



Cultural Competency Plan Report

August 28, 2010



Community Behavioral Health Services
Department of Public Health – Community Programs
City and County of San Francisco

Cultural Competence Plan Report Community Behavioral Health Service City and County of San Francisco

INTRODUCTION

The San Francisco Mental Health Plan (MHP) is required by the State Department of Mental Health to establish a Cultural Competence Plan for achieving cultural and linguist competency under specialty mental health services for Medi-Cal beneficiaries.

Under the San Francisco MHP, services are expanded beyond the target population of severely mentally ill and the number of Medi-Cal beneficiaries covered by Community Behavioral Health Services (CBHS) is approximately 16,500. The need to ensure that all eligible beneficiaries meeting medical necessity criteria, including monolingual, limited English speaking, and other emerging populations are informed about and provided culturally competent services is critical. Although this Cultural Competence Plan Report is targeted to address the Medi-Cal beneficiaries, it shall also serve as a guide to serve identified indigent populations. CBHS of San Francisco is committed to providing a standard of care which provides equal and quality services.

Mental health services are currently provided to about 25,000 unduplicated clients (17,000 Medi-Cal and 8,000 indigent) of which 67% are non-White, primarily African Americans, Latinos/Hispanics, and Asian Pacific Islanders. In addition, the cultural diversity of San Francisco includes significant client populations of Russian emigrants, lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Questioning (LGBTQIQ), and homeless individuals and families. Over 20% of our current clients are provided services in languages other than English.

PHILOSOPHY and BACKGROUND

San Francisco's Cultural Competence Plan Report is based on a premise that provision of medically necessary mental health services in a culturally competent manner is fundamental to ensuring 1) access to services, 2) quality and cost-effective care and 3) quality outcomes. Cultural competence is addressed at multiple levels, including administration and policy, human resource department, training, service delivery and evaluation; and is defined as:

"...a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural settings."

In mental health, cultural competence refers to the valuing of diversity and the ability to provide treatment and support to different ethnic, cultural, linguistic, and special population groups. A system of care which is culturally competent and culturally responsive strives to be accessible to all groups and makes available program models which consider differences in cultural values, languages, help seeking strategies, communication patterns, and behavioral styles of those being served.

THE PLAN

The Cultural Competence Plan Report is formatted according to the specific new standards and criteria for the entire County Mental Health System. This includes all Medi-Cal services, Mental Health Services Act (MHSA), and Realignment (per California Code of Regulations, Title 9, Section 1810.410). The Plan consists of eight criteria. Criterion I provides an overview of the City and County's commitment to cultural competence. Criterion II provides an assessment of San Francisco's population and its Medi-Cal beneficiary population. Criterion III addresses strategies and efforts for reducing racial, ethnic, cultural, and linguistic mental health disparities, including specific implementation of the Mental Health Service Act (MHSA) Prevention and Early Intervention (PEI) and Workforce Education Development and Training (WET) strategies and plans. Criterion IV illustrates the client/family member/community committee integration efforts in the county mental health system. Criterion V provides San Francisco's culturally competent training activities and plans. Criterion VI provides a review of the county's commitment to growing a multicultural workforce. Criterion VII reviews the county's linguistic services and capacity. Finally, Criterion VIII provides an illustration of how the county ensures that clients/consumers are provided effective, understandable, and respectful care. Additionally, this criterion provides a review of client driven/operated recovery and wellness programs.

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CRITERION 1

COUNTY MENTAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE

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

I. County Mental Health System commitment to cultural competence

The county shall include the following in the Cultural Competence Plan Report (CCPR):

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

Policies and Procedures at all levels of the San Francisco Department of Public Health – Community Behavioral Health Services (CBHS) are expected to address the values of cultural competence. For example, cultural competence performance objectives and goals are included on documents such as Request for Proposals (RFP), interview protocols, employment announcements, and key managed care, system of care and quality management planning documents. Some excerpts follow:

Excerpts from CBHS Issued Request for Proposal

“Cultural Competency Requirements

A scarcity of programs demonstrating cultural competence is one of the significant factors preventing access to treatment, program adherence, and successful recovery for many behavioral health clients in San Francisco. Positively engaging each client through culturally relevant services and effective communication is essential to healing and enduring recovery. Community Behavioral Health Services is committed to ensuring that culturally and linguistically appropriate and proficient services are available to San Franciscans in all of their diversity.

Effective communication requires, at a minimum, the provision of services and information in appropriate languages, at appropriate educational and literacy levels, and in the context of the individual’s cultural identity. Cultural competency requires a demonstrated respect, awareness and acceptance of and openness to learning from the beliefs, practices, traditions, religions, history, languages, and

current needs of each individual. Cultural competency must be reflected throughout all levels of an organization, from board and staff recruitment, to planning and policy making, to administrative and policy implementation, to service delivery...”

“Elimination of Disparities – Cultural Competent Care

The mission of SFDPH is to protect and promote the health of all San Franciscans. CBHS supports the Department’s mission by promoting cultural and linguistic competency in our services and supports & training the behavioral health workforce in practices which seek to eliminate ethnic, racial, gender, sexual orientation and age disparities in health and life expectancy”

Excerpts from CBHS Integration of Mental Health and Substance Abuse Policy & Procedure

“This policy defines the Community Behavioral Health Services (CBHS) position for co-occurring issues/dual diagnosis capability (COI/DD), welcoming, universal screening, and billing issues related to the integration of Mental Health and Substance Abuse services in San Francisco. CBHS has made a commitment to develop a welcoming, accessible, integrated, culturally competent, recovery oriented, continuous and comprehensive system of care...”

System of Care Goals and Guiding Principles: A set of general principles adopted by our organization provides the guidance and process in implementing the operational guidelines for cultural and linguistic competence. These principles also serve as guidelines for assessing for agency cultural competence. For a fuller description of these principles are provided on pages 9 and 10 of the MEGA RFP in *Appendix A*. A select few are provided as follow:

Goals:

- Reduce the stigma of mental illness and discrimination towards those with mental illnesses or emotional disturbances
- Hire consumer widely within the behavioral health programs in variety of roles
- Foster cultural competence throughout the system of care, and in all programs and services

Guiding Principles:

- Programs and services are geographically accessible to consumers and families to increase their ability to live successfully in their local communities and neighborhoods;
- Programs and services are welcoming, culturally and linguistically competent, and age-appropriate;
- All levels of the behavioral health system are committed to continual training and education of consumers, their families, the behavioral health system workforce, and the greater community in order to improve their knowledge about behavioral health issues, the recovery-orientation, and effective service and treatment approaches;
- Consumers and families are integrally involved in all aspects of the

behavioral health system including planning, policy development, service delivery, and evaluation;

Office of Cultural Competence and Consumer Relations

In 1996, an Office of Cultural Competence and Consumer Relations was instituted as part of the Mental Health Plan's administrative structure. This office is staffed by a senior manager who is a part of the Executive Management Team and is responsible for the strategic development, planning and implementation of a system-wide culturally competent public mental health system of care, as well as 4.5 FTE support staff. Functions of this office specific to cultural competence include the development and overview of the Cultural Competence Plan, training, consultation and the development of system wide cultural and linguistic resources. Organizational charts of the San Francisco Mental Health Plan and the Office of Cultural Competence & Client Relations, located in *Appendix A* provide a fuller description of functions and staffing. **Section II B** below also provides more description of the function and activities of the Office of Cultural Competence Staff.

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

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

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

Each of these documents is provided in full description in *Appendix A* of this report. Mission (Vision) and Statement of Philosophy are included and illustrated in the MEGA RFP pages 10-12 in the Appendix A.

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

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

The county shall include the following in the CCPR:

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

CBHS has developed and implements community outreach, engagement, and involvement through a number of strategic mechanisms to ensure inclusion of and input from racial, ethnic, cultural and linguistic communities to address mental health disparities in the most culturally competent, culturally sensitive, and culturally responsive matter. The following are some of the community and consumer advisory boards, planning committee, stakeholder committee, and task forces that provide critical and regular input, feedback and recommendations to support the continuous quality improvement for the county's mental health plan and services:

- **The San Francisco Mental Health Board (MHB)** The MHB is committed to cultural competence, and values diversity in both mental health and in its own composition. MHB members are appointed by members of the Board of Supervisors. To ensure a diverse pool of applicants, vacancy notices and flyers are publicized in ethnic/racial/cultural (i.e., LGBTQIQ) newspapers and sent to diverse groups such as family support groups and consumer self-help organizations. Members of the Board of Supervisors are assisted by MHB staff in the recruitment and appointment of individuals who reflect the ethnic and cultural diversity of the client population of the County.
- **SF DPH Cultural Competency Task Force** In 2000, with recommendations from the San Francisco Health Commission, the SF DPH established a Task Force on Cultural Competency to assist in the implementation of its policy directive. The Task Forces has since been very critical in the implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards issued by the United States Department of Health & Human Services, Office of Minority Health as general guidelines to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services as provided by the Department and its direct service providers. The Task Forces provides input, recommendations and reviews policies, procedures, and inclusions of cultural and linguistic objectives in all funding contracts and activities.
- **MHSA Advisory Committee**
In March 2005, San Francisco began its implementation of the Mental Health Services Act (MHSA) with the establishment by the Mayor of a 40-member citywide taskforce. The Behavioral Health Innovations (BHI) Task Force, headed by the Deputy Director of Health, led the planning process and assisted in the development of San Francisco's three-year plan for MHSA funds by identifying and prioritizing mental health needs. The BHI Task Force was selected through a

month long application process to provide representation and leadership for San Francisco's planning process.

At the end of the initial planning process, all the task force members were requested to apply for membership in the new MHSA Advisory Committee. About half of the previous task force are now members of the MHSA Advisory Committee and additional members have been recruited to ensure diverse community representation. About thirty percent of the current membership is comprised of individuals who have or have had personal experience as consumers of mental health services

The MHSA Advisory Committee meets every two months, alternating between committee meetings and community forums. These meetings and forums serve as platforms to discuss the progress of the MHSA implementation and provide updates about further State implementation of the other components of MHSA. The priority of the MHSA Advisory Committee's goal is the inclusion of un-served, under-served and inappropriately served communities and individuals, many of who come from cultural and ethnical communities, and may have Limited-English-Proficiency. See membership listing in *Appendix A*.

- **African American Health Equity Committee**

In 2008, the SFPDPH Deputy Director of Health convened the Health Equity and Population Health Leadership (HEPL) Group in the Community Programs section to address and evaluate health inequity issues that impact health disparities in the cultural and ethnic communities of the City and County of San Francisco.

After an extensive review process, the HEPL Group selected two priority focused to be addressed across all DPH Community Programs: Improving African American Health and Decreasing the Impact of Alcohol. The African American Health Equity Committee was formed to develop a strategic planning and evaluation process to develop measurable objectives to be implemented across all Community Program sections to improve African American health.

- **CBHS Client Council** The Client Council is 100% consumer/client driven and operated and meets on a monthly basis. The Council has 20+ active members that represent multi-cultural, multi-lingual, and multi-ethnic backgrounds. It strives to involve consumers/clients at every level of decision-making, in our own efforts to achieve consumer/client participation and self-determination, especially relative to perceived program and treatment difficulties and discrepancies, as well as program and treatment development. Each member has peer based experience within CBHS systems of care. Two representatives of the Council attend various CBHS community and provider meetings, as well as Board Hearing, Budget Hearings. The Council members have participated in the CBHS RFP processes, as well as a number Quality Management activities.

- **CBHS- Children, Youth, and Family System of Care – Youth Task Force**

Established in 2001, The San Francisco Youth Task Force provides skills development in leadership, advocacy, public speaking, policy through creative media. The Task Force consists of 13-18 youth previously or currently involved in multiple systems, including Mental Health/Substance Abuse, Foster Care, Special Education, and Juvenile Justice. The goal of the Task Force is have

youth use their personal experiences to help constructively change the systems they are in and make a positive transformation in their own lives. The youth also are actively involvement in the CBHS System of Care policy, program, and treatment development as an advisory body.

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

CBHS has developed and implements community outreach, engagement, and involvement through a number of strategic mechanism to ensure inclusion of and input from racial, ethnic, cultural and linguistically diverse clients, family members, advisory committees, mental health board, and community organization in the mental health system's planning process for services. The following committee and mechanisms are in place to advance optimal inclusion and participation:

Office of Cultural Competence and Client Relations

The Office of Cultural Competence is one the key primary points of connecting and engaging the involvement and communication with our County's racial, ethnic, cultural and linguistically diverse clients, and family members. This office is staffed by a senior manager, Health Educator, Administrative Analyst, and three health workers. These staff perform cultural competence training, community outreach to community events/street fairs/cultural events/health fairs, etc., workshops, translation and interpretation services, implementing and developing peer internship program (entry level consumer work internship), wellness and recovery support groups, and some of the staff participate in grievance process, contractual and technical assistance committee, disaster responsiveness committee, training committee, and annual data collection of ethnic, cultural, and linguistic capacity of behavioral health workforce.

Cultural Diversity within the Organization

Advisory Board and Committees strive to involve a culturally diverse group of stakeholders, including consumer and family members, providers and advocates in its composition, planning, and decision making. Some of these groups include:

- **The San Francisco Mental Health Board (MHB)** (see above)
- **SF DPH Cultural Competency Task Force** (see above)
- **MHSA Advisory Committee** (see above)

CBHS Client Council (see above)

- **CBHS Change Agent Committee**

In 2004, Community Mental Health Services, now Community Behavioral Health Services established the Change Agent committee to help the system guide and develop the integration of mental health and substance abuse services. The Change Agents' role in the successful integration process has been most critical in providing the voice and the needs of all consumers, and provided guidance in inclusion of cultural and linguistic goals and objectives for the new integrated system of care. Specifically the role of the Change Agent is "to help staff learn attitudes, values, knowledge, and skills related to treatment of individuals with co-occurring disorders..." *Appendix A* provides a complete list of committee members.

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

Currently, CBHS provides an array of trainings and workshops to available to all contract and civil service programs that includes cultural competency and cultural sensitivity, clinical documentation, clinical assessment/diagnosis/treatment, best practices and evidence-based practices, IT and billing, coding, compliance, and quality improvement (data, research, and evaluation). The Office of Cultural Competency is also implementing a pilot Grant Writing training to those applicants that were not funded for any of the previous funding applications in the past year for MHSA or the MEGA RFP, and who are community-based organization that predominantly serve ethnic and cultural populations.

CBHS provided extensive and comprehensive training the past four months on the new IT system (AVATAR) to make sure that each contract and civil service sites gained the skills and technology capacity. AVATAR combines the old billing system, Insyst, and the old electronic clinical record system, Clinicians Gateway, into one unified electronic records keeping and billing system. Once fully in place, this system should streamline record keeping and billing and also allow greater review of data so that client outcomes and productivity can be measured.

SF DPH Community Programs' Community Assessment, System/Program Evaluation and Research (CASPER) workgroup committee (of epidemiologists, researchers, and analysts – including the CBHS Director of Cultural Competence and Client Relations) have recently revised and updated the ***Principles of Collecting, Coding, and Reporting Social Identity Data Ethnicity Guidelines***. The new guideline is a critical instrument in monitoring health outcomes and support intervention on behavior s that are the underlying causes of disease and injuries. Additionally, this new guideline expands and refines specific ethnic population categories and sub-categories that previously was not indicated; thus, improve our data collection for these populations. The SF DPH – Community Programs Ethnicity Guidelines is provided in ***Appendix A*** in full description. CASPER is currently developing additional ***Principles of Collecting, Coding, and Reporting Sex and Gender Guidelines*** as well.

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

One of the key lessons learned is that strategic community outreach, engagement and involvement requires the System to develop a supportive relationship with community-based organizations, cultural and ethnic communities/neighborhoods, and un-served/under-served communities. This includes providing more meetings and community forums in each of the respected communities.

Another lesson learned is that many of these cultural/ethnic communities have resources, knowledge, skills, and interest in being more actively involved in the efforts to make the System better serve the City and County; however, lack financial resources and other systematic barriers.

E. *Identify county technical assistance needs.*

None identified at this time.

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

The CC/ESM (Director of Cultural Competence and Client Relations reports directly to the SFDPH Community Programs Deputy Director of Health, which oversees all four sections of community programs, including CBHS. Additionally, CC/ESM has direct access to the SFDPH Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

The county shall include the following in the CCPR:

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

Office of Cultural Competence and Consumer Relations

Not only have CBHS designated a senior CC/ESM manager, Director of Cultural Competence and Client Relations, it also established the Office of Cultural Competence and Consumer Relations department. The Director of Cultural Competence is part of the Executive Management Team and is responsible for the strategic development, planning and implementation of a system-wide culturally and linguistically competent public mental health system of care.

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

The full written job description for the Director of Cultural Competence and Client Relations (*Manager II-Assistant Director of Clinical Services I*) is provided in Appendix A.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

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

As demonstrated and discussed in previous sections the Office of Cultural Competence and Consumer Relations was instituted as part of the CBHS Plan's administrative structure. This office is staffed by a senior manager who is a part of the Executive Management Team and is responsible for the strategic development, planning and implementation of a system-wide culturally competent public mental health system of care, as well as 4.5 FTE support staff. Functions of this office specific to cultural competence include the development and overview of the Cultural Competence Plan, training, RFP processes, contracts and technical assistance process, assessments and training development, consultation and the development of system wide cultural and linguistic resources.

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

CBHS currently has a total annual budget of \$14,000 allocated for any translation and interpreter services, and has consulting contracts with two private vendors to

fulfill these obligations. These activities are facilitated and processed by the Office of Cultural Competence and Client Relations.

CBHS sponsors, supports and collaborates with other public health departments in the facilitation of a number of community based outreach and community/cultural health & wellness events such the bi-monthly Project Homeless Connects that provides a one-stop shop of health and human services for thousands of homeless San Franciscans, large scale vaccination efforts such as H1N1 virus, as well as participating in community and cultural street fairs to provide information on mental health, anti-stigma information dissemination, brief depression screening, etc. Some of the community/cultural street fairs that the Office of Cultural Competence have participated in including: Friendship House Association of American Indians-Indian Market, Native American Health Center, Inc.-Gathering of the Lodges, Carnival, Samoan Community Health Fair, Richmond District Community Fair, Vietnamese Youth Development Center Grand Opening, TET Festival (Vietnamese New Year), South of Market Community Fair, and the Annual Filipino-American Counseling and Treatment Team community gathering.

The Office of Cultural Competence and Client Relations coordinates the ***Multicultural Student Stipend Program*** (MSSP), a human resources development program established in 1988, to address the need to recruit staff with special skills and sensitivities to provide culturally and linguistically competent mental health services to San Francisco's increasingly diverse population. The CBHS continues to find funding and sustain this very critical program even during current bleak economic shortfalls and budget cuts. Stipends are available to students interning in mental health, substance abuse, and integrated treatment programs of Community Programs. The program is designed to assist students in their development of skills to work with culturally diverse populations, to encourage ethnic and cultural diversity amongst our Community Programs interns and to increase the pool of applicants with special skills and knowledge, including language, culture, disabilities and principles on wellness and recovery for future employment with Community Programs. As part of our human resource development commitment, the MSSP is aimed at providing support to students interested in public sector work, community behavioral health services, working with populations with health disparities and shortages of culturally and linguistically competent staff. A total of \$50,000 in stipends were allocated during the academic year 2008-2009 and a total of \$25,000 during the summer academic sessions 2009 to bi-lingual and bi-cultural, disabled, and older adults student interns.

Mental Health Services Act PEI: Holistic Wellness Promotion initiative

In effort to support and implement culturally relevant and culturally appropriate effective practices, CBHS funded four community-based, ethnic or cultural organizations to support wellness services, designed to address the impacts of trauma, including outreach and education, pro-social community building events, community wellness promotion activities and traditional healing, and service linkages to individuals and families. Holistic Wellness grantees included CBOs

who predominately provides services to Latinos/Hispanics, Native Americans (America Indians), and African American Communities, and other hard-to-reach populations with special needs, including the Promotores program for Mayan specific population. A total of \$1,000,000 (one million) was funded for fiscal 2009-2010.

