COVER SHEET

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

Name of County: Tehama

Name of County Mental Health Director: Elizabeth (Betsy) Gowan, LMFT

Name of Contact: Charla Heibel

Contact's Title: Quality Assurance Manager

Contact's Unit/Division: Mental Health

Contact's Telephone: (530) 527-8491, ext 3014

Contact's Email: charla.heibel@tchsa.net

CHECKLIST OF THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

- CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE
- CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS
- CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES
- CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM
- CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES
- CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF
- CRITERION 7: LANGUAGE CAPACITY
- CRITERION 8: ADAPTATION OF SERVICES

CRITERION 1
COUNTY MENTAL HEALTH SYSTEM
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

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

Tehama County embraces the value of racial, ethnic and cultural diversity within the mental health system. The current mission statement is:

The Tehama County Health Services Agency, Mental Health Division (TCHSA-MH) is committed to being a place where:

- The client is always our first priority.
- The atmosphere is open, welcoming and respectful.
- Staff, clients and families use a strength based approach that maximizes optimal outcomes for all.
- All decisions are client led or focused, ethical, culturally sensitive, and cost effective.

First question to always ask ourselves: Would I want my loved ones to be treated this way?

Policies and procedures are in place to assure that the cultural aspects of this mission statement are present. These policies and procedures include language line interpreter services, use of American Sign Language interpreters, services to deaf residents, translated materials, beneficiary rights, respect for Mental Health Plan beneficiaries, Cultural Competency Committee roles and responsibilities, etc. Bilingual staff are available at all sites during regular operating hours. At the Community Crisis Response Unit (CCRU), when bilingual staff is not available, the language line is used. Tehama County strives to hire bilingual and bicultural staff whenever possible, and a differential pay rate is available for individuals that are bilingual in the threshold language of Spanish.

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

A. TCHSA values the importance of community outreach and engagement, especially with identified racial, ethnic, cultural and linguistic communities with mental health disparities. As part of the Mental Health Services Act (MHSA), Community Services and Supports (CSS) plan, there is a community outreach work plan that focuses on several areas of outreach, with the majority being outreach to the Latino and Native American communities. Activities have included, but are not limited to outreach at the PATH homeless shelter and Friendly Acres mobile home park, crisis outreach,

cultural events and celebrations, and health fairs. Every year, we maintain a booth at the Tehama County Fair and celebrate May as Mental Health Month, conducting many events and stigma-reducing activities.

During the MHSA planning processes, we included special outreach to the Latino and Native American community to gain input and were very successful in engaging the Latino community in this process. As part of the MHSA, CSS Outreach work plan, we increased bilingual services in the community, including counseling services to individuals that do not qualify for funding for health care. These services are provided in a variety of settings including homes, family resource centers, schools, and traditional mental health settings. We partnered with the local Department of Education and Corning Union High School to provide bilingual counseling services to high school students in Corning, which has the highest percentage of Latino students in the county. We have increased the number of bi-lingual therapists from 1 to 3 in the agency. We continue to recruit for additional bilingual therapists; bi lingual positions have a 7.5 % pay differential which is attractive to employees.

In our MHSA Prevention and Early Intervention (PEI) plan, we have incorporated cultural diversity as well. One component is providing Nurturing Parenting classes. We trained bilingual staff in this project and they play an integral role in providing culturally appropriate services, including classes for monolingual Spanish speaking families. Within this class, we have incorporated a cultural history component for the children. We have also trained bilingual staff to provide TEENSCREEN services. These services are provided at local high schools. We have also trained bilingual staff in the practice of Trauma Focused Cognitive Behavioral Therapy. We have been successful in outreach to culturally diverse youth and families in both the TEENSCREEN program and Nurturing Parenting. Nurturing Parenting classes are provided in both English and Spanish once a week in Corning and Red Bluff.

Our innovation plan, Drumming for Wellness, focuses on cultural diversity, with the goal of decreasing stigma and increasing access to underserved and unserved groups within the community. Community based cultural drumming events are free and open to the public. At these events, different cultural drumming occurs with active participation from the community. In addition, health and wellness information, from the focus of specific cultures, are available. Drumming outreach events include drumming events at the Red Bluff senior center and child/youth outreach at Red Bluff schools. Drumming circles are also provided as an adjunct to traditional therapy to invite increased participation by individuals that are not comfortable with traditional therapy models. The Innovative Drumming Plan is a part of our MHSA plan which is attached per instructions.

In the commitment to engage and involve a diverse group of individuals in the mental health system's planning process for services, we strive to involve all racial, ethnic, cultural and linguistically diverse clients, family members, staff, advisory group members, board members, and community organizations. There are currently several

ways that individuals can participate in the mental health system planning process for services. These include but are not limited to: the mental health leadership team, Cultural Competency Committee, MHSA Stakeholder Committee, Quality Improvement Committee, Tehama County Mental Health Board, Client Council, Performance Improvement Projects committees, and Youth Empowerment Services (YES) Transition Age Consumer/Staff Meeting (includes male, female, Latino, LGBTQ and special education college students). For example, the MHSA Stakeholder Committee is actively involved with the development of all MHSA components and ongoing oversight of implementation. Members include Tehama County Mental Health Board members (including clients, family members, Board of Supervisor representation, and education representatives), community members, law enforcement, a wide variety of county and nonprofit agencies, and consumers and family members and TCHSA-MH staff. Members come from a variety of cultural backgrounds including Latino, Native American, African American, and Caucasian. The committee is open to enrollment at any time and does not restrict participation. Clients and family members from a variety of cultural groups are encouraged to participate. Another example would be the YES transition age Consumer/Staff group. It is made up of any and all transition age youth that is active at the YES Center, and staff as well. This is a diverse group, including representatives from the LGBTQ community. Another example is the Tehama County Mental Health Board, which includes clients, family members, and community representatives. Individuals petition the board for membership and the composition of the board must follow statute. Therefore, it is somewhat limited in the ability to fully engage other cultural groups. In an attempt to address this issue, the Board currently meets at the Vista Way Recovery Center throughout the year at noon so that all the consumers can participate and provide input.

B. Share lessons learned and technical assistance needs.

We have learned that it is important to be willing to flex service hours to meet the needs of the consumer and consider alternative locations. Instituting Nurturing Parenting classes in alternative locations such as a Red Bluff church has been very successful. We continue to expand integrated services by co-locating with other TCHSA divisions.

Related to training, costs are an issue as well as having the time to commit to training due to staff shortages and trying to meet the needs of the consumers we serve. It is helpful to partner with no or low cost providers to decrease the cost. We have found it is easier to provide shorter trainings, so less time is taken from client services. It is difficult to assure that staff provides follow up training to all other staff after attending training. We have also found that in this rural area it is hard to maintain and continue sharing information at times. We have learned that it is important that we continue to focus on the cultural aspects of Transformational Care Planning (TCP).

Lessons learned related to committees are that it is critical to have diverse involvement. The current Cultural Competency Committee is composed of staff from

all TCHSA Divisions (mental health, public health, drug and alcohol, and the health clinic). Ongoing outreach and engagement with all TCHSA staff is necessary.

As a blended health agency it can be a juggling act to try and make sure we are meeting all of the cultural competency requirements from each Division of our agency, public health, mental health, drug and alcohol, and the clinic. Each have unique requirements, they all have the same underlying intent and much crossover. Trying to sort them out can be a tedious process which takes the focus away from overall cultural competency training. This is not a unique issue to Tehama County but one that is shared by all blended agencies.

Lessons learned related to skill development are that a comprehensive training plan needs to be in place to help fill the gaps in the current level of cultural competency. It is important to include cultural competency as a component of all trainings and formalize cultural competency training requirements for all new hires as part of orientation process.

Technical assistance needs that would be helpful would include examples of cultural competency training curriculum for new staff. In a small county we would need stand-alone training modules that could be easily used or accessed via internet on an as needed basis.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence. The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

A. The position of Cultural Competence/Ethnic Services Manager is a part of the MHSA Coordinator's duties, which is currently an unfilled position. The QAM is standing in for the time being.

