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This Cultural Competence Plan is available separately and can be found in the Technical Resource Library at: www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html *(Section 4)*.

Progress Towards Reducing Disparities in Mental Health Services

San Diego County Behavioral Health Services

Fiscal Years: 2001-2002; 2006-2007; 2009-2010; and 2012-2013

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Version Date: 8/26/2014

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Executive Summary

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Executive Summary

The purpose of the Progress Towards Reducing Disparities report is to report progress towards the reduction of disparities across racial/ethnic groups and age groups. The report covers four time points spanning across 11 years (Fiscal Years 2001-02, 2006-07, 2009-10, and 2012-13) and notes disparities that exist in San Diego County for FY 2012-13.

The Mental Health Services Act (MHSA), which passed in 2004, allowed San Diego County to begin a large-scale implementation of programs in FY 2007-08. The influx of dollars made possible the creation of new services and, most importantly, the enhancement of current services and programs. This included the implementation of Full Service Partnership (FSP) services with a "whatever it takes" approach to address the clients' path to recovery. FSP programs provide comprehensive services offered by a team of mental health professionals. Services under FSP may also include the availability of short term housing for adult clients. Overall, the additional MHSA funding enhanced the level and quality of care for San Diego County's unserved and underserved populations.

This report assesses racial/ethnic and age group disparities in service utilization (penetration rates), engagement (retention rates), type of services used (e.g., Outpatient vs. Emergency), and diagnosis.

Utilization and other client data for this report were obtained from both the Anasazi and INSYST medical information systems (MIS). The INSYST MIS was replaced by the Anasazi MIS midway through FY 2008-09. Analyses of service utilization (penetration rates) required the calculation of a ratio consisting of behavioral health care system clients divided by the population eligible for services (target population) for a specific race/ethnicity or age segment. Eligible clients were defined as those individuals in San Diego County who were: Medi-Cal OR uninsured, AND under 200% of the Federal Poverty Level (FPL) that could potentially have a serious mental illness (SMI).

Children's System Findings (CYF BHS):

For children and youth, comparisons across fiscal years demonstrated that service utilization for Hispanic clients increased from FY 2001-02 to FY 2012-13. There was a decreasing trend in service utilization over the studied time periods, with decreases in service utilization from FY 2001-02 to FY 2012-13 for all racial/ethnic groups except for Hispanics. Hispanic clients showed increasing service utilization across all time points.

The disparities found for racial/ethnic groups for clients ages 0-17 were similar to those found in the A/OA system. Hispanic, Asian/Pacific Islander, and Native American children utilized services less frequently than would be expected based on their proportion in the target population. However, it should be noted that 62% of children and youth clients were Hispanic. Engagement for extended services (10+) was lowest for the Asian/Pacific Islander group.

When examining types of services used, it was found that while a majority of clients (98%) used Outpatient services, there were some racial/ethnic groups that utilized a disproportionate share of more restrictive levels of service. In FY 2009-10 and FY 2012-13, the Asian/Pacific Islander group used Inpatient services without receiving any Outpatient services more than any other group. African American clients used more Juvenile Forensic Services (JFS) without receiving any Outpatient services compared to other groups.

Furthermore, several disparities were found when examining racial/ethnic differences in diagnoses. Native American clients had the highest rates of Adjustment Disorders (30%). Depressive Disorders were most common for Asian/Pacific Islander, Hispanic, and White clients. Oppositional/Conduct Disorders

and Attention-Deficit/Hyperactivity Disorder (ADHD) were the most frequently diagnosed disorders among African American clients.

Service utilization decreased among clients ages 6-11, when comparing from FY 2001-02 to FY 2012-13. Service utilization slightly increased among clients ages 0-5 across the same 11-year time period. For the 12-17 age group, service utilization showed an increase from FY 2001-02 to FY 2012-13 (11.9% and 12.9%, respectively,) with rates peaking in FY 2006-07 at 13.3%. While there has been minimal change in the service utilization since 2001, it is important to note that these numbers do not reflect the addition of prevention and early intervention services and the enhancement of services through the Mental Health Services Act (MHSA). Additionally, the CYF system of care experienced a large influx of clients from 1997 through 2001 with the implementation of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and school-based services. Service utilization rates differed markedly by racial/ethnic and age groups. In addition, the type of service used varied notable by age group.

Adult System Findings (A/OA BHS):

For adults and older adults, the most notable pieces of evidence demonstrating progress towards reducing disparities were the steady increases in the total number of clients served from FY 2001-02 to FY 2012-13. There was an overall increase in service utilization for all non-White racial/ethnic groups from FY 2001-02 to FY 2012-13, with peak utilization rates observed in FY 2009-10. Also notable was the observed steady increase and stabilization in service utilization for those over the age of 60 across the four fiscal years examined in this report.

While service utilization generally increased for Hispanics, Asian/Pacific Islanders, and Native Americans, since FY 2001-02, the number of clients in these racial/ethnic groups who utilized services was less than would be expected based on their proportion in the target population.

The most marked finding with regard to engagement with services (retention rates) was that for all racial/ethnic categories there was a substantial increase in the proportion of clients who were retained in services for 10 visits or more from FY 2006-07 to FY 2012-13. In FY 2012-13, lower levels of engagement were most pronounced for African American and Hispanic clients, who had the highest proportions of clients with only 1 service visit.

Furthermore, disparities were observed when examining racial/ethnic differences in diagnoses. African American clients had the highest prevalence rates of Schizophrenia and Schizoaffective Disorders. Asian/Pacific Islander clients also had high rates of Schizophrenia and Schizoaffective Disorders closely followed by high rates of the Major Depression Disorders. Major Depression Disorders were the most common diagnosis for Hispanic clients. The highest prevalence rates of Bipolar Disorders were seen in White and Native American clients.

There were also some notable trends evident in the age group analysis. Service Utilization for all age groups increased from FY 2006-07 to FY 2009-10 and rates remained relatively stable from FY 2009-10 through FY 2012-13 for Older Adult (OA) clients, while dropping slightly for Transition Age Youth (TAY) clients during the same period. However, the TAY group utilized fewer services than would be expected given the number of potential TAY age clients in the target population. As for engagement in services, there was an increasing trend in retention rates across all age groups from FY 2009-10 to FY 2012-13 for 10 or more visits. Notably, OA clients had large increases in engagement from FY 2006-07 to FY 2012-13 for 10 or more service visits.

A goal of A/OA BHS has been to encourage appropriate usage of the services to help stabilize symptoms and progress towards recovery. Progress towards meeting this goal was observed in the TAY population and with clients ages 25-59. The proportion of TAY clients and clients ages 25-59 who used Out-

patient services increased from FY 2009-10 to FY 2012-13 while the proportion of TAY who utilized Inpatient/Emergency services decreased over the same time period.

Progress Towards Reducing Disparities

Efforts to decrease barriers to behavioral healthcare among racial/ethnic minorities and clients in different age groups have been a focus for the County of San Diego Behavioral Health Services (SDCBHS) for many years. This process is complicated by the fact that the demographic breakdown of those eligible for services in the SDCBHS differs markedly from the demographic make-up of the county as a whole. For example, although persons of Hispanic origin makeup 30% of the adults in the population of San Diego County, this segment accounts for 60% of the target (eligible client) population. Therefore, efforts to increase service utilization often need to focus on specific groups disproportionately to their presence in the overall county population.

The key findings from this study indicated that improvements have been made; however, significant disparities still persist. A comparison of the San Diego County target population to those who received behavioral health services (pages 10 through 12) demonstrated that disparities continued; most notably for Hispanic adults. Hispanics comprised 60% of the adult target population* but only 25% of the adult clients who received behavioral health services. While the numbers were

much better for children, with Hispanic children and youth representing 71% of the population and 62% of the clients who received behavioral health services, there is still room for improvement.

Although Hispanic, Asian/Pacific Islander, and Native American individuals were less likely to utilize services than expected given the number of potential clients, their service utilization rates have varied across the four time periods examined. The most noticeable increases in service utilization from FY 2001-02 to FY 2012-13 were seen for Hispanic and African American clients for all services.

* The target population was defined as those eligible for services. Eligible clients were defined as those individuals in San Diego County who were: Medi-Cal OR uninsured, AND under 200% of the Federal Poverty Level (FPL) who may potentially have a SMI.

Key Findings by Age

Children and Youth

Ages 0-5:

- Had the lowest service utilization rates among age groups given the rarity of diagnosable mental health problems in this age category. However, service utilization rates increased slightly over time as a result of the implementation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Mental Health Services Act-funded Prevention and Early Intervention (PEI) programs.
- Had the lowest retention rates among age groups, indicating they were more likely to receive only one visit. In addition to treatment programs, there are also assessment only programs for this age group, which may explain why many youth ages 0-5 have only one visit.

Ages 6-11:

- Penetration rates dropped from 8.1% in FY 2001-02 to a low of 6.3% in FY 2009-10, and increased to 7.1% in FY 2012-13.
- Were more likely to use Outpatient services than clients ages 12 and older, and about the same as clients ages 0-5.
- Were less likely to receive more than 10 services in FY 2012-13, which is consistent with the SDCBHS' shift to a short-term treatment model.

Ages 12-17:

- Had the highest service utilization rates among other children's age groups across all four time points, indicating they were more likely to utilize services.
- Use of Outpatient services increased and use of JFS only services decreased from FY 2006-07 to FY 2012-13.

Adults and Older Adults

Ages 18-24 (Transitional Age Youth):

- Had the lowest Outpatient service utilization rates among adult and older adult age groups. However, their service utilization to services increased from FY 2006-07 to FY 2012-13 as specific services for TAY clients were put into place.
- Had the lowest long term engagement rates among adult and older adult age groups, with 54% having had 10 or fewer visits.
- Were more likely to use Inpatient/Emergency services (27%) or only Jail services (20%) and were less likely to use Outpatient services than the other A/OA BHS age groups.
- Use of only Jail services decreased from 26.5% in FY 2006-07 to 20.4% in FY 2012-13.

Ages 25-59:

- Had higher penetration and retention rates than both TAY and older adult clients.
- Had lower usage of Inpatient/Emergency services than TAY or OA clients.
- Were less likely to use Inpatient/Emergency services (16%) and only Jail services (17%) and more likely to use Outpatient services (68%) than TAY.

Ages 60 and older (Older Adults):

- Had lower service utilization/penetration rates compared to clients ages 25-59. However, rates markedly increased in FY 2009-10 and were maintained through FY 2012-13.
- Higher retention rates were observed in OA clients with 10 or more visits from FY 2006-07 to FY 2012-13.
- Were the most likely age group to utilize Outpatient services, and least likely to utilize only Jail services than either of the other adult age groups.

Key Findings by Race/Ethnicity

Children and Youth

Hispanics:

- 62% of children and youth clients were Hispanic.
- Penetration rates increased from 2.8% in FY 2001-02 to 5.8% in FY 2012-13.
- Retention rates for 10 or more sessions (56.1%) were the second lowest of all the racial/ethnic groups, just higher than Asian/Pacific Islander clients (55.4%).

African Americans:

- Penetration rates decreased from 12.4% in FY 2001-02 to 9.3% in FY 2012-13.
- Had the largest proportions of clients diagnosed with Oppositional/Conduct Disorders or ADHD of all racial/ethnic groups.
- Were the highest users of JFS of all the racial/ethnic groups.

Asian/Pacific Islanders:

- Had among the lowest penetration rates compared to the other racial/ethnic groups (except for Native American), and the penetration rates decreased from 4.6% to 3.1% from FY 2001-02 to FY 2012-13.
- Were the most likely to have had 1 visit only (12.6%) compared to the other racial/ethnic groups.
- Were more likely to have had Inpatient/ESU only services compared to other racial/ethnic groups.

Native Americans:

- Penetration rates for Native American children and youth are the lowest among all the racial/ethnic groups and rates and decreased from 4.0% to 1.8% from FY 2001-2 to FY 2012-13.
- Retention rates were the highest among all the racial/ethnic groups for 10 or more sessions (61.5%).

Adults and Older Adults

Hispanics:

- Penetration rates went up slightly over the study time period. However, Hispanic adults and older adults were proportionally less likely to utilize services based on their presence in the target population.
- Retention rates for 10 or more visits went up from 45.4% to 54.4% since FY 2006-07 among the Hispanic clients.

African Americans:

- Penetration rates for Outpatient services and All Services (Excluding Jail) increased across all 4 fiscal years.
- Retention rates among the African American clients increased from 45.9% to 53.8% since FY 2006-07; however, they were the most likely to have had only one visit (9.9%).
- Were more likely to have had only Jail services (24%) than the other racial/ethnic groups.
- Had the highest rate of being diagnosed with Schizophrenia or Schizoaffective Disorder (38.0%).

Asian/Pacific Islanders:

- Retention rates for 10 or more visits increased greatly from 39.1% in FY 2006-07 to 55.6% in FY 2012-13.
- Were the least likely to use only Jail services than other racial/ethnic groups and the tendency continued to decrease from FY 2006-07 to FY 2012-13.
- A large majority (73%) of Asian/Pacific Islander clients were diagnosed with either Schizophrenia and Schizoaffective Disorders (37%) or Major Depression Disorders (36%).
- Were more likely to be insured than all of the other racial/ethnic groups.

Native Americans:

- There was a net increase in penetration rates for Native American clients over the 4 time points. However, Native American clients had the lowest penetration rates among racial/ethnic groups, indicating they were less likely to utilize services.
- Retention rates for Native American clients for 10 or more visits increased from 48.7% to 56.5% from FY 2006-07 to FY 2012-13.

Data Summary

General Population, Target Population, and BHS Client Populations for San Diego County

Children, Youth, and Families Behavioral Health Services Distribution Rates

Adult and Older Adult Behavioral Health Services Distribution Rates

Factsheets by Race/Ethnicity

General Population, Target Population, and BHS Client Populations for San Diego County

RACE/ETHNICITY	Estimates of San Diego County Population (age 0-17)*	Target Population Children and Youth**	Actual Clients CYF BHS (FY 2012-13)
White (non Hispanic)	35%	13%	23%
Hispanic	49%	71%	62%
African American	6%	9%	12%
Asian/Pacific Islander	10%	6%	3%
Native American	<1%	2%	1%

RACE/ETHNICITY	Estimates of San Diego County Population (age 18+)*	Target Population A/OA**	Actual Clients A/OA BHS (FY 2012-13)
White (non Hispanic)	53%	22%	53%
Hispanic	30%	60%	25%
African American	5%	8%	15%
Asian/Pacific Islander	12%	9%	6%
Native American	<1%	2%	1%

*Source: 2011-2012 California Heath Interview Survey data.

**Estimates of target population (eligible clients) were derived from California Health Interview Survey (CHIS) estimates applied against 2013 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% FPL that could potentially have a SMI.

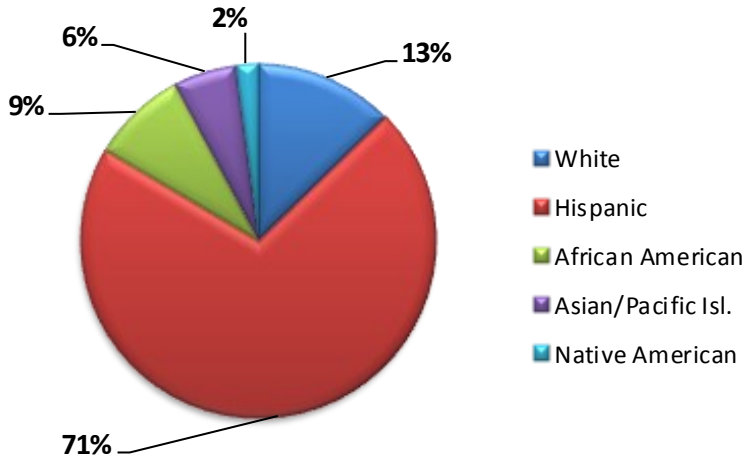
NOTE: Percentages may not add up to 100% due to rounding.

Children, Youth and Families Behavioral Health Services Distribution Rates

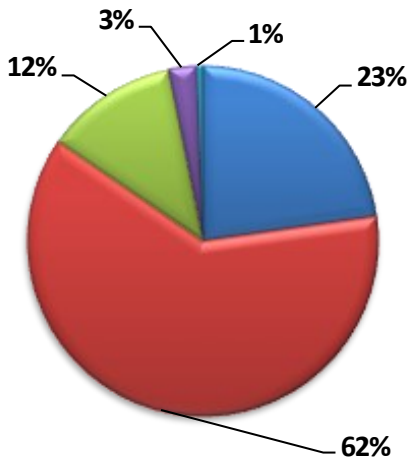
Target Population (Eligible Clients*) versus CYF BHS Clients FY 2012-13

	FY 2012-13			
	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2013		CYF BHS Clients	
Race/Ethnicity**	Number	%	Number	%
White	31,855	13%	3,805	23%
Hispanic	177,589	71%	10,346	62%
African American	22,007	9%	2,044	12%
Asian/Pacific Isl.	14,179	6%	437	3%
Native American	5,109	2%	91	1%
Total Clients	250,739	100%	16,723	100%

Eligible Clients: Estimates of San Diego County Uninsured or Medi-Cal under 200% FP for 2013



Actual Clients: CYF BHS Clients FY 2012-13



* Estimates of target population (eligible clients) were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% FPL that could potentially have a SMI.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.

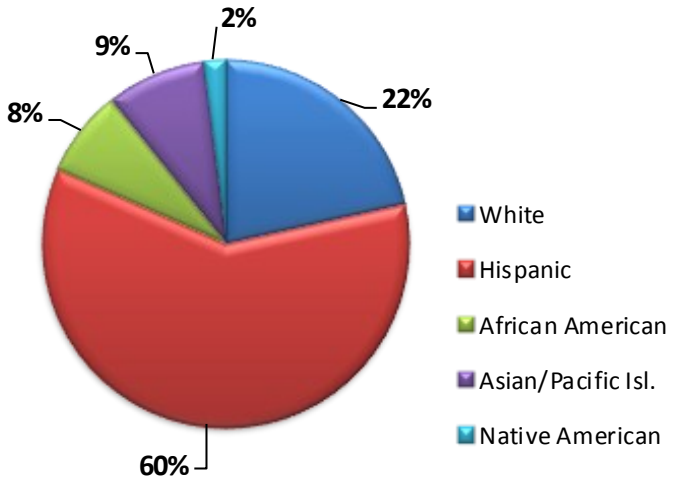
NOTE: Percentages may not add up to 100% due to rounding.

Adult and Older Adult Behavioral Health Services Distribution Rates

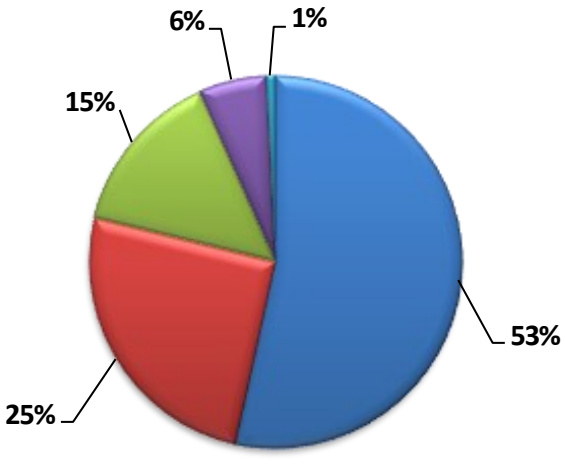
Target Population (Eligible Clients*) versus A/OA BHS Clients FY 2012-13

	FY 2012-13			
	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2013		A/OA BHS Clients	
Race/Ethnicity**	Number	%	Number	%
White	75,783	22%	19,619	53%
Hispanic	211,751	60%	9,294	25%
African American	26,911	8%	5,348	15%
Asian/Pacific Isl.	30,668	9%	2,147	6%
Native American	6,954	2%	276	1%
Total Clients	352,068	100%	36,684	100%

Eligible Clients: Estimates of San Diego County Uninsured or Medi-Cal under 200% FPL for 2013



Actual Clients: A/OA BHS Clients FY 2012-13



* Estimates of target population (eligible clients) were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% FPL that could potentially have a SMI.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories are reported (36,684). An additional 4,440 (11%) were of 'other' or 'unknown' race/ethnicity.

NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: White Children and Youth

Total Clients Served:

3,805 White children and youth clients were served by CYF BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, over half of the White children and youth clients (52%) were 12-17; however, the proportion of this age group has decreased since FY 2009-10. The proportion of White males has decreased since FY 2009-10.

Preferred Language:

The vast majority of White children and youth clients (99%) reported English as their preferred language.

Top 3 Diagnoses:

1. Depressive Disorders (19%)
2. Adjustment Disorders (18%)
3. Attention-Deficit/Hyperactivity Disorder (ADHD; 17%)

Service Utilization (Penetration Rates):

FY 2001-02:	28.2%
FY 2006-07:	15.6%
FY 2009-10:	13.7%
FY 2012-13:	11.9%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	26.4%
	10+ visits	63.1%
FY 2009-10:	<6 visits	26.3%
	10+ visits	61.5%
FY 2012-13:	<6 visits	29.2%
	10+ visits	58.4%

Type of Service Used in FY 2012-13:

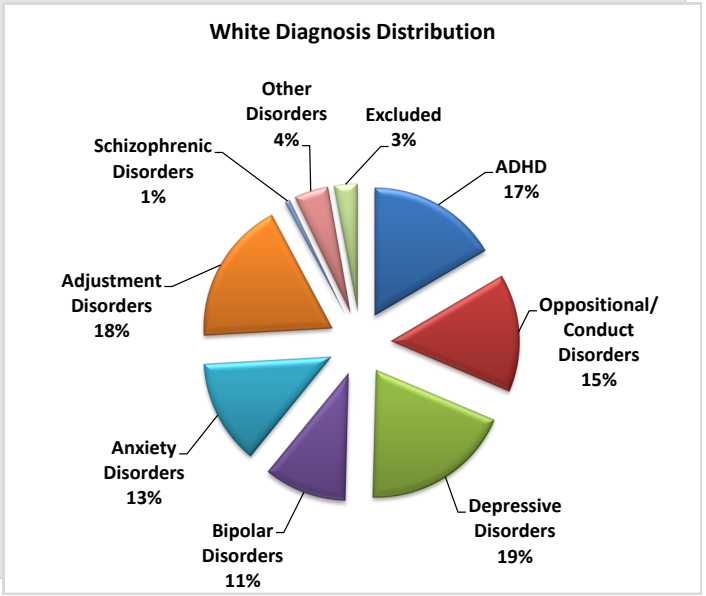
White children and youth predominantly used Outpatient services (98%).

Insurance Status in FY 2012-13:

6% of White children and youth were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
0-5	10%	9%	10%
6-11	29%	30%	32%
12-17	57%	57%	52%
18+	5%	5%	5%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	39%	38%	43%
Males	60%	62%	57%
Other/Unknown	<1%	<1%	<1%



NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: White Adults and Older Adults

Total Clients Served:

19,619 White adult and older adult clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

The proportion of older adult clients (ages 60+) served in A/OA BHS has been gradually increasing from 9% in FY 2006-07 to 14% in FY 2012-13. There is an increasing trend in the proportion of White males served since FY 2006-07.

Preferred Language:

The vast majority of White clients (97%) reported English as their preferred language.

Top 3 Diagnoses:

1. Major Depression Disorders (27%)
2. Schizophrenia and Schizoaffective Disorders (26%)
3. Bipolar Disorders (19%)

Service Utilization (Penetration Rates):

FY 2001-02:	33.7%
FY 2006-07:	28.2%
FY 2009-10:	30.2%
FY 2012-13:	25.9%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	33.0%
	10+ visits	47.2%
FY 2009-10:	<6 visits	33.1%
	10+ visits	47.7%
FY 2012-13:	<6 visits	26.9%
	10+ visits	56.4%

Type of Service Used in FY 2012-13:

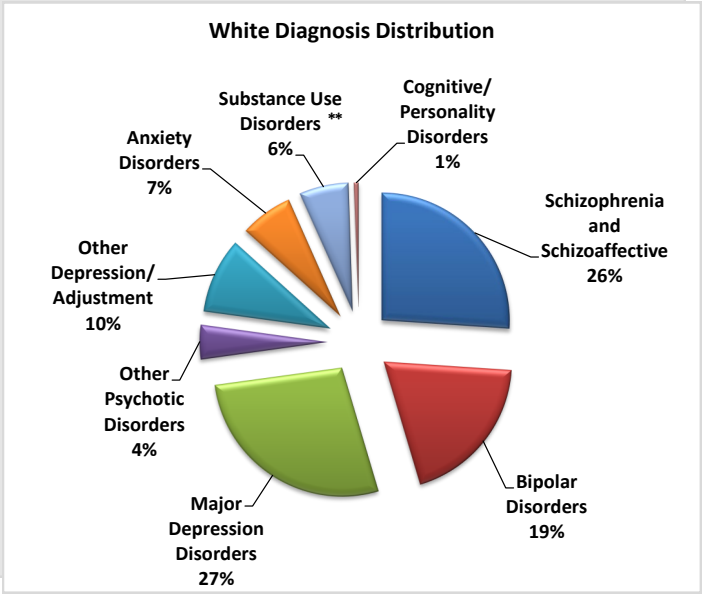
White clients used a higher proportion of Inpatient/Emergency services (21%) than any other racial/ethnic group.

Insurance Status in FY 2012-13:

45% of White clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18-24*	12%	13%	12%
25-59	79%	75%	74%
60+	9%	12%	14%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	48%	47%	45%
Males	51%	53%	55%
Other/Unknown	1%	<1%	<1%



* A small number of clients treated in A/OA BHS were under the age of 18.

** Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.

NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: Hispanic Children and Youth

Total Clients Served:

10,346 Hispanic children and youth clients were served by CYF BHS in FY 2012-13 (62% of the CYF BHS client population).

Age and Gender:

In FY 2012-13, half of the Hispanic children and youth clients (50%) served by CYF BHS were between the ages of 12 and 17 and 60% were male.

Preferred Language:

The majority of Hispanic children and youth clients (69%) reported English as their preferred language and 30% reported Spanish as their preferred language.

Top 3 Diagnoses:

1. Depressive Disorders (23%)
2. Adjustment Disorders (20%)
3. Oppositional/Conduct Disorders (19%)

Service Utilization (Penetration Rates):

FY 2001-02:	2.8%
FY 2006-07:	5.1%
FY 2009-10:	5.3%
FY 2012-13:	5.8%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	29.0%
	10+ visits	59.2%
FY 2009-10:	<6 visits	29.8%
	10+ visits	57.8%
FY 2012-13:	<6 visits	30.1%
	10+ visits	56.1%

Type of Service Used in FY 2012-13:

The majority of services utilized by Hispanic children and youth clients were Outpatient services (98%).

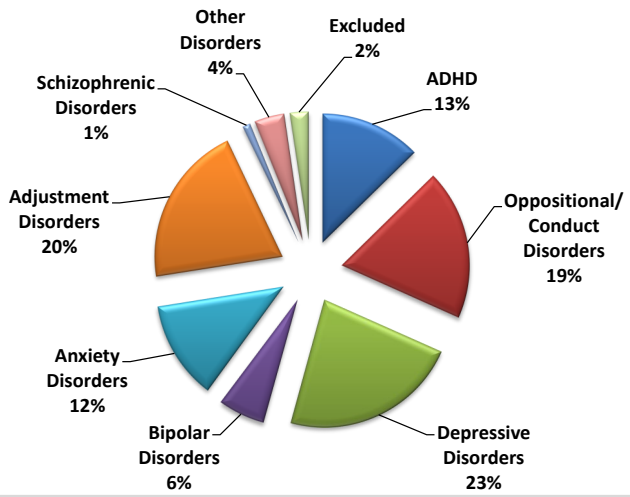
Insurance Status in FY 2012-13:

5% of Hispanic children and youth clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
0-5	10%	11%	11%
6-11	30%	30%	34%
12-17	57%	55%	50%
18+	4%	4%	5%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	38%	38%	40%
Males	61%	62%	60%
Other/Unknown	1%	<1%	<1%

Hispanic Diagnosis Distribution



Hispanic Ethnicity Categories	N	%
Mexican American/Chicano	8,466	82%
Other Hispanic/Latino	1,731	17%
Puerto Rican	76	1%
Dominican	35	<1%
Cuban	18	<1%
Salvadoran	20	<1%
TOTAL	**10,346**	**100%**

NOTE: Percentages may not add up to 100% due to rounding.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Factsheet: Hispanic Adults and Older Adults

Total Clients Served:

9,294 Hispanic adult and older adult clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, 69% of Hispanic clients were between the ages of 25 and 59. There has been an increasing trend in the proportion of Hispanic males served since FY 2006-07.

Preferred Language:

The majority of Hispanic clients (70%) reported English as their preferred language and 28% reported Spanish as their preferred language.

Top 3 Diagnoses:

1. Major Depression Disorders (31%)
2. Schizophrenia and Schizoaffective Disorders (27%)
3. Other Depression/Adjustment Disorders (12%); and Bipolar Disorders (12%)

Service Utilization (Penetration Rates):

FY 2001-02:	3.5%
FY 2006-07:	4.2%
FY 2009-10:	4.3%
FY 2012-13:	4.4%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	34.0%
	10+ visits	47.7%
FY 2009-10:	<6 visits	35.5%
	10+ visits	46.5%
FY 2012-13:	<6 visits	31.3%
	10+ visits	54.4%

Type of Service Used in FY 2012-13:

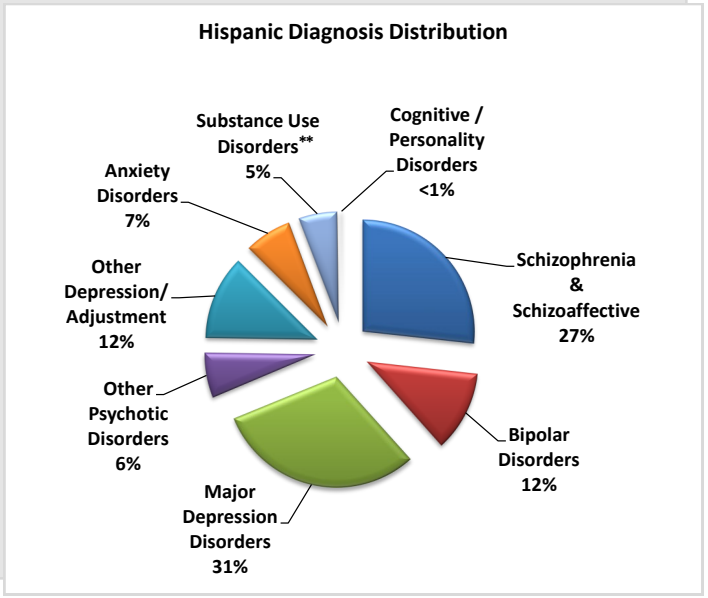
The majority of services utilized by Hispanic clients were Outpatient services (66%).

Insurance Status in FY 2012-13:

39% of Hispanic clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18-24*	19%	22%	24%
25-59	75%	71%	69%
60+	7%	6%	7%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	52%	50%	44%
Males	47%	50%	55%
Other/Unknown	1%	<1%	<1%



Hispanic Ethnicity Categories	N	%
Mexican American/Chicano	7,281	78%
Other Hispanic Latino	1,585	17%
Puerto Rican	223	2%
Cuban	97	1%
Dominican	69	1%
Salvadoran	39	<1%
Total	**9,294**	**100%**

* A small number of clients treated in A/OA BHS were under the age of 18.
** Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.
NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: African American Children and Youth

Total Clients Served:

2,044 African American children and youth clients were served by CYF BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, the majority of the African American children and youth clients (53%) were between the ages of 12 and 17, and the proportion of clients ages 18 and over increased from FY 2006-07. Nearly two thirds of the clients were male (62%).

Preferred Language:

2,036 out of 2,044 African American children and youth clients (nearly 100%) reported English as their preferred language.

Top 3 Diagnoses:

1. Attention-Deficit/Hyperactivity Disorder (ADHD; 20%)
2. Oppositional/Conduct Disorders (20%)
3. Depressive Disorders (16%); and Adjustment Disorders (16%)

Service Utilization (Penetration Rates):

FY 2001-02:	12.4%
FY 2006-07:	12.4%
FY 2009-10:	10.9%
FY 2012-13:	9.3%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	28.2%
	10+ visits	60.6%
FY 2009-10:	<6 visits	26.0%
	10+ visits	61.8%
FY 2012-13:	<6 visits	28.5%
	10+ visits	59.9%

Type of Service Used in FY 2012-13:

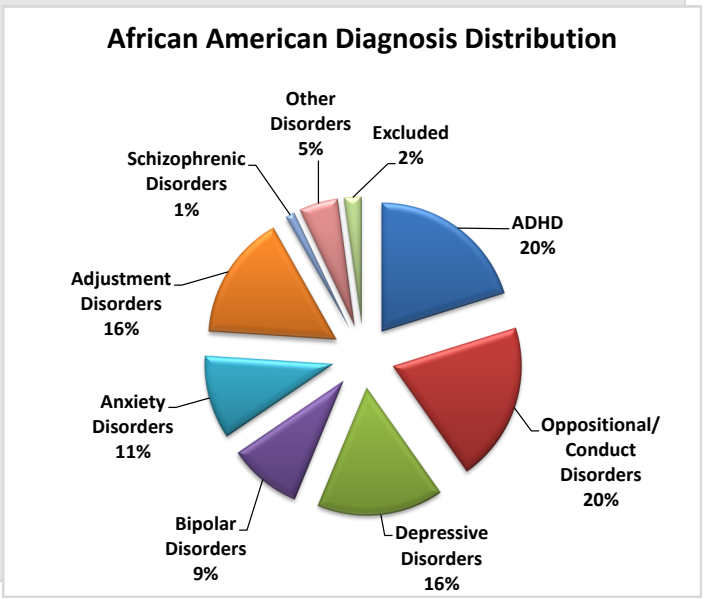
African American children and youth clients predominantly used Outpatient services (97%) and were the largest racial/ethnic group to utilize JFS Only services (2.2%).

Insurance Status in FY 2012-13:

4% of African American children and youth clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
0-5	9%	9%	9%
6-11	29%	28%	29%
12-17	58%	57%	53%
18+	5%	6%	8%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	38%	38%	38%
Males	61%	61%	62%
Other/Unknown	1%	<1%	<1%



NOTE: Percentages may not add up to 100% due to rounding.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Factsheet: African American Adults and Older Adults

Total Clients Served:

5,348 African American adult and older adult clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, the largest majority (75%) of African American clients were between the ages of 25 and 59 and were male (61%).

Preferred Language:

Most African American clients (98%) served by A/OA BHS reported English as their preferred language.

Top 3 Diagnoses:

1. Schizophrenia and Schizoaffective Disorders (38%)
2. Major Depression Disorders (22%)
3. Bipolar Disorders (11%); and Other Depression/ Adjustment Disorders (11%)

Service Utilization (Penetration Rates):

FY 2001-02:	17.9%
FY 2006-07:	19.0%
FY 2009-10:	20.5%
FY 2012-13:	19.9%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	34.4%
	10+ visits	45.9%
FY 2009-10:	<6 visits	33.3%
	10+ visits	47.6%
FY 2012-13:	<6 visits	31.4%
	10+ visits	53.8%

Type of Service Used in FY 2012-13:

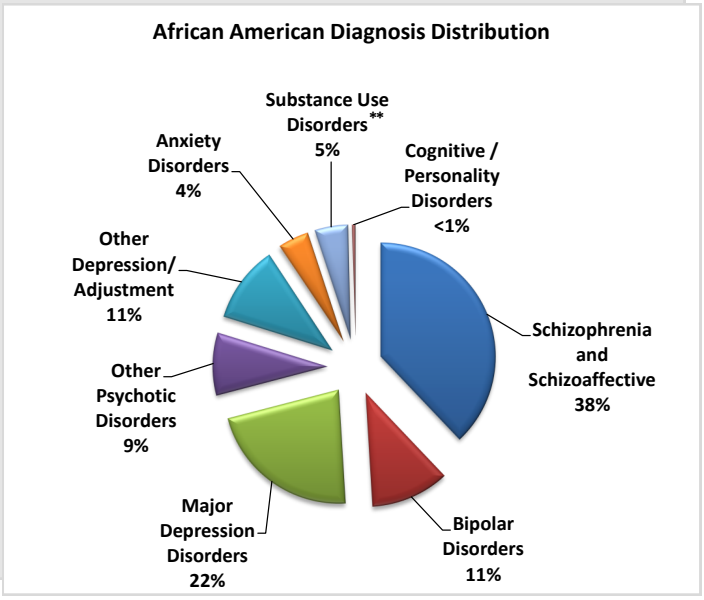
African American A/OA clients had the highest proportion of Jail Only services (24%), 6% higher than the second highest group that used Jail Only services (Hispanic, 17%).

Insurance Status in FY 2012-13:

38% of African American clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18-24*	13%	17%	17%
25-59	82%	76%	75%
60+	5%	7%	8%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	47%	43%	38%
Males	53%	56%	61%
Other/Unknown	<1%	<1%	<1%



* A small number of clients treated in A/OA BHS were under the age of 18.

** Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.

NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: Asian/Pacific Islander Children and Youth

Total Clients Served:

437 Asian/Pacific Islander children and youth clients were served by CYF BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, over half of the Asian/Pacific Islander CYF clients (53%) were between the ages of 12 and 17, but the proportion of that age group has decreased since FY 2006-07. The proportion of clients ages 6-11 has increased over three fiscal years. Nearly two thirds of the clients were male (61%).

Preferred Language:

85% of Asian/Pacific Islander children and youth clients reported English as their preferred language, 4% preferred Vietnamese and 4% preferred Tagalog.

Top 3 Diagnoses:

1. Depressive Disorder (25%)
2. Adjustment Disorders (19%)
3. Anxiety Disorders (14%)

Service Utilization (Penetration Rates):

FY 2001-02:	4.6%
FY 2006-07:	3.2%
FY 2009-10:	3.4%
FY 2012-13:	3.1%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	33.8%
	10+ visits	54.1%
FY 2009-10:	<6 visits	28.7%
	10+ visits	56.8%
FY 2012-13:	<6 visits	33.6%
	10+ visits	55.4%

Type of Service Used in FY 2012-13:

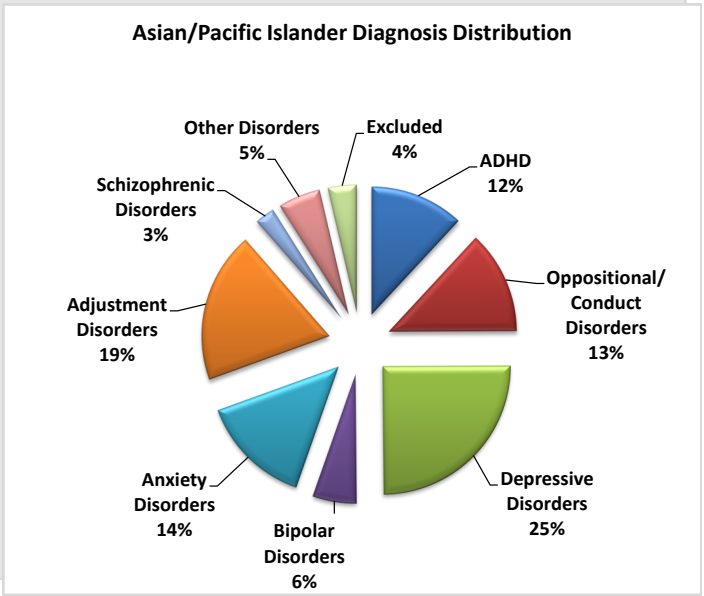
Asian/Pacific Islander children and youth clients predominantly used Outpatient services (94%). They also used Inpatient/ESU Only services the most out of all other racial/ethnic groups (5%).