African American Health Equity Committee

SFDPH Community Programs Health Equity and Population Leadership (HEPL) Team was established in 2008 to review and analyze health disparity and health inequity in ethnic and cultural populations in the City and County. In 2010, the African American Health Equity Committee was formed to develop strategies of goals and objectives to improve African American health and wellness recommended by HEPL Team. The committee selected two priorities for all divisions of Community Programs to focus on: 1) health disparities facing African American, and 2) disproportionate impact of alcohol abuse/dependence on minority communities. These focus areas, further, turned into a directive to incorporated program objectives for FY10-11 contracts to incorporate performance objectives addressing these two priorities. All CBHS contractors have these performance objectives in their contracts. The Performance Objectives are can be found on page 6 of the DPH Community Behavioral Health Services – Updated Performance Objectives for Fiscal Year 2010-2011 attached in *Appendix A*.

Urban Trails San Francisco

Urban Trails San Francisco is a new behavioral health system partnership between Child, Youth and Family System of Care within the SF DPH-CBHS and the Native American Health Center, Inc., a six-year Substance Abuse and Mental Health Administration System of Care Grant project. Goals: Urban Trails San Francisco will expand access for culturally and spirituality-based behavioral health services for most needy and vulnerable Native American (American Indians/Alaska Natives) and other indigenous children (children of Mayan descent and/or Mayan-speaking children). The Urban Trails San Francisco also will build the capacity of local behavioral health providers to provide more culturally and spiritually-based services to Native American clients through annual trainings and technical assistance offerings. The annual funding for Urban Trails San Francisco is \$1 million for the fiscal years 2009-2015.

Integration of Consumer Employees into CBHS Work Force

Presently, CBHS has the following three consumer employee programs that provide an array of clinical, administrative, and operational support to contract and civil services programs: Peer Internship Support Program, Pathways to Discovery, and MHSA Peer Program.

- *Peer Internship Program*: The Office of Cultural Competence and Client Relations coordinates the Peer Internship Program which has, currently, 22 participants. The peer interns are mental health consumers or family member who are placed in community mental health contract and civil service sites, including 1380 Howard, to provide peer counseling support,

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wellness and recovery activity facilitators, basic case management support, system navigation support, and clerical and administrative support. Peer Interns are provided stipends through the SF Study Center (a fiscal intermediary of CBHS) with no more than 20 maximum hours per week. The Peer Internship placement is 12 months

- *Pathways to Discovery* is a consumer/family member employment program within MHSA. Under the direction of the Cultural Competency Director, located at 1380 Howard, the Pathways staff facilitates support groups, WRAP groups, wellness and recovery activities at a number civil service programs. Pathways provides system navigation support services to peers for appointments, and works with City College to provide support to consumers enrolled in the newly established Mental Health Certificate program.
- **MHSA Consumer Employment Program:**
The CBHS MHSA Implementation Specialist Program employees are consumers or family members of a consumer of the mental health system. The Implementation Specialists assist other consumers through funding provided by the MHSA. They are classified as 9924 Public Service Aide and hired in both “as needed” and regular employees.” MHSA Implementation Specialists work on various tasks at the central administration site for Community Behavioral Health Services including in Welcoming Reception in the main building lobby, and MHSA administration and CBHS training departments. These positions are intended to be entry level employment to gain skills to obtain higher level employment in the civil service system. This program was honored for Public Policy Leadership by the San Francisco Mental Health Association in 2008.

CRITERION 2

COUNTY MENTAL HEALTH SYSTEM

UPDATED ASSESSMENT OF SERVICE NEEDS

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

Note: All counties may access 2007 200% of poverty data at the DMH website on the following page:

http://www.dmh.ca.gov/News/Reports_and_Data/default.asp within the link titled "Severe Mental Illness (SMI) Prevalence Rates".

Counties shall utilize the most current data offered by DMH.

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

I. General Population

The county shall include the following in the CCPR:

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

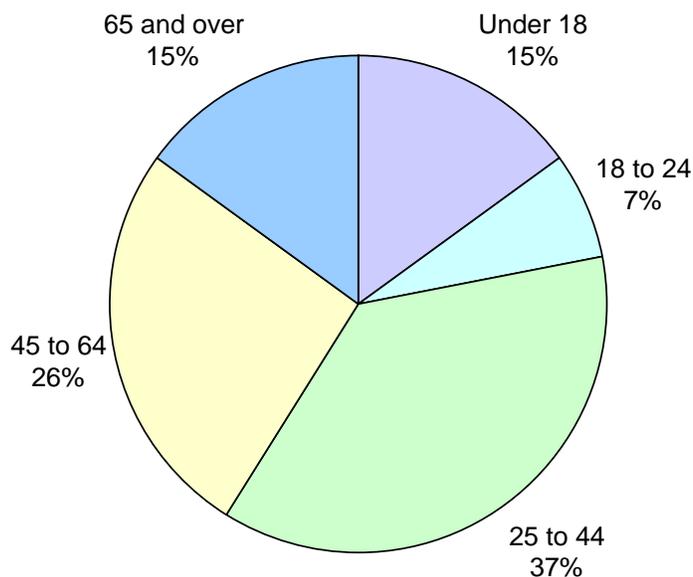
The demographic information for San Francisco was obtained primarily from the most recent population data available from the US Census Bureau, and was supplemented by the 2006-2008 American Community Survey estimates in cases where the census

data lacked sufficient detail to adequately describe the county's population. The 2009 population estimate for San Francisco was 815,358, with gender almost evenly divided between women (49%) and men (51%). The age, ethnicity, and language characteristics of the city are described below.

Age

The distribution of age in San Francisco is shown in Figure 1(2006-2008 American Community Survey 3-Year Estimates). Youth under the age of 18 make up almost 26% of the California population, but they represent a much smaller proportion of San Francisco's population at only 15%. San Francisco has a slightly higher proportion of seniors (15% vs. 11%), and the majority of adults are between the ages of 25 and 44.

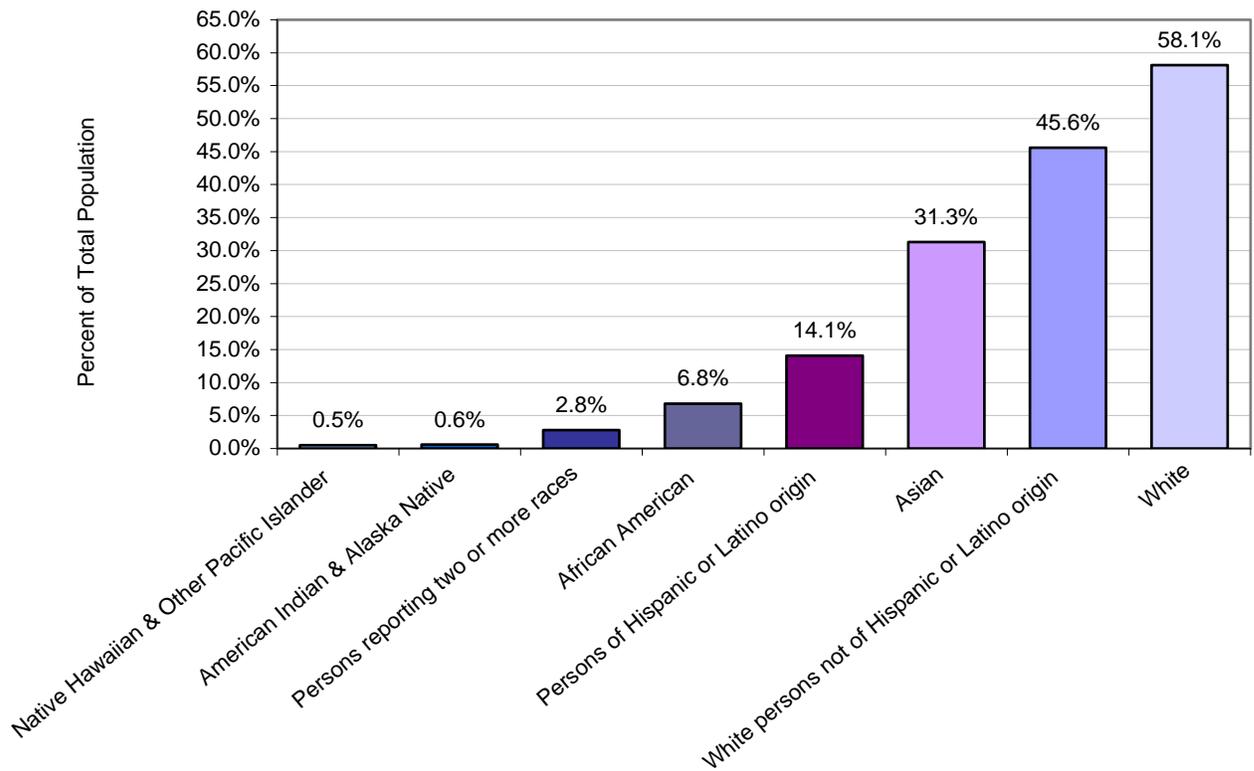
Figure 1: Age Ranges of General Population



Ethnicity

US Census Bureau distinguishes between “ethnicity” (Hispanic Origin) and “race” (American Indian or Alaskan Native, Asian, Native Hawaiian and Other Pacific Islander, African American, White). Therefore, the categories in Figure 2 below are not mutually exclusive and total more than 100%. San Francisco is a culturally diverse city with over 50% of the population comprised of persons from ethnically diverse backgrounds. The majority of this ethnically diverse population is composed of persons of Asian backgrounds (31%), followed by persons of Hispanic or Latino origins (14%), and African Americans (7%).

Figure 2: Ethnicity of General Population



Language

Almost half of San Francisco’s population speaks a language other than English at home, with 26% speaking an Asian or Pacific Islander language, 12% speaking Spanish, and 7% speaking another Indo-European language (2006-2008 American Community Survey 3-Year Estimates) as illustrated in Figure 3 below.

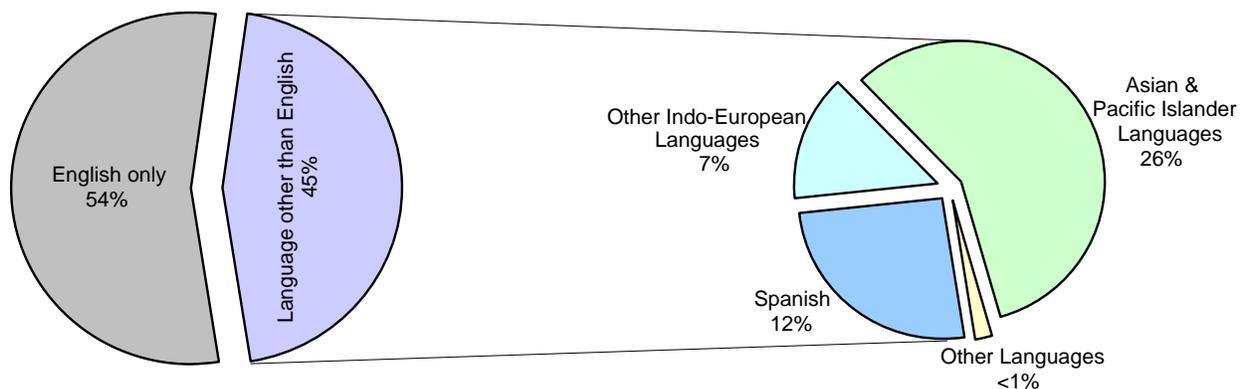


Figure 3: Language of General Population

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

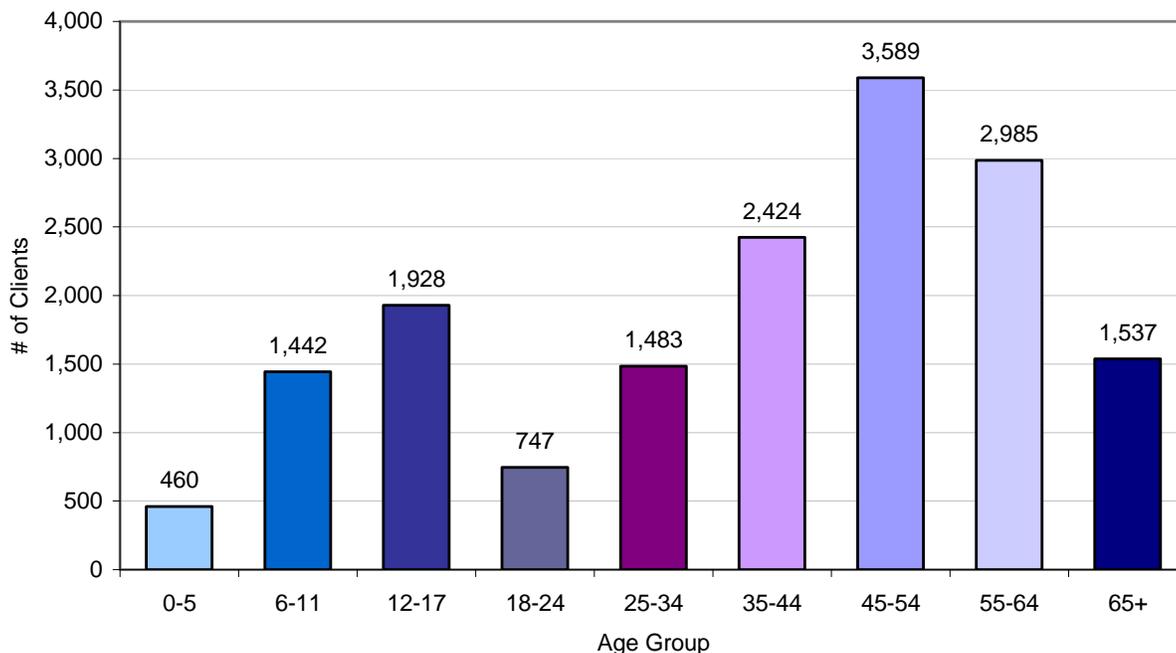
A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

The source of data for these analyses was San Francisco's FY 2008-2009 mental health billing data. San Francisco served a total of 16,595 Medi-Cal clients, which represented approximately 65% of the county's total clients served. A higher proportion of males than females were served, at 54% and 46% of the population respectively.

Age

The frequency of Medi-Cal clients served by age group is represented in Figure 4. The majority (68%) of these clients are adults between the ages of 18 and 64.

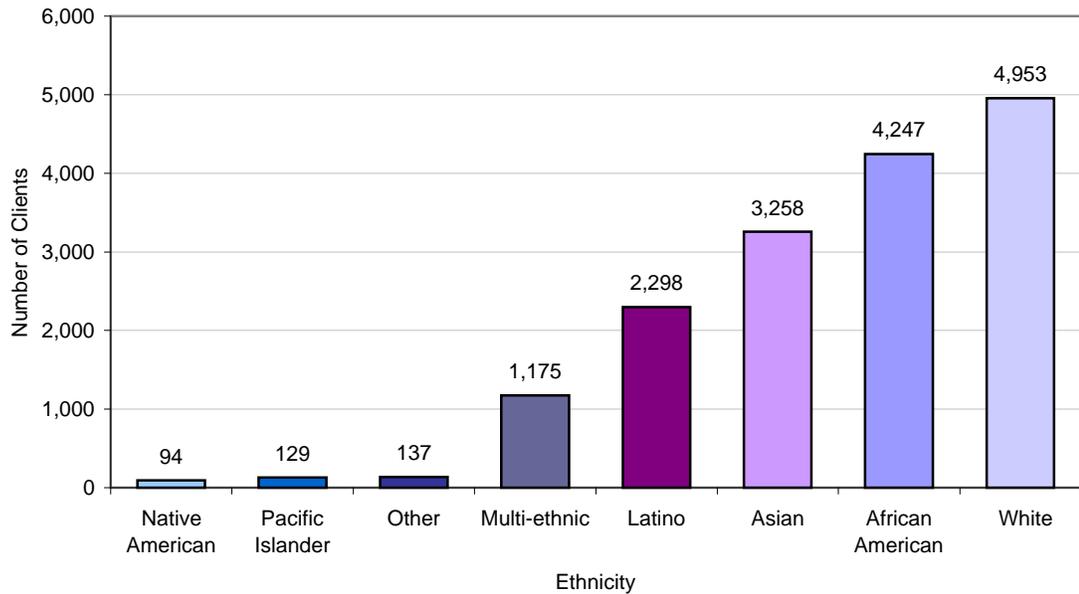
Figure 4: Medi-Cal Clients Served by Age



Ethnicity

The frequency of Medi-Cal clients served by ethnicity is shown in Figure 5. Seventy percent of San Francisco's Medi-Cal client population is comprised of persons from ethnically diverse backgrounds. The majority of this diverse population is composed of African American (26%), Asian (20%), Latino (14%), and Multi-ethnic (7%) clients.

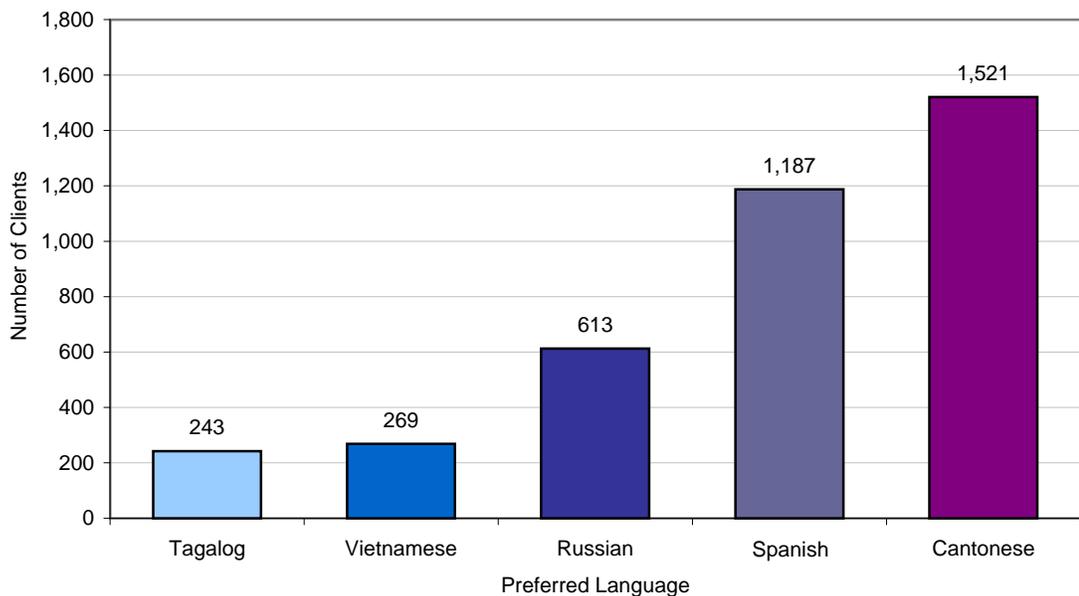
Figure 5: Medi-Cal Clients Served by Ethnicity



Language

A significant portion (28%) of San Francisco’s Medi-Cal clients indicated a language preference other than English. The frequency of Medi-Cal clients served for preferred languages with greater than 100 clients is shown in Figure 6.

Figure 6: Medi-Cal Clients Served by Preferred Language



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

In order to identify possible disparities, the number of clients served was compared to Dr Charles Holzer’s data from State of California Department of Mental on the estimated need for mental health services among persons living at <200% of poverty, as shown in Figure 7 below. Dr Holzer’s data did not include detailed information on language preference; therefore additional analyses on language capacity were conducted and can be found in section VI.B.