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: located in the MHSA plan.

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: This is included in the budget noted above, but is also included in our general budget.
   2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities: This is one of the primary purposes of the MHSA, CSS budget noted above. This is accomplished through a variety of methods within the noted budget. Staff funded in this work plan includes a Bilingual Health Educator, Bilingual clinician,

Consumer Support Workers, and Psychiatric Aides. These staff performs a variety of activities that support the reduction of racial, ethnic, cultural and linguistic mental health disparities.

3. Outreach to racial and ethnic county-identified target populations: This is another primary purpose of the MHSA, CSS budget noted in A above, and the same staff noted above perform this function.
4. Culturally appropriate mental health services: This is primarily accomplished through the MHSA, CSS Work Plan with the bilingual therapist. However, the budget also includes ongoing training for staff in providing culturally appropriate mental health services.
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers. Bilingual staff receive a 7.5% pay enhancement.

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.

I. General Population

A. Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). The following table is a summary of the most recent census data for Tehama County by the U.S. Census Bureau (2010).

Population	Tehama County Estimated Number	Percent	Statewide Percent
Total	63,463	100%	
Under 5	4,409	6.9%	6.8%
5 to 19	13,411	21.1%	21.3%
20 to 64	35,572	56.1%	60.5%
65 and older	10,071	15.9%	11.4%
Median age	39.5		
Female	31,853	50.2%	50.3%
Male	31,610	49.8%	49.7%
White	51,721	81.5%	57.6%
African American	406	0.6%	6.2%
American Indian/Alaskan Native	1,644	2.6%	1%
Asian	656	1%	13%
Native Hawaiian and other Pacific	76	0.1%	0.4%

Islander			
2 or more races	2,702	4.3%	4.9%
Other	6,258	9.9%	16.9%
Latino or Hispanic (of any race)	13,906	21.9%	37.6%
Language other than English spoken at home*	11,332	19.2%	43.5%
All people with income below poverty level in last 12 months*	Unavailable	20.3%	15.3%

*Data estimates from 2008-2012 American Community Survey

II. Medi-Cal population service needs

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

The following table is Tehama County's 2014-2015 fiscal year Medi-Cal data as provided by DHCS).

ADULTS	**# Medi-Cal Eligibles**	**# Beneficiaries Served**	**TCHSA-MH Penetration Rate**
TOTAL	15303	1285	8.4%
AGE GROUP			
21-44	7948	668	8.4%
45-64	5457	540	9.9%
65+	1898	77	4.1%
GENDER			
Female	8446	765	9.1%
Male	6857	520	7.6%
RACE/ETHNICITY			
Alaskan Native/ Native American	293	23	7.8%
Asian/Pacific Islander	269	17	6.3%
African-American	131	14	10.7%
Hispanic	2560	118	4.6%
White	10876	985	9.1%
Other	63	0	0%
Unknown	1111	0	0%

Children/Youth	**# Medi-Cal Eligibles**	**# Beneficiaries Served**	**TCHSA-MH Penetration Rate**
TOTAL	13893	641	4.6%

AGE GROUP			
0-5	4483	50	1.1%
6-11	4127	237	5.7%
12-17	3275	260	7.9%
18-20	2008	94	4.7%
GENDER			
Female	6902	326	4.7%
Male	6991	315	4.5%
RACE/ETHNICITY			
Alaskan Native/ Native American	157	0	0%
Asian/Pacific Islander	198	0	0%
African-American	102	0	0%
Hispanic	4814	121	2.5%
White	7100	450	6.3%
Other	17	0	0%
Unknown	1505	55	3.7%

Total	**TCHSA-MH Penetration Rate**	**Other Small County Penetration Rates**
TOTAL	6.6%	8.11%
RACE/ETHNICITY		
Alaskan Native/ Native American	5.1%	5.98%
Asian/Pacific Islander	3.6%	2.32%
African-American	6.0%	9.27%
Hispanic	3.2%	3.85%
White	8.0%	7.35%
Other	0%	6.57%
Unknown	2.1%	Not given

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

Our penetration rate for Hispanic eligiblies has increased slightly since 2012 but comes closer to the penetration rates of small counties in total. The penetration rate ratio for Latino/Hispanic to White beneficiaries is .4, which is a large increase from .23 in 2012. This data appears to show that our outreach efforts have been somewhat effective. We will continue to provide them in order to work toward a higher level of parity.

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

The county shall include the following in the CCPR:

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

For Tehama County, the 200% of poverty data reveals similar data to that of the Medi-Cal population except the percentage of Latino individuals is higher by approximately 5%, at 30.65%. The Caucasian population is 62.5%, with the remaining cultural groups having very small percentages. Youth make up 31.2% of the 200% of poverty group, compared to 45.8% of the Medi-Cal population and 25% of the general population. The SMI prevalence rates are at 8% for youth and 5.6% for adults in the overall population, and 9.2% for youth and 8.9% for those at the 200% of poverty level. The comparison for males and females is 6.9% females, and 5.5% males for the general population, and 10.2% for females and 8.1% for males in the 200% of poverty level. Ethnicity percentages are as follows:

Ethnicity group	General population SMI Prevalence rate	200% of poverty level SMI Prevalence Rate
White	5.95%	9.8%
African American	6.5%	7.9%
Asian	3.5%	5.3%
Pacific Islander	4%	0%
American Native	8.4%	10.8%
Multi	7.2%	9.5%
Hispanic	6.9%	8.2%

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

Clearly, the estimated prevalence of serious mental illness is higher in the majority of the categories (the exception being Pacific Islander, which goes from 4% to 0%) for those individuals at the 200% of poverty level. It is most significantly higher for Caucasians and females.

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

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

Child/Youth 0-17	**Fully Served**		**Underserved/ Inappropriately Served**		**03-04 Served**		**Poverty Pop**		**Total Pop**	
	M	**F**	**M**	**F**	**#**	**%**	**#**	**%**	**#**	**%**
Total 47	34	13	79	59	501	100	7354	100	15304	100
White	20	11	63	35	415	82.9	4353	59	10372	68

African American	1	0	1	5	14	2.8	23	.4	81	.6
Asian/Pac.Isl	0	0	0	1	--	0	65	.9	135	1
Native American	5	1	5	5	15	2.9	154	2	264	.8
Latino	8	1	6	10	45	8.9	2502	34	3938	26
Other/Multi	0	0	4	3	12	2.5	257	3.7	514	3.5
TAY 18-20	**Fully Served**		**Underserved/ Inappropriately Served**		**03-04 Served**		**Poverty Pop**		**Total Pop**	
	M	**F**	**M**	**F**	**#**	**%**	**#**	**%**	**#**	**%**
Total	5	2	15	26	74		1048		1960	
Caucasian	3	1	12	22	59	80	679	65	1433	73
African American	1	0	1	0	4	5.3	9	.9	9	.6
Asian/Pac. Islander	0	0	0	0	1	1.4	6	.7	16	.9
Native American	0	0	1	1	1	1.4	34	3.2	50	2.7
Latino	1	1	0	3	4	5.3	286	27	399	20
Other/Multi	0	0	1	0	5	6.6	34	3.2	53	2.8
Adult 21-64	**Fully Served**		**Underserved/ Inappropriately Served**		**03-04 Served**		**Poverty Pop**		**Total Pop**	
	M	**F**	**M**	**F**	**#**	**%**	**#**	**%**	**#**	**%**
Total	74	92	184	321	1100		10600		29125	
Caucasian	60	75	153	277	937	85	7473	71	23385	80
African American	1	0	1	2	11	1	83	.8	154	.6
Asian/Pac. Islander	0	2	0	4	8	.8	121	1	263	1
Native American	6	9	8	15	17	1.5	357	3.2	579	2
Latino	6	3	12	15	40	3.7	2259	21	4068	14
Other	1	1	10	8	87	8	307	3	676	2.4
Older Adults 65+	**Fully Served**		**Underserved/ Inappropriately Served**		**03-04 Served**		**Poverty Pop**		**Total Pop**	
	M	**F**	**M**	**F**	**#**	**%**	**#**	**%**	**#**	**%**
Total	1	6	5	8	36		3148		8650	
Caucasian	1	5	4	7	23	63.5	2840	90	8034	93
African American	0	0	0	0	1	3	14	.5	19	.2
Asian/Pac. Islander	0	0	0	0	1	3	10	.4	37	.4

