old.
- The ethnic composition of poverty population varies across age groups, for example 40% of the older adults in poverty are white and 5% are Hispanic while the poverty population under 18 is 15% White and 39% Hispanic.
- A larger percentage of the prevalence population of males is served than the prevalence population of females. This service gap is true for both adults and children.

In the Children and Youth population, Caucasians and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos. A larger percentage of the prevalence population of males is served than the prevalence population of females.

Transition Age Youth (ages 16-24) are the least likely to receive services:

- The prevalence populations of TAY who are African American, Asian/PI and Latinos are roughly the same size (about 1,600).
- Ninety seven percent (97%) of the African American TAY live northern and central regions of the county.
- There are great disparities of service provision to this age group. Asian/Pacific Islanders are the most unserved. The 18-24 year olds are over 6 times less likely to be served than African Americans and over 2 times less likely than Caucasians.

Overall, Adults (ages 18-59) are more underserved than children in Alameda County. Comparing the prevalence population to clients served produces a rate of only 58% for adults. The rate for children is 75%. Specifically:

- Asian/Pacific Islanders and Latinos are much less likely to be served than African Americans and Caucasians. Countywide, Latinos are four times less likely than African American and about two time less likely than Caucasians to receive mental health services. Disparities in service provision are also quite marked in the Asian/PI population. Compared to the prevalence population only they are 38% served while the rate for Caucasians is 68% and 102% for African Americans. Asian/PI.

* Served as a percent of the prevalence population equals the number of users divided by the prevalence population for each age group. The overall prevalence rate for the county was estimated by California DMH at 8.69%. This rate was estimated using prevalence data that did not include high-risk populations such as the incarcerated and homeless. This prevalence population (SED/SMI) only includes the most acutely ill and greatly underestimates the actual need for mental health services. For example, the Surgeon General’s 1999 Mental Health Report estimates that about one in five (20%) of Americans experiences a mental disorder in the course of a year.

### Adults age 18 and older

<table>
<thead>
<tr>
<th>Age</th>
<th>Prevalence</th>
<th>Population</th>
<th>Prevalence Rate</th>
<th>Served</th>
<th>Served as % of Poverty Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult total</td>
<td>20,457</td>
<td>238,151</td>
<td>8.59</td>
<td>11,035</td>
<td>54%</td>
</tr>
<tr>
<td>18-24</td>
<td>5,315</td>
<td>50,866</td>
<td>10.45</td>
<td>1,008</td>
<td>19%</td>
</tr>
<tr>
<td>25-34</td>
<td>4,049</td>
<td>53,096</td>
<td>7.63</td>
<td>1,985</td>
<td>49%</td>
</tr>
<tr>
<td>35-44</td>
<td>5,023</td>
<td>46,606</td>
<td>10.78</td>
<td>3,035</td>
<td>60%</td>
</tr>
<tr>
<td>45-54</td>
<td>2,335</td>
<td>31,470</td>
<td>7.42</td>
<td>3,037</td>
<td>130%</td>
</tr>
<tr>
<td>55-64</td>
<td>1,366</td>
<td>18,093</td>
<td>7.55</td>
<td>1,543</td>
<td>113%</td>
</tr>
<tr>
<td>65+</td>
<td>2,369</td>
<td>38,019</td>
<td>6.23</td>
<td>427</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Prevalence</th>
<th>Population</th>
<th>Prevalence Rate</th>
<th>Served</th>
<th>Served as % of Poverty Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6,828</td>
<td>104,039</td>
<td>6.56</td>
<td>4,430</td>
<td>65%</td>
</tr>
<tr>
<td>Female</td>
<td>13,629</td>
<td>134,085</td>
<td>10.16</td>
<td>6,546</td>
<td>48%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Prevalence</th>
<th>Population</th>
<th>Prevalence Rate</th>
<th>Served</th>
<th>Served as % of Poverty Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>5,744</td>
<td>66,150</td>
<td>8.68</td>
<td>3,418</td>
<td>60%</td>
</tr>
<tr>
<td>African American</td>
<td>4,302</td>
<td>51,275</td>
<td>8.39</td>
<td>3,897</td>
<td>91%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>4,353</td>
<td>50,814</td>
<td>8.57</td>
<td>1,619</td>
<td>37%</td>
</tr>
<tr>
<td>Native American</td>
<td>76</td>
<td>1,330</td>
<td>5.73</td>
<td>83</td>
<td>109%</td>
</tr>
<tr>
<td>Other</td>
<td>1,107</td>
<td>11,336</td>
<td>9.77</td>
<td>208</td>
<td>19%</td>
</tr>
<tr>
<td>Latino</td>
<td>4,874</td>
<td>57,246</td>
<td>8.51</td>
<td>1,166</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Prevalence as a % of Poverty Prevalence equals the number of users divided by the prevalence population for each age group. The overall prevalence rate for the county was estimated by California DMH at 8.69%. This rate was estimated using prevalence data that did not include high-risk populations such as the incarcerated and homeless. This prevalence population (SED/SMI) only includes the most acutely ill and greatly underestimates the actual need for mental health services. For example, the Surgeon General's 1999 Mental Health Report estimates that about one in five (20%) of Americans experiences a mental disorder in the course of a year.*
- The relatively high rate of service provision to African American adults is partly a result of the methodology used to estimate the prevalence population. The prevalence rates reflected the household population and did not include homeless and incarcerated populations which have very high prevalence rates and large numbers of African Americans.
- White and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos. A larger percentage of the prevalence population of males is served than the prevalence population of females.

**Older Adults** (ages 60+) are the least likely to receive mental health services:
- The percentage of clients served compared to the prevalence population is 15% for Asian/Pi’s and Latinos and 20% for African Americans. This ethnic composition of this group is more heavily weighted toward Caucasians (41%) than any other age group. Also, compared to other age groups older adults are very unlikely to be Latino.
- White and African American individuals are served at nearly four times the rate of Asian/Pacific Islanders and three times the rate of Latinos.

---------------------------------------------

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

The population assessment from the approved CSS Plan includes an in-depth analysis of disparities. A more structured analysis of the identified disparities for each target population is included under Criterion 3, Item II.
V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations

A. Which PEI priority population(s) did the county identify in their PEI plan?

All six of the PEI priority populations are identified in the Alameda County PEI Plan:

Priority populations that apply to all age groups:
1. Underserved cultural populations;
2. Trauma-exposed;
3. Individuals experiencing onset of serious psychiatric illness;

Priority populations that apply to children and youth:
4. Children and youth in stressed families;
5. Children and youth at risk for school failure; and
6. Children and youth at risk of or experiencing juvenile justice involvement.

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

The PEI Survey Results from 2010 (Attachment 2VB-1), and a summary of the Alameda County Community Meetings and Focus Group Discussion (Attachment 2VB-2) are included as attachments to this report. This data was used by the OPC to prioritize the six priority populations as key groups to address through the PEI funds. The MHSA Ongoing Planning Council (OPC) decided that all PEI programs would address the first three priority populations, and that the PEI programs that serve children and youth would address the last three priority populations.

In addition to the information under Criterion 2: Item VB, the Community Services and Supports (CSS) planning data, described under Criterion 2: Items IVA and IVB, provides additional information and context relating to the PEI priority populations. A more structured description of the selection process, rationale and analysis of identified disparities for the PEI priority populations is included under Criterion 3: Items I and II.
CRITERIA 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. Identified unserved/underserved target populations (with disparities); and
II. Identified disparities (within the target populations)

IA. List identified target populations, with disparities, within each of the selected populations (Medi-Cal, CSS, WET, and PEI priority populations);
IA1. 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); and
IIA. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI’s priority/targeted populations).

Please note that there is a section and table below for each of the following populations:
- Medi-Cal;
- Community Services and Supports (CSS);
- Workforce Education and Training (WET); and
- Prevention and Early Intervention (PEI).

Each section begins with a narrative summary of the planning process for that particular population. The tables describe the identified target populations, and identified disparities within each target population.
- The first column in each table describes the identified target populations, with disparities.
- The second column in each table describes the disparities for each of the identified populations.

**Medi-Cal Population**

The table below describes the identified target population within the Alameda County Medi-Cal population with the highest priority disparities. Please see Criteria 2, Item II for a more detailed narrative description.

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Rationale for selection and disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islanders (API)</td>
<td>In 2009, Asian/Pacific Islanders (API) comprised 23% of the Medi-Cal beneficiaries but only 11% of the Medi-Cal clients. Between 2006 and 2009, the number of API Medi-Cal beneficiaries increased by 22% (or 10,613 beneficiaries), but the number of API Medi-Cal clients, who received Mental Health Services, increased by 7% (or 158 clients) only. The API penetration rate of 3.8% was well below the 8% County average. African American, Caucasian, and Native American Children and Transitional Age Youth (TAY) were served over twice the rate of API Children and TAY. API Older Adults were the least served. The API Older Adults penetration rate of 1.4% was the lowest of all ethnicities among all age groups in 2009.</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>Although the Hispanic/Latino penetration rate increased from 5.1% in 2006 to 5.5% in 2009, it was still second to the lowest and was considerably lower than the 8% County average. In 2009, 17% (or 42,696) of the Medi-Cal beneficiaries reported being primary speakers of Spanish; however, only 8% of the Medi-Cal clients listed Spanish as their primary language. Latino Older Adults were especially under served. Along with API Older Adults, they had second to the lowest penetration rate (1.6%) among all the ethnicities.</td>
</tr>
<tr>
<td>Older Adults</td>
<td>The Older Adults penetration rate (3.2%) was the lowest of all age groups in 2009, despite the fact that it has been consistently increasing since 2006. Even with adjustment, the Older Adult Special Population (i.e. the Older Adult beneficiaries who had Medi-Cal related to disabilities or foster care) still had the lowest penetration rate (10%), which was less than half of the County average (21%).</td>
</tr>
</tbody>
</table>
Community Services and Supports (CSS) Population
– For Both Full Service Partnership (FSP) and Outreach, Education/System Development (OESD) –

The table below describes the identified target populations with disparities, and the identified disparities within each of these target populations. This information is based on the Alameda County CSS Planning Process.

The Alameda County CSS Plan was developed through the CSS Planning Process, which involved over 250 individuals organized into four planning panels; thirteen workgroups; a project management team; and a Stakeholder Group. Each layer of planning was representative of the diverse stakeholder communities required by the State Department of Mental Health’s Planning Requirements: consumers, family members, ethnic minorities, providers, non-mental health providers, line staff, organized labor, and people from all four regions of our large and geographically diverse county.

Outreach was conducted through surveys; focus groups; interviews; a telephone call-in line; conference calls; consumer and family group meetings; public meetings; town hall meetings; video conferences; media announcements; and brochures and other written materials. Whenever possible, BHCS collaborated with community leaders and providers who work with Alameda County’s diverse cultural, ethnic, linguistic and geographic communities to facilitate the meaningful representation of these groups within the planning process. Training was provided to ensure that participants had full understanding of the objectives and concepts of the MHSA, the CA DMH Planning Requirements, Alameda County’s ethnic disparities and the structure of its mental health system. Reimbursement was provided to facilitate the participation of diverse consumers and family members throughout the planning process.

The draft CSS projects were developed by the CSS Workgroups and informed by the CSS outreach efforts. These draft projects were then distributed for comment among the CSS Planning Panel, MHSA Ongoing Planning Council (OPC) and BHCS Administration before being submitted to the public for review and comment.

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Rationale for selection and disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>High rates of involuntary services, hospital-based services and frequent emergency care. High rates of poverty, exposure to crime, trauma, homelessness and involvement with the criminal justice system. High rates of unemployment and difficulty managing independence among formerly incarcerated individuals, and high rates of isolation among homeless individuals. High rates of out-of-home placement and school drop-out among children and youth. African American males are particularly impacted by many of these issues.</td>
</tr>
<tr>
<td>Asian/Pacific Islander (API)</td>
<td>High rates of poverty, exposure to crime, trauma and frequent emergency care. High rates of isolation and unemployment among recent immigrants due to language barriers. Lack of access to care due to language barriers. Although API individuals in Alameda County represent 22% of the low-income SMI/SED population, they represent only 11% of the population receiving mental health services through BHCS. No name for mental illness in their culture. Many diverse ethnicities within group.</td>
</tr>
</tbody>
</table>
### Table 8. CSS and FSP Target Populations and Disparities (Page 2 of 2)

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Rationale for selection and disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hispanic/Latino</strong></td>
<td>High rates of poverty, trauma and frequent emergency care. High rates of isolation and unemployment among recent immigrants due to legal status and language barriers. High rates of school drop-out among youth. Lack of access to care due to language barriers. Although Hispanic/Latinos individuals in Alameda County represent 26% of the low-income SMI/SED population, they represent only 19% of the population receiving mental health services through BHCS.</td>
</tr>
<tr>
<td><strong>Children and Youth</strong></td>
<td>High rates of peer and family problems. Many children and youth have out-of-home placement and involvement in the juvenile justice system. Youth are one of the age groups most likely to experience onset of SMI. Among children and youth, API, Latinos and the 0-5 population were identified as the most underserved.</td>
</tr>
<tr>
<td><strong>Transition-Age Youth (TAY)</strong></td>
<td>High rates of co-occurring substance use disorders and homelessness. Difficulties transitioning into adulthood in terms of finding jobs, places to live and meaningful activities. TAY are the age group most likely to experience onset of psychosis. According to the DMH prevalence rates and County data on TAY served, at least seventy percent of 16-24 year olds with SED are unserved in Alameda County. Moreover, when youth turn 18 they are legally considered adults and lose eligibility for many services. Lack of services specifically designed for TAY.</td>
</tr>
<tr>
<td><strong>Older Adults</strong></td>
<td>High rates of poverty, isolation, inability to manage independence, marginal housing or homelessness and institutionalization. High rates of co-occurring physical and substance use issues. Among older adults, API and Latinos were identified as the most underserved.</td>
</tr>
<tr>
<td><strong>Lesbian, Gay, Bisexual, Transgender (LGBT)</strong></td>
<td>High rates of isolation, trauma, co-occurring substance use issues and suicide. Lower rates of family connection and support.</td>
</tr>
<tr>
<td><strong>Consumers</strong></td>
<td>Lack of social support and meaningful activities. Stigma and discrimination.</td>
</tr>
<tr>
<td><strong>Family Members</strong></td>
<td>Lack of information and support. Stigma and discrimination.</td>
</tr>
</tbody>
</table>
Workforce Education and Training (WET) Population

The table below describes the identified target populations with disparities, and the identified disparities within each of these target populations. This information is based on the Alameda County WET Planning Process.

BHCS recruited a diverse Coordinating Team to develop a structure for the WET Planning Process. The Coordinating Team worked with BHCS Staff to recruit a Planning Panel comprised of 45 members representing diverse backgrounds and sectors. Training was provided to help participants fully understand the objectives and concepts of the MHSA, the CA DMH Planning Requirements, Alameda County’s ethnic disparities and the structure of its mental health system. Reimbursement was provided to facilitate the participation of diverse consumers and family members throughout the planning process. Planning Panel members were invited to meetings, and to join workgroups, which met more frequently to create strategies for the larger Planning Panel’s consideration. The workgroups were specific to Consumer Employment, Career Pathways and Family Employment. The larger Planning Panel was responsible for developing the preliminary WET Actions.

The required California Department of Mental Health Needs Assessment was administered from April through September 2008. To provide a comprehensive understanding of BHCS’ entire workforce, the Needs Assessment collected and analyzed data from four distinct sources:

1. Workforce Staff Survey for CBOs contracting with BHCS – With an organizational response rate of over 82%, over 1,400 surveys were returned from 61 CBOs;
2. Workforce Executive Director Survey for CBOs contracting with BHCS – With an organizational response rate of 74%, surveys were returned from 55 CBOs;
3. BHCS Language Proficiency Survey – With a response rate of 73% based on responses from the 346 staff within BHCS that completed the survey;
4. Review of BHCS Human Resources data – This included a review of data on all 453 staff within BHCS.

The Needs Assessment provided an additional layer of information for examining community needs and the completeness of the preliminary WET Actions.

Planning Panel recommendations and the Needs Assessment results provided complementary information about workforce needs and both were used to inform the development and refinement of the nine Actions within the County’s draft WET Plan. These Actions were then distributed for comment among the WET Planning Panel, MHSA OPC and BHCS Administration before being submitted to the public for review and comment.