Insurance Status in FY 2012-13:

7% of Asian/Pacific Islander children and youth clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
0-5	11%	8%	8%
6-11	25%	28%	32%
12-17	59%	59%	53%
18+	5%	5%	6%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	39%	38%	39%
Males	60%	62%	61%
Other/Unknown	1%	<1%	<1%



CYF BHS Asian Subcategories					
Description	N	%	Description	N	%
Filipino	140	32%	Samoan	19	4%
Vietnamese	76	17%	Korean	14	3%
Other Asian	35	8%	Guamanian	13	3%
Cambodian	33	8%	Asian Indian	12	3%
Laotian	23	5%	Hawaiian Native	7	2%
Other Pacific Islander	23	5%	Hmong	2	<1%
Japanese	21	5%	**Total**	**437**	**100%**
Chinese	19	4%			

NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: Asian/Pacific Islander Adults and Older Adults

Total Clients Served:

2,147 Asian/Pacific Islander adult and older adult clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, a large majority (73%) of Asian/Pacific Islander clients were between the ages of 25 and 59 and more than half were female (56%).

Preferred Language:

54% of Asian/Pacific Islander clients reported English as their preferred language with 19% preferring Vietnamese and 15% preferring 'Other Asian' languages.

Top 3 Diagnoses:

1. Schizophrenia and Schizoaffective Disorders (37%)
2. Major Depression Disorders (36%)
3. Bipolar Disorders (8%)

Service Utilization (Penetration Rates):

FY 2001-02:	6.1%
FY 2006-07:	7.9%
FY 2009-10:	8.3%
FY 2012-13:	7.0%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	33.6%
	10+ visits	39.1%
FY 2009-10:	<6 visits	37.5%
	10+ visits	37.0%
FY 2012-13:	<6 visits	24.4%
	10+ visits	55.6%

Type of Service Used in FY 2012-13:

Asian/Pacific Islander A/OA clients had the lowest proportions of Jail Only services (7%) and Inpatient/Emergency services (14%), and the highest proportion of Outpatient services (79%) than any other racial/ethnic group.

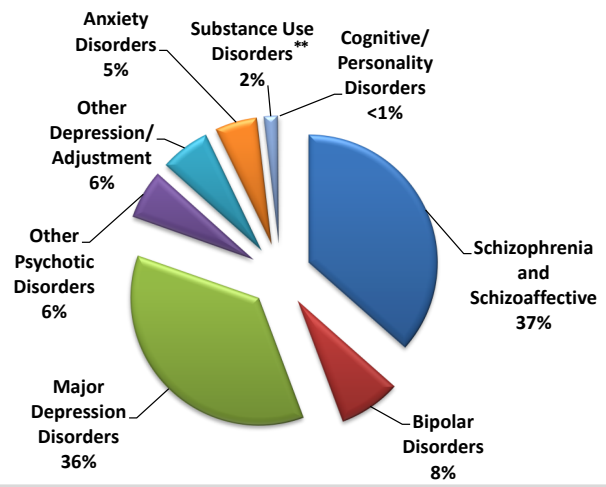
Insurance Status in FY 2012-13:

31% of Asian/Pacific Islander clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18-24*	10%	11%	10%
25-59	75%	73%	73%
60+	15%	15%	17%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	54%	54%	56%
Males	46%	45%	44%
Other/Unknown	1%	<1%	<1%

Asian/Pacific Islander Diagnosis Distribution



A/OA BHS Asian/Pacific Islander Subcategories					
Description	N	%	Description	N	%
Filipino	638	30%	Other Pac.Isl.	56	3%
Vietnamese	557	26%	Asian Indian	43	2%
Other Asian	178	8%	Hawaiian Native	40	2%
Cambodian	177	8%	Samoan	31	1%
Chinese	118	5%	Guamanian	29	1%
Laotian	95	4%	Hmong	3	<1%
Korean	92	4%	**Total**	**2,147**	**100%**
Japanese	90	4%			

* A small number of clients treated in A/OA BHS were under the age of 18.
** Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.
NOTE: Percentages may not add to 100% due to rounding.

Factsheet: Native American Children and Youth

Total Clients Served:

91 Native American children and youth clients were served by CYF BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, slightly less than half (47%) of the Native American children and youth clients were ages 12-17, and 51% were female.

Preferred Language:

98% of Native American children and youth clients reported English as their preferred language.

Top 3 Diagnoses:

1. Adjustment Disorders (30%)
2. Oppositional/Conduct Disorders (15%)
3. Depressive Disorders (15%)

Service Utilization (Penetration Rates):

FY 2001-02:	4.0%
FY 2006-07:	2.4%
FY 2009-10:	2.5%
FY 2012-13:	1.8%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	28.7%
	10+ visits	59.4%
FY 2009-10:	<6 visits	26.2%
	10+ visits	61.5%
FY 2012-13:	<6 visits	28.6%
	10+ visits	61.5%

Type of Service Used in FY 2012-13:

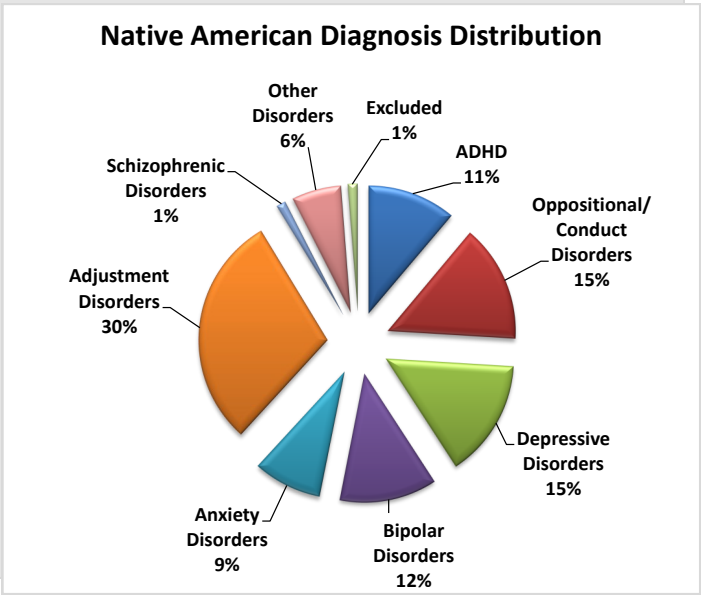
Native American children and youth clients predominantly used Outpatient services (99%). Only 1% of Native American clients used Inpatient/Emergency services and no Native American children or youth clients used Jail Only services (0%).

Insurance Status in FY 2012-13:

4% of Native American children and youth clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
0-5	7%	6%	11%
6-11	32%	34%	36%
12-17	54%	52%	47%
18+	6%	8%	5%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	44%	42%	51%
Males	56%	58%	49%
Other/Unknown	<1%	0%	0%



NOTE: Percentages may not add up to 100% due to rounding.

Factsheet: Native American Adults and Older Adults

Total Clients Served:

276 Native American adult and older adult clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

In FY 2012-13, a large majority (76%) of Native American clients were ages 25-59 and more than half were female (53%). The proportion of clients ages 60 and over has increased since FY 2006-07, while the proportion of clients ages 25-59 has decreased.

Preferred Language:

97% of Native American clients reported English as their preferred language.

Top 3 Diagnoses:

1. Schizophrenia and Schizoaffective Disorders (32%)
2. Major Depression Disorders (26%)
3. Bipolar Disorders (18%)

Service Utilization (Penetration Rates):

FY 2001-02:	3.6%
FY 2006-07:	3.5%
FY 2009-10:	4.7%
FY 2012-13:	4.0%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	34.2%
	10+ visits	48.7%
FY 2009-10:	<6 visits	33.8%
	10+ visits	45.9%
FY 2012-13:	<6 visits	23.0%
	10+ visits	56.5%

Type of Service Used in FY 2012-13:

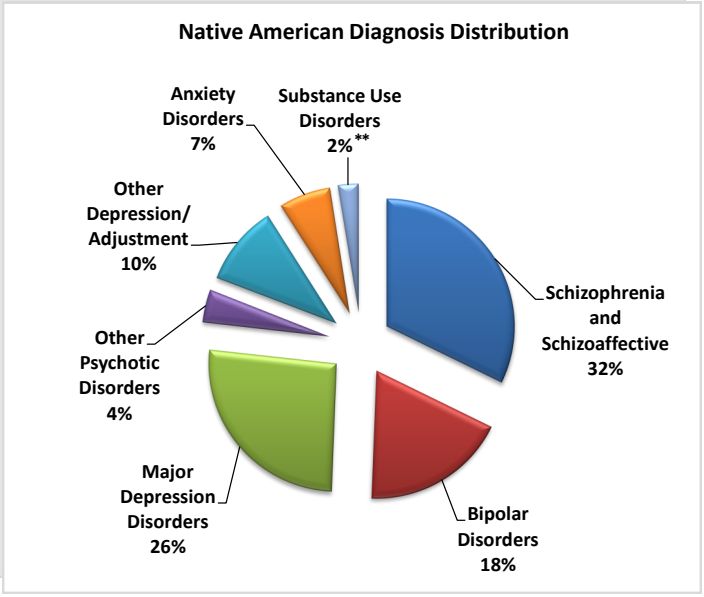
Native American A/OA clients utilized mostly Outpatient services (73%), and were the second least likely racial/ethnic group to utilize JFS Only services (11.2%).

Insurance Status in FY 2012-13:

38% of Native American clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18-24*	13%	14%	14%
25-59	83%	79%	76%
60+	4%	7%	9%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	56%	52%	53%
Males	44%	48%	47%
Other/Unknown	<1%	0%	0%



* A small number of clients treated in A/OA BHS were under the age of 18.

** Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.

NOTE: Percentages may not add to 100% due to rounding.

Service Utilization and Engagement

Disparities in Service Utilization: Analysis of Penetration Rates

Penetration Rates:
by Age
by Race/Ethnicity

Disparities in Engagement: Analysis of Retention Rates

Retention Rates:
by Age
by Race/Ethnicity

Disparities in Service utilization:

Analysis of Penetration Rates

Disparities in service utilization were identified by comparing the target population to the number who received San Diego County Behavioral Health Services (penetration rate). An algorithm—based on the 2007-2013 California Health Interview Survey (CHIS) estimates of the proportional representation of the population who were uninsured or Medi-Cal/Medi-Care, and were under 200% of the federal poverty level that could potentially have a serious mental illness—was used to estimate the eligible population for each ethnicity and age category. This resulted in a constant for each category that was applied against the population estimate from the most recent census data to derive the estimates for the eligible target population.

Penetration Rates:
Children and Youth—Penetration Rates by Age

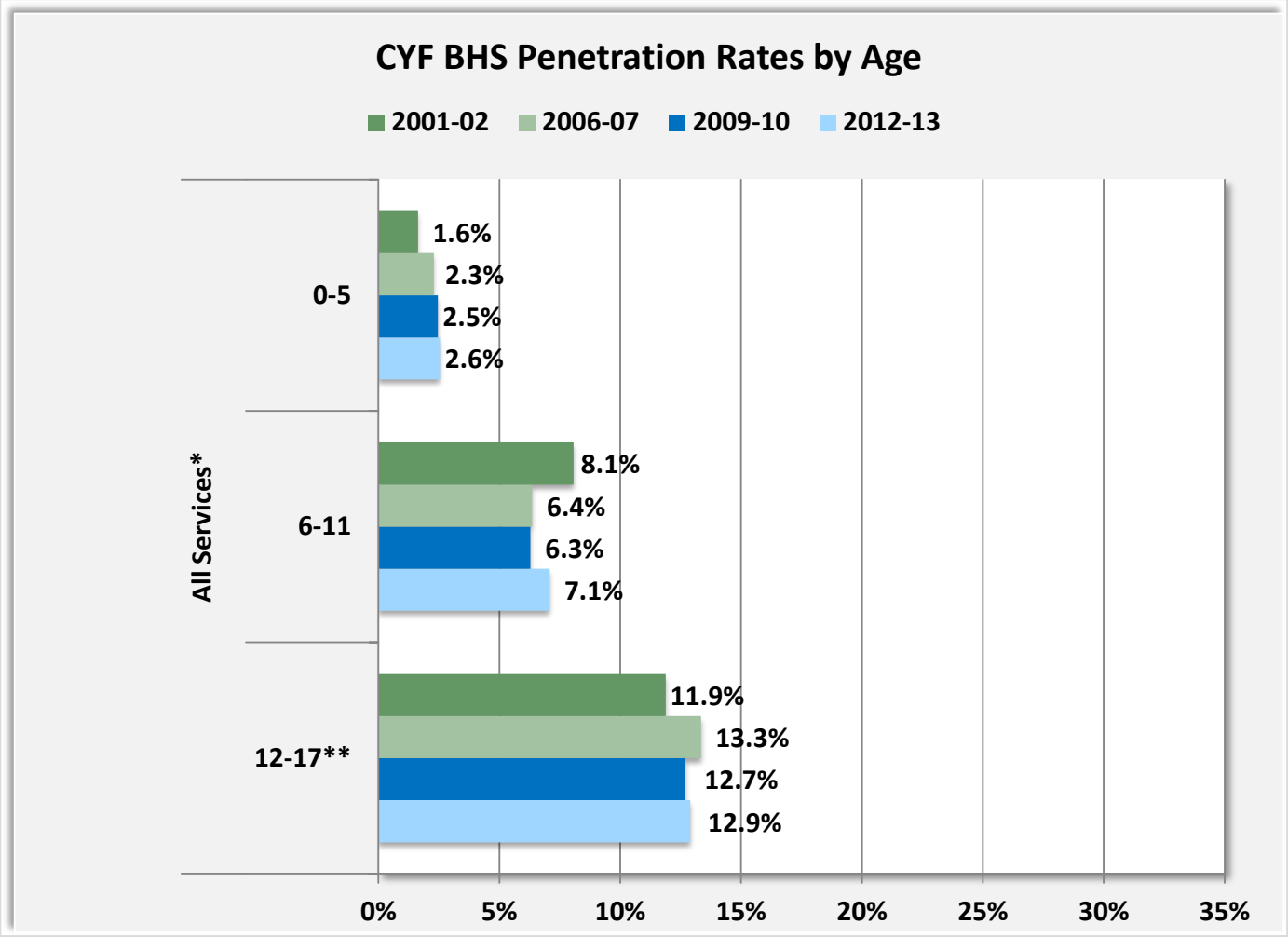
Penetration rates for CYF BHS clients were examined across three age groups: 0-5, 6-11, and 12-17. Penetration rates were calculated as the number of actual clients within a specific age group (i.e. 0-5, 6-11, and 12-17) who received services (CYF BHS clients) divided by number of potential clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries that could potentially have a SMI) within that age group (i.e. 0-5, 6-11, and 12-17).

Differences in penetration rates were examined across years by comparing penetration rates in FYs 2001-02, 2006-07, 2009-10, and 2012-13.

Detailed tabular data are provided in Appendix A, Table 1.

- Clients ages 12-17 had the highest penetration rates across all fiscal years.
- Clients ages 0-5 had the lowest penetration rates across all fiscal years.
- Penetration rates for clients ages 0-5 increased across all fiscal years.

*Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.



NOTE: Percentages may not add up to 100% due to rounding.
* All CYF services were combined into the All Services so that the data would be comparable to how it was generated in previous fiscal years.
** This category includes the 9,191 clients ages 12-17, plus an additional 923 clients ages 18+ who although over 18 years of age also received services through CYF BHS.

Penetration Rates:
Children and Youth—Penetration Rates by Race/Ethnicity

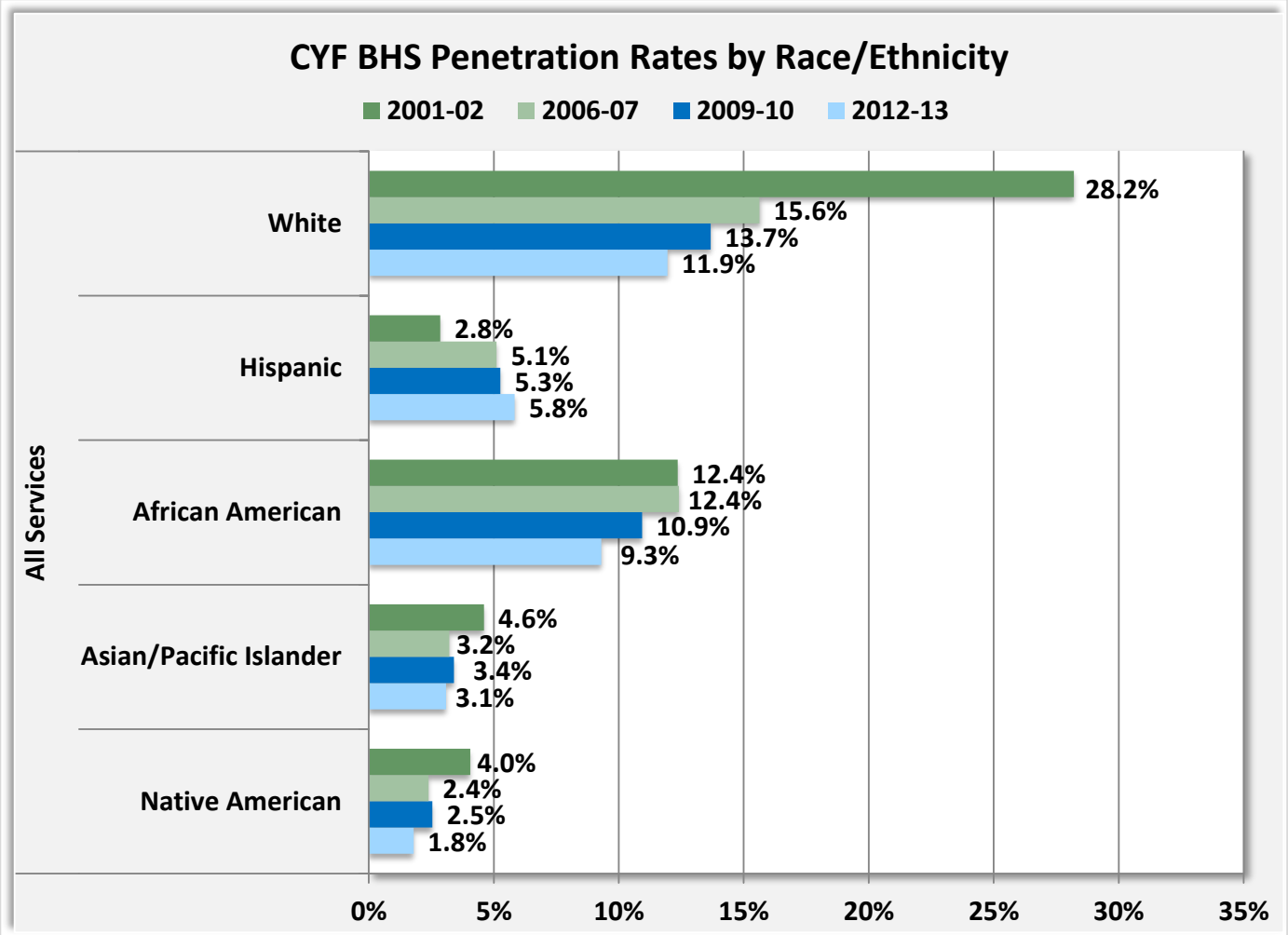
Penetration rates for CYF BHS clients were examined across five race/ethnicity groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Penetration rates were calculated as number of actual clients within a specific racial/ethnic group (i.e. Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans) who received services (CMHS clients) divided by number of potential clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries that could potentially have a SMI) within that racial/ethnic group.

Differences in penetration rates were examined across years by comparing penetration rates in FYs 2001-02, 2006-07, 2009-10, and 2012-13.

Detailed tabular data are provided in Appendix A, Table 2.

- Although White clients had the highest penetration rates across all the fiscal years, there was a steady decline in penetration rates for White clients over time.
- Hispanic, Native American, and Asian/Pacific Islander clients had the lowest penetration rates across all the fiscal years. While similarly low, the penetration rates for the Hispanic CYF clients have increased since FY 2001-02 to FY 2012-13 from 2.8% to 5.8%.

*Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.



NOTE: Percentages may not add up to 100% due to rounding.

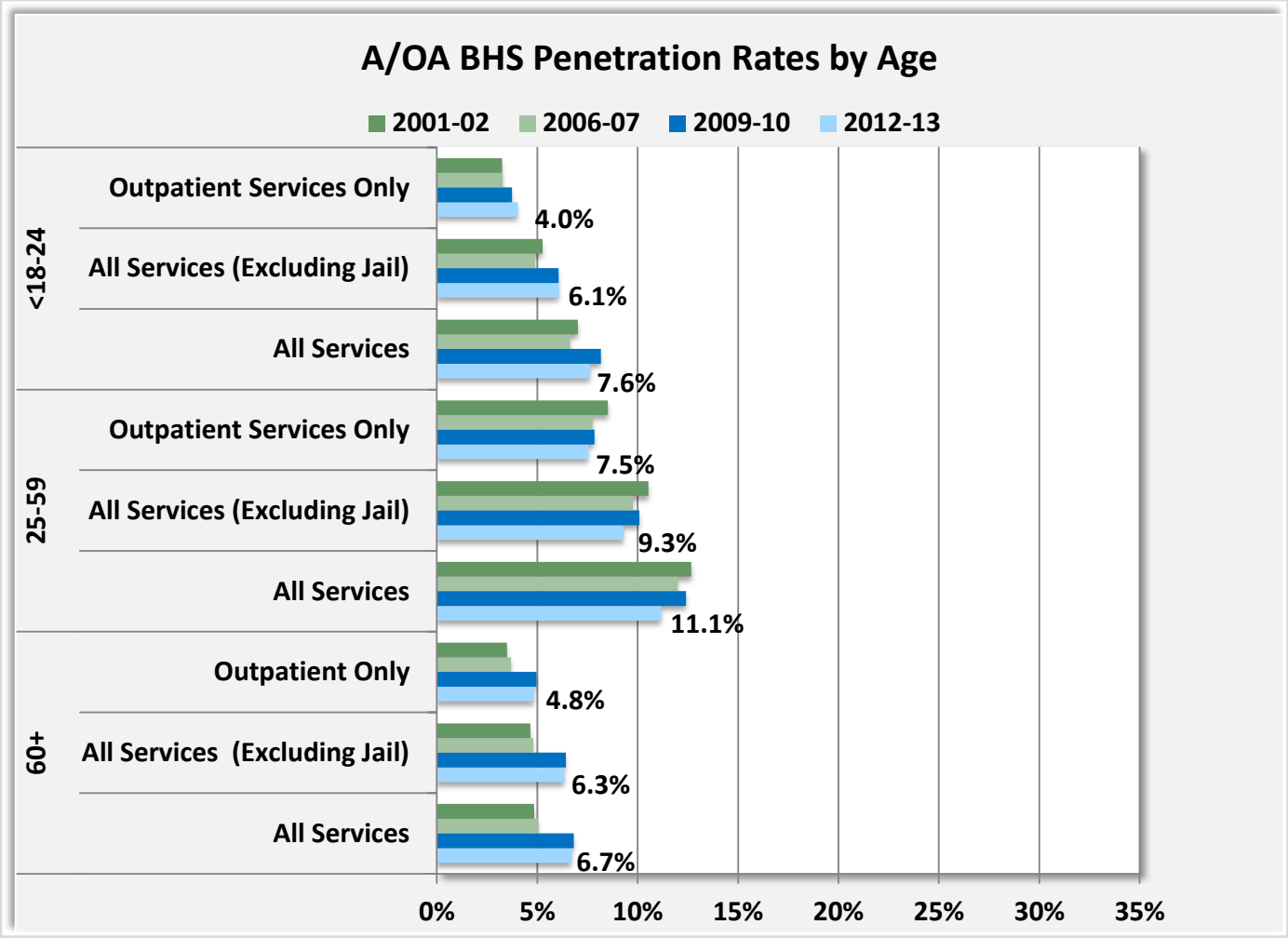
Penetration Rates:
Adults and Older Adults—Penetration Rates by Age

Penetration rates for Outpatient Services Only, All Services (Excluding Jail), and All Services, were examined across three age groups: <18-24, 25-59, and 60+. Penetration rates were calculated as number of actual clients within a specific age group (i.e. <18-24, 25-59, and 60+) who received services (A/OA BHS clients) divided by number of potential clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries that could potentially have a SMI) within that age group (i.e. <18-24, 25-59, and 60+). Each age grouping was further broken down by three service categories: (1) Outpatient Services Only, (2) All Services (Excluding Jail), and (3) All Services. The category excluding services provided while in Jail allows for the examination of penetration rates uninfluenced by mandatory services such as those provided as part of the justice system. Differences in penetration rates were examined across years by comparing penetration rates in FYs 2001-02, 2006-07, 2009-10, and 2012-13.

Detailed tabular data are provided in Appendix A, Table 3. The numbers displayed in the graph below are the penetration rates for FY 2012-13.

- Clients ages 18-24 had the lowest penetration rates for Outpatient Services for all four fiscal years.
- Clients ages 25-59 had the highest penetration rates for All Services for all four fiscal years.
- Clients ages 60+ had the lowest penetration rates for All Services combined for all four fiscal years.

*Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.



NOTE: Percentages may not add up to 100% due to rounding.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Penetration Rates:
Adults and Older Adults—Penetration Rates by Race/Ethnicity

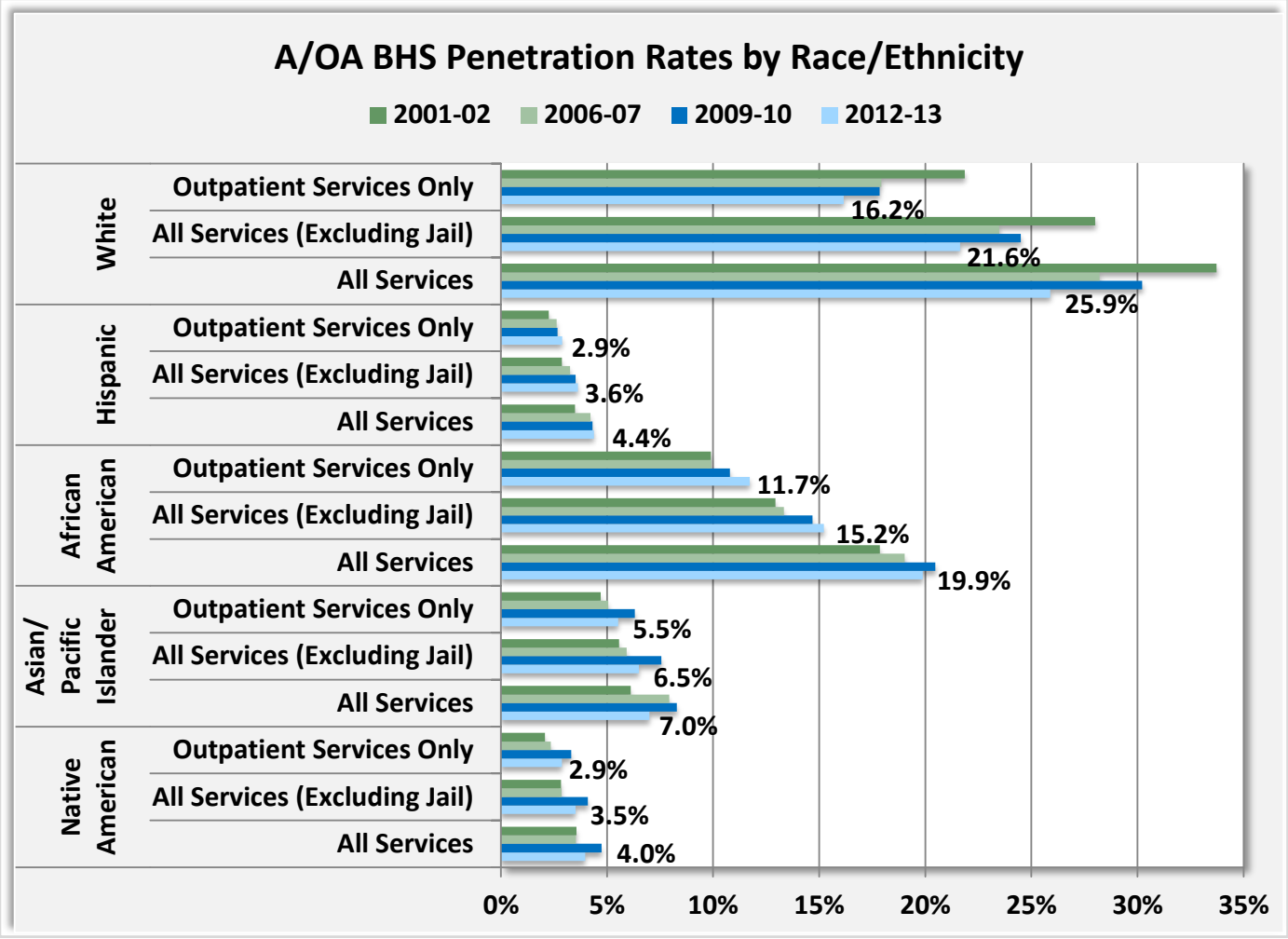
Penetration rates for Outpatient Services Only, All Services (Excluding Jail), and All Services, were examined across five race/ethnicity groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Penetration rates were calculated as number of actual clients within a specific racial/ethnic group (i.e., Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans) who received services (A/OA BHS clients) divided by number of potential clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries that could potentially have a SMI) within that racial/ethnic group.

Differences in penetration rates were examined across years by comparing penetration rates in FY 2001-02 , 2006-07, 2009-10, and 2012-13.

Detailed tabular data are provided in Appendix A, Table 4. Then numbers displayed in the graph below are the penetration rates for FY 2012-13.

- There was a generally increasing trend in penetration rates from FY 2001-02 to FY 2012-13 across all types of services for every racial/ethnic group except for White.
- Hispanic and Native American clients had the lowest penetration rates for all three categories of services across all the fiscal years.
- White clients had the highest penetration rates for all three categories of services over all the fiscal years.

*Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.



NOTE: Percentages may not add up to 100% due to rounding.

Disparities in Engagement:

Analysis of Retention Rates

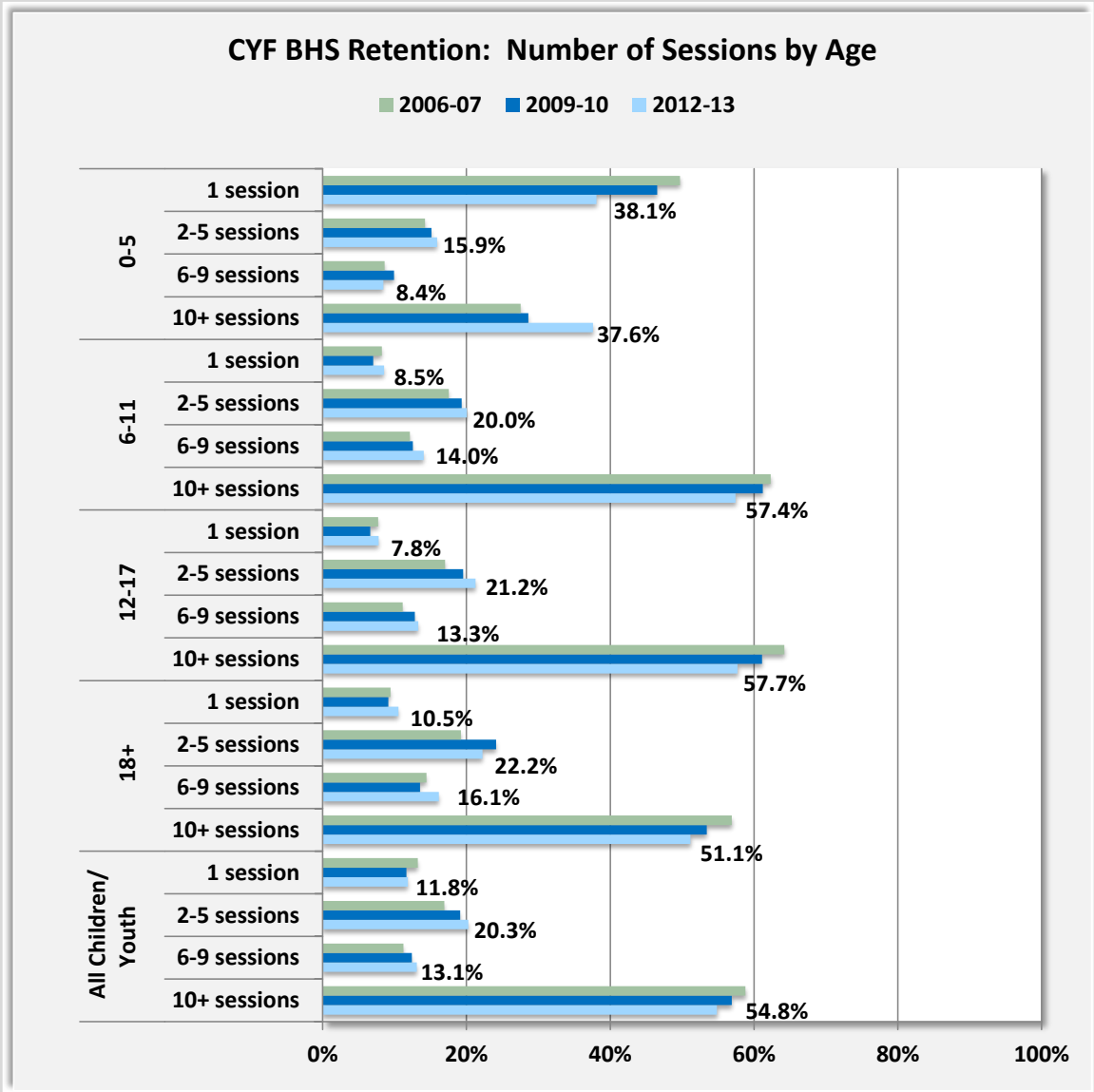
Disparities in engagement were identified by analyzing the percentage of clients who continued services by number of visits for adults and the number of sessions for children (retention rate). For the analyses of retention rates, only data from FY's 2006-07, 2009-10, and 2012-13 were compared. Fiscal year 2001-02 was omitted from these analyses because the data from that fiscal year was recorded in the previously used INSYST MIS, which tracked numbers of visits and sessions differently than Anasazi (the current MIS) and thus comparable numbers could not be calculated.

Retention Rates:
Children and Youth—Retention Rates by Age

Service retention rates for CYF BHS clients were examined in FYs 2006-07, 2009-10, and 2012-13 across four age groups: 0-5, 6-11, 12-17, 18+. Retention rates were defined as the number of sessions for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 5. Numbers displayed in the graph below are retention rates for FY 2012-13.

- 54.8% of all child and youth clients were in services for 10 or more sessions.
- Among the clients ages 0-5, retention rates for 10 or more sessions increased greatly since FY 2006-07, while simultaneously the retention rates for 10 or more sessions decreased for all other age categories over the same time period.
- Clients ages 0-5 were most likely to have only one session (in many cases, this visit was for assessment purposes).
- Clients ages 6-11 and 12-17 had the highest retention rates, and were more likely than the other age groups to continue services past 10 sessions.



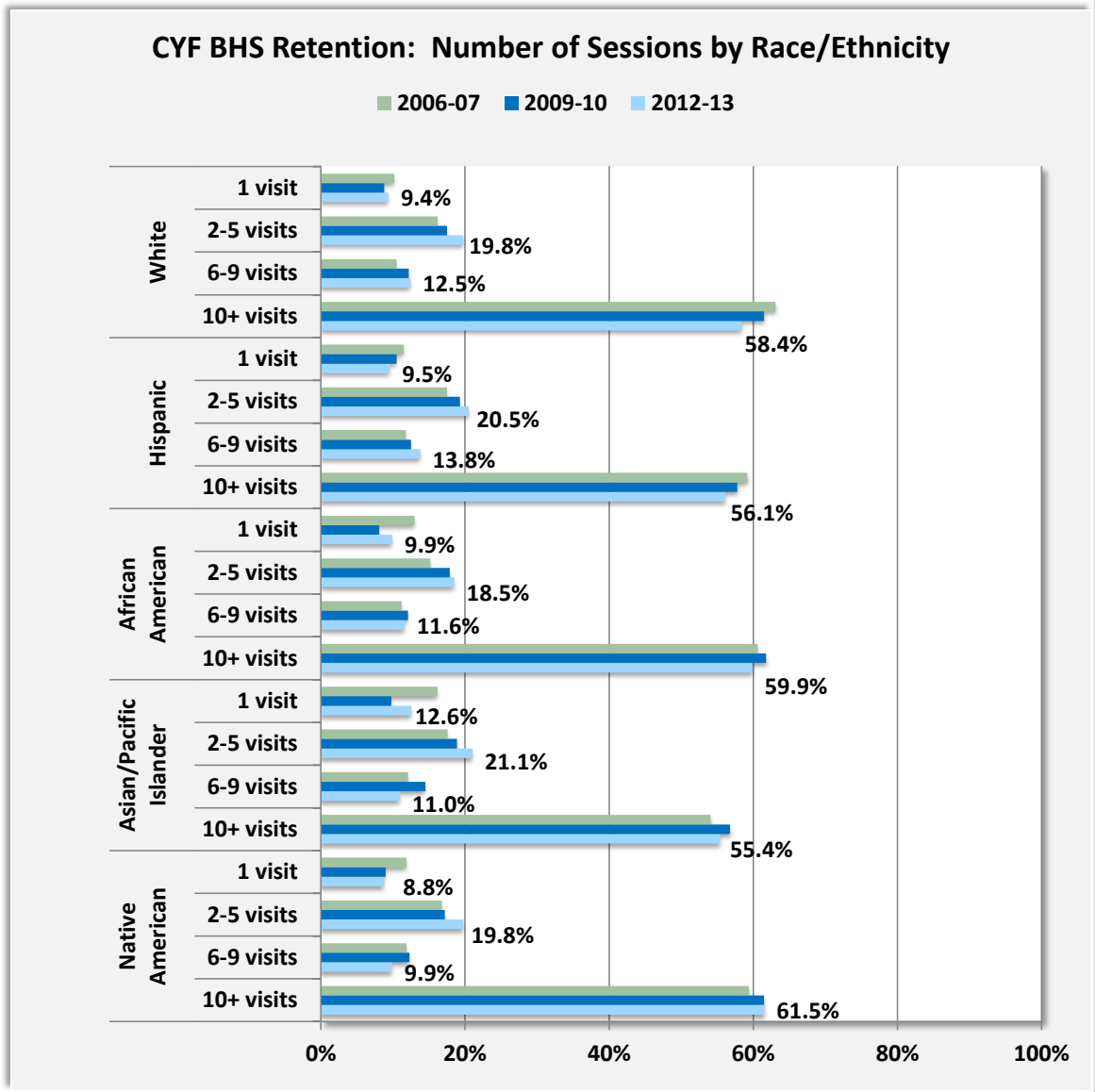
NOTE: All CYF services were included in the data reported above so the data would be comparable to how it was generated in previous fiscal years. Percentages may not add up to 100% due to rounding.

