California Department of Mental Health Cultural Competence Plan Requirements

COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due October 15, 2010 to:

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

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CHECKLIST OF THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

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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.

Butte County Department of Behavioral Health (BCDBH) procedures and practices reflect the Department’s commitment to recognize and value racial, ethnic, and cultural diversity within the county mental health system. The Department has a solid foundation of honoring diversity in program design and implementation. In the past five years this foundation has grown exponentially with a Substance Abuse and Mental Health Services Administration (SAMHSA) youth system of care grant and Mental Health Services Act (MHSA) funding.

The Connecting Circles of Care (CCOC) program, funded by SAMHSA’s system of care grant program, offers culture-based wraparound. To implement this grant, a collaborative between Butte County cultural communities, Butte County Department of Behavioral Health, Feather River Tribal Health (FRTH), Northern Valley Catholic Social Service (NVCSS), Butte County Office of Education (BCOE), Four Winds School (a Tribal education program), and Youth for Change (YFC, a foster care service provider) was formed. Oversight of this program includes a governance board made up of members of the local culturally diverse communities, family members and consumers, youth, and other stakeholders. This program has received notice nationwide as a model for its integration of cultures and level of cultural competence. This includes a newsletter regularly published in three languages; an annual cultural diversity festival during mental health awareness month; and presentations at regional, statewide, and national conferences. CCOC staff members wrote a research article on implementing culture-based wraparound, which is in press:

Culture-based wraparound is an approach that expands on the wraparound services model defined by the National Wraparound Initiative by establishing a high standard for cultural competence. This article describes how to implement these cultural components, and offers preliminary comparative findings based on the experience of Connecting Circles of Care (CCOC), a SAMHSA funded systems of care grantee. Families receive treatment services that are grounded in their cultures, that are designed by members of their culture, and that are provided by culturally matched staff. Four cultural groups received services: African-Americans, Hmong, Latinos and Native Americans. Implementing culture-based processes in wraparound services are examined relative to requisite community and organization structural supports, the four phases of wraparound, and adaptations for specific cultural communities. Statistically significant differences were found among CCOC youth and family participants compared to systems of care grantee sites.
The CCOC program has received national attention and has been honored with the following awards (see Appendix K):

1. The National Substance Abuse and Mental Health Services Administration (SAMSHA) Gold-Level Performance in Youth and Family Member Involvement in Evaluations
2. Bronze Award for Excellence in Internal Communications for the Connections Newsletter
3. Butte County Board of Supervisors Certificate of Congratulations

Additionally, CCOC consumers and staff members have presented at over 10 national conferences on providing culture-based services.

The MHSA community input processes have provided the opportunity for the Department to become acquainted with unserved and underserved populations in Butte County. Community Services & Supports (CS&S) and Prevention & Early Intervention (PEI) community meetings were held across the County at locations where childcare and translators were available to ensure that young families and monolingual adults could participate. During the PEI input process, nine focus groups were conducted to obtain input from our unserved and underserved populations. African American, Native American, GLBTQ (Gay, Lesbian, Bisexual, Transgender, and Questioning), Latino, Hmong, older adults, and a mixed group of consumers participated. The BCDBH Director and other leadership staff were in attendance at all of these focus groups. The information obtained was integrated into the data presented to the workgroups who developed the PEI Plan. The PEI Workgroup used this information to rank the development of several programs that were specifically designed for diverse populations, and/or were implemented at communities/sites where diverse populations may access services.

These include:

- The African American Family and Cultural Center
- Integration of Primary Care and Mental Health. The focus of the integration will be Federally Qualified Health Centers (FQHCs) where large percentages of our diverse populations receive services.
- Promotores. Providing services to the Latino population in the Gridley community and to Latinos and Hmong populations at two specific apartment complexes in Chico.
- The Live Spot programs in Oroville and Gridley, which provide prevention services to students from high schools with large ethnic populations.
- The GLBTQ Suicide Prevention and Education Program
- The Older Adult Suicide Prevention and Education Program

The approved MSHA Innovation Plan has a program designed specifically for the Hmong population known as A Community Based Treatment for Historical Trauma to Help Hmong Elders.
BCDBH has a commitment to developing a culturally and linguistically competent behavioral health workforce throughout the county. This was illustrated by the way BCDBH was able to hire and maintain the culturally and linguistic diverse CCOC program through a difficult financial time that included layoffs of staff.

Furthermore, BCDBH specifically recruits for Spanish and Hmong language clinicians and counselors, most recently in September 2010.

In working with contractors BCDBH makes a concerted effort to ensure that culturally competent practices are followed. Efforts included:

- All contracts include a separate cultural competence statement and the inclusion of all five fundamental concepts of MHSA, which specifically sites cultural competence.
- Contract providers are members of the Cultural Competency Advisory Act (CCAT) and the Quality Improvement Committee (QIC).
- Contract providers have been involved in the process of developing the plan and implementation of the Butte County Behavioral Health Workforce Cultural Competence Assessment.
- Some of our programs designed to meet the needs of our culturally diverse populations are implemented by our contracts that mandate hiring local and culturally competent staff.
- Contract providers will be a part of the workgroup that develops the Workforce Education and Training (WET) Cultural Competency Academy.

The overall BCDBH tone of valuing and respecting the diverse members of our workforce and community includes written responses to unacceptable behavior experienced by staff members, and follow-up on grievances and complaints by consumers.

Finally, working with the Cultural Competency Advisory Team (CCAT), BCDBH has developed a plan to conduct a cultural competency assessment of the Butte County Behavioral Health Workforce. The first phase of this assessment has been completed and the next portions of the assessment are scheduled for the end of 2010 and the beginning of 2011. The analysis of this assessment will guide the development of the MHSA WET Plan’s Cultural Competency Academy.

### B. The county shall have the following available on site during the compliance review (see Evidence Binder):

<table>
<thead>
<tr>
<th>Documents</th>
<th>Completed</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mission Statement</td>
<td></td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>2. Statements of Philosophy</td>
<td>X</td>
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<td>3. Strategic Plans</td>
<td>X</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>4. Policy and Procedure Manuals</td>
<td>X</td>
<td>Policy and Procedure Manuals Volume I and II</td>
</tr>
<tr>
<td>5. Human Resource Training and Recruitment Policies</td>
<td>X</td>
<td>Evidence Binder</td>
</tr>
</tbody>
</table>

Submitted to DMH 10/15/10
II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system.

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; include, 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.

Program Planning and Development Input

- During MHSA CS&S and PEI planning processes large community meetings were held in the four major population centers in Butte County. Interpreters and childcare were available at all of these. Publicity regarding the meetings was in English, Spanish, and Hmong. Publicity included posting in culturally diverse gathering spots and businesses, and were published in local papers, including those read by the Spanish speaking community.

- Every effort was made to develop MHSA CS&S and PEI community workgroups, which consisted of members who provided a balanced representation of the Butte County population. The culturally diverse make up of the PEI workgroup are depicted in the following Graph 1:

Graph 1

- While we were underrepresented in the Asian and Native American communities, we had full representation from the African American and Latino communities. The relationships built during the PEI planning and program implementation
Criterion 1: Commitment to Cultural Competence

phases have strengthened our relationships with all of our diverse communities. In future groups we will seek increased participation from the Asian and Native American communities.

- Focus groups were held during MHSA planning processes. They were arranged using the guidance of local residents from identified unserved and underserved populations. Focus groups included childcare, dinner, and translators. They were held with the following communities:
  1. African American
  2. Native American
  3. Latino
  4. Hmong
  5. GLBTQ
  6. Older Adults
  7. Consumer Groups

- BCDBH has a department-wide budget workgroup that provides input into the development of the Department’s budget. Care was taken in the development of this committee to include culturally diverse members.

- The CCOC has a culturally diverse governance body that regularly meets and provides input to program development, makes decisions about how the program services are delivered, and makes budgetary recommendations.

- BCDBH provided an intensive community development process in one of our most culturally diverse and impoverished neighborhood, Southside Oroville. The community development process had three main goals:
  1. To identify what the community wanted to do in order to create positive change.
  2. To develop an implementation plan for the PEI African American Family and Cultural Center (AAFCC).
  3. To increase trust between BCDBH and the Southside community.

- BCDBH allocated resources to develop and submit an application for a SAMSHA transformation grant. The grant proposal was based on a developing a program entitled Circles Offering Recovery and Empowerment Connections (CORE Connections). The purpose of CORE Connections will be to transform Butte County’s mental health services conventional recovery model to a trauma-informed culture-based recovery model for adults. The focus of CORE Connections is to help trauma survivors re-establish connections within themselves, their families, their friends, and their cultural communities torn apart through repeated exposure to trauma.

- The cultural competency manager has been involved in all aspects of MHSA planning and is a part of the Behavioral Health Board (BHB) MHSA Advisory Committee.

- African American community members from Southside Oroville were involved in the development of the Request for Proposal (RFP) as well as the RFP review process for the African American Family and Cultural Center.
Community Outreach, Engagement, and Involvement
Through the CCOC program and MSHA planning BCDBH has developed an effective relationship with the Hmong Cultural Center of Butte County. This relationship has grown stronger during the Path to Positive Change process and MHSA program development.

- The CCOC holds an annual Multicultural Mental Health Fair:
  “The impact of CCOC in Butte County was evident at the Winter Family Celebration in a multitude of ways. The most important transformation was seen in the youth enrolled in the program. Youth – that only a year ago avoided social interaction – actively participated in activities and demonstrated strong social skills at the event. Youth took a leadership role in ensuring the celebration was a success. They were proactive and responsible, and their cheerful attitudes were contagious. There was also a strong sense of partnership between the ethnic communities not present just a year ago. As we celebrate, support, and acknowledge the diversity of Butte County, our communities are becoming less isolated. This will foster a spirit of cooperation and strengthen CCOC as we go forward, not only transforming systems of health care, but our community as well.”
  (CCOC Connections) The Winter Family Festival is generally attended by over 500 people, there is food representing all the main cultural traditions, as well as cultural performance (e.g. Hmong dances, Native American drumming).

- Key BCDBH staff in Gridley are bilingual and bicultural employees who are embedded in the community and actively involved in such community activities as soccer, church, cultural events, etc.

- The Promotores program in Gridley and Chico provide outreach to the Latino and Hmong communities with staff from the community and who are bilingual and bicultural.

- Several MHSA priorities include program funding for community and cultural events: African American Family and Cultural Center, Promotores, GLBTQ, and CCOC.

- BCDBH staff serve on the Elder Services Coordinating Council.

- BCDBH staff regularly attend and are active with the Gridley Guardians, a local group in Gridley, which is devoted to the improvement of life in Gridley for families and youth.

- The Promotores program and the African American Family and Cultural Center are both contracted services. In order to maintain a close working relationship and involvement with each program BCDBH has a fulltime liaison that is embedded in each program.

- In order to develop a deeper relationship with the African American community in Southside the African American Family and Cultural Center liaison has been working as a liaison since July 2009 providing groups, conducting community outreach, and working with the community in a variety of others ways.

- The CCOC collaboration has been developing and strengthening relationships with Feather River Tribal Health, Hmong Cultural Center of Butte County, the Latino community, and the African American Community.
B. 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.

BCDBH has successfully used the MHSA PEI Technical Training Assistance & Capacity Building (TTACB) funds to provide skill development and strengthen community organizations in order to increase the ability to effectively serve our diverse communities and address disparity in mental health access and outcomes. Two multi-year projects have been funded with these resources: The Sustainability Project and The Path to Positive Change. A third area in which the county is working to develop and strengthen community organizations is embedded in the RFP design and subsequent contract for the African American Family and Cultural Center.

**Sustainability Project**
The Sustainability Project is a research-based model that identifies and explores the elements of healthy nonprofit organizations. Strategies Training & Technical Assistance Program provided services to the following four nonprofits:
- Stonewall Alliance
- Hmong Cultural Center
- Southside Family Resource Center
- Greater Oroville Family Resource Center

The project consisted of individualized consultation and five group trainings:
2. **Topic: Allies and Champions** – *Who Do We Need To Achieve Our Purpose & Priorities?* Empathy, communication skills, and marketing tools were discussed.
3. **Topic: Results Based Accountability/Performance Measures** – *How Do We Know if We’re Achieving Our Purpose & Priorities?* An organization’s ability to “tell its story,” track data, and use that data to determine what, if any, changes need to occur to improve service delivery were discussed, as well as an organization’s ability to successfully adapt to both internal and external changes.
4. **Topic: Organizational Infrastructure** – *Do We Have the Right Structure in Place to Achieve Our Purpose & Priorities?* Best Practices & Red Flags of Nonprofit Structures and organizational assessment tools were part of this training. Creating a healthy organizational culture was also discussed.
5. **Topic: Diversified Resources** – *What Resources Do We Need to Achieve Our Purpose and Priorities?* Human, fiscal, and in-kind resources, the need for decision trees, and the use of mind maps and theories of change were discussed.

Three of the four sites successfully participated in all five trainings, receiving a Certificate of Completion during the last training. One agency completed three trainings.
and dropped out of the process due to time constraints. They have indicated they would like to receive further training and technical assistance.

Participants indicated the process had helped them identify a variety of ways to build the infrastructure in their agencies and showed them ways in which they could be more effective in competing for and collaborating with others for funding.

The next steps in this process, provided in FY 10-11, include: providing a combination of individualized follow up technical assistance that helps non-profits successfully integrate new learning and tools into their work sites; conduct group meetings in order to strengthen the relationships they have built with each other, and; to continue to find ways to partner in providing services to their communities.

In addition to those services discussed above, we are underway to provide similar services to the African American Family and Cultural Center and National Alliance on Mental Illness (NAMI).

**The Path to Positive Change** (see Appendix A)

During the PEI community planning process, the desire to develop an African American Family and Cultural Center in Southside Oroville was identified as one of the PEI projects. In order to ensure successful development of this center the first step in implementation was an intensive community development process with the goal of uniting the Southside Oroville African American community in order to implement, participate, and advise all aspects of this African American Family and Cultural Center. The goal of the first stage of the community development process was to have an identified advisory team and a completed implementation plan.

Butte County Department of Behavioral Health joined with the S.H. Cowell Foundation to bring National Community Development Institute (NCDI) to Butte County to conduct a community development process. NCDI was chosen because of their past experience and commitment to build capacity for social change in communities of color, as well as other marginalized communities, using culturally-based approaches. The goal of the process combined BCDBH’s goals with the S.H. Cowell Foundation’s goals of helping the Southside Oroville community identify the best ways to make positive change in their community.