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Rationale for selection and disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual staff that speak Spanish</td>
<td>There is a dramatic need for staff that speak the threshold language of Spanish (roughly 292 staff needed).</td>
</tr>
<tr>
<td>Bilingual staff that speak Asian/Pacific Islander (API) languages</td>
<td>There is a dramatic need for staff that speak threshold API languages: Cantonese (roughly 86 staff needed), Vietnamese (39 needed), Mandarin (31 needed) and Farsi (19 needed). There is very little or no local capacity in languages including, but not limited to: Arabic, Cambodian, Hmong, Lao, Mien, and Thai.</td>
</tr>
<tr>
<td>Bilingual staff that speak other languages</td>
<td>There is very little or no local capacity in other languages such as Russian</td>
</tr>
</tbody>
</table>

10 For more information, please see the WET Needs Assessment (Criteria 6, Item 1A).
Table 9. WET Target Populations and Disparities (Page 2 of 2)

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Rationale for selection and disparity\textsuperscript{11}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff that are Hispanic/Latino</td>
<td>Hispanic/Latinos comprise only 11% of the BHCS workforce compared to 29% of the projected low income individuals living with serious mental illness/serious emotional disturbance (SMI/SED) that BHCS is charged to serve.</td>
</tr>
<tr>
<td>Staff that are Asian/Pacific Islander (API)</td>
<td>APIs comprise only 16% of the BHCS workforce compared to 26% of the projected SMI/SED population that BHCS is charged to serve.</td>
</tr>
<tr>
<td>Staff that are African or Native American</td>
<td>Though the data from the WET Needs Assessment did not identify the same level of need for African American or Native American Staff, stakeholders from our community have expressed concerns that the state has underestimated the SMI/SED estimates for these populations. Anecdotal information suggests that significant staffing shortages also exist for these groups.</td>
</tr>
<tr>
<td>Staff with Lived Experience</td>
<td>Executive Director Survey responses indicate that over 232 FTEs are currently authorized to be filled by consumers or family members within the system, and suggest that an additional 373 FTEs may be needed in the workforce to fully meet the needs of Alameda County’s mental health service population.</td>
</tr>
</tbody>
</table>

\textsuperscript{11} For more information, please see the WET Needs Assessment (Criteria 6, Item 1A).
Prevention and Early Intervention (PEI)

– Includes PEI Priority Populations –

The table below describes the identified target populations with disparities for PEI, and the identified disparities within these target populations. This information is based on the Alameda County PEI Planning Process.

BHCS mobilized its staff and partners to provide outreach and education, and to include diverse stakeholders at each stage of the planning process. Efforts were made to provide targeted outreach to groups traditionally underserved by the mental health system and provide opportunities for them to participate in a meaningful way. The process included the engagement of diverse local stakeholders, including those from required strategic sectors, systems and organizations.

Members of the community participated in the PEI Planning Process in a variety of ways:
- 629 individuals provided input through Community Meetings/Focus Groups;
- 1,083 individuals provided input through the Community Survey;
- 27 organizations and groups provided input through Community Reports;
- 59 members of the two PEI Planning Panels discussed community input and developed draft strategies;
- 45 members of the MHSA Ongoing Planning Council (OPC) prioritized and refined draft strategies.

The planning process included two Planning Panels: one that was general, and one that was specific to the needs of underserved ethnic and language populations. Training was provided to help participants fully understand the objectives and concepts of the MHSA, the CA DMH Planning Requirements, Alameda County’s ethnic disparities and the structure of its mental health system. Reimbursement was provided to facilitate the participation of diverse consumers and family members throughout the planning process.

Prior to the PEI Community Input Process, three groups were convened by ACBHCS to study priority issues identified through CSS. Those three issues were: the needs of underserved ethnic and language populations (UELPs); programs to address early intervention at the onset of psychosis; and the needs identified by mental health consumers. Each of these UELP groups, as well as the Alameda County Study Group on Early Intervention at the Onset of Psychosis, and the Alameda County Pool of Consumer Champions (ACPOCC) was successful in submitting a Community Report.

<table>
<thead>
<tr>
<th>Identified target/priority population</th>
<th>Rationale for selection and disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition-Age Youth</td>
<td>See rationale under CSS Table.</td>
</tr>
<tr>
<td>Older Adults</td>
<td>See rationale under CSS Table.</td>
</tr>
<tr>
<td>Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Inquiring, Intersex and Allies (LGBTQQII)</td>
<td>See rationale under CSS Table.</td>
</tr>
<tr>
<td>Identified target/priority population</td>
<td>Rationale for selection and disparity</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>☒ Underserved cultural populations</td>
<td>These priority populations were selected for all of the PEI Programs. The needs of underserved cultural populations and trauma exposed individuals were identified as key local issues in our PEI Community Planning Process, and both the PEI Planning Panels and the Ongoing Planning Council identified them as major issues for each of the PEI Program to address. There was recognition that many existing services do not adequately recognize or address the needs of underserved cultural populations or trauma exposed individuals, and that this can result in less effective services for these groups.</td>
</tr>
<tr>
<td>☒ Trauma Exposed Individuals</td>
<td>This priority population was selected for all of the PEI Programs. The PEI Community Needs Assessment found a lack of existing services for individuals experiencing onset of serious psychiatric illness, which results in a disparity in their ability to access effective care. Two of our PEI Planning Panel Workgroups and the Ongoing Planning Council identified early intervention for individuals experiencing onset of serious psychiatric illness as one of the key areas for PEI funding. This resulted in PEI Program #2: Early Intervention for the Onset of First Psychosis and SMI among TAY. Due to the importance of this issue, it was decided that each PEI Program will provide information about this issue, and that all programs that have contact with TAY will link with this program.</td>
</tr>
<tr>
<td>☒ Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>These priority populations were selected for all of the PEI Programs, except #3. PEI Program #3 has a specified focus on older adults and will not be serving children and youth. There was broad consensus from our PEI Community Planning Process, PEI Planning Panels and Ongoing Planning Council that these are key target populations to reach in serving children and youth, and that there is significant overlap between these priority populations. Services must acknowledge the unique characteristics and needs of these priority populations in order to effectively engage youth and families, provide support and reduce disparities.</td>
</tr>
<tr>
<td>☒ Children and Youth in Stressed Families</td>
<td>These priority populations were selected for all of the PEI Programs, except #3. PEI Program #3 has a specified focus on older adults and will not be serving children and youth. There was broad consensus from our PEI Community Planning Process, PEI Planning Panels and Ongoing Planning Council that these are key target populations to reach in serving children and youth, and that there is significant overlap between these priority populations. Services must acknowledge the unique characteristics and needs of these priority populations in order to effectively engage youth and families, provide support and reduce disparities.</td>
</tr>
<tr>
<td>☒ Children and Youth at Risk for School Failure</td>
<td>These priority populations were selected for all of the PEI Programs, except #3. PEI Program #3 has a specified focus on older adults and will not be serving children and youth. There was broad consensus from our PEI Community Planning Process, PEI Planning Panels and Ongoing Planning Council that these are key target populations to reach in serving children and youth, and that there is significant overlap between these priority populations. Services must acknowledge the unique characteristics and needs of these priority populations in order to effectively engage youth and families, provide support and reduce disparities.</td>
</tr>
<tr>
<td>☒ Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>These priority populations were selected for all of the PEI Programs, except #3. PEI Program #3 has a specified focus on older adults and will not be serving children and youth. There was broad consensus from our PEI Community Planning Process, PEI Planning Panels and Ongoing Planning Council that these are key target populations to reach in serving children and youth, and that there is significant overlap between these priority populations. Services must acknowledge the unique characteristics and needs of these priority populations in order to effectively engage youth and families, provide support and reduce disparities.</td>
</tr>
</tbody>
</table>
III. Identified strategies/objectives/actions/timelines

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

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; and
   V. PEI priority population(s) selected by the county, from the six PEI priority populations.

The tables below describe the identified strategies, under each of the MHSA funding streams, to address the identified target populations and disparities. Please note that the 1st section, below focuses on the Medi-Cal Population; the 2nd focuses on the 200% of poverty population; the 3rd focuses on Community Services and Supports (CSS) and Prevention and Early Intervention (PEI); and the 4th focuses on Workforce Education and Training (WET).

- The first table in each section describes the strategies, or programs, for addressing the identified disparities.
- The subsequent table(s) in each section describe the specific objectives and actions for each of the programs.
- In terms of timeline, it is currently anticipated that all of the strategies will be implemented by December 2013.

**Medi-Cal Population**

As indicated in the following tables ACBHCS recognizes it’s mandate to serve this population. The strategies identified are largely community defined.

**200% of Poverty Population**

Our MHSA funded CSS, WET and PEI Plans were developed using data collected from looking at the needs of Alameda County’s residence living at 200% of Poverty. Please refer to the tables for the outlined strategies.
### Table 11. CSS and PEI Strategies for Addressing Identified Disparities (Page 1 of 6)

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Strategies for addressing disparities</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td><strong>Disparities Addressed in CSS Plan:</strong></td>
</tr>
</tbody>
</table>
|                             | - *Homelessness and isolation/poverty/exposure to crime/trauma*  
|                             |   - FSP 1. Homeless Outreach and Stabilization Team (HOST)  
|                             |   - FSP 2. North County Senior Homeless Program  
|                             |   - FSP 3. Supportive Housing for Transition-Age Youth (TAY)  
|                             |   - FSP 4. Greater HOPE  
|                             |   - FSP 5. Forensic Assertive Community Treatment (FACT)  
|                             |   - FSP 6. Transition to Independence Process (TIP)  
|                             |   - FSP 7. CHOICES for Community Living  
|                             |   - OESD 12. Older Adult Peer Support Program  
|                             |   - OESD 14. TAY Resource Center  
|                             |   - OESD 15. Recovery Education Centers  
|                             | - *Involvement with the criminal justice system and difficulty managing independence/unemployment/poverty/trauma*  
|                             |   - FSP 5. Forensic Assertive Community Treatment (FACT)  
|                             |   - FSP 9. Transitional Behavioral Health Court ACT Team  
|                             |   - OESD 7. Mental Health Court Specialist Program.  
|                             |   - OESD 8. Transformation of the Juvenile Justice Guidance Clinic  
|                             |   - OESD 9. Multi-Systemic Therapy (MST)  
|                             | - *High rates of involuntary services/hospital-based services/emergency care*  
|                             |   - OESD 11. Crisis Receiving Facility for Adolescents  
|                             |   - OESD 12. Older Adult Peer Support Program  
|                             |   - OESD 14. TAY Resource Center  
|                             |   - OESD 15. Recovery Education Centers  
|                             | - *Males and trauma*  
|                             |   - Administration. Pool of Consumer Champions  
|                             | - *School drop-out and trauma/exposure to crime*  
|                             |   - OESD 14. Transition-Age Youth (TAY) Resource Center
<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Strategies for addressing disparities</th>
</tr>
</thead>
</table>
| **African American** (Continued) | **Disparities Addressed in PEI Plan:**  
  - School drop-out and trauma/exposure to crime  
    - 1A. Mental Health Consultation in Preschools  
    - 1B/C. Mental Health Consultation in Schools  
  **No Specific Strategy in CSS or PEI Plan:**  
  - Children in out of home placement. |
| **Asian/Pacific Islander (API)** | **Disparities Addressed in CSS Plan:**  
  - Language barriers/legal status/frequent emergency care.  
    - FSP 8. Wraparound Program for API and Latino Children/Youth  
    - OESD 3A. Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) for APIs  
  - School drop-out.  
    - FSP 8. Wraparound Program for API and Latino Children/Youth  
  **Disparities Addressed in PEI Plan:**  
  - Trauma/isolation/language barriers/unemployment/poverty/school drop-out among youth  
    - 6. Outreach, Education and Consultation for the API Community  
  - Language barriers/frequent emergency care.  
    - 3B. Mental Health-Primary Care Integration for API Older Adults  
    - 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations |
| **Latino** | **Disparities Addressed in CSS Plan:**  
  - Language barriers/legal status/frequent emergency care.  
    - FSP 8. Wraparound Program for API and Latino Children/Youth  
    - OESD 3B. Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) for Latinos  
  - School drop-out.  
    - FSP 8. Wraparound Program for API and Latino Children/Youth  
  **Disparities Addressed in PEI Plan:**  
  - Trauma/isolation/legal status/language barriers/unemployment/poverty/school drop-out among youth  
    - 5. Outreach, Education and Consultation for the Latino Community |
<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Strategies for addressing disparities</th>
</tr>
</thead>
</table>
| Latino (Continued)          | *Language barriers/frequent emergency care.*  
|                             |   o 3A. Mental Health-Primary Care Integration for Latino Older Adults  
|                             |   o 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations |
| South Asian/Afghan          | **Disparities Addressed in PEI Plan:**  
|                             |   *Trauma/isolation/language barriers*  
|                             |   o 7. Outreach, Education and Consultation for the South Asian/Afghan Community  
|                             |   *Language barriers/frequent emergency care.*  
|                             |   o 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations |
| Native American             | **Disparities Addressed in PEI Plan:**  
|                             |   *Trauma/isolation/unemployment/poverty/exposure to crime*  
|                             |   o 8. Outreach, Education and Consultation for the Native American Community  
|                             |   *Language barriers/frequent emergency care.*  
|                             |   o 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations |
| Children and Youth          | **Disparities Addressed in CSS Plan:**  
|                             |   *Involvement in the Juvenile Justice System.*  
|                             |   o OESD 8. Transformation of the Juvenile Justice Guidance Clinic  
|                             |   o OESD 9. Multi-Systemic Therapy (MST)  
|                             |   **Onset of SMI.**  
|                             |   o OESD 11. Crisis Receiving Facility for Adolescents  
|                             |   **API and Latinos.**  
|                             |   o FSP 8. Wraparound Program for Asian/Pacific Islander (API) and Latino Children/Youth  
|                             | **Disparities Addressed in PEI Plan:**  
|                             |   *Peer and family problems/school drop-out/0-5 population.*  
|                             |   o 1A. Mental Health Consultation in Preschools  
|                             |   o 1B/C. Mental Health Consultation in Schools  
|                             | **No Specific Strategy in CSS or PEI Plan:**  
<p>|                             |   o <em>Out of home placement.</em> |</p>
<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Strategies for addressing disparities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition-Age Youth (TAY)</strong></td>
<td><strong>Disparities Addressed in CSS Plan:</strong></td>
</tr>
<tr>
<td></td>
<td>- <em>Co-occurring substance use.</em></td>
</tr>
<tr>
<td></td>
<td>- OESD 13. Co-Occurring Disorders Program</td>
</tr>
<tr>
<td></td>
<td>- <em>Homelessness.</em></td>
</tr>
<tr>
<td></td>
<td>- FSP 3. Supportive Housing for TAY</td>
</tr>
<tr>
<td></td>
<td>- FSP 6. Transition to Independence Process (TIP)</td>
</tr>
<tr>
<td></td>
<td>- <em>Lack of access to services/jobs/meaningful activities.</em></td>
</tr>
<tr>
<td></td>
<td>- OESD 14. TAY Resource Center</td>
</tr>
<tr>
<td></td>
<td><strong>Disparities Addressed in PEI Plan:</strong></td>
</tr>
<tr>
<td></td>
<td>- <em>Onset of psychosis.</em></td>
</tr>
<tr>
<td></td>
<td>- 2. Early Intervention for the Onset of First Psychosis and Serious Mental Illness (SMI) Among TAY</td>
</tr>
<tr>
<td><strong>Older Adults</strong></td>
<td><strong>Disparities Addressed in CSS Plan:</strong></td>
</tr>
<tr>
<td></td>
<td>- <em>Isolation/inability to manage independence/institutionalization.</em></td>
</tr>
<tr>
<td></td>
<td>- FSP 2. North County Senior Homeless Program</td>
</tr>
<tr>
<td></td>
<td>- OESD4A. Mobile Integrated Assessment Program for Older Adults</td>
</tr>
<tr>
<td></td>
<td>- OESD 12. Older Adult Peer Support Program</td>
</tr>
<tr>
<td></td>
<td>- <em>Poverty/housing.</em></td>
</tr>
<tr>
<td></td>
<td>- FSP 2 is a North County Senior Homeless Program.</td>
</tr>
<tr>
<td></td>
<td>- <em>Co-occurring issues.</em></td>
</tr>
<tr>
<td></td>
<td>- OESD 13. Co-Occurring Disorders Program</td>
</tr>
<tr>
<td></td>
<td>- OESD4A. Mobile Integrated Assessment Program for Older Adults</td>
</tr>
<tr>
<td></td>
<td>- <em>API and Latinos.</em></td>
</tr>
<tr>
<td></td>
<td>- OESD4A. Mobile Integrated Assessment Program for Older Adults</td>
</tr>
<tr>
<td></td>
<td><strong>Disparities Addressed in PEI Plan:</strong></td>
</tr>
<tr>
<td></td>
<td>- <em>Co-occurring issues.</em></td>
</tr>
<tr>
<td></td>
<td>- 3A/B. Mental Health-Primary Care Integration for Asian/Pacific Islander (API) and Latino Older Adults at Community Clinics</td>
</tr>
<tr>
<td></td>
<td>- 3C. Mental Health-Primary Care Integration for Older Adults in Emergency Rooms</td>
</tr>
<tr>
<td>Identified target population</td>
<td>Strategies for addressing disparities</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------</td>
</tr>
</tbody>
</table>
| Lesbian, Gay, Bisexual, Transgender (LGBT) | No Specific Strategy in CSS or PEI Plan:  
- *Isolation/trauma/co-occurring substance use issues/suicide/lack of family connection and support.* |
| Consumers | Disparities Addressed in CSS Plan:  
- *Isolation/lack of meaningful activities*  
  - OESD 15. Recovery Education Centers  
Disparities Addressed in PEI Plan:  
- *Stigma and Discrimination*  
  - 4. Stigma and Discrimination Reduction Program |
| Family Members | Disparities Addressed in CSS Plan:  
- *Lack of information and support*  
  - OESD 2. Family Education Resource Center  
Disparities Addressed in PEI Plan:  
- *Stigma and Discrimination*  
  - 4. Stigma and Discrimination Reduction Program |
| PEI Priority Populations | |
| Trauma Exposed Individuals | Addressed in PEI Plan:  
  - 1A/B/C. Mental Health Consultation in Preschools/Schools  
  - 2. Early Intervention for the Onset of First Psychosis and Serious Mental Illness (SMI) Among Transition-Age Youth (TAY)  
  - 3A/B. Mental Health-Primary Care Integration for Asian/Pacific Islander (API) and Latino Older Adults at Community Clinics  
  - 3C. Mental Health-Primary Care Integration for Older Adults in Emergency Rooms  
  - 4. Stigma and Discrimination Reduction Program  
  - 5. Outreach, Education and Consultation for the Latino Community  
  - 6. Outreach, Education and Consultation for the API Community  
  - 7. Outreach, Education and Consultation for the South Asian/Afghan Community  
  - 8. Outreach, Education and Consultation for the Native American Community  
  - 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations |
| Individuals Experiencing Onset of Serious Psychiatric Illness | |
Table 11. CSS and PEI Strategies for Addressing Identified Disparities (Page 6 of 6)