“Penetration rates” were calculated to determine the degree to which the estimated need for mental health services was met. The Total Penetration Rate reflects the overall proportion of those estimated in need who received services (Total Clients Served ÷ Estimated Need), and the Medi-Cal Penetration Rate reflects the proportion of those estimated in need who received services paid for by Medi-Cal (Clients with Medi-Cal ÷ Estimated Need). Penetration rates falling below 100% are highlighted in Figure 7.

Figure 7: Comparison of Clients Served vs. the Numbers of Persons Estimated in Need of Mental Health Services

	Total Clients Served	Clients with Medi-Cal	Clients without Medi-Cal	Estimated Need	Total Penetration Rate	Medi-Cal Penetration Rate
Ethnicity						
African American	5,741	4,247	1,494	1,836	313%	231%
Asian	4,436	3,258	1,178	2,735	162%	119%
Latino	4,064	2,298	1,766	2,822	144%	81%
Multiple	1,614	1,175	439	456	354%	258%
Native American	154	94	60	70	220%	134%
Pacific Islander	190	129	61	110	173%	117%
White	8,345	4,953	3,392	4,735	176%	105%
Gender						
Female	11,309	7,663	3,646	7,120	159%	108%
Male	13,889	8,888	5,001	5,643	246%	158%
Age						
0-5	548	460	88	1,001	55%	46%
6-11	1,754	1,442	312	880	199%	164%
12-17	3,046	1,928	1,118	971	314%	199%
18-24	1,629	747	882	908	179%	82%
25-34	3,297	1,483	1,814	2,136	154%	69%
35-44	4,205	2,424	1,781	3,067	137%	79%
45-54	5,165	3,589	1,576	1,952	265%	184%
55-64	3,823	2,985	838	1,034	370%	289%
65+	1,792	1,537	255	815	220%	189%
Total	25,259	16,595	8,664	12,764	198%	130%

Total Clients Served = CBHS unduplicated mental health clients served during FY 0809

Clients with Medi-Cal = CBHS unduplicated mental health clients served with Medi-Cal during FY 0809

Clients without Medi-Cal = CBHS unduplicated mental health clients served without Medi-Cal during FY 0809

Estimated Need = Dr Charles Holzer’s data on the estimated need for mental health services for CY 2007; [http://www.dmh.ca.gov/Statistics and Data Analysis/Total Population by County.asp](http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Total_Population_by_County.asp)

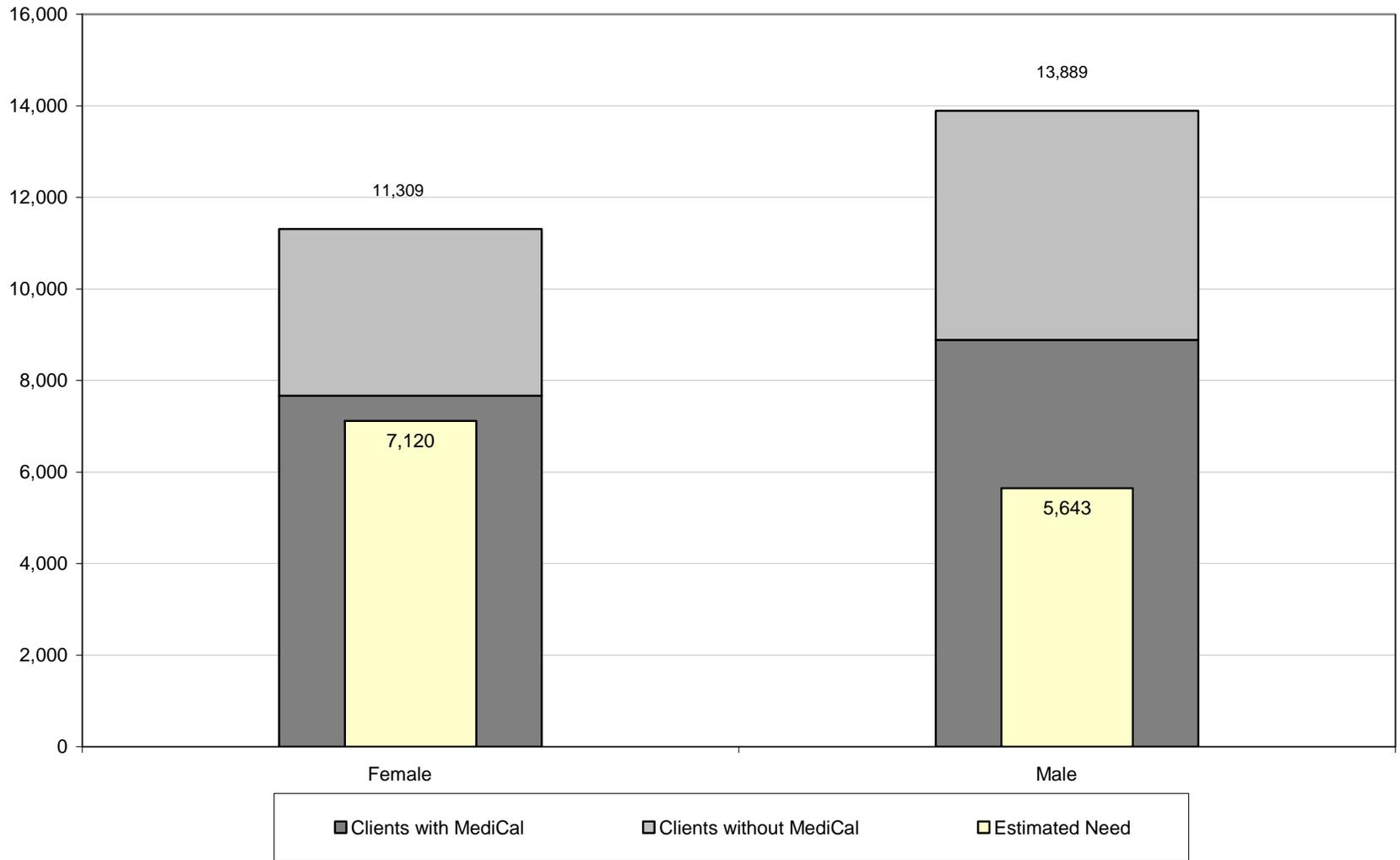
Total Penetration Rate = Total Clients Served ÷ Estimated Need

Medi-Cal Penetration Rate = Clients with Medi-Cal ÷ Estimated Need

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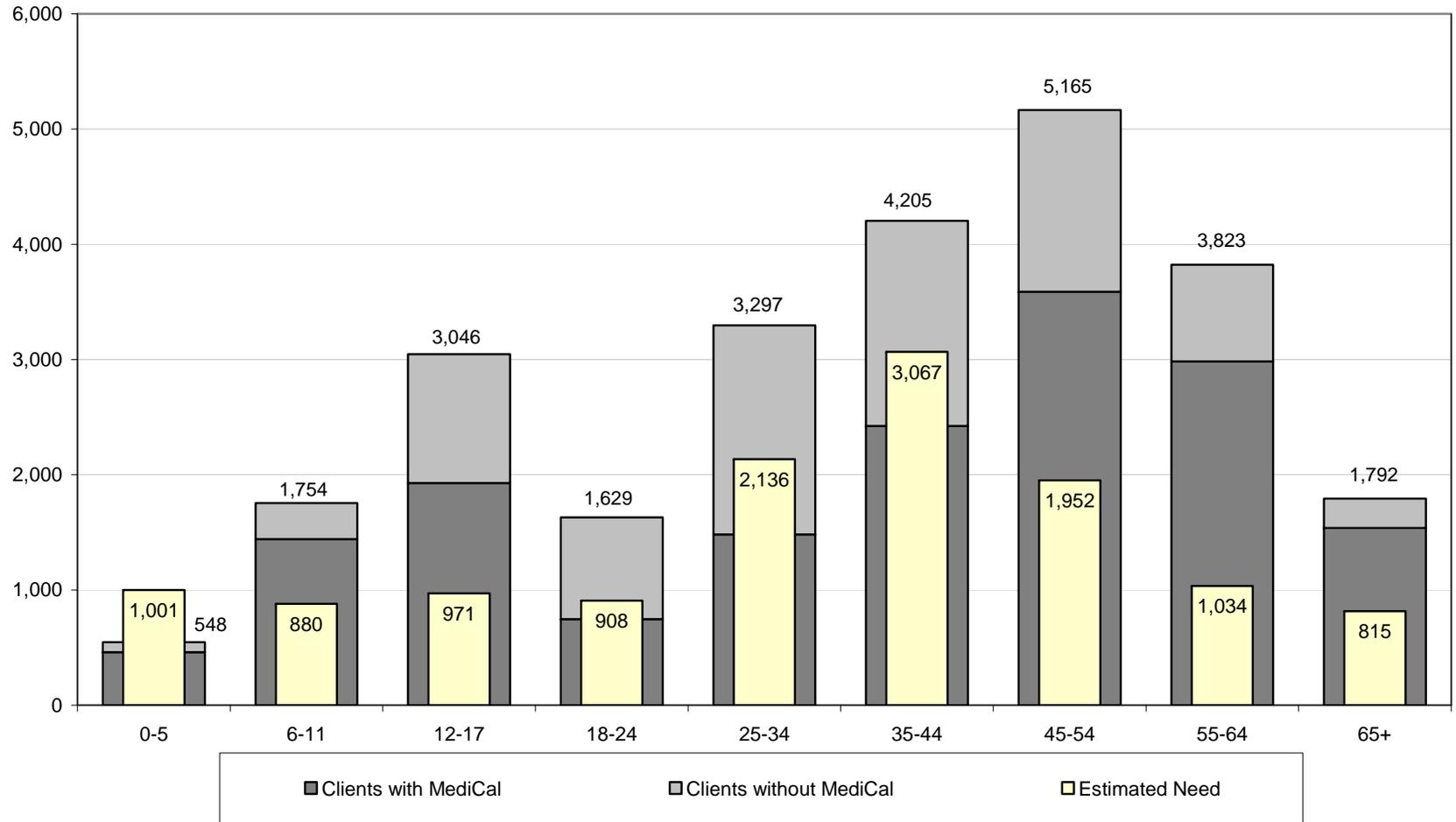
Bar charts which provide a visual representation of this data for gender, age, and ethnicity are found in Figures 8, 9, & 10 respectively. The yellow bars represent Dr Holzer's estimates of need, and the grey bars represent the total clients served; the darker grey represents Medi-Cal clients and the lighter grey represents clients without Medi-Cal.

Figure 8: Comparison of Clients Served to the Estimated Need for Mental Health Services by Gender



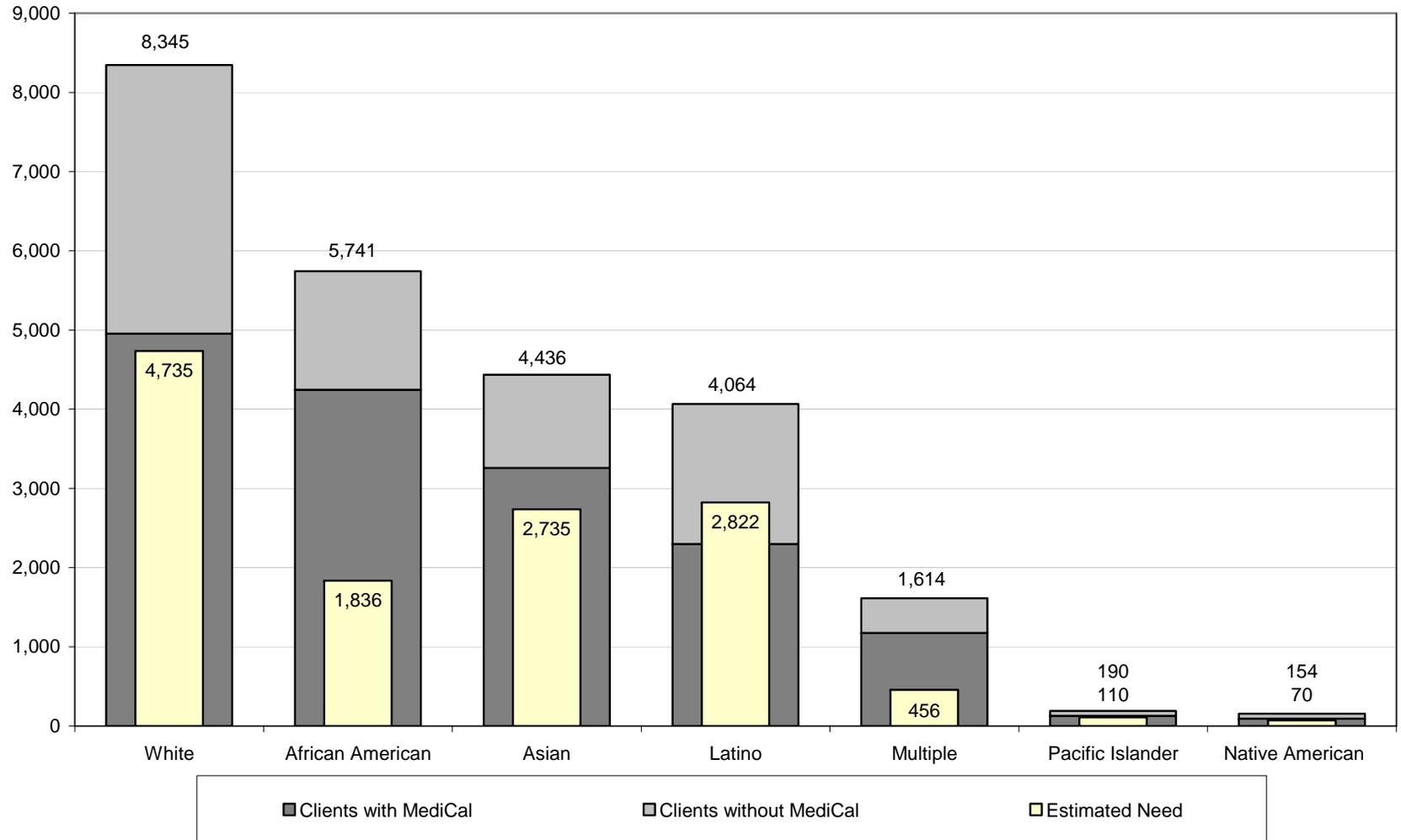
California Department of Mental Health Cultural Competence Plan Requirements

Figure 9: Comparison of Clients Served to the Estimated Need for Mental Health Services by Age



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Figure 10: Comparison of Clients Served to the Estimated Need for Mental Health Services by Ethnicity



Gender

The overall penetration rates and the Medi-Cal penetration rates exceeded 100% for both men and women, with a higher proportion of men receiving services.

Age

The only age group which fell short of 100% for both the overall and Medi-Cal penetration rates was for children ages 0 to 5. However, many of the services provided for this age group are prevention or school-based activities which would not be accounted for in our billing system and would be missing from these counts. Therefore, it is difficult to determine whether a disparity exists for this age group.

The age groups falling between 18 and 44 years of age each had a smaller number of Medi-Cal clients served than the numbers estimated in need, however the overall number of clients served exceeded the numbers estimated in need.

Ethnicity

The overall number of clients served exceeded the number estimated in need for all ethnic groups. Only one group, Latino clients, had fewer Medi-Cal clients served than the number estimated in need. One possible explanation for this could be that some clients of Latino descent are not U.S. citizens, and therefore are not eligible for Medi-Cal.

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

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 data sources that were used for these comparisons included Dr. Charles Holzer's population, as recommended by the California Department of Mental Health, estimates of the numbers of persons with incomes at less than 200% of the poverty level, the number of Medi-Cal clients served, and the number of clients served without Medi-Cal coverage. "Penetration rates" were calculated by dividing the number of clients served without Medi-Cal coverage by the population in poverty numbers (minus the Medi-Cal clients). The average overall penetration rate was 5.19%. The data is shown in Figure 11 in the following page.

Figure 11: Penetration Rates of Clients without Medi-Cal vs. <200% Poverty Data

	<200% Poverty Population	Medi-Cal Beneficiaries	<200% Poverty – Medi-Cal Beneficiaries	Clients without Medi-Cal	Penetration Rate
Totals					
	183,622	16,595	167,027	8,664	5%
Age					
0-5	11,270	460	10,810	88	1%
6-11	9,984	1,442	8,542	312	4%
12-17	10,987	1,928	9,059	1,118	12%
18-24	20,507	747	19,760	882	4%
25-34	23,678	1,483	22,195	1,814	8%
34-44	29,129	2,424	26,705	1,781	7%
45-54	22,358	3,589	18,769	1,576	8%
55-64	18,982	2,985	15,997	838	5%
65+	36,727	1,537	35,190	255	1%
Gender*					
Female	96,304	7,663	88,641	3,646	4%
Male	87,317	8,888	78,429	5,001	6%
Ethnicity**					
Asian	65,639	3,258	62,381	1,178	2%
Pacific Islander	1,710	129	1,581	61	4%
Latino	36,714	2,298	34,416	1,766	5%
White	54,084	4,953	49,131	3,392	7%
African American	20,214	4,247	15,967	1,494	9%
Native American	674	94	580	60	10%
Multi-ethnic	4,587	1,175	3,412	439	13%

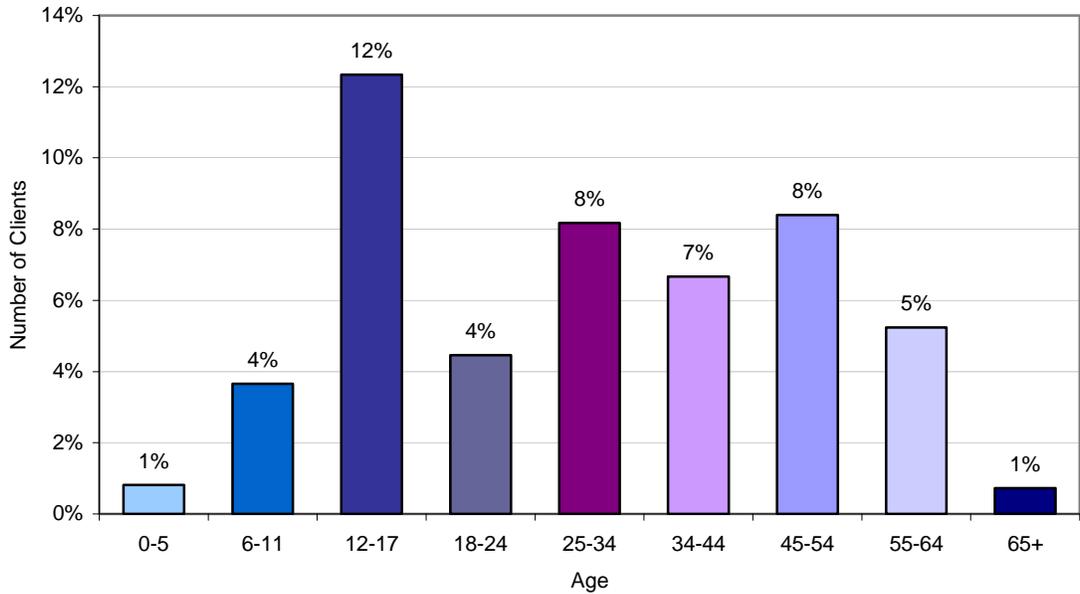
*Gender coded as 'Other' or 'Unknown' was not included and represented 44 Medi-Cal Clients and 17 Clients without Medi-Cal

**Ethnicity coded as 'Unknown' was not included and represented 441 Medi-Cal Clients and 274 Clients without Medi-Cal

Age

The penetration rates by age group for clients without Medi-Cal are shown in Figure 12.