The initial Path to Positive Change community development consisted of 10 meetings and a day long retreat that took place between June 2009 and February 2010. During the Path to Positive Change process four workgroups were developed after the community identified common themes that need to be addressed in order to implement a Path to Positive Change in Southside. The workgroups and their overall goals are presented below:

- Community Pride, Blight, & Housing
  - To improve community pride, reduce blight and improve housing in Southside Oroville.
Criterion 1: Commitment to Cultural Competence

- Crime & Safety, Drugs, Community Relations, & Racial Tensions
  - To create a safe and unified Southside Oroville through a collective effort by EVERYONE!
- Education & Employment
  - To build capacity of Southside schools and community, support job development, and improve positive communication through opportunities that build understanding through meeting the needs of Southside families.
- Family Connections, Sports, Recreation, & Youth
  - To create support for families in Southside by education and building trust through the offering of life skills, parenting and safety education.
- African American Family and Cultural Center
  - Developed Mission Statement: “To empower and embrace African American families and community by reclaiming, restoring, and revitalizing our cultural heritage, values and identity. The African American Family and Cultural Center is a place where people convene, connect, and celebrate the essence of our community in order to bring about healing to create prosperous vibrant lives.”
  - Developed an implementation plan which can viewed in Appendix A (page 17-27).

The second phase of the NCDI Path to Positive Change included a presentation to funder’s in Butte County and a trip to the S.H. Cowell Foundation headquarters in San Francisco. Subsequently S.H. Cowell Foundation provided a modest amount of money to each workgroup so that they can begin to implement their workgroup goals. Additionally, the Foundation is funding NCDI to train 30 Southside Oroville leaders in the “SOUL Academy”. The members of the African American Family and Cultural Center Community Advisory Team (CAT) will all take part in the Southside Oroville Unity Leadership (SOUL) Academy.

Additionally, NCDI continued work with the African American Family and Cultural Center workgroup and with community members to develop and implement a process for identifying members of the African American Family and Cultural Center Community Advisory Team. This subsequently led to a two day retreat for the African American Family and Cultural Center CAT.

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

- It is crucial to have ongoing relationships within the communities so that we can access real and comprehensive input regarding what is working and what is not.
- When gathering input it is important to complete the communication loop and get back to the community with an explanation of how the input was used, and what -if any - actions were taken.
- Providing food and translators is vital when hosting meetings to gather community input. It is equally important to set the tone as warm, friendly, and to understand how past and/or current actions by the Department or other
government agencies can influence the comfort level of participants and their likelihood to speak freely.

- Engagement, recruitment, and buy in are essential in the success of long processes.
- Sometimes someone from the outside needs to lead and facilitate the meeting. A government agency is not neutral. No matter how open the agency is to change and no matter how skillful staff members are at facilitation, they are not perceived as neutral.
- Doing things by collaboration and with community governance bodies is an element of true transformation and will increase the likelihood of success.
- Patience and the willingness to let the process unfold, even when it doesn’t adhere to tasks and timelines, is essential.
- A community process takes a long time: you must prepare the ground fully if you want successful community programs.
- Department representatives must be able to listen to negative feedback without getting defensive.
- It is important to continually communicate with stakeholders, ask how the process is going, and what could improve the process.

B. Identify county technical assistance needs.

- Facilitation Skill Training to increase leadership skills for members of unserved/underserved communities.
- Advocacy training for members of unserved/underserved communities.
- Continued training on cultural competence for the entire behavioral health workforce: cultural views of family, crisis, and mental health.

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

The County has an identified Cultural Competence Manager (CCM). The CCM:

- Regularly participates in California Mental Health Directors Association (CMHDA) ESM conference calls and meetings.
- Chairs the Superior Region ESM committee.
- Has been involved in all aspects of MSHA planning, development and implementation.
- Is a member of the BCDBH Leadership Team.
- Is a member of the BCDBH Quality Improvement Committee (QIC).
- Regularly advocates for services that meet the needs of the diverse and unserved/underserved populations as evident in the approved MHSA plans.
- Coordinates the BCDBH Cultural Competency Advisory Team.
- Consistently takes steps to strengthen relationships between BCDBH and the diverse unserved and underserved populations in Butte County.
Criterion 1: Commitment to Cultural Competence

See Appendix B for copy of Cultural Competency Manager Roles and Responsibilities.

IV. Identify budget resources targeted for culturally competent activities

The following programs are specifically funded services to culturally diverse groups:

- African American Family and Cultural Center
- Promotores
- GLBTQ Suicide Prevention and Education Program
- Connecting Circles of Care (CCOC)
- Historical Trauma & Hmong Elders
- Interpreter/Translation Services

Additionally, the following services are provided in a culturally competent manner and have percentages of participants who are members of Butte County’s diverse populations:

- Live Spot Gridley
- Live Spot Oroville
- Therapeutic Childcare
- Integrated Health & Mental Health

Department wide services include:

- Interpreters/Translators
- 24 hour interpreter line
- Culturally appropriate mental health services
- Compensation for culturally and linguistically competent providers and non-traditional providers/healers

Financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers include:

- BCDBH bilingual staff are encouraged to take advantage of the County’s bilingual staff pay differential.
- BCDBH encourages contract providers to provide financial incentives for their bilingual staff members.
- Multiple BCDBH grant proposals and RFP’s specify use of shamans, natural healers, and non-traditional providers.
- We are in consultation with California Institute for Mental Health (CiMH) to identify the best trainers to train staff in African American cultural and family values as related to mental health and crisis services. Money has been identified for this training.

Detailed funding allocation for cultural competency activities can be found in Appendix C.

Evidence:
Criterion 1: Commitment to Cultural Competence

1:I:B:3. Butte County Behavioral Health Master Plan FY 01/FY 05

1:I:B:5.
- Non-Discrimination Policy & Procedure
- Personnel Rules
- Employee Reference Guide

1:I:B:6. Mental Health Services Agreement Between The County of Butte and Northern Valley Catholic Social Services Promotores/Master Lease FY 2010-2011
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 population estimates for 2010 for Butte County is 221,768.1 Though current race and ethnicity for the current year is not available, according to California Department of Finance estimates whites comprise about three-quarters (76.15%) of the County’s population followed by Hispanics at 14.54%, Asians at 3.45%, Blacks at 1.21%, American Indians at 1.64%, and persons of multi races, 2.88%.2

The age distribution in Butte County is presented in Table 1:

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total by Age</th>
<th>Percent of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>6427</td>
<td>5925</td>
<td>12352</td>
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</tr>
<tr>
<td>5 – 9</td>
<td>5452</td>
<td>5773</td>
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<tr>
<td>10 – 17</td>
<td>12,102</td>
<td>10571</td>
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<tr>
<td>18 – 21</td>
<td>10,221</td>
<td>10,219</td>
<td>20440</td>
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<td>38,609</td>
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<td>12,811</td>
<td>18,769</td>
<td>18782</td>
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<td></td>
<td>93,732</td>
<td>111,020</td>
<td>204,752</td>
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</tbody>
</table>

There are four distinct racial and ethnic subgroups in Butte County:

**Native American Context**

Native Americans indigenous to the area are primarily Maidu, with sizable numbers of Wintu, Pomo, and Miwok. Many are unaffiliated with a Rancheria (a problem in California caused by federal tribal termination policies), and hold no voting power on the Rancherias. There are approximately 8,000 Native Americans living in the area. Of those about half are from local tribes. According to the 2000 U.S. Census, 1.9% of the population of Butte County is Native American, located mostly in the Oroville area. This census estimate is thought to be a low statistic for many reasons including that many Native Americans are being reported as Hispanic due to surnames. Among the four Rancherias in the area, the population distribution is as follows: Berry Creek Rancheria: 450; Mooretown Rancheria: 1,170; Enterprise Rancheria: 395; and, Chico Rancheria: 321 (Individual Rancheria data, 2003).

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**Hmong American Context**

There are about 10,000 Hmong in Butte County. Language remains a major barrier, due in large part to the absence of a single written form of the Hmong language. The Hmong language is second only to English as the most common primary language of BCDBH care recipients. The Hmong are a subgroup of Asian descent with no country of origin, but are known as strong and collective mountainous tribesmen who have forcefully fought their way to become free from slavery and warfare. After the fall of Saigon, many Hmong escaped Laos due to fear of prosecution because they had assisted the United States during the Vietnam War, and over a half million resettled in the U.S. between 1975 and 2004. Many faced trauma, torture, rape and starvation in Laos or in refugee camps prior to leaving Southeast Asia. As a result, the Hmong community suffers extremely high rates of mental health disorders: i.e., posttraumatic stress disorder, anxiety, depression, and the like. The Hmong's transition from a simple agrarian lifestyle based on strong cultural traditions, to the fast-paced, technological industry of western culture has resulted in extreme cultural adjustment issues among this population, especially the elders. The Hmong culture has strong traditions that value family and clan leadership.

**Latino American Context**

Latino Americans comprise about 13% of the Butte County population. While the vast majority of residents are originally from Mexico, there are Latino Americans in Butte County that are also from many countries in Central and South America. Latino Americans live throughout Butte County, though the majority of people live in Gridley. Gridley is the fourth smallest of Butte County cities with its primary economy based on the local agricultural business. “La familia” and “la comunidad” (family and community) are central for the Latino culture’s wellness, which includes its language (Spanish or Indian dialect), traditions, folklowers/mythology, music, food, and religious or spiritual affiliation: all are fundamental for family norms to be transmitted from one generation to the next. Latino families needing services, however, are predominately from family systems that are culturally broken, have ceased to bond or prosper due to assimilation/acculturation, experience severe trauma via violence in the home, have strict male patriarchy via machismo, ongoing immigration legal issues, and traumatic deportation histories. Although migration experiences to the U.S. may be similar, each family has its own story that often reflects an ongoing generational trauma and can be an extremely painful experience. Situations leading to U.S. immigration include poverty, political persecution, drug cartel wars, hope of a better future for their children, and limited job opportunities within countries of origin. When Latino families experience mental health, drug and substance abuse issues, and/or the presence of gang influences/violence within the home, it often creates ongoing shame and embarrassment for individuals, ostracism from their religious community, and the fracturing of the family system.

**African American Context**

African Americans are about two percent of the population in Butte County and are primarily living in the cities of Oroville and Chico, with the greater concentration occurring in Oroville. Most African Americans in Butte County live in poverty and have
insufficient healthcare. Infant mortality among African Americans in the County is more than twice that of other ethnic groups (8.8 per 1000 births) and about one in 20 of their children are living in out-of-home placements. Most African American community members in Butte County are descendants of Africans who were forcibly removed from their homeland and enslaved in America. Sadly, the forced separation of family members in slavery continued in a new form under Jim Crow laws and Black Codes. In Butte County, many African American families came due to assurances of good jobs associated with building the Oroville Dam, with the state promising that much of the economic boom of this project would be directed to Butte County. Unfortunately, this economic boom did not materialize, and the African American families that moved to this county for employment and benefits of the project were left without local jobs. Many leaders and gifted members of the community have moved for higher paying jobs in other areas resulting in disconnecting families and/or poverty. Many local African American families have for generations been subject to trauma, had disrupted family life, and struggled with poverty. The experience of perceived racial discrimination leads to lower levels of mastery, and higher levels of psychological distress. Many males respond to trauma and other stressors through aggressive and angry behavior towards self and others and/or using drugs. With the immense difficulties of coping and racial profiling, many of these males in the community were criminalized.

In addition to the four distinct cultural groups in Butte County two unserved/underserved groups surfaced in both the MHSA CS&S and PEI community planning processes: GLBTQ and Older Adults. Therefore, we are including the context of these groups in this report.

**Gay, Lesbian, Bisexual, Transgender, & Questioning (GLBTQ) Context**

Over the past 15 years, research has suggested that adolescence can continue into the third decade of life. As those of us who work with adolescents and their families can attest, getting there is half the battle. And while adolescence is a period of increased stress and excitement for a majority of youth, some definitely have more of a struggle on their hands than others. Numerous studies report on the high percentage of GLBTQ youth that feel isolated from peers and additional feelings of isolation, and difficulties caused by their parents’ rejection due to their sexual orientation. As a result of their families’ rejection, as many as 26% of GLBTQ youth feel forced to leave home.

Schools often unwittingly or by complicity reinforce that it is not healthy or safe to be gay, lesbian, or bisexual. A study at Lincoln-Sudbury Regional High School in Boston revealed that 97% of the student body reported hearing anti-gay comments on campus. Such disparaging and often prejudicial remarks are often ignored or, even worse, tacitly encouraged by faculty and administration. Over the last two decades, research findings have pointed to disproportionately high rates of suicidal behavior among GLBTQ adolescents and young adults. Suicide attempts in this population have been linked to a variety of factors including lack of support, family problems, violence/ victimization, and mental health problems, notably depression and substance abuse or dependency. One study found that when compared to their heterosexual peers, GLBTQ youth are:

- Over five times more likely to have attempted suicide in the past year.
Criterion 2: Updated Assessment of Service Needs

- Over three times more likely to miss school in the past month because of feeling unsafe.
- Over three times more likely to have been injured or threatened with a weapon at school.

Parents' attitudes and behaviors toward their gay, lesbian, and bisexual offspring are key determinants of their children's risks of suicide, substance abuse, and depression, according to a new study (December 2009) published in the journal *Pediatrics*. The study in *Pediatrics* found that rejection by one or both parents and/or efforts to change sexual orientation were significantly associated with higher risks of suicide and poorer health outcomes among this population.

Lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. It is important to note that stigma associated with homosexuality and gender identity causes many affected individuals to be wary of “governmental” service providers, and of receiving services at typical governmental offices. The mental health field especially has a long history of institutionalize homophobia which is in of itself a barrier to treatment for GLBTQ community.

Trust is a most significant factor for the GLBTQ populations and the effort to reach out with trusted community liaisons will lead to improved prevention efforts and lessen the risk of suicide, depression, and other risky behaviors.

Older Adult Context
In Butte County, 20% of the population is over the age of 59, compared to the statewide proportion of 14%. Almost two-thirds of those seniors live in Chico and Paradise.

Older adults are at considerably higher risk for mental illness, particularly depression. According to national statistics, they are the most likely individuals to successfully complete suicide. A key finding of Enloe Medical Center, the primary hospital in Butte County, found that 29% of adults in this area had depression lasting two years or more, particularly, people aged 65 and older (2007 Community Health Survey, Enloe Medical Center). Many older adults have chronic health conditions that contribute to signs and symptoms of mental illness, e.g. diabetes and stroke are very closely correlated to depression in older adults. In fact, the 2007 Community Health Survey shows that in Butte County 3.2% of adults suffer from or have been diagnosed with cerebrovascular disease (stroke), a rate higher than the statewide figure of 2.4%. More than 18% of adults older than age 65 have diabetes (Centers for Disease Control and Prevention). Butte County has a higher rate of this disease in adults (10.5%) than the state proportion of 7.1%.
Criterion 2: Updated Assessment of Service Needs

It is acknowledged that in Butte County, the incidence of mental illness and severe emotional distress among older clients is high; older adult have presented with symptoms/diagnoses of depression, bipolar disorder, complicated grief/loss, anxiety, PTSD (post-traumatic stress disorder), panic disorders, psychotic disorders, medication misuse, overuse and mismanagement; and obsessive-compulsive disorder. Furthermore, older adults who are experiencing initial symptoms of substantial emotional distress are not accessing mental health services in proportion to their numbers. These older adults are facing profound and unremitting sadness, grief/loss, social isolation, fear, and physical symptoms. They frequently do not know the cause of these symptoms, or that the proper early intervention treatment of older adults is generally successful. They may believe and accept that the nature of being old is to be sad: that depression is a “normal” part of aging. They often express the sentiment that these feelings are “their fault” and that they need to “pick themselves up by the bootstraps” if they want to feel better. If they have had treatment that did not include thorough education, support, and follow-up, then they may believe that treatment, in general, doesn’t work. Consequently, they may not seek help or disclose symptoms after that failed intervention.