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>Strategies for addressing disparities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEI Priority Populations (Continued)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Children and Youth in Stressed Families**
- Addressed in PEI Plan:
  - 1A/B/C. Mental Health Consultation in Preschools/Schools
  - 2. Early Intervention for the Onset of First Psychosis and Serious Mental Illness (SMI) Among Transition-Age Youth (TAY)
  - 4. Stigma and Discrimination Reduction Program
  - 5. Outreach, Education and Consultation for the Latino Community
  - 6. Outreach, Education and Consultation for the Asian/Pacific Islander (API) Community
  - 7. Outreach, Education and Consultation for the South Asian/Afghan Community
  - 8. Outreach, Education and Consultation for the Native American Community
  - 9. Behavioral Health-Primary Care Integration for Underserved Ethnic and Language Populations

**Children and Youth at Risk for School Failure**

**Children and Youth at Risk of or Experiencing Juvenile Justice Involvement**

Table 12. Description of Approved CSS Programs (Page 1 of 3)

**FSP 1** is the Homeless Outreach and Stabilization Team (HOST). The objective is to engage homeless adults; and link them to a range of community services with a focus on subsidies and supports for obtaining and retaining housing. This program provides outreach; integrated assessment teams; integrated community services and support teams; supportive housing; supportive employment; and family support education services.

**FSP 2** is the North County Senior Homeless Program. The objective is to engage older adults with or at risk for homelessness; and to link them to a range of community services with a focus on support for obtaining and retaining housing. This program provides outreach; integrated assessment teams; integrated community services and support teams; supportive housing; supportive employment; and family support education services.

**FSP 3** is the Supportive Housing for TAY Program. The objective is to provide permanent supportive housing for youth who are homeless, are aged out of foster care, leaving the justice system or leaving residential treatment. The program provides integrated service teams to provide comprehensive services; supportive housing; supported employment/education; family support; and recreational and social activities.

**FSP 4** is the Greater HOPE Program. The objective is to add housing, Personal Service Coordinators and medication capacity to an existing mobile homeless outreach provider in South and East County; and to reduce homelessness. This program provides outreach; integrated assessment teams; integrated community services and support teams; supportive housing; supportive employment; and family support education services.
Table 12. Description of Approved CSS Programs (Continued – Page 2 of 3)

**FSP 5** is the Forensic Assertive Community Treatment (FACT) Team. The objective is to break the cycle of repeat involvement with the criminal justice system among incarcerated adults with SMI. This program provides outreach services for persons who are homeless or at risk of homelessness; integrated community services with law enforcement and courts; intensive community services and supports; and supportive housing.

**FSP 6** is a Transition to Independence Process. The objective is to improve access to mental health services among TAY who are homeless or leaving foster care or the criminal justice system; promote and assist these TAY in achievement of wellness and recovery goals; and emphasize transition to community competence by building on youths’ strengths, community resources, and resiliency. Through integrated service teams affiliated with the 2034 model, this program provides outreach; development of peer support, self help and youth family run programs; development of housing options; and supportive employment.

**FSP 7** is the CHOICES for Community Living Program. The objective is to help clients exit the Adult Service Teams and live “ordinary,” meaningful lives, guided by their choices, in the community. This program provides a broader and more intensive array of services for participants; and to offers a “mutual support community” and resources to pursue client-identified goals within a recovery-oriented setting. This program closely links with OESD 15, the Recovery Education Centers. This program provides supported housing; supported education; supported employment; and peer support.

**FSP 8** is a Wraparound Program for API and Latino children and youth. The objective is to improve access to mental health services for these populations; and to promote and assist in the achievement of wellness and resilience goals by building on child, youth and family strengths and community resources. The program provides child, youth and family engagement; wraparound planning that is child, youth and family centered; and treatment via community-based supports.

**FSP 9** is the Transitional Behavioral Health Assertive Community Treatment (ACT) Team. The objective is to reduce incarceration for individuals with SMI who are repeatedly incarcerated, often due to their mental illnesses and lack of intensive community treatment; and to enhance their participation in community treatment and recovery. This program provides Assertive Community Treatment through ACT Teams.

**OESD 1** is the Wellness, Recovery and Resiliency Resource Hub. The objective is to develop self-help, peer support and client, family and youth run programs; and to promote the involvement of these groups in ACBHCS decision-making. This program provides training; and organizational consultation.

**OESD 2** is the Family Education Resource Center. The objective is to provide education and support to family members. This program provides family education, support and consultation; self help groups; and mentoring.

**OESD 3/A/B** is the program to provide Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) for API and Latinos. The objective is to reduce ethnic disparities caused by the current lack of language/cultural specialty services. This program provides culturally responsive outreach services; linguistically appropriate services; and crisis assessment, intervention and stabilization services.

**OESD 4/A** is the Mobile Integrated Assessment Program for older adults in South County. The objective is to reduce the frequency of emergency room visits and psychiatric hospitalizations by identifying mental illness in older adult patients who are seeking treatment at primary care community clinics; and to reduce the isolation and the inability to manage independence of older adults by offering mobile psychiatric services with the ability to offer home treatment. This program provides education for primary care providers to coordinate and integrate services; onsite services with primary care; culturally responsive services to Spanish and Asian language communities; and mobile services to reach older adults.
### Table 12. Description of Approved CSS Programs (Continued – Page 3 of 3)

**OESD 5A/B** is the Crisis Response Program for Tri-Valley and Tri-Cities. The objective is to augment ACCESS and crisis evaluation services for residents of South and East County; and to reduce disparities due to lack of geographic access to services. This program provides crisis services to adults and older adults.

**OESD 7** is the Mental Health Court Specialist Program. The objective is to place a team of mental health staff in Alameda County courtrooms to provide assessment, advocacy, and alternatives to incarceration for defendants with severe mental illness. This program provides integrated services with law enforcement, probation and court staff.

**OESD 8** is the program to transform the Juvenile Justice Guidance Clinic. The objective is to reduce the repeated involvement of youth with the juvenile justice system and mitigate other issues such as peer and family problems through detection and treatment of Severe Emotional Disturbance (SED). The program provides in-depth mental health assessment and treatment for youth in the juvenile justice system, as well as linkages to community based services.

**OESD 9** is the Multi-Systemic Therapy (MST) Program. The objective is to promote family preservation for chronic juvenile offenders with SED co-occurring with substance abuse and violent behavior; and to mitigate other problems such as school failure and peer and family problems. This program provides values-driven evidence-based MST services with plans and goals; integrated services and supports for youth and their families; and family preservation services.

**OESD 11** is the Crisis Receiving Facility for Adolescents. The objective is to address needs of adolescents in acute distress to avoid hospitalization or safely delay their transfer to a Psychiatric Health Facility (PHF) until a bed is available (within 23 hours of arrival at the Crisis Stabilization Center). The program provides assessment of adolescents in acute distress; safe delay of transfer to appropriate services; and support and education to families.

**OESD 12** is the Older Adult Peer Support Program. The objective is to address the needs of older adults who have SMI; and to decrease emergency medical care and frequent hospitalization. This program provides individual and group counseling; and psycho-education to older adults by their peers.

**OESD 13** is the Co-Occurring Disorders Program that includes an ongoing Medication Support Program, and a time-limited Co-Occurring Issues Initiative. The objective is to enhance outcomes among clients with co-occurring substance abuse and mental health disorders. The first component provides assessment, evaluation, monitoring and adjustment of medications to reduce the impacts of those medications on physical and mental health. The second component provides training and forums for stakeholder discussion about best practices for better supporting individuals with co-occurring substance use issues.

**OESD 14** is the TAY Resource Center which provides outreach and mental health services at Youth Uprising, an existing youth resource center, to TAY with mental health issues. The objective is to improve access to mental health services; promote and assist these TAY in achievement of wellness and recovery goals; and emphasize transition to community competence by building on youths’ strengths, community resources, and resiliency.

**OESD 15** is the Recovery Education Centers. The objective is to program build a community of participants; emphasize a “self-help” ethic; and decrease reliance of participants on professionals to solve problems and provide supports. This program provides wellness, recovery, resilience and peer support to the participants of FSP 7, the CHOICES for Community Living Program.
**Table 12. Description of Approved PEI Programs (Page 1 of 2)**

**PEI 1A/B/C** is the Mental Health Consultation Program for Preschools and Schools. The objective is to promote early identification of mental health issues and appropriate response within preschools and schools; and to interrupt the progression to more serious issues such as school failure, involvement with the criminal justice system and suicide. This program provides general consultation; program consultation; child-specific consultation; training; direct mental health services (low-intensity, short-term); and advocacy and referral services.

**PEI 2** provides Early Intervention for the Onset of First Psychosis and SMI Among Transition-Age Youth (TAY). The objective is to build awareness in the community about the onset of psychosis and SMI; educate the community about the effectiveness of early intervention; and provide culturally responsive treatment. This project will provide outreach and education; stigma reduction; family involvement; assessment; case management; counseling; supported education/employment; crisis intervention; cognitive interventions; stress reduction; and peer support.

**PEI 3A/B** is the Mental Health-Primary Care Integration Program for Asian/Pacific Islander (API) and Latino Older Adults at Community Clinics. The objective is to address stigma and disparities in access to services; and to create a real-time collaborative relationship between primary care staff and the Mental Health Specialist. This program serves Central County and provides the following services at one API-serving and one Latino-serving community clinic: orientation and ongoing training of pertinent primary care staff; brief non-stigmatizing screening; direct mental health services (low-intensity, short-term); and referral services.

**PEI 3C** is the Mental Health-Primary Care Integration Program for Older Adults in Emergency Rooms. The objective is to create a Geriatric Assessment and Response Team (GART) that would serve emergency rooms in Central County; and to reduce frequent and inappropriate use of emergency care. This program provides orientation and ongoing training of pertinent emergency room staff; referral to the GART, as needed; assessment and direct mental health services (low-intensity, short-term) provided by the GART; and linkage and referral services provided by the GART.

**PEI 4** is the Stigma and Discrimination Reduction Campaign. The objective is to decrease stigma and discrimination; and promote community inclusion for individuals living with SMI and SED. This program develops targeted action plans; targeted anti-stigma educational and media products; technical assistance to other PEI projects and the larger disability community; an expanded Speakers Bureau and ‘Mental Health Matters’ TV shows; and an expansion of personal empowerment and spirituality trainings.

**PEI 5** is the Outreach, Education and Consultation for the Latino Community. The objective is to increase knowledge about mental health; decrease stigma and discrimination; and increase culturally and linguistically appropriate supports for individuals with or at risk for serious mental health issues. This program provides outreach and education; mental health consultation; and early intervention.

**PEI 6** is the Outreach, Education and Consultation for the Asian/Pacific Islander (API) Community. The objective is to increase knowledge about mental health; decrease stigma and discrimination; and increase culturally and linguistically appropriate supports for individuals with or at risk for serious mental health issues. This program provides outreach and education; mental health consultation; and early intervention.

**PEI 7** is the Outreach, Education and Consultation for the South Asian/Afghan Community. The objective is to increase knowledge about mental health; decrease stigma and discrimination; and increase culturally and linguistically appropriate supports for individuals with or at risk for serious mental health issues. This program provides outreach and education; mental health consultation; and early intervention.
**Table 12. Description of Approved PEI Programs (Page 2 of 2)**

**PEI 8** is the Outreach, Education and Consultation for the Native American Community. The objective is to increase knowledge about mental health; decrease stigma and discrimination; and increase culturally responsive supports for individuals with or at risk for serious mental health issues. This program provides outreach and education; mental health consultation; and early intervention.

**PEI 9** is the Behavioral Health-Primary Care Integration Program for Underserved Ethnic and Language Populations. The objective is to increase access to care by serving the client at a non-stigmatizing location where they already seek care. This program provides behavioral health screening in a primary care clinic; ‘warm hand-off’ when further behavioral health services are needed; behavioral health consultation; and referral.

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**Workforce Education and Training (WET)**

**Table 13. WET Strategies for Addressing Identified Disparities (Page 1 of 1)**

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>WET strategies for addressing disparities</th>
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</thead>
<tbody>
<tr>
<td>Bilingual staff that speak Spanish</td>
<td>o 4. Coordinated Community College Career Pathway into Public Mental Health</td>
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<tr>
<td>Bilingual staff that speak Asian/Pacific Islander (API) languages</td>
<td>o 5. Educational Campaign to Increase Workforce Diversity and Language Capacity</td>
</tr>
<tr>
<td>Bilingual staff that speak other languages</td>
<td>o 6. Coordinated Internship Program</td>
</tr>
<tr>
<td>Staff that are Hispanic/Latino</td>
<td>o 7. Financial Incentives Stipend Program for High School; Peer Certificate Training Programs; Community College; and Undergraduate Programs</td>
</tr>
<tr>
<td>Staff that are Asian/Pacific Islander (API)</td>
<td>o 8. Graduate Level Stipend Program</td>
</tr>
<tr>
<td>Staff that are African or Native American</td>
<td>o 9. Loan Assumption Program</td>
</tr>
<tr>
<td>Staff with Lived Experience</td>
<td>o 3. Peer Employment Toolkit</td>
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<tr>
<td></td>
<td>o 4. Coordinated Community College Career Pathway into Public Mental Health</td>
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<tr>
<td></td>
<td>o 7. Financial Incentives Stipend Program for High School; Peer Certificate Training Programs; Community College; and Undergraduate Programs</td>
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<td>Table 13. Description of Approved WET Programs (Page 1 of 2)</td>
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<tr>
<td><strong>WET 1</strong> is the activity for Workforce, Education and Training Development, Support and Coordination. The objective is to create the infrastructure necessary to implement a comprehensive workforce program that drives the development of an integrated mental health workforce pipeline to meet the needs of the BHCS workforce (which includes County and CBO Contractors). This program provides staffing to support the management, implementation and evaluation of all WET efforts; to develop a Workforce Advisory Committee; and to participate in other county, regional and state WET efforts.</td>
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<tr>
<td><strong>WET 2</strong> is the Training Institute. This program develops and implements the Strategic Training Plan. The objective is to incorporate consumer and family voice, wellness, recovery and resiliency principles and practices, and cultural responsiveness into trainings; to create management curriculum to meet organizational and succession planning needs; to recruit consumer and family member presenters and trainers; to increase the number of continuing education units offered to licensed providers; and to develop evaluation tools to measure training effectiveness.</td>
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<td><strong>WET 3</strong> is the Peer Employment Toolkit. The objective is to create an integrated, coordinated approach to consumer and family member employment; to increase the number and type of consumer and family member positions across the system; to train and recruit diverse consumers and family members into open positions; and increases job satisfaction, success and retention rates among consumer and family member employees, including those from unserved, underserved and inappropriately served communities. This program provides training and ongoing supports for peer providers; training for supervisors; and preparation to the existing workforce to welcome consumers and family members as colleagues.</td>
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<td><strong>WET 4</strong> is the Coordinated Community College Career Pathway into Public Mental Health. The objective is to develop an articulated mental health educational pipeline, linking these programs to four year colleges and universities; to increase the number of Transitional Age Youth (TAY) clients, consumers and family members enrolled in community college pipeline programs; to develop college-based supported education programs; to increase the number of internship opportunities; and, over time, to increase diversity, language capacity and hard-to-fill skill sets within the BHCS workforce. This program establishes collaborative relationships with Alameda County community colleges and high schools; publicizes the BHCS Stipends Program and employment opportunities within the BHCS workforce; and provides outreach and recruitment to culturally diverse and bilingual students, including consumers and family members.</td>
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<td><strong>WET 5</strong> is the Educational Campaign to Increase Workforce Diversity and Language Capacity. The objective is to develop culturally and ethnically appropriate workforce campaigns for the County’s unserved, underserved and inappropriately served communities to increase understanding of and interest in mental health employment. This program develops culturally responsive workforce campaigns and communication plans; publicizes the BHCS Stipends Program and employment opportunities within the BHCS workforce; and identifies and supports interpreter programs that can help to address the needs of under and inappropriately served language groups.</td>
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<td><strong>WET 6</strong> is the Coordinated Internship Program. The objective is to create a coordinated approach to internships in the BHCS workforce (which again includes County and CBO Contractors); to increase awareness of internship opportunities among educational institutions; to increase the capacity of interns and intern supervisors; and, over time, to increase diversity, language capacity and hard-to-fill skill sets within the BHCS workforce. This program convenes an Internship Workgroup; identifies existing and potential internship placements; develops new internship placements; serves as the single point of contact for educational institutions to publicize internship opportunities; and provides group orientation, training and support.</td>
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<tr>
<td>Program</td>
<td>Description</td>
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<td><strong>WET 7</strong></td>
<td>The Financial Incentives Stipend Program for High School; Peer Certificate Training Programs; Community College; and Undergraduate Programs. The objective is to develop, expand and diversify the BHCS workforce (which again includes County and CBO Contractors). This program convenes a Financial Incentives Committee; develops eligibility criteria for stipend programs within each of these settings that will increase diversity, linguistic capacity, hard-to-fill skill sets; provides outreach and education about the program to peers and to unserved, underserved and inappropriately served communities; contracts with a vendor to manage this program; provides annual stipends; and tracks the educational/career progress of program awardees.</td>
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<tr>
<td><strong>WET 8</strong></td>
<td>The Graduate Level Stipend Program. The objective is to provide 20 $5,000 stipends to graduate students/interns on an annual basis to support students who are enrolled in specific academic programs and who meet the county’s hard to fill or retain workforce needs (bilingual; bicultural; consumers and family members) and hard to fill skill sets. This program develops eligibility criteria and a selection process; contracts with local agencies to manage the stipends; and documents the employment rates and career paths of awardees.</td>
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<tr>
<td><strong>WET 9</strong></td>
<td>The Loan Assumption Program. The objective is to provide local loan assumption awards of $10,000 to 15 employees on an annual basis, to support individuals who meet the county’s hard to fill or retain workforce needs and hard to fill skill sets. This program develops eligibility criteria and a selection process; contracts with a vendor to manage the program; and tracks the awardees’ retention rates and career paths.</td>
</tr>
</tbody>
</table>
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.