Retention Rates:
Children and Youth—Retention Rates by Race/Ethnicity

Service retention rates for CYF BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13 across five racial/ethnic groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Retention rates were defined as the number of sessions for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 6. Numbers displayed in the graph below are retention rates for FY 2012-13.

- Asian/Pacific Islander clients were slightly more likely to have only one session than the other racial/ethnic groups in FY 2012-13.
- African American clients had slightly higher retention rates for six or more sessions.
- Asian/Pacific Islander clients had lower retention rates than any other racial/ethnic group for 10 or more sessions.



NOTE: All CYF services were included in the data reported above so the data would be comparable to how it was generated in previous fiscal years. Percentages may not add up to 100% due to rounding.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

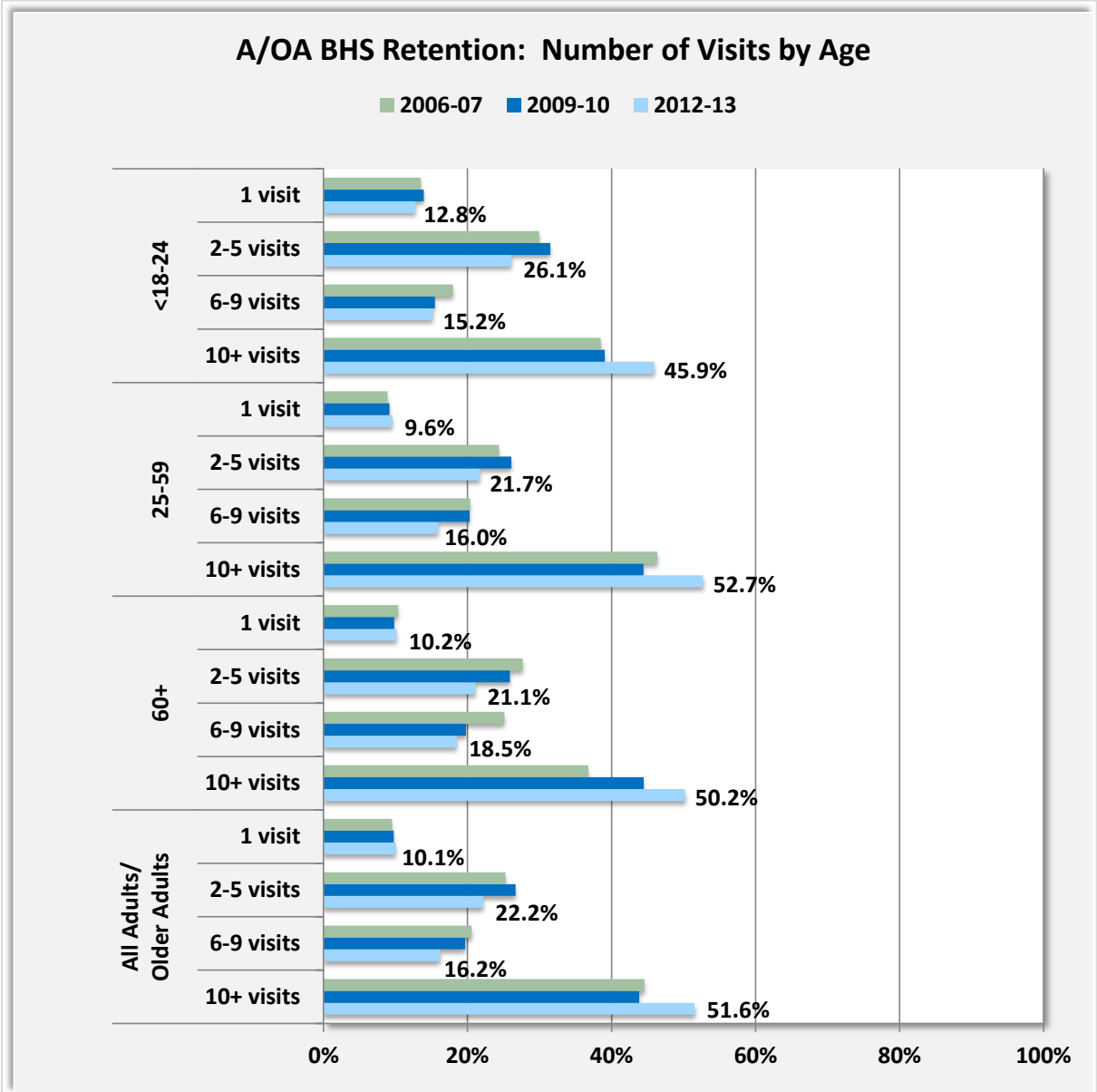
Retention Rates:
Adults and Older Adults—Retention Rates by Age

Outpatient service* retention rates for A/OA BHS clients were examined in FYs 2006-07, 2009-10, and 2012-13 across three age groups: <18-24, 25-59, and 60+. Retention rates were defined as the number of Outpatient visits for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 7. The numbers displayed in the graph below are the retention rates for FY 2012-13.

- 51.6% of all clients continued services with A/OA BHS for 10 or more visits.
- Clients age <18-24 were the most likely age group to have had less than 6 visits.
- Clients age 25-59 were most likely to have had 10 or more visits.
- Retention rates for 10 or more visits increased across all age groups.

* Outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention services.



NOTE: Percentages may not add up to 100% due to rounding.

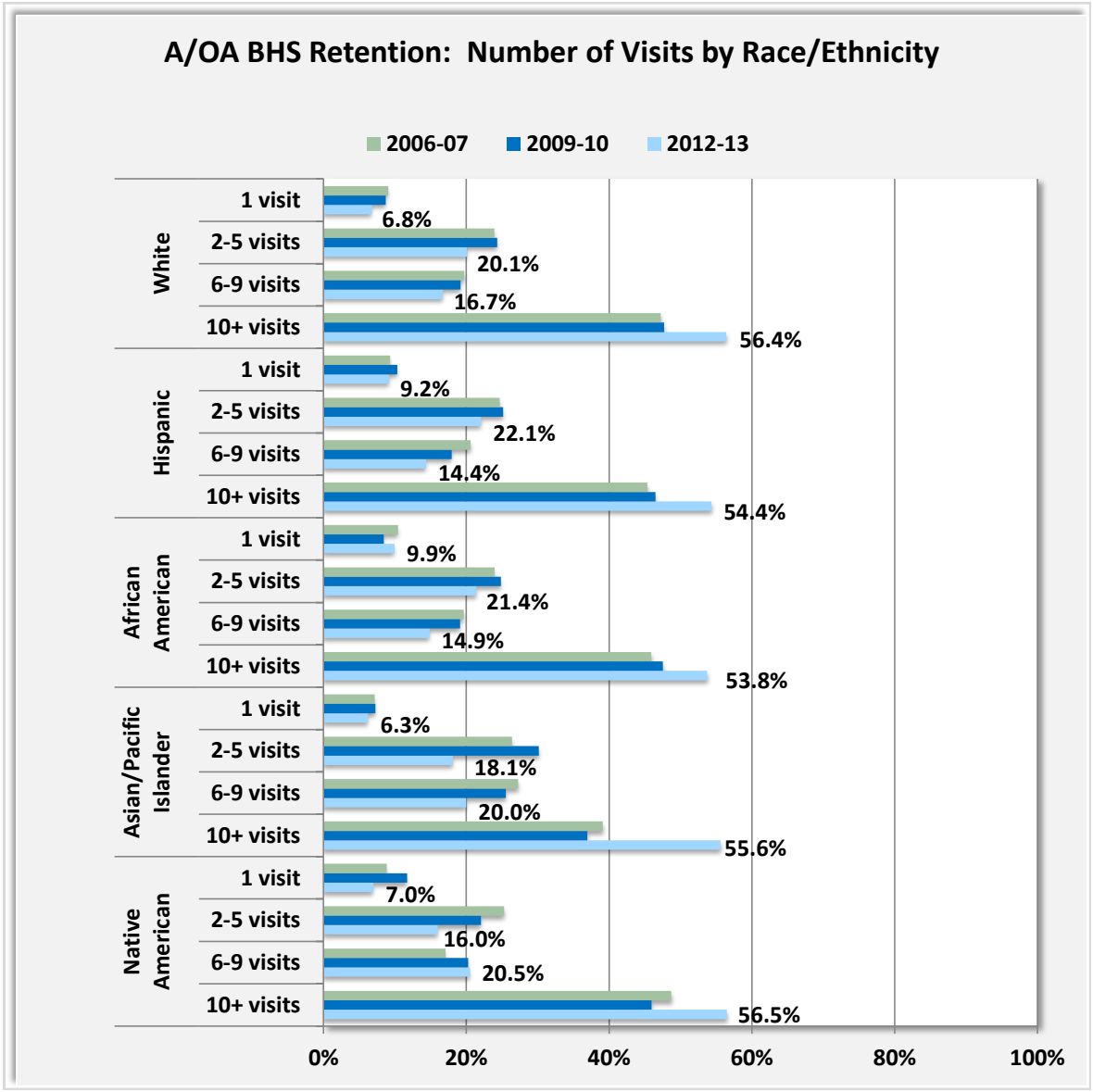
Retention Rates:
Adults and Older Adults—Retention Rates by Race/Ethnicity

Outpatient service* retention rates for A/OA BHS clients were examined in FYs 2006-07, 2009-10, and 2012-13 across five racial/ethnic groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Retention rates were defined as the number of Outpatient visits for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 8. Numbers displayed in the graph below are retention rates for FY 2012-13.

* Outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention services.

- African American and Hispanic clients were the most likely to have had only one visit (9.9% and 9.2%, respectively).
- Hispanic and African American clients had the highest retention rates for 2-5 visits of all other racial/ethnic groups (22.1% and 21.4%, respectively).
- Native American (77.0%) and Asian/Pacific Islander (75.6%) clients were the most likely to have six or more visits and least likely to have fewer than 6 visits (23.0% and 24.4%, respectively).
- Across all the racial/ethnic groups more than half of the clients were retained in services for 10 or more visits.



NOTE: Percentages may not add up to 100% due to rounding.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Type of Service Used

Disparities in Type of Service Used:
By Age
By Race/Ethnicity

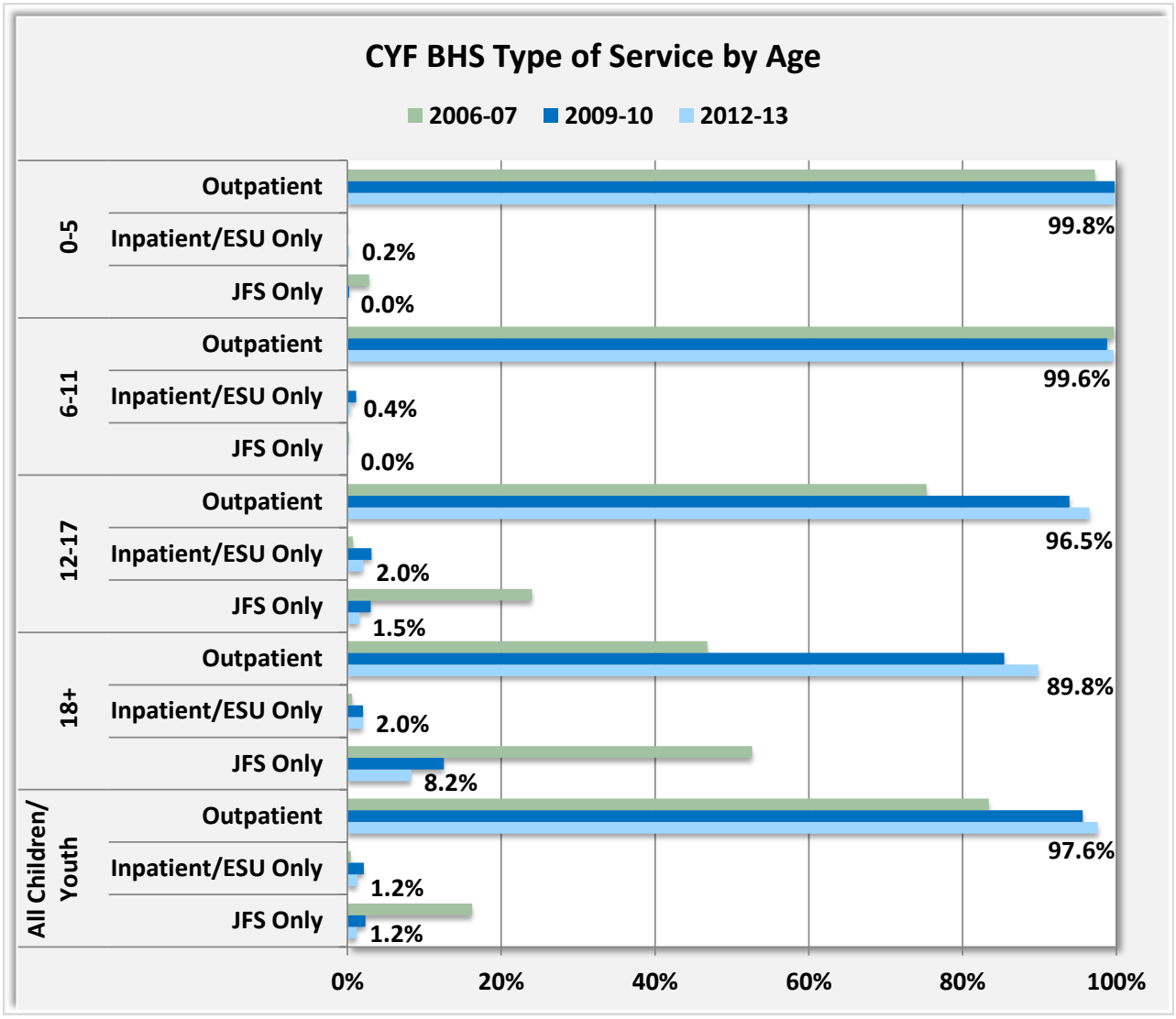
Disparities in Type of Service Used: Children and Youth—Type of Service Used by Age

A goal of CYF BHS has been to increase use of Outpatient services and decrease use of Inpatient/Emergency services. Types of services used by all CYF BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13 across four age groups: 0-5, 6-11, 12-17, 18+. Utilization rates were calculated as number of clients within a specific age group (i.e. 0-5, 6-11, 12-17, 18+) who used a specific type of service (i.e. Outpatient, Inpatient/Emergency only, and JFS only) divided by number of total clients within that age group.

Detailed tabular data are provided in Appendix A, Table 9.

Numbers displayed in the graph below are utilization rates for FY 2012-13.

- 97.6% of all clients used Outpatient services. This represents a 14% increase from FY 2006-07.
- 1.2% of all clients used only Inpatient/Emergency services during the fiscal year.
- Clients ages 18+ used more JFS only services and less Outpatient services than the other age groups.



NOTE: Percentages may not add up to 100% due to rounding.

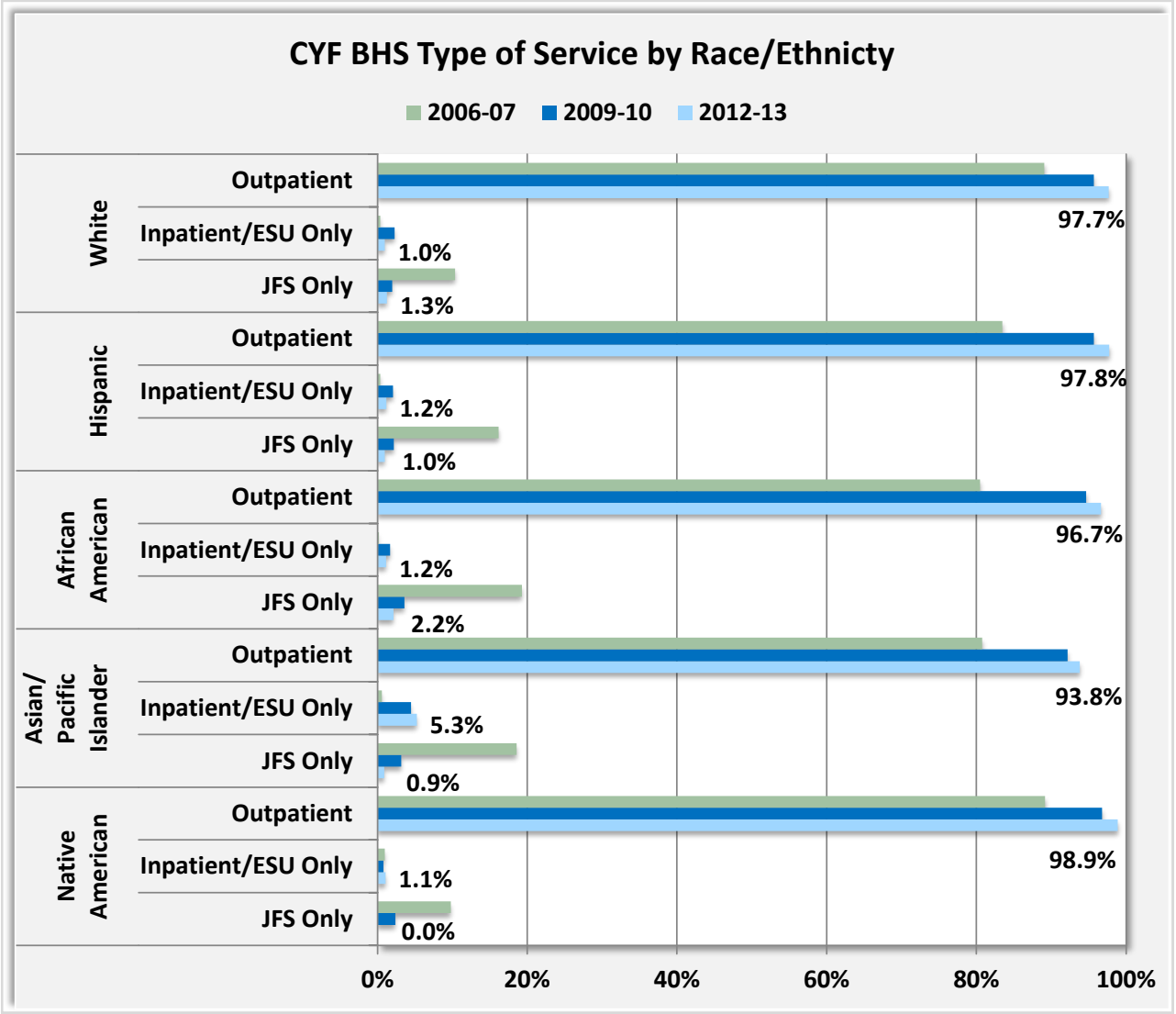
Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Disparities in Type of Service Used: Children and Youth—Type of Service Used by Race/Ethnicity

Types of services used by CYF BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13 across five racial/ethnic groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Utilization rates were calculated as number of clients within a specific racial/ethnic group who used a specific type of service (i.e., Outpatient, Inpatient/Emergency only, and JFS only) divided by number of total clients within that race/ethnicity group.

Detailed tabular data are provided in Appendix A, Table 10. Numbers displayed in the graph below are utilization rates for FY 2012-13.

- The majority of clients in each racial/ethnic group used Outpatient services, while fewer clients used only Inpatient/Emergency services or JFS services.
- Slightly more African American clients used JFS-only services than the other racial/ethnic groups.
- A higher proportion of Asian/Pacific Islander clients used only Inpatient/ESU services than any other racial/ethnic group.



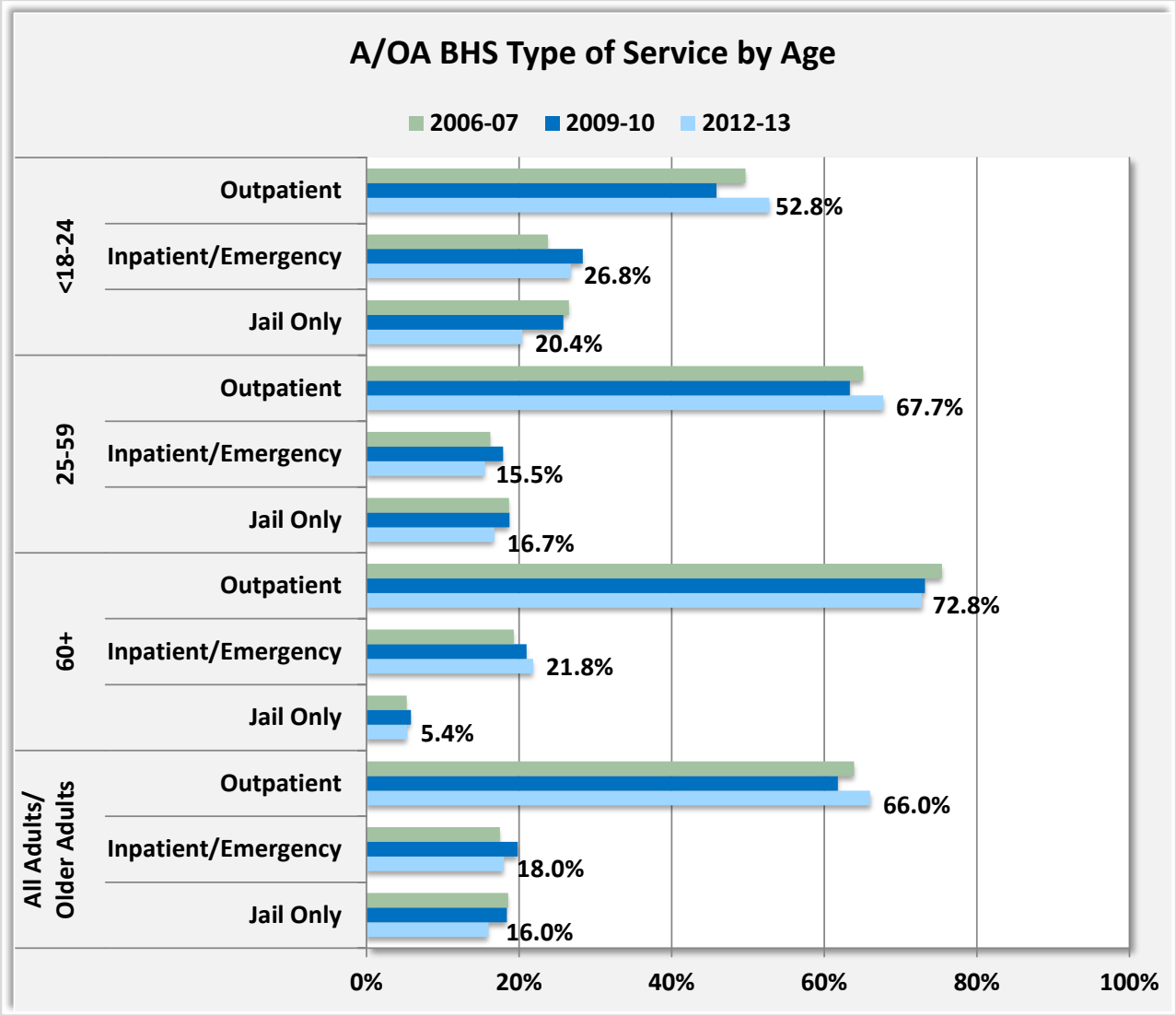
NOTE: Percentages may not add up to 100% due to rounding.

Disparities in Type of Service Used: Adults and Older Adults—Type of Service Used by Age

A goal of A/OA BHS has been to increase use of Outpatient services and decrease use of Inpatient/Emergency services. Types of services used by all A/OA BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13 across three age groups: <18-24, 25-59, and 60+. Utilization rates were calculated as number of clients within a specific age group (i.e. <18-24, 25-59, and 60+) who used a specific type of service (i.e. Outpatient, Inpatient/Emergency, and Jail Only) divided by number of total clients within that age group (i.e. <18-24, 25-59, and 60+).

Detailed tabular data are provided in Appendix A, Table 11. Numbers displayed in the graph below are utilization rates for FY 2012-13.

- From FY 2009-10 to FY 2012-13, Outpatient services increased while Inpatient/Emergency and Jail Only services decreased for both the <18-24 and 25-59 age groups.
- The <18-24 group used more Inpatient/Emergency and Jail Only services and fewer Outpatient services than the other age groups.
- Clients age 25-59 used fewer Inpatient/Emergency services than other age groups.
- Clients age 60+ used more Outpatient services and the least amount of Jail Only services than other age group.



NOTE: Inpatient/Emergency may include some clients that also have Jail services, and percentages may not add up to 100% due to rounding.

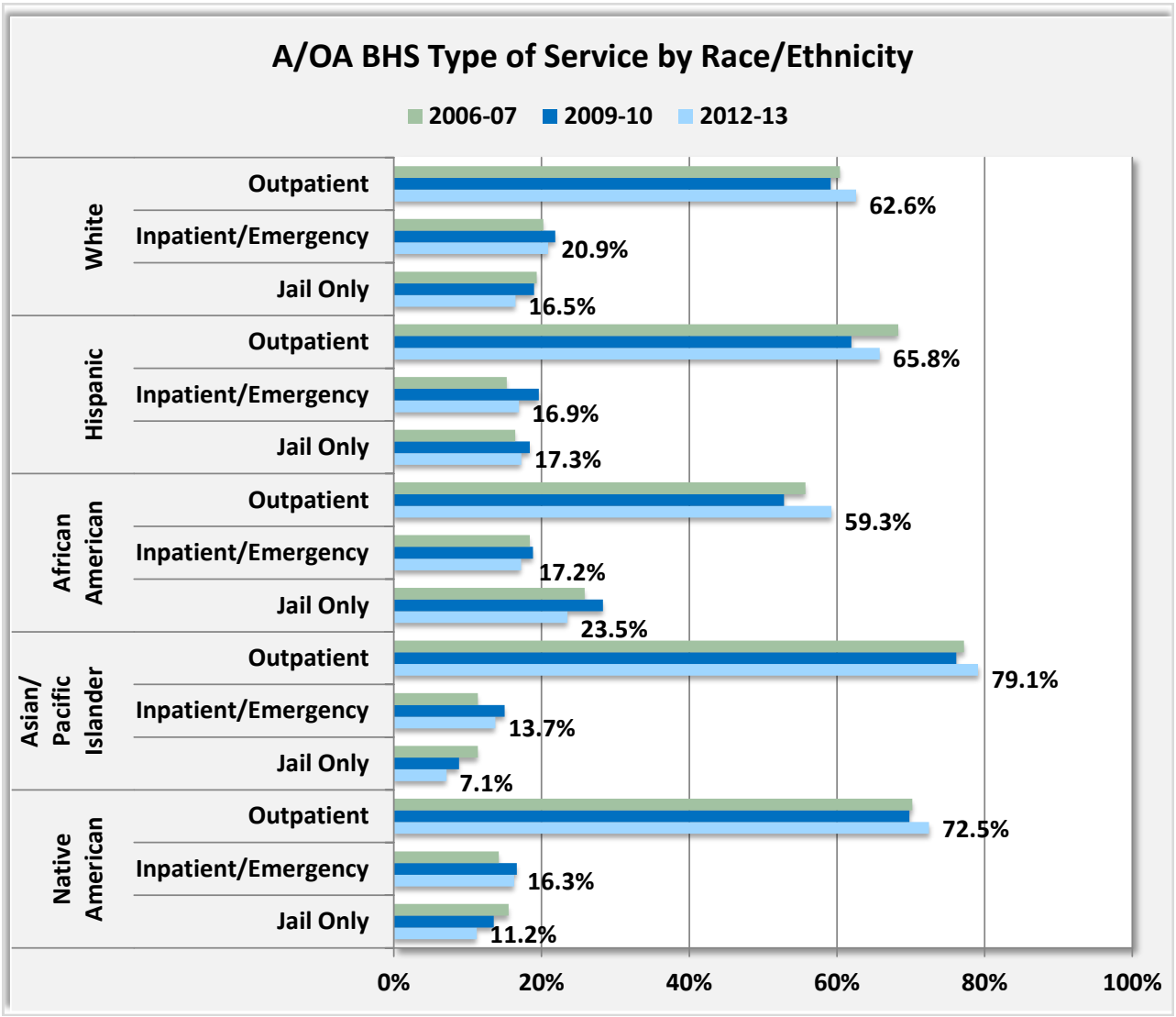
Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Disparities in Type of Service Used: Adults and Older Adults—Type of Service Used by Race/Ethnicity

Types of services used by A/OA BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13 across five racial/ethnic groups: Whites, Hispanics, African Americans, Asians/Pacific Islanders, and Native Americans. Utilization rates were calculated as number of clients within a specific racial/ethnic group who used a specific type of service (i.e. Outpatient, Inpatient/Emergency, and Jail Only) divided by number of total clients within that race/ethnicity group.

Detailed tabular data are provided in Appendix A, Table 12. Numbers displayed in the graph below are utilization rates for FY 2012-13.

- White clients had the highest usage of only Inpatient/Emergency services of all other racial/ethnic groups.
- African American clients had the highest usage of only Jail services of all other racial/ethnic group.
- Asian/Pacific Islander, and to a lesser extent, Native American clients, used more Outpatient services of all other racial/ethnic groups.
- Asian/Pacific Islander clients had the lowest usage of only Inpatient/Emergency services and only Jail services than any other racial/ethnic group.

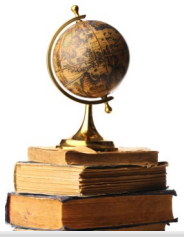


Note: Inpatient/Emergency may contain some clients that also have Jail services, and percentages may not add up to 100% due to rounding.

Diagnosis

Disparities in Diagnosis:
Children and Youth
Adults and Older Adults

Disparities in Diagnosis



Children and Youth

Diagnosis by Race/Ethnicity:

Diagnosis data for children and youth clients were examined by race/ethnicity. These data are graphically displayed on page 41.

Detailed tabular data are provided in Appendix A, Table 13.

- White and African American clients had the highest prevalence rates of ADHD across all three fiscal years.
- White and Native American clients had the highest prevalence rates of Bipolar Disorders in FY 2012-13.
- African American clients had the highest rates of externalizing disorders (i.e., Oppositional/Conduct Disorders and ADHD) and among the lowest rates of internalizing disorders (i.e., Depressive and Anxiety Disorders) of all other racial/ethnic groups across all three fiscal years.
- Asian/Pacific Islander clients had the highest prevalence rates of Depressive Disorders (25%) and the lowest prevalence rates of Oppositional/Conduct Disorders (13%) of all other racial/ethnic groups in FY 2012-13.
- Hispanic clients had the second highest prevalence rates of both Depressive Disorders and Oppositional/Conduct Disorders across all three fiscal years.
- Native American clients had the highest prevalence rates of Adjustment Disorders of all other racial/ethnic groups across all three fiscal years.

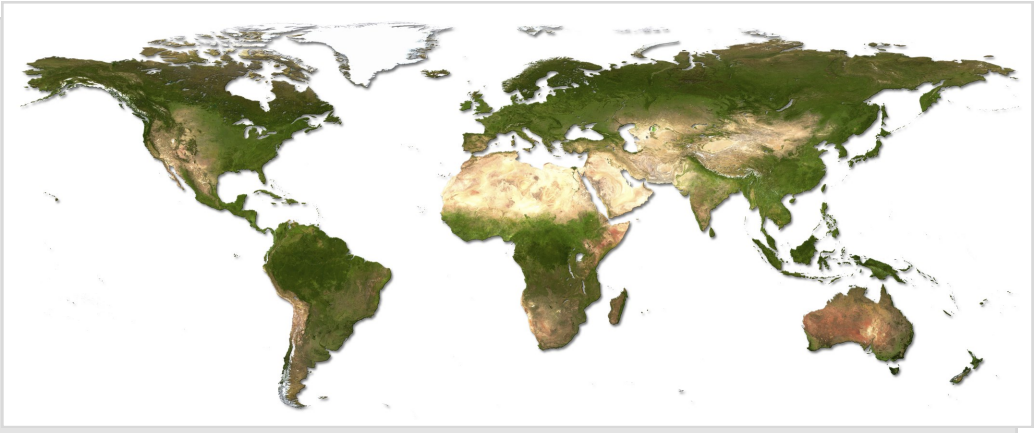
Adults and Older Adults

Diagnosis by Race/Ethnicity:

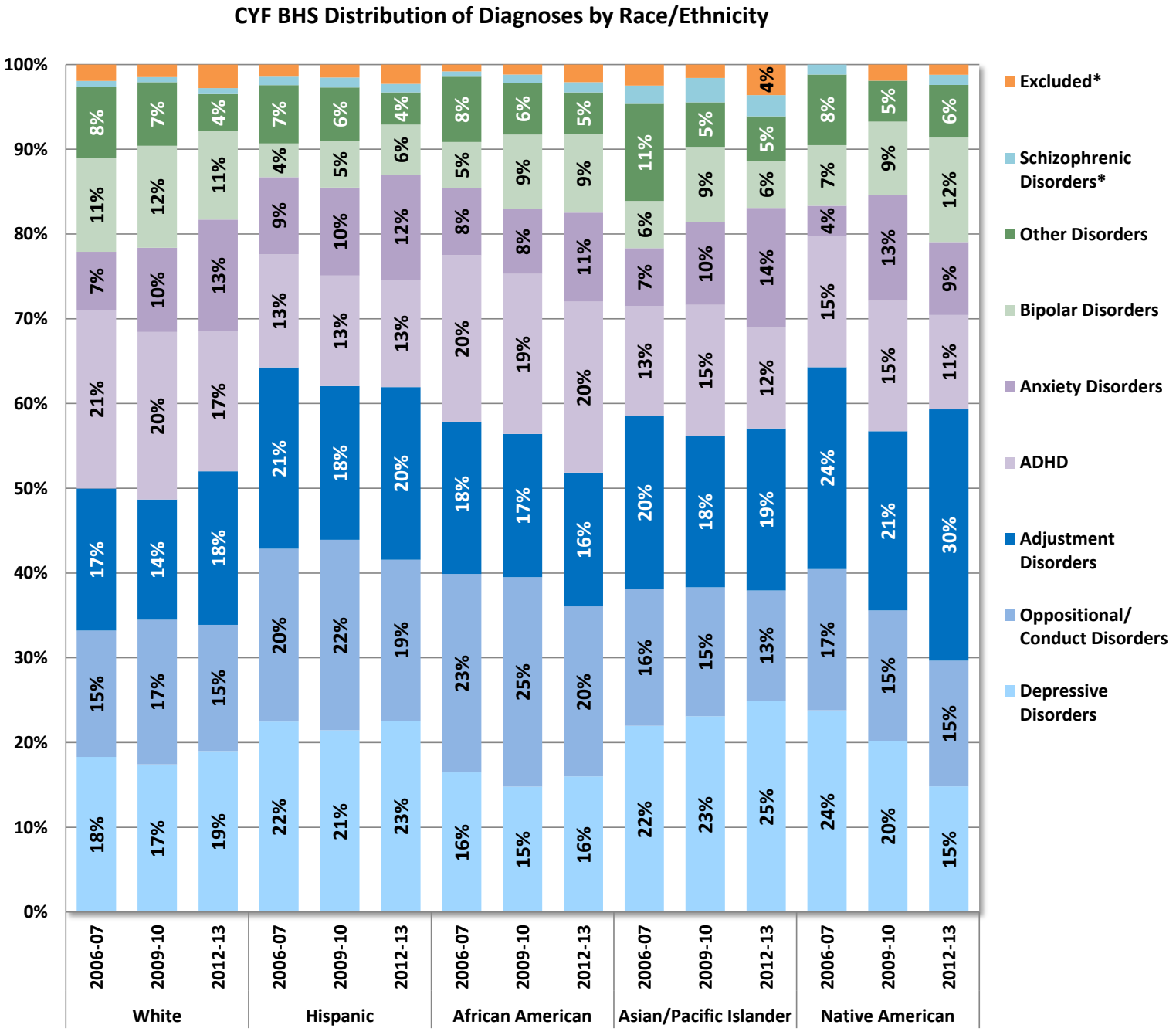
Diagnosis data for adults and older adults were examined by race/ethnicity. These data are graphically displayed on page 42.

Detailed tabular data are provided in Appendix A, Table 14.

- African American clients had the highest prevalence rates of Schizophrenia and Schizoaffective Disorders across all three fiscal years.
- A large majority (73%) of Asian/Pacific Islander clients were diagnosed with either Schizophrenia and Schizoaffective Disorders (37%) or Major Depression Disorders (36%) in FY 2012-13.
- The prevalence of Other Depression/Adjustment Disorders has lessened for all racial/ethnic groups from FY 2006 -07 to FY 2012-13.
- White and Native American clients had the highest prevalence rates of Bipolar Disorders in FYs 2009-10 and 2012-13 than the other racial/ethnic groups.
- Hispanic clients were more likely to be diagnosed with Major Depression Disorders in FY 2012-13 (30%) than any other disorder.
- Anxiety disorders were most prevalent in White (7%), Hispanic (7%), and Native American (7%) clients in FY 2012-13. African American clients had the lowest prevalence rates of Anxiety Disorders across all three fiscal years.