The result of the lack of early identification and appropriate in-home intervention and services are substantial and include escalation of symptoms, institutional placement, self harm, and suicide.

II. MEDI-CAL population service needs (Use Current EQRO data if available.)

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

In 2009 there were 48,780 Medi-Cal recipients in Butte County. This represents approximately one-quarter of the resident population. The first place to examine is utilization by race/ethnicity. Figure 1 shows the utilization rate by Butte County residents who have Medi-Cal. One can see that over 15% of African Americans accessed services at BCDBH. This was the highest cultural group. All cultural groups were accessing at similar or higher rates than whites except the Latino cultural group, where only 4% of Latinos on Medi-Cal accessed our services. This client utilization rate for Latinos with Butte County Medi-Cal is significantly higher than the statewide averages for the same population. Despite having this excellent penetration and service rate, BCDBH continues to actively pursue a variety of programs from Los Promotores, Gridley Live Spot, and CCOC that works to increase services and access to this group. In addition, the Department makes continuing effort to increase its bilingual, bicultural support, clinical, and supervisorial staff (Hmong and Spanish).

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3 http://www.dhcs.ca.gov/datAfricanAmericanstats/statistics/Pages/RASS_County_Enrollment.aspx
Criterion 2: Updated Assessment of Service Needs

B. Provide an analysis of disparities as identified in the above summary. Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

The chart below, Figure 2, portrays utilization patterns by race and ethnicity of clients by services categories, and compares the race and ethnicity of staff (green bar) relative to each of these services. The graph provides information in two areas:

1) Proportionality for the number of African American, Asian, and Latino consumers and BCDBH staff members by cultures across BCDBH programs. Unfortunately, there is a need for more BCDBH Native American staff.

2) Latino consumers underutilizing services (Butte County actually does better than other California counties in this area).

The graph assumes that all groups will have the same need for services as other groups, and particularly the white group. However, the numbers in the graph do not reflect that some cultural groups have experienced historical trauma (e.g., Hmong war and refugee camps; Native American Forced Boarding schools, etc.) and therefore have a higher need for services. Stakeholders from culturally diverse groups substantiate that there are many unmet service needs in their communities, in particular, culture-based services that are congruent with cultural traditions.
So far, data have been used to investigate: 1) whether there were disparities in penetration rates; 2) disproportional service rates between cultural backgrounds of consumers accessing Medi-Cal services; 3) proportionality of consumers accessing Medi-Cal services versus MHSA PEI and MHSA CS&S services.

The focus will now shift to reviewing data on diagnoses by ethnicity/race. Consumers receiving outpatient and inpatient services during the 2009 calendar year by race and ethnicity is presented in Tables 2 and 3.
Table 3

<table>
<thead>
<tr>
<th>Categories</th>
<th>African American</th>
<th>Hmong</th>
<th>Native American</th>
<th>Other Asian</th>
<th>Other/Unknown</th>
<th>White</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disruptive</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0.39%</td>
</tr>
<tr>
<td>ADHD</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>0.98%</td>
</tr>
<tr>
<td>Psychoses</td>
<td>8</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>18</td>
<td>128</td>
<td>161</td>
<td>31.69%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>114</td>
<td>123</td>
<td>24.21%</td>
</tr>
<tr>
<td>Mood</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>12</td>
<td>116</td>
<td>142</td>
<td>27.95%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>1.57%</td>
</tr>
<tr>
<td>PTSD</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>26</td>
<td>30</td>
<td>5.91%</td>
</tr>
<tr>
<td>Adjustment</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>16</td>
<td>3.15%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>14</td>
<td>2.76%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>1.38%</td>
</tr>
<tr>
<td>Total Diagnoses</td>
<td>15</td>
<td>2</td>
<td>12</td>
<td>8</td>
<td>41</td>
<td>430</td>
<td>508</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

It is interesting to note that outpatient African American consumers were more likely to be diagnosed with psychosis than with bipolar (13% vs. 6%), while white consumers were less likely to be diagnosed with psychoses than with bipolar (11 vs. 13%). On a limited sample for inpatient services this discrepancy is even greater with African Americans having a 6% likelihood of having a bipolar diagnosis and a 53% chance for psychosis while whites had a 27% likelihood of having bipolar versus 30% likelihood of psychosis. This is concerning in that professional literature indicates that African Americans have a higher chance to be misdiagnosed with psychosis when they actually have bipolar. BCDBH is hiring a Medical Director who will work with the Assistant Director and Cultural Competence Manager to ensure that diagnoses are accurate across all cultures.

The main purpose of the following graphs (Figures 3-5) is to show the number of consumers receiving inpatient, crisis stabilization, and outpatient services. Each of the graphs below illustrate that Latinos constitute the largest population among the culturally diverse groups that receive services (although the penetration rate is lower for Latinos, they are the largest ethnic group after whites). Looking at inpatient services in the Figure 3, it is evident that Hmong consumers have a low utilization rate. Moreover, inpatient services for ethnic minorities overall is 15% of the total inpatient population. This is significantly lower than the 27% of all DBH consumers.
**Criterion 2: Updated Assessment of Service Needs**

**Figure 3**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Miscellaneous</th>
<th>Substance Abuse</th>
<th>Adjustment</th>
<th>PTSD</th>
<th>Anxiety</th>
<th>Mood</th>
<th>Bipolar</th>
<th>Psychoses</th>
<th>ADHD</th>
<th>Disruptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hmong</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Latino</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Asian</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Clients who self-identified as "White" represented 409 (i.e., 80.51%) of the total distribution. In terms of diagnostic category frequencies:
  - Disruptive: 2
  - ADHD: 2
  - Psychoses: 123
  - Bipolar: 112
  - Mood: 109
  - Anxiety: 6
  - PTSD: 24
  - Adjustment: 12
  - Substance Abuse: 12
  - Miscellaneous: 7

The crisis stabilization chart (Figure 4) indicates a somewhat similar use pattern as the inpatient chart. However, no Hmong clients participated in these services, and a higher proportion of Native Americans participated in these services as compared with the inpatient services.
This chart for outpatient services (Figure 5) shows significant numbers from each major ethnic group accessing services. Therefore, the department needs to, and does provide, services that are culturally-competent and culture-based to each of these groups.
Looking at all three graphs together, it would appear that the Hmong population is aware of, and is accessing, outpatient services but not crisis-level services. Additionally, it shows a higher level of PTSD in the Hmong community when compared to the other populations.

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).

According to the American Community Survey’s 2006-2008 three-year estimates, 89,726 persons in Butte County have incomes below 200% of the Federal Poverty Level. Based on 48,780 Medi-Cal recipients in the County, the difference in persons at 200% of poverty that do not receive Medi-Cal is 40,946 (89,726 – 48,780). Based on the limitations of available data, BCDBH estimates 3.7% penetration rate for this population and a proportional distribution of race and ethnicity that is analogous to Medi-Cal consumers.

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4 American Community Survey, 2006-2008 3-year estimate
B. Provide an analysis of disparities as identified in the above summary. Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

Individuals at or below 200% of poverty without Medi-Cal are much less likely to receive services at BCDBH than their Medi-Cal counterparts (3.7% vs. 9.14%). This difference pertains to the core target population of BCDBH: 1) BCDBH is the provider for people with Medi-Cal, and 2) Butte County focuses on the severely impaired who are more likely to be on long-term disability and have Medi-Cal. Latinos underutilize mental health services compared to other groups, which is typical at Butte County Behavioral Health, and in the United States in general.

![Figure 6: 200% Poverty Comparison by Culture/Ethnicity](image)

IV. MHSA Community Services and Supports (CS&S) population assessment and service needs.

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

The full population and utilization assessment from the originally approved CS&S plan can be found in Appendix D (pages 12-17).
In summary, the goal of the initial CS&S Plan was to provide system development in the form of a Crisis Stabilization Unit (CSU), the development of wellness centers, and increased services to homeless and at risk of homeless youth and adults. Subsequent increases in the budget saw the inclusion of services for older adults, a hospital alternative program for youth, and a consumer run warm-line.

The overall CS&S cultural competence strategy was to integrate cultural competency within the new MHSA programs through staff training. Specific strategies included:

- Specific training for Crisis Stabilization Unit staff on GLBTQ issues.
- Targeted outreach to the homeless.
- Target outreach to the homeless Latino population.
- Development of an Older Adult Program.
- Targeted outreach to the Hmong Elders in conjunction with an older adult program.

B. Provide an analysis of disparities as identified in the above summary.
Note: Objectives will be identified in Criterion 3, Section III.

The data suggests that in 2005, when the CSS plan was developed, all age groups and ethnicity were being underserved. It is particularly noteworthy that at that time only 9 youth from African American, Asian, Latino and Native America communities were receiving all services needed through a recovery plan. Today, with the help of MHSA funding and the CCOC grant program, the number is almost 150. To date, only 27 adults and elders from these ethnic groups are receiving these services. Two MHSA programs that are being used to address this need include Hmong Culture Based Treatments for Trauma in Elders and the African American Family and Cultural Center. For all types of services Latinos are under accessing any type of service. A new MHSA program Los Promotores is being used to address this difficulty.

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

A. The county shall include the following the Cultural Competence Plan (CCP):
   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
Table 4

<table>
<thead>
<tr>
<th>PEI Projects</th>
<th>PEI Priority Populations</th>
<th>Age Groups</th>
<th>Adults</th>
<th>Older Adults</th>
<th>Transition Age Youth (TAY)</th>
<th>Children and Youth (C/Y)</th>
<th>PEI Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many of these projects address multiple Community Mental Health Needs and multiple PEI Priority Populations. This chart shows each program by the Need and Priority Population that are its greatest focus. To see all of the needs and priority populations addressed by each project, see the full PEI Plan program descriptions.</td>
<td></td>
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<tr>
<td>PEI Projects</td>
<td>PEI Priority Populations</td>
<td>Age Groups</td>
<td>Adults</td>
<td>Older Adults</td>
<td>Transition Age Youth (TAY)</td>
<td>Children and Youth (C/Y)</td>
<td>PEI Projects</td>
</tr>
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<tr>
<td>Disparities in Mental Health Services Access</td>
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<td>Promotores</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>African American Family and Community Center</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Integrated Primary Care and Mental Health</td>
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<td>X</td>
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<td>At-Risk Children/Youth, Young Adult Population</td>
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<td>Mobile Transition Age Youth (TAY) Project</td>
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<tr>
<td>Gridley Live Spot</td>
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<tr>
<td>Therapeutic Childcare</td>
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<tr>
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<tr>
<td>Mental Health Awareness*</td>
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<td>Suicide Risk</td>
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<tr>
<td>GLBTQ Suicide Prevention and Education</td>
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<tr>
<td>Older Adult Suicide Prevention and Education</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* This prevention program will be available for all populations, including the general population.

**Current PEI Strategies/projects to address:**
- **Underserved Populations**
  - African American Family and Cultural Center
  - Promotores
  - GLBTQ Suicide Prevention and Education
  - Older Adult Suicide Prevention and Education
  - Integrated Health and Mental Health
- **Individuals experiencing onset of serious psychiatric illness**
  - Transition Age Youth (TAY) Mobile Program
- **Trauma Exposed**
  - Therapeutic Childcare
- **Children/Youth at risk of school failure and at risk or experiencing juvenile justice involvement**
  - Live Spot Gridley
Criterion 2: Updated Assessment of Service Needs

- All PEI Priority Populations
  - Mental Health Awareness

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

BCDBH designed a process for collecting and analyzing data for the PEI Community Workgroup to study and determine priority populations and service needs. The workgroup reviewed six sources of community input, and data were gathered between September 2007 and March 2008 included: survey, community meetings, targeted focus groups, additional written input from staff and the community, census data, and Butte County Behavioral Health service data. The 32 member community workgroup identified seven local needs for PEI services, matched them with the PEI State priority populations. The group subsequently recommended the development of specific services and programs, and this ultimately became the approved MHSA PEI plan. (see Appendix E and F)

The overall strategy to ensure that PEI priority populations were addressed in the plan included expanded outreach, community involvement, and input access points to diverse demographical populations. BCDBH made extensive efforts to include previously identified unserved/underserved populations. This process included:

- Community Input Meetings held in Chico, Oroville, Paradise, and Gridley that focused on the five PEI Community Needs: disparities in access to mental health services, psycho-social impact of trauma, at-risk children/youth/youth adults, stigma and discrimination, and suicide risk. Participants were asked to identify what condition the community was in, and possible solutions.
- Targeted focus groups were conducted for traditionally unserved/underserved populations: Latinos, Hmong, Native Americans, African Americans, consumers with serious mental illness (SMI), older adults, and GLBTQ members. These meetings were tailored to be sensitive and relevant to each diverse group. Questions include the five PEI Community Needs, personal experiences with BCDBH, and services they would like to see. Meetings included flyers in threshold languages and translators.
- Survey of Behavioral Health staff, partner organization staff, consumers and family members, community members, and Behavioral Health Board members. Surveys were distributed at staff meetings, drop-in center consumer meetings, and community meetings. The surveys requested demographical information and input on the PEI Community Needs.
- Community members, families, consumers, and service providers were offered opportunities to contact the BCDBH with additional input.
- Census data focused on comparing age, location, race/ethnic, poverty, and threshold languages spoken at home.
- Butte County Department of Behavioral Health service data.

This was a facilitated process designed to identify key community mental health needs and priority populations. After the information was compiled, it was presented to the PEI
Community Workgroup. The Workgroup represented Butte County’s diverse ethnic, cultural, and racial populations. The Workgroup utilized the above information when developing the PEI Plan, which designed nine programs that assist all of the priority populations, as seen in Table 4.