- The first table describes the new strategies to address the identified target populations, outside of Medi-Cal, 200% of poverty, CSS, WET or PEI.
- The second table provides more information about the new strategies.

<table>
<thead>
<tr>
<th>Identified target population</th>
<th>New strategies</th>
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<tbody>
<tr>
<td>African American</td>
<td>Currently addressing the needs of these groups:</td>
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<tr>
<td></td>
<td>o African American Utilization Study Group</td>
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<td></td>
<td>o Clarifying Assessments for Children Age 0-5</td>
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<td></td>
<td>o California Brief Multi-Cultural Scale</td>
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<tr>
<td></td>
<td>o Clergy Round Tables around Behavioral Health Issues</td>
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<td></td>
<td>o Mental Health 101 for Faith-Based Providers</td>
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<td></td>
<td>o Spirituality 101 for Mental Health Providers</td>
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<td></td>
<td>Potential to address the needs of this group:</td>
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<td></td>
<td>o Innovative Grants Program</td>
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<td></td>
<td>o PEI Statewide Reducing Disparities in Communities Project</td>
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<tr>
<td>Asian/Pacific Islander (API)</td>
<td>Currently addressing the needs of these groups:</td>
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<tr>
<td>Latino</td>
<td>o Clarifying Assessments for Children Age 0-5</td>
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<tr>
<td>South Asian/Afghan</td>
<td>o California Brief Multi-Cultural Scale</td>
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<tr>
<td>Native American</td>
<td>o Clergy Round Tables around Behavioral Health Issues</td>
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<td></td>
<td>o Mental Health 101 for Faith-Based Providers</td>
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<td></td>
<td>o Spirituality 101 for Mental Health Providers</td>
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<td>Potential to address the needs of this group:</td>
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<td>o Innovative Grants Program</td>
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<td>o PEI Statewide Reducing Disparities in Communities Project</td>
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<td>Identified target population</td>
<td>New strategies</td>
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<td><strong>Children and Youth</strong></td>
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<tr>
<td><strong>Transition-Age Youth (TAY)</strong></td>
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<td>o California Youth Empowerment Network (CAYEN)</td>
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<td><strong>Older Adults</strong></td>
<td><strong>Currently addressing the needs of these groups:</strong></td>
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<td></td>
<td>o Capacity-building to better address the needs of LGBT seniors</td>
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<tr>
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<td>o SAMHSA Older Adult Get Connected Toolkit</td>
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<td><strong>Lesbian, Gay, Bisexual, Transgender (LGBT)</strong></td>
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<td>o ACBHCS PRIDE Coalition</td>
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<td>o LGBT Heightening Awareness Campaign</td>
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<td>o PEI Statewide Reducing Disparities in Communities Project</td>
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<td>o Capacity-building to better address the needs of LGBT seniors</td>
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<td><strong>Consumers</strong></td>
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<td></td>
<td>o Mental Health First Aid</td>
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<td>o Emotional CPR</td>
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<td><strong>Family Members</strong></td>
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<td>Identified target population</td>
<td>New strategies</td>
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<td></td>
<td>▪ California Brief Multi-Cultural Scale</td>
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<td></td>
<td>▪ Clergy Round Tables around Behavioral Health Issues</td>
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<td>▪ Mental Health First Aid</td>
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<td>▪ Emotional CPR</td>
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<td>▪ Capacity-building to better address the needs of LGBT seniors</td>
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<td><strong>Potential to address the needs of this group:</strong></td>
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<td></td>
<td>▪ Innovative Grants Program</td>
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<td></td>
<td>▪ Trainings events/ “Telling Our Stories”</td>
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<td>Individuals Experiencing Onset of Serious Psychiatric Illness</td>
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<td></td>
<td>▪ California Brief Multi-Cultural Scale</td>
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<td></td>
<td>▪ Clergy Round Tables around Behavioral Health Issues</td>
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<td></td>
<td>▪ Mental Health First Aid</td>
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<td>▪ Emotional CPR</td>
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<td>▪ Capacity-building to better address the needs of LGBT seniors</td>
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<td></td>
<td><strong>Potential to address the needs of this group:</strong></td>
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<td></td>
<td>▪ Innovative Grants Program</td>
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<td></td>
<td>▪ Outreach from TAY PREP Program</td>
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<tr>
<td>Children and Youth in Stressed Families</td>
<td><strong>Currently addressing the needs of these groups:</strong></td>
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<tr>
<td></td>
<td>▪ Clarifying Assessments for Children Age 0-5</td>
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<tr>
<td>Children and Youth at Risk for School Failure</td>
<td>▪ California Brief Multi-Cultural Scale</td>
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<tr>
<td>Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>▪ Clergy Round Tables around Behavioral Health Issues</td>
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<td><strong>Potential to address the needs of this group:</strong></td>
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<td></td>
<td>▪ Innovative Grants Program</td>
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<td></td>
<td>▪ Coordination with SART Program</td>
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<tr>
<td>Bilingual Staff</td>
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<td>Innovative Grants Program</td>
</tr>
<tr>
<td>Staff from underserved and inappropriately served communities</td>
<td></td>
</tr>
<tr>
<td>Staff with lived experience</td>
<td><strong>Potential to address the needs of this group:</strong></td>
</tr>
</tbody>
</table>
**Innovative Grants Program**

**Workforce Mentor Program**

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**Table 15. Description of Programs (Page 1 of 2)**

<table>
<thead>
<tr>
<th>Program Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACBHCS PRIDE Coalition.</strong> This is a recent project that was funded in spring 2010. It is made up of consumers, family members, local providers of LGBT services, and BHCS staff. The objective is to heighten the awareness of the needs of individuals challenged with mental health concerns who also identify as LGBT.</td>
</tr>
<tr>
<td><strong>African American Utilization Study Group.</strong> In December 2008, BHCS convened this Study Group to develop recommendations on how to improve behavioral health services to the African American population, which experiences a high rate of poor outcomes despite receiving high rates of care within the behavioral health system. The Study Group has developed a preliminary report which includes specific recommendations on what should be implemented by the wider county system, BHCS and individual providers. Some of the recommendations are listed below as steps that BHCS has already started to initiate. BHCS and the Study Group will do additional work to flesh-out when and how additional recommendations from the report will be implemented.</td>
</tr>
<tr>
<td><strong>California Brief Multi-Cultural Scale (CBMCS).</strong> The objective is to train mental health providers on four modules: 1) Multi-cultural knowledge, 2) Awareness of cultural barriers, 3) Sensitivity and responsiveness to consumers, and 4) Socio-cultural diversities. In December 2009 the ACBHCS took the first steps toward implementing a comprehensive cultural competency train the trainer’s project. Sponsored by the ACBHCS Cultural Competency Committee, 16 ethnically and culturally diverse individuals representing the consumer/client, family, provider and other stakeholder voice were selected to begin a process of becoming Master Trainers. BHCS will continue its roll-out CBMCS Trainings.</td>
</tr>
<tr>
<td><strong>California Youth Empowerment Network (CAYEN).</strong> The objective is to reduce disparities for TAY by supporting youth empowerment and policies that promote improved youth engagement across California. The CC/ESM is participating in the CAYEN Adult Advisory Committee.</td>
</tr>
<tr>
<td><strong>Capacity-Building to Better Address the Needs of LGBT Seniors.</strong> The objective is to prevent serious mental health issues among LGBT seniors. This recently approved project will identify gaps in services for LGBT seniors with or at risk for serious mental health issues; provide training and technical assistance to two health and human service agencies on how to better serve LGBT seniors with mental health issues; and provide a regional training to increase knowledge and awareness about the issues faced by LGBT seniors and to promote best practices for better serving this population.</td>
</tr>
<tr>
<td><strong>Clarifying Assessments for Children Age 0-5.</strong> Clarifying Assessments are an emerging practice for mental health providers serving young children with complex issues. The assessment of young children with complex issues requires significant understanding of the impact of development, caregiver-child relationships, regulation, and cultural contexts on the developing child. Clarifying Assessments may include observation and assessment of the child’s functioning in all domains of functioning to better understand the impact of development, caregiver-child relationships, regulation, and cultural contexts on the developing child. The objective is to identify the areas of risk and impairment and determine the best course of action for the family/caregiver to pursue to support the child.</td>
</tr>
<tr>
<td><strong>Clergy Round Tables around Behavioral Health Issues.</strong> The objective is to convene and recognize diverse spiritual and faith leader’s role as first responders to many mental health consumers and family members in crisis and to provide an open dialogue with each other and BHCS around the issues they face. To date, BHCS has convened four Clergy Round Tables that were attended by numerous spiritual and faith leaders representing</td>
</tr>
</tbody>
</table>

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Page 66 of 103
Table 15. Description of Programs (Page 1 of 2)

**Innovative Grants Program.** The objective is to fund short-term, innovative learning projects that have not previously been done in the field of mental health. All of the proposals must demonstrate a clear focus on mental health, and an Innovations Grant Board will recommend the most promising projects for funding under the Innovative Grants Program. Though it is still unclear which proposals will ultimately be selected, this is a potential funding source for projects to address, or further address, the needs of identified target populations facing specific disparities. Over the last few months, there has been intensive outreach and education about the Innovative Grants Program, with a specific emphasis on reaching the target populations identified through the MHSA Planning Processes. The Innovative Grants Program has just been launched within Alameda County, and applications for the first funding cycle will be due on September 30, 2010. It is anticipated that subsequent funding cycles will occur in regular intervals (TBD) over the next few years.

**LGBT Heightening Awareness Campaign.** This is a recent project that was launched in fall 2010 in response to an increase in reported cases of suicide among TAY that identify as LGBT. The objective is to promote local resources for TAY who identify as LGBT and struggle with stigma, mental health issues and suicide risk. The target audience is the general public.

**Mental Health 101 for Faith-Based Providers.** The objective is to: broaden the awareness and competency of spiritual/faith-based leaders (as first responders) to mental health issues and crises in the community; build relationships within faith-based communities; and teach spiritual leaders and caregivers how to support individuals as they seek help from the mental health community and include spirituality as a resource for wellness and recovery in a culturally responsive manner. These trainings are scheduled to start in spring 2011.

**PEI Reducing Disparities in Populations Statewide Project.** The objective is to identify community-defined approaches which will result in improved outcomes for five priority ethnic and cultural groups: African American, API, Latino/Hispanic, Native American and LGBT. The CC/ESM is participating in the Statewide Workgroup for the African American Project and providing consultation and input to the remaining four projects.

**SAMHSA Older Adult Get Connected Toolkit.** The objective is to increase knowledge and understanding of behavioral health issues among older adults; to decrease stigma and discrimination around behavioral health issues and its effects on the day-to-day provision of Adult Day Care services; and to identify and address organizational challenges in order to help Adult Day Care providers better serve older adults with or at risk for serious behavioral health issues onsite. These trainings are scheduled to start in spring 2011.

**Spirituality 101 for Mental Health Providers.** The objective is to facilitate discussions around the role that spirituality and faith play in the recovery process for consumers and family members, and to provide an entry-level training around conducting spiritual assessments with consumers and families when appropriate. These trainings are scheduled to start in spring 2011.
A1. Share what has been working well and lessons learned through the process of the county’s development of strategies, objectives, actions, and timelines that work to reduce disparities in the county’s identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

BHCS has found that it is effective to identify and implement existing evidence-based practices and adapt them to better meet the needs of unserved, underserved and inappropriately served communities in collaboration with those communities. For example, WRAP and Motivational Interviewing are tools that have been adapted to better address the needs of specific communities. Additionally, it is important to identify and implement community-defined strategies that are developed by or in collaboration with the community that they are intended to serve as was done with the UELP plans. Early indicators suggest that these practices are improving outcomes at the local level.

BHCS has learned that the process of inclusive community planning, procurement, implementation and evaluation of projects is valuable but lengthy. BHCS is starting to examine ways in which we may be able to shorten this process while still retaining the meaningful input of diverse unserved, underserved and inappropriately served communities.
V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

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.).

A description of the strategies, objectives and actions are provided in Section III and IV. In terms of timeline, it is currently anticipated that all of the strategies will be implemented by December 2013.

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.

ACBHCS’s Decision Support Unit monitors penetration rates and utilization by service modalities as a means to measure the progress being made to reduce disparities. At the same time we recognize penetration rates and service modalities provide us with useful data BHCS also periodically conducts utilization studies as needed to identify more specific needs and approaches to reduce disparities.

C. Identify county technical assistance needs.

BHCS staff, including the WET Manager and CC/ESM, will follow-up with other counties about resource issues, which seems to be the major barrier to effectively implementing programs in a timely manner.
CRITERIA 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

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

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

More than three months ago, the members of the BHCS Cultural Competency Committee decided to rename the committee. It is now the ACBHCS Cultural Responsiveness Committee (CRC), which is more in line with the belief that it is an ongoing process needed to help support our system to be more responsive to those we serve. The members of the CRC all agreed that the word “competency” didn’t adequately reflect our mission. The BHCS CRC meets on the third Thursday of each month from 1:15PM to 2:45PM at 2000 Embarcadero Cove in Oakland. The group decided that this meeting time and place was the most suitable to accommodate the majority of the members. The CRC reduces barriers to participation in the CRC through:

- Ride sharing;
- The CC/ESM providing rides to members who need transportation support; and
- Reimbursements (Attachment 1 IV B-3) to remove financial barriers such as the cost of transportation, childcare and respite care.

Although informal in nature, the CRC elects a new chair annually and develops three measurable goals and a work plan to achieve these measurable goals. The CC/ESM prepares an annual report at the end of each fiscal year. The report is submitted to the CRC committee for approval and is widely disseminated to serve two purposes: to heighten awareness around cultural responsiveness issues throughout the BHCS system of care; and to be transparent and accountable to limited English proficiency unserved, underserved and inappropriately served communities who rely on the CRC to carry their concerns forward.

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;

The CRC regularly analyzes the composition of its membership and develops plans to fill empty spaces and recruit additional underrepresented voices when appropriate. The CRC is committed to filling empty slots swiftly. The members decided that if someone from the committee is missing more than 50% of the time, it is not fair to the community they represent to have the voice missing. The CRC will conduct a few courtesy calls to ensure that the member is okay, and then seek out another suitable person to carry the missing or representative voice.