Native American	0	1	0	1	--	0	47	1.6	86	1
Latino	0	0	0	0	2	3	145	4.6	328	3.8
Other	0	0	1	0	9	24.5	92	2.9	146	1.6

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

This data from 2003/2004 indicates that cultural groups are significantly underserved or not served. More current data reveals improvement in this area. For example, for Fiscal Year 2007-2008, the target numbers compared to those served were as follows:

Ethnicity	White	Hispanic	African American	Asian Pacific Islander	Native American	Other
Target number to be served	1578	662	12	10	66	76
Number served	1405	296	21	13	28	172
Percentage	89%	45%	175%	130%	43%	226%

In reviewing this data, we have not been successful in reaching our targets for the Latino and Native American population groups. However, it should be noted that the large number of individuals listed as "other" may be from these groups. In analyzing our CSI data, we have discovered that individuals that are identified with one of these two groups are considered "other" in the CSI data. We have attempted to analyze this issue and have hypothesized that data may not have been gathered properly in all cases. We have retrained staff in an attempt to improve the integrity of the data.

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

A. Which PEI priority population(s) did the county identify in their PEI plan?
   1. Underserved cultural populations
   2. Children/youth in stressed families
   3. Trauma-exposed
   4. Children/youth at risk or experiencing juvenile justice involvement

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

In the PEI planning process, we used a variety of methods to determine priority population. These methods included a written survey, focus group meetings, stakeholder meetings, evaluation of all the data gathered by the MHSA Steering Committee, and ultimately voting by the Steering Committee. Our goal was to obtain a wide range of input from consumers, family members, staff, nonprofit providers, health care providers,

law enforcement, education, etc. All of these groups were represented on the Steering Committee and were given the opportunity to complete a survey, attend a focus group, or a stakeholder meeting. The meetings and groups were held in a variety of settings throughout the county to allow for as much participation as possible. We specifically had a Spanish speaking focus group and held meetings at the local casino in collaboration with the Native American community to attempt to gather information from these cultural groups.

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).

I. List identified target populations, with disparities your county identified in Medi-Cal and all MHSA components (CSS, WET, and PEI).

Target Population – Medi-Cal, CSS, WET, and PEI	Disparity
Latino	In FY 2007-2008, We were at 45% of target
Native American	In FY 2007-2008, We were at 43% of target
LGBTQ	No appropriate method of gathering data regarding this population, but it is believed that it is significantly underserved in Tehama County

Target Population – PEI Priority Population	Disparity
Underserved cultural populations	Latino and Native American are significantly underserved.
Children/youth in stressed families	Traditionally, Tehama County has had an appropriate penetration rate, but has not maintained services sufficiently.
Trauma-exposed youth	See above
Children/youth at risk or experiencing juvenile justice involvement	See above

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

In the PEI planning process, we used a variety of methods to determine priority populations. These methods included a written survey, focus group meetings, stakeholder meetings, evaluation data gathered by the MHSA Steering Committee, voting by the Steering Committee. Our goal was to obtain a wide range of input from consumers, family members, staff, nonprofit providers, health care providers, law enforcement, education, etc. All of these groups were represented on the Steering Committee and were given the opportunity to complete a survey and attend a focus group or a stakeholder meeting. The meetings and groups were held in a variety of settings throughout the county to allow for as much participation as possible. We specifically had a Spanish speaking focus group and held meetings at the local casino in collaboration with the Native American community to attempt to gather information from these cultural groups.

II. List disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Disparities include:

1. Underserved cultural groups across all age groups, especially Latino and Native American.
2. Access issues due to transportation, stigma, and limited locations.
3. Traditional mental health settings and services do not meet the need. Integration at health care providers and other alternative settings needs to be increased.
4. Limited availability of bilingual providers.

III. List strategies for the Medi-Cal population as well as those strategies identified in the MHSA plans (CSS, WET, and PEI) for reducing those disparities described above.

1. Prevent the development of mental illness by fostering healthy behaviors, healthy community environments, and support of good health outcomes. The unserved and underserved communities are those who have low levels of access and/or use of mental health services and who face pervasive institutional and socioeconomic barriers to obtaining health and mental health care. This strategy is addressed through the MHSA, PEI plan by providing Nurturing Parenting classes, TEENSCREEN evaluations, and early intervention with trauma-focused cognitive behavioral therapy.
    a. Nurturing Parenting classes are provided in both English and Spanish once a week in Corning and Red Bluff.
    b. TEENSCREEN – continue in schools
    c. A bilingual clinician was doing early intervention with trauma-focused behavioral therapy for Spanish-speaking clients until May 30, 2014. We have hired new bilingual clinicians who will be providing this service for Spanish-speaking clients once trained in TF-CBT.

2. Assure the use of a "Cultural Broker." Cultural brokers facilitate relationship building between communities and institutions providing information regarding community strengths and assets and breaking down barriers of mistrust. When engaging communities, it is crucial to collaborate with and develop relationships with "cultural brokers" to establish trust. Cultural brokers have prior knowledge and trusting relationships with particular communities and can help to create bridges between people or organizations of different cultures.
    a. Cultural Broker (Bilingual Health Educator) involved in regular outreach activities and programs including Nurturing Parenting classes provided in both English and Spanish once a week in Corning and Red Bluff. Bilingual Health Educator also coordinates/participates in annual outreach events.

3. Use effective engagement principles in ongoing outreach services. Specifically, a) identify local community resources and leaders; b) develop and nurture relationships with community leaders, members and community based organizations; c) build and maintain trust and respect among all; d) support capacity building in unserved and underserved communities; e) continue to allocate funding to sustained community engagement activities; f) recognize the contributions of diverse partners; g) pay attention to histories of discrimination, h) recognize and address differences in power among communities and agencies, i) build on existing community strengths; and g) structure decision-making to be responsive to community identified needs and priorities.
    a. Outreach activities include:
        i. Drumming/Innovation outreach events – now integrating into regular services
        ii. Homeless outreach – presentations given by mental health staff at PATH homeless shelter about mental health and mental health services
        iii. Crisis outreach – trained 3 supervisors on Critical Incident Stress Debriefing.
        iv. Senior outreach – drumming being done at senior center in Red Bluff
        v. Child/youth outreach – drumming at Red Bluff schools and SERF (after-school program).
    b. Second bilingual Consumer Resource Specialist (CRS) hired – expanding outreach to community
    c. Additional mental health outreach activities were done for the "May is Mental Health Month – Each Mind Matters" Campaign
        - Proclamation by Board of Supervisors
        - Wellness activities

4. Address transportation needs by a variety of means, including providing transportation, and/or providing public transit passes.
    a. Public transit passes provided.
    b. "Transporter of the Day" position provides client transportation 11am to 8am.
    c. Case Resource Specialists are able to provide client transportation.

5. Provide flexible service provision to meet the needs of underserved and unserved communities. This can include flexible hours as well as providing alternative sites for provision of services.
    a. Outreach activities occur in the community.
        i. Bilingual Nurturing Parenting classes in Red Bluff and Los Molinos
        ii. Parenting Inside-Out classes in Tehama County Jail
        iii. TEENSCREEN program is held at schools in Red Bluff and Corning
        iv. "Transporter of the Day" position provides client transportation 11am to 8am.
        v. Homeless outreach – presentations given by mental health staff at PATH homeless shelter about mental health and mental health services
        vi. Crisis outreach – provided immediately by mental health staff to witnesses of death of construction worker in Red Bluff.
        vii. Senior outreach – drumming being done at senior center in Red Bluff
        viii. Child/youth outreach – drumming at Red Bluff schools and SERF (after-school program).
        ix. Additional mental health outreach activities were done for the "May is Mental Health Month – "Each Mind Matters" Campaign

6. Increase successful use of the TCP process, specifically focusing on cultural aspects.
    a. Clinical documentation training initiated 5/20/14, which includes addressing the importance of including clients' cultural experiences and perspectives in the assessment and service plan process, as well as progress notes. The biannual training is mandatory for staff to attend and will be scheduled more often as needed.