Disparities in Diagnosis: Children and Youth—Diagnosis by Race/Ethnicity

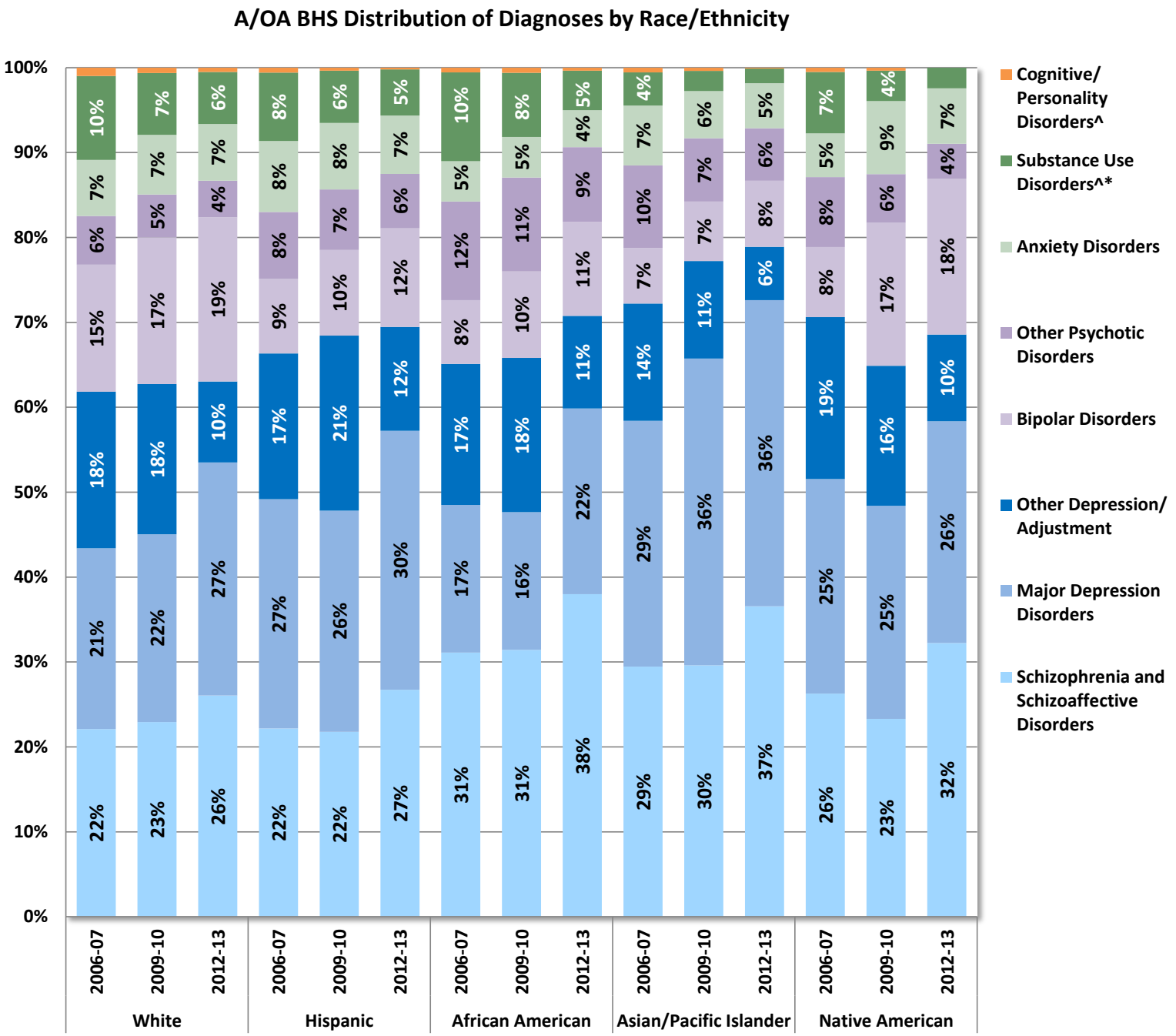


NOTE: Percentages may not add to 100% due to rounding.

* Data labels were not shown for percentages less than 4%.

Data Sources: INSYST and Anasazi
Report Source: HSRC (MM, BL, ST) and CASRC (EVT)

Disparities in Diagnosis: Adults and Older Adults—Diagnosis by Race/Ethnicity



NOTE: Percentages may not add up to 100% due to rounding.

^ Data labels were not shown for percentages less than 4%.

* Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessment, the diagnosis remains in the MIS. An example of when this may occur is when a client enters the MHS through such pathways as Jail or Emergency Psychiatric Unit services.

Transition Age Youth Ages 18-24 (TAY)

TAY Factsheet

TAY Penetration Rates

TAY Retention Rates

TAY Type of Service Used

TAY Factsheet

Total Clients Served:

6,317 TAY clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

46% of TAY clients were ages 18-21. The majority of TAY clients were male (62%).

Preferred Language:

The majority of TAY clients (86%) reported English as their preferred language, and 7% of TAY clients preferred Spanish.

Top 3 Diagnoses:

1. Major Depression Disorders (31%)
2. Other Depression/Adjustment Disorders (18%)
3. Schizophrenia and Schizoaffective Disorders (15%)

Service Utilization (Penetration Rates):

FY 2001-02:	7.0%
FY 2006-07:	6.6%
FY 2009-10:	8.2%
FY 2012-13:	7.6%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	43.5%
	10+ visits	38.5%
FY 2009-10:	<6 visits	45.4%
	10+ visits	39.1%
FY 2012-13:	<6 visits	38.9%
	10+ visits	45.9%

Type of Service Used in FY 2012-13:

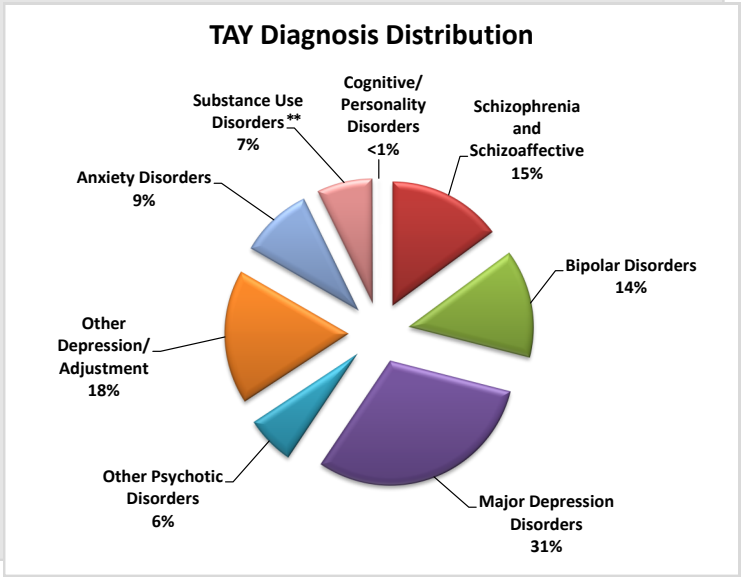
52.8% of TAY clients utilized Outpatient services, 26.8% used Inpatient/Emergency services, and 20.4% used only Jail services.

Insurance Status in FY 2012-13:

37% of TAY clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
<18*	6%	11%	14%
18-21	48%	49%	46%
22-24	46%	41%	41%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	43%	41%	38%
Males	56%	59%	62%
Other/Unknown	1%	<1%	<1%



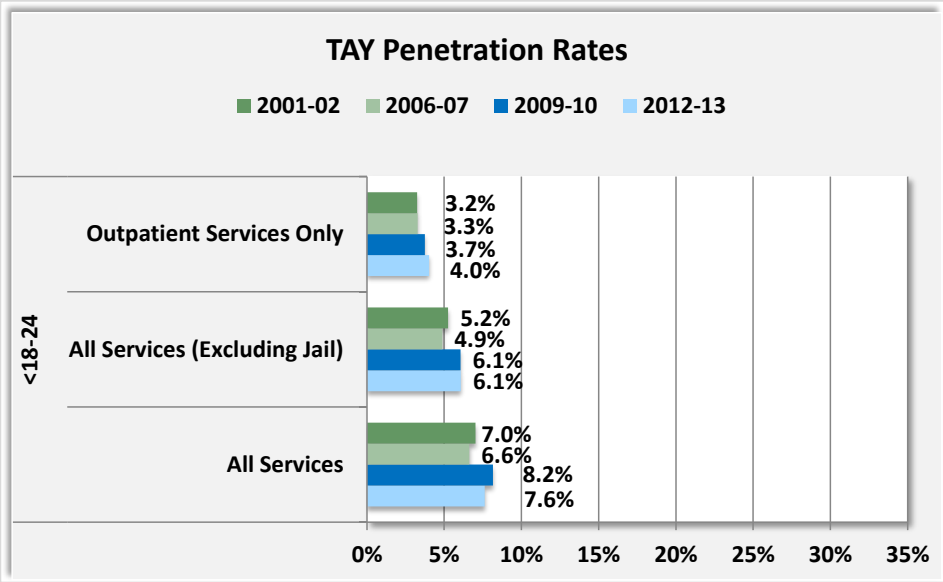
* A small number of clients treated in A/OA BHS were under the age of 18.

** Although Substance Use Disorders are generally not considered a primary diagnosis in the BHS, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS. An example of when this may occur is when a client enters the A/OA BHS through such pathways as Jail or the Emergency Psychiatric Unit services.

NOTE: Percentages may not add up to 100% due to rounding.

TAY Penetration Rates

Penetration rates for All Services, All Services (Excluding Jail), and Outpatient Services Only were examined and calculated as the number of TAY A/OA BHS clients who received services divided by the number of potential TAY clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries). Data are presented by three service categories: (1) Outpatient Services Only, (2) All Services (Excluding Jail), and (3) All Services. The category excluding services provided while in Jail allows for the examination of penetration rates uninfluenced by mandatory services such as provided as part of the justice system.



Differences in penetration rates were examined across years by comparing penetration rates in FYs 2001-02, 2006-07, 2009-10, and 2012-13. Detailed tabular data are provided in Appendix A, Table 1.

- Penetration rates for all three service categories above showed an increasing trend from FY 2006-07 to FY 2012-13, however rates for All Services decreased from their highest in FY 2009-10 (8.2%) to 7.6% in FY 2012-13.

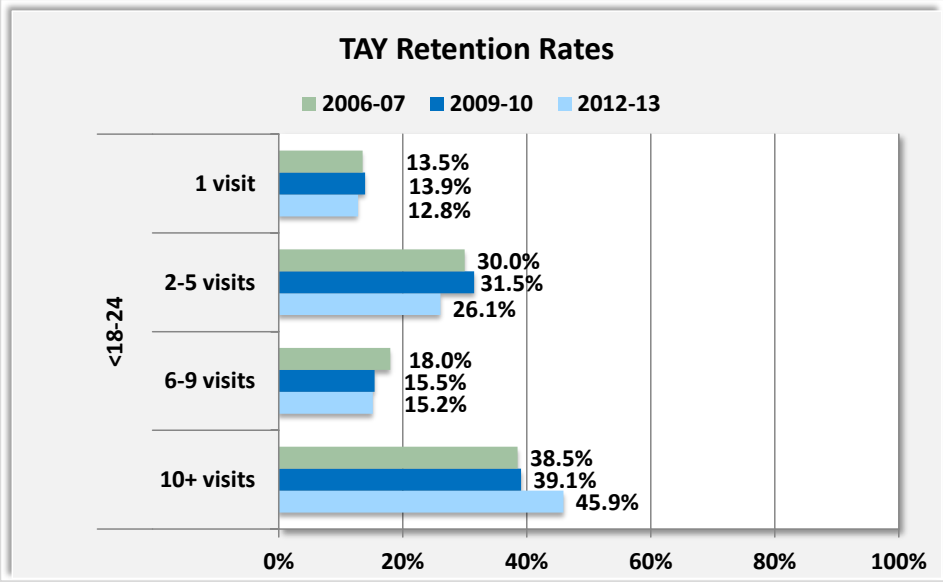
* Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.
NOTE: Percentages may not add to 100% due to rounding.

TAY Retention Rates

TAY Outpatient Service* retention rates for A/OA BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13. Retention rates were defined as the number of Outpatient visits for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 5.

- More TAY clients continued services for 10 or more visits in FY 2012-13 than in FY 2006-07.
- TAY clients were slightly less likely to have only one service visit in FY 2012-13 than in previous fiscal years.



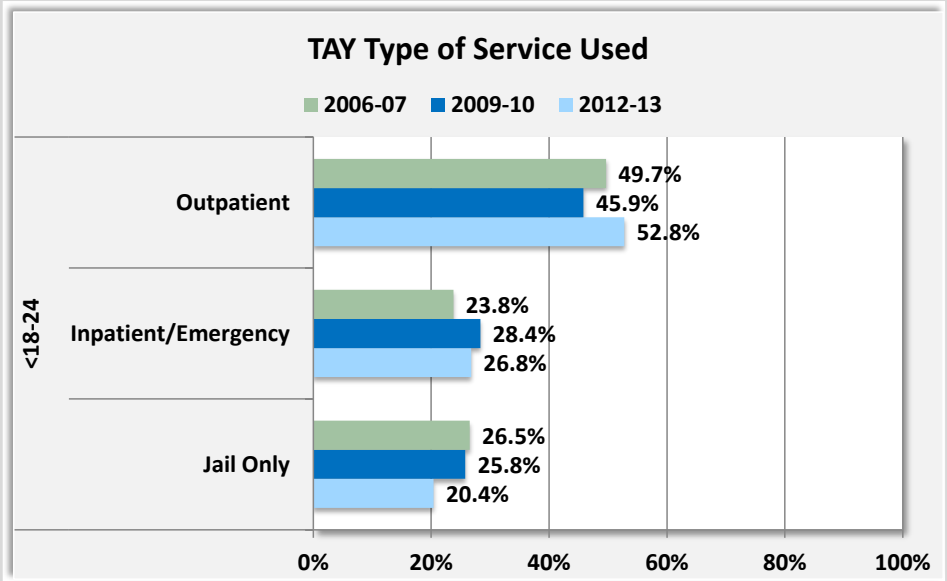
* Outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention type services.
NOTE: Percentages may not add up to 100% due to rounding.

TAY Type of Service Used

A goal of A/OA BHS has been to increase use of Outpatient services and decrease use of Inpatient/Emergency services. Types of services used specifically by TAY A/OA BHS clients were examined for FYs 2006-07, 2009-10, and 2012-13.

Utilization rates were calculated as number of TAY clients who used a specific type of service (i.e. Outpatient, Inpatient/Emergency, and Jail Only) divided by number of total TAY clients.

Detailed tabular data are provided in Appendix A, Table 9.



- In FY 2012-13, TAY clients in the A/OA BHS system of care utilized a higher proportion of Outpatient services and lower proportions of both Inpatient/Emergency and Jail Only services compared to FY 2009-10.

Note: Inpatient/Emergency may include some clients that also have Jail services and percentages may not add up to 100% due to rounding.

Older Adults Ages 60+ (OA)

OA Factsheet

OA Penetration Rates

OA Retention Rates

OA Type of Service Used

OA Factsheet

Total Clients Served:

4,809 OA clients were served by A/OA BHS in FY 2012-13.

Age and Gender:

76% of OA clients were between the ages of 60 and 69. Over half (57%) of OA clients were female but the proportion of female OA clients has decreased since FY 2006-07.

Preferred Language:

The majority of OA clients (73%) reported English as their preferred language, 7% preferred Spanish, 3% preferred Vietnamese, and 3% preferred Arabic.

Top 3 Diagnoses:

1. Major Depression Disorders (37%)
2. Schizophrenia and Schizoaffective Disorders (31%)
3. Bipolar Disorders (13%)

Service Utilization (Penetration Rates):

FY 2001-02:	4.8%
FY 2006-07:	5.0%
FY 2009-10:	6.8%
FY 2012-13:	6.7%

Engagement (Retention Rates):

FY 2006-07:	<6 visits	38.1%
	10+ visits	36.8%
FY 2009-10:	<6 visits	35.7%
	10+ visits	44.5%
FY 2012-13:	<6 visits	31.3%
	10+ visits	50.2%

Type of Service Used in FY 2012-13:

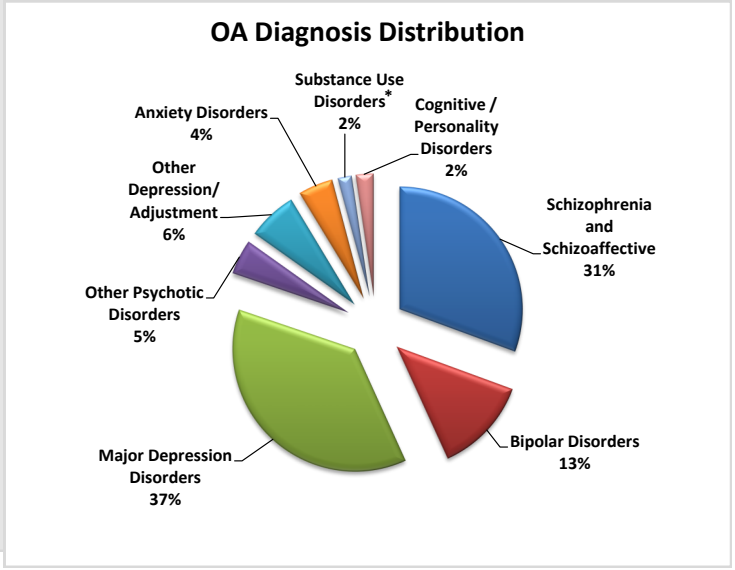
72.8% of OA clients utilized Outpatient services, 21.8% used Inpatient/Emergency services, and 5.4% used Jail Only services.

Insurance Status in FY 2012-13:

25% of OA clients were uninsured.

AGE	FY 2006-07	FY 2009-10	FY 2012-13
60-69	75%	75%	76%
70-79	15%	15%	15%
80+	10%	10%	9%

GENDER	FY 2006-07	FY 2009-10	FY 2012-13
Females	60%	59%	57%
Males	39%	41%	43%
Other/Unknown	1%	<1%	<1%

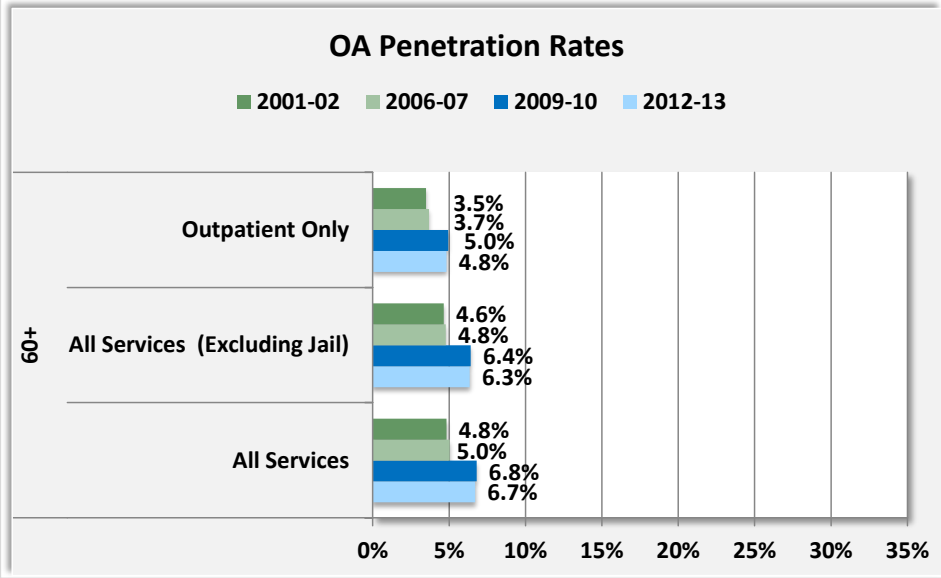


* Although Substance Use Disorders are generally not considered a primary diagnosis in the Behavioral Health System, clients are sometimes diagnosed as such at an initial assessment. In the absence of a qualifying alternative primary diagnosis that takes its place at subsequent assessments, the diagnosis remains in the MIS system. An example of when this may occur is when a client enters the A/OA BHS through such pathways as jail or the Emergency Psychiatric Unit services.

NOTE: Percentages may not add up to 100% due to rounding.

OA Penetration Rates

Penetration rates for All Services, All Services (Excluding Jail), and Outpatient Only services were examined for older adults. Penetration rates were calculated as number of actual OA clients who received services divided by the number of potential OA clients* (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries). Data were analyzed by three service categories: (1) Outpatient Services Only, (2) All Services Excluding Jail, and (3) All Services. The category excluding services provided while in Jail allows for the examination of penetration rates uninfluenced by mandatory services such as provided as part of the justice system.



Differences in penetration rates were examined across years by comparing penetration rates in FYs 2001-02, 2006-07, 2009-10, and 2012-13. Detailed tabular data are provided in Appendix A, Table 1.

- Penetration rates for OA clients increased from FY 2006-07 to FY 2009-10 and remained relatively stable through FY 2012-13 for all categories graphed above.

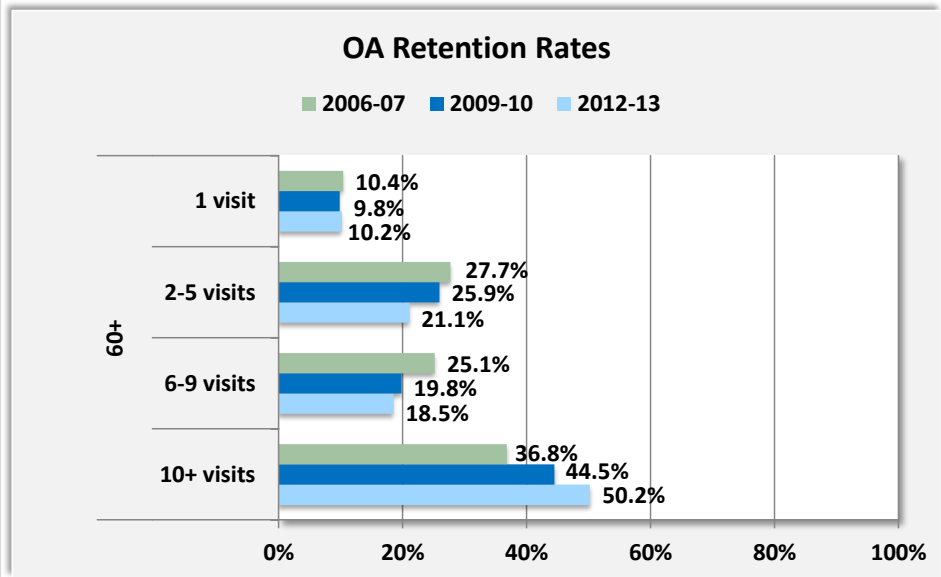
* Estimates of potential clients were derived from California Health Interview Survey (CHIS) estimates applied against 2013 Census population estimates.
NOTE: Percentages may not add up to 100% due to rounding.

OA Retention Rates

Outpatient service* retention rates for older adult clients were examined in FYs 2006-07, 2009-10, and 2012-13. Retention rates were defined as the number of Outpatient visits for each client during the fiscal year.

Detailed tabular data are provided in Appendix A, Table 5.

- Retention rates for 2-5 visits and 6-9 visits decreased from FY 2006-07 to FY 2012-13, while retention rates steadily increased from 36.8% in FY 2006-07 to 50.2% in FY 2012-13 for 10 or more visits.

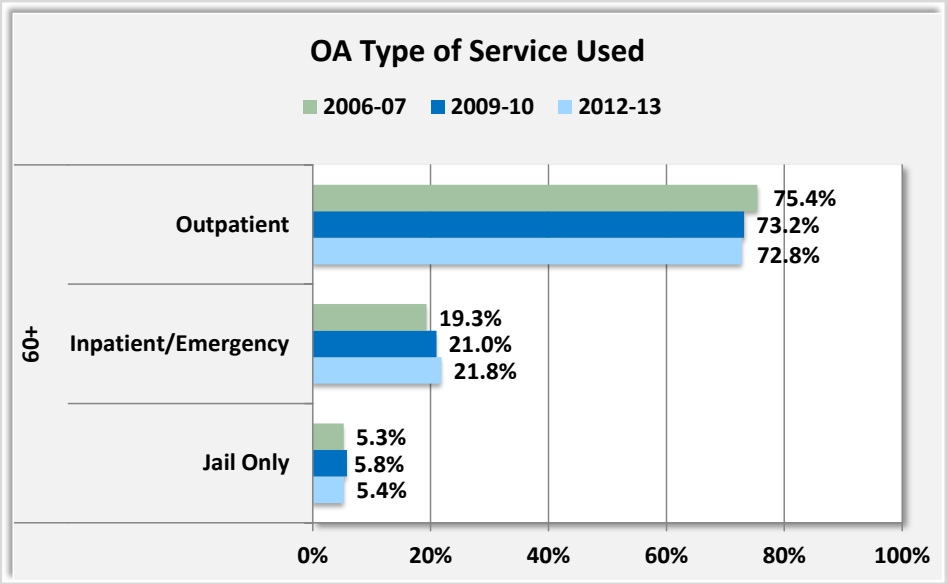


* Outpatient services include Assertive Community Treatment (ACT), Behavioral Health Court, Case Management, Fee-For-Service, and Prevention type services.
NOTE: Percentages may not add up to 100% due to rounding.

OA Type of Service Used

A goal of A/OA BHS has been to increase use of Outpatient services and decrease use of Inpatient/Emergency services. Types of services used by OA clients were examined for FYs 2006-07, 2009-10, and 2012-13. Utilization rates were calculated as the number of OA clients who used a specific type of service (i.e. Outpatient, Inpatient/Emergency, and Jail Only) divided by number of total OA clients.

Detailed tabular data are provided in Appendix A, Table 9.



- OA clients' usage of Outpatient services decreased from 75.4% in FY 2006-07 to 72.8% in FY 2012-13, while Inpatient/Emergency service use increased from 19.3% in FY 2006-07 to 21.8% in FY 2012-13.

Note: Inpatient/Emergency services category may include some clients that also have Jail services, and percentages may not add up to 100% due to rounding.

Attachments

Race/Ethnicity Determination

Glossary

Race/Ethnicity Determination

How was race/ethnicity defined?

Race/ethnicity data were collected from the INSYST (FY 2001-02 and FY 2006-07) and Anasazi (FY 2009-10 and FY 2012-13) MIS. The two systems utilized different descriptors for certain racial/ethnic categories, which were then recoded into common labels to facilitate multi-year comparisons. The classification procedure for the purposes of this report follows the United States Census Bureau definitions of race. The term race/ethnicity reflects a social/cultural definition. The definition of race/ethnicity does not conform to any biological, anthropological or genetic criteria. Hispanic ethnicity is tracked separately than race. People who identify their origin as Mexican American, Chicano, or Latino are classified as Hispanic but may be of any race (i.e. White or African American). See the following website for further information: http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf. Hispanic Ethnicity categories specific to the A/OA BHS and CYF BHS systems of care can be found on pages 15 and 16.

Race/ethnicity mapping for INSYST and Anasazi systems:

Description in InSyst	Race/Ethnicity Determination in InSyst	Description in Anasazi	Race/Ethnicity Determination in Anasazi
African American	African American	Asian Indian	Asian
Amerasian	Asian	Black/AfricanAm	African American
Asian Indian	Asian	Cambodian	Asian
Cambodian	Asian	Chaldean	Other
Chinese	Asian	Chinese	Asian
Cuban	Hispanic	Cuban	Hispanic
Dominican	Hispanic	Dominican	Hispanic
Ethiopian	Other	Eskimo/Alaskan Native	Native American
Filipino	Asian	Ethiopian	Other
Guamanian	Asian	Filipino	Asian
Hawaiian Native	Asian	Guamanian	Asian
Hmong	Asian	HawaiianNative	Asian
Iranian	Other	Hmong	Asian
Iraqi	Other	Iranian	Other
Japanese	Asian	Iraqi	Other
Korean	Asian	Japanese	Asian
Laotian	Asian	Korean	Asian
Mexican American/Chicano	Hispanic	Laotian	Asian
Multiple	Other	Mexican American/Chicano	Hispanic
Native American	Native American	Mien	Asian
Other	Other	Native American	Native American
Other Asian	Asian	Other Asian	Asian
Other Hispanic	Hispanic	Other Hispanic Latino	Hispanic
Other Latin American	Hispanic	Other Non-White/NonCaucasian	Other
Other Non-White	Other	Other Pacific Islander	Asian
Other Southeast Asian	Asian	Puerto Rican	Hispanic
Pacific Islander	Asian	Salvadoran	Hispanic
Puerto Rican	Hispanic	Samoan	Asian
Salvadoran	Hispanic	Somali	Other
Samoan	Asian	Sudanese	Other
Somali	Other	Unknown	Unknown
Sudanese	Other	Unknown/Not Reported	Unknown
Unknown	Unknown	Vietnamese	Asian
Vietnamese	Asian	White/Caucasian	White
White	White		

Glossary

200% Federal Poverty Level (FPL): Poverty level requirements to qualify for San Diego County behavioral health services; annual income for family of 2 less than $29k.

A/OA BHS: Adult and Older Adult Behavioral Health Services provides services to transition age youth, adults, and older adults with severe, persistent mental health needs or those experiencing a mental health crisis.

Cultural Competence: Ability to interact effectively with people of different racial/ethnic, cultural, or socio-economic backgrounds.

Cultural Sensitivity: Awareness of cultural and ethnic differences, without judgments of right or wrong.

CYF BHS: Children, Youth and Families Behavioral Health Services provides services to youth with serious emotional disturbances who are ages 0-17, with a small number of programs serving young adults 18 and older.

Disparities: Differences or inequalities between groups of people.

Eligible Clients (Target Population): Eligible clients were defined as those individuals in San Diego County who were: Medi-Cal OR uninsured, AND under 200% of the Federal Poverty Level (FPL) that could potentially have a serious mental illness (SMI).

Emergency Services: One-time use services such as the psychiatric emergency room (Emergency Psychiatric Unit; EPU), Psychiatric Emergency Response Team (PERT), and the Emergency Service Unit (ESU).

Externalizing Disorders: Constitutes acting-out behaviors, such as aggression, impulsivity, and noncompliance. Common externalizing disorders include: Attention-Deficit/Hyperactivity Disorder and Oppositional/Conduct Disorders.

Inpatient Services: Acute services, typically in psychiatric inpatient hospitals or crisis residential facilities.

Internalizing Disorders: Describes withdrawn, depressed, and anxious behaviors. Common internalizing disorders include: Depressive and Anxiety Disorders.

Jail Services: Any mental health services offered to those serving Jail sentences.

Juvenile Forensic Services (JFS): Services provided through JFS are typically delivered to probation-involved youth, and are not entered into the INSYST billing system.

Outpatient Services: Services such as case management, individual or group therapy, and medication management.

Penetration: The degree to which services are used.

Racial/Ethnic Identity: Identifying with a specific racial or ethnic group.

Retention: The ability to retain clients in services for a desired or necessary amount of time to maximize treatment effects.

Self-Awareness: Being aware of one's own thoughts and the impact those thoughts or actions derived from those thoughts may have on other people.

Service Utilization: Having the necessary resources and ability to obtain behavioral health services.

Transition Age Youth (TAY): Transition Age Youth are clients ages 18-24 that received services in the A/OA system of care. (NOTE: for a focused look at TAY clients in both A/OA and CYF BHS see the *Transition Age Youth SYSTEMWIDE REPORT* for San Diego County Behavioral Health Services, July 2014.)

Utilization: The manner in which a service is used.

Appendix A

Tabular Data Used in Figures:

Table 1. CYF BHS Penetration Rates by Age

Table 2. CYF BHS Penetration Rates by Race/Ethnicity

Table 3. A/OA BHS Penetration Rates by Age

Table 4. A/OA BHS Penetration Rates by Race/Ethnicity

Table 5. CYF BHS Retention Rates by Age

Table 6. CYF BHS Retention Rates by Race/Ethnicity

Table 7. A/OA BHS Retention Rates by Age

Table 8. A/OA BHS Retention Rates by Race/Ethnicity

Table 9. CYF BHS Type of Service Used by Age

Table 10. CYF BHS Type of Service Used by Race/Ethnicity

Table 11. A/OA BHS Type of Service Used by Age

Table 12. A/OA BHS Type of Service Used by Race/Ethnicity

Table 13. CYF BHS Diagnosis by Race/Ethnicity

Table 14. A/OA BHS Diagnosis by Race/Ethnicity

Table 15. CYF BHS Insurance Status by Race/Ethnicity

Table 16. A/OA BHS Insurance Status by Race/Ethnicity

Table 1. CYF BHS Penetration Rates by Age

Table 1. Children and Youth - Penetration Rates by Client Age

Children and Youth Penetration Rates by Age	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
0-5	78,728	80,705	84,348	87,508	1,294	1,850	2,075	2,232	1.6%	2.3%	2.5%	2.6%
6-11	76,077	77,987	81,508	84,561	6,146	4,959	5,129	5,992	8.1%	6.4%	6.3%	7.1%
12-17*	70,778	72,555	75,830	78,671	8,410	9,684	9,623	10,114	11.9%	13.3%	12.7%	12.9%
TOTAL	225,583	231,247	241,687	250,739	15,850	16,493	16,827	18,338	7.0%	7.1%	7.0%	7.3%

* This category includes 9,191 clients ages 12-17, plus an additional 923 clients ages 18+ who, although over 18 years of age, also received services through CYF BHS.

Table 2. CYF BHS Penetration Rates by Race/Ethnicity

Table 2. Children and Youth - Penetration Rates by Race/Ethnicity*

Race/Ethnicity	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
White	28,660	29,379	30,705	31,855	8,082	4,590	4,198	3,805	28.2%	15.6%	13.7%	11.9%
Hispanic	159,771	163,783	171,177	177,589	4,549	8,354	8,990	10,346	2.8%	5.1%	5.3%	5.8%
African American	19,799	20,296	21,212	22,007	2,446	2,515	2,318	2,044	12.4%	12.4%	10.9%	9.3%
Asian/Pacific Islander	12,757	13,077	13,667	14,179	587	420	464	437	4.6%	3.2%	3.4%	3.1%
Native American	4,597	4,712	4,925	5,109	186	112	125	91	4.0%	2.4%	2.5%	1.8%
TOTAL	225,584	231,247	241,687	250,739	15,850	15,991	16,095	16,723	7.0%	6.9%	6.7%	6.7%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.

Table 3. A/OA BHS Penetration Rates by Age

Table 3. Adults and Older Adults - Penetration Rates by Client Age by Service Type*

All Services	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
<18-24	74,552	76,425	79,875	82,867	5,232	5,061	6,514	6,317	7.0%	6.6%	8.2%	7.6%
25-59	242,191	248,273	259,482	269,201	30,651	29,725	32,163	29,998	12.7%	12.0%	12.4%	11.1%
60+	64,543	66,164	69,151	71,741	3,118	3,338	4,706	4,809	4.8%	5.0%	6.8%	6.7%
TOTAL	381,287	390,862	408,508	423,809	39,001	38,124	43,383	41,124	10.2%	9.8%	10.6%	9.7%

Excluding Persons Only Receiving Services in Jails	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
<18-24	74,552	76,425	79,875	82,867	3,913	3,725	4,835	5,029	5.2%	4.9%	6.1%	6.1%
25-59	242,191	248,273	259,482	269,201	25,489	24,222	26,145	24,984	10.5%	9.8%	10.1%	9.3%
60+	64,543	66,164	69,151	71,741	3,000	3,168	4,434	4,554	4.6%	4.8%	6.4%	6.3%
TOTAL	381,287	390,862	408,508	423,809	32,402	31,115	35,414	34,567	8.5%	8.0%	8.7%	8.2%

Including Only Persons Receiving Outpatient Services	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
<18-24	74,552	76,425	79,875	82,867	2,413	2,502	2,986	3,330	3.2%	3.3%	3.7%	4.0%
25-59	242,191	248,273	259,482	269,201	20,620	19,204	20,346	20,278	8.5%	7.7%	7.8%	7.5%
60+	64,543	66,164	69,151	71,741	2,252	2,438	3,424	3,469	3.5%	3.7%	5.0%	4.8%
TOTAL	381,287	390,862	408,508	423,809	25,285	24,144	26,756	27,077	6.6%	6.2%	6.5%	6.4%

* Excluding services provided while in Jail allows for the examination of penetration rates uninfluenced by mandatory services such as provided as part of the justice system.

Table 4. A/OA BHS Penetration Rates by Race/Ethnicity

Table 4. Adults and Older Adults - Penetration Rates by Race/Ethnicity* by Service Type**

All Services	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
White	68,180	69,892	73,047	75,783	22,991	19,716	22,077	19,619	33.7%	28.2%	30.2%	25.9%
Hispanic	190,506	195,290	204,106	211,751	6,660	8,242	8,801	9,294	3.5%	4.2%	4.3%	4.4%
African American	24,211	24,819	25,939	26,911	4,323	4,723	5,310	5,348	17.9%	19.0%	20.5%	19.9%
Asian/Pacific Islander	27,591	28,284	29,561	30,668	1,686	2,242	2,452	2,147	6.1%	7.9%	8.3%	7.0%
Native American	6,256	6,413	6,703	6,954	223	227	318	276	3.6%	3.5%	4.7%	4.0%
TOTAL	316,744	324,698	339,356	352,068	35,883	35,150	38,958	36,684	11.3%	10.8%	11.5%	10.4%

Excluding persons only receiving services in jails	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
White	68,180	69,892	73,047	75,783	19,092	16,415	17,897	16,394	28.0%	23.5%	24.5%	21.6%
Hispanic	190,506	195,290	204,106	211,751	5,465	6,363	7,183	7,692	2.9%	3.3%	3.5%	3.6%
African American	24,211	24,819	25,939	26,911	3,132	3,310	3,809	4,095	12.9%	13.3%	14.7%	15.2%
Asian/Pacific Islander	27,591	28,284	29,561	30,668	1,536	1,676	2,236	1,994	5.6%	5.9%	7.6%	6.5%
Native American	6,256	6,413	6,703	6,954	177	183	275	245	2.8%	2.9%	4.1%	3.5%
TOTAL	316,744	324,698	339,356	352,068	29,402	27,947	31,400	30,420	9.3%	8.6%	9.3%	8.6%

Including only persons receiving outpatient services	POTENTIAL CLIENTS				ACTUAL CLIENTS				PENETRATION RATE			
	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13	2001-02	2006-07	2009-10	2012-13
White	68,180	69,892	73,047	75,783	14,900	12,528	13,034	12,242	21.9%	17.9%	17.8%	16.2%
Hispanic	190,506	195,290	204,106	211,751	4,308	5,131	5,444	6,106	2.3%	2.6%	2.7%	2.9%
African American	24,211	24,819	25,939	26,911	2,396	2,465	2,801	3,156	9.9%	9.9%	10.8%	11.7%
Asian/Pacific Islander	27,591	28,284	29,561	30,668	1,299	1,431	1,866	1,694	4.7%	5.1%	6.3%	5.5%
Native American	6,256	6,413	6,703	6,954	130	151	222	200	2.1%	2.4%	3.3%	2.9%
TOTAL	316,744	324,698	339,356	352,068	23,033	21,706	23,367	23,398	7.3%	6.7%	6.9%	6.6%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (36,684). An additional 4,440 clients (11%) were of 'other' or 'unknown' race/ethnicity.

** Excluding services provided while in Jail allows for the examination of penetration rates uninfluenced by mandatory services such as provided as part of the justice system.