The CRC feels comfortable using this approach and is proud of the process it uses to ensure that the committee is reflective of the county’s demographics. The CRC has developed several sub committees to support our mission to give a platform for communities or issues that need more energy or efforts to reduce disparities:
The first CRC subcommittee is the Ethnic Languages and Disparities Committee that is largely made up of providers who deliver services to ethnic specific communities with language barriers. This group was instrumental in getting the BHCS to have to a separate Underserved Ethnic and Language Populations (UELP) Planning Panel for PEI. This subcommittee initially met two times per month to prepare for PEI planning, and now meets as needed to address pressing concerns as they arise.

The second CRC subcommittee is the African American Utilization Study Group that focuses its attention on issues of concern in the African American Community, which many stakeholders view as inappropriately served due to its high rates of service utilization and poor mental health outcomes. This group took on an almost two year project that led to a report with findings and recommendations to guide BHCS, and the larger county system, in reducing disparities specific to this population. Institutionalized racism was found to be a major root cause for the disparities in this community.

The third CRC subcommittee is the Mental Health and Spirituality Workgroup that works closely with the Office of Consumer Relations to promote the much known fact that consumers of all ethnicities and cultures have determined their faith/spiritual practices to be an important support in their recovery. As mentioned in Criterion 1, partnership with faith/spiritual communities is also an avenue for engaging unserved, underserved and inappropriately served communities. This subcommittee meets on the first Thursday of each month from 1:00-2:30PM and is largely attended by consumers, families and leaders of diverse faith/spiritual communities. It is facilitated by a consumer who was hired by one of our consumer-operated programs, through funding from BHCS, to further BHCS work around this issue.

In March the CRC formed a subcommittee to support its efforts to complete the 2010 Cultural Competency Plan. Recognizing the importance of having input from our CRC members we started meeting at first two times a month and then weekly each Friday from 10-12:00 noon. The members of this subcommittee attended as we covered important concerns and they provided key content and input. After submission of the 2010 Cultural Competence Plan, the subcommittee will disburse and reconvene, as needed, to address any concerns that DMH may have and to monitor the implementation of the plan.

The last CRC subcommittee was established in June 2010 and was formed after the CC/ESM received several calls expressing an interest in addressing concerns specific to the disparities experienced by the largely unserved LGBTQI community. The name of this group is the BHCS PRIDE Coalition. It is largely attended by providers of LGBTQQI services and BHCS staff but has a few consumers who also attend regularly. The CC/ESM is working to recruit more consumers and family member and will look for individuals that represent diverse ethnic and cultural groups within the LGBTQQI2S community.

To stay abreast of all the current issues and needs of the larger community the CC/ESM also actively participates and hosts the Bay Area Region Ethnic Services Managers Committee. The Greater Bay Area Region meets every other month on the fourth Thursday and has an attendance of 6-7 CC/ESMs. Three or four of the CC/ESMs typically phone in to participate. They are joined by their DMH State liaison who provides updates and offers technical assistance. The agenda covers topics specific to reducing disparities and pushing forth efforts to raise
awareness of health disparities. The BHCS CCC/ESM was a chair of this committee and played a big role in the rebirthing of this group in 2007, shortly after being hired.

C. Organizational chart.

Attachment 1 A-1

D. Committee membership roster listing member affiliation if any.

Please see Attachment 4 I D-1, the CRC Membership Roster with member affiliations.

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

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee’s activities.

The Cultural Responsiveness Committee (CRC) members are utilized to provide subject matter expertise on various efforts throughout the BHCS system of care. To increase capacity and support the CC/ESM, our system has established a practice of inviting one or two CRC members to BHCS planning processes and other efforts such as the MHSA Ongoing Planning Council (OPC) and the Mental Health Board (MHB Demographics) Attachment 4 II A-1. It will be important to also include members of the CRC in future planning processes, such as those around the Affordable Healthcare Act (i.e., Healthcare Reform). Most recently the CRC Chair was asked to sit on the BHCS Communications Committee. The CRC Chair has followed the established practice of bringing updates back to the larger CRC meetings so that all members can have the opportunity to provide feedback that they wanted him to share with the Communications Committee.

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

Please see the attached rosters to support our members’ representation on the OPC (Attachment 1 II A-4) and MHB Attachment 4 II A-1.

The Ongoing Planning Council (OPC) is made up of a diverse set of stakeholders, including consumers and family members, and the BHCS Administrative Team. The purpose of the Council is to make recommendations to the Behavioral Health Care Director regarding MHSA programs:

1. Planning: Advise the Mental Health Director and staff on planning process for each MHSA funding stream and assist with community outreach and education. This includes assessment, comment, and prioritization of strategies developed for these plans.

2. Implementation: Assess the overall impact of MHSA programs in transforming the current public mental health system.

The OPC’s deliberations are based on MHSA program reports and presentations from MHSA planning staff, providers, consumers, family members and the community-at-large. The Council will convene committees that will meet separately to work more in depth on specific issues and report findings and provide recommendations to the full Council.
The CC/ESM also participates on the BHCS Utilization Management Committee, Continuing Medical Evaluations Committee and our Quality Improvement Committee to ensure the concerns /needs of unserved, underserved and inappropriately served are represented.

Attachments: 4 II B-1, 4 II B-2 and 4 II B-3. Committee rosters etc.
C. Annual Report of the Cultural Competence Committee’s activities.

Cultural Responsiveness Committee Annual Report Fiscal Year 09-10

July 20, 2010

The committee met 10 times over the last year and began using conference calls as an option for those not able to attend in person. Our attendance rates fluctuated depending on the season but we managed to have a core group of 12 that attended regularly. Our roster has 22 slots available to ensure we are reflecting our community. In this fiscal year we added 9 new voices to the committee. Two were to bring representative voices from the LGBTQQI community and two more were added for more inclusion from the AOD community. One served to bring a voice for those with complex issues as well as African American concerns. One was added to recapture the voice from the Mental Health Board and the final new member replaced the missing TAY voice. We have continued concerns about not having a voice from the API community due to a resignation and poor attendance. Unfortunately 5 individuals were dropped from our roster due to poor attendance and no response to pleas to attend. They have all been replaced.

BHCS is currently completing the Cultural Competency Plan for the State Department of Mental Health. To ensure inclusion in the development of the CC plan, in March we developed a Cultural Competency Requirement Plan Work Group. We meet weekly to help develop the plan and several CRC members are lending their support. We will request a one month extension so we plan to submit the plan by the end of September 2010. The primary culturally competency objective will be to increase management and staff knowledge of culturally responsive skills and practices through the implementation of the California Brief Multicultural Competency Scale (CBMCS).

As you recall in late 2009, BHCS entered into an agreement with Dr. Gloria Morrow, a CBMCS Master Trainer, to provide training and technical assistance during the CBMCS implementation, and purchased 22 CBMCS training kits. The Ethnic Services Manager, working with the Training Officer, identified 22 Cultural Brokers from ethnically and culturally focused communities, including four BHCS staff fully representing the Systems of Care, to be trained as trainers on the CBMCS tool.

Dr. Morrow provided the initial 32 hour “Train the Trainers” session to 16 individuals in December 2009. Three individuals were added at the June 2010 follow-up training and a practice training session was held in August 2010. Practicum assignments will be given out in mid October and BHCS intends to certify 10 CBMCS trainers by December 31, 2010.

We created a CBMCS training implementation strategy and identified initial training settings from each of the four age-specific systems of care, starting with newly operating programs. The first four trainings will occur before the end of the 2010 calendar year and will include an assessment of each training site and recommendations for increasing culturally responsive practices.

Our second cultural responsive objective is to review the African-American Utilization Study and identify recommendations for consideration. The final report is currently under review by the County’s Public Health Department and will be finalized by BHCS Administration before dissemination to stakeholders and the broader community.

We also have continued to participate as needed in the California Reducing Disparities in Populations efforts addressing the API, Native American, Latino/Hispanic, and African American and LGBTQQI communities. Several of us are on state wide workgroups and provided monthly updates at our meetings.

We continued our discussions about reminding folks each ethnicity has its own subgroups and clustering all Latinos/Hispanics in one group doesn’t meet their needs best because it’s such a broad group. This detects the need for county interpreters to ideally be native speakers. Many are not and offer a fair solution but first choice should be someone the client/consumer or family member can also relate to culturally.
Finally, in June we added another sub committee that focuses on reducing disparities for those in the LGBTQI community. It meets on the 1st Thursday of each month from 11-1:00PM just before the Spirituality Workgroup which is now meeting at 333 Hegenberger from 1-2:30pm each month. It was attended by 12 people in June and 15 in July. Many of the attendees are BHCS staff but we do have 3 new providers attending.

Respectfully submitted by,

Gigi R. Crowder, LE
Gigi Crowder
CC Coordinator/Ethnic Services Manager

Cultural Responsiveness Committee Human Resources Annual Report
Fiscal Year 2009-10

As the Alameda County Behavioral Health Care Services Human Resources Liaison to the Cultural Responsiveness Committee, my role is to provide technical assistance to the committee, share and distill ideas regarding the cultural responsiveness of our organization, and to receive feedback from the committee in regards to cultural responsiveness in the organization particularly as it relates to recruitment, hiring, and retention practices. This agency was well represented at the Cultural Competency Plan Requirements Technical Assistance training provided by the California Department of Mental Health (DMH) Office of Multicultural Services earlier this year. The training was piloted here in Alameda County in February 2010 and was attended by several other counties in the Bay Area region. Our human resources office is well aware of the requirements and worked closely with key BHCS staff to ensure the Cultural Competency Plan will aid our efforts in culturally responsive recruitment, hiring and retention practices.

Human Resources recognizes the need to support and promote policies and practices that encourage recruitment, hiring and retention of individuals with the background, experience, and skills set needed to work most effectively with unserved, underserved, and/or inappropriately served communities in Alameda County. For example, in accordance with the Mental Health Services Act (MHSA) and its Workforce Education and Training (WET) Plan, we work closely with the Workforce Education and Training Manager, Consumer Relations Manager, and Family Relations Manager to further our department’s efforts to include mental health consumers and family members as employees and or community representatives who can help us meet our goal to reduce language and other cultural barriers to mental health services.

I highly value my role as liaison to the Cultural Responsiveness Committee and am regularly available as a resource and to provide technical assistance as needed. I will continue to attend monthly meetings and to respond to concerns articulated by the committee.

Respectfully submitted,

Laura Sanders, Personnel Officer
Alameda County Human Resources
Behavioral Health Care Services Liaison
## 2010 GOALS AND OBJECTIVES
ACBHCS Cultural Responsiveness Committee

### Top Three Concrete Goals

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE</th>
<th>TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a strategic approach to reducing mental health disparities in Alameda County</td>
<td>Receive an approval on our CC Plan from the State DMH. Began implementation of strategic approaches outlined in the CC Plan. Specifically conducting first CBMCS Training.</td>
<td>12/10</td>
</tr>
<tr>
<td>To make CRC more an advisory committee giving input to the Executive team as well as other decision making bodies before decisions are made.</td>
<td>Work with QI team to establish a protocol to ensure decisions, BHCS planning efforts, etc. have input from our ESM and CRC members.</td>
<td>6/11</td>
</tr>
<tr>
<td>To improve quality of care for all populations, to include more culturally responsive and community defined services e.g.</td>
<td>Put a process in place to monitor progress toward having 1/3 of our workforce receive at the very least an overview to CBMCS as well as exposure to other tools that heighten self awareness and help identify needed core competencies. Start with Executive team to get necessary buy in system wide.</td>
<td>1/11</td>
</tr>
</tbody>
</table>

*As of June 17, 2010*
CRITERIA 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

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

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.

The 2009-2011 BHCS Training Plan includes the development and implementation of a Core Staff Training on cultural responsiveness. As recommended by the CC-R, Alameda County recognizes the importance of training our entire workforce, including both county and contract CBO staff, to increase cultural responsiveness across our system. According to the 2008 Mental Health Workforce Needs Assessment, there are approximately 2,400 staff currently in the workforce for the BHCS System, including: approximately 400 unlicensed mental health direct service staff; 934 licensed mental health direct service staff; 99 other health care direct service staff; 582 managers and supervisors; and 385 non-direct service support staff. BHCS contracts out more than 85 percent of our services and we embrace those workers as part of our workforce. This approach ensures us the ability to reach a larger number of ethnic and cultural communities in a cost effective manner by contracting with ethnic specific providers.

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

Step 1: Identifying the Unduplicated Number of Staff Trained

BHCS is developing mechanisms to identify the unduplicated number of staff that will be targeted to receive cultural responsiveness training during any three-year period. Major challenges include the size of the workforce, the number of CBO contractors (roughly 83 just for mental health), and documenting the unduplicated number of staff that receive these trainings. The completion of this process will allow BHCS to ensure that all relevant staff receive training over a three-year period.

Step 2: California Brief Multicultural Competency Scale (CBMCS)

BHCS has begun the process of implementing a 3 year intensive Cultural Responsiveness Training utilizing the California Brief Multicultural Competency Scale (CBMCS) training tool. Our goal is to provide the CBMCS training to 100% of all staff providing mental health services over the next 3 years. In the latter part of 2008, BHCS invited a representative from Sage Publication, the distributors of the training, to come to BHCS and provide us with an overview of the product to the CRC. In addition to CRC members, we opened the overview and extended an open invitation to all in our system of care. This included a diverse group of providers, family members and consumers. Over 50 interested individuals participated to learn more about the vCBMCS.

BHCS sought feedback from the attendees through a written survey and a request for phone calls from those who had questions or concerns about the training. The responses were overwhelmingly favorable, so BHCS contracted with Dr. Gloria Morrow, one of the four identified CBMCS Master Certified Trainers. Please see Attachment 1 IV B-2 for more information about the CiMH contract with Dr. Morrow. Dr. Morrow supported stakeholders in Alameda County in designing a “train the trainers” curriculum that is expected to initially train 22 diverse
individuals with broad representation from across the system of care. The majority of these providers, consumers, family members, clergy representatives and cultural brokers already had some background in providing cultural competency trainings. They were offered the opportunity to participate in this CBMCS training because of their commitment to reducing ethnic, linguistic and cultural disparities. The CC/ESM did targeted outreach to ensure inclusion. She also made sure all age groups were represented.

CBMCS Facilitator and Ethnically and Culturally Diverse Training Participants

Our initial introduction to the training for the 22 invited trainers took place in December 2009. BHCS had a “meet and greet” over lunch and then spent two full days with Dr. Morrow. Dr. Morrow administered the pre-assessment test and gave us an overview of the four modules explaining what would be expected of us when we began providing the 32 hour trainings to our system of care.

BHCS then purchased the 22 CBMCS kits that we needed from Sage publications and received them in May 2010. Five of the original participants received additional CBMCS training by attending a free, two session training from CiMH in May and June. We spent two days with Dr. Morrow in May becoming more familiar with Modules one and Two; and then came back in June to cover Modules Three and Four with Dr. Morrow the first day and Robin Musgrove, another Master Trainer, the second day.

Dr. Morrow was back in Alameda County the end of June and 12 people from our original group and 3 new trainers joined us. Unfortunately several of the original participants weren’t able to continue; some had scheduling conflicts, others changed jobs and one went to school to pursue his Ph.D. The three new trainers met our target profile of trainers who are ethnically and culturally reflective of our county. The group reviewed each module and completed home work assignments to demonstrate our readiness to be trainers.

We last meet in August when Dr. Morrow came back for a full three days of training and practices. She gave practicum assignments to ten of the participants whom she felt were ready to move closer to becoming Alameda County Certified CBMCS trainers. She will continue to work with the other six individuals who joined the group late or needed a bit more time. The CC/ESM will schedule a conference call in October to discuss next steps.
The ten trainers moving toward certification will do their practicum assignments the first week of December as we provide the CBMCS training to the first 22 staff from newly funded programs in our system, which we believe will benefit from this training, as they begin to implement new programs. We will provide CBMCS training to:

- 3-4 staff working with our newly developed SAMHSA-funded Early Connections program for children 0-5
- Identified staff in school-based program
- 4-5 newly hired clinicians working with our new PREP program for TAY experiencing their first onset of mental distress.

We will work with both the Adult System of Care Director and the Older Adult System of Care Director to identify new programs from these domains and suggest their staff attend the initial training. Our desire is to have some of these earlier participants join forces with us and become BHCS CBMCS Certified Trainers taking back their expertise to their own agencies.

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

Because Alameda County is such a diverse county many of our contract agencies have regular cultural responsiveness trainings incorporated into their annual staff development plans. BHCS wants to encourage this to continue among our contract providers. Our plan is to support these agencies by providing technical assistance and offering relevant tools to their staff. As we certify our CBMCS trainers, they will support efforts to train our system in the CBMCS training tool and will also collaborate with the CC/ESM and Training Officer to offer technical assistance to contract agencies developing Cultural Competency Plans and other relevant trainings.