The diversity of the PEI Community Workgroup is evidence of the inclusive manner in which the community was invited to participate in the planning process. The community meetings, targeted focus groups, and written input also speak to the effectiveness of the community planning process, which ensures that mental health needs concerning all priority populations were considered.
I. Identified unserved/underserved target populations (with disparities):

(see Evidence Binder)

CS&S FSP Populations
- Homeless and risk of homelessness adults
- Homeless, at-risk of homelessness TAY, and foster children
- Older adults

WET - Targets for Workforce Growth
Findings from the BCDBH MHSA WET Workforce Needs Assessment include a shortage of bilingual/bicultural staff in the local public mental health workforce. Specifically, Latino/Spanish speaking and Hmong/Hmong speaking staff remain hard to recruit/retain. BCDBH is committed to expanding the diversity of it’s workforce to include a higher percentage of staff members from all unserved and underserved groups.

Prevention Early Intervention
- Unserved & Underserved Populations
- Stressed Families and Children
- African American
- Hmong
- Latino
- GLBTQ
- Older Adults

1. Underserved cultural populations
   a. Latino
   b. Hmong
   c. African American
   d. Gay, Lesbian, Bisexual, Transgender, Questioning (GLBTQ)

2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
   a. Latino
   b. Hmong
   c. African American

4. Trauma-exposed
   a. Latino
   b. Hmong
   c. African American
   d. GLBTQ

5. Children/youth at risk of school failure
   a. Latino

6. Children/youth at risk or experiencing juvenile justice involvement
   a. Latino
II. Identified disparities (within the target populations)

CS&S FSP Populations:

Homeless and Risk of Homelessness Adults:

The Homeless Continuum of Care, which BCDBH partnered with, conducted a Point in Time Homeless Census and Survey. This survey tallied 1,422 individual surveys and tallied 541 homeless individuals who did not participate in the survey. The survey contained demographic information that assisted BCDBH is identifying homeless disparities. The information below are direct excerpts from the 2010 Point in Time Homeless Census and Survey that highlight homeless families and breakdown homelessness by race and ethnicity. (see Appendix J)

Age and Family Make-Up

Table 5

<table>
<thead>
<tr>
<th>Location</th>
<th>Chico</th>
<th>Gridley</th>
<th>Oroville</th>
<th>Paradise</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Adults</td>
<td>523</td>
<td>62</td>
<td>315</td>
<td>41</td>
<td>4</td>
<td>945</td>
</tr>
<tr>
<td>Adults in Families</td>
<td>204</td>
<td>6</td>
<td>36</td>
<td>24</td>
<td>3</td>
<td>273</td>
</tr>
<tr>
<td>Children</td>
<td>138</td>
<td>11</td>
<td>35</td>
<td>18</td>
<td>2</td>
<td>204</td>
</tr>
<tr>
<td>Total</td>
<td>865</td>
<td>79</td>
<td>386</td>
<td>83</td>
<td>9</td>
<td>1422</td>
</tr>
</tbody>
</table>

The family make-up was similar across the communities of Chico, Oroville, and Paradise, consistently showing that the majority of homeless individuals counted were single adults. The number of children reported is likely low, considering that the Butte County Office of Education has collected data from 2005-2008 which reflect between 400-600 school aged children experiencing homelessness in Butte throughout one academic year. One reason for this discrepancy could be the difference in methodology (i.e. point-in-time versus year long data collection). Additional reasons could be the difference between the HUD and Department of Education definitions of homelessness.
and/or the unwillingness of survey respondents to share information about their children.

Race/Ethnicity

<table>
<thead>
<tr>
<th>Location</th>
<th>Chico</th>
<th>Gridley</th>
<th>Oroville</th>
<th>Paradise</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/ Alaskan Native</td>
<td>32</td>
<td>1</td>
<td>22</td>
<td>2</td>
<td>0</td>
<td>57</td>
</tr>
<tr>
<td>Asian</td>
<td>19</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>Black/ African American</td>
<td>45</td>
<td>1</td>
<td>29</td>
<td>1</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>Native Hawaiian/ Pacific Islander</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>White</td>
<td>650</td>
<td>54</td>
<td>301</td>
<td>66</td>
<td>8</td>
<td>1079</td>
</tr>
<tr>
<td>Other Multi-Racial</td>
<td>121</td>
<td>18</td>
<td>47</td>
<td>12</td>
<td>1</td>
<td>199</td>
</tr>
<tr>
<td>Total</td>
<td>865</td>
<td>79</td>
<td>386</td>
<td>83</td>
<td>9</td>
<td>1422</td>
</tr>
</tbody>
</table>

When asked about race, 75% of Butte survey respondents answered White, 5% answered Black/African American, 1% answered Asian, 1% answered Native Hawaiian/Other Pacific Islander, 7% answered American Indian, 15% answered Other Multi-racial, 2% answered Unknown, and 2% answered Decline to State. When asked about ethnicity, 9% of Butte survey respondents answered Hispanic. These results are somewhat surprising when compared to the Butte County general population. According to U.S. Census data, Butte County is 89% White, 1.6% Black, 12% Hispanic, 4.2% Asian, 0.2% Pacific Islander, and 2.1% American Indian (U.S. Census Bureau).

The survey results indicate that the homeless population in Butte is disproportionally made up of people of color, which fits with other research findings about the “new homeless”. The American Indian homeless population is significantly larger than would be expected based on the general population census data. The data also reflects a
lower percentage of Hispanic and Asian respondents than expected. One reason that the Hispanic and Asian count is low is surely related to surveys not consistently being translated into Spanish or Hmong, languages spoken in many homes in Butte County. Additional reasons could include the fact that these groups may choose to share housing for cultural rather than strictly economic reasons and may not self-identify as homeless.

Homeless and at-risk of homeless Transitional Age Youth (TAY) and Foster Children: Below are direct excerpts from the 2010 Point in Time Homeless Census and Survey identifying homeless by age and foster care. (see Appendix J)

**Homelessness and Foster Care**

![Figure 9](image)

*Figure 9: Butte County Current or Former Youth*

Most studies that have looked at the relationship between foster care and homelessness have found that anywhere from 9-30% of the homeless population are former foster youth. 20% of Butte County homeless survey respondents reported that they had been foster youth.

The age distribution among survey respondents clearly shows that most of Butte’s homeless individuals are adults between the ages of 25-55. Of the children reported, the largest age group is the 5 and under category. 294 homeless individuals fall into the TAY age range.

**Older Adults**

One of the biggest barriers for older adults is isolation and lack of transportation. It is important that in-home services are offered for this population. In the ethnically diverse populations elders are a key part of the family system and the community. The Hmong community has gone through a revolutionary change of geography and culture in the last 40 years. Many of the Hmong elders are suffering from severe trauma and loss. The Native American and African American elders suffer from untreated generational trauma, have low levels of trust for the government and government services, and
Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

generally have a significant level of is stigma associated with accessing mental health services.

PEI Priority Populations

- The Hmong and Latino populations face many of the same barriers in accessing mental health services. These barriers include: (1) language barriers for community members with limited English proficiency; (2) lack of information and education about emotional wellness, mental health issues, and behavioral health services; (3) currently funded programs that do not provide the prevention/early intervention services most desired by these cultural populations; (4) linguistic specialty programs that are not adequately resourced to meet the needs of the populations; (5) stigma, shame, and discrimination associated with recognizing symptoms and seeking treatment; and (6) fear of the consequences of seeking help from the public mental health system.

- The Latino population has expressed their unique trauma in Gridley associated with (1) gang violence and (2) drug trafficking.

- The African American population spoke to their cultural disparities: (1) young adults who don’t know how to help their parents with mental illness; (2) being unable to access county mental health services because people were not “sick enough” (did not meet “medical necessity”); (3) young men who return from prison to no jobs, discrimination, and who decline into depression, lowering self-esteem, and giving up; (4) “healthy” African Americans don’t stay in the community to mentor youth; (5) a feeling of stress with no one to talk to who has been through the same thing as an African American; (6) feeling invisible in a world dominated by white people; (7) cultural trauma; and (8) African American youth with a very high rate of incarceration and involvement in violence.

- The GLBTQ cultural population attributes their disparities to (1) a lack of support from families or services, (2) violence or victimization, (3) depression, (4) substance abuse or dependency, (5) family rejection due to sexual orientation, (6) feel forced to leave home, (7) feeling of severe isolation, and (8) institutional (school system) reinforcement of GLBTQ lifestyle being unhealthy.
Butte County has proposed projects that reach a wide array of geographical, age, and cultural populations within our county. Projects include prevention and early intervention for very young children, youth, TAYs, adults, and older adults. Many of the projects will occur throughout the county. The African American, Latino, Hmong, and GLBTQ communities will receive specialized PEI services previously unavailable to them. Mental health services access will be expanded by the proposed projects, including services for people with mild to moderate mental health issues. All programs include elements to address suicide prevention and the reduction of stigma and discrimination. Most of the programs address multiple identified needs and priority populations. Each of the programs has a primary focus. Table 7 illustrates current identified strategies, objections, actions, and timelines.

### Table 7

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Strategies</strong></td>
<td></td>
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</tr>
<tr>
<td>African American Family and Cultural Center</td>
<td>200% of Poverty MHSA PEI</td>
<td>To provide a place for prevention and early intervention services that is located in the community and feels safe to the African American community. Health staff will be located in the Center to provide services such as suicide prevention and mental health awareness activities. The center will serve as a bridge in the community between the people and the providers, utilizing trained community members as liaisons. The goal is to enhance families, increase access, reduce mental health crises, and strengthen the skill and capacity of organizations and leaders to serve the African American community.</td>
<td>Develop RFP with African American community input.</td>
<td>Completed May 2010</td>
</tr>
<tr>
<td>Mission Statement: To empower and embrace African American Families and community by reclaiming, restoring, and revitalizing our cultural heritage, values and identity. The AAFCC is a place where people convene, connect and celebrate the essence of our community in order to bring about healing to create prosperous vibrant lives.</td>
<td></td>
<td></td>
<td>Have African American community representation on the RFP Review Team.</td>
<td>Completed June 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Award RFP to an agency that will take the lead of the AAFCC, with feedback and guidance from the African American CCAT, and hire staff from the community.</td>
<td>Completed September 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identify CCAT.</td>
<td>To be completed by end of November 2010</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hire Staff.</td>
<td>Has been involved in the</td>
</tr>
<tr>
<td>Strategy</td>
<td>Populations</td>
<td>Goal</td>
<td>Actions</td>
<td>Timelines</td>
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</tr>
<tr>
<td><strong>Connection Circles of Care (CCOC)</strong></td>
<td>CS&amp;S Medi-Cal 200% of Poverty</td>
<td>The goal of this program is to provide culturally and linguistically congruent wraparound services to youth and their families. To increase BCDBH collaboration with community based contract providers, and with unserved/underserved cultural populations in Butte County.</td>
<td>CCOC currently has: 2 Latino Teams 1 African American Team 2 Native American Teams 1 Hmong Team 2 Rural Mountain Teams</td>
<td>To continue to provide CCOC services. To analyze need for additional groups and implement when budget allows. There is a request to increase the number of Native American and African American Groups.</td>
</tr>
<tr>
<td><strong>SOUL ACADEMY</strong></td>
<td>Medi-Cal 200% of poverty MHSA/CS&amp;S MHSA PEI priority</td>
<td>To provide training to members of culturally diverse, impoverished, communities with the goal of providing skills that allow community members to become leaders and advocates in their local communities.</td>
<td>This is a collaborative process between BCDBH and S.H. Cowell Foundation. NCDI is delivering the services. Candidates for the program have applied and been chosen. The SOUL Academy is scheduled and will begin in November 2010.</td>
<td>The SOUL Academy will be completed at the end of six sessions. It is hoped that we may be able to have a 3 month, 6 month, and year follow up to check in with candidates and see what they have implemented.</td>
</tr>
</tbody>
</table>
### Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotores</td>
<td>Medi-Cal 200% of poverty MHSA PEI priority</td>
<td>A primary goal of the Latino and Hmong PEI Promotores strategy is to reduce disparities. It is designed to leverage resources by reaching individuals and families through current infrastructures that serve the Latino and Hmong communities.</td>
<td>Develop RFP with Latino &amp; Hmong community input. Have Latino and Hmong Community representation on the RFP Review Team. Award RFP to an agency that will understands and has relationships with both the Hmong and Latino communities and that will hire staff from the community. Identify Promotores BCDBH Liaison and have liaison embedded in development and implementation of the Program.</td>
<td>Completed</td>
</tr>
<tr>
<td>Support, Employment, Assistance, Recovery, Consumer Housing (SEARCH) Project</td>
<td>Medi-Cal 200% of poverty MHSA/CS&amp;S</td>
<td>This program provides FSP services to homeless individuals who suffer from mental illness. To increase outreach to the homeless Latino Community especially in South County.</td>
<td>Develop Contract with Stonewall Alliance of Chico.</td>
<td>Ongoing – Quarterly meetings with contract provider, Systems performance unit, and annual review</td>
</tr>
<tr>
<td>GLBTQ Suicide Prevention and</td>
<td>MHSA PEI priority</td>
<td>This program will decrease rejecting behaviors by parents of</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Program — SAYes</td>
<td>GLBTQ youth, increase staff knowledge about suicide, and increase understanding of how to prevent depression and suicide by providing suicide prevention services and mental health education for GLBTQ individuals and their families.</td>
<td>Implement services.</td>
<td>TAY support group running. Attendance at weekly Thursday night Farmer’s market to increase awareness of program. High school support running. Have provided staff training for BCDBH programs and MHSA programs. Beginning to implement parent’s groups. Planning to take part in Chalk Messages Campaign.</td>
<td></td>
</tr>
<tr>
<td><strong>Comprehensive Senior Companion Program</strong></td>
<td>Medi-Cal 200% of poverty MHSA/CS&amp;S</td>
<td>This program will provide intensive support for isolated seniors experiencing mental health issues providing in-home services, case management, counseling, nurse/psychiatric support, and senior companions. The goal of this program provide what it’s needed to prevent more intrusive intervention.</td>
<td>Program has been active since July 1, 2010. As this program was implemented and the needs of the older adult population became clearer it has been determined that the services being provided make this program and FSP program. We are in the process of converting this program to an FSP program.</td>
<td>Conversion to FSP program will be complete by January 2011. The Senior Companion Program is currently recruiting volunteers. A Hmong consultant has been hired as of October 1, 2010.</td>
</tr>
<tr>
<td>Older Adult Suicide Prevention and Education Program</td>
<td>MHSA PEI priority</td>
<td>The goal of this program is to expand the continuum of care provided to older adults by including suicide prevention</td>
<td>This program is providing services.</td>
<td>Butte County Seniors can contact the Senior Run ‘Friendship Line’.</td>
</tr>
</tbody>
</table>
### Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit for Hmong and Spanish Speaking Staff</td>
<td>Medi-Cal 200% of poverty MHSA/CS&amp;S MHSA PEI priority</td>
<td>Increase number of bilingual, bicultural staff.</td>
<td>Complete recruitment for Hmong and Spanish speaking staff.</td>
<td>Recruitment for Hmong and Spanish speaking clinicians closed on September 30, 2010.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BCDBH is in the process of filling several vacancies. At this time this includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 1 Spanish Speaking Clinician - 1 in hiring process for OOP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 1 Spanish Speaking Psychiatric Technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 1 African American Counselor in the Adult Employment Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 2 Hmong Clinicians- 1 hired for CAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The BCDBH Director is bilingual in Spanish.</td>
</tr>
<tr>
<td>CSU staff trained in GLBTQ issues</td>
<td>Medi-Cal 200% of poverty MHSA/CS&amp;S MHSA PEI priority</td>
<td>This goal was identified in the original CS&amp;S planning process. Now that the CSU and the GLBTQ suicide prevention and education programs are successfully up and running it is a good time to implement this goal.</td>
<td>Include this as a part of our Cultural Competency Academy.</td>
<td>Cultural Competency Academy will be developed in Spring/Summer 2011.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Implementation will begin in fall 2011.</td>
</tr>
</tbody>
</table>
**IV. Additional strategies/objectives/actions/timelines and lessons learned**