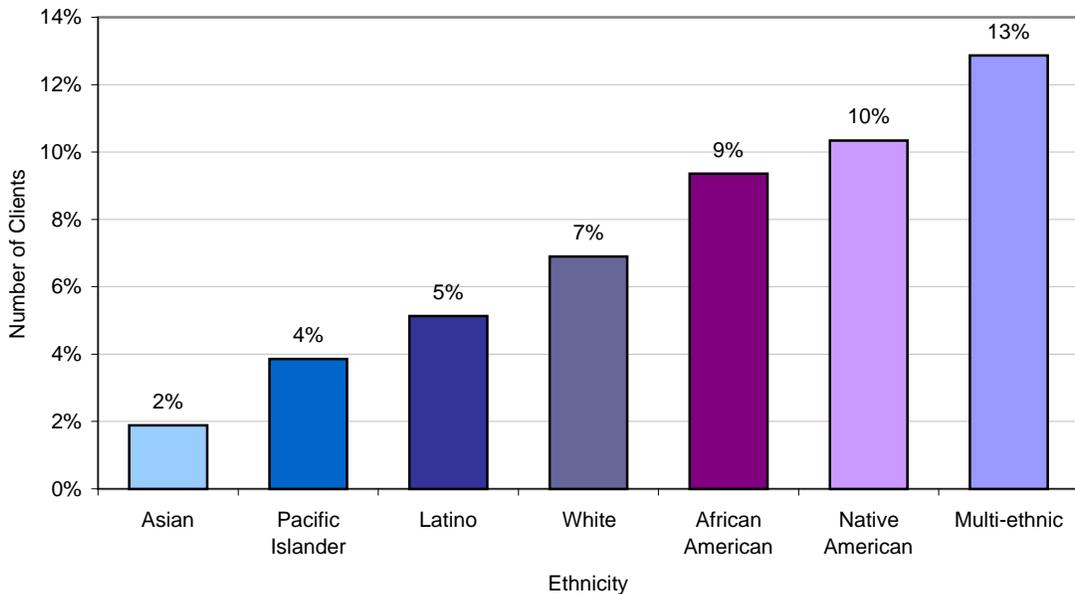
Figure 12: Clients without Medi-Cal vs. <200% Poverty Data Penetration Rate by Age



Ethnicity

The penetration rates by ethnicity for clients without Medi-Cal are shown in Figure 13 in the following page.

Figure 13: Clients without Medi-Cal vs. <200% Poverty Data Penetration Rate by Ethnicity



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

The groups with penetration rates below the mean are noted below. However, it is difficult to interpret or draw conclusions based on this data without also considering the relative need for mental health services and the variation in rates of Medi-Cal coverage across groups.

Gender

Females had slighter lower penetration rates than males, at 4% and 6% respectively.

Age

The age groups 0-5, 6-11, 18-24, and 65+ all fell below the average penetration rate.

Ethnicity

The Asian and Pacific Islander groups both fell below the average penetration rate.

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

The county shall include the following in the CCPR:

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

A recent analysis of unduplicated clients served by MHSA funded programs as of the end of Fiscal Year 2008-2009 show the following age, race/ethnicity, and primary language illustrated in the following tables

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FY 08-09 Unduplicated Client Count	
AGE GROUP	# of individuals
Child and Youth	1,750
Transition Age Youth (TAY)	769
Adult	5,142
Older Adult	989
TOTAL UDC FY 08-09	8,650

The total unduplicated client count reported in FY08-09 totaled 8,650. Children Youth and Families comprised 20% of clients served; Transitional Aged Youth 9%; Adults 59% and Older Adults 11%.

RACE/ETHNICITY	UDC	%UDC
African American	3005	35%
White	2296	27%
Latino/Hispanic	1441	17%
Asian	1224	14%
Other	256	3%
Multi	176	2%
Pacific Islander	165	2%
Native	87	1%
TOTAL COUNT	8650	100%

Of the total unduplicated client count, 580 (6.7%) identified as LGBTQQ, of whom, 144 are CYF; 215 are TAY; 200 are Adults; and 21 are Older Adults

PRIMARY LANGUAGE		
English	7,044	81%
Spanish	949	11%
Cantonese	262	3%
Tagalog	105	1%
Mandarin	85	1%
Vietnamese	52	1%
Unknown	51	1%
Other	40	0%
Russian	30	0%
Cambodian	20	0%
Arabic	8	0%
Farsi	4	0%
TOTAL CT COUNT	8,650	100%

English is the primary language of 81% of clients served, followed by Spanish (11%), Cantonese (3%), and 5% spoke various languages.

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

Note: Objective will identified in Criterion 3, Section III.

Compared with the general population, CYF constitute a higher percentage of MHSAs clients served (20% MHSAs vs. 15% of general population); TAY slightly higher at 9% compared 7%; Adults lower at 59% compared to 63%; Older Adults also lower at 11% compared to 15%. African Americans continue to exhibit higher mental health services utilization, comprising 35% of MHSAs clients but representing only 6.8% of the general population. Conversely, API's are not utilizing mental health services as much as their population indicates, with only 14% being served by MHSAs compared to 31% of the population. This under-utilization could be a reflection of stigma about mental illness and the inherent tradition of protecting the family name within this community. Similarly, Latinos are also under-represented among MHSAs clients at 17% when this group constitutes 46% of the general population. Besides stigma, this under-representation could be due to this group's unawareness of services that are available to them and their hesitancy to seek services because of their immigration status. It is worth observing that although Latinos comprise 17% of MHSAs clients, only 11% stated Spanish as their primary language.

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

The county shall include the following in the CCPR:

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

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

In 2005, the San Francisco MHSAs Behavioral Health Innovations Task Force launched a community-wide planning process to identify the priority unmet service needs of persons with serious mental illness in San Francisco. Mayor Gavin Newsom appointed the 40 member committee to oversee the development of the county's Community Services and Supports (CSS) plan. San Francisco's process spanned four months and entailed public meetings, interviews with consumers and family members, and the submission of 80 position papers from community stakeholders.

The PEI-specific community planning process convened in 2008, building upon the work of the original CSS plan. Two CSS sub-committees, the Prevention and Early Intervention (PEI) and the Children, Youth and Family (CYF), were of particular relevance to the San Francisco PEI planning process. Review of the minutes of these sub-committee meetings revealed that the members raised six of seven populations and key community needs that were later designated by the state as PEI planning priorities. The findings of these two sub-committees informed the PEI prioritization process, and were included in meeting materials distributed to PEI Planning Committee members.

Our PEI planning process reached representatives from the identified unserved/underserved populations. The process also successfully engaged representatives of all age groups, with an emphasis on those working with children, youth and transition age youth.

During our MHSAs planning, we have reached out to and recruited agencies that could help represent the interests of traditionally underserved and/or challenged populations, specifically:

- Specific underserved ethnic groups were represented by many agencies:
 - Latino – Instituto Familiar de la Raza, La Casa de las Madres, Horizons Unlimited

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- Asian – APA Family Support Services, Japanese Community Youth Council
- Native American – Native American Health Center
- Refugees - Survivors International
- Lesbian Gay Bisexual Transgender Questioning Intersex Queer (LGBTQIQ) community was represented by LYRIC, Lyon Martin Health Services, and Larkin Street
- The homeless population was represented by Larkin Street and Family Service Agency.
- Juvenile probation had representation from Jail Health Services, Youth Justice Institute, and Superior Court.
- San Francisco has a large and diverse population of non-English speaking individuals and households, many of which were represented by community-based organizations in this process, such as Instituto Familiar, APA Family Support Services, Japanese Community Youth Council, SF Welcome Back Center, and RAMS Fu Yau Project.
- Youth in foster care had a number of organizations representing their needs and priorities, including Aspira Foster and Family Services, Honoring Emancipated Youth, Larkin Street Youth Services, and DCYF.

In the first four meetings of the PEI planning process, the stakeholders participated in examining the needs data, identifying risk and protective factors for priority populations, and reporting on existing capacity and gaps related to prevention and early intervention services in the County. Additionally, in meeting four, the Assistant Director of Research, Evaluation, and Quality Management at CBHS trained the participants to understand and use data. He also provided updated needs assessment data for the County

As a result of these discussions and extensive prioritization activities, the Committee established seven workgroups, organized around the five priority populations and two additional key community mental health needs identified in the PEI guidelines. The issue of *disparities in access* was integrated into all of the workgroups (listed below).

1. Trauma-Exposed Individuals and Families
2. Children and Youth At-Risk for School Failure
3. Children and Youth At-Risk for Juvenile Justice Involvement
4. Children and Youth in Stressed Families
5. Individuals Experiencing Onset of Serious Psychiatric Illness
6. Reduction of Stigma and Discrimination
7. Suicide Prevention

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

This section was discussed in previous sections.

VI. Supplemental Data Used to Inform San Francisco's Needs Assessment

A. African American Health Disparities

A study was conducted by the San Francisco Department of Public Health on the leading causes of premature death

(http://www.sfdph.org/dph/files/reports/StudiesData/CHE_Rpt07242007C.pdf).

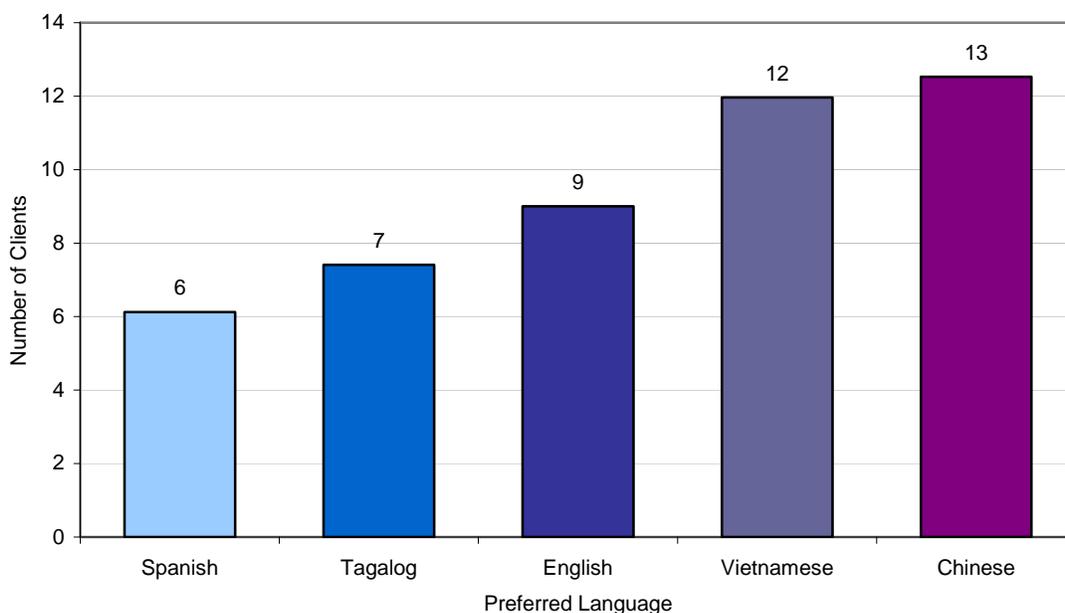
Two years of data from San Francisco's death registry and information on life expectancy were used to calculate and rank the years of life lost (YLL) due to the leading causes of premature death. When this information was compared across demographic factors, African Americans were found to have significantly worse outcomes with higher overall and cause-specific age-adjusted YLL.

African American men had age-standardized years of life lost rates (ASYRs) that were 2.44 times higher than white men, and African American women had ASYRs that were 2.31 times higher than white women. The causes of death associated with markedly higher ASYRs for African American men were violent assault (homicide), followed by HIV/AIDS, vascular diseases, accidental drug overdose, and lung cancer. African American women had notably greater ASYRs for vascular diseases, breast cancer, HIV/AIDS, and accidental drug overdose.

B. Linguistic Capacity

San Francisco's FY 2008-09 mental health billing data was used to assess the language preferences of our clients and the language capabilities of our staff. We then calculated a ratio of clients to staff for each language, as shown in Figure 14.

Figure 14: Number of Clients per Staff by Language



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The number of clients per staff ranged from a low of 6 for Spanish up to 13 for Chinese. If the ratio of 9 clients per staff for English speakers is considered a benchmark, then we could conclude that the demand for staff to provide services in Vietnamese and Chinese is slightly elevated. However, if we consider that an average caseload is approximately 40 clients per staff, these numbers do not seem to indicate an unmet need. Unfortunately, information on staff language capacity in Russian was not available from our billing system. We will assess our capacity to provide services in Russian in the future as this information will be available via our new staff credentialing system, implemented July 1st 2010.

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

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

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

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

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

The county shall include the following in the CCPR:

- Medi-Cal population***
- Community Services Support (CSS) population: Full Service Partnership population***

SF City & County unserved/underserved target populations:

Children, Youth, and Families

San Francisco's in-depth analysis of its unserved and underserved populations indicated that Asian and Latino children are not served in the mental health system at the levels expected. Asian and Latino children and youth, especially those who are immigrants or undocumented, are at risk for exposure to violence (including gang-related activity) and for suicidal ideation. Although African American children are disproportionately represented in mental health, they are overrepresented in the County's juvenile justice and child welfare systems, and are more likely to be exposed to violence.

San Francisco's Full Service Partnership program focuses on children and

youth who are: exposed to violence homeless/runaway, involved with juvenile justice and/or child welfare, immigrants and undocumented and autistic children. Within these categories, the groups that are primarily served are African American (particularly males), Asian Pacific Islander, Latino children and youth and youth who identify as LGBTQIQ.

Transitional Age Youth

Among transitional age youth, the data analysis shows that Latinos are not served at the rates anticipated. Latinos youth have significant involvement with the child welfare and juvenile and criminal justice systems, and are at particular risk for exposure to violence (including gang-related activity). African American youth in this age group are also disproportionately represented in the child welfare and juvenile and criminal justice system, among the homeless, and are more likely, along with Latinos, to be exposed to violence.

The Full Service Partnership for transitional age youth meets the needs of youth who are: exposed to violence; homeless/runaway; emancipating from the child welfare system; and involved with the juvenile justice or criminal justice systems. The services focus specifically on African Americans (particularly males), Latinos (including immigrants), and youth who identify as LGBTQIQ.

Adults

Analysis of San Francisco's data revealed that Asian and Latino adults are not provided with adequate levels of service. These two ethnic groups have among the highest rates of non-proficiency in English. There is also a large homeless population that includes disproportionate numbers of African American and Native Americans and that is unserved. African American males in need of mental health treatment are overrepresented among the incarcerated adult population, and along with Latino males, are most likely to be impacted by exposure to violence.

The Full Service Partnership for adults serves adults who are: homeless; involved with the criminal justice system; hospitalized; and exposed to violence. Specific emphasis is on African Americans, Asian Pacific Islanders, Latinos/Hispanics, and veterans.

Older Adults

With respect to older adults who are underserved or unserved, the analysis again shows that Asians and Latinos are not being served in the mental health system at the expected levels. Among homeless older adults are significant numbers of White men, as well as African American male veterans.

San Francisco's Full Service Partnership for older adults meets the needs of older adults who are: isolated, homeless, and hospitalized. In these categories, the focus is on seniors who live alone, immigrants including Russians, Asian Pacific Islanders, Latinos, seniors who are hospitalized, and older adults who identify as LGBTQIQ.

▪ ***Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce***

Occupational Shortages:

The SF Workforce Assessment findings indicate that the county experiences significant challenges recruiting, hiring and retaining Child and Geriatric Psychiatrists. Community Based Organizations also appear to have difficulty filling psychiatric positions – including child, geriatric, medical director, and general psychiatric positions. There were also quite a few openings for LCSW and MFT licensed positions. These numbers are drawn from a point in time survey in 2005-06 and should, therefore, be considered generally reflective of the vacancies in the CBO provider community but should not be assumed to be completely accurate for the current timeframe. In addition, there are substantial openings among “other” unlicensed direct service staff such as residential counselors.

Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

Based on needs assessments conducted during the CSS process and other demographic data from the 2000 Census, it is clear that African Americans are underrepresented among licensed staff and management staff, while their representation among support and unlicensed staff is much higher.

Latino/as who are in licensed or managerial positions are relatively lower compared to support services. Asians, on the other hand, have very high representation in Other Health Care Direct Services staff, adequate licensed and unlicensed MH staff, but are not well represented in the managerial and supervisory levels.

▪ ***Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations***

As discussed in the previous section, the PEI priority populations are:

- Trauma Exposed Individuals and Families
- Children and Youth At-Risk for School Failure
- Children and Youth At-Risk for Juvenile Justice Involvement
- Children and Youth in Stressed Families

- Individuals Experiencing Onset of Serious Psychiatric Illness

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

CSS

CYF

- Children and Youth who have been exposed to violence
- Youth in Juvenile Justice System
- Homelessness
- Behavioral Problems Associated with Children with Autism
- Suicide Risk/Attempted Suicide
- LGBTQIQ

TAY

- Homeless and Runaway Mentally Ill TAY
- LGBTQQ youth developing psychological problems or exacerbating underlying emotional or mental disorders
- Former foster youth who are also at a high risk of becoming homeless
- Youths in Juvenile Justice System
- Suicide Attempts and Self-Inflicted Injuries
- Unemployment
- Youth affected by Violence
- Disparities related to management of a first break especially in the areas of assessment, treatment, and aftercare

Adults

- Homelessness
- Hospitalization
- Suicide
- Inability to Work
- Violence

Older Adults

- Isolation is a significant issue for many of San Francisco's older adults for a number of reasons, including living arrangements, physical health and long-term substance abuse problems, and linguistic and cultural factors
- Hospitalization
- Homelessness
- Dementia
- Suicide

WET

- African Americans among licensed MH staff and managerial/supervisory positions
- Multi-race in all work categories (licensed and unlicensed MH staff, managerial/supervisory positions, and support staff)
- Asian/Pacific Islander in managerial/supervisory positions
- Latino/as who are in licensed or managerial positions are relatively lower compared to support services
- Native Americans were unrepresented in all categories.

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

The process for selecting the PEI priority populations is described in the previous section.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

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

CSS

Homelessness - San Francisco estimates that 50% of the homeless population has a mental health problem.

Native American Population - Native Americans in San Francisco are four times more likely to be homeless and mentally ill than average San Franciscans, and are five times more likely to commit suicide.

LGBTQIQ - Data on suicide and suicide attempts confirm that this group is in need of a greater level of services than they now access. Many youth and young adults who cannot turn to family for support around sexual identity and cannot find professional and peer services may find themselves in crisis.

Youth in Foster Care and Juvenile Probation – About 1/3 of foster care placement population is served by Children's Mental Health Services. Similarly, about 1/3 of the Juvenile Probation caseload also receives mental health services.

Mentally Ill Adult Offenders – 60% of the jail population had a behavioral health problem severe enough to warrant treatment in jail. Homeless people comprised nearly half of the mentally ill jail treatment population

People with Co-Occurring Disorders The dual treatment proportion of the mental health clientele is higher than gender-specific mean, is highest among adults ages 35-44, and tends to run higher than the age-specific means for African Americans, Native Americans, and Whites.

Non- English speaking individuals - In the 2000 US Census, 13.3% of San Francisco households were deemed “linguistically isolated.” Of particular concern are the 28,815 households where Asian and Pacific Island languages are spoken and no individual in the household is linguistically proficient in English. For these households, the problem posed by the sheer magnitude of the numbers (8.7% of all SF households) is compounded by the many different home languages spoken within this group. The 7,544 (22.3%) of Spanish-speaking households, and 7,322 (22.4%) households where an “other” (or “other Indo-European”) language is preferred, are also at risk of language barriers to adequate care. These households add up to 4.5% of all San Francisco households.

People with HIV/AIDS - Living with an ultimately fatal, communicable disease carries a grave risk for depression and substance abuse, which in turn may present a public health risk. Appropriate, adequate and accessible services to all HIV/AIDS are an important priority, especially as this disease affects homeless men and women, incarcerated populations, LGBTQIQ transitional age youth, IV drug users disproportionately - groups often uninsured, underinsured and low-income.

People without health insurance - Without health insurance, mental health services become difficult if not impossible to access. According to the data derived from the California Health Interview Survey 2001, 2003, there are a total of 94,050 people living in San Francisco without health insurance. API, White, Latinos comprised majority of the uninsured then.