In addition to the trainings with a direct focus on cultural competence, there is also a requirement that all additional trainings sponsored by the BHCS Training Unit address cultural competence in some way. The CC/ESM sits on the Training Committee and provides key input into this process. The ESM also sits on the Continuing Medical Education (CME) committee and works with the other members to make certain each of the trainings offered to our System of Care physicians meet CME requirements to be culturally responsive. (Attachment – 5 IA 3-1 CME Agenda). (Attachment – 5 IA 3-2 CME Training on HIV+ Flyer)

Over the next three-to-six months, BHCS will look into developing at least one question focused on cultural competence that can be utilized as a standard evaluation question for all trainings. It is anticipated that this evaluation data will strengthen the Training Department’s ability to: a) monitor how staff knowledge and understanding of cultural competence changes as a result of different trainings; and b) to develop best practices for the incorporation of cultural competence into trainings based on the findings.
II. Annual cultural competence trainings

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); and

B. Report on annual cultural competence trainings topics.

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How Long &amp; Often</th>
<th>Number of Attendees by Function</th>
<th>Date(s) of Training</th>
<th>Name of Presenter(s)</th>
<th>CEU or CME Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Brief Multi-Cultural Scale (CBMCS) Training of Trainers</td>
<td>The purpose of the CBMCS is to: examine sources of bias that have resulted in inadequate services for underserved populations; raise awareness of the effects of discrimination and oppression on access and responsiveness to care; increase understanding of the influence of worldviews, values, beliefs related to mental illness intervention and recovery; and increase multicultural competency skills for mental health providers. This is a best practice model for cultural competence.</td>
<td>▪ 3 full days of training  ▪ This is a series that reflects BHCS’ process to integrate CBMCS into the wider system</td>
<td>▪ Admin/Mgmt: 2  ▪ Direct Svc-County: 3  ▪ Direct Svc-Contract: 12  ▪ Consumers: 1  ▪ Family members: 2  ▪ Total: 12</td>
<td>▪ 06/21/10-06/23/10  ▪ 12/07/09-12/09/09</td>
<td>▪ Dr. Gloria Morrow</td>
<td>▪ N/A</td>
</tr>
<tr>
<td>Immersion in the Principles of Recovery</td>
<td>This training offers a dynamic blend of workshops, consumer storytelling, interactive groups and field experience to illustrate a strengths-based approach to helping people cope with their mental illness. This training is a best practice model for recovery &amp; includes consumer &amp; family member presenters.</td>
<td>▪ 3 full days of training  ▪ BHCS is sending 4 staff per session each time its offered</td>
<td>▪ Admin/Mgmt: 2  ▪ Direct Svc-County: 5  ▪ Total: 7</td>
<td>▪ 06/16/10-06/18/10</td>
<td>▪ Momentum for Mental Health</td>
<td>▪ N/A</td>
</tr>
</tbody>
</table>
| Motivational Interviewing (MI) Skills Integration for Clinical Staff | This training series focuses on the basic, fundamental skills necessary for clinical staff to utilize motivational interviewing strategies.  
Part 1 - Participants learn about MI as a method and “a way of being with people”, as well as basic MI skills and strategies.  
Part 2 - Building on Part I, participants learn and practice more advanced techniques, which include the Stages of Change model and specific strategies to enhance behavior change.  
Part 3 – Clinical consultation and practice with trainers. | Series of three trainings; two that are full day and one that is ½ day  
This is an ongoing training series | Admin/Mgmt: 10  
Direct Svc-County: 25  
Direct Svc-Contract: 30  
CBO/Agency Directors: 5  
Consumers: 5  
Family members: 5  
Total: 80 | Part 1:  
01/22/10  
02/05/10  
Part 2:  
03/12/10  
03/19/10  
Part 3:  
04/16/10 | Jennifer Mullane  
Scott Madover | CEU & CME (5.75) |
| Historical Trauma in the African American Experience: New Directions for Engagement | The purpose of this training is to provide participants with awareness, knowledge and effective engagement strategies in order to enhance services for African American/Black clients, families and communities. | 1 full day of training  
This was a one-time event | Admin/Mgmt: 20  
Direct Svc-County: 30  
Direct Svc-Contract: 180  
Community-General: 15  
Consumers: 25  
Family members: 10  
Total: 280 | 02/10/10 | David Wee  
Babalwa Kwanele  
Fiona Glas  
Barbara Ann White  
Gigi Crowder | CEU (6) |
| Suicide Prevention in Work with High Risk Youth in Out of Home Care | The purpose of this training is to teach participants how to effectively identify and intervene with suicidal patients in a variety of therapeutic settings, including short-term and outpatient care; to use a new empirically-based approach to providing services to potentially suicidal youth; and how to provide effective care that should be | 1 full day of training  
This was a one-time event | Admin/Mgmt: 2  
Direct Svc-County: 20  
Direct Svc-Contract: 68  
Consumers: 5  
Family members: 5  
Total: 100 | 11/02/09 | David A. Jobes | CEU (6) |
| Seeking Safety | The purpose of this training is to: review research and clinical issues in treating trauma and substance abuse; increase empathy and understanding of trauma and substance abuse; describe *Seeking Safety*, an evidence-based model for trauma and/or substance abuse; and provide assessment and treatment resources. | 1 full day of training | Admin/Mgmt: 5  Direct Svc-County: 15  Direct Svc-Contract: 15  Consumers: 30  Family members: 10  Total: 75 | 10/08/09 | Lisa M. Najavits | CEU (5) |
| Spirituality Workgroup Trainings | To promote cross cultural trainings each month the Spirituality Workgroup has a speaker from specific ethnic or cultural group give a brief overview of their traditional/common cultural practices as well as their key spiritual principles. To date the Afghan, African American, European, Native American, Hispanic/Latino and Punjabi. The faiths covered were Muslim, Christian, Buddhist, Sikh Native American Spirituality, Confucianism and Catholicism. | 30 – 45 minutes monthly on the 1st Thursday of each month. | Admin/Mgmt: 2  Direct Svc – County: 2  Direct Svc- Contract: 3  Consumers: 12  Family members: 4  Total: 20 | Various Cultural Brokers | N/A |
III. Relevance and effectiveness of all cultural competence trainings

A. Training Report on the relevance and effectiveness of all cultural competence trainings.

The 2009-2011 BHCS Training Plan includes the following as a responsibility of the Training Officer during this period: “Develop and implement an ongoing evaluation process based on Continuous Quality Improvement (CQI) methods to ensure that trainings offered through the department will meet individual, unit and organizational goals.” As one of the primary BHCS operational goals, Cultural Responsiveness will be a major topic for these CQI efforts.

The CC/ESM is a member of the Training Committee which meets every fourth Thursday of the month and is made up of a representative group of stakeholders that ensure all trainings are designed to meet the needs of our system of care. The BHCS Training Officer, in collaboration with the BHCS Training Committee, is developing a framework for evaluating the relevance and effectiveness of all trainings offered through the department, including cultural responsiveness trainings. This system will track the following:

- Rationale and need for the trainings, including how the training is relevant in addressing identified disparities;
- Results of pre/post tests (when applicable);
- Summary report of evaluations;
- Description of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings; and
- County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

It is anticipated that this information will be added to the bi-annual Training Reports that are already being developed and disseminated by the BHCS Training Officer by December 2011. This information will be used to promote CQI in BHCS in terms of both the selection of trainings and the extent that BHCS will require tailoring in the delivery of trainings to best meet local needs in terms of cultural responsiveness.
IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

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

BHCS has collaborated on or offered an annual training or conference with a focus on Client Culture that includes a client’s personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Over the past four years, BHCS has offered:

- A Breaking the Ties that Bind Conference, sponsorship of a LGBTQI training in Santa Clara County, and a major training on Healing Trauma in 2008;
- A Regional Spirituality Conference modeled after the Cultural Competency Summits in 2009 (attended by 600 individuals);
- A major training on Historical Trauma in the African American Experience in 2010 and
- BHCS leadership and other key staff participated in a “courageous conversations” dialogue facilitated by Dr. Ken Hardy which addressed racial concerns to consider when working with diverse consumer groups.

In addition to these annual trainings on Client/Consumer and Family Culture, BHCS also supports the attendance of consumers and family members as both presenters and participants at numerous local, statewide and national conferences, such as Alternatives, CASRA and ADP.

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.

BHCS has invested in trainings which coached clients/consumers and family members/loved ones to tell their stories. BHCS always wants to include the stakeholder perspective in terms of experiences with treatment services and resilience/recovery, including the parent or caretakers perspective for children, adolescent and transition-age youth clients. The CC/ESM will continue to work with the Training Officer, and System of Care Directors for Children and Youth and Transition-Age Youth to identify ways to maximize these activities. Utilizing diverse family member voices, appropriate client representation on training panels and on the Training Committee will help to infuse these essential voices into training design and development.
CRITERIA 6: COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE – HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

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

The MHSA Workforce Assessment submitted for the WET component is included as Attachment 6 I A-1 WET Needs Assessment-Methodology and 6 I A-2 WET Needs Assessment-Results.

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

The table below provides a comparison of the Workforce Needs Assessment, the general population, the Medi-Cal population, and the 200% of poverty (minus Medi-Cal) populations by ethnicity. It can be noted that there is a particularly low proportion of Latino staff (11%) from the Workforce Needs Assessment compared to the proportion of Latinos in the general population (21%), the Medi-Cal population (25%) or the 200% of poverty (minus Medi-Cal) population (34%). This points towards a particular need for recruiting, hiring and maintaining Latino staff within the BHCS system. For other ethnic groups, the proportion of staff from the Workforce Needs Assessment falls somewhere between the proportion of individuals from that ethnic group within the other population categories. For example, 19% of the staff surveyed in the Workforce Needs Assessment identified as African American, which falls between the estimates for the general population (13%), the Medi-Cal population (29%) and the 200% of poverty (minus Medi-Cal) population (5%).

<table>
<thead>
<tr>
<th>Population</th>
<th>Workforce Assessment</th>
<th>General Population</th>
<th>Medi-Cal Population</th>
<th>200% of Poverty (Minus Medi-Cal) Population**</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>19%</td>
<td>13%</td>
<td>29%</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>16%</td>
<td>24%</td>
<td>23%</td>
<td>12%</td>
</tr>
<tr>
<td>Latino</td>
<td>11%</td>
<td>21%</td>
<td>25%</td>
<td>34%</td>
</tr>
<tr>
<td>White</td>
<td>45%</td>
<td>37%</td>
<td>13%</td>
<td>54%</td>
</tr>
<tr>
<td>All Other/Unknown*</td>
<td>8%</td>
<td>5%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,741</td>
<td>1,457,169</td>
<td>258,231</td>
<td>98,719</td>
</tr>
</tbody>
</table>

* Includes Native American, South Asian and Multi-racial.
** Note: These are rough estimates and percentages do not add up to 100% as the Medi-Cal data is from 2009 and the Poverty data is from 2000.

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.
Attachment 6 I C-1 describes the cultural competence technical assistance (TA) recommendations as reported to the county during the review of their WET Plan submission to the state, and BHCS’ preliminary response to these TA recommendations. Since the time of BHCS’ preliminary response, BHCS has implemented a number of concrete strategies, described below, towards improving cultural sensitivity in the continued planning and implementation of the WET plan, particularly for clinical staff. Recognizing the importance of having a diverse workforce that is reflective of the community being served, BHCS has a commitment toward being more culturally responsive and will continue to build off of the TA recommendations for WET in subsequent years.

**Consumer and Family Employment Workgroup**

This Workgroup was launched by the WET team in January 2010 to develop tools and strategies for the training, recruitment and retention of a diverse and culturally responsive workforce that will meet the needs of our County as identified in the Workforce Needs Assessment and other local planning efforts. This workgroup is composed of a diverse group of consumers, family members and County and CBO providers, who represent the various unserved, underserved and inappropriately served cultural groups in the county and work across the four age-based systems of care. The first outcome will be the development of a curriculum on the benefits of hiring consumers and family members, which will include an emphasis on understanding lived experience across different cultures. The curriculum will be piloted in 2011, through a series of facilitated dialogues with the existing workforce at direct service sites. To promote cultural sensitivity and inclusion, the WET Team will conduct targeted outreach to direct service sites that serve a high proportion of unserved, underserved and inappropriately served cultural groups.

**Interagency Language Roundtable (ILR) Scale**

To increase language capacity in direct care settings, the WET team worked with a team of providers serving unserved, underserved and inappropriately served cultural groups to review the Interagency Language Roundtable (ILR) Scale and adopt the scale for use in mental health settings. The scale is a tool to assess an individual’s language fluency and ability to provide therapeutic services in a threshold language. The scale will be incorporated into the WET Financial Incentives Program applications, which we plan to implement in early 2011.

**Mental Health Specialist Job Description**

The WET team has collaborated with Human Resources to develop a new Mental Health Specialist job description, which includes criteria, based on experience with consumers, families and diverse cultures, and can be used to support a variety of consumer and family roles.

**CSU East Bay’s School of Social Work Advisory Board**

The Workforce Development Manager participates on California State University (CSU) East Bay’s School of Social Work Mental Health Advisory Board. This program’s focus is on urban social work and promoting social justice policy and practices. It attracts and admits a diverse student population that reflects our hard to fill workforce needs and includes consumers and family members. BHCS staff participates in student interviews and guest lectures and assists in the placement of these MSW interns in our system. Additional efforts will be made to include these interns in training efforts around cultural sensitivity and to retain these diverse staff within our system.

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

Using data from the MHSA Workforce Needs Assessment, BHCS identified the following as our highest priority workforce needs in terms of language, culture and positions that are particularly hard to fill or retain:

- **Language**: Licensed providers, or those on the license track, who are bi-lingual in one of the County’s threshold languages (Spanish, Cantonese, Mandarin, Vietnamese and Farsi).
• **Culture:** Licensed providers, or those on the license track, who represent the ethnically and culturally diverse communities that ACBHCS serves, including Afghans, African Americans, Asian/Pacific Islanders, Latinos/Hispanics, Native Americans and South Asians and the LGBTQ community.

• **Hard to fill or retain:** This includes Advanced Practice Registered Nurses; Child Psychiatrists; and other licensed providers, or those on the license track, who have expertise/experience in serving older adults and/or youth in the juvenile justice in the system.

**Loan Assumption Program**
BHCS used the above criteria to determine eligible Alameda County applicants for the State’s Mental Health Loan Assumption Program, funded by MHSA. This resulted in 18 awardees that are in hard to fill or retain positions and also bi-lingual and/or representative of the County’s diverse cultural communities. These awardees included 4 County providers and 14 contract CBO providers (half of which serve ethnic communities) and each will receive $9500 towards their student loans for one year of employment in our system.

**Local Financial Incentives Programs**
BHCS is developing a comprehensive stipend program, designed to support students from high school to community and four year colleges and o to graduate/professional schools. The Financial Incentives are designed as a recruitment tool for individuals who reflect the hard to fill or retain criteria described above, and to support existing county and contract community-based organization staff who are interested in advancing their education and their career opportunities in our system. In addition, Alameda County is developing a local loan assumption program, modeled after the State’s Mental Health Loan Assumption Program. Implementation is targeted for early 2011.

**Partnership with PEI Programs for Underserved Ethnic and Language Populations**
Through the PEI funding, BHCS developed outreach and engagement programs to better address the needs of the County’s Underserved Ethnic and Language Populations (UELPs), including the Afghan, Asian/Pacific Islander, Latino, Native American and South Asian communities. The contracts for these programs were awarded in early 2010. In 2011, WET staff will increase its partnership with the UELP providers, many of whom already participate in WET planning efforts, to refine workforce strategies and identify appropriate community settings to share information about local opportunities related to WET. The goal is to increase awareness of behavioral health issues and needs in underserved communities and to highlight the employment opportunities in our system.

**High School to College Career Pathway**
Increasing Alameda County’s workforce capacity and diversity through a strategic, articulated pathway is a critical component of the WET Plan. In June 2010, WET staff convened a High School Mental Health Career Pathway Workgroup, charged with developing a high school curriculum that reflects the values, knowledge and skills needed in the workforce. The work group, composed of high school and college faculty, providers and community-based partners, reviewed several core competency standards and identified those that would be essential for a high school curriculum, with a major emphasis on cultural competency. Once the draft curriculum is completed, it will be vetted with BHCS Administration and academic/provider partners, and then piloted in the Health Academy of Health and BioScience, an Oakland high school with a student body reflective of Alameda County’s underrepresented communities. The long-term goal is to share the curriculum and provide technical assistance to targeted high schools throughout the county.

To attract underrepresented students into the mental health field, BHCS is exploring the development of a Summer High School Mental Health Institute with Tomas Magana, MD, Co-Founder and Director of Faces for the Future (www.facesforthefuture.org) at Children’s Hospital and Research Center in Oakland. FACES serves disadvantaged high school students from demographic groups that are underrepresented in the health care professions: Native
Americans, African Americans, Latinos, South East Asians and Pacific Islanders, and prepares them for careers in all areas of the health professions. FACES offers a very successful high school summer program and there is mutual interest in creating a two week mental health program. Discussions are underway with an implementation target date of Summer 2011.