Table 8 illustrates new strategies, objectives, actions, and timelines.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Strategies</strong></td>
<td></td>
<td></td>
<td>Implement Approved MHSA Innovation Plan: A Community Based Treatment for Historical Trauma to Help Hmong Elders.</td>
<td>Spring/Summer 2010 - during plan development</td>
</tr>
<tr>
<td>New Strategies</td>
<td></td>
<td></td>
<td>Collaborate with Hmong Cultural Center of Butte County to insure success of Hmong Elder Program.</td>
<td></td>
</tr>
<tr>
<td>Trauma and depression treatment for elders, which is provided in the</td>
<td>Medi-Cal population</td>
<td>To decrease isolation of Hmong Elders.</td>
<td>Gather stakeholders to develop implementation timeline and plan.</td>
<td>November 2010</td>
</tr>
<tr>
<td>Hmong Cultural Center of Butte County and includes cultural Activities.</td>
<td>200% of poverty population</td>
<td>To increase community and generational connections.</td>
<td>Complete implementation timeline and plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To decrease impact of trauma in daily living.</td>
<td>Implement program according to implementation timeline and plan.</td>
<td>Begin completion of program implementation plan December 2010.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>When possible, through BCDBH or BCDBH contractors hire local staff from the community that is being served.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSA/CS&amp;S population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSA-PEI Populations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to increase the number of African American, Native American,</td>
<td>Medi-Cal population</td>
<td>To increase bicultural and bilingual capacity throughout BCDBH.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino, Hmong, GLBTQ, staff members. Including bilingual staff.</td>
<td>200% of poverty population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSA/CS&amp;S population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSA-PEI Populations</td>
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<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hire residents of Southside or those with historical interest/roots in Southside African American community to staff the AAFCC.</td>
<td></td>
<td></td>
<td></td>
<td>Fall 2010</td>
</tr>
<tr>
<td>Continue to increase the number and types of services available to African American, Native American, Latino, Hmong, GLBTQ, and Older Adults in community settings. Provide more culturally specific treatment and education modalities.</td>
<td>Medi-Cal population 200% of poverty population MHSA/CS&amp;S population MHSA-PEI Populations</td>
<td>Continue to increase the number and types of services available in community settings.</td>
<td>Implement new MHSA community based programs.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identify ways which current programs and services can increase their relationships unserved/underserved populations and collaborate with community groups.</td>
<td>Ongoing</td>
</tr>
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<td></td>
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<td></td>
<td>Brainstorm culturally relevant activities to “carry the message”. Make better use of “word of mouth”. Encourage people to share their experience of services with others.</td>
<td>Ongoing</td>
</tr>
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<td></td>
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<td></td>
<td>Include input from local community members in design and implementation of MHSA programs to ensure culturally specific and appropriate modalities are implemented.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To decrease transportation as a barrier to services.</td>
<td>Work with existing and planned programs to identify ways to decrease transportation barriers of Hmong consumers.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Strategy</td>
<td>Populations</td>
<td>Goal</td>
<td>Actions</td>
<td>Timelines</td>
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<tr>
<td>Outreach to other Asian communities (Laotian, Mien, Vietnamese)</td>
<td>Medi-Cal population</td>
<td>200% of poverty population</td>
<td>Work with Hmong Cultural Center of Butte County to find translators for Mien consumers.</td>
<td>Spring 2011</td>
</tr>
<tr>
<td></td>
<td>MHSA/CS&amp;S population</td>
<td></td>
<td>Set up meeting with Hmong Cultural Center and members of Gridley Community Counseling Center to identify ways to increase services to the Mien community.</td>
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<td></td>
<td>MHSA-PEI Populations</td>
<td></td>
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<tr>
<td>Increase services for unserved and underserved youth and families outside of CCOC.</td>
<td>Medi-Cal population</td>
<td>200% of poverty population</td>
<td>To increase numbers of unserved and underserved populations participating in BCDBH programs</td>
<td>Fall 2010 and ongoing</td>
</tr>
<tr>
<td></td>
<td>MHSA/CS&amp;S population</td>
<td></td>
<td>Work with Live Spot and other youth programs throughout the county to connect with youth populations in the African American, Hmong, Native American, Latino, and GLBTQ populations through collaboration with existing MHSA programs.</td>
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<tr>
<td></td>
<td>MHSA-PEI Populations</td>
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<tr>
<td>Identify ways to support Hmong parents through Special Education processes with their children.</td>
<td>Medi-Cal population</td>
<td>200% of poverty population</td>
<td>Work in collaboration with schools to identify a way to effectively serve Hmong children receiving special education services.</td>
<td>Fall 2010</td>
</tr>
<tr>
<td></td>
<td>MHSA/CS&amp;S population</td>
<td></td>
<td>Include representation from all unserved and underserved groups in the Innovation Youth Program: African American Native American GLBTQ Hmong Latino</td>
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<td></td>
<td>MHSA-PEI Populations</td>
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<td></td>
<td>Call meeting of stakeholders in special education with leaders of the Hmong cultural center and identify how to better serve Hmong families.</td>
<td>Winter 2010</td>
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<tr>
<td></td>
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<td></td>
<td>Continue to collaborate with Department of Employment and Social Services to identify and provide services for at risk youth and foster youth.</td>
<td>Ongoing</td>
</tr>
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<table>
<thead>
<tr>
<th>Strategy</th>
<th>Populations</th>
<th>Goal</th>
<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage messages to decrease stigma and denial of mental illness in older adults on societal level.</td>
<td>Medi-Cal population 200% of poverty population MHSA/CS&amp;S population MHSA-PEI Populations</td>
<td>Increase awareness of mental health issues in older adults.</td>
<td>Work with Passages MHSA programs to identify current older adult public awareness campaigns.</td>
<td>Fall 2010</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Work with FQHC’s and emergency departments to implement screening tools which identify alcohol and drug &amp; mental health issues in older adults</td>
<td>2011</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Advocate for inclusion of older adult messages in statewide MHSA mental health awareness campaigns.</td>
<td>Fall 2010</td>
</tr>
<tr>
<td>Include Mental Health in health screenings for older adults.</td>
<td>Medi-Cal population 200% of poverty population MHSA/CS&amp;S population MHSA-PEI Populations</td>
<td>Increase awareness of and diagnosis of mental health issues in older adults.</td>
<td>Work with Passages MHSA programs to identify current older adult public awareness campaigns.</td>
<td>Fall 2010</td>
</tr>
<tr>
<td>When implementing the AAFCC take care to intentionally utilize African American community members in all ways possible and to implement African American Specific modalities.</td>
<td>Medi-Cal population 200% of poverty population MHSA/CS&amp;S population MHSA-PEI Populations</td>
<td>Utilize our elders more, with knowledge and wisdom. Utilize community member’s life experience. Survey common folk in the community.</td>
<td>Follow the AAFCC mission statement while implementing the AAFCC.</td>
<td>Fall 2010 and ongoing</td>
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<td></td>
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<td>Provide resources for the African American Family &amp; Cultural Center, the AAFCC Community Advisory Team, and Youth for Change including National Community Development Institute and support available through CiMH.</td>
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<tr>
<td>Continue to implement strategies to increase trust and enhance positive working relationships with the</td>
<td>Medi-Cal population 200% of poverty</td>
<td>Increase trusting relationships with unserved and underserved communities.</td>
<td>Continue to provide liaisons to communities.</td>
<td>Fall 2010 and ongoing</td>
</tr>
<tr>
<td>Strategy</td>
<td>Populations</td>
<td>Goal</td>
<td>Actions</td>
<td>Timelines</td>
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<tr>
<td>Develop environments at BCDBH and contract providers that allow GLBTQ staff to feel safe in coming out at work.</td>
<td>African American, Hmong, Latino, GLBTQ, Native American, and older adult communities.</td>
<td>Continue to collaborate with communities members.</td>
<td>Be intentional and specific about collecting input from communities and providing feedback to the same communities.</td>
<td>Fall 2010 and ongoing</td>
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<td></td>
<td>Increase numbers of GLBTQ staff that are ‘out’ at work and can therefore provide expertise regarding the GLBTQ community to both staff and consumers.</td>
<td>Discuss with staff members how to increase safety level for GLBTQ staff members at work.</td>
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<td>Identify strategies to implement and monitor implementation progress.</td>
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<tr>
<td>Develop ways to communicate that BCDBH and BCDBH contract providers are safe zones for GLBTQ consumers and family members to ‘come out’ in order to fully partake in services.</td>
<td>Medi-Cal population</td>
<td>Increase safety level for GLBTQ consumers and family members.</td>
<td>Utilize Stonewall Alliance of Chico to provide training in GLBTQ community to BCDBH and BCDBH contract providers.</td>
<td>Fall 2010 and ongoing</td>
</tr>
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<td></td>
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<td></td>
<td>Have BCDBH programs and contract providers identify ways in which to develop ‘safe zones’.</td>
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<td>Identify ways in which BCDBH department leadership follows up on identified strategies to promote and assist with successful implementation of strategies.</td>
<td>Medi-Cal population</td>
<td>To have BCDBH department leadership actively engaged in monitoring of implementation of cultural competency strategies.</td>
<td>Have BCDBH cultural competency manager review cultural competency strategies with BCDBH Director on a minimum of a quarterly basis.</td>
<td>Fall 2010 and ongoing</td>
</tr>
<tr>
<td>Strategy</td>
<td>Populations</td>
<td>Goal</td>
<td>Actions</td>
<td>Timelines</td>
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<td>Provide training in unique issues related to psychiatric crisis and in</td>
<td>BCDBH and contract provider staff</td>
<td>Implement Cultural</td>
<td>Conduct Cultural Competency Assessment.</td>
<td>Winter/Spring 2010-2011</td>
</tr>
<tr>
<td>the African American Native American GLBTQ, Hmong, Latino, and older</td>
<td>Medi-Cal population</td>
<td>Competency Academy</td>
<td>Develop workgroup to design and implement cultural competency academy.</td>
<td>Spring/Summer 2011</td>
</tr>
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<td>adult communities.</td>
<td>200% of poverty population</td>
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<td></td>
<td>MHSA/CS&amp;S population</td>
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<tr>
<td></td>
<td>MHSA-PEI Populations</td>
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<td></td>
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<tr>
<td>Provide training and education to department staff about Native</td>
<td>BCDBH and contract provider staff</td>
<td>Implement Cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American, African American, Hmong, Latino, GLBTQ communities.</td>
<td>Medi-Cal population</td>
<td>Competency Academy</td>
<td></td>
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<td></td>
<td>200% of poverty population</td>
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<th>Actions</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training and education to tribal communities about MH, substance abuse, and co-occurring disorders, including outreach.</td>
<td>MHSA/CS&amp;S population&lt;br&gt; MHSA-PEI Populations</td>
<td>Provide training to local tribal communities.</td>
<td>Develop workgroup to identify methods of training and outreach regarding co-occurring disorders in the Native American Population. Identify action steps to take regarding training and outreach.</td>
<td>Spring 2011</td>
</tr>
<tr>
<td>Develop a regular language line training for Crisis Services staff that includes a feedback loop to the quality assurance committee, to ensure regular review about usefulness of the language lines.</td>
<td>BCDBH and contract provider staff&lt;br&gt; Medi-Cal population&lt;br&gt; 200% of poverty population&lt;br&gt; MHSA/CS&amp;S population&lt;br&gt; MHSA-PEI Populations</td>
<td>To increase effective use of language line by staff members in order to enhance services provided to non-English speaking consumers.</td>
<td>Review this issue at the Quality Assurance Committee and identify steps for implementation.</td>
<td>Spring 2011</td>
</tr>
</tbody>
</table>
V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

Lessons learned
- Implementation of all programs has been impacted by the continued pace of change and implementation of new programs brought about by MHSA. This funding stream has been incredibly valuable and yet has brought about fatigue at all levels from community input to program implementation. This fatigue has been exacerbated by the unprecedented fiscal crisis which added a new layer of change to a system in the midst of transformation.
- When working closely with unserved and underserved populations relationship and trust are the foundation for moving forward and being successful. The first step is to build the relationship and trust. This takes time and patience, and does not always look like typical behavioral health work; however, it is essential to have active community buy-in if programs are going to be successful. Pragmatically this means that implementation will be slower and it may look like nothing is happening for a long time. There is no way to hurry community development and buy in. It needs to be funded adequately and this part of the work needs to honored as essential.
- It is important to be clear about what can and cannot be done for the community. A key to success is providing a clearly identified decision making process, which includes where decision points lay and who has the authority to make final decisions. Never overpromise and always be truthful.
- In some instances someone from outside the community and outside of the government agency must lead or facilitate input processes. If there is a history of broken promises or ineffective relationships it is highly detrimental to success.
- Staff members cannot be defensive. It is vital to listen and honor the stories that are being told by community members. Staff members must realize this and have the ability to listen without defending past and/or current actions of the Department.
- It is essential to provide consultation to new contract providers. The county billing system is confusing at best; unclear communication and follow up can get in the way of providing services.
- Serving communities in this way is new for many county staff. They need to be trained as well.

Identify county technical assistance needs
- Training regarding the unique needs of our unserved and underserved populations in relationship to their views of mental illness and views of crisis situations.
- Training on efficient contract monitoring techniques.
- Training on how to make the workplace safe for GLBTQ staff members and staff members from other diverse cultures.
- Strategies for continuing to increase cultural competence amongst BCDBH and contract provider staff.
Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

- Training to help the entire Butte County Department of Behavioral Health workforce continue to build a welcoming, hopeful workplace, and service culture.