7. Increase engagement processes such as reminder calls, follow up calls, peer outreach activities, etc.
    a. Follow-up calls continue to be made to clients after they receive CCRU services. Bilingual staff assists with calls made to Spanish-speaking clients.

8. Continue to provide educational events in the community to reduce stigma and reduce barriers to accessing services.
    a. Outreach activities include:
        - Drumming/Innovation outreach events
        - Homeless outreach – presentations given by mental health staff at PATH homeless shelter about mental health and mental health services
        - Senior outreach – drumming being done at senior center in Red Bluff
        - Child/youth outreach – drumming at Red Bluff schools and SERF (after-school program).
    a. Second bilingual Consumer Resource Specialist (CRS) hired – expanding outreach to community

b. Additional mental health outreach activities for the "May is Mental Health Month – Each Mind Matters" Campaign
   - Proclamation by BOS
   - Wellness activities

9. Integrate the innovation component of Drumming for Health to regular services.
   a. Drumming events for clients, staff, and public including a bilingual drumming session in Corning
   b. Senior outreach – drumming being done at senior center in Red Bluff
   c. Child/youth outreach – drumming at Red Bluff schools and SERF (after-school program).

10. Increase integrated services at primary care.
   a. Integrating services under one room with new TCHSA integration plan. Mental Health Medication Support Services will be moving into this site during FY 17-18, followed by Mental Health assessment services.

11. Continue to recruit/retain more bilingual providers.
   a. Currently have bilingual staff in all positions, including clinical and front desk staff
   b. Recruitment continues for bilingual staff in multiple positions.

12. Additional goals:
   a. Incorporate cultural competency as a component of all trainings.
   b. Conduct cultural competency trainings at division staff meetings twice a year.
   c. Conduct cultural competency trainings at agency staff meetings twice a year.
   d. Formalize cultural competency training requirements for all new hires as part of orientation process.
   e. Maintain bilingual staff and continue to recruit for additional bilingual positions.
   f. Increase outreach with Latino community leaders and garner input about what they think will help improve service access for the Hispanic/Latino populations.
   g. Improve Spanish-speaking skills of staff interested in learning; purchase Rosetta Stone and make available to those interested in improving skills.
   h. Increase the number of Spanish-speaking groups being offered to mental health consumers based on need. Continue to offer weekly bilingual MRT and Seeking Safety groups.
   i. In conjunction with symptom reduction and suicide prevention develop English/Spanish stigma reduction campaign.
   j. Change name from Mental Health to Behavioral Health

IV. Discuss how the county measures and monitors activities/strategies for reducing disparities.

Outreach efforts are monitored, and evaluated for possible changes/adaptations.

Share what has been working well and lessons learned through the process of the county's development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET and PEI).

The PEI components have been very successful in reducing disparities, especially for the Latino community. We have successfully completed Nurturing Parenting groups with parenting teens at the two alternative high schools in Tehama County. We assisted several schools become certified for TEENSCREEN. Having bilingual treatment providers is highly critical to reducing disparities and we continue to recruit for additional providers. Providing services at primary care has also been very successful in increasing access for underserved clients and reducing disparities. Our plan is to continue to increase these types of services and, in our PEI plan; we have proposed additional resources be used specifically for this service. Finally, utilizing non-traditional methods of outreach are much more successful than traditional methods. Non-traditional outreach methods have included handing out 'salsa gardens' with mental health information at Tehama's annual Cinco De Mayo Celebration. Our Drumming services have provided outreach to our homeless shelter population, rural communities, schools, and senior citizens. Our agency is working on identifying how to use social media as a tool to increase our ability to spread prevention to a variety of communities.

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

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

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community and integrates its responsibilities into the mental health system.

The county shall include the following in the CCPR:

A. The Tehama County Health Services Agency (TCHSA) has a Cultural Competency Committee that is responsible for addressing cultural competency for all TCHSA staff. TCHSA-MH staff participates on this committee. In addition, there are TCHSA-MH subcommittees specific to cultural competency programs or activities. The TCHSA Cultural Competency Committee is made up of 1-2 representatives from each division, specifically Mental Health, Drug and Alcohol, Public Health, Primary Care Clinic and the Fiscal division. Administrative and line staff participate in the committee, which reports to the TCHSA administrative team. The committee meets at least quarterly. The mission of the Cultural Competency Committee is to develop and maintain an Agency environment where cultural differences are valued and respected. Goals of the Cultural Competency Committee are:

1. Encourage an Agency environment where cultural differences are valued and respected.
2. Suggest training and outreach opportunities that promote cultural awareness and greater understanding of others' values, attitudes, beliefs, customs and behaviors.
3. Annual yearly reports presented at the Cultural Competency Committee meeting in January to highlight community events and accomplishments.

In addition, the MHSA Steering Committee addresses cultural issues as related to overall MHSA planning and implementation.

B. If so, briefly describe how the committee integrates within the county mental health system by participating in and reviewing the MHSA process.

It is the goal to fully use all committees or workgroups, as well as stakeholders, clients, family members, board members, etc. in the MHSA planning process. As such, MHSA plans are presented at a variety of meetings to obtain input. This includes the above-mentioned group. In addition, there are representatives from the cultural competency committee on the MHSA Stakeholder Committee at all times to assure that cultural competency is addressed on an ongoing basis.

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).

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

The county shall include the following in the CCPR modification (2010):

A. The county shall develop a three year training plan for required cultural competence training that includes the following (the County may submit information from the county's WET plan provisions for training). The County shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).

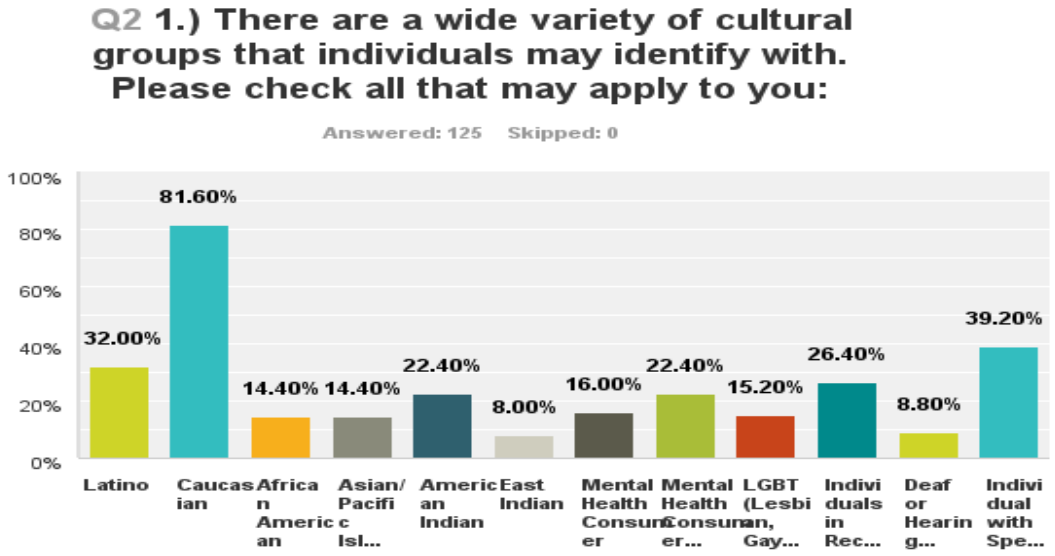
1. Steps the county will take to provide required cultural competence training to 100% of their staff:

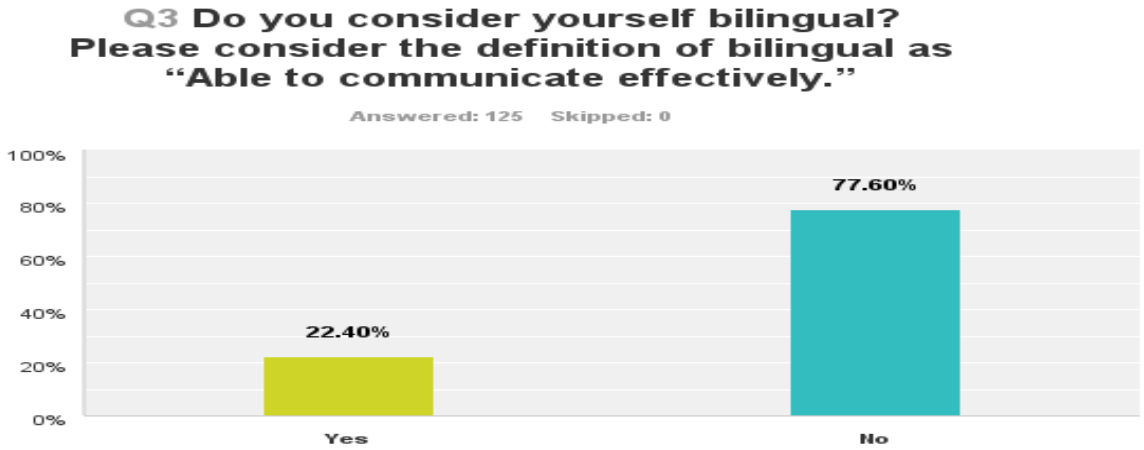
Tehama County will provide training in a variety of ways to ensure that 100% of the staff receives cultural competence training, including providing Agency-wide trainings, new-hire cultural competency training, sending select staff to trainings and having these staff train other staff, offering a variety of sites and topics for staff to choose from, providing time-limited training on a more frequent basis, etc. A commitment has also been made to make trainings available to contract providers so that there is consistency in skill development.

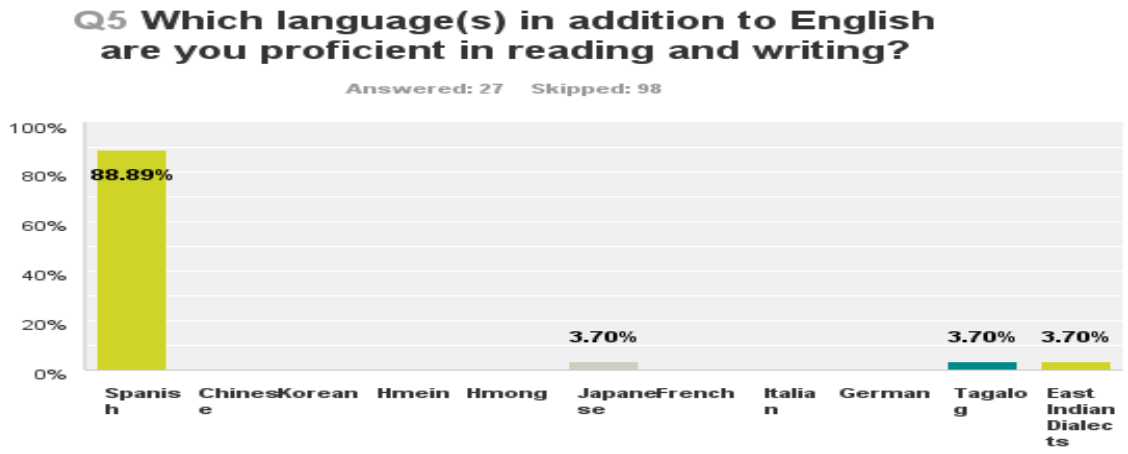
Agency-wide cultural competency trainings are provided twice a year at the all-Agency staff meetings. Providers, Mental Health Board members, and other community stakeholders are invited to these trainings. As a follow up to the Agency-wide cultural competency training on April 18, 2013 a survey was sent to all Agency employees to complete. Approximately one half of employees responded (80 staff members). Cultural groups with which respondents identified (multiple answers could be chosen) included: 34% Latino, 75% as Caucasian, 10% as African American, 9% as Asian/Pacific Islander, 18% American Indian, 4% as East Indian, 18% mental health consumer, 16% mental health consumer family member, 6% LGBT (lesbian, gay, bisexual, transgender), 19% individuals in recovery, 6% deaf or hearing impaired, 40% individuals with specific spiritual beliefs. Just over one quarter of respondents reported they were bilingual and 65% believed they could describe the different cultural communities in our service area well. Of those who responded, nearly 60% reported they had little familiarity with different cultural communities' perspectives of mental health/illness and one fifth reported they did not use cultural strengths and resources well when planning services. Cultural Competency Committee Members met in November 2013 and reviewed the survey findings.

In response to the survey data, the Cultural Competency Committee provided training to all Agency staff at the Red Bluff Community Center on April 17, 2014. The focus of the training was on improving staff members' awareness and confidence in including cultural considerations when providing care for clients. The goal of the training was to increase employees' use of cultural strengths and

resources when planning services. A survey was sent out to all employees after the cultural competency training. Approximately three quarters of employees responded (125 staff members) to the Cultural Competency Survey. The key findings are below:

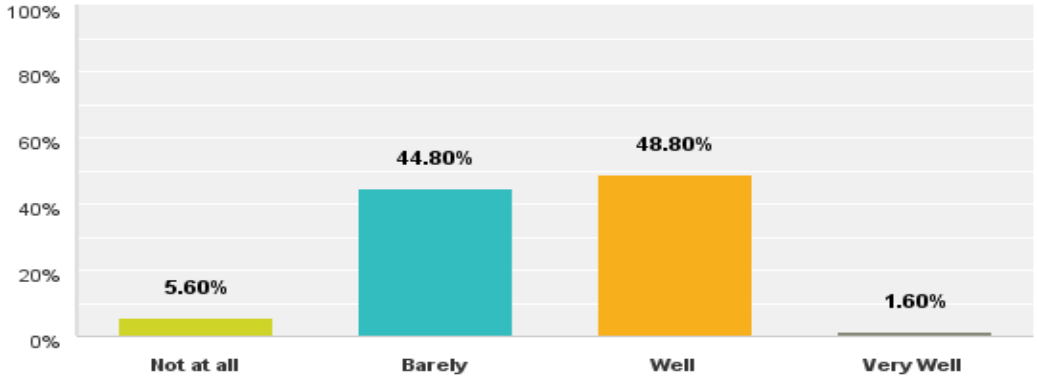





Q5 Which language(s) in addition to English are you proficient in reading and writing?
Answered: 27 Skipped: 98
100%
80%
60%
40%
20%
0%
88.89%
3.70%
3.70%
3.70%
Spanish
Chinese
Korean
Hmein
Hmong
Japanese
French
Italian
German
Tagalog
East Indian Dialects

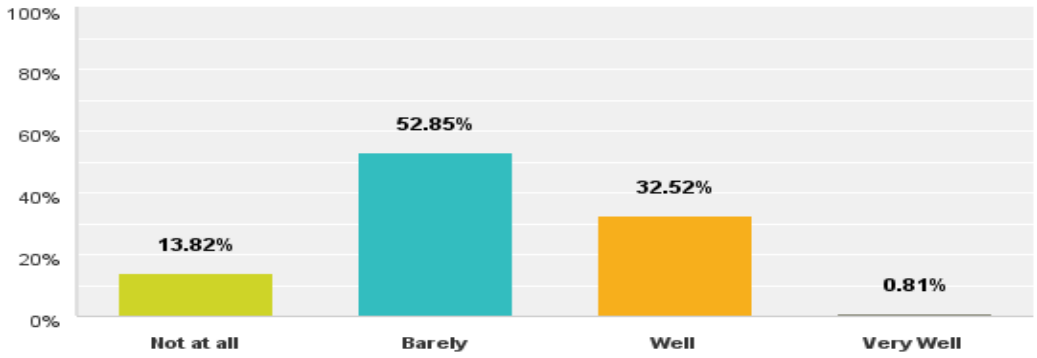
Q7 Do you know the beliefs, customs, norms and values within the different cultures in our service area?