Table 5. CYF BHS Retention Rates by Age

Table 5. Children and Youth - Retention Rates by Client Age (FY 2012-13)

Age	Number of Sessions									
	1		2-5		6-9		10+		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
0-5	850	38.1%	355	15.9%	188	8.4%	839	37.6%	2,232	100.0%
6-11	510	8.5%	1,201	20.0%	841	14.0%	3,440	57.4%	5,992	100.0%
12-17	714	7.8%	1,953	21.2%	1,221	13.3%	5,303	57.7%	9,191	100.0%
18+	97	10.5%	205	22.2%	149	16.1%	472	51.1%	923	100.0%
TOTAL	2,171	11.8%	3,714	20.3%	2,399	13.1%	10,054	54.8%	18,338	100.0%

Table 6. CYF BHS Retention Rates by Race/Ethnicity

Table 6. Children and Youth - Retention Rates by Race/Ethnicity* (FY 2012-13)

All Services	Number of Sessions									
	1		2-5		6-9		10+		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
White	357	9.4%	753	19.8%	474	12.5%	2,221	58.4%	3,805	100.0%
Hispanic	988	9.5%	2,125	20.5%	1,429	13.8%	5,804	56.1%	10,346	100.0%
African American	203	9.9%	379	18.5%	238	11.6%	1,224	59.9%	2,044	100.0%
Asian/Pacific Islander	55	12.6%	92	21.1%	48	11.0%	242	55.4%	437	100.0%
Native American	8	8.8%	18	19.8%	9	9.9%	56	61.5%	91	100.0%
TOTAL	1,611	9.6%	3,367	20.1%	2,198	13.1%	9,547	57.1%	16723	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.

Table 7. A/OA BHS Retention Rates by Age

Table 7. Adults and Older Adults - Outpatient Retention Rates by Client Age (FY 2012-13)

Age	Number of Visits									
	1		2-5		6-9		10+		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
<18-24	426	12.8%	869	26.1%	506	15.2%	1,529	45.9%	3,330	100.0%
25-59	1,943	9.6%	4,407	21.7%	3,238	16.0%	10,690	52.7%	20,278	100.0%
60+	353	10.2%	732	21.1%	642	18.5%	1,742	50.2%	3,469	100.0%
TOTAL	2,722	10.1%	6,008	22.2%	4,386	16.2%	13,961	51.6%	27,077	100.0%

Note: Outpatient Services include ACT, BH Court, Case Management, FFS, Outpatient, and Prevention type services.

Table 8. A/OA BHS Retention Rates by Race/Ethnicity

Table 8. Adults and Older Adults - Outpatient Retention Rates by Race/Ethnicity* (FY 2012-13)

All Services	Number of Visits									
	1		2-5		6-9		10+		Overall	
	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate	Clients	Retention Rate
White	830	6.8%	2,462	20.1%	2,046	16.7%	6,904	56.4%	12,242	100.0%
Hispanic	562	9.2%	1,348	22.1%	877	14.4%	3,319	54.4%	6,106	100.0%
African American	314	9.9%	676	21.4%	469	14.9%	1,697	53.8%	3,156	100.0%
Asian/Pacific Islander	106	6.3%	307	18.1%	339	20.0%	942	55.6%	1,694	100.0%
Native American	14	7.0%	32	16.0%	41	20.5%	113	56.5%	200	100.0%
TOTAL	1,826	7.8%	4,825	20.6%	3,772	16.1%	12,975	55.5%	23,398	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (36,684). An additional 4,440 clients (11%) were of 'other' or 'unknown' race/ethnicity.
Note: Outpatient Services include ACT, BH Court, Case Management, FFS, Outpatient, and Prevention type services.

Table 9. CYF BHS Type of Service Used by Age

Table 9. Children and Youth - Type of Service Used by Client Age (FY 2012-13)

Age	Outpatient		Inpatient/ESU		JFS Only		TOTAL	
	Clients	%	Clients	%	Clients	%	Clients	%
0-5	2,228	99.8%	4	0.2%	0	0.0%	2,232	100.0%
6-11	5,970	99.6%	22	0.4%	0	0.0%	5,992	100.0%
12-17	8,867	96.5%	185	2.0%	139	1.5%	9,191	100.0%
18+	829	89.8%	18	2.0%	76	8.2%	923	100.0%
TOTAL	17,894	97.6%	229	1.2%	215	1.2%	18,338	100.0%

Table 10. CYF BHS Type of Service Used by Race/Ethnicity

Table 10. Children and Youth - Type of Service Used by Race/Ethnicity* (FY 2012-13)

Race/Ethnicity	Outpatient		Inpatient/Emergency		JFS Only		TOTAL	
	Clients	%	Clients	%	Clients	%	Clients	%
White	3,718	97.7%	38	1.0%	49	1.3%	3,805	100.0%
Hispanic	10,117	97.8%	126	1.2%	103	1.0%	10,346	100.0%
African American	1,976	96.7%	24	1.2%	44	2.2%	2,044	100.0%
Asian/Pacific Islander	410	93.8%	23	5.3%	4	0.9%	437	100.0%
Native American	90	98.9%	1	1.1%	0	0.0%	91	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.

Table 11. A/OA BHS Type of Service Use by Age

Table 11. Adults and Older Adults - Type of Service Used by Client Age (FY 2012-13)

Age	Outpatient		Inpatient/Emergency		Jail Only		TOTAL	
	Clients	%	Clients	%	Clients	%	Clients	%
<18-24	3,330	52.8%	1,690	26.8%	1,288	20.4%	6,308	100.0%
25-59	20,278	67.7%	4,652	15.5%	5,014	16.7%	29,944	100.0%
60+	3,469	72.8%	1,041	21.8%	255	5.4%	4,765	100.0%
TOTAL	27,077	66.0%	7,383	18.0%	6,557	16.0%	41,017	100.0%

Table 12. A/OA BHS Type of Service Use by Race/Ethnicity

Table 12. Adults and Older Adults - Type of Service Used by Race/Ethnicity* (FY 2012-13)

Race/Ethnicity	Outpatient		Inpatient/Emergency		Jail Only		TOTAL	
	Clients	%	Clients	%	Clients	%	Clients	%
White	12,242	62.6%	4,088	20.9%	3,225	16.5%	19,555	100.0%
Hispanic	6,106	65.8%	1,572	16.9%	1,602	17.3%	9,280	100.0%
African American	3,156	59.3%	917	17.2%	1,253	23.5%	5,326	100.0%
Asian/Pacific Islander	1,694	79.1%	294	13.7%	153	7.1%	2,141	100.0%
Native American	200	72.5%	45	16.3%	31	11.2%	276	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (36,684). An additional 4,440 clients (11%) were of 'other' or 'unknown' race/ethnicity.

Table 13. CYF BHS Diagnosis by Race/Ethnicity

Table 13. Children and Youth - Distribution of Diagnoses by Race/Ethnicity* (FY 2012-13)

Primary Diagnosis**	White		Hispanic		African American		Asian/ Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
ADHD	524	16.5%	1,115	12.7%	361	20.2%	43	11.9%	9	11.1%
Oppositional/Conduct Disorders	472	14.9%	1,672	19.0%	359	20.1%	47	13.0%	12	14.8%
Depressive Disorders	602	19.0%	1,990	22.6%	286	16.0%	90	24.9%	12	14.8%
Bipolar Disorders	332	10.5%	519	5.9%	166	9.3%	20	5.5%	10	12.3%
Anxiety Disorders	419	13.2%	1,089	12.4%	187	10.5%	51	14.1%	7	8.6%
Adjustment Disorders	573	18.1%	1,800	20.4%	282	15.8%	69	19.1%	24	29.6%
Schizophrenic Disorders	23	0.7%	88	1.0%	21	1.2%	9	2.5%	1	1.2%
Other Disorders	137	4.3%	337	3.8%	87	4.9%	19	5.3%	5	6.2%
Excluded	90	2.8%	202	2.3%	37	2.1%	13	3.6%	1	1.2%
TOTAL	3,172	100.0%	8,812	100.0%	1,786	100.0%	361	100.0%	81	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.

** The Primary Diagnosis information presented above represents data for the clients who received services from county contracted organization providers during FY 2012-13 and for whom a primary diagnosis was available.

Table 14. A/OA BHS Diagnosis by Race/Ethnicity

Table 14. Adults and Older Adults - Distribution of Diagnoses by Race/Ethnicity* (FY 2012-13)

Primary Diagnosis**	White		Hispanic		African American		Asian/ Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Schizophrenia and Schizoaffective	4,272	26.1%	2,065	26.7%	1,709	38.0%	697	36.6%	79	32.2%
Bipolar Disorders	3,172	19.3%	897	11.6%	498	11.1%	148	7.8%	45	18.4%
Major Depression Disorders	4,501	27.4%	2,356	30.5%	985	21.9%	687	36.0%	64	26.1%
Other Psychotic Disorders	705	4.3%	495	6.4%	397	8.8%	118	6.2%	10	4.1%
Other Depression/Adjustment	1,563	9.5%	946	12.2%	490	10.9%	120	6.3%	25	10.2%
Anxiety Disorders	1,097	6.7%	532	6.9%	195	4.3%	101	5.3%	16	6.5%
Substance Use Disorders	1,005	6.1%	419	5.4%	210	4.7%	33	1.7%	6	2.4%
Cognitive / Personality Disorders	83	0.5%	16	0.2%	16	0.4%	2	0.1%	0	0.0%
TOTAL	16,398	100.0%	7,726	100.0%	4,500	100.0%	1,906	100.0%	245	100.0%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (36,684). An additional 4,440 clients (11%) were of 'other' or 'unknown' race/ethnicity.

** The Primary Diagnosis information presented above represents data for the clients who received services from county contracted organizational providers during FY 2012-13 and for whom a primary diagnosis was available.

Table 15. CYF BHS Insurance Status by Race/Ethnicity

Table 15. Children and Youth - Insurance Rates by Race/Ethnicity* (FY 2012-13)

Insurance Type	White		Hispanic		African American		Asian/ Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Medi-Cal Only	2,899	76%	8,281	80%	1,771	87%	331	76%	79	87%
Any Private Insurance	267	7%	261	3%	115	6%	29	7%	3	3%
Other Insurance	395	10%	1,270	12%	87	4%	47	11%	5	6%
Uninsured**	244	6%	534	5%	71	4%	30	7%	4	4%
TOTAL	3,805	100%	10,346	100%	2,044	100%	437	100%	91	100%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (16,723 clients). An additional 1,615 clients (9%) were of 'other' or 'unknown' race/ethnicity.
** This category specifically represents clients that have no insurance on record in the Anasazi MIS for FY 2012-13.

Table 16. A/OA BHS Insurance Status by Race/Ethnicity

Table 16. Adults and Older Adults - Insurance Rates by Race/Ethnicity* (FY 2012-13)

Insurance Type	White		Hispanic		African American		Asian/ Pacific Islander		Native American	
	Clients	%	Clients	%	Clients	%	Clients	%	Clients	%
Uninsured**	8,859	45%	3,581	39%	2,031	38%	670	31%	104	38%
Medi-Cal Only	6,494	33%	4,295	46%	2,397	45%	998	46%	124	45%
Medi-Cal + Medicare	3,223	16%	916	10%	675	13%	383	18%	34	12%
Medicare Only	202	1%	33	0%	25	0%	11	1%	2	1%
Private	841	4%	469	5%	220	4%	85	4%	12	4%
TOTAL	19,619	100%	9,294	100%	5,348	100%	2,147	100%	276	100%

* For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (36,684). An additional 4,440 clients (11%) were of 'other' or 'unknown' race/ethnicity.
** This category specifically represents clients that have no insurance on record in the Anasazi MIS for FY 2012-13.

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

UCSD's Health Services Research Center provides a comprehensive variety of research services to academia, health services organizations, corporations, and individuals worldwide. We are a non-profit research organization within the University of California San Diego's School of Medicine, Department of Family and Preventive Medicine. Our mission is to support research focused on understanding how clinical and treatment services affect health outcomes. The center brings together experts in the fields of health outcomes, program evaluation, quality of life measurement, and medical research informatics, providing the infrastructure for clinical and academic research and program and performance evaluation studies.

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Adult/Older Adult Mental Health Services
Mission/Guiding Principles Statement for Outpatient Mental Health Clinics and BPSR Centers

MISSION

The Adult/Older Adult Mental Health Services System of Care is based on Biopsychosocial and Rehabilitation (BPSR) principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members.

PRINCIPLES

BPSR guiding principles specify that services shall be:

- Person-centered;
- Comprehensive and integrated with a broad array of services;
- Individualized, culture-centered, and built upon person's strengths;
- Provided in the least restrictive and most appropriate setting;
- Coordinated both at the system and service delivery levels;
- Delivered with clients as full partners in their treatment and care;
- Protective of client rights.

The mission and principles of the organization are a yardstick against which to measure outcomes. Consumers (clients and family members) of mental health services are valued members of the community.

Treatment and care shall be person-centered and:

- Planned in consideration of the person's individual goals, diverse needs, concerns, strengths, and motivations.
- Culturally, linguistically, and developmentally appropriate to the individual.
- Based on a continuing analysis of the person's need and flexible enough to incorporate new information and new technology.
- Planned and delivered in a quality-based, cost-effective manner.
- Built on the assets of the clients and their support systems (family and friends).
- Developed with priority given to services in the community.

CHILDREN'S SYSTEM OF CARE PRINCIPLES

BACKGROUND

Beginning in 1995, a broad based group of community stakeholders developed values and principles for San Diego County Mental Health Children's System of Care (CSOC). Over the years, the values have been implemented and have set forth new practices and approaches for our delivery system.

In 2010, the Children's System of Care Council recommended that the principles be reviewed to ensure that they are contemporary with our current practice as driven by the needs of the community. In the CSOC workgroup review process, it was concluded that the initial core principles remain relevant. Refinements were made to reflect our current direction which complemented the *Live Well, San Diego!* initiative. This evolution:

- integrates mental health and substance abuse into a behavioral health system,
- integrates physical health for the overall advancement of health and wellness,
- underscores the importance of natural community resources,
- values the complexity of cultural diversity, AND
- strengthens our commitment to youth and families

In 2016, The Children's System of Care Council recommended that a Trauma Informed Care Principle be added to the Children's System of Care Principles; a principle that:

- Realizes the widespread impact of trauma
- Recognizes the signs and symptoms of trauma
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices, and
- Actively seeks to prevent re-traumatization while promoting self-care and resilience

All of these refinements re-affirm our system of care principles, the advancements made, and the pathway for our future direction.

CSOC Council Vision: *San Diego youth are healthy, safe, successful in school, and in their transition to adulthood, while being law abiding, while living in a home and community that supports strong family connections.*

Mission: *The purpose of the System of Care Council is to ensure that all agencies serving San Diego county youth from age 0 through age 21 have coordinated services resulting in improved youth and family, and system outcomes consistent with System of Care Values and Principles.*

1. **Collaboration of four sectors:** The cornerstone of the CSOC is a strong four sectors partnership between youth/families, public agencies, private organizations and education that ensure accountability to achieve System of Care (SOC) goals and quality outcomes consistent with SOC philosophy.

2. **Integrated:** Among the four sector partners services are comprehensive, accessible coordinate behavioral and physical health care, provide seamless transition of care and utilize natural community supports,

3. **Youth guided, family driven:** Youth and families actively participate in service delivery, planning, and program and policy development.

4. **Individualized:** Services are flexible and designed to meet and build upon the unique needs, strengths and potential of each youth, and family**.**

5. **Strength-based:** Individualized plans and services identify and utilize youth/family strengths to facilitate health and wellness.

6. **Community-based**: Sector partners offer an array of services in each region and strengthen family and youth connections to neighborhood and local community resources.

7. **Outcome driven**: Service delivery systems continuously improve services by measuring and evaluating outcomes and use results to modify practices.

8. **Culturally Competent:** Service providers honor the diversity of cultures; address the complexities within and between cultures, and provide accessible and relevant services.

9. **Trauma Informed:** Sector partners recognize that trauma and chronic stress influence coping strategies and behavior, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care and resilience.

H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2010 United States Census reports a 10% population increase in San Diego County, with no single racial/ethnic group comprising a majority. Whites make up 48% of the population, Hispanics 32%, Asians 11%, Blacks 5% and Native Americans/American Indians 1%.

As the diversity of the population continues to increase, the FY 2012-13 Disparities Report noted an increase in the number of Medi-Cal mental health clients from various minority populations. While progress has been made in addressing disparities in service among ethnic and racial populations, the SDCBHS Cultural Competence Plan notes that minority populations are still underrepresented among total mental health clients, especially among adult populations. For example, in FY 2012-13, 9% of the County uninsured/Medi-Cal under 200% Federal Poverty Level adult population and 6% of the children's population were Asian/Pacific Islander, but only 6% of the A/OA mental health clients and 3% of CYF clients were from these ethnic groups. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed ethnic, racial and cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with an estimated 23.5% being 55 years of age or older.

Cultural Competence Plan

To address these issues in the 2016 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

1) Continue to conduct an ongoing evaluation of the level of cultural competence of the

mental health system, based on an analysis of gaps in services that are identified by comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.
2) Continue to compare the percentage of each target population with provider staffing levels.
3) Investigate possible methods to mitigate identified service gaps Enhance cultural competence training system-wide.
4) Evaluate the need for linguistically competent services through monitoring usage interpreter services.
5) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs.
6) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

***Culturally and Linguistically Appropriate Services (CLAS) Standards**:*

The Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competence across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards.

The Standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center (TKC) for County operated program staff at no cost and for a small number of providers on a fee basis.

- Cultural Competence Trainings are available through some of SDCBHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. offer their own such trainings to their own program staff but other providers may send staff on a fee basis.
- SDCBHS Contracted Trainings are available through the Behavioral Health Education and Training Academy (BHETA). Limited classroom training and on-line trainings are available at no cost to staff of County contracted and County operated programs. BHETA also offers a one-hour webinar on the implementation of CLAS Standards.
- SDCBHS Cultural Competence Academy Intensive Training—a 32-40 hour course is offered to two groups of up to 60 staff per year to implement a CADRE model for cultural competence training.

Cultural Competence Monitoring and Evaluation:

The MHP QM Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QM Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement:

Program Level Requirements:

1. Cultural Competence Plan (CCP). As of December 2013, Cultural Competence Plans are required for all legal entities. If your organization does not have a Plan, the CCP Component Guidelines outlined below may be used to assist you in developing a CCP. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library website at: http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html The CCP Component Guidelines are as follows:

   - Current Status of Program
     - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
     - Identify how program administration prioritizes cultural competence in the delivery of services.
     - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
     - Goals accomplished regarding reducing health care disparities.
     - Identify barriers to quality improvement.
   - Service Assessment Update and Data Analysis
     - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
     - Comparison of staff to diversity in community.

- A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
- Use of interpreter services.
- Service utilization by ethnicity, race, language usage, and cultural groups.
- Client outcomes are meaningful to client's social ecological needs.

➢ Objectives
- Goals for improvements.
- Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
  - Trauma-informed principles and concepts integrated
  - Faith-based services

New contractors need to submit a CCP, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CCP.

Plans can be sent via email to BHSQIPOG@sdcounty.ca.gov.

2. Culturally Competent Program Annual Self-Evaluation (CC-PAS) – Every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided two weeks to complete a 20-item clinical or non-clinical survey. The survey can be completed in approximately one hour or less. For your information, a copy of the clinical and the non-clinical CC-PAS protocols has been included in the Organization Provider Handbook, Appendix H-A.H.1.

3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

California Brief Multicultural Competence Scale (CBMCS). Every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their multicultural competence in providing behavioral health services. The CBMCS is a 21-item assessment that can be completed in less than 30 minutes. For your information, a copy of the CBMCS protocol has been included in the Organization Provider Handbook, Appendix H-A.H.2.

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

a. All new staff must meet the requirements within 90 days of hire; including temporary staff who have been on site at least 90 days.
b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".
c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

***Consumer Preference: Cultural/Ethnic Requirements**:*
Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

***Consumer Preference: Language Requirements**:*
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the ESU are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key

Points of Entry for the languages listed:

- Spanish
  - EPU
  - All Outpatient and Case Management programs
- Vietnamese
  - UPAC
- Tagalog
  - UPAC
- Arabic
  - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

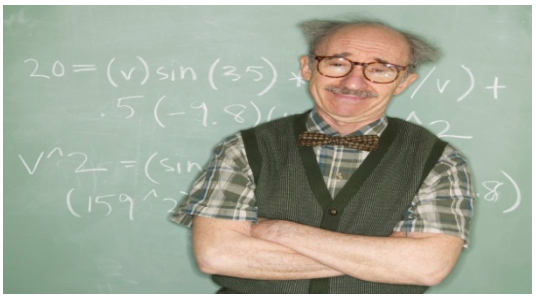
- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Topics that may be covered in the survey or focus group include:

  - Regarding Language:
    - Offers of providers who speak the client's language, or interpreter services.
    - Linguistic proficiency of staff providing services or interpreters who provide services.
    - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language.
    - Availability of written materials, including alternate formats in client's preferred language.
  - Regarding Culture/Ethnicity:
    - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment.
    - Direct services staff's knowledge of culturally appropriate referral

resources.

- Direct services staff's familiarity with variant beliefs regarding mental illness.
- Appropriateness of clinic environment.
- The County has provided technical assistance with developing survey/focus group questions in the enhanced Cultural Competence Handbook published in July 2014. The Handbook is located in Section 4 on the Technical Resource Library website at: http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.
- Explore whether there are barriers to service being created by cultural competence issues.
- Document the results of the focus group(s) including findings and plans for interventions, as needed.



Cultural Competence Handbook

San Diego County Behavioral Health Services
March 2016

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Report Prepared by:

San Diego County Behavioral Health Services (SDCBHS)
Quality Improvement Unit
In collaboration with The Cultural Competence Resource Team

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Cultural Competence Handbook

Introduction

The County of San Diego is richly diverse, beyond ethnicity; cultures are dynamic and unique. We celebrate the wealth of diversity and the demographics below are just one indication of our cultural wealth. The Agency, providers, and community partners face a unique opportunity when engaging culture sensitivity. One way is our recent integration of trauma-informed systems. Being trauma-informed is a philosophy, a component of cultural competence; an approach to engage all people we serve, all staff and those we encounter whilst conducting business. Cultural norms, values, beliefs, customs, and behaviors may influence behavioral health and medical issues, so authentic engagement and developing relationships with those we serve will guide our work with positive outcomes as the intent. On July 13, 2010, the County Board of Supervisors took a bold and innovative leap forward in the area of health policy by adopting a 10-year health strategy agenda to improve the health of our region. This highly innovative strategy agenda aims to improve the health and well-being of county residents through four key pillars: 1) Building a Better Service Delivery System, 2) Supporting Positive Healthy Choices, 3) Pursuing Policy and Environmental Changes, and 4) Improving the Culture from Within County Government.

	2010 United States Census Data	2010 San Diego County Census Data	FY 2014-15 Behavioral Health Services
White	231,040,398 (74.8%)	1,981,442 (64.0%)	22,615 (36.4%)
Hispanic	50,477,594 (16.4%)	991,348 (32.0%)	19,877 (32.0%)
African American	42,020,743 (13.6%)	158,213 (5.1%)	7,171 (11.5%)
Asian/Pacific Islander	17,320,856 (5.6%)	351,428 (11.4%)	2,722 (4.4%)
Native American	5,220,579 (1.7%)	26,340 (0.9%)	424 (0.7%)
LGBTQI	9,083,558* (2.9%)	300,000** (9.6%)	1,786*** (2.8%)
Veterans	26,403,703 (8.5%)	292,034 (9.4%)	*1,672*** *(3.8%)*
Age 0-17	74,181,467 (24.0%)	821,263 (26.5%)	17,308 (27.9%)
Age 18-24	30,672,088 (9.9%)	270,750 (8.8%)	8,492 (13.7%)
Age 25-59	146,806,075 (47.6%)	1,502,564 (49.0%)	30,826 (49.6%)
Age 60+	57,085,908 (18.5%)	500,736 (16.2%)	5,471 (8.8%)
For additional information on BHS client demographics, go to the HHSA, BHS Technical Resource Library: http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html			

**The information on adult LGBT population in the US was obtained from The Williams Institute, UCLA School of Law.*
***This number is approximate based on the information from Behavioral Health Education and Training Academy*
Note: the percentages are based on the total 2010 US population (308,745,538), 2010 San Diego County (3,095, 313) population, and FY 2012-13 BHS population (59,462).
****Information is based on FY 2013-14 BHS client population. Proportion of veterans is based on A/OA client count.*

In alignment with "*Live Well, San Diego!"*, the Health and Human Services Agency Behavioral Health Services Division (BHS) continually works toward the complete integration of systems and services. Within this integration process, BHS is working to fully incorporate the recognition of the personal experiences within cultural diversity and sees the creation of an integrated culturally competent and trauma-informed Behavioral Health system as a developmental process. BHS has demonstrated commitment to cultural competence and trauma-informed systems; continually enhancing strategies and efforts for enhancing wellness and reducing all disparities; cultural competence evaluation and training activities; the continued development of a multicultural workforce; and continued integration of systems and services. As part of our goal to enhance well-being and reduce disparities for all populations, SDCBHS presents this Cultural Competence Handbook. The Handbook contains tools that will assist Behavioral Health providers in making improvements throughout the system of care.

County of San Diego, Health and Human Services Agency

Vision:

Healthy, Safe, and Thriving San Diego Communities

Mission:

To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. **Building a Better System** focuses on systems and how the County delivers services. How it can further strengthen partnerships to support better health and wellbeing. For example, being trauma-informed is a component of cultural competency therefore the County is integrating physical and mental health given the bi-directional connectivity and making the systems and services easier to access.
2. **Supporting Healthy Choices** provides information and educates residents so they are aware of how their choices may impact their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within**. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk." Simply said, change starts with the County as we practice what we teach.

Behavioral Health Services

Vision:

Safe, mentally healthy, addiction-free communities

Mission:

In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees to reach their full potential.

The Importance of Cultural Competence

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

The National Center for Cultural Competence has identified six salient reasons to incorporate cultural competence into organizational policy:

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and health outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the market place.
6. To decrease the likelihood of liability/malpractice claims.

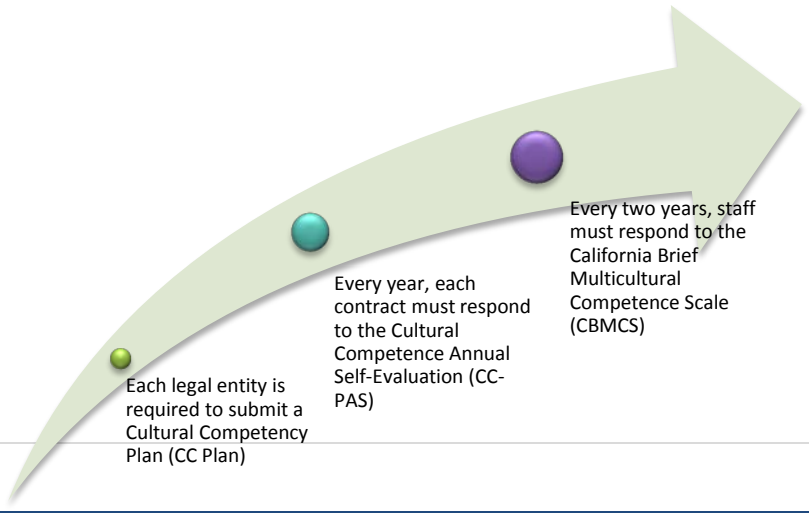
For more details go to: http://nccc.georgetown.edu/foundations/need.html.

To support the needs of our diverse populations SDCBHS recommends that all providers be committed to prioritizing cultural competence. This goal can be achieved through the following:

1. Incorporating trauma-informed and cultural competencies throughout the provider's:
    i. Mission Statements
    ii. Guiding Principles
    iii. Policies and Procedures
2. Development or enhancement of a Cultural Competence Plan.
3. Periodic evaluation of staff, programs and clients.
4. Ensuring that the clinical practice is based on trauma-informed care, cultural awareness, and life-long enhancement of knowledge and skills.

This Cultural Competence Handbook provides timelines, guidelines, and examples of methods and tools that are recommended and can be used to guide programs in achieving the goal of enhancing wellness and reducing disparities.

Behavioral Health Services Cultural Competency Expectations for Providers



Cultural Competency Rollout			
When	**What**	**Who**	
		Alcohol and Drug Services (ADS)	***Mental Health Services (MHS)***
1 Time	Cultural Competency Plan (CC Plan)	*Required for all Legal Entities as of December 2013* *Updates as needed*	
Annual	Cultural Competence Program Annual Self-Evaluation (CC-PAS)	*April 2016* *April 2017* *April 2018*	
2 Years	The California Brief Multicultural Competence Scale (CBMCS)	*October 2017* *October 2019*	

Cultural Competency History		
CC-PAS	**CBMCS**	**CC Plan**
Year 1: April 2012 (MHS only) Year 2: April 2013 (MHS only) Year 3: April 2014 (MHS and ADS) Year 4: April 2015 (MHS and ADS)	October 2011 (MHS only) October 2013 (MHS and ADS) October 2015 (MHS and ADS)	April 2012 (MHS) December 2014 (ADS)

The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) were developed by the Health and Human Services Office of Minority Health and are intended to advance health equity, improve quality, and help eliminate health care disparities (see the Resources section). Implementing strategies to improve and ensure cultural and linguistic competency in the behavioral health care systems using the CLAS standards is a powerful way to address disparities and ensure all populations have equal access to services and supports. In addition to the new requirements in each programs' Statements of Work for adhering to CLAS standards, the following chart shows how CLAS Standards are already embedded into cultural competence evaluation tools provided in the Handbook.

CLAS Standards	CC-PAS	CBMCS	CC Plan
Principal Standard:			
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	•	•	•
Governance, Leadership, and Workforce:			
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	•		•
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	•	•	•
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	•		•
Communication and Language Assistance:			
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	•		•
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.			•
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	•		•
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.			•
Engagement, Continuous Improvement, and Accountability:			
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	•		•
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	•	•	•
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	•		•
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	•		•
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	•		•
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.			•
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	•		•

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
For more information and to access CLAS standards visit www.thinkculturalhealth.hhs.gov/Content/clas.asp.

Cultural Competence Plan

An outline for the development of a Cultural Competence Plan

Cultural Competence Plan Development Guidelines

Goal: To provide guidelines to assist and guide programs to develop a plan that enhances their current capability for providing trauma-informed and culturally competent systems and services.

Background: As stated in all SDCBHS contracts, it is an expectation that the organizations develop and provide trauma-informed and culturally competent systems and services, and work to continually enhance levels of cultural competence. This complements the expectation that the California Department of Health Care Services (DHCS) has for each county. The guidelines below, developed by SDCBHS with input from the Cultural Competence Resource Team (CCRT), can be used as a tool as your organization works to assess the current cultural competence and integrate the plan components into the system of care. If you do not have a Cultural Competence Plan in place currently, please ensure the following components are addressed. If you already have a Cultural Competence Plan in place, please evaluate to determine adding any of the elements noted in these guidelines could enhance your plan.

Cultural Competence Plan Component Guidelines:

- Current Status of Program
  - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
  - Identify how program administration prioritizes cultural competence in the delivery of services.
  - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
  - Goals accomplished regarding reducing health care disparities.
  - Identify barriers to quality improvement.

- Service Assessment Update and Data Analysis
  - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
  - Comparison of staff to diversity in community.
  - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
  - Use of interpreter services.
  - Service utilization by ethnicity, race, language usage, and cultural groups.
  - Client outcomes are meaningful to client's social ecological needs.

- Objectives
  - Goals for improvements.
  - Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.
    - Trauma-informed principles and concepts integrated
    - Faith-based services

The checklist on page 13 may serve as a resource for incorporating Cultural Competence Plan components into your policies and procedures. **It's provided for reference only**.

Please note: As of December 2013, Cultural Competence Plans are required for all legal entities for both mental health and alcohol and drug services. For legal entities with multiple programs, please consider a Cultural Competence Plan per program.

Cultural Competence Plan Implementation Checklist

SDCBHS recommends the use of this tool

CULTURAL COMPETENCE PLAN COMPONENTS:	COMPONENT IMPLEMENTATION					In response to what data or information was the change/innovation/ improvement made?
	In Progress:	Approx. Impl. Date:	Met:	Resources Used:	Date Met:	
Current Status of Program						
Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.	☐		☐			
Identify how program administration prioritizes cultural competence in the delivery of services.	☐		☐			
Agency training, supervision, and coaching incorporate trauma-informed systems and service components.	☐		☐			
Goals accomplished regarding reducing health care disparities.	☐		☐			
Identify barriers to quality improvement.	☐		☐			
Service Assessment Update and Data Analysis						
Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.	☐		☐			
Comparison of staff to diversity in community.	☐		☐			
A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.	☐		☐			
Use of interpreter services.	☐		☐			
Service utilization by ethnicity, race, language usage, and cultural groups.	☐		☐			
Client outcomes are meaningful to client's social ecological needs.	☐		☐			
Objectives						
Goals for improvements.	☐		☐			
Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.	☐		☐			
a) Trauma-informed principles and concepts integrated **b) Faith-based services**	☐ ☐		☐ ☐			

Example:

Client outcomes are meaningful to client's social ecological needs.	☐		☒	Client Focus Group	Dec 13	Part of client-focused initiative.

CLAS standards offer a strong framework to provide culturally and linguistically appropriate services, and because they are already embedded into cultural competence evaluation tools in the Handbook, the programs will be adhering to the Standards by utilizing the tools, following the established Cultural Competence Plan, and completing regularly scheduled evaluations as noted in the Rollout on page 9.

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Evaluating Cultural Competence

Evaluation

Included in this handbook are the following tools for evaluating program and staff in regards to cultural competence. Programs are required to use the CC-PAS and CBMCS as directed by San Diego County Behavioral Health Services. Evaluations for other areas may be done by using the tools noted or other tools that your program or legal entity has identified that meet the same criteria.

- Cultural Competence – Program Annual Self-Evaluation (CC-PAS)
- California Brief Multicultural Competence Scale (CBMCS)
- Certification of Language Competence
- Assessing Cultural Competence – Client Survey
- Assessing Cultural Competence – Client Focus Groups
- Assessing Cultural Competence – Community Survey
- Training Needs Assessment

Culturally Competent Program Annual Self-Evaluation

CC-PAS

(Clinical and non-clinical)

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Behavioral Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed, programs should use the space at the end of the CC-PAS to develop new or revised goals and objectives/targets for their program's Cultural Competence Plan that will lead to ratings indicating a higher level of cultural competence in subsequent years.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.

- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.

- Tally the score in each category using the following scale:
  - 5 points for Met Standard
  - 3 points for Partially Met Standard
  - 1 point for Standard Not Met

- Determine the total score.

- If your program needs technical assistance on certain topics, you can note that by checking at the end of any question:
  ___ Technical Assistance needed.

- The annual evaluation will serve as a baseline for your program. Keep a record of the results of the CC-PAS to use to evaluate your progress over time.

- Repeat the CC-PAS annually.

- Some items may not be applicable if program is not a direct service provider.

CLINICAL CC-PAS Protocol

1) The program/facility has developed a Cultural Competence Plan (CCP). Attach a copy of the CCP or describe the plan.

_____

_____

☐ STANDARD MET
Program has a written CCP that addresses the specific needs of the program.

☐ STANDARD PARTIALLY MET
Legal Entity has a written CCP but the specific needs of that program are not identified, or there is no written CCP but there is some other evidence of a plan.

☐ STANDARD NOT MET
There is no plan to achieve cultural competence for the program.

Score = _____ _____ Technical Assistance Needed

Note: A suggested format and checklist that may be used for developing a CCP, if needed, have been provided on pages 11-12.

2) The program/facility has assessed the strengths and needs for services in its community. Describe the strengths and need for services:

_____

_____

☐ STANDARD MET
The strengths and needs of the community are clearly identified in the CCP. Community members, program advisory groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

☐ STANDARD PARTIALLY MET
The strengths and needs of the community are not clearly identified in the CCP, but there is evidence that the program is aware of the strengths and needs of the community.

☐ STANDARD NOT MET
The program is not aware of the strengths and needs of the community.

Score = _____ _____ Technical Assistance Needed

3) The staff in the program/facility reflects the diversity within the community. Attach a report that delineates staff diversity and compares the composition of the staff to the community, or describe:

_____

_____

☐ STANDARD MET
The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ STANDARD PARTIALLY MET
The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ STANDARD NOT MET
The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

Score = _____ _____ Technical Assistance Needed

4) The program/facility has a process in place for ensuring language competence of *DIRECT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Attach or describe the process:

_____

_____

☐ STANDARD MET
The program has a policy or written process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.

☐ STANDARD PARTIALLY MET
The program has an informal process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual.

☐ STANDARD NOT MET
The program does not have a process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual.

Score = _____ _____ Technical Assistance Needed

5) The program/facility has a process in place for ensuring language competence of *SUPPORT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Describe the process:

_____

_____

☐ STANDARD MET
The program has a policy or written process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.

☐ STANDARD PARTIALLY MET
The program has an informal process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual.

☐ STANDARD NOT MET
The program does not have a process for testing the language competence of **support services staff** who identify themselves as bi or multi-lingual.

Score = _____ _____ Technical Assistance Needed

6) The program/facility supports/provides direct and indirect services staff training on the use of interpreters. Describe the process:

_____

_____

☐ STANDARD MET
The program has evidence that demonstrates direct and indirect services staff training on the use of language interpreters.

☐ STANDARD PARTIALLY MET
There is informal training of direct and indirect services staff on the use of language interpreters.

☐ STANDARD NOT MET
There has been no direct or indirect services staff training on the use of interpreters.

Score = _____ _____ Technical Assistance Needed

7) The program/facility uses language interpreters as needed. Describe the use of language interpreters and languages used:

_____

_____

☐ STANDARD MET
The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.

☐ STANDARD PARTIALLY MET
The program occasionally uses language interpreters.

☐ STANDARD NOT MET
The program does not use language interpreters and cannot demonstrate the offer of interpreters.

Score = _____ _____ Technical Assistance Needed

8) The program/facility has a process in place for assessing cultural competence of direct and support services staff. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility has a written/formal process in place for assessing cultural competence of direct and support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members.

☐ STANDARD PARTIALLY MET
The program/facility has a process in place for assessing cultural competence of direct and support services staff.

☐ STANDARD NOT MET
The program/facility does not have a process in place for assessing cultural competence of direct and support services staff.

Score = _____ _____ Technical Assistance Needed

9) The program/facility has a process and a tool in place for direct and support services staff to self-assess cultural competence (e.g. California Brief Multicultural Competence Scale – CBMCS). Describe the process and give the tool name:

_____

_____

☐ STANDARD MET
The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CBMCS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.

☐ STANDARD PARTIALLY MET
The program encourages staff to complete the CBMCS or a similar tool.

☐ STANDARD NOT MET
The program does not support opportunities for staff to complete the CBMCS or a similar tool and does not have evidence of the results of those evaluations.

Score = _____ _____ Technical Assistance Needed

10) The program/facility has conducted a survey amongst its clients to determine if the program is perceived as being culturally competent. Summarize the results of the survey:

_____

_____

☐ STANDARD MET
The program/facility has conducted a survey amongst its clients and their family members to determine if the program is perceived as being culturally competent.