**Method for monitoring CCP strategies**

The annual Cultural Competence Plan will be reviewed by the Cultural Competency Advisory Team, the Leadership Team, and the Behavioral Health Board on a regular basis. The following chart illustrates the plan for monitoring implementation:

<table>
<thead>
<tr>
<th>Who Will Review and Comment</th>
<th>Frequency</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Competency Manager</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td>BCDBH Director</td>
<td>Quarterly</td>
<td>Cultural Competence Manger will meet with BCDBH Director and review plan</td>
</tr>
<tr>
<td>Cultural Competency Advisory Committee</td>
<td>Quarterly</td>
<td>Will review plan during meeting and make comments/recommendations regarding progress</td>
</tr>
<tr>
<td>BCDBH Leadership Team</td>
<td>Quarterly</td>
<td>Member of the Cultural Competency Committee will report results of their review with comments and recommendations to the BCDBH Leadership Team</td>
</tr>
<tr>
<td>BCDBH Behavioral Health Advisory Board</td>
<td>Quarterly</td>
<td>The BCDBH Behavioral Health Advisory Board will receive a quarterly update regarding the progress of the CCP.</td>
</tr>
</tbody>
</table>

**Evidence:**

3:I:A. Exhibit 3: Workforce Needs Assessment
I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

(see Evidence Binder)

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

Organizational Structure
The Cultural Competency Advisory Team is comprised of BCDBH’s target populations: Native American, GLBTQ, African American, Hmong, and Latino. CCAT includes various community members, cultural organizations, and BCDBH staff. The organizational structure currently consists of the main Cultural Competency Advisory Team. There are two subcommittees labeled Cultural Competence Plan Update Team and Cultural Competence Academy Development Team. The Plan Update Team has target groups to focus on specifics criterion in the Cultural Competence Plan Report.

Frequency of Meetings
At a minimum meeting take place quarterly. However, when working on large projects the committee has, and will, meet monthly. At this time the committee has agreed to meet monthly for six months and then reevaluate whether to continue the monthly meeting schedule or move back to the quarterly meeting schedule. Sub-committees meet between the full committee meetings.

Functions and Roles
The committee’s current goals are to assist in updating the Cultural Competence Plan based on the new state guidelines, guide the department as a mental health workforce Cultural Competence Assessment is completed, and actively participate in the development of a Cultural Competency Academy as described in the MHSA Workforce Education and Training Plan.

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

General practice for retaining culturally/linguistically members in the Cultural Competency Advisory Team is to maintain a membership that includes various cultural/linguistic backgrounds that reflect the makeup of the County, which includes a mix of community members, contract providers, and BCDBH staff members. The balance of the Cultural Competency Advisory Team is assessed on an ongoing basis and when needed new members are identified to fill gaps.
Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

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

(see Evidence Binder)

In 2009 and 2010, the BCDBH Cultural Competency Advisory Team reviewed its history and contribution to the Department; identified a committee structure and identified and three goals: a workforce cultural competency assessment; development of a cultural competency academy; participation in the input and review of the CCP. These goals are being successfully and actively worked on.

Workforce Assessment
The CCAT created a sub-committee to identify how to go about a cultural competency assessment of the Butte County behavioral health workforce. The CCAT was clear that participation from BCDBH and BCDBH contract providers was essential. Another key desire was to have input from all levels, consumers, volunteers, line staff, supervisor/manager, and administration. Additionally, a review of organizational cultural competency was desired. To the CCAT this meant a review of policies, procedures, forms and other documents, and evaluation of the organization structure.

The sub-committee reviewed several cultural competency assessment tools and field tested the California Brief Multicultural Competence Scale (CBMCS). Analysis of the field test revealed that individuals experienced the CBMCS as being hard to understand with language that was not "user friendly". Subsequently the sub-committee reviewed several different cultural competency assessment tools. The sub-committee engaged Robert Martinez to review the Greenbook Assessment. Robert Martinez identified the Greenbook as a tool that would meet the needs of BCDBH. The sub-committee presented its finding to the entire CCAT who recommended that BCDBH use the Greenbook Assessment. The CCAT further recommended that the questions be expanded to include questions about specific unserved/underserved groups. The goal of these additional questions is to be able to identify specific areas in which the workforce is doing well and areas that would benefit from training and education.

The Greenbook Project Cultural Competency Organizational Self Assessment Toolkit was adopted as the BCDBH cultural competency assessment tool. Gary Bess Associates and BCDBH Systems Performance Unit developed and field tested the additional questions. In July 2010 the first phase of the cultural competence assessment took place. This was a survey of BCDBH consumers. The Greenbook questions were combined with some recovery questions. The assessment was available in English, Spanish, and Hmong. The analysis of this first phase can be found in Appendix G.

The second phase of the process will begin in November and the entire Workforce Cultural Competence Assessment will be completed by March 2011.

Cultural Competency Academy
Development of the Cultural Competence Academy will begin after the cultural competency assessment is complete.
Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

CCAT Input and Review of the CCP
The CCAT has provided active input into the CCP by identify and evaluating current and existing strategies and recommending new strategies.

BCDBH held focus groups with the six identified cultural and unserved/underserved populations in order to gather input for the CCP. CCAT members participated in these focus groups. As a group the CCAT reviewed focus group input that was collected for the CCP and made recommendations for new strategies to address issues of disparity and cultural competence. Additionally, all members of the CCAT had the opportunity to review the draft Cultural Competence Plan and make recommendations before it was submitted.

Evidence:

4:I:B.
- Cultural Competency Planning Meeting 11/5/09 Notes
- Cultural Competency Advisory Team December 2, 2009 Discussion Summary

4:I:C. Cultural Competence Team Flowchart

4:I:D. Cultural Competence Advisory Committee

4:II:A:2.
- Quality Improvement Committee 2010-2011 Annual Goals
- Quality Improvement Committee Toll Free 800-Number Test Calls Conducted in English and Threshold Languages: Butte County Department of Behavioral Health July 15, 2010
- Quality Improvement Committee Minutes June 9, 2010-July 8, 2009

4:II:A:5
- Prevention and Early Intervention Community Workgroup Roster
- Prevention & Early Intervention (PEI) Plan Development Committee (PDC) Committee Members & Attendance
- Innovation Committee Roster
- BCDBH MHSA Education and Training Committee 2007 Roster – as of 8/6/07
- Internal Review Committee for MHSA Capital Facilities and Technological (CAP/IT) Plan October 12, 2008

- Plan Development Committee Members
- PEI Planning Workgroup Roster
- Butte County Behavioral Health Board Mental Health Services Act (MHSA) Advisory Committee November 12, 2008
- Butte County Behavioral Health Board Mental Health Services Act (MHSA) Advisory Committee February 12, 2009
- Butte County Behavioral Health Board Mental Health Services Act (MHSA) Advisory Committee April 9, 2009
- Butte County Behavioral Health Board Mental Health Services Act (MHSA) Advisory Committee September 9, 2009
Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

- Butte County Behavioral Health Board Mental Health Services Act (MHSA) Advisory Committee May 12, 2010
- RFP’s, Contracts & Implementation Teams To Be Developed June 2009
- Southside Oroville A Path to Positive Change January 13, 2010
- Agenda to Review African American Family and Cultural Center Draft RFP April 21, 2010
- African American Family and Cultural Center - Thursday, June 10, 2010

- Cultural Competency Advisory Team June 23, 2010
- Cultural Competency Advisory Team December 2, 2009 Discussion Summary

4:II:B.
- Quality Improvement Committee Membership
- Prevention and Early Intervention Community Workgroup Roster
- BCDBH MHSA Education and Training Committee 2007 Roster – as of 8/6/07
- Internal Review Committee for MHSA CAP/IT Plan
- PEI Plan Development Committee: Committee Members & Attendance
- Innovation Committee Roster
I. The county system shall require all staff and stakeholders to receive annual cultural competence training.

Action #8 of the BCDBH MHSA Workforce Education and Training Plan (see Appendix H, page 28-29) provides for the assessment and subsequent training of the Department’s workforce. The assessment is underway and is being driven by the CCOC program. Development and implementation of the Cultural Competence Academy will be informed by the analysis of the assessment. The Department’s Cultural Competency Manager, Cultural Competency Advisory Team, and MHSA WET Coordinator will collaborate in development of the Cultural Competency Academy.

The CCOC program provides extensive training in a variety of cultural competence topics. The CCOC program has tracked staff attendance at trainings and evaluated the impact of the training on an annual basis. Results can be found in the graphs on pages 56-59.

As appropriate, the MHSA fundamental concepts, which include cultural competence, are embedded into all training. For example, support staff is completing a year-long communication training program. During the planning process, the trainer reviewed the MHSA fundamental concepts, and incorporated relevant elements into the curriculum.

II. Annual cultural competence trainings

(see Evidence Binder)

During the past few years, cultural competence training has been housed within the county’s Connecting Circles of Care (CCOC) program. CCOC provides comprehensive, culturally appropriate wraparound services for the diverse populations in Butte County including Latino, Hmong, Native American, and African American families. The training is open to the entire Butte County mental health workforce. The trainings have been well attended and include the following topics:

- Mooretown Summer Youth Program training on culture and racism.
- Certified Hmong Training of Trainer Parenting Class - Southeast Asian Parenting Education
- Certified Latino Training of Trainer Parenting Class - Los Ninos Bien Educados Program
- Historic Trauma and Family Dynamics
- Cultural and Spiritual Approach to Healing
- Intergenerational Trauma in Native American and Hmong Communities
- The Horrors of Violence through the Souls of Native American Women
- Culturally Based Wraparound: Listening to Culturally Diverse Families
- Keeping the Circle Strong

A goal from BCDBH’s last Cultural Competence Plan was realized in the summer of 2010 when a three day Mental Health Interpreter Training and a one day Using Language Interpreters in Mental Health Services was provided. (see Appendix I)
III. Relevance and effectiveness of all cultural competence trainings

An evaluation of BCDBH’s CCOC program reflects an increase in staff confidence and ability in a variety of key cultural competence areas. Though this cannot be solely contributed to training, training was a key component. As the following graphs below depict cultural competency training has increased staff confidence in the following areas:

- Better understanding of the Needs of Families and Children within the identified population of the training.
- Ability to understand and evaluate how local services meet, or do not meet the needs of populations served.
- Increased understanding of the stigma consumer’s face in trying to access services. “I feel that services in our area meet the needs of the population.”
- Identified tools that can be incorporated into Treatment for youth and Families.
Criterion 5: Culturally Competent Training Activities

Attendees were asked to respond to the statement, “After attending the training today, I have a better understanding of the needs of families and children within this population” utilizing the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Neither Disagree, Nor Agree; 4 = Agree; and 5 = Strongly Agree

With a mean score of 4.50, it appears overall that attendees reported agree to strongly agree with the statement. Mean scores for each of the trainings were also in the agree to strongly agree range – Wraparound services (4.36), Native American culture (4.65), and Hmong culture (4.49). The distribution of attendees among each category (i.e., each ranking in the scale) is reported in Figure 7 for all trainings combined and disaggregated by the cultural competency trainings for wraparound services, Native American culture, and Hmong culture. Greater than 70 percent (72.1%) of attendees at the Native American training strongly agree with the statement, “After attending the training today, I have a better understanding of the needs of families and children within this population.”

Figure 7: Agreement with the Statement, “After Attending the Training Today, I Have a Better Understanding of the Needs of
Criterion 5: Culturally Competent Training Activities

Families and Children within this Population.”

Attendees were asked to respond to the statement, “After attending the training today, I feel that services in our area meet the needs of the population” utilizing the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Neither Disagree, Nor Agree; 4 = Agree; and 5 = Strongly Agree

With a mean score of 3.48, it appears overall that attendees reported a degree of uncertainty with the statement. Mean scores for each of the trainings also supported this degree of uncertainty – Wraparound services (3.53), Native American culture (3.67), and Hmong culture (3.29). The distribution of attendees among each category (i.e., each ranking in the scale) is reported in Figure 8 for all trainings combined and disaggregated by the cultural competency trainings for wraparound services, Native American culture, and Hmong culture. Approximately one-quarter (24.6%) of all attendees at the trainings disagree or strongly disagree with the statement, “After attending the training today, I feel that services in our area meet the needs of the population.”

Figure 8: Agreement with the Statement, “After Attending the Training Today, I Feel that Services in Our Area Meet the Needs of the Population.”
Attendees were asked to respond to the statement, “The training today increased my understanding of stigma faced by the population regarding receiving services” utilizing the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Neither Disagree, Nor Agree; 4 = Agree; and 5 = Strongly Agree

With a mean score of 4.38, it appears overall that attendees reported to agree to strongly agree with the statement. Mean scores for each of the trainings were also in the agree to strongly agree range – Wraparound services (4.29), Native American culture (4.49), and Hmong culture (4.35). The distribution of attendees among each category (i.e., each ranking in the scale) is reported in Figure 9 for all trainings combined and disaggregated by the cultural competency trainings for wraparound services, Native American culture, and Hmong culture. Slightly greater than 60 percent (60.5%) of attendees at the Native American training strongly agree with the statement, “The training today increased my understanding of stigma faced by the population regarding receiving services.”

Figure 9: Agreement with the Statement, “The Training Today Increased my Understanding of Stigma Faced by the Population
Attendees were asked to respond to the statement, “The training today provided me with tools that can be incorporated into treatment for youth and families” utilizing the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Neither Disagree, Nor Agree; 4 = Agree; and 5 = Strongly Agree

With a mean score of 4.41, it appears overall that attendees reported to agree to strongly agree with the statement. Mean scores for each of the trainings were at least in the agree range – Wraparound services (4.54), Native American culture (4.57), and Hmong culture (4.17). Additionally, variances in mean scores among were found to be statistically significant\(^5\) \((p<.005)\). The distribution of attendees among each category (i.e., each ranking in the scale) is reported in Figure 10 for all trainings combined and disaggregated by the cultural competency trainings for wraparound services, Native American culture, and Hmong culture. Slightly less than two-thirds (64.3%) of attendees at the Native American training strongly agree with the statement, “The training today provided me with tools that can be incorporated into treatment for youth and families.”
Criterion 5: Culturally Competent Training Activities

Figure 10: Agreement with the Statement, “The Training Today Provided me with Tools that can be Incorporated into Treatment for Youth and Families.”
Additionally, there is a two year increase in data showing the ability to understand culturally historical trauma and how that would impact a clinical relationship.

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

(see Evidence Binder)

BCDBH has demonstrated a strong support of the client culture through a variety of trainings. In 2009 and 2010 these have included the following:

The 2009/2010 California State University, Chico (CSUC) Book in Common was *The Soloist* by Steve Lopez. This book focuses on the life of Nathaniel Ayers and shows in detail his struggles with mental illness and the relationship he developed with Steve Lopez who became a friend and mentor in his journey of recovery. The Book in Common is a community event in Chico which includes several student and community wide events. The Cultural Competency Manager and the Housing Consultant were thoroughly involved in planning of a variety of events associated with *The Soloist*. They served on the committee which planned, designed, and implemented the student and community homeless issue town halls. These events were attended by 500 people and included a video presentation of behavioral health information and vignettes of local homeless mentally ill individuals speaking about their experiences in Butte County. A consumer and staff member from BCDBH SEARCH program were featured speakers at the event.