Answered: 125 Skipped: 0



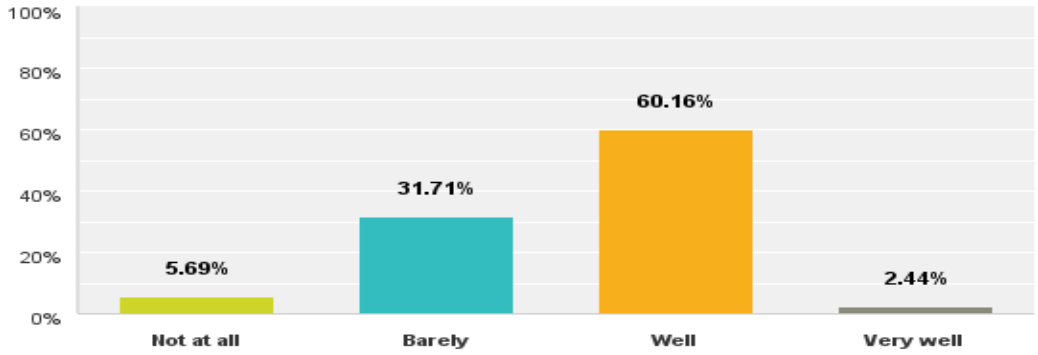
Q9 Do you know the cultural-specific perspectives of mental health/illness as viewed by various cultural groups in our area?

Answered: 123 Skipped: 2



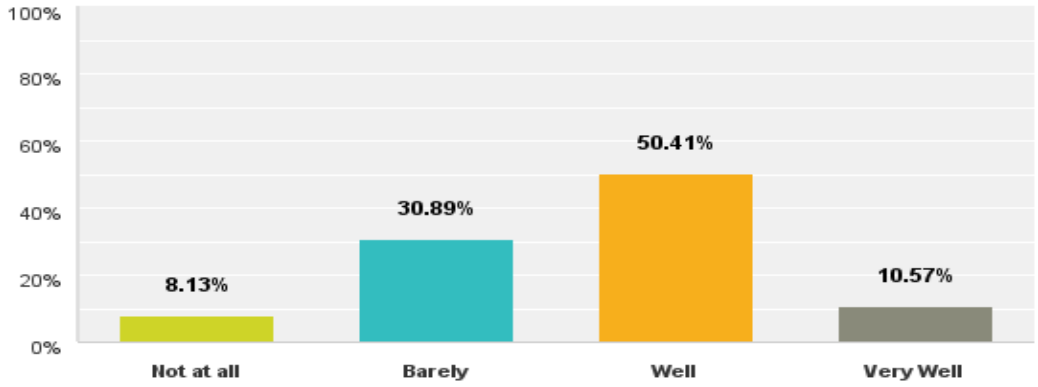
Q10 Can you identify the different languages used in our area that reflect cultural diversity?

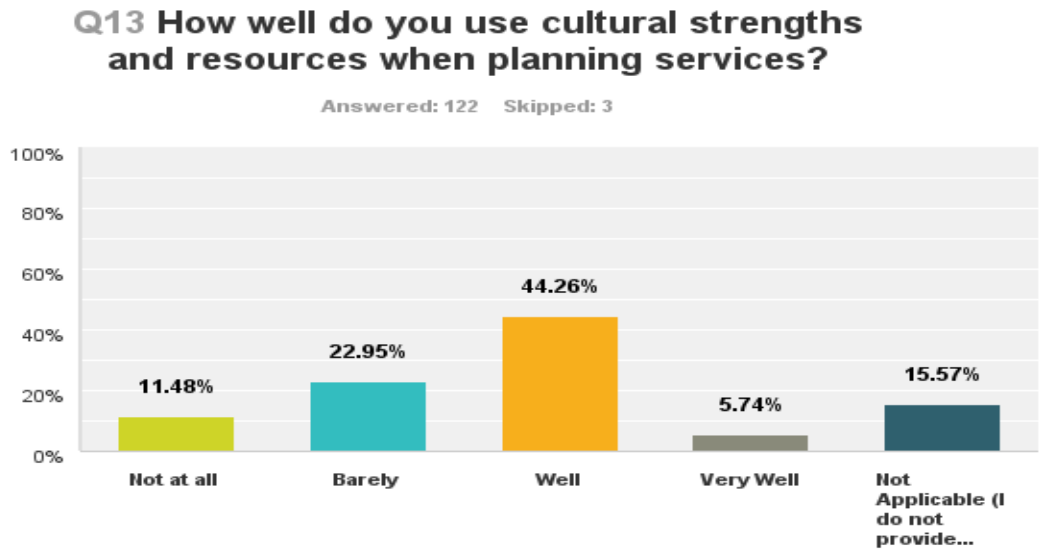
Answered: 123 Skipped: 2



Q12 Does your Division provide information focusing on culturally diverse groups?

Answered: 123 Skipped: 2





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

   Cultural competence will be embedded into all trainings provided by staff, and attempts will be made to assure that other trainers include cultural competence in their training modules as well.

3. A report list of annual training for staff and documented stakeholder invitations. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors; Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Directors, and if available, include if they are clients or family members.

   Example:

Training Event	**Description of Training**	**How long and how often**	**Attendance by Function**	**No. of Attendees**	**Date of training**
CLAS Training	Culturally and linguistically appropriate service standards	One-time	Admin/Management Direct Services Support Services Interpreters Total	60	9/5/2013
LGBTQ Training	Working with LGBTQ clients	One-time	Admin/Management Direct Services	1	8/13/13
Walking Our Talk	Working with Native American clients	One-time	Direct Services	2	8/21/13
TCHSA Cultural Competen	Working with Latino/Hispanic and Native	2 hours annually	Admin/Management Direct Services Support Services	75	4/18/14

cy Training	American clients		Intrepreters		

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

1. Cultural Formulation	Annually
2. Multicultural Knowledge	Annually
3. Cultural Sensitivity	Quarterly
4. Historical Trauma and Native Americans	Annually
5. Assisting the Mixteco population access and receive services	Annually
6. Cultural Awareness	Quarterly
7. Social/Cultural Diversity- LGBTQ, Elderly, SES.	Annually
8. Interpreter Training in Mental Health Settings	Annually
9. Training staff in the use of mental health interpreters	Annually
10. Client Personal Experiences	Annually
11. Family personal experiences regarding Family Focused Treatment	Annually
12. Family personal experiences on navigating multiple agency services	Annually
13. Family personal experiences regarding Resiliency	Annually

We will identify local and statewide trainings to attend as well as identifying trainings to conduct locally. When choosing specific training topics we will be using input from our ongoing staff meetings to provide trainings to meet current needs. These trainings will be made available to all staff, as well as other stakeholders that are interested in attending, including contract providers, Tehama County Mental Health Board members, clients, and family members.

III. 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 annual training on Client Culture that includes a client's personal experience, inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

Tehama County provides bi-annual cultural competency trainings on varying topics.

Additionally, using PEI funding we are currently working with NAMI Butte County to begin an, In Our Own Voice, or similar consumer speaker's program. We are working with our Tehama County NAMI to have them present the Provider's Education Program to our staff members. Another new project in this area is to have our staff work with a Public Health educator to identify how to plan and implement a local mental health awareness campaign using the Each Mind Matters materials as the core of the campaign.

B. The training plan will 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
   3. Resiliency

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. Below are the results 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.