☐ STANDARD PARTIALLY MET
The program/facility is using the annual San Diego County Behavioral Health Services (SDCBHS) client satisfaction survey to determine if the program is perceived as being culturally competent.

☐ STANDARD NOT MET
The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

Score = _____ _____ Technical Assistance Needed

11) The program/facility conducted a survey amongst its clients to determine if the program's CLINICAL SERVICES are perceived as being culturally competent. Summarize the results of the survey:

_____

_____

☐ STANDARD MET
The program/facility has conducted a survey amongst its clients to determine if the program's **clinical services** are perceived as being culturally competent.

☐ STANDARD PARTIALLY MET
The program/facility uses the annual SDCBHS state survey to determine if the program's **clinical services** are perceived as being culturally competent.

☐ STANDARD NOT MET
The program/facility does not use a survey amongst its clients to determine if the program's **clinical services** are perceived as being culturally competent.

Score = _____ _____ Technical Assistance Needed

12) The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards. Describe how the standards are utilized:

_____

_____

☐ STANDARD MET
The program utilizes the CLAS Standards and trains all staff and managers on them at least annually.

☐ STANDARD PARTIALLY MET
The program utilizes the CLAS Standards but has little or no training.

☐ STANDARD NOT MET
The program does not utilize the CLAS Standards.

Score = _____ _____ Technical Assistance Needed

13) The program/facility supports cultural competence training of *DIRECT SERVICES STAFF*. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility supports cultural competence training of **direct services staff**, and 80-100% of staff have attended at least 4 hours of training.

☐ STANDARD PARTIALLY MET
The program/facility supports cultural competence training of **direct services staff**, and 50-79% of staff have attended at least 4 hours of training.

☐ STANDARD NOT MET
The program/facility does not support cultural competence training of **direct services staff**.

Score = _____ _____ Technical Assistance Needed

14) The program/facility supports cultural competence training of *SUPPORT SERVICES STAFF*. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility supports cultural competence training of **support services staff**, and 80-100% of staff have attended at least 4 hours of training.

☐ STANDARD PARTIALLY MET
The program/facility supports cultural competence training of **support services staff**, and 50-79% of staff have attended at least 4 hours of training.

☐ STANDARD NOT MET
The program/facility does not support cultural competence training of **support services staff**.

Score = _____ _____ Technical Assistance Needed

15) Services provided are designed to meet the needs of the community. Describe how the services meet the needs of the community:

_____

_____

☐ STANDARD MET
Services provided include additional after-hours or weekend services, child care, transportation, or other options that are targeted to meet the specific community needs.

☐ STANDARD PARTIALLY MET
Services provided include groups that are targeted to meet the specific community needs.

☐ STANDARD NOT MET
Services provided do not include options that are targeted to meet the specific community needs.

Score = _____ _____ Technical Assistance Needed

16) The program has implemented the use of any evidence-based practices or best practice guidelines *appropriate for the populations served*. Describe the practices:

_____

_____

☐ STANDARD MET
The program has implemented the use of evidence-based practices or best practice guidelines *appropriate for the populations served.*

☐ STANDARD PARTIALLY MET
The program has implemented the use of any evidence-based practices or best practice guidelines.

☐ STANDARD NOT MET
The program has not implemented the use of any evidence-based practices or best practice guidelines.

Score = _____ _____ Technical Assistance Needed

17) The program collects client outcomes *appropriate for the populations served*. Describe the client outcomes that are collected and how the information is used:

_____

_____

☐ STANDARD MET
The program collects client outcomes *appropriate for the populations served.*

☐ STANDARD PARTIALLY MET
The program collects client outcomes.

☐ STANDARD NOT MET
The program does not collect client outcomes.

Score = _____ _____ Technical Assistance Needed

18) The program conducts outreach efforts *appropriate for the populations in the community*. Describe the outreach efforts:

_____

_____

☐ STANDARD MET
The program conducts effective and ongoing outreach efforts *appropriate for the populations in the community.*

☐ STANDARD PARTIALLY MET
The program conducts occasional outreach efforts *appropriate for the populations in the community.*

☐ STANDARD NOT MET
The program does not conduct outreach efforts.

Score = _____ _____ Technical Assistance Needed

19) The program is responsive to the variety of stressors that may impact the communities served. Examples of responsiveness:

_____

_____

☐ STANDARD MET
The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

☐ STANDARD PARTIALLY MET
The program is aware of the variety of stressors that may impact the communities served.

☐ STANDARD NOT MET
The program is not aware of stressors that may have an impact on the communities served.

Score = _____ _____ Technical Assistance Needed

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices:

_____

_____

☐ STANDARD MET
The program reflects its commitment to cultural and linguistic competence in **all** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

☐ STANDARD PARTIALLY MET
The program reflects its commitment to cultural and linguistic competence in **some** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

☐ STANDARD NOT MET
The program does not reflect its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.

Score = _____ _____ Technical Assistance Needed

After completing all of the items 1 through 20 above, add all the individual scores together to come up with a CC-PAS rating for the program.

TOTAL SCORE = _____

New or revised objectives for the programs Cultural Competence Plan:

_____

_____

_____

_____

_____

_____

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NON-CLINICAL CC-PAS Protocol

1) The program/facility has developed a Cultural Competence Plan (CCP). Attach a copy of the CCP or describe the plan.

_____

_____

☐ STANDARD MET
Program has a written CCP that addresses the specific needs of the program.

☐ STANDARD PARTIALLY MET
Legal Entity has a written CCP but the specific needs of that program are not identified, or there is no written CCP but there is some other evidence of a plan.

☐ STANDARD NOT MET
There is no plan to achieve cultural competence for the program.

Score = _____ _____ Technical Assistance Needed

Note: A suggested format and checklist that may be used for developing a CCP, if needed, have been provided on pages 11-12.

2) The program/facility has assessed the strengths and needs for services in its community. Describe the strengths and need for services:

_____

_____

☐ STANDARD MET
The strengths and needs of the community are clearly identified in the CCP. Community members, program advisory groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

☐ STANDARD PARTIALLY MET
The strengths and needs of the community are not clearly identified in the CCP, but there is evidence that the program is aware of the strengths and needs of the community.

☐ STANDARD NOT MET
The program is not aware of the strengths and needs of the community.

Score = _____ _____ Technical Assistance Needed

3) The staff in the program/facility reflects the diversity within the community. Attach a report that delineates staff diversity and compares the composition of the staff to the community, or describe:

_____

_____

☐ STANDARD MET
The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ STANDARD PARTIALLY MET
The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ STANDARD NOT MET
The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

Score = _____ _____ Technical Assistance Needed

4) The program/facility has a process in place for ensuring language competence of *ADMINISTRATIVE SERVICES STAFF* who identify themselves as bi- or multi-lingual. Attach or describe the process:

_____

_____

☐ STANDARD MET
The program has a policy or written process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.

☐ STANDARD PARTIALLY MET
The program has an informal process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual.

☐ STANDARD NOT MET
The program does not have a process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual.

Score = _____ _____ Technical Assistance Needed

5) The program/facility has a process in place for ensuring language competence of *SUPPORT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Describe the process:

_____

_____

☐ STANDARD MET
The program has a policy or written process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.

☐ STANDARD PARTIALLY MET
The program has an informal process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual.

☐ STANDARD NOT MET
The program does not have a process for testing the language competence of **support services staff** who identify themselves as bi or multi-lingual.

Score = _____ _____ Technical Assistance Needed

6) The program/facility supports/provides ALL staff training on the use of interpreters. Describe the process:

_____

_____

☐ STANDARD MET
The program has evidence that demonstrates all staff training on the use of language interpreters.

☐ STANDARD PARTIALLY MET
There is informal training of all staff on the use of language interpreters.

☐ STANDARD NOT MET
There has been no staff training on the use of interpreters.

Score = _____ _____ Technical Assistance Needed

7) The program/facility uses language interpreters as needed. Describe the use of language interpreters and languages used:

_____

_____

☐ STANDARD MET
The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.

☐ STANDARD PARTIALLY MET
The program occasionally uses language interpreters.

☐ STANDARD NOT MET
The program does not use language interpreters and cannot demonstrate the offer of interpreters.

Score = _____ _____ Technical Assistance Needed

8) The program/facility has a process in place for assessing cultural competence of ALL staff. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility has a written/formal process in place for assessing cultural competence of all staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members.

☐ STANDARD PARTIALLY MET
The program/facility has a process in place for assessing cultural competence of all staff.

☐ STANDARD NOT MET
The program/facility does not have a process in place for assessing cultural competence of staff.

Score = _____ _____ Technical Assistance Needed

9) The program/facility has a process and a tool in place for ALL staff to self-assess cultural competence (e.g. California Brief Multicultural Competence Scale – CBMCS). Describe the process and give the tool name:

_____

_____

☐ STANDARD MET
The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CBMCS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.

☐ STANDARD PARTIALLY MET
The program encourages staff to complete the CBMCS or a similar tool.

☐ STANDARD NOT MET
The program does not support opportunities for staff to complete the CBMCS or a similar tool and does not have evidence of the results of those evaluations.

Score = _____ _____ Technical Assistance Needed

10) The program/facility has conducted a survey amongst its clients/target population to determine if the program is perceived as being culturally competent. Summarize the results of the survey:

_____

_____

☐ STANDARD MET
The program/facility has conducted a survey amongst its clients and their family members to determine if the program is perceived as being culturally competent.

☐ STANDARD PARTIALLY MET
The program/facility is using the annual San Diego County Behavioral Health Services (SDCBHS) client satisfaction survey to determine if the program is perceived as being culturally competent.

☐ STANDARD NOT MET
The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

Score = _____ _____ Technical Assistance Needed

11) The program/facility conducted a survey amongst its clients/target population to determine if the program's services are perceived as being culturally competent. Summarize the results of the survey:

_____

_____

☐ STANDARD MET
The program/facility has conducted a survey amongst its clients to determine if the program's services are perceived as being culturally competent.

☐ STANDARD PARTIALLY MET
The program/facility uses the annual SDCBHS state survey to determine if the program's services are perceived as being culturally competent.

☐ STANDARD NOT MET
The program/facility does not use a survey amongst its clients to determine if the program's services are perceived as being culturally competent.

Score = _____ _____ Technical Assistance Needed

12) The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards. Describe how the standards are utilized:

_____

_____

☐ STANDARD MET
The program utilizes the CLAS Standards and trains all staff and managers on them at least annually.

☐ STANDARD PARTIALLY MET
The program utilizes the CLAS Standards but has little or no training.

☐ STANDARD NOT MET
The program does not utilize the CLAS Standards.

Score = _____ _____ Technical Assistance Needed

13) The program/facility supports cultural competence training of *ADMINISTRATIVE SERVICES STAFF*. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility supports cultural competence training of **administrative services staff**, and 80-100% of staff have attended at least 4 hours of training.

☐ STANDARD PARTIALLY MET
The program/facility supports cultural competence training of **administrative services staff**, and 50-79% of staff have attended at least 4 hours of training.

☐ STANDARD NOT MET
The program/facility does not support cultural competence training of **administrative services staff**.

Score = _____ _____ Technical Assistance Needed

14) The program/facility supports cultural competence training of *SUPPORT SERVICES STAFF*. Describe the process:

_____

_____

☐ STANDARD MET
The program/facility supports cultural competence training of **support services staff**, and 80-100% of staff have attended at least 4 hours of training.

☐ STANDARD PARTIALLY MET
The program/facility supports cultural competence training of **support services staff**, and 50-79% of staff have attended at least 4 hours of training.

☐ STANDARD NOT MET
The program/facility does not support cultural competence training of **support services staff**.

Score = _____ _____ Technical Assistance Needed

15) Services provided are designed to meet the needs of the community. Describe how the services meet the needs of the community:

_____

_____

☐ STANDARD MET
Services provided include additional after-hours or weekend services, child care, transportation, or other options that are targeted to meet the specific community needs.

☐ STANDARD PARTIALLY MET
Services provided include groups that are targeted to meet the specific community needs.

☐ STANDARD NOT MET
Services provided do not include options that are targeted to meet the specific community needs.

Score = _____ _____ Technical Assistance Needed

16) The program has implemented the use of any evidence-based practices or best practice guidelines *appropriate for the target populations served*. Describe the practices:

_____

_____

☐ STANDARD MET
The program has implemented the use of evidence-based practices or best practice guidelines *appropriate for the target populations served.*

☐ STANDARD PARTIALLY MET
The program has implemented the use of any evidence-based practices or best practice guidelines.

☐ STANDARD NOT MET
The program has not implemented the use of any evidence-based practices or best practice guidelines.

Score = _____ _____ Technical Assistance Needed

17) The program collects client outcomes *appropriate for the populations served*. Describe the client outcomes that are collected and how the information is used:

_____

_____

☐ STANDARD MET
The program collects client outcomes *appropriate for the populations served.*

☐ STANDARD PARTIALLY MET
The program collects client outcomes.

☐ STANDARD NOT MET
The program does not collect client outcomes.

☐ Not applicable (the program is not a direct service provider)

Score = _____ _____ Technical Assistance Needed

18) The program conducts outreach efforts *appropriate for the populations in the community*. Describe the outreach efforts:

_____

_____

☐ STANDARD MET
The program conducts effective and ongoing outreach efforts *appropriate for the populations in the community.*

☐ STANDARD PARTIALLY MET
The program conducts occasional outreach efforts *appropriate for the populations in the community.*

☐ STANDARD NOT MET
The program does not conduct outreach efforts.

Score = _____ _____ Technical Assistance Needed

19) The program is responsive to the variety of stressors that may impact the communities served. Examples of responsiveness:

_____

_____

☐ STANDARD MET

The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

☐ STANDARD PARTIALLY MET

The program is aware of the variety of stressors that may impact the communities served.

☐ STANDARD NOT MET

The program is not aware of stressors that may have an impact on the communities served.

Score = _____ _____ Technical Assistance Needed

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices:

_____

_____

☐ STANDARD MET

The program reflects its commitment to cultural and linguistic competence in **all** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

☐ STANDARD PARTIALLY MET

The program reflects its commitment to cultural and linguistic competence in **some** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

☐ STANDARD NOT MET

The program does not reflect its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.

Score = _____ _____ Technical Assistance Needed

After completing all of the items 1 through 20 above, add all the individual scores together to come up with a CC-PAS rating for the program.

TOTAL SCORE = _____

New or revised objectives for the programs Cultural Competence Plan:

_____

_____

_____

_____

_____

_____

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California Brief Multicultural Competence Scale

(CBMCS)

Scoring Guide and Administration Packet

A tool for self-evaluation of multicultural competence of providers of behavioral health services

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Description

The CBMCS is an evidence-based, replicable 21-item scale that was developed by researchers at the University of La Verne in response to the request of the California Mental Health Directors Association for a standardized cultural competency assessment tool. It measures individual, self-reported multi-cultural competency and training needs of behavioral health staff in the following four areas: Multicultural Knowledge (5 items); Awareness of Cultural Barriers (6 items); Sensitivity and Responsiveness to Consumers (3 items); and Socio-cultural Diversities (7 items).

The areas of the CBMCS survey measure the following aspects of cultural competence:

Multicultural Knowledge	Includes recognizing deficiencies in research conducted on minorities; psychosocial factors to consider when providing services to a culturally diverse consumer population; providing a culturally competent mental health assessment; diagnosis and understanding; and evaluating wellness, recovery, and resilience.
Awareness of Cultural Barriers	Includes awareness of self (cultural self-awareness, worldview, racial/ethnic identity) and awareness of others (oppression, racism, privilege, gender differences, sexual orientation).
Sensitivity & Responsiveness to Consumers	Includes acknowledgement and understanding of divergent social values; communication styles; and ability to understand consumers' experiences of racism, oppression and discrimination.
Socio-cultural Diversities	Includes knowledge of socio-cultural groups in which ethnicity may not be the major or immediate focus of professional attention (i.e., age, gender, sexual orientation, social class, physical-mental intactness, and disability status); awareness of bias, oppression and discrimination experienced by members of socio-cultural groups; and knowledge about best practices and treatment considerations for members of socio-cultural groups.

The names of the areas were somewhat modified to be more descriptive than what appears in the original source.

Scoring

The answers to each of the 21 survey questions are assigned a number based on a Likert scale (1=Strongly Disagree, 2=Disagree, 3=Agree, and 4=Strongly Agree) and totaled according to the pre-determined areas of cultural competence. The scores are then analyzed based on thresholds to identify proficiency levels and training needs. CBMCS yields four individual scores from each area of cultural competence.

For training purposes, the four individual area scores can be obtained by adding the ratings of the items as follows:

1. **Multicultural Knowledge** items are 7, 12, 15, 17, and 19
2. **Awareness of Cultural Barriers** items are 1, 8, 10, 11, 14, and 16
3. **Sensitivity and Responsiveness to Consumers** items are 2, 4, and 9
4. **Socio-cultural Diversities** items are 3, 5, 6, 13, 18, 20, and 21

Administration in San Diego

The survey will be administered electronically for SDCBHS by the Quality Improvement Performance Improvement Team. Staff will be asked to fill in all the subunits for which they work. Each staff member will only have to fill out the survey once, and the data will be incorporated into each of their designated subunit's returns.

To obtain information on the demographics of staff, questions on the following areas have been included:

- Gender:
- Race and ethnicity
- County of origin
- Languages spoken
- Highest Degree or Diploma
- Years of experience in the field of behavioral health since highest degree

Questions on staff training will include:

- Course work on multicultural counseling while in school
- Skill training skills desired
- Training needed in cultural competence content areas
- Training needed on specific ethnic and racial groups
- Training needed by age group

California Brief Multicultural Competence Scale (CBMCS)

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	**1**	**2**	**3**	**4**
2.	I am aware of how my own values might affect my client.	**1**	**2**	**3**	**4**
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	**1**	**2**	**3**	**4**
4.	I am aware of institutional barriers that affect the client.	**1**	**2**	**3**	**4**
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	**1**	**2**	**3**	4
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	**1**	**2**	**3**	**4**
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	**1**	**2**	**3**	**4**
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	**1**	**2**	**3**	**4**
9.	My communication skills are appropriate for my clients.	**1**	**2**	**3**	**4**
10.	I am aware that being born a White person in this society carries with it certain advantages.	**1**	**2**	**3**	**4**
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	**1**	**2**	**3**	**4**
12.	I have an excellent ability to critique multicultural research.	**1**	**2**	**3**	**4**
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	**1**	**2**	**3**	**4**
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	**1**	**2**	**3**	**4**
15.	I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	**1**	**2**	**3**	**4**
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	**1**	**2**	**3**	**4**
17.	I can discuss research regarding mental health issues and culturally different populations.	**1**	**2**	**3**	**4**
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	**1**	**2**	**3**	**4**
19.	I am knowledgeable of acculturation models for various ethnic minority groups.	**1**	**2**	**3**	**4**

20. I have an excellent ability to assess, accurately, the mental health needs of women.	**1**	**2**	**3**	**4**
21. I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	**1**	**2**	**3**	**4**

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development, 37, 3,163-187.*

Certification of Language Competence

Suggested process for certifying language competence

Proposed Process for Certification of Language Competence

In order to establish a process for certifying the ability of bi-lingual staff or interpreters the following is proposed for the consideration of providers:

- Legal Entities/programs to establish a panel of expert speakers – minimum of 2 persons whenever possible.

- Certification process to be conducted by the panel and contain a minimum 30 minutes worth of material to be reviewed in the designated language.

- Material must cover knowledge of behavioral health, clinical terminology, ability to communicate ideas, concerns and the societal framework, familiarity with designated culture and variant beliefs concerning behavioral illness.

- Written and verbal language assessment:

    - Some language – able to provide basic information.
    - Conversational – able to communicate and provide information and support services.
    - Fluent – written and verbal. Ability to communicate and converse. Ability to discuss behavioral health terminology, and conduct therapy, if applicable.

- Ongoing supervision of each language's certification process by native speaker of language.

Cultural Competence Survey for Program Clients To Complete

Suggested survey tool for clients to assess the cultural competence of the program

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Proposed Survey for Clients to Assess a Program's Cultural Competence

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

Behavioral Health Program Name: _____

Client Demographics:

Age: _____ **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Choose not to disclose

Race/Ethnicity: ☐ Hispanic ☐ Asian/Pacific Islander ☐ African-American ☐ American Indian ☐ White ☐ Other: _____

Other Cultural Group: ☐ Gay/Lesbian/Bisexual/Transgender ☐ Other: _____

Language Preference: ☐ Spanish ☐ Vietnamese ☐ Tagalog ☐ English ☐ Chinese ☐ Japanese ☐ Laotian ☐ Cambodian ☐ Farsi ☐ Arabic

Please rate this behavioral health program on the following items:

Please note that "trauma informed" means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

1) The environment of this program is trauma informed and culturally welcoming.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

2) There are written materials available in a language or format (large print/tape) I can understand.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

3) The staff at the front desk are welcoming and respectful (e.g., they address me by my name).
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

4) Services are provided in my language of choice.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

5) The services provided are trauma informed.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

6) The clinical staff (if staff are bilingual) are linguistically proficient and is able to communicate ideas, concerns, and rationales in my preferred language.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

7) The clinical staff are familiar with my cultural beliefs regarding mental illness.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

8) The clinical staff are knowledgeable about culturally appropriate referral resources.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

9) The clinical staff are knowledgeable about trauma and practice trauma-informed care.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

10) The physician is familiar with my cultural beliefs regarding mental illness.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

11) The physician is knowledgeable about trauma and practices trauma-informed care.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

12) The interpreter (if one was used) is linguistically proficient and is able to communicate ideas, concerns, and rationales in my preferred language.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

13) The interpreter (if one was used) is professional and understanding of my ethical, cultural, and personal beliefs.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

14) All staff are trauma informed and knowledgeable about my culture.
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐Strongly Disagree

Cultural Competence Focus Groups for Program Clients

Suggested format for using focus groups for assessing cultural competence

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CLIENT FOCUS GROUPS FORM

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

Behavioral Health Program: _____ Date: _____

==========

Demographics of client focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

Please note that "trauma informed" means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

1) Does this program offer a culturally welcoming, comfortable setting to be in?
2) Does the program support and offer trauma-informed practices, policies, language, and environment?
3) Does this program provide you with written materials available in a language or format (large print, color, spacing, etc.) that you can understand?
4) What other materials would you like to have available? For example: audio tape, CD, VHS Tape, DVD, etc.
5) Does this program provide you with services in your language of choice?
6) Does this program practice trauma-informed care with you?
7) Are bilingual, clinical staff linguistically proficient and able to communicate ideas, concerns and the societal framework in your preferred language?
8) Are clinical staff familiar with your cultural beliefs surrounding mental illness?
9) Are clinical staff knowledgeable about how to make culturally appropriate referrals?
10) If you see a program psychiatrist, is s/he familiar with your cultural beliefs surrounding mental illness?
11) If you see a program psychiatrist, has s/he asked about any trauma and or adversity in your past?
12) If you need to use an interpreter provided by the program, is s/he linguistically proficient and able to communicate ideas, concerns and rationales in your language of choice?

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Cultural Competence Survey for Program Community

Suggested survey tool for assessing cultural competence

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Community Focus Groups Form

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to your specific population served.

Behavioral Health Program: _____ Date: _____

==========

Demographics of Community focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

Please note that "trauma informed" means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

1) Is this program known within the community?
2) Does the community feel that the services provided by this program are needed?
3) Does the community believe that people who come here for mental health services improve and feel better as a result of the services they receive?
4) Does this program offer a culturally welcoming, comfortable setting to be in?
5) Is this program trauma informed?
6) What are some things we can improve about our program?
7) What are the barriers that people have to coming to this program to receive services?
8) Would you recommend a friend or family to seek services here if they were needed?
9) What else can we do to become an integral part of the community?

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Training Needs Survey

Suggested survey to assess staff training needs regarding cultural competence

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Training Needs Survey

Behavioral Health Program: _____ Date: _____

==========

1) Does your program provide services to different cultural groups?

☐ Yes ☐ No

If yes, what cultural groups does your program provide services to? (Please list)

_____

_____

2) Does your program provide services to individuals who have experienced trauma?

☐ Yes ☐ No

3) What type of training is needed by <u>all</u> your staff to ensure they are linguistically proficient and able to communicate ideas, concerns and rationales in languages other than English? (Please list)

_____

_____

4) What type of training is needed by <u>all</u> staff to ensure they are trauma informed? (Please list)

_____

_____

5) What type of training is needed by your <u>clinical staff</u> to ensure that they are familiar with client cultural beliefs surrounding behavioral health issues that often co-occur with other health and wellbeing-related issues? (Please list)

_____

_____

6) What type of training is needed by <u>clinical</u> staff to be trauma informed and provide integrated care?

_____

_____

7) Does your staff need training on how to make culturally appropriate referrals?

☐ Yes ☐ No

8) Does your staff need training on trauma-informed systems and services?

☐ Yes ☐ No

9) Do program psychiatrists need training about client cultural beliefs surrounding behavioral health issues that often co-occur with other health and wellbeing-related issues?

☐ Yes ☐ No ☐ N/A

10) Do program psychiatrists need training on trauma-informed systems and services?

☐ Yes ☐ No ☐ N/A

11) What type of training is needed for interpreters used by your staff to ensure that they are linguistically proficient and able to communicate ideas, concerns, and rationales in the client's language of choice? (Please list)

_____

_____

Resources

CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The National CLAS Standards were developed by the Health and Human Services Office of Minority Health in 2000 and further enhanced in 2010-2013 to address the importance of cultural and linguistic competency at every point of contact throughout the health care and health services continuum.

The following CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
For more information and to access a Blueprint for Advancing and Sustaining CLAS Policy and Practice visit www.thinkculturalhealth.hhs.gov/Content/clas.asp.

Context for the Development and Evaluation of Cultural Competencies

Summary of the plethora of cultural competence assessments available

(These resources have not been reviewed or approved by the County of San Diego or CCRT and are for additional reference as a supplement to tools in the Handbook)

As background, most of the available assessment scales fall into four broad areas:

1) Multicultural knowledge, self-awareness, and skills for working across cultures;
2) Intercultural skills in working across international borders (i.e., flexibility, sensitivity, open-mindedness, perceptual acuity, personal autonomy, empathy, and respect);
3) Behavioral assessments; and
4) Vignette assessments.

The assessments in the first two categories are primarily self-report scales relying on an individual to report on their personal perceptions of their own competency. The latter two categories attempt to sidestep the limitations of self-report. Many of the multicultural assessments (category #1) are publicly available. Unfortunately, however, most of the intercultural scales (category #2) have been "privatized" and are sold at a fee, with access to a summary report only (rather than item-by-item responses). Assessments in categories #3 and #4 are available either publically or by request to the authors.

Researchers have evaluated the statistical properties of these multicultural and intercultural instruments (categories #1 and #2), so that consumers can have confidence that the questions generate reliable patterns of responses when asked to large numbers of people. Naturally, some of the assessments are more reliable in this respect than others. Whether statistically validated or not, any instrument that relies on people reporting their perceptions of their own cultural competence, the scores can be significantly biased by the respondent's desire to (a) appear better than they are, or (b) by the respondent's lack of insight on where they need to improve. The multicultural and intercultural instruments have also been critiqued for their lack of scope, in that they do not cover the skills needed to work with the more complex issues of (a) power/privilege, and (b) complexities of identity associated when individuals are marginalized by race as well as by sexual orientation, socioeconomic status, religion, gender, body size, immigration status, health, disability, and other dimensions. The *Alliant Intercultural Competency Scale* (AICS) discussed below attempts to overcome this latter critique.

Also, it is important to keep in mind that the quality of any individual's "culturally competent skills" will vary by the context. That is, one may be far more culturally competent with Native American girls in the school setting than with Asian American professional men and women in the hospital setting, solely as a result of where they have done their training. Thus, many organizations may try to overcome this contextual issue by designing their own hybrid scale by selecting individual items from the other previously validated instruments. The *California Brief Multicultural Competence Scale* (CBMCS: Gamst, et al., 2004) is an example of this approach.

Recently scholars have brought forth broader concept of *cultural intelligence*, which refers to an individual's ability to function effectively and fluidly among people of different cultures, in different settings, with the sensitivity to avoid causing the "cultural ruptures" that others with less cultural intelligence will stumble into quickly; the analogy of course is emotional intelligence. Scales assessing Cultural Intelligence may be available. Similarly, the concept of "negotiated space" has also emerged in the literature, which refers to someone's capacity to "share culture" in meetings such that decision-making and problem-solving can be conducted in a milieu were all cultures are present are weighted equally. "Negotiated space" is a concept of full participation where maintaining culturally respectful relationships is as important as the issues being worked through. The AICS is designed to evaluate skills in "negotiated space".

In a manuscript in press, Dr. Sheila Henderson and additional co-authors wrote a brief review of various measures available in the fields of psychology, education, and business. The scales found and discussed were:

- Multicultural scales:
  - *Multicultural Awareness-Knowledge-and-Skills Survey* (MAKSS; D'Andrea, Daniels, & Heck, 1991)
  - *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994)

- *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002)
- *Multicultural teaching competency scale* (Spanierman et al., 2011)

(Please note that reviews and objective statistical testing of these instruments have been conducted by Constantine & Ladany, (2003), Hays (2008), and Ponterrotto, Rieger, Barrett, & Sparks (1994).)

- Intercultural scales:
  - *Assessment of Intercultural Competence* (AIC: Fantini, 2007)
  - *Intercultural Development Inventory* (IDI; Hammer, Bennett, & Wiseman, 1993)
  - *Global Competency and Intercultural Sensitivity Index* (ISI; Olson & Kroeger, 2001)
  - *Intercultural Sensitivity Inventory* (ICSI: Bhawuk & Brislin, 1992)
  - *Cross-Cultural Adaptability Inventory* (CCAI: Kelley & Meyers, 1995)

Alliant International University, concerned about training professionals across business, forensics, education, law, and psychology for both local and global careers has recently developed a scale that spans both the multicultural and international arena with promising statistical properties in initial testing. This instrument is called:

- *Alliant Intercultural Competency Scale* (AICS; 2014)

For available reviews and statistical evaluations of these two categories of scales, see Constantine, Gloria, & Ladany (2002); Constantine & Ladany (2002); Hays (2008); Olebe & Koester (1989); Ponterotto, Reiger, Barrett, & Sparks (1994); Pope-Davis, Coleman, Liu, & Toporek (2003); Sinicrope et al. (2008); and Worthington, Mobley, Franks, & Tan (2000).

There are another two instrument categories—behavioral and vignette assessments—that try to surmount the "self-report" problem referred to above:

- Behavioral assessment instruments:
  - *Multicultural Teaching Competency Scale* (Spanierman et al., 2011)
  - *Missouri Multicultural Counseling Self-Efficacy Scale* (Mobley, Worthington, & Soth, 2006)
  - *Behavioral Assessment Scale for Intercultural Communication* (BASIC: Olebe & Koester, 1989; Ruben, 1976; Ruben & Kealey, 1979)
- Vignette-style measures:
  - *Cross-Cultural Counseling Assessment-Revised* (CCCI-Revised: LaFromboise et al., 1991)
  - *Multicultural Interactive Theatre* (Burgoyne et al., 2007)
  - *Instructor Cultural Competence Questionnaire* (ICCQ: Roberson, Kulik, & Pepper, 2002)
  - *Cultural incidents in the University Classroom Vignettes* (Henderson, Horton, Saito, Shorter-Gooden (in press)

Additional Resources

Implementation of CLAS Standards

Think Cultural Health, Office of Minority Health, US Department of Health & Human Services
www.thinkculturalhealth.hhs.gov/Content/clas.asp

Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence, Georgetown University, Center for Child and Human Development
www.clcpa.info/

SDCBHS Resources

Cultural Competence Plan 2010 and Executive Summary
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetencePlan2010.pdf

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CCP2010ExecSumm110111.pdf

Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/1_C.pdf

Organizational Provider Operations Handbook (section H)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Combined_OPOH_010113_Rev_021214.pdf

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health (Eight Year Comparison: FY 2001-2002, FY 2006-2007, and FY 2009-2010)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/DisparitiesReport110212.pdf

Trauma-Informed Systems and Services

The National Council for Behavioral Health: Trauma Informed Care
www.thenationalcouncil.org/topics/trauma-informed-care/

The Trauma Informed Project
www.traumainformedcareproject.org/

University of North Carolina Family and Children's Resource Program: Trauma and Behavior – How Trauma Affects the Brain
www.youtube.com/watch?v=lPftosmseYE

What Does "Trauma Informed Care" Really Mean? – The Up Center
www.cpe.vt.edu/ocs/sessions/csa-trauma.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Trauma-Informed Approach and Trauma-Specific Interventions
beta.samhsa.gov/nctic/trauma-interventions

Druss B.G. & Reisinger Walker E. (2011). Mental disorders and medical comorbidity. *Research Synthesis Report*, No. 21. Princeton, NJ: Robert Wood Johnson Foundation.
www.rwjf.org/files/research/71883.mentalhealth.report.pdf

Edwall, G.E. (2012, Spring). Intervening during childhood and adolescence to prevent mental, emotional, and behavioral disorders. *The Register Report*, 38, 8-15.

Felitti V. & Anda, R., (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare, In R. Lanius and E. Vermetten, Eds., *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press. 2010.

Finch, R. A. & Phillips, K. (2005). An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services.
www.businessgrouphealth.org/publications/index.cfm

Substance Abuse and Mental Health Services Administration (2011). *Helping Children and Youth Who Have Experienced Traumatic Events.* HHS Publication No. SMA-11-4642.

Substance Abuse and Mental Health Services Administration & National Association of State Mental Health Program Directors. (2004). *The damaging consequences of violence and trauma.*
www.theannainstitute.org/Damaging%20Consequences.pdf

Van der Kolk, B, McFarlane, A, & Weisaeth, L. (2007). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: The Guilford Press.

Behavioral Health Services
CCRT Chair Recommendations for Implementation
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CCRT CRDP Workgroup Recommendations (Starting Point FY 13-14)

Over the past fiscal year (FY 13-14) the Leads for the CCRT CRDP Work Groups volunteered to address the recommendations put forth by the CCRT Chair per their request to move forward and enhance the BHS System of Care as it addresses equity and disparities in the prevention and early intervention arena, access to care and in the treatment delivery system for diverse communities of San Diego County. In this document the CCRT CRDP Leads offer their insight and recommendations. I want to thank and appreciate the diligence and efforts of Dr. Dixie Galapon, Rosa Ana Lozada, Minola Clark-Manson, Dr. Leon Altamirano, Wendy Maramba and Kristina Maxwell for their work and commitment.

Latino Recommendations

Recommendation #2: Access to Mental Health Care – Secure and enhance school based mental health programs.

Focus on adolescents and the impact of failing to adequately screen, detect, and diagnose potential mental health problems in a timely manner. School constitutes a safe setting in which to educate families and their children about mental health. Tie mental health program to academic achievement and performance.

- Secure funding to ensure availability and accessibility of school-based programs for students experiencing mental illness.
- Collaboration with schools as a hub for education and training of teachers and parents on reducing mental health false beliefs of mental illness
- Promote mental health through a mental health career pathway at the high school level that can be integrated into the mental health certificate program at the community college level.
- Work with schools that have an existing conditional use permits allowing for the community to use the school facility during evening and weekend hours.
- Focus on normal transition issues between middle and high school to reduce negative impact
- Apply culturally relevant engagement approaches that include child care. Food and other resources.

School based programs are referenced in the capacity of a community centric location to provide teacher, parenting and community member's classes on mental health. These partnerships will provide access to mental health programs and eliminate the tendencies that schools personal have of misdiagnosing student and labeling them as behavioral issues when in reality the student may have been affected by a mental illness.

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CYF Response

- BHS has School Based Services in more than 360 schools countywide
- **Collaboration among agencies (schools):**
  Global Oversight Analysis Linking Systems (GOALS) MOU signed: Information sharing and cross systems collaboration between San Diego County School District, Law Enforcement, Child Welfare, Probation, and HHSA BHS
- For Full Service Partnership School based services, providers work closely with school personnel to engage and support youth and their families and provide outreach at schools. School based clients may receive individual/group/family treatment, case management/rehabilitative services, crisis intervention, and medication management services. Contractors coordinate with school partners to provide education that assists the schools in understanding the target population eligible for services under EPSDT and MHSA. Contractor also coordinate with schools to identify the SED children and youth most in need of services
- Palomar Family Counseling Services –MHSA Prevention and Early Intervention School Age Services. The Family Community Partnership (FCP) provides behavioral health prevention and early intervention services through a parent-peer partner model. FCP serves the families of children attending one of four elementary schools (Laurel and Mission Elementary Schools in Oceanside Unified School District; Rose and Pioneer Elementary Schools in Escondido Unified School District). The program employs Community Outreach Specialists (COS) as parent peer partners from each of the participating schools' catchment areas. It serves families who are identified by the school, through self-referral, or are engaged through outreach by the COS'. Services are developed through a collaborative process between the FCP staff and the target population for the purpose of determining prevention needs and provide a variety of mental health primary prevention/early intervention services. These services shall focus on family wellness, strengthening resilience, reducing disparities in accessing mental health services, reducing stigma and discrimination and helping families make connections with the schools and other services and supports in the community. PEI activities are delivered in and around the school-community environment. PEI activities are scheduled according to the needs of the target population. Target population is underserved and living in high risk communities. Escondido and Oceanside have high ratios of Latino and socio-economically disadvantaged families, many of whom are unemployed, often burdened with poverty, illiteracy, limited education, and homelessness. Many families are single parent households, monolingual Spanish. Children are at risk for developing social and emotional problems that may include depression, anxiety, and behavioral disorders. Other risk factors include exposure to trauma, violence and substance abuse. Children in stressed families are more vulnerable to school failure and involvement in the juvenile justice system.

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- Rady Children's Outpatient Psychiatry – Central/East/South The FSP/MHSA program provides outreach psychiatric services to children and adolescents at school sites and homes for families without mental health resources who meet SED criteria and are referred by the schools for services. Services are provided in both English and Spanish (5 schools) at 13 schools in the C-E-S regions of the county (Elementary, Middle, High Schools). Services provided consist of individual and family therapy, case management, and medication evaluation and medication management. Specific outreach to underserved Asian and Latino children and youth
- Recommended to Board of Supervisors to: Offer specialty behavioral health services for CAT and Diversion clients through the existing BHS clinic and school based and recovery service networks and enhance existing regional specialty mental health contracts to ensure capacity for services. Recommendations to be presented November 5, 2013
- Incredible Years program
- Children's System of Care Academy
- School Based Suicide Prevention and Early Intervention program serving middle and high school students
- Early Childhood Mental Health (ECMH) Incredible Years for children ages birth to five in San Diego Unified School District pre-school(s) who have been assessed and diagnosed with aggressive behavior problems and other emotional disturbance. Provides school-based mental health services that utilizes the Incredible Years curriculum. Targets Latino and Asian Pacific Islander Severely Emotionally Disturbed children and their families
- Palomar Family Counseling-Childnet in Escondido. Serves Medi-Cal and MHSA eligible, children ages 0-5 and their families. Provides assessment, behavioral intervention, teacher intervention at designated preschools and uses the Incredible Years Curriculum. Provides behavioral intervention and preschool teacher training to assist young children succeed in preschool and the community
- Para Las Familias Center in Imperial Beach serves children, ages 0 - 5, on Medi-Cal and non-insured children. Provides assessment, individual, filial and family therapy. Services provided at clinic, pre-school sites and in-home services

Recommendation #3: Health Care Navigator Model to promote wellness and symptom management

Promote wellness and symptom management that integrate with other health care and social service through the access of health navigators. Health Care Navigators can strengthen the ability of Latino communities address issues of concerns in the area of health care, confront barriers related to accessing services, inform community of policies changes to improve individual and community health outcomes.