The CCM was a member of the overall Book in Common committee. As part of this committee BCDBH had the opportunity to help sponsor the presentation by author Steve Lopez. This community presentation was well covered in the local media. BCDBH’s sponsorship allowed 25 consumers to attend this event and hear Steve Lopez’s articulate and heartwarming discussion of Nathanial Ayers and of mental health recovery.

Prior to Steve Lopez’s presentation, BCDBH had Dr. Mark Ragins return to Butte County to work with our staff. Additional venues were identified for Dr. Ragins, billing him as the psychiatrist discussed in *The Soloist*. In collaboration with NAMI, a community forum was sponsored and attended by approximately 75 community members and featured on the front page of the local paper the following morning. Additionally there was a presentation to current Social Work and Psychology students at California State University, Chico a local National Public Radio (NPR) call in show featured Dr. Ragins and discussed mental health recovery (this show was so well received that an additional segment of the show featured a panel of BCDBH consumers), and our psychiatry staff were invited to have lunch with Dr. Ragins.

The BCDBH adult system of care has undergone a redesign of services which focuses on consumer culture. Dave Pilon provided training and technical assistance in how to implement the Milestones of Recovery (MORS) tool.
BCDBH has contracted with our local NAMI chapter to provide a variety of consumer culture trainings, support groups and events. Last year this included organizing the first Butte County NAMI Walk. The walk was an outstanding success. Long time members of Butte County NAMI were deeply touched at seeing the level and openness of community support and reveled in the celebratory feel of the event.

BCDBH is currently working with NAMI and the Butte County Behavioral Health Board in collaborating with other counties to have Northern California training of teams who will subsequently be able to implement NAMI’s Provider Training Series. The goal is to have the teams trained and training begun by the end of FY 10-11.

BCDBH is collaborating with the MHSA Superior WET Collaborative to bring Mary Ellen Copeland’s Certified Wellness Recovery Action Plan (WRAP) facilitator training to Butte County in October. The goal of providing this training is to develop a cadre of consumers who are able to lead WRAP groups and help consumers complete WRAP plans. The collaborative has plans to broaden WRAP resources in the region by offering a train the trainer workshop as soon as the first cohort of certified WRAP facilitators are eligible. It is hoped that placing this emphasis on WRAP plans will highlight their effectiveness and increase their use throughout BCDBH.

Evidence:
5:II:B. BCDBH Cultural Competence Training Fiscal Year 2009/2010
5:IV:B. BCDBH Client Cultural Training Fiscal Year 2009/2010
I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

The WET Plan identifies the following areas of growth in the workforce.

A major obstacle has been recruiting and retaining psychiatrists, family nurse practitioners, and nurses, as well as licensed Hmong, African American, Native American, and Latino staff. An issue that has been identified in focus groups subsequent to the completion of the MHSA WET Plan is the difficulty in identifying the number of GLBTQ staff members in some part due to the perception that it is not safe to “come out” at work.

There is a need to hire more Latino, Hmong, and African American staff. Our SAMHSA funded Connecting Circles of Care program has focused on underserved communities and has improved both the workforce race/ethnicity comparability and the penetration rates in serving these communities for our youth. A clinician in Chico and a psychiatric technician on the Psychiatric Health Facility (PHF), have expanded the Department’s ability to provide culturally and linguistically competent services to the Hmong community. Spanish speaking staff are available in Chico, Oroville, and through Crisis Services. Unfortunately, our existing staff still does not represent our service population, with Caucasian (White) staff at 80.2% compared to population percentage of 78.2%. The ethnic community least well represented is the Hispanic/Latino population where our Latino staff are only 6.8% yet Latino ethnicity is 13% of our service population. Severe budget shortfalls have made efforts to overcome these disparities more challenging.

One strategy that has increased the multicultural nature of the workforce is designating positions that require consumer/family member experience. A variety of BCDBH and contract provider programs have employed this method including: CCOC, Wellness Centers, SEARCH, LINK (Living, Insight, New Knowledge), MHSA INNOVATION programs, GLBTQ Suicide Prevention and Education Program, Promotores, African American Family and Cultural Center, A Community Based Treatment for Historical Trauma to Help Hmong Elders, The Warm Line, and Passages Older Adult programs. (see Appendix H, pages 10-16)
I. Increase bilingual workforce capacity

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

Action #14 (Internships) of the Butte County MHSA WET plan supports Butte County’s relationship with CSUC’s Social Work and Psychology programs. Behavioral Health continues to work closely with CSUC to recruit students into internship positions throughout the workforce. For the current academic year, 46 interns are placed in department and contractor service sites. Of those, nine are bilingual and/or bicultural. Stipend recipients for 2009/2010 school year included the following bicultural/bilingual individuals: 2 Latinas and 3 Hmong individuals. Stipend recipients for 2010/2011 include the following bicultural/bilingual individuals: 2 Latinas, 1 Nicaraguan, and 1 Hmong individual.

In addition, BCDBH has actively encouraged staff members to apply for the Mental Health Loan Assumption Program. In 2009, two BCDBH bilingual, bicultural Hmong staff members received awards. In 2010, two additional bilingual/bicultural BCDBH Hmong staff members received awards. Furthermore an African American staff member received a loan assumption award through the Licensed Mental Health Service Providers Education Program in March 2009.

Butte County recognizes the Department’s need for “bilingual language skills or specialized communication skills” to improve costumer experience and reduce cultural/linguistic disparities, therefore, implemented Personnel Rule 11.15 Bilingual Pay Differential. Bilingual pay differential is an incentive for bilingual staff to utilize their skills and for departments to discover untapped resources. This rule does require verification of language and communication skills as defined and administered by the Butte County Human Resources Department.

The implementation of the MHSA has given counties the opportunity and encouragement to increase linguistic capacity. Since implementation, a couple of strategies have been created to combat language barriers between staff and consumers, with the goal of building bilingual capacity. While dedicating bilingual positions is not new, MHSA embeds this idea into cultural competent programs. For example, the PEI Promotores project dedicates a full time Behavioral Health Counselor “to provide culturally and linguistically appropriate services including screening, assessment, and case management services” (PEI Plan, page 116).

MHSA Workforce Education and Training is another strategy utilized by BCDBH. The WET Plan dedicates a project to a cultural competence. The mission of this project is “to promote culturally and linguistically competent, recovery-oriented service delivery, the Department of Behavioral Health is committed to organizational assessment, provision of education and training, recruitment and retention of bilingual/bicultural direct service employees” (WET Plan, page 28). The intention is to increase our bilingual staff capacity, thereby, decreasing linguistic barriers. Additionally as seen in the following
Criterion 7: Language Capacity

graphs the training and supervision provided for the BCDBH CCOC program has resulted in staff with an increased level of competencies. There is a marked improvement in staff cultural and linguistic competency over a three year period in the following areas:

- Culturally appropriate policies and procedures.
- Front line culturally competent staff.
- Staff communication skills with other races, ethnicities, or cultures.
- Staff assessment of their ability to work with interpreters.
- Staff’s ability to elicit assessment history from diverse populations.
- Staff’s ability to collaborate with community other than their own.
- Ability to recognize and define their own biases and stereotyping.
- Ability to recognize occasional discomfort with other races and cultures, and not let it interfere with client interactions.
- Ability to negotiate and problem-solve with consumers of another race, etc.

BCDBH also uses contractor translators/interpreters for non-bilingual staff to utilize. The goal of this strategy is to increase the availability of translators/interpreters to staff and decrease language barriers for consumers, thereby, increasing our bilingual capacity.
Materials available for consumers are culturally appropriate. My agency’s policies are culturally competent for consumers.

My agency’s front line staff (e.g., receptionists) is culturally competent.

My communication skills with other races, ethnicities, or cultures are sufficient.

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*Ns for 2008 range from 10 to 15, Ns for 2009 range from 25 to 33, and Ns for 2010 range from 39 to 46.*
Criterion 7: Language Capacity

Connecting Circles of Care: Cultural and Linguistic Competency Report 2008, 2009, and 2010 Data

My ability to work with interpreters is sufficient.

I have the ability to collaborate with communities that are made-up of races, ethnicities, and cultures other than my own.

I have the ability to elicit a social/behavioral assessment history from diverse populations.

I have the ability to recognize and define my own biases and stereotyping.

Submitted to DMH 10/15/10
Criterion 7: Language Capacity

Connecting Circles of Care: Cultural and Linguistic Competency Report 2008, 2009, and 2010 Data

I have the ability to recognize occasional discomfort with members of other races, ethnicities and cultures, and to not let it interfere with my client interactions.

I have the ability to negotiate and problem-solve with consumers of another race, ethnicity, or culture.

I have the ability to elicit information in a family-centered context.
I have an understanding of culturally historical trauma and how that trauma may impact a clinical relationship.

CCOC is currently establishing a therapeutic foster care program to ensure culturally competent services are provided.

CCOC is currently addressing the needs of children, with a focus on reducing the number of out-of-home placements.

* Ns for 2009 range from 26 to 33 and Ns for 2010 range from 36 to 43.
CCOC is currently empowering parents to find the services they need and to have a voice in treatment and policy decisions.

**2009 Mean:** 4.30 (Agree to Strongly Agree)

**2010 Mean:** 3.95 (Agree)

CCOC is currently incorporating family involvement into the evaluation process.

**2009 Mean:** 4.09 (Agree)

**2010 Mean:** 4.19 (A Little More Than Agree)

CCOC is currently utilizing interagency collaboration in the evaluation process.

**2009 Mean:** 3.88 (Nearing Agree)

**2010 Mean:** 3.95 (Agree)
II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services

(see Evidence Binder)

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

Clients can call our toll-free, 24-hour Crisis Line at 1-800-334-6622 (Adult) or 1-800-371-4373 (Youth) to contact our Crisis Services or Access department. Crisis phone operators will connect individuals to the AT&T Language Line (1-800-974-9246) if there is a language barrier and bilingual staff are not available, as dictated in Policy and Procedure BCDBH – 089. Policy and Procedure – 92 provides instruction to assist hearing-impaired individuals. Citing to use the California Relay Service (1-800-735-2929) for TDD to Voice and/or (1-800-735-2922) for Voice to TDD.

Standardized procedures are used for contacting AT&T Language Line Services for interpretation when required for non-English speaking clients who are on the telephone or in the office. The AT&T language Line service is a quick, easy way to help Butte County Department of Behavioral Health provide quality service to our clients who speak limited or no English. The list in the evidence book explains the procedures to follow when the AT&T Language Line Service is needed.

New staff orientation includes review of all policies and procedures, which incorporate instructions on accessing the 24-hour Language Line or California Relay Service systems. Staff regularly using the 24-hour phone line are trained onsite by their supervisors.

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

BCDBH sites are provided a list of material in threshold languages to make available in their lobbies. The Mental Health Patients’ Rights poster specifically state “You have the right: To services and information in a language you can understand and that is sensitive to cultural diversity and special needs”. The Member Information brochure is another source of information stating under Member Rights “Receive services that are culturally competent and sensitive to language and cultural differences. Interpreter services are provided at no charge. A list of interpreters can be obtained at the reception desk.” The client will most likely make first contact with the front desk. If there is a language barrier issue, front desk staff are provided a Determining Language Preference list that they may hand to the individual who can then indicate what language they need assistance in. The literature required in lobbies are provided by the Cultural Competency Manager and must be available in English, Spanish, and Hmong. Provided in Guide to Medi-Cal Mental Health Services.
Criterion 7: Language Capacity

C. Evidence that the county/agency providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

BCDBH strives to accommodate person that may struggle with linguistic barriers through use of bilingual staff and/or interpreter services. When an individual first enters the system and their language has been identified, staff will schedule those individuals with bilingual staff for future meetings. Bilingual staff are self-identified or part of the bilingual pay differential program. If bilingual staff are unavailable, staff are trained to utilize the Translator List provided by the Cultural Competency Manager.

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

   a. The Quality Improvement Committee conducted test-calls to the 1-800-number in English, Spanish, and Hmong during fiscal year 09-10. The overall results were positive, English and Spanish clients were efficiency and effectively assisted. Spanish speaking staff or interpreters were obtained in a timely manner. There were three test calls in Hmong, two of which did face some issues from the AT&T Language Line. One call resulted in misidentification of the language until a fourth translator was contacted. The other call was disconnected while the Language Line was obtaining a translator. The third call connected with an interpreter without incident. The program manager reported the incidents to AT&T following contact. The challenge was with the AT&T Language Line.

   b. Ensuring availability of translated documents does pose a challenge due to the number of service sites, and a tendency to keep outdated material on file. BCDBH resolved this issue by providing all BCDBH offices a current list of required literature to be posted and access to electronic versions in threshold languages. Additionally, all outdated materials are being deleted from computers.

   c. The department continues to improve its cultural competent services, but economic conditions have stunted the ability to retain bilingual staff. Decreased budgets result in positions being eliminated, which meant bilingual staff being laid-off. Personnel Rules set forth by the county dictate lay-off procedures, therefore, BCDBH has no control over who is laid off. The general rule is that layoffs occur by seniority, thus layoffs can literally wipe out years of effort in pursuit of a culturally and linguistically diverse workforce.

E. Identify county technical assistance needs.

   • Alternatives to language lines
   • Language identification training
   • Standardized literature for state documents
   • Training on accessing Language Line
Criterion 7: Language Capacity

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

(see Evidence Binder)

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

BCDBH sites are provided a list of material in threshold languages to make available in their lobbies. The Mental Health Patients’ Rights poster specifically state “You have the right: To services and information in a language you can understand and that is sensitive to cultural diversity and special needs”. The Member Information brochure is another source of information stating under Member Rights “Receive services that are culturally competent and sensitive to language and cultural differences. Interpreter services are provided at no charge. A list of interpreters can be obtained at the reception desk.” The client will most likely make first contact with the front desk. If there is a language barrier issue, front desk staff are provided a Determining Language Preference list that they may hand to the individual who can then indicate what language they need assistance in. The literature required in lobbies are provided by the Cultural Competence Manager and must be available in English, Spanish, and Hmong.

Notice of availability on website: Interpreter services are available for non-English speaking clients, including clinicians and counselors fluent in Spanish, interpreters in non-threshold languages, ATT Language Line Services and TDD Services for the hearing impaired. Translator List available through website.

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

Once an individual becomes a client, the offer and acceptance of interpreter services is documented in their Progress Notes.

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

Refer to Evidence Binder.

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

New to this county, BCDBH offers The Mental Health Interpreter Training developed by the National Latino Behavioral Health Association (NLBHA), National Asian American Pacific Islander Mental Health Association (NAAPIMHA), California Department of Mental Health, and the Texas Department of State Health Services. The training directly deals with interpreters/ translators of mental health services. There is an intensive 21
Criterion 7: Language Capacity

hour course for proficiently fluent bilingual individuals and seven hour training for providers who use interpreter services.