Insured Without Mental Health Coverage - During the MHSA planning process, there was ample testimony from members of the community that many people who have health insurance are not able to access mental health services because their benefit plan does not include mental health services. This is a hidden population of un-served individuals, not captured in earlier figures for uninsured.

Veterans - An estimated 30% of the homeless in San Francisco are veterans. Swords to Ploughshares serve homeless veterans in San Francisco and reports of their clients that: “close to 60% suffer from mental health disorders, including Post Traumatic Stress Disorder (PTSD); more than 70% have substance abuse issues; [and] about 50% are dual diagnosed.” Furthermore,

Swords to Ploughshares anticipates that the population of veterans who suffer from mental health issues and end up homeless will grow as 1 in 6 war veterans returning from Iraq are reporting mental health issues such as major depression, general anxiety or PTSD.

WDET

The **African American community** in San Francisco is facing serious traumatic challenges from ambient violence, poverty and other assaults. Efforts should be made to provide adequate number of African American mental health practitioners to better serve the community. One of the obvious barriers is economics – with African Americans being among the lowest income residents of San Francisco. Lack of financial resources may well impact the ability of individuals who are interested in entering the mental health field or those who wish to get the education necessary to become licensed providers. Another barrier is the relatively low educational attainment of African American students in San Francisco's public schools. There is a 12.2% dropout rate among African Americans, and of the students who do graduate, only 32.2% of them have completed high school with the admission requirements to enter the UC or CSU systems.

Latino community - Poverty and educational attainment are also likely to be barriers that are reflected in the relatively lower rate of Latino/as who are in licensed or managerial positions as compared to support services. In San Francisco Latino students are also more likely to experience high dropout rates (11%) and low levels of qualification for the UC/CSU systems (36.6%).

The twin barriers of poverty and low educational attainment must be addressed in order to further diversify the San Francisco Mental Health workforce.

Another barrier to diversifying the Mental Health workforce in San Francisco is cultural and attitudinal issues such as stigma and lack of belief in western medicine. These barriers militate against certain cultural groups utilizing the public mental health system, and they also act as barriers to young people selecting a career in the mental health field. As a result better outreach and community education are necessary to overcome these barriers. Only when the workforce is truly representative of the community we serve will we begin to break down the barriers to access and ensure that affected individuals will receive early assessment and intervention.

PEI:

- The Mayor's Office Communities of Opportunity Initiative released a report in 2006 focused on four high-risk street corners in Bayview Hunters Point and Visitacion Valley. The report found: approximately 40% of residents in this area feel unsafe whenever alone, compared to the 16% city average; homicides had increased 25% to 45% annually in the San Francisco police districts that

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encompass these areas; and at age 17, 70% of African American males and 44% of African American females had at least one referral to the juvenile probation system; and eight of 14 schools in this sector of the city rank in the bottom 20% of the state's demographically similar schools.

- Over 40% of the population in four SF neighborhoods is low income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% is low income in the Mission and North Beach. (DPH Population Health and Prevention Management Information Systems).
- While 15% of all SF children live in poverty, that percentage varies depending on ethnicity: 29% of African-American children and youth live in poverty, followed by 27% of Latinos, 10% of Asian/Pacific Islanders, and 1% of Whites (kidsdata.org). Over 40% of four SF neighborhoods' population is low income (at or below 200% of the federal poverty level): Tenderloin, Bayview-Hunters Point, South of Market, and Chinatown; over 30% of the Mission and North Beach population is low income. (DPH Population Health and Prevention MIS).
- Homicide is the leading cause of death among youth ages 15 to 24 in San Francisco (30 per 100,000), almost twice the statewide rate of 18 per 100,000. There were 98 homicides in 2007, of which 93% were male. In 2007, 90% of young homicide victims were either African-American (54%) or Latino (37%).
- On the Youth Risk Behavior Survey (YRBS) administered to 9-12th graders in 2007: 13% had seriously considered suicide (6% attempted); 53% had tried alcohol and 22% had drunk in the last month; 26% were sexually active of which 29% had not used a condom the last time they had sex; 23% had been in a fight in the last year and 7% had felt unsafe going to school in the last month. On the California Healthy Kids Survey, over half (53%) of 5th graders report that 'kids at school spread mean rumors or lies about them at least some of the time,' and 57% report that 'other kids hit or pushed them at school when they are not just playing around'.
- Approximately 1,800 or 2% of children and youth ages 0-17 in San Francisco were in the foster care system on July 1, 2007. This rate is twice the rate of California, Alameda County, and Contra Costa County.
- Federal studies estimate that 50-75% of incarcerated youth have diagnosable mental health disorders and nearly half have substance abuse problems; Up to 92% of incarcerated girls have experienced one or more forms of physical, sexual and emotional abuse before entering the juvenile justice system (Physicians for Human Rights, Health and Justice for Youth).
- The majority of JPD referrals came from the following neighborhoods: Bayview/Hunters Point (22.6%), Outer Mission/Excelsior (11.1%), Inner Mission/Bernal Heights (10.7%), Visitacion Valley (10.6%), %, and the Western Addition (8.0%).

- Between 2002-2004, 21% of suicides in San Francisco were committed by older adults (60 years of age and older). Suicide rates among older adults are highest for white men, followed closely by Chinese women.

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

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

CSS

There is substantial evidence of the disparities experienced by the initial populations selected for Full Service Partnerships in all age groups. In order to provide treatment that will effectively meet the needs of these populations, as well as to reduce the current disparities, San Francisco's program will expand its definition of cultural competence as broadly as possible and include the following critical elements: strengths-based and family focused individualized care planning; provision of developmentally-appropriate and gender-specific services including traditional cultural healing practices; and staff who are culturally appropriate and clinically and linguistically competent. With these elements as a foundation, the public mental health clients will become actively involved in their treatment plans, with the underlying notion that a consumer's success depends on his/her own involvement in his/her recovery and in his/her ability to develop her skills.

Full Service Partnerships:

There were eight Full Service Partnerships (FSP) that were implemented in FY06-07 (2 CYF; 2 TAY; 3 Adults; 1 Older Adults). Following the defunding of the AB2034 program, an additional adult FSP was added in FY08-09.

CYF - One FSP focuses on children and adolescents up to 18 with challenging behaviors in high level group homes with the goal of living in a family setting. The other FSP focuses on children and adolescents up to 18 who are in or at risk of out of home placements

TAY – One FSP focuses on TAY with substance abuse problems, HIV/AIDS and homeless. The other focuses on youths exiting the foster care system

Adults – The adult FSPs focus on homeless individuals and/or dually diagnosed individuals, who are high users of multiple systems and present with multiple and complex issues, and on mentally ill offenders referred from the Behavioral Health Court.

Older Adult – The older adult FSP focuses on dually and multiply diagnosed SMI older adults ages 60 and higher.

General System Development:

The General System Development initiative provides funding to improve the mental health service delivery system by assisting agencies in achieving the goals and principles embodied by MHSA. Eleven agencies in the general system development service track provide housing services and supports, vocational rehabilitation services, peer based centers, a school-based wellness center, specific services to youths and individuals affected by trauma, and increase culturally specific and relevant services to Asian Pacific Islander children, youth and families. Additionally, three primary care clinics integrated behavioral health services within their systems.

WET

Trainings:

Trainings are geared towards developing and maintaining a culturally competent MH workforce, foster a consumer/family driven services. These trainings aim to educate staff to gain a greater understanding of the cultural and linguistic issues and needs that affects recovery & resiliency in the following ethnic/cultural groups: African American, API, Native American, Russians, LGBTQIQ, TAY, and older adults.

Educational Programs:

Summer Bridge Program is an 8 week summer mentoring program for 16-20 year-olds currently enrolled or recently graduated from SFUSD to get them interested in a career in mental health

Peer Mental Health Certificate Program is an 12-week, twice per week program for consumers in early recovery and not yet ready to work in higher levels in the workforce. The certificate program provides trainings in mental health and service concepts to facilitate employment in the mental health system.

Community Mental Health Certificate Program is a 16 unit program to train a diverse group of front-line health workers (focusing on consumers/family members) to provide culturally responsive and recovery focused services

Supported Education at a public university and private college provides individualized wraparound educational/psycho-educational assessments, peer counseling, and education and wellness plans to assist students in successfully graduating from undergraduate and graduate schools of learning.

Internships

Internships for Hard-to-Fill Positions & Under-represented Populations – will develop protocols, policies & procedures to create a coordinated and centralized effort for recruiting and placing graduate students at various sites.

All the above WET Initiatives began implementation in FY09-10. The initial funding will support continued operation of these initiatives for three years. Depending on the outcomes of these initiatives and available funding, some or all of these programs will be continued using CSS funding.

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

Strategies for the CSS population are described in Section A (above)

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

The following projects were developed by the PEI Planning Committee. The committee understood very well that many cultural groups are over represented in these priority populations. The selection of proposals included a significant focus on the goal of addressing disparities in access and outcomes for different populations.

- Trauma-Exposed Individuals and Families

Trauma and Recovery Services: This project consists of two similar but distinct community-based trauma recovery programs that serve youth and their families primarily in the Mission, Excelsior and Southeast Sector. Services include outreach, assessment, crisis and short-term counseling, case management and mental health consultation to community organizations

Holistic Wellness Promotion in a Community Setting: This project uses a holistic wellness approach that is based on cultural values and traditions as a foundation for a healthy community. It addresses the breadth, depth and scope of trauma, including the effects of historical trauma. The model includes community outreach and education, prosocial community building events, direct services, and linkages to other services. Funding has been allocated to four separate providers, each grounded in a distinct cultural community in San Francisco.

Older Adult Behavioral Health Screening and Response: Building upon efforts to increase the capacity of community-based primary care providers to provide early identification of clients with behavioral health issues, this project focuses on training providers to better screen, refer, and serve older adults struggling with behavioral health risk factors such as anxiety, stress, depression, suicidal thoughts, substance abuse and isolation. The project funds implementation of

an evidence-based collaborative care model in two primary care clinics and two older adult centers. The model includes training for clinic staff, screening for all older adult patients, and a Care Manager to work with the patients and physicians to develop care plans, provide immediate short-term intervention and/or referrals, monitor progress, and provide service linkages and follow-up support.

- Children and Youth At-Risk for School Failure

School-Based Youth Centered Wellness: K-12 School Based Services – This project engages community-based organizations to provide school-based services that address non-academic barriers to learning. Using public schools as hubs, this approach brings together many partners to offer a range of supports and opportunities to children, youth and families before, during and after school. Lead agencies provide and coordinate preventive mental health and wellness services with other supports available at the school.

Re-Engagement of Truant and Out-of-School Youth: This project reengages and supports truant and out-of-school youth to stabilize their lives and be successful in school. It targets a neighborhood with high truancy and related risky behaviors among youth. It is located at a local high school that does not have an existing reentry program. The design has four components: outreach; reentry classes with academic support, enrichment opportunities, and PEI mental health services; service linkages; and incentives. The program engages a cohort of youth for one semester of intensive services after which students are placed in the most appropriate comprehensive or alternative high school.

- Children and Youth At-Risk for Juvenile Justice Involvement

Mental Health Consultation for Providers Working with At-Risk Youth: This project funds mental health professionals to provide consultation services at community-based organizations that work with youth who are at-risk or already involved with the juvenile justice system. The consultants build staff capacity via group trainings and consultation, individual coaching, observation and case consultation and service linkages. They also provide short-term intervention with youth and families. The project fosters coordination across agencies (those involved in a similar DCYF initiative and those funded via this project), and documentation of the model and methods so it can be expanded in the future.

Screening, Planning and Supportive Services for Incarcerated Youth: This project addresses risk factors faced by incarcerated youth – e.g. violence, substance abuse, poverty, fractured support systems and poor access to appropriate health and basic needs services. The project identifies emerging mental health needs and ensures this knowledge guides case planning and support services as youth reenter the community. It funds universal mental

health needs and strengths assessments for youth entering Juvenile Hall, case planning and advocacy for those with moderate mental health needs, and direct service and resource linkages during and after detention.

- Children and Youth in Stressed Families

Early Childhood Mental Health Consultation (ECMHC): ECMHC seeks to build the capacity of childcare providers and families to prevent, identify and reduce the impact of mental health and behavioral challenges among children aged 0-5. Funds expand the ECMHC Initiative to 16 additional childcare classrooms (including five at Family Resource Centers), four family childcare networks, and six drop-in childcare programs within parental drug treatment programs. Mental health consultants provide professional development, child observation, individual and group consultation to teachers and staff, and service linkage and short-term direct services to children and their families. The project includes a Training Institute for the consultants to increase capacity and quality of their service.

- Individuals Experiencing Onset of Serious Psychiatric Illness

Early Intervention and Recovery for Young People with Early Psychosis: This project serves young people with or at risk for early psychosis. It builds capacity of the field to identify and intervene early and effectively with this vulnerable population, promoting their self-sufficiency and quality of life, and preventing future social and economic costs. The project has four components: outreach and consultation; intake and assessment; treatment; and training. It utilizes an integrated team approach in which all elements are brought to the service of the client in a coordinated fashion.

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

The county shall include the following in the CCPR:

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

CSS

Behavioral Health Access Center (BHAC)– is a co-location of five separate behavioral health programs in a centralized venue to provide: (1) mental health service authorizations into the Private Provider Network; (2) assessment and placement into addiction and dual diagnosis treatment, (3) including those that have been court-mandated to receive treatment as condition of probation; (4) evaluation and placement into Opiate Replacement Therapy; and (5) Pharmacy

for medication consultation and prescription and medication management. BHAC is ideally located within short distance from the Mission District, which has a large Latino population and the Tenderloin District and 6th Street Corridor, where majority of behavioral health clients congregate and where various behavioral health providers are also located. Since the opening of BHAC in July 2008, we have seen an influx of Spanish-speaking clients.

Consumer Employment Expansion – since the inception of MHSAs, all job requisitions for MHSAs positions within CBHS list personal experience as consumer of behavioral health services as a desired qualification. The expansion of consumer employment strengthens CBHS' strategy of providing Recovery-Oriented services, consumer and family involvement, stigma reduction, and the elimination of disparities in mental health care. To date, 31 consumers have been hired. Of the 31, 18 are Caucasian, 6 African American, 3 Hispanic, 1 Vietnamese, 1 Chinese, 1 Filipina, 1 Russian, and 1 Alaska Native. Four are conversant in Vietnamese, Cantonese, Spanish, and Russian and three identify as LGBTQIQ.

Wellness Recovery Action Plan Groups – WRAP groups facilitated by a consumer employee, have been extended to a community based peer wellness center, vocational rehabilitation agency, permanent housing site, and TAY FSP program to promote the wellness and recovery model. A WRAP group was conducted in Chinese at one permanent housing site where Chinese-speaking residents participated.

GSD Housing for TAY – The need for housing responsive to the TAY issues has been one of the challenges with MHSAs implementation. In partnership with the Tenderloin Neighborhood Development Corporation and the Mayor's Office of Housing, General System Development funds were set aside to finance the rehabilitation and eventual master leasing of a 40 unit building exclusively for TAY. Once completed, this building will have onsite supportive services and organized socialization and recreational activities, as well support from FSP Service Coordinators. This building will be ready for occupancy in April 2011.

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

CSS

In a March 2010 survey of MHSAs funded agencies, all programs report that they have diversified staff, with respect to ethnicity/race, culture, sexual orientation, and language capabilities, as well as in hiring consumers and

family members in the workforce. All programs also reported inclusion of cultural competency trainings and workshops in their professional development efforts. Unfortunately, discrimination persists in the community toward clients seeking housing and employment. An increase in age discrimination has also been observed since the onset of the economic decline, especially among transitional aged youth seeking employment. Most often discrimination emerges in response to clients' criminal background, age, housing eviction history, history of violence, drug use, mental health issues, credit problems, and/or being non-English speaking. One program astutely noted that "the disproportional over-representation of African American and Latino youth in our juvenile justice systems is NOT reflected in our medical school and child psychiatry residencies and fellowships".

WET

Since WET implementation only began in FY08-09, no qualitative data is available as of yet to glean lessons learned in the first year.

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

The county shall include the following in the CCPR:

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

All the MHSA PEI and WET projects listed in Section I thru IV have been RFP-ed and just completed the first funding cycle in June 2010.

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

Note: Counties shall be ready in 2011 to capture and establish current baseline data to be used for ongoing quality improvement and qualitative analysis of the county's efforts to reduce identified disparities. Baseline data information and

updates of the county's ongoing progression in the reduction of mental health disparities will be required in 2011 and in subsequent CCPR Annual Updates.

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

The County MHSA program team at CBHS has provided a number technical assistance training on Logic Models and Developing Outcome Objectives for all MHSA PEI and WET projects to develop outcome objectives for each project sites and cross-site evaluation strategies.

C. Identify county technical assistance needs.

No technical assistance needs have been identified at this time.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

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

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

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

The county shall include the following in the CCPR:

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

Cultural Competency Task Force In 2000, with firm recommendation from the San Francisco Health Commission, the SF DPH established the Cultural Competency Task Force to assist in the implementation of its policy directive. The Task Force has since been very critical in the implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards issued by the United States Department of Health & Human Services, Office of Minority Health as general guidelines to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services as provided by the Department and its direct service providers. The Task Force provides input, recommendations and reviews policies, procedures, and inclusions of cultural and linguistic objectives in all funding contracts and activities. The Task Force meets bi-monthly as a committee and meets with the Health Commission every six-months to provide general updates and evaluate department-wide cultural competence activities. The Task Force is responsible for developing, implementing, and evaluation of Cultural Competency Report that are completed by annual by contract and civil services programs. As well, the Task Force sponsors the annual "Promising Practices in Cultural Competency Workshop" during the National Public Health Week to support and acknowledge contract and civil services programs who have demonstrated promising and effective cultural

competence implementations.

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 SF Health Commission reviews all current Cultural Competency Task Force membership at all their meetings with the Task Force (every six months) and makes recommendations accordingly.

C. Organizational chart; and

D. Committee membership roster listing member affiliation if any.

Current stakeholders and representatives included in the Cultural Competency Task Force are as follow:

- Jason Hashimoto EEO and Cultural Competency (Co-Chair)
- Nelson Jim Community Behavioral Health Services (Co-Chair)
- Jacquie Hale DPH Community Programs Contracts
- Bill Blum HIV/Health Services
- Sonia Bailey Housing and Urban Health
- Johnson Horr Walden House, Inc.
- Estela Garcia Instituto Familiar de la Raza
- Michele Maas Native American Health Center, Inc.
- Lance Toma Asian Pacific Islander Wellness Center
- Jill LeCount Laguna Honda Hospital

As mentioned previously, The Cultural Competency Task Force is currently in transition due to the larger integration of the SF DPH Community Programs (which includes the development of a centralized Business and Contracts Development Offices) and actively doing outreach to include more contract representatives that service the following ethnic and cultural communities: African American, Mayan, Russian, LGBTQIQ, TAY, and Children. Departments: Contracts Development and Technical Assistance, Business Office (Compliance), and Behavioral Health Access.

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

The county shall include the following in the CCPR:

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

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;

The Cultural Competency Task Force developed and implemented the annual Cultural Competence Report that is required for completion by CBHS contract and civil services programs. Fiscal year 2010-2011 is an assessment year where the Cultural Competence Report requires a full narrative assessment report. The Cultural Competency Task Force will be developing an evaluation instrument that will be utilized to evaluate each of these reports. The report addresses each of the major domains of cultural and linguistic competence.

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

The Cultural Competency Task Force reviews all policies and procedures that are related to cultural and linguistic competency, health disparity and/or health equity initiative across Community Programs, and has regular meetings with the San Francisco Health Commission to monitor the integration of CLAS standards into the overall DPH Community Programs, and how each department (CBHS) is advancing this policy.

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

The Cultural Competence Report developed and implemented by the Cultural Competency Task Force provides a direct and standardize mechanism in the advancement of cultural and linguistic competency in the CBHS system of care and operations. The Office of Cultural Competence and Client Relations is directly involved with the contracts and Technical Assistance.