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- Services to be offered by trained community members using concepts of the Promotores model
- Conduct outreach in the community to inform residents of local health resources and assist clients in accessing these services.
- Collaborate with other community leaders
- Help residents identify a medical home and teach residents how to navigate through the health care system.
- Capacity must include navigation beyond physical health and behavioral health to include other healthcare specialists, pharmacy.
- Incorporate health management through management of Personal Health Care Records
- Include a Wellness and Recovery Plan

There are clear gaps in coordinated care between physical, behavioral health other health services providers even when multiple services are being provided at one location.

Workgroup Lead Response

1. Expand the education provided out of the WIC, Women's Programs, HIV Case Management and Elderly programs
   a. Initiate trauma-informed prevention education for expecting & new parents and for those grandparents that are caring for grandchildren (Well-Parent Program).

2. Support the WET Program to help meet the high need for psychiatry and mental health services.
   a. The need for psychological / therapeutic interventions in primary care is critical for this population as mental health stigma results in high "No Show" rates for patients referred to the internal mental health providers.
   b. Warm Hand-off's are received extremely well by Latinos on the medical side and are proving to increase treatment compliance while providing Medical Staff with hands-on suicide prevention and trauma-informed care training/education.
      i. Create/begin a training program in public mental health that provides training and education to interns about taking warm hand-offs in Patient Centered Medical Homes. It would cut the cost for clinics so they could provide more services and fill the gap of not being able to bill for same day services.
   c. Prenatal – Perinatal – Post Partum Screenings for parents with focus on trauma prevention, mental health and wellness (A Latino Live Well, San Diego campaign)
      i. This is an extension of the Well-Parent Program noted above.

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3. Emphasize BH Integration and a greater focus on rising health disparities due to the low utilization of BH Services overall. This is conducted through existing councils and the MHSA Stakeholder process.
4. Initiate or expand Case Management Services to assist Latino Residents navigate the system without having to end up in ER's. This is currently being accomplished through the existing system.
5. Considering the growing Latino population, I think it would be a huge help if BHETA offered a basic cultural competence course for medical/mental health providers that focused on Spanish trauma-informed medical/mental health terminology and prevention education language.
   a. We don't have enough providers to adequately serve the Latino population. This would help close the cultural barrier and better address health disparities.
6. Mobile clinics. This would be a phenomenal option to provide greater services to the many disabled at Independent Living Facilities without transportation (Mobile medical/psychiatric/dental and mental health).

CYF Response

- Family Youth Roundtable completed the Wellness Recovery Action Plan (WRAP) and will train other youth/family partners in WRAP process to implement with youth and families
- CYF worked with Healthy San Diego Health plans to establish a continuum of care and bidirectional interface between Primary Care Mental Health and Specialty Mental Health and implemented Care Coordination form with all BHS programs
- Contractors connect clients to a "**medical home**" for 100% of those clients who do not already have a primary health provider. Contractor shall document information about the medical home and on-going efforts to communicate with the primary care physician in the medical record.
- Contractors assist all parents/caregivers in developing a "**Wellness Notebook**," which is a tool that is used to organize information about a child's health condition and care. The Wellness Notebook is particularly important for clients with chronic health issues including, but not limited to, diabetes, asthma and obesity
- For outpatient services, contractor shall provide **on-site consultation** to teachers regarding specific clients and with regard to the classroom environment as a whole
- RFP for Mental Health First Aid Youth curriculum. Contract anticipated to start January 1, 2014
- CYF SOC goals for FY 13/14 include: to contribute to the development/implementation of Stigma Reduction campaign in alignment with CalMHSA project, including but not limited to make recommendations for Stigma Reduction Strategy and activities for contracted programs.

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FY14-15 Focus
AOA
1. Mobile clinics: work with FQHC to facilitate services to clients in ILF locations identified in the ILF Website that may not have access to transportation to health care services.
2. Discuss with the Council of Community Clinics the possibility of creating an e-learning for medical/mental health providers on basic cultural competence focusing on Latino specific trauma-informed care.
CYF
1. Pre-/Peri-/Post- natal screenings
2.

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African American Recommendations

Recommendation #1: Staff must have experience and/or training on the clients they serve.

A. Continue offering the African American Cultural Competence Academy series
B. Continue to fund and support those programs that are currently providing mental health services to African Americans.
C. Increase and advertise African American internship opportunities.
D. Continue and expand mental health promotion in the African American community.

Workgroup Lead Response

A. African American CCA offered in FY2012-13.The recruitment process was not well established resulting in low turnout. The training demonstrated effectiveness for those who participated.
   Recommendations:
   - Continue offering the clinical track of the CCA African American cohort every other year.
   - CORs to incorporate sustainment of learning for participants, including adding an ongoing cultural competence agenda item for discussion at provider collaboratives.
   - Determine the impact on programs that have participants that completed the CCA.
   - Determine the impact of having multiple CCA graduates has on the whole behavioral health system.

B. Identify and support traditional and nontraditional programs that are providing services to African Americans but might not be contracted with the County or contracted specifically to service African Americans.
   Recommendations:
   - Mental Health America is compiling a list of programs that provide both traditional and nontraditional mental health services to the African American community. Disseminate the list to all providers for reference.
   - Look into recruitment process for African American internship opportunities. Consider tying in volunteerism to WET programs. Look into a connection with High Tech High, focusing on AA youth to volunteer and gain experience within the BH system.
   - Increase the paraprofessional volunteer opportunities for African Americans.

C. Increase and advertise African American internship opportunities.
   - The Association of Black Psychologists (ABPsi) is developing opportunities for African American internships.

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- California School of Professional Psychology (Alliant University) is promoting MFT internships looking for lived experience and diversity.

Recommendations:

- Advertise the application process widely; provide that advertising to BHS for distribution.
- Rate programs on their effectiveness with recruiting diversity matching the need in the community

D. Continue and expand mental health promotion in the African American community.

Recommendation:

- Continue not yet saturated

CYF Response

- CYF is an active participant in the Save Our Children project that serves the southeast community
- CYF enhanced the Cultural Broker program by adding parenting groups for African-American fathers/parents
- CYF supports the African/American Cultural Competence Academy and monitors attendance to ensure that CYF programs access this training

Additional Opportunities for African Americans

1. Provide Mental Health First Aid training for African Americans, once the Request for Proposal process is complete.
2. Stigma and Discrimination campaign plan for next 5 years and how it addresses the African American community to improve access to care.
3. Evaluate the penetration and retention rates of African Americans receiving BH services.

**Submitted by Minola Clark-Manson, May 2014*

FY14-15 Focus
AOA
1. Offer an African-American CCA cohort in FY14-15.
2. Continue to expand mental health promotion in the AA community through the faith based initiative, AB109, outpatient and residential programs.
CYF
1.
2.

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Asian Pacific Islander Recommendations

Recommendation #1: Capacity Building – Empower the community by supporting community capacity building through efforts such as leadership development, technical assistance, inclusion of community participation in the decision-making process, and establishment of infrastructures that can maximize resource leveraging.

The API Sub Group reviewed the Promising Practices identified in the API Reducing Disparities report. The Sub Group recommended adopting promising programs for San Diego API communities which would emphasize the following:

- behavioral health and physical healthcare integration
- the linkage of mental health and spirituality
- reduction in stigma from a culturally relevant framework

Recommendations:

Item	Feasibility / Additional comments
Behavioral health and physical healthcare integration	This item is already occurring in the Adult/Older Adult System of Care, and also Children's System of Care as it is a contract requirement for contracted providers to link with primary care providers; and/or to identify a medical home for system of care recipients. However, it should be noted that additional supports may be needed if a client is linked with an API private practitioner doctor in the community. Some private API physicians may have limited resources to collaborate for provision of behavioral health services. Some of these physicians may also have some stigma around mental health services.
Linkage of mental health and spirituality	This item is already occurring in the Adult/Older Adult System of Care, and also Children's System of Care as it will be a new contract requirement for contracted providers to integrate with faith-based providers. However, it should be noted that the current faith-based initiative in the County has recruited predominantly Christian-faith representatives from the African American and Latino communities. Additional supports may be needed to recruit faith-based representatives from API Christian-faith communities, as well as Muslim and Buddhist communities. Similar to the API physicians, some API faith-based representatives may have limited

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	resources to collaborate for provision of behavioral health services. Some of these physicians may also have some stigma around mental health services.
Reduction in stigma from a culturally relevant framework	This item is partially being addressed through It's Up to Us Campaign. There are a variety of API videos on the It's Up to Us website. However, these videos have not have sufficient promotion. Recommend additional promotion of API materials; and/or more focus on API communities with Ad Ease project.

The API Sub Group identified 6 **priority** promising programs to be considered at this time. These include:

- API Connections
- Qi-Gong
- Horticultural Therapeutic Community Centers
- Partners in Healing Group
- From Killing Fields to Growing Gardens
- Nikkei Tomadachi (Friendly Visitors)

Action: *AOA and Children's ADD and/or designee with API community to identify and select a promising practice proposal for BHS to consider as part of their planning stakeholder process for Innovations funding for FY 14-15.*

Recommendations:

Item	Feasibility / Additional comments
Action: Select Promising practice proposal for stakeholder process	This Action item has been accomplished. Some of the programs above (From Killing Fields to Growing Gardens; and Nikkei Tomodachi) have been submitted for MHSA Innovations Review
Promising Practices – other	This item has some additional feasibility. Some clubhouses are already doing some type of community gardening. System of Care Leads can review if they can strengthen Scope of Work requirements in this area. Also recommend that "INN" Design Teams review the 6 priority promising programs to consider if the entire program, or a component of the program could be considered during this current review phase.

**Submitted March 4, 2014 by Dr. Dixie Galapon*

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CYF Response

- Contractor shall connect clients to a "medical home" for 100% of those clients who do not already have a primary health provider. Contractor shall document information about the medical home and on-going efforts to communicate with the primary care physician in the medical record.
- CYF worked with Healthy San Diego Health plans to establish a continuum of care and bidirectional interface between Primary Care Mental Health and Specialty Mental Health and implemented Care Coordination form with all BHS programs
- Contractors assist all parents/caregivers in developing a "Wellness Notebook," which is a tool that is used to organize information about a child's health condition and care. The Wellness Notebook is particularly important for clients with chronic health issues including, but not limited to, diabetes, asthma and obesity
- CYF SOC goals for FY 13/14 include: to contribute to the development/implementation of Stigma Reduction campaign in alignment with CalMHSA project, including but not limited to make recommendations for Stigma Reduction Strategy and activities for contracted programs.
- North and Central regions CYF contracted programs were invited to participate in the Live Well Faith Base Community Dialogues

FY14-15 Focus
AOA
1.
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CYF
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Native American Recommendations

Recommendation #1: Increase mental health services and increase access to care.

Partner with WET, UCSD Psychiatry Residency program, and masters levels (MSW/MFT) of various educational institutions (Alliant University, SDSU).

Recommendations:

- Create a partnership with the University of California at San Diego's Gifford Clinic and Psychiatry Residency program **utilizing telemedicine** that could increase access for all adult AI/ANs living in rural or urban areas that are in need of psychiatric services or for those who have transportation barriers.
  - Indian Health Council & San Diego American Indian Health Center both provide mental health services on site.

  Information below provided in collaboration with Dr. Leon Altamirano

  Rural Southeast San Diego
  - **Southern Indian Health Council** has telemedicine equipment but has not implemented for telepsychiatry. Administration has organizational and complex needs and issues related to implementing mental health services. Challenges regarding documentation and confidentiality as well as concerns about legal/ethical/regulatory/employment practices are concerns due to Sovereign Immunity Protections. Currently, in SIHC there are 2 licensed therapists, a soon-to-be licensed social worker, and one intern. They are seeking to hire another FT intern. They do not have a psychiatrist.
  - **Mountain Health and Community Services** has telemedicine capacity and has used this as a means to serve their service area for both AI/AN and non-Indian patients. They do not currently have a psychiatrist. The clinic has limited mental health with 1 Ft psychologist and 2 interns. MHCS has and would continue to deliver access for psychiatry to the AI/AN population while working with SIHC primary care physicians for continuity and multidisciplinary care coordination. MHCS has clinics in Alpine, Campo, Escondido (Urban Indians) and near Logan Heights (Urban Indians) as well as a community center in Campo.
  - **Sycuan Medical-Dental Health clinic**. This clinic is more isolated as it is located on the Sycuan Reservation. However, the administrator and the tribe have considered expansion to include opening a more accessible, larger health center with behavioral health services. Sycuan does not have mental health therapists or psychiatry. However, they do have a nurse that is assigned to schedule and facilitate all telemedicine and have been effectively using telemedicine for many

services. They have had limited success with its use for psychiatry. They have a primary care and dental clinic that serves AI/AN and non-Indian populations.

Rural Northeast San Diego:

- **Indian Health Council** does provide psychiatry for approximately 8-10 hours per week on two half-days. They have a psychiatrist however, availability is limited. IHC has 2 psychologists and a typically have another therapist. Their restrictions limit services to only AI/AN population and make it an excellent training ground for rural/public health psychiatry. They do have telemedicine capacity and have medical and dental services. The primary challenge falls on the issue of Sovereign Immunity.
- **San Diego American Indian Health Center**: The urban clinic has a dual board certified family medicine-psychiatry medical director. However, they only have 1 part-time therapist and are experiencing multiple demand and capacity challenges. As a consequence, the physician is managing the bulk of the mental health interventions and has stated that approximately 70% of her patients are primarily psychiatry cases. This clinic sees a great deal of clients with trauma histories that, in addition are experience identity and alienation issues as Urban Indians. The additional significant challenge is that this clinic receives significantly less Indian Health Service funding to provide services to the many Urban AI/AN Indians that live in the area. Due to their location, this clinic has the capacity to also serve the many homeless AI/AN veterans in the area. Their current structure would not allow much of an increase in volume for mental health services.

- MHSA Workforce Education and Training (WET) funded programs such as UCSD Community and Child Psychiatry Residency to enhance residency experience by facilitating access to a **rural/public health rotation** in the Native American communities for psychiatry fellows.
  - The Consortium takes interns directly, not through the County.
  - Need to consider identifying providers that serve the Native American population that could be approached to see if they were interested in hosting interns and/or fellows.

    Dr. Melissa Deer, at San Diego American Indian Health Center is dual-board certified and would be willing to take on fellows/residents for psychiatry rotations. This is an administrative and policy question to pursue with SDAIHC.

    Many of the challenges with the Indian clinics is the issue of retaining the protection of sovereign immunity. Despite the benefit to the AI/AN communities served, the clinics regularly seek to avoid any indemnities/waivers of sovereign immunity as tribal politics often dictate practice at the clinics.

In these cases, the regulatory and other provider governing board legal/ethical guidelines are affected.

Mountain Health may be a potential desirable location to explore. Alvarado Parkway Institute may be sought out to support this project by providing Psychiatric Supervision for Interns and training opportunities at their inpatient and outpatient programs. Thereby increasing Native Americans access to care.

Additional challenges to serve the AI/AN population is related to identifying non-Indian interns to work with the AI/AN population. The challenges are of a cultural competence and trauma-informed care nature that can be overcome with appropriate training. The potential challenges that are typically cited can be overcome for the majority of potential clients.

We can also explore psychiatrists that may be interested in an opportunity to work with existing AI/AN providers/clinics in the various locations serving the AI/AN population. As such, an option would be to evaluate the feasibility of an Innovation project specifically to expand the public mental health reach of WET program resources into rural communities for psychiatry, therapy, case management and social services.

- Masters level programs Alliant International University, University of San Diego and San Diego State University (LCSW, MFT , MSW and PsyD programs) to **introduce the availability of rural/urban/public health internship opportunities** while increasing ease of access to affordable therapy and case management services that have traditionally been unavailable to this rural area of the county.
  - See recommendations above.

Recommendation #2: Continue the Cultural Competence Academy with a Native American cohort.

- Piedad to pursue funding for a Cultural Competence Native American Academy.
  - Piedad has pursued with Clinical Director's Office and BHETA to provide this training in FY 14-15.

**Submitted by Kristina Maxwell in collaboration with Dr. Leon Altamirano*

CYF Response

- The Indian Health Council-(IHC) Dream Weaver Consortium offers four different PEI programs provided by the Urban Youth Center, Indian Health Council, Southern Indian Health Council, and the Sycuan Medical/Dental Center. These providers offer prevention activities that promote community and cultural awareness. These activities include: traditional health gatherings, cultural programs, basket

weaving instruction (a local tradition for many tribes), nutrition programs, self-esteem workshops, positive parenting classes, exercise programs, and the promotion of overall increased medical and dental health. Additionally, the Urban Youth Center provides counseling services. All of these activities are intended to prevent the onset of serious mental health problems. Co-occurring Youth Counselor was trained to implement White Bison's 'Mending the Broken Hearts for Youth Healing Unresolved Grief and Intergenerational Trauma with youth.

- The IHC Youth Center provides youth with tours to local colleges and universities. Additionally, clients participate in College and career fairs
- IHC hosted a Sexual Trafficking and Commercial Sexual Exploitation of Children in Indian Country Summit on May 17, 2013. This event was the first of its kind out Indian Country in the US. Federal and local law enforcement as well as northern California and out of state presenters participated in this conference held at Pala reservation

FY14-15 Focus
AOA
1. Provide Native American Cohort of the CCA.
2. WET team to follow up on number of NA pre-med students in any Southern California medical universities. Explore feasibility to attract NA pre-med students via the WET program.
CYF
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2.

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LGBTQ Recommendations - Pending

Recommendation #1: Training

- Coordinate county funded training providers to ensure integrated approaches in content and advancement of practice
- Include LGBTQ in the 4 hours of culture competence
- Require training for all levels of staff including Administrators, QA, Support Staff and COTRs
- Provide training opportunities for system partners

Workgroup Lead Response

- The Cultural Competence Academy- LGBTQI was established in FY 14-15
- A one hour LGBT introductory webinar is available through BHETA
  - System partners have access to the webinar

Recommendations:

- Require all levels of County and program staff to complete the trainings.
  - This would include Administrators, QA, Support Staff and CORs
- Require to include LGBTQ training as one of the 4 hours of culture competence training options.

Recommendation #2: Learning Community

- Increase collaboration with the local San Diego LGBTQ Project
- Collaborate in training activities

Action: BHS has 2 LGBTQ contracts. AOA and Children's Services designees to identify increased learning opportunities and capacity building with these contractors.

Action: CCRT member added in FY 2012-2013. Consult with representatives as to opportunities to broaden BHS collaboration and partnership.

Recommendation #3: Practice

A. Culturally relevant LGBTQ services integrated between Alcohol/Drug, Mental Health, and Physical Health Providers
B. Anasazi- new forms have a section for sexual orientation and sexual identity

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C. Include LGBTQ culturally specific services in all levels of care (outpatient, day treatment, residential) and throughout all age groups Children, TAY, Adult/Older Adult
D. Incorporate LGBTQ training awareness/orientation for caretakers including foster parents including areas such as:
    - risk and Wellness and Recovery Plans
    - spirituality
    - identity
    - sexual orientation

Recommendation:

A. CORs to review and evaluate BHS programs/contracts for language integrating LGBTQ services. This can also be done through the Provider Manual
B. Ensure providers are proficient to address gender identity and/or gender preference issues through their own education, training, and transcendence of personal values. Provide training opportunites via organizational provider or via BHS training opportunities.
B. Increase assessment and treatment attention to risk factors and suicide. Can be achieved through High Risk evaluation.

<u>Additional Recommendations by Workgroup Lead</u>

2. Continue to track status of 2013- 2014 Recommendations
    - All areas are at least partially achieved; continue to work toward full achievement
    - Track the status
    - Establish outcome indicators

3. Incorporate Academy Participant Feedback *(see attachment)*
    - Review evaluations and projects from the Cultural Competence Academy, LGBTQI participants. This information will be useful to determine next steps for planning, understanding system impact, and setting forth priorities.
    - Review and integrate specific recommendations from Academy participants to improve the Children and Adult County Behavioral Health Assessments

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4. Health Outcomes Management System (HOMS)
   Currently some adult mental health providers are required to input data through the HOMS (Health Outcomes Management System). The Sexual Orientation/Gender Identity is not consistent with the County Behavioral Health Assessment. Recommend review and modification of forms as needed for consistency.
5. Ongoing Training
   The establishment of the Cultural Competence Academy for LGBTQI populations is a comprehensive design. If the Cultural Competence Academy for LGBTQI will not be sustained, it is recommended that an alternate plan be identified for ongoing trainings.

**Submitted by Rosa Ana Lozada*

FY14-15 Focus
AOA
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Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
ALL-OE	Deaf Community Services	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within the County of San Diego	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Children, adults and older adults who are deaf or hard of hearing and who have a SMI (Serious Mental Illness) or alcohol and other drugs (AOD) use or abuse problems	• Outpatient mental health services • Case management • Integrated substance abuse treatment and rehabilitation	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S. Suite 300 San Diego, CA 92108 (619) 398-2437	All
ALL-OE	Deaf Community Services Clubhouse	Recovery and Skill Center/Clubhouse for the Deaf and Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Adults/Older Adults, TAY who are deaf or hard-of-hearing who have or are at risk of a SMI (Serious Mental Illness) or co-occurring disorder	• Member-operated recovery and skill development center (clubhouse) program for deaf and hard-of-hearing transitional age youth and Adults/Older Adults who are at risk of or recovering from a mental health issue including those who may have a co-occurring substance use disorder • Services include social skill development, rehabilitative, recovery, vocational and peer support	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S. Suite 300 San Diego, CA 92108 (619) 398-2437	All
ALL- OE	Survivors of Trauma Torture International	Outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and children who suffer from a severe emotional disturbance	Improve access to mental health services, culture specific, outreach and education to persons with a serious mental illness or emotional disturbance who have been victims of torture and provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity	Seriously mentally ill transition age youth, adults, and older adults who are victims of trauma and torture	• Bio-psychosocial rehabilitation services recovery • Strength based, client and family driven and culturally competent programs	Survivors of Trauma Torture International Confidential location for office (619) 278-2400	ALL
ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Provides Psychiatric and Addiction Consultation and Family Support Services for primary care, pediatric and obstetric providers who serve patients with Medi-Cal or who are uninsured, throughout San Diego County, youth (TAY), adults and older adults (AOA)	Improve the confidence, competence, and capacity of primary care pediatrics, and obstetricians in treating behavioral health conditions; increase identification of behavioral health issues, including suicide risk; provide education, referrals, and linkages to support families	For children, adolescents, transitional age youth (TAY), adults and older adults (AOA)	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	All
ALL-OE	Mental Health and Primary Care Services Integration Services	Provide services and treatment to adult patients with behavioral health problems through the Enhanced Screening, Brief Intervention and Referral to Treatment (SBIRT) model	Provide effective, evidence-based treatment for behavioral health interventions in a primary care setting	Adults aged 18 - 59	• Mental health assessment • Dual diagnosis screening Information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network 7535 Metropolitan Dr. San Diego, CA 92108 (619) 542-4300	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
ALL-SD	Psychiatric Emergency Response Team	Connect law enforcement officers with psychiatric emergency clinicians to serve children and adults throughout the County	Improve collaboration between the mental health and law enforcement systems with the goal of more humane and effective handling of incidents involving law enforcement officers and mentally ill and developmentally disabled individuals	Services to all ages, with a focus on, veterans, homeless and the Native American community	• Case coordination • Linkage and limited crisis intervention services • Training for law enforcement personnel	PERT, Inc. 1094 Cudahy Pl. Suite 314 San Diego, CA 92110 (619) 276-8112	All
ALL- SD	Chaldean and Middle-Eastern Social Services	Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	Provide culturally competent treatment, services and referrals for individuals of Middle Eastern descent who experience mental health issues or a serious mental illness	Individuals who are 18+ and eligible for Medi-Cal funded services	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services S. Magnolia Ave. Suite 201 El Cajon, CA 92020 (619) 631-7400	ALL
CY-OE	Social Advocates for Youth	Expand Medi-Cal funded mental health services located on school sites	Increase outreach and access to services to uninsured and underserved children, youth and their families with Serious Emotional Disturbance	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative services • Psychiatric evaluation, medication, monitoring and pharmaceutical resources • Integrated co-occurring disorders treatment	Social Advocates for Youth 4275 El Cajon Blvd. Suite 101 San Diego, CA 92105 (619) 283-9624	4
CY-FSP	South Bay Community Services	Individual/group/family services provided at schools, home, or office/clinic locations	Increase access to services for uninsured and underserved children, youth and their families with Serious Emotional Disturbance	Transition age youth and families who are eligible for Medi-Cal, meet Title 9 medical necessity and are experiencing co-occurring disorders	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention, medical management, outreach at schools and the community	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	WrapWorks	Wraparound services for Child Welfare Services or Probation Services to maximize the capacity of the family to meet the child's needs and reduce the level of care from a group home placement to a home or home-like setting	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children, youth and young adults up to age 21 from Child Welfare Services or Probation Services	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medical management • Outreach at schools and the community	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 633-4100 North County 235 W. 5th Ave. Suite 130 Escondido, CA 92025 (760) 466-3984 Southeast 123 Worthington St. Suite 201 Spring Valley, CA 91977 (858) 633-4135	All
CY-SD	Behavioral Crisis Center and Mobile Assessment Team Services	Provide mobile crisis mental health services in conjunction with a walk-in assessment clinic for the North County region. An assessment team of licensed clinicians will respond to client calls within four hours and provide voluntary services	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Underserved and uninsured children, youth and their families who are experiencing a mental health crisis or urgent need for mental health services	• Assessment • Information • Referral • Medication management • Linkage to hospital when required • Follow-up visits	North County Crisis Intervention and Response Team 225 West Valley Pkwy. Suite 100 Escondido, CA 92025 (760) 233-0133 1020 S. Santa Fe Ave. Suite B-1 Vista, CA 92084	5
CY-FSP	ALLY National City & South Bay	Individual/group/family services provided at schools, home, or office/clinic locations	Provide community and school-based outpatient mental health services for youth ages 5 to 21 years	Transition age youth and families who are eligible for Medi-Cal, meet Title 9 medical necessity and are experiencing co-occurring disorders	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medical management • Outreach at schools and the community	Prime Healthcare Paradise Valley 502 Euclid Ave. Suite 103 National City, CA 91950 (619) 472-4714	1
CY-FSP	Child/Youth Case Management	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide full service partnership services. Enhance services to clients and families by providing case management in clinics in addition to the services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children and youth diagnosed with Serious Emotional Disturbance and their families, who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultations • Coordination, referrals, and linkages to services • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy. • Psychiatric services including medication • Full service partnership services	Rady Children's Hospital North Inland 625 W. Citracado Pkwy. Suite 102 Escondido, CA 92025 (760) 294-9270	3

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	School-Based Central-East-South	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide full service partnership services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children and youth diagnosed with Serious Emotional Disturbance and their families, who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation • Coordination • Referral and linkage • Family outreach through home visits • Rehabilitation groups • Individual group and family therapy • Psychiatric services including medication • Full service partnership services	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd. Suite 101 San Diego, CA 92123 (858) 966-8471	1,2,4
CY-FSP	Child/Youth Case Management	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide full service partnership services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children and youth diagnosed with Serious Emotional Disturbance and their families, who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation • Coordination • Referral and linkage • Family outreach through home visits • Rehabilitation groups • Individual group and family therapy • Psychiatric services including medication • Full service partnership services	Rady Children's Hospital Central 3665 Kearny Villa Rd. San Diego, CA 92123 (858) 966-5832	1,4
CY-FSP	Children's Mental Health Counseling and Treatment Center	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide full service partnership services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children and youth diagnosed with Serious Emotional Disturbance and their families, who are receiving mental health services in outpatient clinics	• Intensive outpatient individual, group and family therapy • Case management • Intensive care coordination • Substance abuse prevention and treatment • Linkage to additional services	Union of Pan Asian Communities Children's Mental Health Counseling and Treatment Center 1031 25th St. Suite C San Diego, CA 92102 (619) 232-6454	1,4,5
CY-FSP	Cultural Language Specific Outpatient	A Full Service Partnership that work collaboratively with contracted Family Peer partners to provide outpatient specialty mental health services to the highly diverse communities in the southeastern region of San Diego	Improve the mental health of children and youth to ultimately enhance family relationships, peer relationships, community, and school performance	Culturally diverse individuals who are Medi-Cal eligible and experiencing co-occurring disorders	• Community Education • Walk-in Screening • Psychosocial assessments • Psychiatry evaluation	Southeast Children's Mental Health Clinic 3177 Oceanview Blvd. San Diego, CA 92113 (619) 595-4400	1,4
CY-FSP	Parent Partner Services	Culturally competent Full Service Partnership mental health services to Latino, Asian, and African American children, youth and their families	Improve access to services for Latino and African American children, youth and families experiencing a Serious Emotional Disturbance	Latino, Asian and African American; Uninsured and underserved, with a secondary focus on Medi-Cal underserved	• Outreach & engagement • Parent Partners • Mental health education • Crisis intervention • Individual, group and family counseling	Harmonium Inc. 5275 Market St. Suite E San Diego, CA 92114 (619) 857-6799	1,4
CY-FSP	Multi-Cultural Community Counseling	Culturally competent Full Service Partnership mental health services to Latino and Asian/Pacific Islander children, youth and their families	Improve access to services for Latino and African American children, youth and families experiencing a Serious Emotional Disturbance	Latino, Asian and African American; Uninsured and underserved, with a secondary focus on Medi-Cal underserved	• Outreach & engagement • Mental health education • Crisis intervention • Individual, group and family therapy • Case management • Psychiatric services including medication • Full Service Partnership services and supports	Union of Pan Asian Communities 5348 University Ave. Suites 101 and 102 San Diego, CA 92105 (619) 232-6454 ext. 801	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	Pathways Cornerstone	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved children, youth and their families with Serious Emotional Disturbance	Children, adolescents, and young adults up to age 21	• Outpatient school based specialty mental health services for Seriously Emotionally Disturbed children and youth • Outreach at schools and in the community • Provides enhanced case management and/or rehabilitative services	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd. Suite 14 San Diego, CA 92115 (619) 640-3269	4
CY-FSP	Counseling Cove	Locate and engage homeless and runaway youth for the purpose of increasing access to mental health services	Increase access to mental and behavioral health services for homeless and runaway children/youth with Serious Emotional Disturbance	Children and youth	• Individual, group and family counseling • Case management • Crisis intervention, rehabilitative services and psychiatric evaluation • Medication monitoring and pharmaceutical resources	San Diego Youth Services Counseling COVE 2250 4th Ave. Suite 301 San Diego, CA 92101 (619) 525-9903	1,4
CY-FSP	San Diego Wraparound	Provide wraparound mental health services to transition age youth and their families currently in Child Welfare Services custody and residential placement back to a home environment	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Dependents and wards ages 3 - 21 years old who are transitioning from residential services to home setting	• Full Service Partnerships • Assessment • Treatment • Case Management • Dual Diagnosis services • Connection to primary care provider and development of a wellness notebook to assist families in organizing children medical information	Fred Finch Wraparound Services 3434 Grove St. Lemon Grove, CA 91945 (619) 281-3706	All
CY-FSP	Therapeutic Behavioral Services	Intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children up to age 21 who are Medi-Cal eligible and without access to other specialty mental health reimbursable interventions	• Full Service Partnerships • Assessment • Treatment • Case Management • Dual Diagnosis services • Connection to primary care provider and development of a wellness notebook to assist families in organizing children medical information	New Alternatives 2535 Kettner Blvd. Suite 1A4 San Diego, CA 92125 (619) 615-0701	All
CY-FSP	Crossroads	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Provide a full range of culturally and linguistically competent, strength-based, comprehensive integrated mental health services to children, youth and their families	Children with youth and diagnosed with Serious Emotional Disturbance and their families who are receiving mental health services in outpatient clinics	•Individual/group/family/treatment • Case management • Rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medical management	Community Research Foundation Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2
CY-FSP	Para Las Familias	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children up to age 21 who are Medi-Cal eligible and without access to other specialty mental health reimbursable interventions	• Individual/group/family/treatment • Case management • Rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medical management	Episcopal Community Services 401 Mile of Cars Way Suite 350 National City, CA 91950 (619) 228-2800 ext.316	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP /CY-OE	Douglas Young Youth and Family Services	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide Full Service Partnership services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children with youth and diagnosed with Serious Emotional Disturbance and their families who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation coordination, referrals, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Coordination, referral, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Psychiatric services including medication • Full service partnership services	Community Research Foundation Douglas Young Youth and Family Services 7907 Ostrow St. Suite F San Diego, CA 92111 (858) 300-8282	4
CY-FSP CY-OE	Child/Youth Case Management	Outpatient clinic providing mental health services for children and their families	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children with youth and diagnosed with Serious Emotional Disturbance and their families who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation • Coordination, referral, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Psychiatric services including medication • Full service partnership services	Rady Children's Hospital North Coastal 3142 Vista Way Suite 205 Oceanside, CA 92056 (760) 758-1480	3,5
CY-FSP/ CY-OE	Nueva Vista	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children with youth and diagnosed with Serious Emotional Disturbance and their families who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation • Coordination, referral, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Psychiatric services including medication • Full service partnership services	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd. Suite B Chula Vista, CA 91911 (619) 585-7686	1
CY-FSP/ CY-OE	Youth Enhancement Services	Enhance outpatient services to children, youth, and families in eight outpatient clinics to provide Full Service Partnership services	Augmenting clinic-based services with case managers, and rehabilitation workers and Alcohol and Drug Counselors who can work with families that have a variety of other unmet needs that may impact resiliency	Children with youth and diagnosed with Serious Emotional Disturbance and their families who are receiving mental health services in outpatient clinics	• Individual, group and family treatment • Case management and rehabilitative services • Intensive Care Coordination	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd. Suite E-101 San Diego, CA 92154 (619) 428-5533	1
CY-OE	Palomar Family Counseling Services	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative Services • Psychiatric evaluation, medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	Palomar Family Counseling Escondido 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 Fallbrook 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	3,5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	School Based Mental Health Services	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative Services • Psychiatric evaluation, medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	Escondido Vista Hill Foundation 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 North Inland Ramona Vista Hill Foundation 1012 Main St. Suite 101 Ramona, CA 92065 (760) 788-9724	3,5
CY-OE	North County Lifeline	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative Services • Psychiatric evaluation, medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	North County Lifeline Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	5
CY-OE	Social Advocates for Youth	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative Services • Psychiatric evaluation, medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	Social Advocates for Youth School Based Outpatient Treatment 4275 El Cajon Blvd. Suite 101 San Diego, CA 92105 (619) 283-9624	4
CY-OE	TIDES	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative Services • Psychiatric evaluation, medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	YMCA-TIDES 4080 Centre St. Suite 103 San Diego, CA 92103 (619) 543-9850	4
CY-OE	Providence Cornerstone	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children, adolescents, and young adults up to age 21	• Outpatient school based specialty mental health services for children and youth with Serious Emotional Disturbance • Outreach at schools and in the community • Enhanced mental health case management and/or rehabilitative services	Providence Cornerstone 4660 El Cajon Blvd. Suite 210 San Diego, CA 92115 (619) 640-3266	4
CY-OE	School Based Mental Health Services	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement • Crisis intervention • Individual, group and family counseling • Case management • Rehabilitative services • Psychiatric evaluation • Medication monitoring and pharmaceuticals • Integrated co-occurring disorders	Rady Children's Hospital of San Diego 625 W. Citracado Pkwy. Suite 102 Escondido, CA 92025 (760) 294-9270	3