Attachment 6 I D-1 High School Structure and Program Components Draft
Attachment 6 I D-2 High School Mental Health Competencies Draft

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

The most important lesson learned throughout the WET implementation is the importance of including all voices at the table, from the beginning of any planning or implementation effort. This is critical to ensuring that all perspectives and experiences are reflected in discussions, strategies and desired outcomes. The WET Team has been working to increase its collaboration with the CC/ESM and providers serving specific cultural communities in order to share best practices and lessons learned for increasing outreach to unserved, underserved and inappropriately served groups. For example, utilizing ethnic specific mediums to advertise job announcements and possibly using local alumnae groups of Historically Black Colleges and Universities or the Bay Area Black Social Workers Association to recruit African American clinicians and other direct service providers. This is a continuing effort.

Another key lesson is the importance of creating a setting that promotes the meaningful participation of many diverse stakeholders in any setting. Two strategies that the WET team has found helpful are setting aside time for group sharing and the development of group agreements. At the first meeting of the Consumer and Family Member Employment Workgroup, the members described their background, experience and interest in participating in the group. This facilitated discussion led to the development of a comfort agreement, through a consensus workshop, which now serves as the framework for their continued work together. At the Consumer and Family Member Workgroup Meetings, the WET team has observed an increase in participation from consumers, family members and representatives of unserved, underserved and inappropriately served communities as a result of these strategies.

The WET team has also learned that one-time trainings are not effective for adult learners and the importance of clustering and sequencing trainings to maximize their impact on individual learning. In addition, we want to focus on trainings that meet specific learning objectives and advance the knowledge, skills and abilities of our workforce. Preliminary evidence suggests that these strategies are improving the effectiveness of trainings around cultural sensitivity and other topics.

F. Identify county technical assistance needs.

BHCS would like to learn more about:
- What other counties are doing in terms of workforce outreach to diverse communities;
- Different training delivery methods that are community defined, culturally responsive; and
- The availability of training materials in other languages.
CRITERIA 7: COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.

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

BHCS is committed to ensuring that accessible services are provided to persons who have limited English proficiency. The goal is to identify and implement promising practices to enhance our workforce and better meet the needs of our linguistically diverse county. Below is a summary of the WET strategies with the greatest focus on increasing the bilingual staff capacity to address language needs. BHCS recognizes that the most effective approach for providing linguistically responsive services is to provide a bilingual staff person that is a native speaker of the language, and that the second choice would be providing a bilingual staff person who has learned proficiency in the language later in life.

The outreach and education strategies in the WET Plan all include an emphasis on increasing the ethnic, cultural and linguistic diversity of the BHCS workforce, which includes the County and contract CBO providers. These outreach and education strategies include the Coordinated Community College Career Pathway into Public Mental Health Careers and the Educational Campaign to Increase the Diversity and Language Capacity of the BHCS Workforce. The WET team is currently gearing-up to conduct targeted outreach with providers serving primarily unserved, underserved and inappropriately served populations. The emphasis will be on convening these providers to discuss strategies for refining outreach, education and recruitment to specific groups such as individuals that are bilingual in and beyond the Alameda County threshold languages of Cantonese, Farsi, Mandarin, Spanish and Vietnamese.

The Alameda County WET Plan also includes a variety of strategies to increase the hiring and retention of staff, particularly those with bicultural and bilingual capacity in hard to fill and retain positions. These strategies include the Coordinated Internship Program, the Financial Assistance Programs such as the Loan Assumption Program. The MHSA Workforce Needs Assessment identified the highest priority workforce needs as being bicultural and bilingual staff in difficult to fill and retain positions. The strategies to increase the hiring and retention of staff also emphasize these highest priority workforce needs. For example, the 18 awardees of the State’s Loan Assumption Program are all bicultural and bilingual staff in hard to fill and retain positions.

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.

BHCS has funded the following strategies through CSS and PEI to grow the number of bilingual staff and increase access to both culturally and linguistically appropriate services:

- The Asian ACCESS Program operated by Asian Community Mental Health Services (ACMHS) and the Latino ACCESS Program operated by La Clinica (CASA del Sol) through CSS. ACMHS is contracted to provide services in multiple languages including: Cantonese, Mandarin, Vietnamese, Japanese, Khmer, Korean, Tagalog and Mandarin. All of the staff in these programs are bilingual or multilingual.
 Programs to better address the needs of underserved ethnic and language populations through PEI. This resulted in new staff, many of who are bilingual, being hired to support services for the Afghan, Asian/Pacific Islander, Latino and South Asian communities. The other CSS and PEI programs also strive to promote linguistically appropriate services, though the programs listed above include the strongest emphasis on bilingual/multilingual staff.

The WET team is small (5.0 FTE), and one bilingual WET staff person (who speaks Spanish) has been hired to date. The other 4.0 FTE bring different elements of cultural and ethnic backgrounds and experience to their positions.

3. Total annual dedicated resources for interpreter services.

ACBHCS has services as needed Memorandums of Understanding, MOUs with several language access providers. Please see the following attachments as evidence.

Attachments 7 IA 3-1 Interpreters Unlimited Purchase Order
Attachments 7 IA 3-2 Language Line Purchase Order

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

A. Evidence of policies, procedures, and practices in place for meeting clients’ language needs.

Below is a copy of the policy and procedures for language and culturally proficient services for the BHCS ACCESS Program, which serves as the primary point of contact for many of our BHCS clients. In addition, BHCS funded two language access programs through CSS: the Asian ACCESS Program operated by Asian Community Mental Health Services (ACMHS) and the Latino ACCESS Program operated by La Clinica (CASA del Sol). ACMHS is contracted to provide services in multiple languages including: Cantonese, Mandarin, Vietnamese, Japanese, Khmer, Korean, Tagalog and Mandarin.

---------------------------------
BHCS ACCESS PROGRAM
POLICY AND PROCEDURES
Language and Culturally Proficient Services

POLICY
ACBHCS and its BHP provides services in a manner that meets all clients language needs in accordance with the CA State Department of Mental Health’s regulations.

Review Specialists will refer to linguistically professional staff or staff with clinical expertise in the use of interpreters when providing services.

Review Specialists will document in the ACCESS Contact Log the provider or agency to which the client was referred and its language capacity or ability to meet the need of the referred clients.
When ACCESS cannot link a client who is not included in the threshold language criteria category to appropriate services, document the progressive steps made to try to ensure proper linkage.

County operated and contracted providers are prohibited from expecting that families will provide interpreter services. If families are willing to participate as an interpreter, this mode of communication should only be used during emergency situations, when other linguistically proficient staff or interpreters are unavailable or when a client requests it independent of family influence. Clinical judgment is important in determining when families are used as interpreters. Minor family members should never be used as interpreters.

I. PROCEDURE for non English speaking callers with an English only Review Specialist

**Review Specialists, Clerks**

1. Identify the language spoken as best as possible.
   a. For clients calling in, make a conference call to Language Line Services (formerly AT&T Languages Services) with the client (to add another party to a call, up to a total of 6 parties).
      1) Press (Conf).
      2) Dial number of new party, i.e., Language Line and wait for answer.
      3) Press (Conf) again.
      4) To drop the last party added to conference call, press (Drop).
   b. For clients who are in the office, use speakerphone by pressing [Speaker].

2. Call Language Line Services by calling the direct phone number, 1-877-261-6608 (follow the Language Line automated access instructions located at the end of this policy). Our “client ID” is 501352 and our “Access code” is 9099.

3. Leave the clinical supervisor a note that such a call to Language Line was completed on a specific date and approximate length of time.

4. Document in the phone log under language and in eCura (ACCESS Contact Log in the “In House Notes” section) that the identified client was non English speaking
   a. If the review specialist is bilingual, specify the language in which the telephone transaction was completed.
   b. If an interpreter (such as Language Line) was used, note who and what language.
   c. If the referral is made to a bilingual provider, note the name and specify the provider’s language capacity.
   d. If we were not able to meet the language need, document our efforts and final outcome.

II. PROCEDURE for hearing impaired callers

A. When a client calls our TFY line (1800 653-2373), the following procedures will apply:

   - **Clerks:**
     1. Answers by following the TTY phone’s manual directions which are located next to the phone. In summary, take off auto answer by pressing ESC, put the telephone handset in the acoustic cups, making sure the cord is on the left side, turn on Superprint 4425, type a greeting (“Hello, ACCESS here.”)
     2. If caller is seeking mental health or AOD information, summon a review specialist or OD to this TTY phone.

   - **Review Specialists or OD:**
     3. Uses the TTY by typing screening questions while the caller reads. When you want the other person to respond, type GA for “go ahead.”
     4. Make Level 1 crisis referrals to UC Center on Deafness by giving caller either their California Relay Service number 1800 735-2922 or the TTY 415 476-7600 and inform them that we made the referral by calling them at 415 476-4980.
     5. End TTY call by typing Sk for “stop keying.”
     6. After answering TTY call, turn the auto answer system back on by holding down Ctrl key and press the +1= key. Press return, and leave on the Superprint 4425.
     7. Document that the caller was hearing impaired and how we were assisted by TTY.
     8. Document the referral to the provider and state their language capacity.
     9. If we are not able to meet the language need, document our efforts and final outcome.

B. When a client calls using the California Relay Service (CRS):

   - **Review Specialists or OD:**
     1. Answers the call working through the CRS. When you want the person to respond, say “go ahead,” wait for the CRS to interpret for you and listen to the reply.
     2. Use the resources as in #4 above.
     3. Document that the caller was hearing impaired and how we were assisted by CRS.
     4. If the referral is made to a provider who treats the hearing impaired, document the name of the provider and their special skills.
     5. If we are not able to meet the language need, document our efforts and final outcome.

III. PROCEDURE for interpretation services for client during treatment

**Review Specialists**

A. Find an appropriate provider who will accept a referral that involves work with an interpreter.

B. For the initial visit, obtain the supervisor’s authorization by completing the Interpretation Services Authorization Form (the name of the client, DOB, Social Security number, explanation of the need for the service, name of the provider). If appropriate, the supervisor selects and writes in the
interpretation service, signs the form and submits the original to the Administrative Specialist, returns a signed copy to the Review Specialist and keeps a copy.

C. Request an appointment time from the provider and give that information to the interpretation service. (In some cases, the parent, family member, Child Welfare Worker or Cal WORKS outreach staff will coordinate the appointment and then must notify the Review Specialist, who will call the interpretation service.)

D. Contact the authorized interpretation service to request the service and give them the client’s name, DOB, SSN, treatment location and time etc.) as well as instructions to fax their confirmation to the authorizing supervisor and forward the invoice to ACCESS, Attn. Accounts Payable.

E. To confirm the plan with the provider, document in letters program notes in CAPITAL LETTERS that the client needs an interpreter, the name and phone number of the interpretation service. Inform the provider that subsequent services or changes, such as cancellations must be arranged by the provider but must be confirmed with the authorizing ACCESS supervisor.

F. For subsequent interpretation services for follow up visits, the interpretation service confirms an order each time by faxing a confirmation letter to the authorizing supervisor, who signs it, fax it back and gives the signed copy to the Administrative Specialist.

G. For clients with Alliance Healthy Families, Family Care, First Care and Group Care, contact Alliance at (895-WELL) inform them that their member needs interpretation services, give the name of the client, provider, language and appointment time and they will take responsibility for the interpretation services for their clients. Alliance is responsible for mental health services for Alliance Medi-Cal clients and is not for their interpretation services needs.

H. Document in our phone log (note the language spoken by the client, even if a third party calls about the client), and in eCura ACCESS Contact “In House Notes” that an interpreter service was used.

I. The following interpretation services have contracts or working agreements with BHCS.

<table>
<thead>
<tr>
<th>Hands On P.O. Box 418</th>
<th>NorCal Center on Deafness, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auburn, CA 95604</td>
<td>1820 Tribute Road, Suite A</td>
</tr>
<tr>
<td>(800) 900-9478 VOICE</td>
<td>Sacramento, CA 95815</td>
</tr>
<tr>
<td>(800) 900-9479 TTY</td>
<td>(916) 921-1243 VOICE</td>
</tr>
<tr>
<td>(800) 900-9477 FAX</td>
<td>(916) 921-1199 FAX (use their service request form; copy included with this policy)</td>
</tr>
<tr>
<td>This agency does sign for the local/Bay Area Services</td>
<td>This agency does sign for the areas east (Modesto/Tracy/Sacramento)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpreter Unlimited</th>
<th>Natka Buturovic</th>
</tr>
</thead>
<tbody>
<tr>
<td>800 726-9891</td>
<td>510 436-3033</td>
</tr>
<tr>
<td>Fax 800 726-9822</td>
<td>Fax 510 436-0233</td>
</tr>
<tr>
<td>Efficient and responsive for Spanish and has a list of many languages/dialects. Good accounting methods for multiple visits.</td>
<td>Bosnian, Croatian. Serbian</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Language Bank</th>
<th>Natasha Young</th>
</tr>
</thead>
<tbody>
<tr>
<td>(415) 885-0827</td>
<td>Russian</td>
</tr>
<tr>
<td>This agency has provided Cambodian speaking translators for testing. Has the capability of accessing many languages.</td>
<td>(925) 253-2421</td>
</tr>
<tr>
<td></td>
<td>cell (925) 212-1520</td>
</tr>
</tbody>
</table>

J. If additional interpreters are needed, inform the supervisor.

K. For Level 1 initial assessments and or prior consuls for the hearing impaired clients, refer to UC Center on Deafness (who accepts Alameda County BHCS referrals irrespective of insurance) by sending a referral letter.

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

Our Quality Assurance department follows DMH guidelines and requires each contracted mental health provider to post and make readily available beneficiary packets in our threshold languages which includes information about their rights to language assistance. These rights are also posted to inform those who need to use services for the hearing impaired.

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

Attachment 7 I A 3-1 Interpreters Unlimited Purchase Order
Attachment 7 I A 3-2 Language Line Purchase Order
D. *Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.*

Our biggest historical challenges have been callers hanging up prior to making contact with a live interpreter and our difficulty retaining native speakers as interpreters.

E. *Identify county technical assistance needs.*

Identifying strategies needed to accommodate limited English proficiency speakers who do not meet our threshold requirements.
Please see Attachment 7 II E-1, ACBHCS’s plan to enhance our current interpretation capacity.

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

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

ACBHCS has a Provider Relations website informing materials e.g. Notification of Beneficiary Rights which can be found in our threshold languages as indicated below:

- **How to Use the Packet: Informing Materials (6/10)** *This document contains important information for 1st-time users!*
- **Informing Material Packet: Your Rights and Responsibilities** - Spanish, Chinese, Farsi, and Vietnamese
  - Consent for Services
  - Freedom of Choice
  - Confidentiality and Privacy Statement (Duty to Report)
  - Advance Directive Information
  - Beneficiary Problem Resolution Information
  - Notice of Privacy Practices (HIPAA)
  - Maintaining a Welcoming and Safe Place (not a required informing material)
  - Notice of Privacy Practices
  - Beneficiary Problem Resolution Information
- **Memo from Marye Thomas, M.D.- Director of ACBHCS- 5/20/10**
- **Notification of Beneficiary Rights Policy- NEW, 5/10**
In an effort to improve services to limited English proficiency communities, BHCS is contracting with the National Latino Behavioral Health Association (NLBHA), a well-respected agency which provides mental health interpreters training. To be as cost effective and inclusive as possible BHCS has decided to use a “Train the Trainers” approach. Our plan is to utilize NLBHA to initially train 30 local providers, which includes administrative support staff, consumers, family members and recipients of the WET Financial Incentives Programs. BHCS will work with NLBHA to identify bilingual individuals with fluency in English and at least one of our County’s threshold languages. Those selected should demonstrate interest in developing the skills to become a competent interpreter and commit to providing both interpreter training and technical assistance to BHCS after being trained. This will help to expand our local capacity to serve individuals with limited English proficiency. This effort was designed to compliment what is currently in place through providers who are already contracted to serve individuals and families with limited English proficiency.

BHCS will provide the initial three day training prior to the end of the 2010 calendar year. Once the training is complete, BHCS will work with NLBHA to identify individuals from each the threshold languages to be lead trainers and assist BHCS with the next step of identifying others from their community who may be interested in being trained. The lead trainers will receive TA from NLBHA and will provide training to the next cohort. All who successfully complete the trainings will become a part of a pool of BHCS certified Mental Health Interpreters.

The trainers will be given assignments through a registry (data base system) which will be updated frequently and monitored through our QI department. Each trained Mental Health Interpreter will be expected to accept four assignments per year and will always be teamed up with at least one peer interpreter. They will have technical assistance made available if needed prior to their assignment. In keeping with the BHCS reimbursement policy, eligible consumers and family members will be reimbursed for their participation.

In addition to providing one-on-one interpretation at our mental health provider sites as requested, we will also ask these interpreters to be available if requested at meetings, trainings and conferences. Our goal is to have a total of
ten Mental Health interpreters for each threshold language available, as needed, to support linguistic access to services.