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

The Director of Cultural Competence and Client Relations reports directly to Mental Health Director and meets on a regular basis, and provides all the recommendations and input from the Task Force that relates to cultural and linguistic competency. The Director of Cultural Competence is a member of the Executive Management team.

5. Participates in and reviews county MHSA planning process;

Members of the Task Force participated in the planning process for each of the MHSA funding components as well as in the development of the RFPs. Some of the Task Force members are also members of the MHSA Advisory Board which provides direct guidance to this initiative.

6. Participates in and reviews county MHSA stakeholder process;

A number of the Task Members are active members of the MHSA Advisory Board that reviews the county MHSA stakeholder process.

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

Members of the Cultural Competency Task Force and MHSA Advisory Board reviews the county MHSA plans for all MHSA components to make sure all stakeholders, and cultural and ethnic communities are represented.

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

The Cultural Competency Task Force does not currently directly review or participate in the planning and development of the wellness, recovery, and peer support program. They are informed either through the MHSA Advisory Board meetings or through the Director of Cultural Competency who is the co-chair of the Task Force and coordinates the peer-specific programs for CBHS.

9. Participates in revised CCPR (2010) development.

The Cultural Competency Plan Report was developed with input and review by a variety of bodies representing a broad range of stakeholders. These include the Cultural Competency Task Force, the Executive Leadership Team of CBHS and CBHS Client Council. Early drafts were distributed through email, allowing providers and other to comment as the Plan evolved, as well as review of the final draft. Program specific data on staff demographics and linguistic proficiency, use of interpreters and consumer/family involvement were obtained through staff surveys.

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

The Cultural Competency Task Force minutes can be found in *Appendix B* that includes discussion items related to the Cultural Competence Plan Report as well as general Community Programs cultural and linguistic competence activities.

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

1. Detailed discussion of the goals and objectives of the committee;

a. Were the goals and objectives met?

Goal One: Develop and Implement a committee to assess and analyze the impact of health disparity and health inequity in the ethnic and cultural population that CBHS serve (facilitated by the Health Equity and Population Leadership committee and the African American Health Equity Committee).

This was successfully completed and the following two performance objectives were identified as priority across Community Programs:

- 1) Improve African American Health
- 2) Address the Impact of Alcohol

The next steps are to have each section of the Community Programs to develop SMART performances objectives that will be included in the revised contracts and civil service plans.

Goal Two: Revised and Implement a full narrative Cultural Competency Report to be completed by CBHS contract and civil services programs by September 30, 2010.

This was successfully completed and implemented. The Task Force is currently providing trainings and TA to contract and civil service programs regarding the revised report requirements.

2. Reviews and recommendations to county programs and services;

See above.

3. Goals of cultural competence plans;

See Goal Two above.

4. Human resources report;

No report indicated.

5. County organizational assessment;

The Director of Cultural Competency and Client Relations will be increasing participation and in some instances directly facilitating the County's effort to advance cultural and linguistic competency across all Community Programs of DPH, including efforts to assess the overall County's organizational cultural and linguistic capacity.

6. Training plans; and

Training information is provided in previous sections.

7. Other county activities, as necessary.

Sources of Information:

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

CRITERION 5

COUNTY MENTAL HEALTH SYSTEM

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

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

The county shall include the following in the CCPR:

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

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

Community Behavioral Health Service Three-Year Training Plan:

Training Institutes Overview

Under the PEI and WDET MHSA Plans, there are a number of training initiatives which have been combined under the *MHSA Training Institutes*. The MHSA Training Institutes include a broad range of training activities designed to promote wellness, recovery and resilience, cultural sensitivity, culturally competent service delivery, meaningful inclusion of consumers and family members, and community collaboration.

Training Goals and Minimum Service Target

Proposed training projects will:

- Promote cross and reciprocal training, and when possible, meet requirements for continuing education units;

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- Employ training evaluation tools and activities to determine if training was useful to participants and whether proposed training goals were achieved; and
- Must incorporate the values and principles of the MHSA, including cultural competence, traditional and natural healing approaches, and CBHS goals and principles.

Community-Based Cultural Sensitivity Trainings

Funding was made available to develop compassionate and culturally competent training programs that will allow members of the public and CBO workforce to gain greater understanding of the cultural and linguistic issues and needs that affect recovery and resiliency in the following ethnic and cultural groups: African Americans; Hispanic/Latinos/as; Asian/Pacific Islanders; Native Americans; Russians; LGBTQIQ consumers; transition age youth; and older adults.

A number of the Community-Based Cultural Sensitivity Trainings have already been implemented and will continue during the next three years.

Training Minimum Service Targets	Min. # of Trainings	Min. # Trained
Family Support via Family-Friendly Practices in the Workplace	9	635
Crisis Intervention for Consumers in the Workplace	5	125
Integration of and Professional Development of Consumers	11	40
Community Violence	3	550
Community-Based Cultural Sensitivity Trainings		
• African Americans	2	85
• Hispanics/Latinos/as	2	85
• Asian/Pacific Islanders	2	85
• Native Americans	2	85
• Russians	2	65
• LGBTQIQ	2	65
• Transitional Age Youth	2	65
• Older Adults	2	65

California Brief Multicultural Competence Scale

In addition to the training plan provided above, the Director of Cultural Competence and Client Relations was also certified to provide California Brief Multicultural Competence Scale (CBMS) training to CBHS SOC staff twice annually beginning November 2010.

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder

attendance by function (If available, include if they are clients and/or family members):

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

The following chart illustrates all the Cultural and Linguistic Competency Trainings and Conferences that were conducted in fiscal year 2009-2010. Please note that the registration form that used for these trainings and conferences did not specifically include the following information: Administration/Management; Direct Services, Counties; Direct Services, Contractors; Support Services; Community Members/General Public; Community Event; Interpreters; and Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Directors. The information collected by function included: licensure, certification, and academic degrees. We have updated our registration to include those recommended in this session for all our current and future trainings.

A complete course description for each of the trainings and conferences are provided immediately after the chart below.

Training Event	Description of the Training	How long and often	Attendance by Function	# of Attendees & Total	Date of Training	Name of Presenter
<i>African American Issues in Health IX Conference</i>	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	50 5 11 2 11 5 270 Total: 354	02/20/09	Dr. Joy DeGruy-Leary, Ph.D.

California Department of Mental Health Cultural Competence Plan Requirements

<i>Increasing Access Services for LGBTQIQ Families and their Children: Cultural Competency for Providers</i>	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	8 0 1 0 0 40 Total: 49	05/08/09	Judy Appel, JD, and Michelle Mapp
<i>Women's Health Conference</i>	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	39 12 6 8 6 6 211 Total: 288	05/14/09	Lisa Najvits, PhD
<i>Women's Health Conference</i>	See Below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	29 11 6 7 5 5 206 Total: 269	05/15/09	Lisa Najvits, PhD
<i>Increasing Access Services for LGBTQIQ Families and their Children: Cultural Competency for Providers</i>	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	2 0 1 0 0 2 34 Total: 39	05/29/09	Judy Appel, JD, and Michelle Mapp
<i>Goals & Objectives for Cultural Competency Report</i>	See below	3 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	7 1 1 2 0 1 26 Total: 38	07/22/09	Nelson Jim, LMFT Jason Hashimoto
<i>Goals & Objectives for Cultural Competency Report</i>	See below	3 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other	5 0 1 3 3 0 12 Total: 24	08/05/09	Nelson Jim, LMFT Jason Hashimoto

California Department of Mental Health Cultural Competence Plan Requirements

Consumer and Family Conference	See below	7 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other Total: 4	3 1 2 0 1 0 39	12/10/09	Heather Hall, MD
Inclusion Plans for LGBTQIQ Youth	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other Total: 21	7 0 0 0 0 0 14	09/18/09	Denny David and Jessica Arevalo-LYRIC
Elimination of Transgender Work Place Violence Training	See below	8 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other Total: 36	4 2 2 2 1 0 25	07/09/09	Jenny Wiley, MPH
Pacific Islander Issues Awareness Training	See below	3 hours	LCSW, MFT, LPT RN, NP, LVN CAADAC CAADE PhD, PsyD MD Other Total: 30	5 2 0 0 3 1 20	08/01/09	Kyoma C. Mamea, MFT

Course Descriptions

African American Issues in Health IX

The African American Issues in Health IX conference highlighted cultural competency for African Americans throughout a continuum of care. Clinicians and practitioners reflected on how historical and personal beliefs impact the engagement and treatment of African American clients and their overall plan of care.

The conference focused on existing and emerging best practice strategies for providing culturally appropriate health services for African American consumers and family members and identifies ways for African Americans in San Francisco to access the most effective care that promotes wellness, recovery, and resiliency

Inclusion Plans for LGBTQIQ Youth

Training participants learned about a wide range of issues and trends impacting LGBTQIQ youth, including: questioning/coming out, parental acceptance, transgender youth in juvenile detention, queer youth fashion/music/hang outs/culture, youth empowerment. The facilitators provided a range of materials and resources to assist providers in supporting LGBTQIQ youth and their families, including: substance abuse resources, supports for parents of LGBTQIQ youth, resources for monolingual non-English speakers, policy recommendations, training curricula for clients and staff.

Increasing Access Services for LGBTQIQ Families and their Children: Cultural Competency for Providers

This is a three hour interactive workshop/training. The trainings are designed to combine anti-bias curriculum with data about lesbian, gay, bisexual, transgender and queer (LGBTQIQ) families and practical actions that organizations and agencies can take to be more welcoming to LGBTQIQ families.

Women’s Health Conference

CBHS realizes that women the San Francisco communities face many difficult challenges that impact their health and wellness, including: homelessness, incarceration and reentry, body image, sexual practices, trauma, and general health issues. This conference addresses the many different aspect of a women’s life involved in our System of Care and provide Evidenced Based skills to take back to the contract and civil service clinical settings and immediately impact your clients.

Goals & Objectives for Cultural Competency Report

The “Goals & Objectives for Cultural Competency Reports” training provides a step-by-step instruction and demonstration on establishing measurable cultural & linguistic competence goals and objectives for positive health outcomes. These goals and objectives provide the essential elements of implementing and developing culturally and linguistically competent services that are sensitive and responsive to the needs of local community, and addresses issues of ethnicity/racial minority, age, gender, sexual orientation, and religious/spiritual beliefs. As well, the goals and objective provide a plan on how programs involve clients and families appropriately in all aspects of service delivery system, including but not limited to: planning, policy development, services delivery, and evaluation. The training is recommended for DPH program managers and contractors who develop or review DPH required Cultural and Linguistic Competency Reports.

Consumer and Family Workshop

“One Voice, We Unite”

Mental Illness and Substance Abuse affects the whole family. Wellness and recovery is a deeply personal and unique journey for consumers and family members. Working together, communicating, and encouraging each other are key in finding ways to live hopeful, satisfying and productive lives. This workshop focuses on providing key strategies to assist families in their recovery. The workshop brings experts in the field, consumers, and family members to share their knowledge and experience. Part of the workshop focuses on how to develop and maintain the Wellness Recovery Action Plan

(WRAP). The Children Youth and Family section of CBHS showcased some of their Digital Stories. Digital Stories have allowed San Francisco youth and caregivers to share their own personal experience in dealing with mental illness, substance abuse, and trauma.

Elimination of Transgender Work Place Violence Training

This workshop specifically provides an overview of employment discriminations transgender people may experience during application, employment, promotion and/or termination. An employee may experience gender identity-based discrimination upon coming out as transgender, transitioning on the job, discovery of their birth sex or even mere suspicion of transgender status. This workshop also highlighted how transgender people are targeted for hate violence based on their non-conformity with gender norms and/or their perceived sexual orientation in work place settings. Effective and supportive intervention and strategies to eliminating work place violence against Transgender individuals will be reviewed.

Pacific Islander Issues Awareness Training

This workshop provides an overview of cultural specific issues and barriers that may be experienced by Pacific Islander clients in clinical treatment settings. Issues such as immigration, linguistic needs, style of communication, cultural-specific clinical presentations, and cultural variations were discussed.

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

- 1. Cultural Formulation;***
- 2. Multicultural Knowledge;***
- 3. Cultural Sensitivity;***
- 4. Cultural Awareness; and***
- 5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).***
- 6. Mental Health Interpreter Training***
- 7. Training staff in the use of mental health interpreters***
- 8. Training in the Use of Interpreters in the Mental Health Setting***

The trainings and workshops listed above in Section II A included information and resources to increase and enhance the participants' knowledge and skills in integration of cultural formulation, multicultural knowledge, cultural sensitivity, cultural awareness and social/cultural diversity in their client and community services.

Specific trainings for and on mental health interpreters and the use of interpreters in the mental health settings were not provided during the fiscal year 2009-2010 to the major departmental transition, system integration, and budget constraints; however,

the Office of Cultural Competence and Client Relations will be providing two separate trainings during the current fiscal year.

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

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

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

CBHS and Office of Cultural Competence see cultural competence as a very important issue for three practical reasons. First, as San Francisco City and County becomes more diverse, clinicians and health care providers will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds. For instance, clients/patients may present their symptoms quite differently from the way they are presented in medical textbooks or in academic settings. They may have limited English proficiency, different thresholds for seeking care or expectations about their care, and unfamiliar beliefs that influence whether or not they adhere to providers' recommendations

Trainings/workshops/conferences are a critical mechanism to inform our system of care, staff, interns, and volunteers of the important role cultural and linguistic competence play in providing effective, quality, and sensitive treatment and services. Additionally, trainings/workshops/conferences provide the opportunity to for staff, interns, and volunteers the clear link between cultural competence and eliminating racial/ethnic disparities in health care.

CBHS training Program has developed extensive procedures for assessing the professional practice gaps of our staff. These procedures include the use of annual surveys, professional practice reviews, and standardized tools to gauge knowledge. The Training Program generates educational interventions based on information obtained through the above procedures and designs such programs to both address identified gaps, health disparities found in our system, and to be relevant to our learners' scope of professional activities.

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

The County does not currently have pre/post test in place for all trainings/workshops/conferences. However, there are some

trainings/workshops/conferences where pre/post test are implemented to demonstrate increase in knowledge and awareness, and directly related to the learning objectives indicated.

The CBHS Training Department does provide a post training/workshop/conference evaluation which is provided in *Appendix C*.

3. Summary report of evaluations; and

In general, the summaries from training/conference/workshop evaluations indicate that most participants find these training/conference/workshop opportunities to be educational, supportive, responsive and relevant to their job tasks and responsibilities. A copy of a general evaluation form is provided in *Appendix E*.

The Training Committee utilizes these evaluation summaries in developing training and conference topics as necessary.

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

The Community-Based Cultural Sensitivity Trainings (indicated in **Section I, A** in this criterion) to be implemented during the next two year will include Follow-Up Technical Assistance training for specific contract and civil service programs to increase skills and provide assistance/guidance in integrating information to develop culturally competent services/treatment. Procedures are currently in development for this follow-up training curriculum.

CBHS Training Program will continue to use individual provider surveys along with client chart review and standardized assessment tools to connect identified practice gaps to individual learners and to the system of care as a whole. Professional practice gaps may either be self identified, by CBHS provider survey results, or may be identified by our program through the use of practice review tools. The Training Program will continue to derive educational needs based on identified practice gaps of system of care staff. As well, CBHS Training committee will also continue reviews completed surveys and look for the most frequent identified practice gaps to derive educational needs. In other cases we look for concrete evidenced of practice gaps that may appear during the process of the year and Departmental policies and priorities for client care.

Training and Skills Development are one of the key strategies that contract and civil service programs must develop and include in their required annual Cultural Competence Report to demonstrate their commitment to keeping their staff informed of current trends and information

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

CBHS Training Department utilizes three main techniques to analyze the change in staff competence, performance and client outcomes as related to educational programming as identified below:

- a. Direct review of Practice: Our organization conducts an annual randomized chart review addressing the specific areas of performance, treatment, monitoring and documentation that have been address in our training program. This review is used to analyze the efficacy of interventions as well as to identify performance gaps that may persist;
- b. Standardized tools: Our organization utilizes standardized tool to measure areas of competence. These tools can be repeated in order t measure current competencies as well as to measure the efficacy of our training interventions over time; and
- c. Evaluation / Survey: Participants are asked to evaluate the efficacy / utility of each training program at its completion. In addition, Directors are regularly surveyed at meetings as to their evaluation of our programming as related to their local staff.

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

The county shall include the following in the CCPR:

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

- ***Culture-specific expressions of distress (e.g., nervios);***
- ***Explanatory models and treatment pathways (e.g., indigenous healers);***
- ***Relationship between client and mental health provider from a cultural perspective ;***
- ***Trauma;***
- ***Economic impact;***
- ***Housing;***
- ***Diagnosis/labeling;***
- ***Medication;***
- ***Hospitalization;***
- ***Societal/familial/personal;***

- *Discrimination/stigma;*
- *Effects of culturally and linguistically incompetent services;*
- *Involuntary treatment;*
- *Wellness;*
- *Recovery; and*
- *Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.*

Note: The following explanation is offered to assist counties in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer. Clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system, and their own ethnic culture. These personal experiences and beliefs can be used to empower clients to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

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.*

The CBHS Children System of Care has provided a number internship employment opportunities for care providers and family members of children who utilized county mental health services. These family members are provided on-the-job training to provide assistance in a number different ways,

California Department of Mental Health Cultural Competence Plan Requirements

including administration support, peer support other family members interns, and providing parents support groups as needed. Additionally, the MHSA PEI has provided opportunities for trainings in family-friendly services, TAY cultural sensitivity training, and community violence and its impact on families and children.

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

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

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

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

The county shall include the following in the CCPR:

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

San Francisco MHSA - EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

San Francisco County hired Hatchuel Tabernik and Associates, an independent consultant, to conduct a needs assessment of the mental health workforce. Workforce data from the 2005-2006 Cultural Competency Survey and the CCSF Mental Health Data Warehouse was provided by County staff and additional US Census data was collected between August and September 2007. Data was processed, matched to the State workforce categories and analyzed by position, credentialing/education, ethnicity and language in October 2007. Findings were reported to the Working Committee in December of 2007 and used to develop final recommendations.

A. Shortages by occupational category:

Our findings for San Francisco indicate that the county experiences significant challenges recruiting, hiring and retaining Child and Geriatric Psychiatrists.

CBOs also appear to have difficulty filling psychiatric positions – including child, geriatric, medical director, and general psychiatric positions. There are also quite a few openings for LCSW and MFT licensed positions. These numbers are drawn from a point in time survey in 2005-06 and should, therefore, be considered generally reflective of the vacancies in the CBO provider community but should not be assumed to be completely accurate for the current timeframe. In addition, there are substantial openings among “other” unlicensed direct service staff such as residential counselors.