The Translator/Interpreter Service Evaluation is used to monitor individuals on their skills and ability to cooperate with staff and consumers.

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

(see Evidence Binder)

A. Policies, procedures, and practices are 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 department extends its invitation for translators/interpreters to all bilingual individuals in the community. If needed, a separate recruitment is sent out to maintain demand for threshold languages. This practice permitted BCDBH to pool a variety of linguists. During the past fiscal year the Translator/Interpreter List listed eight languages.

A provider list with available non-English languages spoken gives staff the ability to refer clients to services that would match their cultural and linguistic needs.

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.

Behavioral Health uses various methods to secure or linked clients to culturally and linguistically appropriate services. At the base, recruitment for contract translators/interpreters is open to all languages. Currently, BCDBH offers five additional languages (Laotian, Mien, Punjabi, Hindi, and Urdu) aside from threshold or disability requirements. This list is available to all staff each fiscal year and is resent when updates occur. Staff follow the contracted translator/interpreter procedures to acquire these services.

We have staff who speak non-threshold languages fluently. Each site is aware of these individuals and utilizes them when necessary.

Initial phone contact with non-threshold language clients will prompt staff to utilize the AT&T Language Line Services policy and procedure, if there are no equally linguistic staff available to the client. Each site has a Determining Language Preference sheet that clients may use to mark which language they speak. It list Chinese, English, Hmong, Japanese, Korean, Laotian, Spanish, Thai, and Mien for choices. If the client
Criterion 7: Language Capacity

chooses a choice and it’s not an available language, the staff will follow AT&T Language Line procedures.

Many Medi-Cal providers we contract with provide services in multiple languages. Listed languages are Polish, Spanish, Tagalog, Russian, Hmong, ASL, Laotian, Thai, Mien, Italian, German, Japanese, and Vietnamese. A few providers have the available to receive services in any language if necessary. All of this information has been complied into a list provided to staff for referrals and provided in the Guide to Medi-Cal Mental Health Services given to clients.

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

Title VI of the Civil Rights Act of 1964 is incorporated in BCDBH Policy and Procedure 207: Protection of Beneficiary Rights and the Guide to Medi-Cal Mental Health Services. Both policies and procedures acknowledge compliance to Federal and State laws, specifically referencing Title VI of the Civil Rights Act of 1964. The guide notifies clients of their right to receive language services, availability of interpreter/translators, and that the service is free. General practice from staff deter client from utilizing minor children as interpreters, but that clients retain the right to use an interpreter of their choice.

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

(see Evidence Binder)

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

<table>
<thead>
<tr>
<th>Documents</th>
<th>Completed</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Member service handbook or brochure</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>2. General correspondence</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>3. Beneficiary problem, resolution, grievance, and fair hearing materials</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>4. Beneficiary satisfaction surveys</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>5. Informed Consent for Medication form</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>6. Confidentiality and Release of Information form</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>7. Service orientation for clients</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>8. Mental health education materials</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
<tr>
<td>9. Evidence of appropriately distributed and utilized translated materials</td>
<td>✗</td>
<td>Evidence Binder</td>
</tr>
</tbody>
</table>

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

The Department of Behavioral Health strives to provide linguistically comprehensive services. Clinical services utilize bilingual staff or receive translator/interpreter assistance to ensure clients are communicated clinical findings/reports in their preferred
Criterion 7: Language Capacity

language. This communication is documented in the client chart. The Client Plans and Annual Medication Treatment Plans, in English and Spanish, are completed with the client.

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

The most recent client satisfaction survey was administered in July of 2010. The test was available in English, Spanish, and Hmong. Analysis of this survey showed no significant differences based on race of respondents. Significant difference based on English Speakers and Non English speakers indicated that Non English speakers experienced a higher level of cultural competence that did English speakers. Though the analysis did not reach a level of significance when reviewing the age of respondents, the younger the respondent the higher they rated cultural competency. The full analysis of Butte County Department of Behavioral Health Cultural Competency Survey Report can be viewed in Appendix G.

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

When there is a request to translate a document we use a contracted translator. The document is sent to the translator and once translation is completed, it is returned to the requestor. The requestor forwards the translated document to a bilingual staff member for review. Feedback and corrections are deliberated and necessary changes made.

DBH contracts with Language World Services, a professional document translator, for massive documentation jobs. This organization has built in back translation procedures.

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

All forms are field tested for clarity and readability. This method measures the general public literacy level. Staff continually ensure public understanding through retesting and adapting per input.

Evidence:

7:II:A:1.
- BCDBH – 92: Americans with Disabilities Act Compliance
- P/P # BCDBH – 089: AT&T Language Line Services

7:II:B.
- Determining Language Preference (Chinese, English, Hmong, Japanese, Korean, Laotian, Spanish, Thai, Mien)
- Member Information brochure (English, Spanish, Hmong)
- Mental Health Patients’ Rights poster (English, Spanish, Hmong)
Criterion 7: Language Capacity

- Guide to Medi-Cal Mental Health Services (English, Spanish, Hmong)

7:II:C.
- Client Registration
- Avatar Print Screen
- Bilingual Staff

7:III:A.
- Determining Language (Chinese, English, Hmong, Japanese, Korean, Laotian, Spanish, Thai, Mien)
- Member Information brochure (English, Hmong, Spanish)
- Mental Health Patients’ Rights (English, Hmong, Spanish)
- Staff Receiving Bilingual Pay Differential

7:III:B.
- Client Registration
- Avatar Print Screen

7:III:C.
- Bilingual Staff
- Butte County Department of Behavioral Health FY 2009-2010 Translator/Interpreter List

7:III:D.
- Department of Human Resources Procedures: Bilingual Pay Differential
- Butte County – Personnel Department: Bilingual Examination
- The MHiT: Mental Health Interpreter Training
- Translator/Interpreter Service Evaluation

7:IV:B.
- P/P # BCDBH – 089: AT&T Language Line Services
- Determining Language Preference
- Butte County Department of Behavioral Health FY 2009-2010 Translator/Interpreter List
- Butte County Mental Health Services Contract Medi-Cal Providers

7:IV:C.
- BCDBH – 207: Protection of Beneficiary Rights
- Guide to Medi-Cal Mental Health Services

7:V:A:1.
- Service Directory (English, Hmong, Spanish)
- Member Information (English, Hmong, Spanish)

7:V:A:2
- Denial Response (Hmong and Spanish)
- Referral Letter (Hmong and Spanish)
- Client Information on Contract Limitations (Hmong and Spanish)

7:V:A:3
- Grievances, Appeals and Expedited Appeals Process (English and Spanish)
- Grievance, Appeal and Expedited Appeal Request (English, Hmong, Spanish)
- Patients’ Rights Orientation (English, Hmong, Spanish)

7:V:A:4
- Satisfaction Survey (English, Hmong, Spanish)
7:V:A:5
- Patient consent to Specified Medications (English, Hmong, Spanish)
- Informed Consent for Services (Hmong, Spanish)

7:V:A:6
- Temporary Authorization for Release of Records (Hmong)
- Consent for Release of Confidential Information (Spanish)
- Temporary Authorization for Release of Records (Spanish)
- Authorization of Use or Disclosure of Protected Health Information (PHI) – Hmong

7:V:A:7
- Service Directory (English, Hmong, Spanish)
- Member Information (English, Hmong, Spanish)

7:V:A:8
- Educational Materials in Hmong and Spanish

7:V:A:9
- Front Lobby Inventory
- Print Screen of Computer Folder

7:V:B.
- Avatar Screen Print
- Client Plan
- Client Plan – Spanish
- Youth Client Plan
- Medication Treatment Plan – Adult
- Medication Treatment Plan (Spanish)
- Annual Medication Treatment Plan – Youth

7:V:C. Satisfaction Survey (English, Spanish, Hmong)

7:V:D. Department of Behavioral Health – Cultural Competence Unit: Process for Reviewing Spanish Translated Material
I. Client driven/operated recovery and wellness programs

Client driven/operated recovery and wellness programs
BCDBH has many programs which are client and family driven/operated. These include many of the programs referred to in previous sections of this document. Client and family driven/operated programs include:

Connecting Circles of Care
The CCOC program is based on a family, cultural, and community driven philosophy. There is a governance board with members representing the community, cultural elders and leaders, parents, and youth. The families involved in CCOC are provided with regular points of input which drive the way the program as a whole provides services and drives the service array which their family participates in.

Wellness Centers
The original MHSA CS&S plan included one Wellness Center, since that time BCDBH has expanded to three Wellness Centers. The Iversen Center in Chico, The Hub in Paradise, and The Oroville Wellness and Recovery Center in Oroville. Each of these centers provides a variety of consumer driven groups and events and are in the process of implementing a computer labs and a variety of employment activities.

The Talk Lounge
The talk lounge is a warm line which is funded by BCDBH and operated by Stairways Recovery. This is a consumer run and operated warm line. The Talk Lounge provides sub-crisis support to a variety of community members. The phone operators went through extensive training and report a high level of satisfaction with their jobs. The Talk Lounge has began accepting calls in August 2010.

The African American Family and Cultural Center
As previously detailed in this document the development and implementation of the AAFCC has been guided by the African American Community in Southside Oroville at all points of development.

The Adult System of Care
The adult system of care has implemented the Milestones of Recovery as a way to highlight the philosophy of recovery and encourage consumer involvement in treatment.

The Sixth Street Center & Coleen’s House
The Sixth Street Center and Coleen’s House provide services to homeless or at risk of homelessness TAY individuals. This program hires youth who have been successful in the program as mentors. The center has a high level of consumer input and services are driven by a recovery model.
Criterion 8: Adaptation of Services

II. Responsiveness of mental health services

(see Evidence Binder)

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 CCP.

The Guide to Medi-Cal Mental Health Services provides a list of Medi-Cal providers contracted with BCDBH and what cultural/linguistic services they offer. The Member Information and Services Directory brochures notify clients of cultural and linguistic services that are available upon request.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

Policy and Procedure BCDBH 207 mandates BCDBH provide and inform Medi-Cal beneficiaries of available services, including the Guide to Medi-Cal Mental Health Services booklet. The booklet provides written information about available specialty mental health services.

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.

Assessment of disparity in accessing behavioral health services have been explored in the all of the MHSA planning processes, the planning and implementation of the SAMSHA CCOC grant, and the planning of SAHMSA CORE grant applications. As noted in other parts of this report BCDBH has made a concerted effort to provide community based services specifically designed for unserved and underserved populations. These programs are embedded in locations comfortable to diverse cultural populations. In the case of CCOC great efforts have been made to design offices that are welcoming to the cultural groups served. Efforts continue to increase the level of multicultural staff members.

Furthermore, BCDBH has implemented a project to create welcoming and inviting environments for persons of diverse cultural backgrounds. Two art projects have been implemented with the purpose integrating cultural art in offices, specifically lobbies. The Recovery Model Pilot Teams were utilized to develop creative and unique ways to make each of their offices welcoming for consumers and staff. The goal of these projects was to integrate and reflect consumer’s cultures within the Department.
III. Quality of Care: Contract Providers

BCDBH contracts with Contract Providers (primarily Organizational Providers) include stipulations of mandatory cultural competency requirements including primary language needs, written materials, documentation, and outreach efforts. Monitoring for quality of services, including specific issues of Cultural Competency, occurs primarily - though not exclusively - within the activity of clinical record Utilization Review (UR) referred to at BCDBH as Quality Management. As defined in the Departments Annual Quality Improvement Plan, a group of licensed Clinical Supervisors reviews a random selection of client charts once a month, including records from contract providers. Included in utilization review the team monitors and measures compliance and efforts to reach cultural competency including notations of primary language, use of interpreters, etc. In addition, routine QI activities includes the analysis of language and ethnic make-up of contract provider caseloads in order to evaluate community needs to meet identified Departmental goals.

IV. Quality Assurance

(see Evidence Binder and Appendix L)

BCDBH has a variety of mechanisms in place to implement and evaluate Cultural Competencies issues within the areas of Quality Assurance/Improvement (QI/QA). Primary to meeting this need is inclusion of the Chair of the Cultural Competency Committee as a standing member of the Quality Improvement Committee. The QIC meets monthly with a standing agenda that addresses issues of Quality Service including access, patient's rights, etc. This forum allows for issues of cultural competency to be fully identified, addressed, and/or corrected - whether related to specific identified improvement activities, or identified problem areas brought to light by the Cultural Competency Committee or the office of Patient's Rights through complaints/grievances. As noted previously, the QIC also analyzes issue of cultural competency needs through data analysis of client caseloads with regard to geographic location of language needs, outreach efforts, etc.

Quality Improvement Committee
The Quality Improvement Committee (QIC) is responsible for monitoring, assessing, and improving client care and service in the Butte County Specialty Mental Health Plan. The QIC recommends policy changes, reviews and evaluates the results of Quality Improvement (QI) activities, institutes needed QI actions, and ensures follow-up of QI processes. The licensed QI Coordinator is responsible for the clinical oversight of the QI process. The QIC meets monthly to monitor State Fair Hearings, Notice of Action (NOAs), Performance Improvement Projects, Beneficiary Grievances and Appeals, Cultural Competence Issues, Provider Information and Provider Grievances, Change of Provider Requests, Training, Timeliness of Consumer Access to services, and Crisis Line response.
Criterion 8: Adaptation of Services

QIC meeting minutes are kept in the QI folder on the DBH intranet and may be accessed electronically by all QI Committee members. Consumer confidentiality is protected at all times in the QIC minutes. The minutes reflect all QI deliberations, decisions, recommendations, and actions to insure that ongoing efforts are made to improve the quality of service provided by the department the QI Committee will establish yearly goals. The goals are selected by the QI Committee and may be directed toward improvement in any area of operation of the department.

The following Department of Behavioral Health Committees and sub-groups report to the Quality Improvement Committee:

- Wellness, Recovery, and Cultural Competence
- Quality Management Chart Review Committee
- Compliance Committee
- Authorization/Access
- Systems Performance
- Organizational Providers
- Patient’s Rights Advocacy
- Training
- BCDBH ACT Team

Evidence:

8:II:B.
- Member Information (English, Hmong, Spanish)
- Services Directory (English, Hmong, Spanish)
- Butte County Mental Health Services Contract Medi-Cal Providers

8:II:C.
- Guide to Medi-Cal Mental Health Services
- BCDBH – 207: Protection of Beneficiary Rights
- BCDBH – 164B: Beneficiary Problem Resolution Process

8:IV.
- Quality Improvement Program Annual Work Plan: July 1, 2010-June 30, 2011
- Quality Improvement Committee 2010-2011 Annual Goals
- Quality Improvement Committee Toll Free 800-Number Test Calls Conducted In English and Threshold Languages: Butte County Department of Behavioral Health July 15, 2010