Workforce Needs Assessment

Occupational category	Est. # FTE Authorized	Hard to Fill?	Est. # to meet need	White Caucasian	Hispanic Latino	Black	Asian	Native American	Multi Race	# FTE Filled
Unlicensed Mental Health Direct Service staff										
County employees:										
Mental Health Rehabilitation Specialist	8	Y	2	4	1	0	0	1	0	6
Case Management Service Coordinator	4	Y	1	4	0	0	0	0	0	4
Employment Services Staff	2	Y	0	2	0	0	0	0	0	2
Housing Services Staff	2	Y	0	1	0	0	0	0	0	1

Consumer Support Staff	8	Y	1	5	0	0	0	0	0	5
Family Member support staff	4	Y	1	3	0	0	0	0	1	4
benefits eligibility specialist	0	N	0	0	0	0	0	0	0	0
Other unlicensed MH direct service staff	4	N	0	4	1	0	0	0	0	5
Subtotal A (county)	32		5	23	2	0	0	1	1	27
All Other (CBO's etc.)- None	0		0							
Licensed Mental Health Direct staff										
County employees:										
Psychiatrist, general	1	Y	0	0	0	0	0	0	0	0
Psychiatrist, child adolescent	1	Y	0	0	0	1	0	0		1
Psychiatrist, geriatric	0	Y	0	0	0	0	0	0	0	0
Psychiatric or Family Nurse Practitioner	1	Y	0	0	0	0	0	0	0	
Clinical Nurse Specialist	0	N	0	0	0	0	0	0	0	0
Licensed Psychiatric Technician	0	Y	0	0	0	0	0	0	0	0
Licensed Clinical Psychologist	1	Y	0	1	0	0	0	0	0	1
Psychologist, registered intern (or waivered)	0	N	0	0	0	0	0	0	0	0
Licensed Clinical Social Worker (LCSW)	6	Y	2	2	1	0	0	1	0	4
MSW, registered or waivered	1	Y	1	0	0	0	0	0	0	0
Marriage and Family Therapist	5	Y	1	4	0	0	0	0	0	4
MFT intern, registered or waivered	0	Y	0	0	0	0	0	0	0	0
Other licensed mental health staff	0	Y	0	0	0	0	0	0	0	0
Subtotal B (county)	16		4	7	1	1	0	1	0	10
CBO’s										
Licensed Clinical Psychologist	1		0	1	0	0	0	0	0	1
Psychologist, registered intern (or waivered)	1		0	1	0	0	0	0	0	1
Licensed Clinical Social Worker (LCSW)	1		1	1	0	0	0	0	0	1
MSW, registered or waivered	0		1	0	0	0	0	0	0	0
Marriage and Family Therapist	1		1	1	0	0	0	0	0	1
MFT intern, registered or waivered	5		0	5	0	0	0	0	0	5
Subtotal B (all other)	9		3	9	0	0	0	0	0	9
Total	25		7	16	1	1	0	1	0	19
Unlicensed mental health direct staff										
Physician	0		0	0	0	0	0	0	0	0
Registered Nurse	5	Y	0	3	1	0	0	0	0	4
Licensed Vocational Nurse	2	Y	0	2	0	0	0	0	0	2

Physician Assistant	1	Y	0	1	0	0	0	0	0	1
Occupational Therapist	0		0	0	0	0	0	0	0	0
Other Therapist	0		0	0	0	0	0	0	0	0
Subtotal	8		0	6	1	0	0	0	0	7
CBO's – None	0		0	0	0	0	0	0	0	00
Total	8		0	6	1	0	0	0	0	7
Managerial and Supervisory										
County employees										
CEO or manager above direct supervisor	1	Y	0	1	0	0	0	0	0	1
Supervising Psychiatrist	1	Y	0	1	0	0	0	0	0	1
Licensed Supervising Clinician	4	Y	0	2	0	1	1	0	0	4
Other managers and supervisors	2	Y	1	2	0	0	0	0	0	2
Consumer Support Staff	2	N	1	1	0	0	0	0	0	1
Subtotal	10		2	7	0	1	1	0	0	9
CBO's										
CEO or manager above direct supervisor	1	Y	0	1	0	0	0	0	0	1
Licensed Supervising Clinician	1	Y	0	1	0	0	0	0	0	1
Subtotal	2		0							
Total	12		2	9	0	1	1	0	0	11
Support Staff										
County Employees										
Analyst, Tech Support, quality assurance	3	Y	1	3	0	0	0	0	0	3
Education, training and research	1	Y	1	0	1	0	0	0	0	1
Clerical, secretary, Administrative Assistants	10	N	1	5	4	0	0	0	0	9
Other support staff	0	N	0	0	0	0	0	0	0	0
Subtotal	14		3	8	5	0	0	0	0	13
CBO's										
Clerical, secretary, Administrative Assistants	2	N	0	2	0	0	0	0	0	2
Other support staff	1	Y	0	1	0	0	0	0	0	1
Subtotal	3			3						
Total	17		3	11	5	0	0	0	0	16
Grand total County employees, independent contractors, volunteers	80	Y	14	51	9	2	1	2	1	66
Grand total all other CBO's	14	Y	3	14	0	0	0	0	0	14
Grand total Workforce	94		17	65	9	2	1	2	1	80

Occupational Category	Est. # FTE authorized to be filled by client or family members	Hard to fill?	# additional client or family member FTE estimated to meet need
Unlicensed Mental Health Direct Service Staff			
- Consumer	8	Y	1

- Family	4	Y	1
- Other	2	Y	1
Licensed Direct Service Staff	1	Y	2
Other health care staff	0	Y	1
Managerial and supervisory	2	Y	1
Support Staff	1	Y	2
Total	18		9

Language Proficiency-Other than English	Number who are proficient	Additional Number that need to be proficient	Total
Spanish			
Direct service staff	4		
Other	3		

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

The cultural make-up of the staff is similar to the overall population of Tehama County, except that the Latino population is underrepresented. We strive to hire culturally diverse staff, and offer incentive pay for Spanish speaking staff, and have been able to increase our bilingual staff over the past few years.

Population Group	Staff	Tehama County	% of Medi-Cal Eligibles	200% of Poverty
Caucasian	77%	81.5%	61.8%	62.5%
Latino	14%	21.9%	28.9%	30.65%
African American	3%	0.6%	0.8%	.85%
Asian	1.5%	1%	1.1%	1%
Native American	3%	2.6%	1.4%	2.5%
2 or more races	1.5%	4.3%	N/A	2.5%

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

Targets include:
1. Significantly increasing Latino bilingual staff-.
2. Continue to increase the numbers of culturally diverse staff.

3. Encourage current bilingual staff to take advantage of opportunities to increase their education including enrolling in MHSA WET Regional supported distance learning programs, loan repayment programs, and MHSA stipend programs.

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

One lesson learned from the WET plan is that providing training is vitally important and also takes a great deal of planning with a relatively small number of staff people. You need to balance keeping client services available and training staff. We continue to make training a priority and understand that we need to plan around service delivery to make training successful.

Though we encourage staff to increase their education it is sometimes difficult to integrate internship requirements into their classification and can cause a disruption to client services. For example the MSW internship is 24 hours a week, there is some flexibility and generally for one year you can find tasks in a staff member's current assignment that increase their learning, benefit their job, and that can count for the internship. However, in the second year it is more difficult and the expectation is that you find tasks or job assignments that are at a Master's level, and that provide new learning. There is no funding to backfill the services that the staff member is providing, so even though they may be able to help the agency by providing services during the internship period, the staff members assigned duties are not being covered for more than half of their full time work hours.

E. Identify county technical assistance needs: No identified technical assistance needs at this time.

CRITERION 7
COUNTY MENTAL HEALTH SYSTEM
LANGUAGE CAPACITY

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

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity (counties shall document the constraints that limit the capacity to increase bilingual staff), including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs. Our goal is to substantially increase the number of bilingual staff by using the bi-lingual specific job classifications in recruitments as appropriate. Additionally, as stated above we are encouraging existing bi-lingual staff to enroll in education to advance their careers. This year the MH Division has gone through a large amount of change and thus was considering not taking interns for a year. We made an exception for an MSW second year intern who was employed extra help by our Drug and Alcohol Division. We provided an internship for this bilingual staff person as a part of reaching our goal of encouraging bi-lingual staff to increase their education and skills.

   Total annual dedicated resources for interpreter services in addition to bilingual staff. There are currently 8 bilingual staff members available as interpreters, with at least one at each site. In addition, we have access to the bilingual staff at the other divisions of the Health Services Agency if none of our staff are available, for a total of 27 bilingual staff throughout the agency. This has increased from our last CCP when we had 5 bilingual staff in the MH Division.