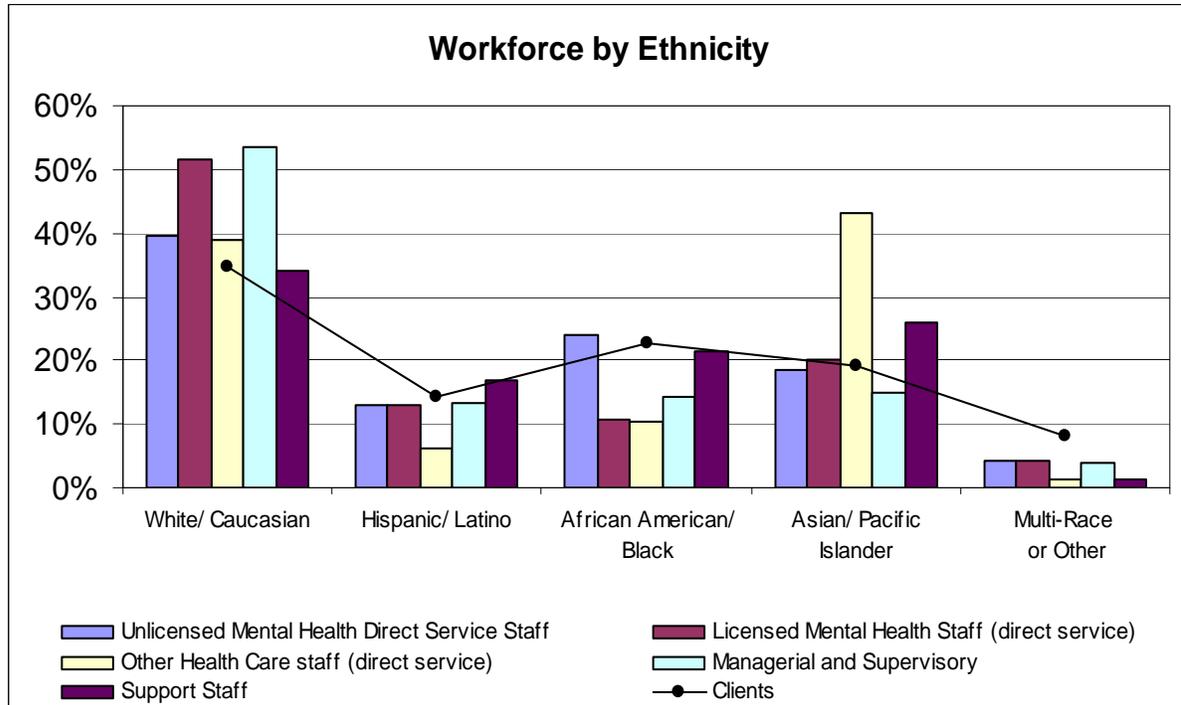
B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

San Francisco County has made significant efforts to align its mental health workforce to the cultural and linguistic composition of the consumers of mental health services in the county. The table below outlines the congruence of the overall workforce (including county staff, CBO staff and the provider network) and consumers.

	White	Latino	Black	Asian/PI	Native American	Multi-Race or Other
Workforce	44.0%	12.3%	16.5%	23.4%	0.5%	3.4%
Consumers	34.7%	14.4%	22.8%	19.2%	0.7%	8.3%
County Population	44.3%	14.1%	6.6%	32.2%	0.2%	2.7%

Overall, therefore, White and Asian/PI workforce representation exceeds the consumer population by ethnicity. Latino, African American and multi-race workforce representation is correspondingly lower than their consumer populations. The largest disparity is that the White workforce is about 26% higher than the consumer population. However, if we consider the overall county population, it seems that the White population is somewhat underrepresented in the public mental health system – perhaps reflecting the relative affluence of the White population in the city. The Black population, however, represents another picture altogether. African Americans are 3.5 times more likely to be a consumer of mental health services than their population would predict. Their representation in the workforce is more than twice that of the overall city population and 28% lower than in the consumer population. Asian/PI populations are much less likely to be consumers of public mental health services than their population would predict, and they are slightly more likely to be represented in the workforce than as consumers. Finally, Latino populations are reasonably representative in the consumer population as

would be predicted by their overall community population, and they are slightly underrepresented in the workforce.



However, if we consider the **categories** of workforce – that is, Unlicensed Direct Service, Other Health Care, Support Staff, Licensed Direct Service, and Managerial staff – compared to consumer populations, the picture is somewhat different. The graph to the left demonstrates that the White workforce is more heavily represented in the managerial and licensed mental health staff categories. Latinos are relatively proportionately represented in all categories with a slightly higher proportion in support staff and a lower representation in other health care staff. African Americans are represented most heavily in the unlicensed and support staff categories and underrepresented in licensed, managerial, and other categories. Asian/PI workers are most likely to be in the other health care and support staff categories, but their overall representation in other categories is reasonably proportionate. Multi-race and Other are generally underrepresented in all staff categories.

These data reinforce the need to ensure that the African American workforce is recruited, trained and educated to fill positions that require licensure and to fill managerial and health care positions. This echoes the community input that the African American community in San Francisco is facing serious traumatic challenges from ambient violence, poverty and other assaults and that efforts should be made to provide African American mental health practitioners to better serve the community.

Based on needs assessments conducted during the CSS process and other

demographic data from the 2000 Census, it is clear that there are barriers to diversifying the mental health workforce in San Francisco. As mentioned above, it is clear that African Americans are underrepresented among licensed staff and management staff, while their representation among support and unlicensed staff is much higher. While this is only one example, it is clear that there are barriers to African Americans moving into the ranks of licensed and management staff. One of the obvious barriers is economics – with African Americans being among the lowest income residents of San Francisco. Lack of financial resources may well impact the ability of individuals who are interested in entering the mental health field or those who wish to get the education necessary to become licensed providers. Another barrier is the relatively low educational attainment of African American students in San Francisco's public schools. There is a 12.2% dropout rate among African Americans, and of the students who do graduate, only 32.2% of them have completed high school with the admission requirements to enter the UC or CSU systems.

Poverty and educational attainment are also likely to be barriers that are reflected in the relatively lower rate of Latino/as who are in licensed or managerial positions as compared to support services. In San Francisco Latino students are also more likely to experience high dropout rates (11%) and low levels of qualification for the UC/CSU systems (36.6%).

The twin barriers of poverty and low educational attainment must be addressed in order to further diversify the San Francisco Mental Health workforce.

Another barrier to diversifying the Mental Health workforce in San Francisco is cultural and attitudinal issues such as stigma and lack of belief in western medicine. As we have mentioned elsewhere these barriers militate against certain cultural groups utilizing the public mental health system, and they also act as barriers to young people selecting a career in the mental health field. As a result better outreach and community education are necessary to overcome these barriers. Only when our workforce is truly representative of the community we serve will we begin to break down the barriers to access and ensure that affected individuals will receive early assessment and intervention.

C. Positions designated for individuals with consumer and/or family member experience:

San Francisco County does not discriminate in hiring. This includes limiting positions to persons designated as consumer and family members. Rather, San Francisco County makes being a consumer or family member a desirable qualification for all positions in CBHS. San Francisco County does, however, track consumer/family member status on its biannual cultural competency questionnaire. The limitation of this questionnaire is that the respondents (both County staff and CBO/Contractor staff) self-determine whether they are considered a consumer or a family member. Because there has been no clear

California Department of Mental Health Cultural Competence Plan Requirements

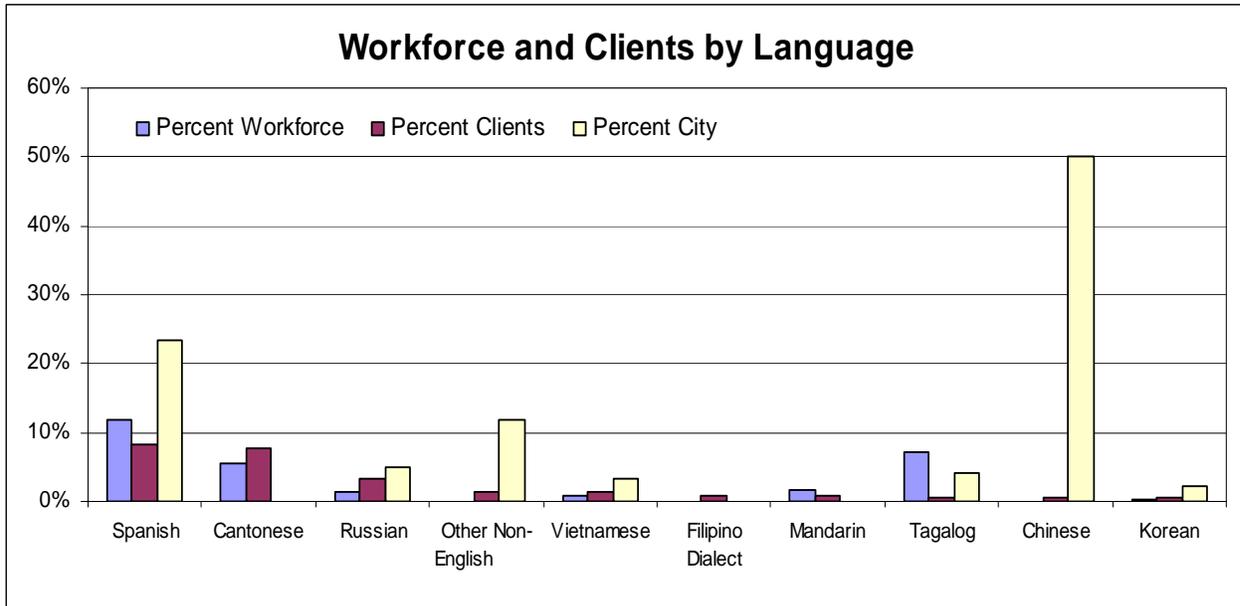
definition of these designations, we expect that there is a high likelihood that underreporting is the norm. The County will set a definition for consumer/family member designation and encourage County and CBO/Contractor staff to self identify on the confidential questionnaire. Employment of consumers and family members is also included in the scoring criteria for behavioral health services Request for Proposals.

	County	CBO
<i>Unlicensed</i> Mental Health Direct Service Staff		
Consumer Support Staff	5.2	12.3
Family Member Support Staff		
Other <i>Unlicensed</i> MH Direct Service Staff	6.7	6.0
<i>Licensed</i> Mental Health Staff (direct service)	0.6	5.4
Other Health Care Staff (direct service)		
Managerial and Supervisory	3.0	2.7
Support Staff (non-direct services)	4.9	13.3
GRAND TOTAL	20.4	39.6

It is also important to note that the last Cultural Competency Questionnaire was conducted for the 2005-06 fiscal year, prior to significant efforts to increase the employment of consumers as a result of the MHSA CSS implementation process. That said, the chart to the above provides information from the Questionnaire, with consumer designation. There was no category for self-report as a family member in this Questionnaire. Because of the limitations inherent in the 2005-06 Questionnaire we do not consider the data above to be particularly accurate, and, as mentioned, we expect a dramatic increase in these self-report numbers in the current Cultural Competence Questionnaire.

Language proficiency:

The graph on the following page provides a snapshot of the language capacities of the San Francisco County and CBO/Contractor workforce in comparison to the languages of the consumers and the City as a whole. These are the 9 most frequently cited languages among consumers, and the composite “other non-English” languages which are many.



The criteria for representing the workforce as possessing the language in question is that they are able to either “interpret” or “provide therapy” in that language. These criteria, therefore, exclude many individuals who may be conversant with a language but do not feel they have high enough skills to provide this standard of fluency.

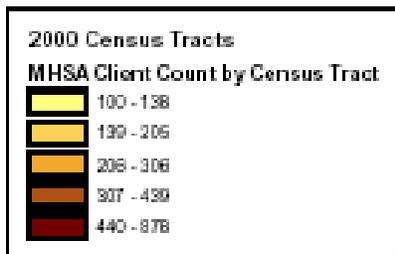
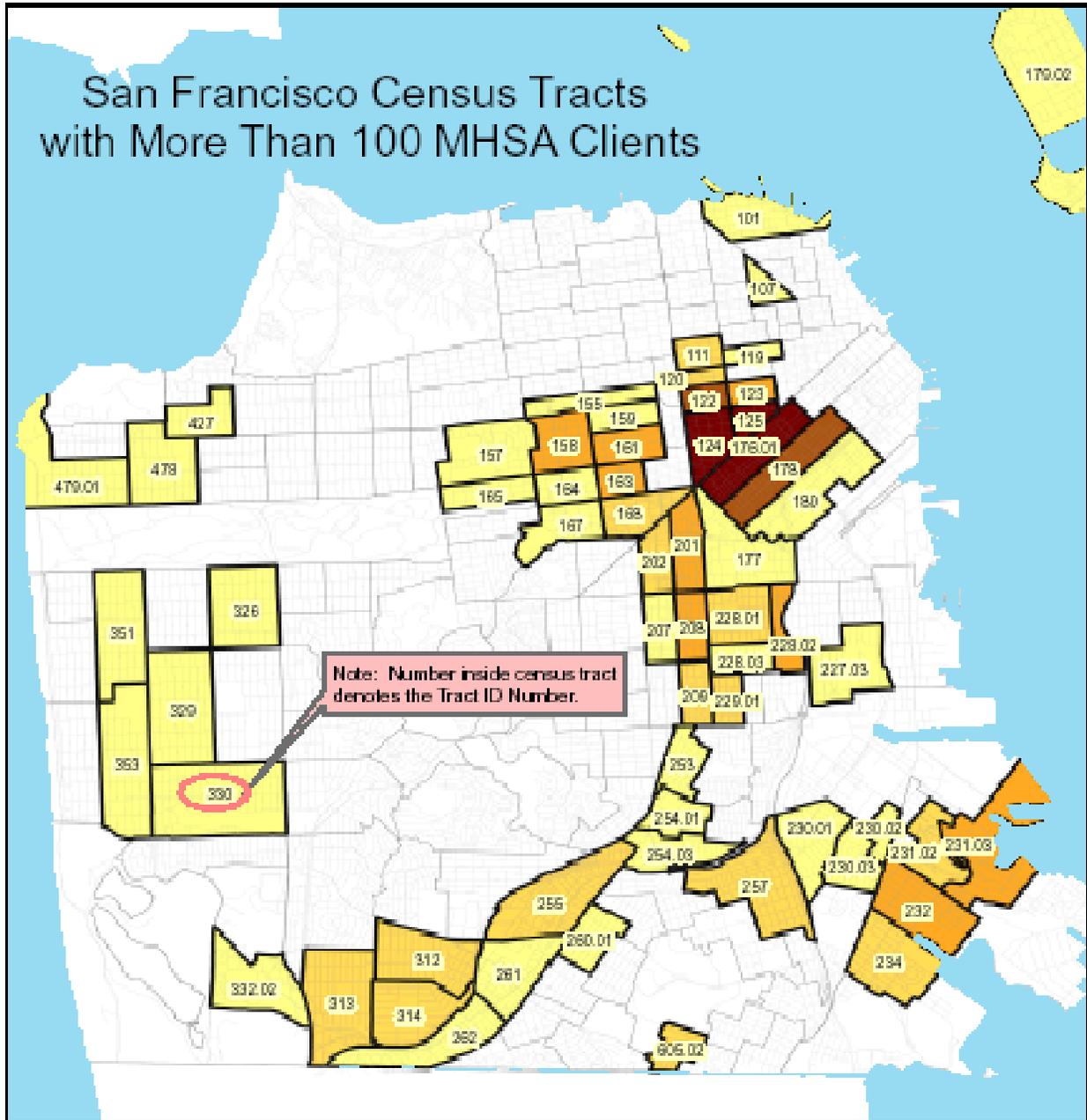
That said, the workforce is highly fluent in Spanish, Korean, Mandarin and Tagalog relative to the **consumer** population (and presumed demand). Somewhat less well represented are languages such as Russian, Vietnamese, and some Filipino and Chinese dialects. There are also a number of low-incidence languages (other non-English) that are not at all well represented in the workforce. It is important to note that, since San Francisco is so diverse from a cultural and language perspective, there are community providers who are drawn upon to provide interpretation and direct services in a wide variety of languages. We believe that there is always potential for improvement, and the County of San Francisco acknowledges that language barriers (often in combination with stigma, cultural mores and practices) can reduce the use and usefulness of mental health services for specific ethnic/language minority groups. To this end, a continued emphasis on hiring, training and educating language and cultural minority groups will factor into this WDET Plan.

If, however, we consider the linguistic representation of the workforce relative to the **overall** linguistic profile of San Francisco, the picture is quite different. In this context, the workforce under-represents Chinese, Other non English, Spanish, Russian, Vietnamese, and Korean populations. Clearly the Chinese disparity is enormous. We see in this context that both language and cultural issues may act as barriers to participation as consumers of public mental health services and as

members of the workforce. Chinese speakers represent 50% of the non-English speaking population of the city, but Chinese speakers represent a small fraction of the consumer population and an even smaller proportion of the workforce. While less dramatic, this disparity is also true of the Spanish speaking population where the overall population is twice the size of the workforce. The consumer population is proportionately even lower, which is likely to be a consequence of linguistic and cultural barriers to service as mentioned above.

E. Other, miscellaneous:

Geographic Distribution: The map to the below indicates the geographic distribution of consumers of public mental health services by census tract. Clearly there are some areas of the city with high densities of consumers. These concentrations are generally in lower income neighborhoods, largely communities of color. As the WDET plan unfolds there will be efforts made to provide trainings in these communities, especially focusing on CBOs with roots in these neighborhoods and the cultural and linguistic competence to reach underserved populations. The distribution of interns (via the internship coordination effort) will also take these geographic realities into consideration. See the illustration on the following page.



Note: Please see following page(s) for the ethnicity and language statistics for highlighted census tracts.

Production Date: 02/06/08
Source: CCSF Dept of Public Health

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

The table below compares the WET Plan Assessment to the general population, Medi-Cal population and 200% of poverty data:

	Ethnicity					
	Caucasian	Latinos	African Americans	Asian/ Pacific Islander	Native American	Multi-Race or Other
WET Plan Assessment - Workforce	44%	12%	17%	23%	0.5%	3%
WET Plan Assessment - Consumer	35%	14%	23%	19%	0.7%	8%
General Population	46%	14%	7%	32%	0.6%	3%
Medi-Cal Population	30%	14%	26%	20%	0.6%	7%
200% Poverty Population	29%	20%	11%	37%	0.4%	2%

The WET Plan Assessment indicated that 42% of the workforce spoke languages other than English while only 27% of clients spoke other languages than English. The table below breaks down the languages spoken by those staff and consumers who indicated that they spoke languages other than English:

	Workforce	Consumer	Workforce	Consumer
African/Middle Eastern	17	95	2%	1%
Asian/Pacific Islander	427	3,130	50%	49%
European	104	892	12%	14%
Spanish	293	1,951	34%	30%
Sign Language	9	35	1%	1%
Other	0	311	0%	5%
TOTAL	850	6,414	100%	100%

Note: Workforce count is by Full Time Equivalent (FTE) not by individual staff. One FTE is equivalent to one full time staff. More than one staff may occupy one FTE.

B. 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.

N/A

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

WET initiatives were implemented in FY09-10. Therefore, no targets have yet been reached as of the end of FY08-09

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

WET Initiatives were implemented in FY09-10. SF County will report shared learning in its WET implementation efforts in the next Cultural Competency Report Update.

E. Identify county technical assistance needs.

There are no identified technical assistance needs at this time.

CRITERION 7

COUNTY MENTAL HEALTH SYSTEM

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

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

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

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

All WET initiatives focus on building a culturally and linguistically diverse workforce. The Request for Proposal requested each proposer to demonstrate their strategies in reaching out to communities that were demonstrably under-represented in licensed and unlicensed mental health professional categories in the WET Plan. All WET funded programs are actively pursuing outreach activities to encourage enrollment of students from disadvantaged communities.

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.

CSS

Based on the March 2010 survey, FSP programs reported successful hiring of African Americans, Vietnamese, Japanese, Russian, Latvian, Asians, and Iranians in their workforce. In addition, FSP programs have recruited staff who are fluent in Spanish, Russian, and Korean and individuals who identify as LGBTQIQ.

Among the GSD programs, the hiring of a diverse racial/ethnic staff and individuals who identify as LGBTQIQ are equally promoted. One agency serving children with behavioral issues associated with severe behavioral issues in Chinatown credits its over-twenty year relationship of trust and collaboration with its partners in assembling a group of Asian clinicians who are matched linguistically and culturally to its client population. Another agency wrote that despite their ability to hire a bilingual and bicultural IT Trainer, they admitted that it was a challenge to compete for qualified individuals meeting this requirement. One agency reported that it fully supported and celebrated one of their staff in initiating a female to male transition process.

WET

Since WET implementation only began in FY08-09, no qualitative data is available as of yet to glean lessons learned in the first year.