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

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 in the ACCESS Policy’s and Procedures every attempt will be made to link all clients/consumers to services that meet their cultural and linguistic needs. Clients who do not meet the threshold language criteria will be referred to agencies that can better assist them through their multi-lingual staff or other resources. ACCESS staff will follow up to ensure they get their needs met.

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

See ACCESS Policy’s and Procedures above.

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

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

As noted in the ACCESS Policy’s and Procedures above, adult family members or friends will only be used at the request of the client/consumer after they have waived their rights to have free interpreter services or when there is a time sensitive emergency. At no time will minors be used as interpreters.
V. Required translated documents, forms, signage, and client informing materials.

A. Culturally and linguistically appropriate written information for threshold languages, including.

1. Member service handbook or brochure

Both are available in threshold languages online or by request through the U.S. Postal Service. Providers are required to offer both to clients at admission, annually and upon request per 2010 Policy. To access this information via the BHCS website, go to www.acbhcs.org/providers and then click on QA tab.

2. General correspondence

BHCS is currently working on updating documentation standards for all correspondence. Upon approval Senior by Administrative staff it will be sent to providers and posted on our BHCS website.

3. Beneficiary problem, resolution, grievance, and fair hearing materials

All of these materials are in the threshold and other languages and should be displayed in waiting areas of every BHCS-funded site that provides services through Medi-Cal funding.

4. Beneficiary satisfaction surveys

In the past, BHCS has done bi-annual system wide consumer satisfaction surveys as directed by the State Department of Mental Health. Recently DMH has assumed responsibility for collecting consumer satisfaction data for all counties. We are continuing to use the consumer satisfaction survey for our FSPs and a modified version of the consumer satisfaction survey for our PEI Programs, in our threshold languages. Please see Attachment 7 V-4 for example, a Spanish language consumer satisfaction survey tool used for FSPs.

5. Informed Consent for Medication form

This is available on BHCS website in threshold and other additional languages under the Medical Director’s tab.

6. Confidentiality and Release of Information form

The confidentiality form is available in the threshold languages. BHCS is working on finalizing the release of information form, has a sample in English and will be translating this form into the threshold languages. In the meantime, BHCS is encouraging providers to create their own forms as necessary to meet state requirements as well as their own provider-specific needs.
7. **Service orientation for clients**

Please see the ACCESS Policy’s and Procedures above.

8. **Mental health education materials**

Materials are made available in threshold and other languages to providers, consumers, family members and other interested parties through our county-funded contracted providers, the Family Education Resource Center and the Mental Health Association of Alameda County.

9. **Evidence of appropriately distributed and utilized translated materials**

Evidence will be captured in auditing of charts and providers sites, and also through the new signature page in the Informing Materials Packet.

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

See ACCESS Policy’s and Procedures above. BHCS is also involved in the preliminary planning to add a question to the annual progress report, which is completed by all CBO subcontractors, that asks, “Were interpretation services offered?”

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

Although this is currently a California DMH responsibility, as part of the Mental Health Interpretation Training being launched by BHCS, we will use the trainers to review all translated materials to ensure that it is as culturally relevant and sensitive as possible. We will also continue to use our language access providers to help us meet this requirement.

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

As part of the Mental Health Interpretation Training being launched by BHCS, we will use the trainers to review all translated materials to ensure that it is as culturally relevant and sensitive as possible. We will also continue to use our language access providers to help us meet this requirement.

**E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).**

BHCS will require its interpreters and language access providers to translate written materials at an appropriate reading level (6th grade) and to provide additional support, as needed, to support the provision of services to those with limited reading skills. BHCS will continue to stay abreast of requirements from the State Department of Mental Health concerning reading levels.
CRITERIA 8: COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

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

Decades prior to guiding principles of the MHSA, BHCS recognized and understood the importance of having client-driven services. BHCS currently provides funding to two client/consumer operated agencies: The Alameda County Mental Health Clients Network (ACMHCN) and Peers Envisioning and Engaging in Recovery (PEERS). BHCS also funds two County-run programs, the Pool of Consumer Champions (POCC) and the BHCS Wellness Recovery Resiliency Hub (the Hub), that are 100% staffed by individuals that identify as having lived experience.

The Alameda County Mental Health Clients Network (ACMHCN) The Network is operated on a client-run, mutual support model. The Network’s Coordinated Self Help System began as a model program funded by an NIMH Services Demonstration Program 3-year grant (1989-1991). It provides certain centralized administrative functions for its member programs which are multi-function service agencies serving predominantly inappropriately served, low-income clients with mental challenges, some of whom also have substance abuse issues. Most of these clients are homeless or marginally housed.

- **Reach-Out** is a client-run hospital visitation program and is one of the first of its kind in the nation. The objective is to reach out to individuals who are hospitalized due to a mental health issue, through visits, and telephone contact. Reach-Out visitors all have lived experience with hospitalization due to mental health issue and know about the isolation and loneliness that can occur for their peers in hospitals. They choose to visit on Saturdays because the weekends are often less structured and boredom can often set in. Reach-Out visitors give clients in hospitals emotional support and the sense that they too can make it in the community with the support and resources that are available through other self-help organizations.

- **Reaching Across** is a program where individuals with mental health issues help each other and themselves through facilitated discussions, information sharing and mutual support. Everyone in the program is encouraged to share responsibility for the program by taking an active part in it. Two nurses attend every meeting to help facilitate discussions and provide information.

The Berkeley Drop-In Center is a multi-purpose community center run by and for mental health clients and persons undergoing significant emotional distress. Program staff and participants are at various stages of recovery. The Center is a safe, informal place for people to meet and socialize, share peer and group support, take part in recreational and social activities, and get help in obtaining basic survival and other life needs.

- **The Best Now Consumer Training Program** provides comprehensive training and job supports for consumers who are interested in pursuing a career in behavioral health care. Participants attend the training course for six months. The training curriculum provides participants with insights on the knowledge and skills that they need to provide effective and culturally responsive active listening, peer support and case management. The curriculum also involves site visits to enhance participant’s understanding of current services. After the training course, participants are provided with three month paid internships working within the BHCS system (which includes CBO contractors). Consumers/clients comprise 10% of the BHCS’s workforce; many of these consumers/clients are graduates of the Best Now Program.

Peers Envisioning and Engaging in Recovery Services (PEERS) is a consumer-run, non-profit organization that advocates for mental health consumers on every level of the mental health system. PEERS is dedicated to the
recovery and wellness of peers experiencing mental health challenges and co-occurring (dual diagnosis) challenges, their families, and the community systems that serve them. PEERS focuses on training methodologies and best practices to teach, support, and implement the recovery vision for people living and working with behavioral health issues. The following are examples of services that are provided by PEERS:

- **Alameda County Social Inclusion Campaign.** PEERS is currently involved in start-up efforts for the Alameda County Social Inclusion Campaign. The campaign will include a Speakers Bureau; the development and dissemination of educational materials through print, web, radio and television; Wellness Recovery Action Plan (WRAP) Trainings; and Pathways to Recovery Trainings.

- **Wellness Recovery Action Plan (WRAP) Groups.** PEERS has been providing WRAP groups in both English and Spanish at various locations throughout Alameda County, as well as monthly WRAP orientations and regular WRAP trainings. Under the Social Inclusion Campaign, PEERS will be expanding WRAP to additional language groups and will be increasing the quantity of WRAP groups, orientations and trainings throughout the County. PEERS, is Alameda County’s local authority on Mary Ellen Copeland’s wellness and recovery model.

- **Speakers Bureau.** PEERS currently organizes consumer participation in the ‘Telling Our Stories’ training and will be coordinating a local Speakers Bureau under the Social Inclusion Campaign. The Mental Health Board’s Public Awareness Committee had hosted a Speakers Bureau had hosted a Speakers Bureau in previous years, and the POCC is currently sponsoring ‘Black Man Speaks.’ Both of these efforts will be coordinated by PEERS in future years to ensure seamless delivery of messages to reduce stigma and discrimination related to mental health issues.

- **Mental Health Matters Shows.** The current monthly half-hour Mental Health Matters television shows are provided through the Mental Health Board’s Public Awareness Committee and funded through a subcontract with the Peers Envisioning and Engaging in Recovery Services (PEERS) organization. The show’s topics are identified from surveys that are distributed to PEERS, the Pool of Consumer Champions (POCC) and the Mental Health Board’s Public Awareness Committee. The topics focus on mental health issues such as diagnoses of SMI and SED; stigma and discrimination reduction; self-help; and peer support. The show is hosted by the Reverend Barbara Meyers and produced by Mission Peak Unitarian Universalist Congregation of Fremont in Alameda County.

- **Promoting Spirituality and Faith as a Recovery Tool.** In addition PEERS, was selected to facilitate the county’s efforts toward promoting spirituality and faith as a recovery tool. A 30 hour per week peer staff is on board to coordinate these efforts and work specifically with unserved, underserved and inappropriately served communities.

- **Promoting Consumer Participation.** PEERS organizes consumer participation at conferences and trainings. PEERS sponsors and organizes mental health conferences to promote stigma and discrimination reduction and the empowerment of diverse consumers and family members towards recovery.

The **Pool of Consumer Champions**, (POCC). The POCC is made up of more then 400 individuals who self identify as having past and/or present mental issues. The POCC has more then 13 committees of their own, with several focused on ethnic specific issues such as the API Committee, the Latino/Hispanic Committee and the Black Male Issues Committee. There is also a Transition-Age Youth (TAY) Committee to address issues specific to TAY and a BHCS TAY Advisory Board which is very ethnically reflective of the TAY receiving services in Alameda County. The group embraces Wellness and Recovery values and principles and works closely with the staff of the county operated Wellness and Recovery Hub which provides technical assistance to our system of care.

The **BHCS Wellness Recovery Resiliency Hub**, (the Hub). The hub offers training, technical assistance and consultation to BHCS county and contract programs, and family and consumer organizations. 100% of the Hub staff identify as being a consumer or family member. The Hub offers recovery education workshops and technical
assistance designed to help teams of consumers, family members, providers and administrative staff share and expand their knowledge and skills in “how-to” build resilience, pursue recovery and experience wellness. The goal of the Hub is to help programs build on their existing strengths and increase the kinds of services and supports that people-in-recovery need to live meaningful lives, guided by their own choices, in their community.

BHCS encourages all of its providers to employ consumers and family members as peer employees as well as in other positions. Our CSS MHSA funded treatment programs were developed with requirements that consumer and/or family positions be included in the staffing. Many of the service providers for these programs recognize the value of hiring consumers and have exceeded this original expectation.

A1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences; and

A2. Briefly describe, from the list in ‘A’ above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

BHCS understands the importance of ensuring our consumer operated programs are able to meet the needs of cultural, racial, ethnic and linguistically diverse consumers. Our CC/ESM has learned about a training tool prepared in partnership with: NAMI STAR Center and the University of Illinois at Chicago, National Research and Training Center. The tool; Cultural Competency in Mental Health Peer-run Programs and Self-help Groups was created to help these program assess cultural competency. By using it, our programs will be able to identify the ways in which activities are already responsive to culturally diverse peers and areas where they could use some improvement. It can also help the programs to create specific actions plans to enhance their cultural competency in important areas.

The Best Now program has offered two trainings for Spanish-speakers and has a bilingual peer provider on staff to offer continued support to those graduates. As another example, PEERS is currently providing WRAP groups in Spanish and is in the process of training a culturally and linguistically diverse cadre of consumers and family members to provide WRAP groups and to participate in the Speakers Bureau.

Below is an excerpt from FY 07-08 Exhibit A contract between ACMHN and ACBHCS which outlines the services rendered for the Spanish Best Now Training.

The Pool of Consumer Champion has utilized our CC/ESM and Wellness Recovery and Resiliency Hub staff to offer consultation and support to the Black Male Issues Committee as they developed the Black Man Speaks, Speaker’s Bureau. They also got consultation and support for other subcommittees such as their ethnic specific API and Latino/Hispanic POC Committee and their POCC Cultural Diversity Committee.

**Best Now Program**

The Best Now staff will provide 2087 hours in the following manner:
- Conduct CLASP (Consumers Learning About Services to Peers) Training for 15 bilingual Latino/a clients in participation with Boston University and CONTAC.
- Provide 890 hours of training which will include personal recovery training, WRAP, mental health system structure, community resources, job search, peer counseling skills, and field work/internship.
- Provide 457 hours of translation of curriculum and other training materials into Spanish; conduct training in Spanish; and provide internship outreach and supervision supports in Spanish for bilingual graduates.
- Provide 610 hours of administrative supports including: assessing graduate needs (peer support, referrals), locating employment opportunities in the community for Best Now graduates, staffing committees related to consumer employment and educational supports, working in partnership with Operation Dignity (OD) and providing supervision of Best Now OD workers.
Partner with ACBHCS and ACVP to provide presentations including topics such as: case management, crisis intervention, conflict resolution, confidentiality and orientation to ACVP and DR services.

130 hours of support to Best Now graduates through newsletters, phone contacts, information on certificate and other educational/training opportunities, peer support meetings and job referrals.

Continue to work with behavioral health care organizations, other providers and employed graduates to identify positions for CLASP internships and Jobs/Best Now graduates.

Although not traditionally defined as consumer-run, our five newly funded PEI programs designed to better meet the needs of Underserved Ethnic and Language Populations (UELP). They are structured to value the consumer/client perspective and be both culturally and linguistically responsive to client needs. Each of the programs relies heavily on input from consumers, family members and community identified cultural brokers/consultants. The API Program has four Peer Facilitators positions and the Latino Program has four Promotor positions.

II. Responsiveness of mental health services

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.

Utilizing PEI dollars, BHCS funded five ethnic specific programs designed to engage Underserved Ethnic and Language Populations (UELP) communities to address mental wellness without stigma and prior to the need for more intensive treatment services. The funded UELP groups were the API, Native American, Afghan, South Asian and Latino/Hispanic communities. Each UELP project was designed utilizing practices and approaches that were defined by that specific community. Several of the projects used peer advocates to support their outreach, engagement and education strategy, as well as other PEI activities.

Attachment 8 II A 1-API Connections Model
Attachment 8 II A 2-Latino Project Organizational Chart

The ACBHCS Vocational Program is collaborating with Asian Community Mental Health Services and the State Department of Mental Health to pilot a new program to better serve consumers seeking employment who speak API languages. The goal is to increase employment opportunities to monolingual API consumers.

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.

ACBHCS maintains a services directory/Resource guide that is made available on our website. It is maintained by our Quality Assurance Office and is updated quarterly. This directory includes all services offered through our system of care.
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)

Attachment 8 II C 1 Power point used by Quality Assurance team to do outreach.
Attachment 8 II C 2 PEERS and La Clinica’s Spanish Speakers Benefits Workshop Flyer

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.

Attachment 8 II D 09-10 ACBHCS Quality Improvement Plan.

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III. Quality of Care: Contract Providers

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.

BHCS requires each prospective bidder to respond to well crafted questions that helps us to rate if the bidder’s qualifications. BHCS includes questions that ask the bidders to demonstrate their understanding of what is needed to provide culturally responsive services and their agency’s ability to provide culturally responsive services.

Historically language access providers were asked to develop Memorandum of Understanding (MOU) with agencies that lacked the ability to met the needs of limited English proficiency consumers/clients. However, in the last few years partnership agreements are being established between primarily English language providers and language access providers, in place of MOU’s, to ensure the needs of non English speakers are being met. Prior to these partnership agreements the MOU’s were rarely honored resulting in limited English proficiency consumer having no access to these programs.

Attachment 8 III A Request for Proposal (RFP) for Anti Stigma and Discrimination Campaign with specific requirements to ensure the services the needs of target populations are considered.
IV. Quality Assurance

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

To ensure that consumers are being served in a culturally responsive manner, each of the UELP programs has an evaluation requirement that will monitor consumer satisfaction as one of its markers.

Transition-Age Youth (TAY) consumers/clients have an advisory committee that provides input into the planning and design of the programming for their age group to ensure it is relevant.

The POCC has currently has both an API and Latino/Hispanic Consumer Advisory committees that meet monthly and provide input to the Office of Consumer Relations.

The African Utilization Study has a recommendation that there be continuous quality improvement measures put in place to monitor both consumer and staff satisfaction.

The Office of Family Relations and the CC/ESM work closely with our Family Education Resource Center to ensure it is meeting the needs of family members from all cultural, ethnic and linguistic communities it is contracted to serve.

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.

At this point there is no systematic approach to gather this information, however, the Quality Improvement Dept. specifically the Ethnic Services Manager will work with the BHCS Leadership to develop a method through our CBMCS Training Tool to provide feedback.

D. 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.

We currently do not compare ethnic group grievances and complaints separately. It is our aim to address 100% of all grievances or complaints as they are brought to our attention. When trends are found to be ethnic specific they are addressed as such.

Attachment 8 IV C-Chinese Language Consumer and Family Grievance/Appeal Form
Consumidores Latinos/Hispanos de el Condado de Alameda con Dolores Huerta