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. Tehama County uses a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service. This is only used when bilingual staff is unavailable.
   F:\tchsa\ad\manualemp\non-English speaking residents.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix A.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix B.doc
   F:\ph\mch\program\Language Line for Interpretation.doc
   F:\mh\CCRU\program\Use of Language Line in the CCRU 2011-10-14.doc
   F:\tchsa\ad\manualemp\deaf residents - access to services.doc
   F:\tchsa\ad\manualemp\deaf residents - access to services Appendix A.doc
   F:\tchsa\ad\manualemp\deaf residents - access to services Appendix B.pdf

2. Other technological options are being considered within our Capital Facilities and Technology MHSA Component. We have video conferencing equipment available, but have not obtained interpreter services as part of these services currently.

3. There is a policy and procedure, as well as a training protocol for implementing language access through the county's 24-hour phone line with statewide toll-free access, and all new staff is trained in this process. In addition, staff that provides crisis services after hours also receives ongoing training refreshers in the process. The process is also posted at main phone sites.
   F:\mh\CCRU\program\Use of Language Line in the CCRU 2011-10-14.doc
   F:\mh\qa\14 Triennial crisis line training.pdf
   F:\tchsa\mh\manualcrisis\CCRU Access Log Protocol 2-10-14.doc
   F:\mh\CCRU forms\Access Log Revised 2011-10-24.doc

B. Evidence that clients are informed in writing, in their primary language, of their rights to language assistance services.
   This is posted in our waiting rooms, and listed in our brochures.
   F:\tchsa\forms\mh\document checklist 02-25-14.doc

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

   Tehama County has a policy and procedure for this process, and tracks use of interpreters. Bilingual staff is assigned to be the primary staff receiving incoming phone calls during regular hours to minimize the need for obtaining a third party interpreter.
   F:\tchsa\ad\manualemp\non-English speaking residents.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix A.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix B.doc

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

   We have found it to be very beneficial to use bilingual staff at the primary points of contact to assure that persons with LEP are easily able to access services. The most difficult area is after-hour crisis services, when we are dependent on the language line, which staff do not always find helpful. We have attempted to hire more bilingual staff for these positions, and have had success in the last year.

E. Identify county technical assistance needs.

   We will be using the technical assistance provided by the results of the Language Line study.

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. Counties should train their staff for the proper

use of language lines but should seek other options such as training interpreters or training bilingual community members as interpreters.

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.

   Spanish is the only threshold language for Tehama County. Bilingual staff is assigned at each point of contact.

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

   There is a policy and procedure regarding this process and each interpreter service is documented.
   F:\tchsa\ad\manualemp\non-English speaking residents.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix A.doc
   F:\tchsa\ad\manualemp\non-English speaking residents Appendix B.doc

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

   As stated previously, bilingual staff is assigned at each point of contact. In addition, there are direct service providers that are linguistically proficient in the threshold language available during regular day operating hours.

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

   When hiring bilingual staff, they must pass a competency test. In addition, training is provided regarding specifically interpreting for mental health services and current interpreters observe new staff to ensure they are meeting necessary proficiency requirements. If needed, a training plan is developed to address additional skills for bilingual staff.

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

The county shall include the following in the CCPR:

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

As stated previously, if other interpretive services are needed, the language line is used. In addition, if we are providing services to a hearing impaired client, we have a contract with a service that provides ASL interpretation.
F:\tchsa\ad\manualemp\deaf residents - access to services.doc
F:\tchsa\ad\manualemp\deaf residents - access to services Appendix A.doc
F:\tchsa\ad\manualemp\deaf residents - access to services Appendix B.pdf

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.

Clients that do not meet the threshold language criteria are to be provided culturally and linguistically appropriate services. This may include providing the services with the use of the language line, ASL interpreters, or locating specific interpreters as needed. In addition, if there are more appropriate services that the client can be linked to, then we will do so.

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.

Tehama County's policies and procedures comply with the requirements above.
F:\tchsa\ad\manualemp\non-English speaking residents.doc
F:\tchsa\ad\manualemp\non-English speaking residents Appendix A.doc
F:\tchsa\ad\manualemp\non-English speaking residents Appendix B.doc

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

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

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
   1. Member service handbook or brochure;
   2. General correspondence;
   3. Beneficiary problem, resolution, grievance, and fair hearing materials;
   4. Beneficiary satisfaction surveys;
   5. Informed Consent for Medication form(translation of this form currently in process);
   6. Confidentiality and Release of Information form;
   7. Service orientation for clients;
   8. Mental health education materials, and
   9. Evidence of appropriately distributed and used translated materials.

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

All appropriate documents are also available in Spanish for those clients that prefer to communicate in this language.
F:\mh\qa\14 Guide to Medi-Cal Mental Health Services-Spanish (County)
F:\tchsa\forms\mh\Providers List Spanish rev 06-10-2014
F:\mh\qa\14 brochure member solution guide spanish managed care 06-03-2014.pub
F:\mh\qa\Right to File Grievance Notice Spanish.doc
F:\tchsa\forms\ad-fd\release of information - revised Aug 2014 (Spanish).doc

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

We continue to use the State mandated survey to gather consumer feedback. Results are often delayed but have begun being captured and reported on.

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

Bilingual staff uses several translation computer programs, as well as more than one bilingual staff reviews translated materials to assure accuracy of the translation.

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

All materials are reviewed for reading level utilizing established computerized programs.

CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

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

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences. Tehama County has two client-driven/operated recovery and wellness programs. The Vista Way Recovery Center is an adult wellness program and drop-in center that is run by the Vista Way Client Council. Diversity is embraced here in a variety of methods. A variety of client-run groups and activities are available, as well as a welcoming committee. Clients provide feedback on an ongoing basis and adaptations are made accordingly. The Youth Empowerment Services (YES) Center is a recovery and wellness program and drop-in center for transition age youth. The youth actively participate in the development and implementation of programs and activities. The group is ethnically diverse and includes a LGBTQ component.

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.

Within our program, we offer a variety of alternatives and options that accommodate individual preference, or cultural and linguistic preferences. These include Nurturing Parenting groups, Spanish-speaking Seeking Safety groups, Vista Way Recovery Center, YES Center, a variety of group options, individual rehabilitation, group rehabilitation, school based services, home based services, community based services, services at primary care, etc. In addition, as part of the TCP implementation, we actively encourage participation by community members, family members, other types of providers, etc. to enrich the client's support system and engage their personal community, rather than focusing on professional staff support. For example, spiritual leaders may be involved. Another example would be arranging for special cultural

celebrations. In addition, we refer to and/or involve natural healers from the community.

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. Clients are informed at the time of assessment (document checklist: F:\tchsa\forms\mh\document checklist 02-25-14) that services and information in Spanish are available.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. Tehama County uses a variety of methods to inform Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. Brochures are provided at all community events throughout the year. At a minimum, these include the Health Spree, Children's Fair, District Fair, Cinco de Mayo, Bi-National Health events, Corning Youth Fair, Recovery Happens, and May is Mental Health Month activities.

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:** In an attempt to address this issue, Tehama County has instituted several options including providing transportation, obtaining alternative locations for services such as community centers or family resource centers, flexed operating hours, providing school based services, providing home based services, etc.

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):** Our primary waiting room was remodeled to accommodate disabled persons and to make it more comfortable and inviting to all consumers. It was doubled in size, is open and inviting, has a separate children's play area, and offers entertainment such as DVDs for individuals waiting for appointments. The YES Center and the Vista Way Recovery Center are open and inviting with extensive client artwork displayed. The Community Crisis Response Unit was updated and new artwork was obtained to make it more comfortable and inviting. The Corning office is a new building that has an open and inviting waiting room as well.

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:** Currently, we have co-located services at a wide variety of settings. These include primary care, social services, family resource centers, schools, community centers, juvenile justice center, jail, etc.

III. 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. 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.

Tehama County keeps a log of grievances and complaints, which are reviewed quarterly at the Quality Improvement Committee. Trends are evaluated and training areas are targeted. The ethnic backgrounds of beneficiaries who file grievances are not currently tracked.