3. Total annual dedicated resources for interpreter services

CBHS has a total annual budget of \$14,000.00 for Interpreter and Translation Services for FY 2010-FY2011 with the following two vendors: Lan Do & Associates, LLC and International Effectiveness Center. The previous year's allocation was \$7,000.00 and we utilized only one vendor. CBHS has an additional contract with Bay Area Communication Access to provide ASL services with an annual budget of \$15,000. To continue our commitment to provide effective communication, we have dedicated additional funds as well as solicited the services of an additional provider of linguistic services.

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

The county shall include the following in the CCPR:

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

- 1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.***

Language Line (24-hour phone line) has been chosen by the City and County of San Francisco to be our provider of linguistic services as a backup linguistic service provider. When our workforce is unable or unavailable to provide interpretation, we have a current agreement with Language Line to provide telephonic assistance. Also the California Relay Service (711) and

TTY lines are utilized to meet the needs for the hearing impaired. The Office of Cultural Competence and Client Relations provides annual update staff information that includes: name of staff, job title, licensure, FTE, job function, gender, ethnicity, language/dialect proficiency (conversational, writing, reading, provides treatment in specified language/dialect, and provides interpretation in specified language/dialect). This data base is utilized whenever a need for interpretation service arises system-wide.

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

CBHS is researching the feasibility of using Video Language Conferencing; however, incorporating the technology while not violating HIPAA laws is a challenging barrier that needs to be addressed.

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

The protocol for utilizing language line services is to call 1-800-752-6096 (Language Line Services) and provide the Department Code. A copy of this protocol can be found in *Appendix G*.

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

At the Key Points of Contact, linguistic services are available and staff are trained to contact the Office of Cultural Competence and Client Relations to locate bilingual providers in the Cultural Competence Staff Information database. If there are no contacts within the database, then Language Line services are used.

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

CBHS provides Key Points of Contact two different types of posters informing clients of their rights to language assistance services. One poster reads, "Point to your language. An interpreter will be called." A copy of this posting is provided in *Appendix G*.

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

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

The Administrative Analyst at the Office of Cultural Competency and Client Relations documents every uncommon linguistic accommodation requests for Limited English Persons (LEP) in a log entitled "Cultural Competence Log".

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

Historical challenges are receiving accurate billing from the vendor Language Line and the lessons learned is to inform co-workers quality linguistic and translation services exists, and the need for coordinated system provision to improve these services system-wide.

E. Identify county technical assistance needs.

Our technical needs are for researching and implementing video remote interpreting services.

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

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

The county shall include the following in the CCPR:

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

CBHS have the following signage posters available at all Key Points of Contact: Patients Rights Mental Health, Language Assistance Available and Interpretation Services Available

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

Documented evidences are as follow: Officer of the Day cards, Initial Risk Assessment form, Phone Logs, Referral and Discharge Instructions, clinical service progress notes, etc.

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

An annual form entitled, "Annual Key Point of Contact Reporting Threshold Languages" is submitted along with annual Cultural Competence Reports. The Office of Cultural Competence and Client Relations provides annual update staff information that includes: name of staff, job title, licensure, FTE, job function, gender, ethnicity, language/dialect proficiency (conversational, writing, reading, provides treatment in specified language/dialect, and provides interpretation in specified language/dialect). This data base is utilized whenever a need for interpretation services arises system-wide.

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

Language competence is monitored through satisfaction surveys, trainings and field testing.

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

The county shall include the following in the CCPR:

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

The CBHS practice in providing services to clients not meeting the threshold language is to contact the Director or Administrative Analyst, Office of Cultural Competency or solicit the services of the Language Line. A search of the Cultural Competence Staff Information database will determine if our workforce employes a service provider who speaks the requested language. Requests are documented and then referrals are made for uncommon linguistic accommodations for Limited English Persons (LEP) in a log entitled, "Cultural Competence Log". The Log dates back to 2002.

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.

CBHS provides free language assistance services at all points of contact in a timely manner. Interpreter services are provided onsite from 8am - 5pm 5 days per week using bilingual staff and assistance from a telephonic agency for clients who do not meet the threshold language criteria. After hours, most services are provided through our language telephonic agency, bilingual staff and prearranged Interpreters.

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.***

The annual Cultural Competency Narrative Report (full report template attached in Appendix G), ***Criterion 3-Linguistic Competence***, addresses compliance with Title VI of the Civil Rights Act of 1964 prohibiting the expectation that family members provide interpreter services. The questions are as follows: 1) Does the Agency provide interpreter services for non-English speaking consumer population? Describe. 2) Does the Agency have a policy and procedure that minimizes the use of family members as interpreters unless preferred by consumer? Describe or explain. 3) Does the Agency have a policy and process for assessing bilingual staff for language proficiency and knowledge of medical or service terminology? Describe. 4) Describe how the agency provides interpretation services or mechanism in place for coordinating these services?

CRITERION 8

COUNTY MENTAL HEALTH SYSTEM

ADAPTATION OF SERVICES

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

1. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

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

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

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

Office of Self Help (OSH)

OSH is a client/consumer-driven support program that leads the target population to greater involvement in their own recovery and in the planning, delivery and support of mental health services. OSH provides one-on-one counseling, information services, and referrals to those trying to avoid the system as well as assisting consumers find their way into the system and in negotiating the system. In Self Help Programs, the services offered do not advise individuals on whether or not to use the system. OSH is neutral on service modalities. Individuals served by OSH learn to build on their strengths to make choices that help them to lead satisfying and productive lives. OSH also will assist any client who asks to have their family involved in the delivery of their services. The primary objective OSH is to fully inform the client of the services available and allow the client to choose what he or she feels is best suited for their own individual needs. OSH provides services to a very ethnically and culturally diverse clients and has collaborates closely with CHBS

Office of Cultural Competence in the provision of linguistically appropriate services and referral services.

Pathways to Discovery

Pathways to Discovery is a fully consumer/family member-driven peer support program within MHSA projects. Under the direction of the Office of Cultural Competency, the Pathways staff facilitates support groups, WRAP groups, wellness and recovery activities at a number civil service programs. Pathways provides system navigation support services to peers for appointments, and work with City College to provide support to consumers enrolled in the Mental Health Certificate program.

San Francisco Study Center

San Francisco Study Center provides fiscal and personnel management for CBHS's Peer & Intern Employment Program. As such, Study Center has employs an average of 30 peers a year, including 45 peers in fiscal year 2009. Each year, the demand for our supported employment services increases. At any given time, a backlog of approximately 20 individuals is waiting for placement at one of the CBHS sites through Study Center's Peer & Intern Employment Program. However, funds to pay for the increased demand for our services and its incumbent administrative needs have not been available. Study Center also provides direct employment to mostly consumers in its direct program staffing.

Central City Hospitality House

Central City Hospitality House has served the homeless community in San Francisco's Tenderloin district since 1967. Through the unique combination of peer-led programs and advocacy efforts, many homeless and low-income people have been empowered to unite their voices to stimulate social change. The Hospitality House includes a drop-in self help center, an employment program, and community arts program, and a shelter for homeless men. Combined, the program uses a holistic approach to enhancing the economic, mental, physical, and social health of the homeless community. This is achieved through a wide spectrum of services that include housing and benefits advocacy, harm reduction-based substance abuse counseling, emergency shelter, money management support, creative expression, and job creation.

Family Services Agency (FSA) of San Francisco, Inc. – The Senior Division

Through its Geriatric Treatment Program, FSA provides treatment and case management to older adults with chronic and severe mental health issues. The Senior Peer Counseling Program trains and matches senior peer counselors with other seniors in need of a caring and sympathetic ear.

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

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

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

CBHS contracts with a number CBOs and employs civil servants that predominately provide clinical and support services to certain racial, ethnic, or cultural populations in its effort to make services more accessible for and to these populations. Some of the specific programs include:

- Instituto Familia de la Raza, Inc. – Latino/a-Hispanic consumers, including consumers of Mayan descent.
- Native American Health Center, Inc. – American Indians
- Richmond Area Multi-Services, Inc. – API and Russian-speaking consumers
- Bayview Hunter’s Point Foundation – African American
- Mission Mental Health – Latino/a-Hispanic and LGBTQIQ
- New Leaf – LGBTQIQ
- Chinatown North Beach – Asian (Chinese)
- Walden House, Inc. – Transgender
- Japanese Community Youth Council – API youth
- Friendship House Association of American Indians – American Indians
- Mission Family Center - Latino/a-Hispanic
- Horizons – Latino/a-Hispanic

- Homeless Children Network – homeless children and families
- Westside – African American
- Chinatown Child Development Center – Asian (Chinese)
- Asian American Recovery Services – API children and families

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.

The Mental Health Association of San Francisco produces and updates annual *San Francisco Behavioral Health Resource Guide* manual that lists all treatment and support services that are available to our county mental health clients, including programs/services that are specific to our ethnic and cultural populations.

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

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

The CBHS Consumer Services Guides (in threshold languages) are attached in *Appendix E*. CBHS intake forms specifically includes the language preference our clients would like to receive services in, and appropriate services and referrals are provided accordingly based on cultural and linguistic needs.

As indicated in **Criterion I, Section VI – B**, CBHS sponsors, supports and collaborates with other public health departments in the facilitation of a number of community based outreach and community/cultural health & wellness events such the bi-monthly Project Homeless Connects (PHC). PHC provides a one-stop shop of health and human services for thousands of

homeless San Franciscans, large scale vaccination efforts such as H1N1 virus. CBHS also participates in community and cultural street fairs to provide information on mental health, anti-stigma information dissemination, brief depression screening, etc. Some of the community/cultural street fairs that the Office of Cultural Competence have participated in including: Friendship House Association of American Indians-Indian Market, Native American Health Center, Inc.-Gathering of the Lodges, Carnival, Samoan Community Health Fair, Richmond District Community Fair, Vietnamese Youth Development Center Grand Opening, TET Festival (Vietnamese New Year), South of Market Community Fair, and the Annual Filipino-American Counseling and Treatment Team community gathering.

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

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

CBHS has contract and civil services programs that are located in all sections of the City and County which are assessable to clients and family members, as well as ADA compliant.

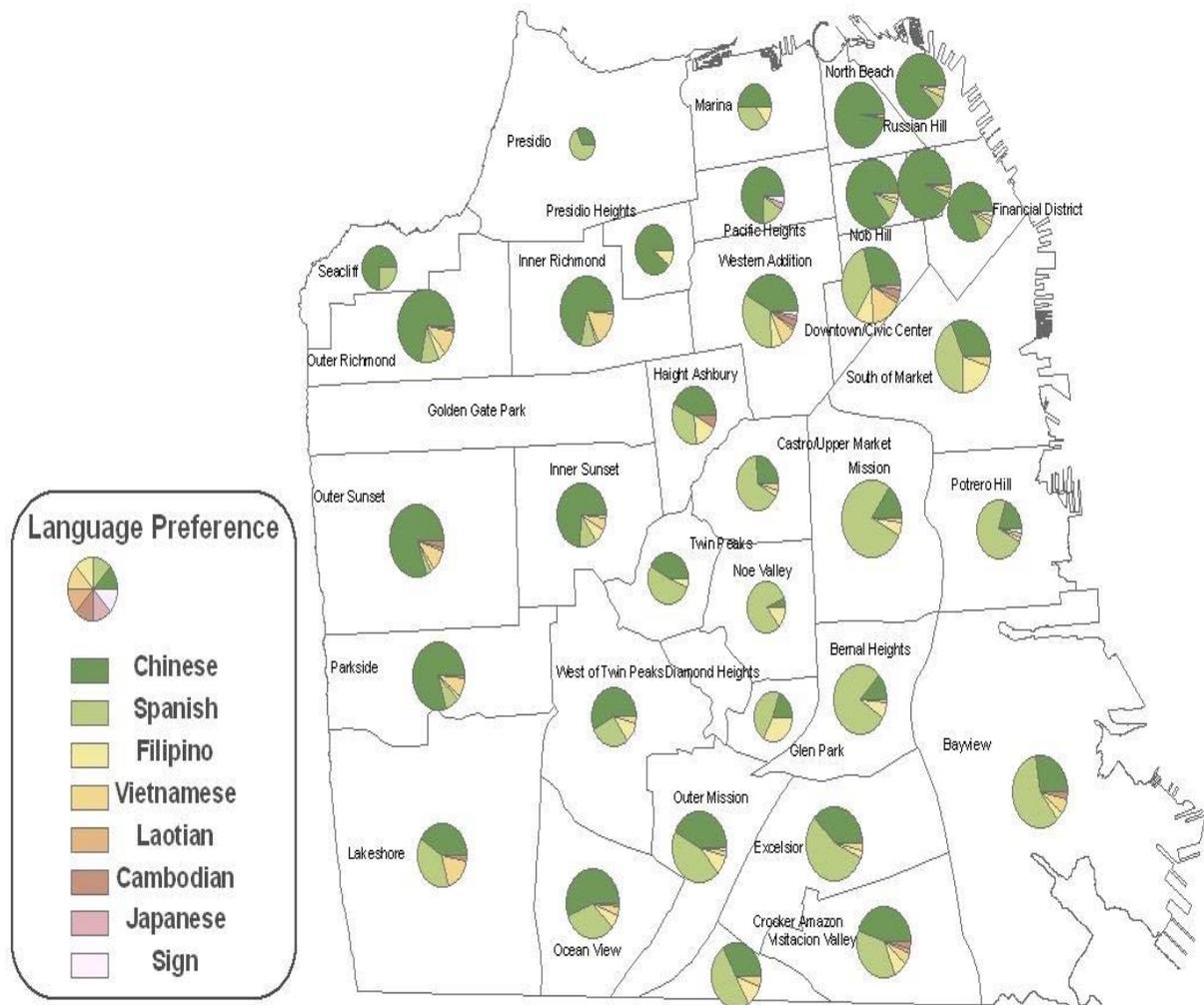
CBHS makes concerted effort to make all points of contact welcoming and inviting to the diverse cultural and ethnic populations served so to provide space and place that are familiar and relevant. As well, some of the contract and civil service provide and participant in annual festivals and cultural holidays that are honored by the clients, i.e., Chinese New Year, Día de los Muertos, Filipino-American Counseling and Treatment Team annual community gathering, TET Festival (Vietnamese New Year), and Gathering of the Lodges (annual Native American wellness and recovery gathering) to name a few.

These activities and events provide an opportunity for cultural honoring and learning for clients, family members, and providers; which naturally leads to positive community building and community development.

Geomapping – Linguistic Data Analysis

A significant proportion (28%) of our county's client population has a preferred language other than English. In order to determine whether geographic barriers might exist for this linguistically diverse population, we produced geomaps of our non-English speaking clients' residences and the location of services available by language. The map below contains information about language preference for clients receiving outpatient services during fiscal year 2008-09 based on the location of client residences (aggregated by neighborhood). The size of each pie chart is relative to the number of clients, a larger pie chart indicates a greater number of clients living in that neighborhood. The map reveals that Chinese and Spanish are the most prevalent non-English languages; most Chinese speaking clients are living in the north and northeast sections of the city and the Spanish speaking clients are primarily living in the more southern neighborhoods of San Francisco.

Client Language Preference Based on Neighborhood of Residence



Includes all clients in San Francisco with mappable addresses. There were 3337 clients from outside San Francisco. Out of the 21,954 clients from within San Francisco, 4564 are represented here. Circle size varies with total amount of clients per neighborhood.

The map below contains information about languages spoken by staff providing outpatient services during fiscal year 2008-09 based on the service location (aggregated by neighborhood). The size of each the pie chart is relative to the number of staff, a larger pie chart indicates a greater number of staff providing services in that neighborhood. The map reveals that staff language capacity is greatest for Chinese and Spanish, which coincides with the language preferences of clients shown in the previous map. Many Chinese speaking staff are working in the northeast section of the city but the map reveals that others are spread out throughout the city as well. Similarly, many of the Spanish speaking providers are concentrated in the Civic Center, Tenderloin,

that location, transportation, hours of operation, etc are adequately addressed and described.

The SF DPH Community Program Cultural Competency Report guideline also specifically asks contractors to provide policy and procedure regarding: “Client reasonable accommodation request (this policy and procedure ensures physical and programmatic access to disabled clients and for disabled clients requesting reasonable accommodation, including ASL and assistive devices.” Additionally, as described in the **Criterion I**, some of Guiding Principles of CBHS include:

- Programs and services are geographically accessible to consumers and families to increase their ability to live successfully in their local communities and neighborhoods;
- Programs and services are welcoming, culturally and linguistically competent, and age-appropriate

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

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

Cultural and linguistic factors are critical components of all CBHS RFP guideline and application protocols. The following excerpt is quoted out of our most recent MEGA RFP:

“Cultural Competency Requirements

A scarcity of programs demonstrating cultural competence is one of the significant factors preventing access to treatment, program adherence, and successful recovery for many behavioral health clients in San Francisco. Positively engaging each client through culturally relevant services and effective communication is essential to healing and enduring recovery. Community Behavioral Health Services is committed to ensuring that culturally and linguistically appropriate and proficient services are available to San Franciscans in all of their diversity.

Effective communication requires, at a minimum, the provision of services and information in appropriate languages, at appropriate educational and literacy levels, and in the context of the individual’s cultural identity. Cultural competency requires a demonstrated respect, awareness and acceptance of and openness to learning from the beliefs, practices, traditions, religions, history, languages, and current needs of each individual. Cultural competency

must be reflected throughout all levels of an organization, from board and staff recruitment, to planning and policy making, to administrative and policy implementation, to service delivery...”

A number of MHSA PEI and WDET projects have some identified required target populations, and all proposals demonstrated effective and realistic strategies for outreach, engagement and inclusions of these populations (many of the ethnic and cultural populations that are unserved or underserved).

Contract and civil service programs are required to complete the SF DPH Cultural Competency Report on an annual basis. These are reviewed by DPH Program Managers and Office of Cultural Competency and are monitored based on its qualitative implementation and development. Trainings are provided annually to support this assessment and planning process.

IV. Quality Assurance

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

The county shall include the following in the CCPR:

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

The Child, Youth and Family System of Care has been using the Child and Adolescent Needs and Strengths (CANS) measure for two years and the Adult and Older Adult System of Care has recently begun using the companion measure, Adult Needs and Strengths Assessment (ANSA) as part of the initial intake assessment and to monitor client outcomes. These instruments have a number of items that clinicians and case managers can use to address needs related to cultural issues. These items include:

- Language, assessing the need for a client to have translation services for successful mental health interactions
- Ritual, assessing the extent to which clients have access to the means to participate in culturally specific activities (e.g, praying at specific times, eating special diet, celebrating special holidays)
- Cultural Identity, assessing the extent to which clients have conflict or confusion related to their cultural identity, often a significant issue for

new immigrants

- Cultural Stress, which assesses the degree to which there is distress related to an individual's cultural identity and the predominant culture in which he or she now lives.

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

CBHS completed a Provider Satisfaction Survey in the summer of 2008, with over three hundred response. In general, the survey illustrated that most are satisfied with their experience with Cultural Competence and Client Relations (CCCR) with CBHS in each sections of the survey. A fuller description of the survey data is included in *Appendix E*. Some feedback and responses related to cultural and linguistic competence included:

- Improve and include cultural and linguistic competence efforts for Arabs and Muslim community;
- Hire more bilingual Latino/a Analysts;
- Hire more bilingual Spanish-speaking providers;
- Enjoyed learning from the African American cultural competence training on historical trauma; and
- More training on Trauma to improved specialty care related to trauma recovery and treatment;

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

CBHS currently does not have a specific process in place for data analysis and any comparison rates between the general beneficiary population and ethnic beneficiaries (for Medi-Cal and non-Medi-Cal client Grievance and Complaints/Issues Resolution Process). However, it should be noted that Office of Cultural Competence and Client Relations staff are active members of a committee that address and monitor all Grievances and Complaints. The Director of Cultural Competence handles all cultural competence-related grievance and complaints. There was only one complaint that was investigated and resolved that was related to cultural competence sensitivity for fiscal year 2009-2010.