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	Mental Health Systems Inc.	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement Crisis intervention Individual, group and family counseling • Case management • Rehabilitative services • Psychiatric evaluation • Medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	4
CY-OE	San Diego Center for Children	Expands Medi-Cal funded mental health services provided on school sites to unserved clients	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Individual/group/family treatment • Case management/rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medical management • Outreach at schools and in the community • Services are provided at schools, home, office or clinics	San Diego Center for Children East Region Outpatient 7339 El Cajon Blvd. Suite K La Mesa, CA 91942 (619) 668-6200	2
CY-OE	Community Circle	School based outpatient children's mental health services in Central and East County	Increase outreach and access to services to uninsured and underserved Seriously Emotionally Disturbed children, youth and their families	Children and youth up to age 21 and their families who are underserved; with a focus on Latino and Asian-Pacific Islanders	• Outreach & engagement Crisis intervention Individual, group and family counseling • Case management • Rehabilitative services • Psychiatric evaluation • Medication monitoring and pharmaceuticals • Integrated co-occurring disorders treatment	Logan Heights Family Health Centers 2204 National Ave. San Diego, CA 92113 (619) 515-2355 Spring Valley Family Health Centers 3845 Spring Dr. Spring Valley, CA 91977 (619) 515-2318	1,2,4
CY-OE	Incredible Years	Provide services to children ages 0-5 and their families at designated preschool sites in San Diego Unified School District as well as to children and families attending other preschools in the surrounding area	Increase pro-social behaviors in children through working with the child, parents, and teachers through parenting groups, children's treatment groups, and individual and family services as needed	Children and youth diagnosed with Serious Emotional Disturbance and their families, who are receiving mental health services in outpatient clinics	• Case management • Alcohol and Drug counseling • Consultation • Coordination, referral, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Psychiatric services including medication	Incredible Years Emerson Elementary 3510 Newton Ave. Bungalow 103 San Diego, CA 92113 (619) 238-0471	1,4
CY-OE	Mobile Adolescent Services Team (MAST)	Mental health assessment and treatment services located at Juvenile Court and Community School sites countywide	Increase access to services to Seriously Emotionally Disturbed youth who attend Momentum Learning Center schools. Provides Full Service Partnership services, including development of "wellness plans" for parents to organize their children's medical information	Uninsured and/or underserved children and youth attending Momentum Learning Center who are involved with the juvenile justice system	• Case management • Alcohol and Drug counseling. • Consultation • Coordination, referral, and linkage • Family outreach through home visits • Rehabilitation groups • Individual, group and family therapy • Psychiatric services including medication • Full service partnership services • Use of Cognitive Behavioral Therapy as an evidence based practice for this population	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-3261	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-OE	Perinatal Outpatient Homeless Outreach	Adding Perinatal Outpatient Homeless Outreach component to enhance the existing Women's Perinatal Non-residential AOD Treatment Services for women who may have a serious mental illness and co-occurring disorder in all regions of San Diego County	Collaborate with providers of services to the homeless to engage homeless or near homeless individuals with substance abuse problems	Pregnant, parenting and perinatal women with mental health and substance abuse issues and have dependent children up to age 17	• Outpatient therapy • Individual, group, and family therapy • Case management • Alcohol and Other Drug counseling	Procurement Underway	All
CY-SD	New Alternatives	Provides support and linkage to services and community resources to children/youth and their families who are being served by the Homeless Outreach program or currently receiving mental health treatment	Improve the ability of children and youth and their families to benefit from mental health services	Children up to 21 years old who meet medical necessity and meet set criteria	• Brief outpatient behavioral health services • Intensive case management to stabilize high risk youth who are leaving a psychiatric hospital • Follow up services to divert or prevent readmission to acute services	New Alternatives Inc. Crisis Action & Connection 730 Medical Center Crt. Chula Vista, CA 91911 (619) 591-5740	1
CY-SD	Breaking Cycles	Offers support to probation youth within the institutions from all regions of the County. A new component of the program will increase staffing to offer screening and programming for Commercially Sexually Exploited Children detained in Juvenile Hall and the Girls Rehabilitation Facility as they transition into the community	Provides services in collaboration with Juvenile Probation and multi-disciplinary teams	Children up to 21 years who meet medical necessity and meet set criteria	Stabilization Treatment and Transition Team (STAT) services include: • Crisis intervention • Counseling • Medical evaluations • Brief assessment • Consultation • Transitional mental health services • Community stabilization	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600 ext.1225	All
CY-SD	Mobile Psychiatric Emergency Response & North County Walk-In Assessment Clinic	Offer emergency mental health services to patients brought by parents/guardians, social workers, law enforcement or ambulance from their family residences or from shelters, Juvenile Hall, hospital emergency rooms, schools, foster homes, group homes, or residential facilities	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and adolescents, age 17 and under who are a experiencing psychiatric emergency	• Psychiatric evaluation • Crisis intervention • Crisis stabilization • Brief outpatient counseling • Case management and emergency medication management to children and adolescents under age 18	New Alternatives Inc. Emergency Screening Unit 730 Medical Center Crt. Chula Vista, CA 91911 (619) 397- 6972	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Phoenix House	Provide short term (no more than 3 months) stabilization with psychotropic medication and linkage to community-based or private facility for on-going treatment	Linkage and coordination to community or private ongoing mental health services	Children, youth and family with Serious Emotional Disturbance who have been referred by the Probation Department Child Welfare Services	• Assessment • Medication management services • Case management • Linkage and referral for on-going care including one-to-one therapy and family counseling when required	Phoenix House of San Diego Inc. 11600 Eldridge Ave. Lake View Terrace, CA 91342 (818) 686-3272	All
CY-SD	Juvenile Court Clinic	Provides short term (no more than 3 months) stabilization with psychotropic medication and linkage to community-based or private facility for on-going treatment	Assist the child and family with support, linkage and coordination to community or private ongoing mental health services if needed	Up to age 21 with medical necessity; Wards; Dependents; Medi-Cal beneficiary	• Assessment • Medication management services • Case management • Linkage and referral to ongoing services	Vista Hill Juvenile Court Clinic 2851 Meadow Lark Dr. San Diego, CA 92123 (858) 571-1964	All
CY-SD	LGBTQI	Provide proper assessment and resources while focusing on educational goals specifically to LGBTQ youth presenting complex forms of trauma	Support LGBTQ children and youth that may have a non-supportive or hostile environment in their homes, schools and communities	Underserved LGBTQ children and youth	• Mental health counseling • Permanent supportive housing • Job training • GED preparation • Clinical services	TBD	All
CY-SD	Probation After Hours	Program will augment current resources with additional staffing and expanded hours of coverage to coincide with periods of free time for the youth	Ensuring that probation youth with mental illness have access to mental health services, with successful reintegration into the community and potential reduction in recidivism	Probation youth currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Assessment • Crisis intervention • Individual therapy • Group therapy • Coordination of care • Medication management • Innovative mental health services	County of San Diego Juvenile Forensic Services 2901 Meadowlark Dr. San Diego, CA 92123 (858) 694-4680	All
CY-SD	New Alternatives	Provides mental health services to clients and their families to stabilize and maintain children and youth in home-like settings. Provides peer mentorship services to Child Welfare Services youth in placement	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and adolescents at San Pasqual Academy with Serious Emotional Disturbance under the age of 21 who are at risk of change of placement to a higher level of care	• Assessment • Evaluation • Case management • Treatment (including evidence based practices) • Case consultation and other needed mental health interventions • Peer mentorship • Services available by referral from Child Welfare Services	New Alternatives Inc. San Pasqual Academy 17701 San Pasqual Valley Rd. Escondido, CA 92025 (760) 233-6005	All
CY-SD	Clark Adolescent Program	Provides mental health services to clients and their families to stabilize and maintain children and youth in home-like settings. Provides peer mentorship services to Child Welfare Services youth in placement	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and adolescents with Serious Emotional Disturbance under the age of 18 who are at risk of change of placement to a higher level of care	• Day treatment and milieu therapy • Individual, group and family therapy • Case management • Medication services • Pathways to Well-being intensive care coordination	San Diego Center for Children 3003 Armstrong St. San Diego, CA 92111 (858) 277-9550	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Fred Finch Youth Center	Provides peer mentorship services to Child Welfare Services youth in placement	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and adolescents with Serious Emotional Disturbance under the age of 18 who are at risk of change of placement to a higher level of care	• Assessment • Evaluation • Case management • Treatment (including evidence based practices) • Case consultation and other needed mental health interventions • Peer mentorship • Services available by referral from Child Welfare Services	Fred Finch Day Rehab 3434 Grove St. Lemon Grove, CA 91945 (619) 281-3706	All
CY-SD	San Diego Center for Children	Provides mental health services to clients and their families to stabilize and maintain children and youth in home-like settings. Provides peer mentorship services to Child Welfare Services youth in placement	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and adolescents with Serious Emotional Disturbance under the age of 18 who are at risk of change of placement to a higher level of care	• Assessment • Evaluation • Case management • Treatment (including evidence based practices) • Case consultation and other needed mental health interventions • Peer mentorship • Services available by referral from Child Welfare Services	San Diego Center for Children 3002-3004 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CY-SD	Incredible Families	Provides mental health treatment and support services to children and families involved in Child Welfare Services	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	The target population includes children ages 2-11, who are dependents of Juvenile Dependency Court due to abuse and/or neglect, and their families	• Weekly multi-family parent-child visitation event and meal for all family members • Utilizing the Incredible Years evidenced-based curriculum • A primary therapist assigned to each family • Clinical support during family visitation events and individual and family therapy	Vista Hill Foundation East Region Incredible Families Program 4990 Williams Ave. La Mesa, CA 91941 (619) 668-4200 Incredible Families Central 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5163 North Inland Mental Health Outpatient Services 765 Chestnut St. Escondido, CA 92025 (619) 615-0227	1,2,4,5
CY-SD	Multi-Systemic Therapy	Offers Multi-Systemic Therapy and Assertive Community Treatment Children's Mental Health Services	Reduce the number of youth in juvenile hall, providing advocacy for appropriate education services, and decreasing the number of mentally ill minority youth detained in juvenile hall	Youth, age 12 to 21 detained in the Kearny Mesa Juvenile Detention Facility and identified as having a mental health diagnosis	• Day treatment and milieu therapy • Outpatient therapy • Individual, group and family therapy • Case management; rehabilitation services/skill building • Alcohol & drug counseling • Pathways to Well-being intensive care coordination • Medication services • School based therapy	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 573-2227	4
CY-SD	Multi-Systemic Therapy (MST)-Assertive Community Treatment (ACT)	Probation staff provides mental health assessment to incarcerated juveniles and refers them to the appropriate additional services	Reduce the number of youth in juvenile hall, providing advocacy for appropriate education services, and decreasing the number of mentally ill minority youth detained in juvenile hall	Youth, age 12 to 21 detained in the Kearny Mesa Juvenile Detention Facility and identified as having a mental health diagnosis	• Mental health screening • Case management • Linkage to services	Kearny Mesa Juvenile Detention Facility 2801 Meadow Lark Dr. San Diego, CA 92123 (858) 694-4500	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Telecare	Provide a Short-Doyle/Medi-Cal certified Assertive Community Treatment (ACT) Full Service Partnership (FSP) program for persons 18 and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Probation-funded Assertive Community Treatment component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Telecare	Provide a Short-Doyle/Medi-Cal certified Short-Term Intensive Case Management services	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults age 18 and older	• Short-term intensive Transition Team to serve people age 18+ who are or have recently been hospitalized	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	NAMI Payee	Payee Case Management services	Key component of the program is increasing clients' money management skills	Adults age 18 and older	• Payee Case Management with a rehabilitation and recovery focus to adults who meet eligibility criteria • Increasing clients' money management skill • Bio-Psycho-Social Rehabilitation (BPSR) principles, shall be evident and operationalized in Contractor's policies, program design, and practice	NAMI San Diego Adult Outpatient 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All
TAOA-FSP	Mental Health Systems Inc.	Full Service Partnership / Assertive Community Treatment with supportive housing and Strengths-Based Case Management	Reduce homelessness and provides comprehensive 'wraparound' mental health services for those adults who are most severely ill, most in need due to severe functional impairments, and who have not been able to be adequately served by the current system	Adults 25-59 years of age who have a serious mental illness, are homeless or at risk of homeless and Adults 18-59 years of age who are eligible for Medi-Cal funded services or are indigent	• Strengths-based case management • Rehabilitation and mental health services with a focus on adults who meet eligibility criteria • Short-Doyle/Medi-Cal certified Full Service Partnership Assertive Community Treatment Team services in the North County	MHS, Inc. Escondido 474 W. Vermont Ave. Suite 104 Escondido, CA 92025 (760) 294-1281	All
TAOA-FSP	Senior IMPACT	Offer intensive, comprehensive, community-based integrated behavioral health services	Increase timely access to services and supports to assist Older Adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes	Adults 60 years and older who are homeless or at risk of homelessness and have serious mental health issues	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance abuse services	Senior IMPACT 928 Broadway San Diego, CA 92102 (619) 977-3716	All
TAOA-FSP	Uptown Safe Haven	Residential transitional housing program that provides supportive services for those who are homeless and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services	Adults/Older Adults who are homeless with a serious mental illness	• Temporary housing for eligible individuals • Provide food • Linkage to transitional housing • Case management	Uptown Safe Haven Transitional Housing 2822 5th Ave. San Diego, CA 92103 (619) 294-7013	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Downtown IMPACT	Fully integrated services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or at-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults age 18 and over who have a serious mental illness and have been homeless, who may be high users of acute inpatient care and medical services and who have resided in the Urban Downtown area of the City of San Diego	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance abuse services	Community Research Foundation IMPACT 1260 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-0355 Downtown IMPACT 995 Gateway Center Way Suite 300 San Diego, CA 92102 (619) 398-2156	1,4
TAOA-FSP	Pathways to Recovery	Assertive Community Treatment and In-Reach for Adults In and Discharged From Long-Term Care	Services are designed using the Assertive Community Treatment model and provided by a trans-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialists, vocational specialists, housing specialists, nurses, nurse practitioners, physician's assistants, medical doctors, and alcohol and drug specialists	Adults 18-59 with very SMI and are, or recently have been, in a long-term care institutional setting	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes an in-reach component for some persons served by the county institutional case management program	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
TAOA-FSP	Center Star ACT	24-hour community-based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults age 25-59 who have a serious mental illness and adults age 18+ who may have been homeless	• Clinical case management • Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. 4283 El Cajon Blvd. Suite 115 San Diego, CA 92105 (619) 521-1743	All
TAOA-FSP	Casa Pacifica	Transitional residential program serves abused and neglected children and adolescents, and those with severe emotional, social, behavioral, and mental health challenges	Increase independent living and reduce hospitalizations through educational and employment opportunities	Adults/Older Adults	• Full Service Partnership program offering medication support • Case management/brokerage • Crisis intervention • Rehabilitation and other rehabilitative and recovery interventions in a transitional residential setting	Casa Pacifica 321 Cassidy St. Oceanside, CA 92054 (760) 721-2171	All
TAOA-FSP	Changing Options	Residential facility for adults with serious mental disorders	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach	Adults with disabling psychiatric disorder requiring a 24-hour Mental Health Rehabilitation Center	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Collaborative Behavioral Health Court	Use the Assertive Community Treatment model to enhance the lives of individuals experiencing a serious mental illness and co-occurring conditions through case management and mental health services	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults who are seriously mentally ill offenders to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system	Underserved adults, age 18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corp 4930 Naples St. San Diego, CA 92110 (619) 276-1176	Central SD
TAOA-FSP	ACTION Central	The 100 Homeless Project is a collaborative effort between the County of San Diego and San Diego Housing Commission which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance abuse	Integrate wrap-around services with accessible housing that supports the homeless population	Homeless transition age youth, Adults, and Older Adults	• Medication management and monitoring • Individual therapy • Outpatient substance abuse treatment • Case management • Employment support • Peer counseling and support • Housing services	ACTION Central 6244 El Cajon Blvd. Suites 15-18 San Diego, CA 92115 (858) 380-4676	1
TAOA-FSP	Alpha Project	Housing Navigator support for adult clinics of BHS clinics	Identify and secure safe and affordable housing	Adults, with a serious mental illness, who are enrolled in a designated mental health program	• Affordable housing • Residential substance abuse treatment • Supportive housing for people with special needs • Basic and emergency services for the homeless • Transportation assistance • Mental health counselling • Employment training • Outreach, prevention, and community services	Alpha Project for the Homeless 3860 Calle Fortunada San Diego, CA 92113 (619) 542-1877	4
TAOA-FSP	ACTION East	Services for homeless persons with serious mental illness or substance abuse	The planned hybrid model will integrate Assertive Community Treatment intensive case management services with AOD treatment and recovery services	Homeless TAY, Adults, and Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance abuse	• Mental health rehabilitation • Treatment and recovery services AOD clients with a primary diagnosis of substance • Integrated case management services with AOD treatment and recovery services	ACTION East 10201 Mission Gorge Rd. Suite O Santee, CA 92071 (619) 383-6868	2
TAOA-FSP	ACTION South	Services for homeless persons with serious mental illness or substance abuse	The planned hybrid model will integrate Assertive Community Treatment intensive case management services with AOD treatment and recovery services	Homeless TAY, Adults, and Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance abuse	• Mental health rehabilitation • Treatment and recovery services AOD clients with a primary diagnosis of substance • Integrated case management services with AOD treatment and recovery services	ACTION South 1196 Third Ave. Chula Vista, CA 91911 (619) 287-8225	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Telecare Agewise	Strengths-Based Case Management (SBCM) Full Service Partnership program for Older Adults	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults/Older Adults who have a SMI	• Care coordination and rehabilitation services for adults age 60+ with a serious mental illness who may be on LPS Conservatorship or who have needs that cannot be adequately met by a lower level of care • Services are field based and have a participant-to-staff ratio that is approximately 25:1. The ICM component provides case management for adults age 60+ who are on Public Conservatorship and reside in a skilled nursing facility (SNF) or other County-identified long-term care institution (LTC)	Telecare Corp Telecare Agewise 6160 Mission Gorge Rd. Suite 108 San Diego, CA 92120 (619) 481-5200	All
TAOA-FSP	Community Research Foundation Esperanza Crisis Center	Twenty-four hours a day, seven days a week service provided as an alternative to hospitalization or step down from acute inpatient care within a hospital for adults with acute symptoms of SMI, including those who may have a co-occurring substance use disorder, and are residents of San Diego County	Provides alternative to hospital or acute inpatient care	Voluntary adults 18 and older with acute and serious mental illness (SMI), including those who may have a co-occurring substance abuse disorder and are residents of San Diego County	• Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All
TAOA-FSP	Probation-FSP-ACT Team	The Probation Department provides a wide array of services to the San Diego community, including interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts. Probation staff work in the community to help prevent criminal activity, and operate detention facilities for both adults and juveniles	Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	Young adults and adults who have a SMI	• Mental health assessments • Interventions • Case management • Outreach and engagement	N/A	All
TAOA-OE	UPAC	Non-Residential Alcohol and Drug Treatment and Recovery for Adults and TAY	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals according to needed	Adults 18+ who are Asian and Pacific Islander	• Non-residential AOD • Family education	UPAC 3288 El Cajon Blvd. Suites 3,6,10,11,12 & 13 San Diego, CA 92104 (619) 521-5720	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-OE	McAlister Institute for Treatment and Education Recovery Center	Non-residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder. Incorporating evidence-based treatment and recovery services	To ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free lifestyle	18+ years old with AOD induced problems, including those who may have co-occurring mental health disorder	• Non-residential alcohol and other drug (AOD) treatment and recovery services to TAY, adults and older adults with alcohol and other drug-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	MITE South Regional Recovery Center 1180 Third Ave. Suite C-3 Chula Vista, CA 91911 (619) 691-8164	1
TAOA-OE	McAlister Institute for Treatment and Education East Regional Recovery Center	Non-residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of alcohol and other drug problems addressing both disorders for adults experiencing co-occurring substance abuse and mental health problems	18+ years old with AOD induced problems, including those who may have co-occurring mental health disorder	• Non-residential AOD rehabilitation services • Treatment and recovery service center AOD clients including co-occurring mental health disorders	MITE East Regional Recovery Center 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
TAOA-OE	McAlister Institute for Treatment and Education North Coastal Regional Recovery Center	Non-residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of alcohol and other drug problems. For clients with co-occurring disorders, the goal is to ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders	18+ years old with AOD induced problems, including those who may have co-occurring mental health disorder	• Evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety • Provide PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	5
TAOA-OE	Episcopal Community Services Regional Recovery Center - Central	Non-residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder	Provide outpatient treatment and recovery services to adults with alcohol and other drug-induced problems, including co-occurring disorders. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	18+ years old with AOD induced problems, including those who may have co-occurring mental health disorder	• AOD treatment and recovery services • Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	Episcopal Community Services 401 Mile of Cars Way Suite 350 National City, CA 91950 (619) 228-2800 Program Site: 4660 El Cajon Blvd. Suite 210 San Diego, CA 92115 (619) 597-7335	

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-OE	Family Health Centers of San Diego, Inc. Solutions for Recovery	Non-residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of alcohol and other drug problems. For co-occurring clients, the goal is to ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	18+ years old with AOD induced problems, including those who may have co-occurring mental health disorder	• Provide non-residential alcohol and other drug (AOD) treatment and recovery services to Transition Age Youth (TAY) (18-25 y.o.), adults (26-59 y.o.) and older adults (60 y.o. and above) with alcohol and other drug-induced problems, including co-occurring mental health disorders • Provide non-residential alcohol and other drug (AOD) treatment and recovery services to LGBTQ adults (as a priority) with alcohol and other drug-induced problems, including co-occurring disorders (COD) • Target adults who have any mental health disorder of sufficient severity, disability and persistence that it would interfere with the person participating successfully in a traditional AOD treatment and recovery program • Incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety	Solutions for Recovery 3928 Illinois St. San Diego, CA 92104 (619) 515-2588	All
TAOA-SD	Jewish Family Service	Patient Advocacy Services for mental health clients will be expanded to County. Identified Skilled Nursing Facilities with Augmented Services Programs	Provides on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities with ASPs. Expands services for County-Appointed Patient Advocate	Adults and children	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24 hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
TAOA-SD	Community Research Foundation Maria Sardiñas Center	South Region (Southern Area) Strengths-Based Case Management	Provides strengths-based case management services	Adults 18+ who have a SMI, including those who may have a co-occurring substance abuse disorder. TAY population and Probation-funded AB109 component	• Outpatient mental health clinic providing SBCM services to adults age 18+, TAY & AB109 who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	Maria Sardiñas Wellness & Recovery Center 1465 30th St. Suite K San Diego, CA 92154 (619) 428-1000	1
TAOA-SD	Public Defender Discharge	Licensed mental health clinicians will provide discharge planning, care coordination, referral and linkage, and short term case management to persons with a serious mental illness who have been referred by the Court for services	Public Defender Connector Team will reduce untreated mental illness by ensuring persons are connected to system of care	Clients with a serious mental illness who are incarcerated adults or TAY at designated detention facilities and will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Project Enable	Provides discharge planning and short-term transition services for clients who are in justice system and identified to have a SMI to assist in connecting clients with community-based treatment once released	Reduce untreated mental illness by ensuring persons are connected to system of care	Clients with a serious mental illness who are incarcerated adults or TAY at designated detention facilities and will be released in San Diego County	• Justice System Discharge Planning	Neighborhood House Association 286 Euclid Ave. Suite 207 San Diego, CA 92114 (619) 263-6155	4
TAOA-SD	VOA East County Emergency Shelter Beds (ESB)	Emergency Shelter Services for Adults with mental illness	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Volunteers of America 290 S. Magnolia St. El Cajon, CA 92020 (619) 447-2428	2
TAOA-SD	Chipper Chalet Emergency Shelter Beds (ESB)	Emergency Shelter Beds for Adults with mental illness	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Chippers Chalet 835 25th St. San Diego, CA 92102 (619) 232-7406	4
TAOA-SD	The Broadway Home Emergency Shelter Beds (ESB)	Emergency Shelter Beds for Adults with mental illness	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	4
TAOA-SD	Interfaith Community Services Emergency Shelter Beds (ESB)	Emergency Shelter Beds for Adults with mental illness	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Interfaith Community Services Administration 550 W. Washington St. Suite B Escondido, CA 92025 (760) 489-6380	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	United Homes Emergency Shelter Beds	Emergency Shelter Services for adults with mental illness	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	United Homes-Emergency Shelter Beds 336 South Horne St. Oceanside, CA 92054 (760) 612-5980	5
TAOA-SD	Mark Alane Inc. Chipper's Chalet ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Chipper's Chalet Augmented Services Program 835 25th St. San Diego, CA 92102 (619) 234-5465	4
TAOA-SD	Fancor Guest Home ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Fancor Guest Home 631 651 Taft Ave. El Cajon, CA 92020 (619) 588-1761	2
TAOA-SD	Vibal, Liliosa D. Friendly Home II ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Liliosa D. Vibal Friendly Home II 504 Ritchey St. San Diego, CA 92114 (619) 263-2127	1,4
TAOA-SD	Vibal, Liliosa D. Friendly Home of Mission Hills ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Liliosa D. Vibal (Friendly Home of Mission Hills) 3025 Reynard Way San Diego, CA 92103 (619) 297-1841	4
TAOA-SD	Mark Alane, Inc. The Broadway Home ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	The Broadway Home 2445 Broadway San Diego, CA 92102 (619) 232-7406	1,4
TAOA-SD	Orlando Residential Care ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Orlando Guest Home LLC 297-299 Orlando St. El Cajon, CA 92021 (619) 444-9411	2
TAOA-SD	Nelson-Haven ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Nelson-Haven Board and Care 1268 22nd St. San Diego, CA 92102 (619) 233-0525	1,4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Volunteers of America (VOA) Troy Center for Supportive Living ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Volunteers of America Troy Center for Supportive Living 8627 Troy St. Spring Valley, CA 91977 (619) 465-8792	2
TAOA-SD	Volunteers of America (VOA) Luhman Center for Supportive Living ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Volunteers of America 3530 Camino Del Rio N. Suite 300 San Diego. CA 92108 (619) 282-8211	All
TAOA-SD	Country Club Guest Home ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Country Club Guest Home 25533 Rua Michelle Escondido, CA 92026 (760) 747-0957	3
TAOA-SD	Recovery Innovations - Client Operated Peer Support Services	Client liaison services aims to increase client participation and involvement in the Behavioral Health Services (BHS) Adult and Older Adult System of Care (AOASOC) through the implementation of the client liaison function, providing peer advocacy throughout the AOASOC	Develop and coordinate continuous efforts toward increasing client involvement, participation and partnership in the development and implementation of existing and evolving BHS AOASOC policies, practices and programs in order to ensure client needs are accommodated	Adults 18+ who have a SMI living in San Diego county	• Increase client participation and involvement in the County Behavioral Health Services (BHS) Adult and Older Adult System of Care (AOASOC) through the implementation of the Client Liaison function, providing peer advocacy throughout the AOASOC. ("Client" is defined as someone who has been diagnosed with a serious mental illness and receives services from the AOASOC)	Recovery Innovations 3565 Del Rey St. Suite 202 San Diego, CA 92109 (858) 274-4650	All
TAOA-SD	Recovery Innovations - Client Operated Peer Support Services	Provide clubhouse services	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults 18+ who have a SMI living in San Diego county	• Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to relevant support agencies • Skill development classes to adults with serious mental illness	Recovery Innovations 3565 Del Rey St. Suite 202 San Diego, CA 92109 (858) 274-4650	All
TAOA-SD	Carroll's Residential Care ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Elderly who have a SMI and reside in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Carroll's Residential Care 655 S. Mollison St. El Cajon, CA 92020 (619) 444-3181	2
TAOA-SD	Carroll's Community Care ASP	Augmented Services Program (ASP)	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18+ who have a SMI living in San Diego county	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) • Identified eligible persons shall receive additional services from these B&C facilities beyond the basic B&C level of care	Carroll's Community Care 523 Emerald Ave. El Cajon, CA 92020 (619) 442-8893	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	NAMI San Diego - Family Mental Health Education & Support	Provide a series of educational classes presented by family members using an established family education curriculum to provide education and support for persons who have relatives (or close friends) with mental illness	Promote integration of family education services. Increase family involvement, coping skills and improving supportive relationships	Family members and friends of persons who have a SMI	• Provides a series of educational classes presented primarily by family members of persons with serious mental illness using an established family education curriculum to provide education and support for persons who have relatives or close family friends with mental illness • Increase family member's coping skills and support increased involvement and partnership with the mental health system	NAMI Family Education Services 5095 Murphy Canyon Rd. Suite 125 San Diego, CA 92123 (619) 398-9851	All
TAOA-SD	Prime Healthcare Paradise Valley LLC Bayview Clubhouse	MHSA Clubhouse Enhancement and Expansion for Employment Services	Provide member-driven Clubhouse Services to individuals experiencing and/or recovering from serious mental illness	Adults 18+ who have a SMI, including those who may have a co-occurring substance use disorder	• Medical and psychiatric services • Employment, education, and social support • Housing support • Linkage to appropriate services	Paradise Valley Hospital Bayview Clubhouse 330 Moss St. Chula Vista, CA 91911 (619) 585-4646	1
TAOA-SD	Neighborhood House Association Friendship Clubhouse	Member-Operated Clubhouse Program in the Central Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/older adults ages 18 or older who have a serious mental illness and who are eligible for Medi-Cal funded services or are indigent, including those with co-occurring substance use	• Provides rehabilitation services to adults/older adults who are low income or Medi-Cal eligible and are diagnosed with a serious mental illness and/or may have a co-occurring substance use disorder • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Neighborhood House Association Friendship Clubhouse 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1,4
TAOA-SD	Community Research Foundation Casa Del Sol Clubhouse	South Region (Southern Area) Clubhouse	Provide member-driven Clubhouse Services to individuals experiencing and/or recovering from serious mental illness	Adults 18+ who have a SMI including those who may have a co-occurring substance use disorder and reside in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	CRF South Bay Casa del Sol Clubhouse 1157 30th St. San Diego, CA 92154 (619) 429-1937	1
TAOA-SD	Mental Health Association Visions Clubhouse	South Region (Northern Area) Clubhouse	Provide member-driven Clubhouse Services to individuals experiencing and/or recovering from serious mental illness	Adults 18+ who have a SMI including those who may have a co-occurring substance use disorder and reside in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Association Visions Clubhouse 226 Church Ave. Chula Vista, CA 91911 (619) 420-8603	1
TAOA-SD	Alvarado Parkway Institute Discovery Clubhouse	Mental Health Weekend Clubhouse Services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Underserved adults/ older adults ages 18 and older with serious mental illness who may have a co-occurring substance use disorder	• Provides a community meeting place and support setting where resources, knowledge, and experience can be offered to the priority population of individuals recovering from serious mental illness • Assist clients with increasing their social and vocational rehabilitation skills; reducing social isolation; and increasing independent functioning and employment	Alvarado Parkway Institute Discovery Clubhouse 5538 University Ave. San Diego, CA 92105 (619) 667-6176	1,4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Community Research Foundation East Corner Clubhouse	East Region Member Operated Clubhouse	Provides Clubhouse Services	Adults 18+ who have a SMI living in San Diego county	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Community Research Foundation East Corner Clubhouse 1060 Estes St. El Cajon, CA 92020 (619) 631-0441	2
TAOA-SD	Episcopal Community Services Friend to Friend (F2F) Clubhouse	Provides a street outreach and site-based program to engage homeless seriously mentally ill adults, including Veterans, 18 years of age and older, who may also have co-occurring substance abuse disorder	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Homeless Adults/Older Adults who have a SMI	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services • Services are in Central Region with an emphasis in downtown San Diego	ECS Friend-to-Friend Program Homeless Services Program 2144 El Cajon Blvd. San Diego, CA 92104 (619) 228-2800	4
TAOA-SD	UPAC BPSR Center (Mid City) UPAC BPSR Center (Serra Mesa) UPAC EAST WIND	Provides outpatient, case management brokerage, clubhouse and vocational support services	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Monolingual and/or limited English proficient Asian/Pacific Islander adults who have a SMI	• Outpatient mental health rehabilitation • Recovery services • Case management • Mobile outreach • Long-term vocational services	UPAC BPSR Mid City 5348 University Ave. Suites 101 &120 San Diego, CA 92105 (619) 229-2999 UPAC BPSR Serra Mesa 8745 Aero Dr. Suite 330 San Diego, CA 92123 (858) 268-4933 UPAC EAST WIND 8745 Aero Dr. Suite 330 San Diego, CA 92123 (858) 268-4933	1,4
TAOA-SD	Community Research Foundation The Corner Clubhouse	Member-operated clubhouse program in the Central Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/older adults with a serious mental disorder, ages 18 and older including those who may have a co-occurring substance use disorder	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	The Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4
TAOA-SD	Mental Health Systems, Inc. Mariposa Clubhouse	Clubhouse services in the North Coastal Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Coastal Region Mental Health Systems, Inc. Mariposa Clubhouse 560 Greenbrier Dr. Suite C-E Oceanside, CA 92054 (760) 439-2785	5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Mental Health Systems, Inc. Escondido Clubhouse	Clubhouse services in the North Inland Region	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults/Older Adults	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	North Inland Region Mental Health Systems, Inc. Escondido Clubhouse 474 W. Vermont Ave. Suite 105 Escondido, CA 92025 (760) 737-7125	3
TAOA-SD	Mental Health Systems, Inc. San Diego Employment Solutions	Supported employment services and opportunities for Transition Age Youth, Adults and Older Adults with SMI	Increase competitive employment of adults age 18 and over who have a SMI and who want to become competitively employed	Adults who have a serious mental illness and need assistance with employment	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment •Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	Mental Health Systems, Inc. Employment Solutions 10981 San Diego Mission Rd. Suite 100 San Diego, CA 92108 (619) 521-9569	4
TAOA-SD	Community Research Foundation Heartland Center	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation (BPSR) clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery services	Provides outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental disorder, ages 18 and older including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	East Region CRF Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2
TAOA-SD	Family Health Centers of San Diego, Inc. Logan Heights Family Counseling	Provides outpatient, case management/ brokerage and vocational support services for seriously mentally ill (SMI) indigent clients aged 18 and older including those who may have a co-occurring substance abuse disorder	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults/Older Adults individuals who have SMI/COD and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation (BPSR) wellness recovery center in the Central Region that provides outpatient mental health, case management/brokerage, and peer support for seriously mental ill indigent adults, including those who may have a co-occurring substance abuse disorder • Provide rehabilitative, recovery and vocational services and supports to the target population	Family Health Centers Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2355	1,4
TAOA-SD	Community Research Foundation Areta Crowell Clinic, ACC	Certified Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults who have a SMI	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder • Services provided at a Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery center	Areta Crowell BPSR Program 1963 4th Ave. San Diego, CA 92101 (619) 233-3432 ext. 1308	1,4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	San Diego Workforce Partnership for Supported Employment Technical Consultant Services	Provides consultant services for increased employment opportunities for adults with serious mental illness (SMI)	Develop Strategic Employment Plan, and destigmatize mental health in the workplace	Does not serve clients directly	• Technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness	San Diego Workforce Partnership 3910 University Ave. Suite 400 San Diego, CA 92105 (619) 228-2900	All
TAOA-SD	Mental Health Systems, Inc. North Inland Mental Health Center	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support.	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	MHS North Inland Mental Health Center 125 W. Mission Ave. Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Ave. Escondido, CA 92025 (760) 480-2255	3
TAOA-SD/CY-SD	SSI Advocacy	Review and submittal of SSI applications to SSA that Clubhouse SSI Advocates have completed with non-General Relief clients	Increase number of applicants that are granted SSI benefits. Review an estimated 300+ applications submitted annually by Clubhouse SSI Advocates for accuracy. Serve six Clubhouses; train new Advocates and consult with them as needed	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers of San Diego County	• Provides Supplemental Security Income (SSI) Advocacy Services for consumers of the following programs: General Relief (GR); Cash Assistance Program for Indigents (CAPI), County Medical Services (CMS), and mental health consumers of San Diego County through a collaborative effort with the Contractor and designated SSI Advocates of the San Diego County Behavioral Health Services "Clubhouse" program	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3258	All
TAOA-SD	START Community Research Foundation CRF Vista Balboa, CRF New Vistas, CRF Halcyon, Crisis Center, CRF Turning Point, CRF Jary Barreto, CRF Isis Crisis Center	Mental Health Short Term Acute Residential Treatment (START)	Provides urgent services in North Coastal, Central, East and South Regions of San Diego to meet the community identified needs	Voluntary adults who may have a serious mental illness and who may have a co-occurring substance abuse disorder that are experiencing a mental health crisis, in need of intensive, non-hospital intervention	• 24 hour, 7-day a week, 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions, and are residents of San Diego County	CRF Vista Balboa (619)-233-4399 CRF New Vistas Crisis Center (619)-239-4663 CRF Halcyon Crisis Center (619)-579-8685 CRF Turning Point (760)-439-2800 CRF Jary Barreto Crisis Center (619) 232-7048 CRF Isis Crisis Center 619-575-4687	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	The Meeting Place	Mental Health Clubhouse/SSI Advocate and Peer Support Line. The program offers a non-crisis phone service seven hours a day, seven days a week that is run by adults for adults who are in recovery from mental illness	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills. . The aim of the program is for the support line to be an essential support service for persons recovering from mental illness	Underserved adults/older adults ages 18 and older with a SMI including those who may have a co-occurring substance use disorder	• Provides rehabilitative, recovery, health and vocational services and supports to the target population	The Meeting Place 2553 & 2555 State St. Suite 101 San Diego, CA 92103 (619) 294-9582	4
TAOA-SD	Mental Health Systems, Inc. North Coastal Mental Health Clinic and Vista BPSR Clinic	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase mental health services for transition age youth (TAY). Decrease incidence of homelessness. Increase client's self-sufficiency through development of life skills	TAY, Adult & Older Adult	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	MHS-North Coastal Mental Health Center 1701 Mission Ave. Oceanside, CA 92058 (760) 967-4483 MHS BPSR Vista 550 West Vista Way Suite 407 Vista, CA 92083 (760) 758-1092	5
TAOA-FSP	Pathways Community Services-Catalyst	Transition Age Youth (TAY) Assertive Community Treatment (ACT) Full Service Partnership (FSP)	Provide Assertive Community Treatment Team intensive, multidisciplinary, wraparound treatment and rehabilitation services for transitional-age youth who have a serious mental illness, may be on LPS Conservatorship, and have needs that cannot be adequately met through a lower level of care. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a participant-to-staff ratio that is approximately 10-12:1	TAY youth ages 16-25 with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) (who may have a co-occurring mental illness and substance abuse disorder) that have been homeless or may be at risk of being homeless	• Assertive Community Treatment ACT mental health services to transition age youth	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Pathways Community Services-Oasis Clubhouse	Transition Age Youth (TAY) Member Operated Clubhouse:	Member-driven center that assists transitional-age youth age 16-25 diagnosed with a serious mental illness (who may have a co-occurring substance use disorder) to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Transitional-Age Youth (TAY), age 16-25, with serious mental illness who reside in San Diego County	• Provides Clubhouse Services to transitional-age youth age 16-25 diagnosed with a serious mental illness and/or have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. Suite C San Diego, CA 92102. (858) 300-0460	All
TAOA-FSP TAY	8West-Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Supplemental Housing for Transitional Age Youth (TAY) in an Independent Living Environment	The provision of housing and support services to homeless mentally ill Transition Age Youth (TAY) by providing accessible short-term and transitional beds for identified clients	Homeless mentally ill Transition Age Youth (TAY)	• Emergency shelter and transitional beds for transitional age youth	Urban Street Angels, Inc. 3090 Polk Ave. San Diego, CA 92104 (619) 415-6616 Shelter Sites: 5308 Churchward St. San Diego, CA 92114 (male house) 4634 Bancroft St. San Diego, CA 92116 (female house)	4
TAOA-SD	Positive Solutions	Assessments and brief intervention for home bound seniors	Increase the number of Older Adults with a serious mental illness and TAY receiving integrated, culturally specific mental health services countywide	Underserved culturally/ethnically diverse or isolated seniors at risk for depression, suicide, & substance use disorder	• Mobile outreach and engagement • Mental health assessment & treatment • Rehabilitation and recovery services • Linkage to community services and care coordination • Employment & education support	UPAC Midtown Center 5348 University Ave. Suites 101 & 120 San Diego, CA 92105 (619) 229-2999	3,4,5
TAOA-SD	Community Research Foundation Jane Westin Wellness & Recovery Center	Walk-in Services - Assessment Center	Provide one time, short-term mental health evaluation, psychiatric consultation, and linkage in the community to assist clients on their path to recovery	Adults 18+ who have a SMI	• Walk-In center providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	Jane Westin Wellness & Recovery Center 1568 6th Ave. San Diego, CA 92101 (619) 235-2600 ext. 201	1,4
TAOA-SD	UCSD Gifford Clinic	Certified Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18+ who have a SMI	• Outpatient mental health clinic providing Short-Doyle Medi-Cal certified treatment, rehabilitation, and recovery services to adults age 18+, living in San Diego County who have serious mental illness, including those who may have a co-occurring substance use disorder • This clinic offers walk in service during their normal hours of operation	UCSD Gifford Clinic 140 Arbor Dr. San Diego, CA 92037 (619) 543-6136	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Community Research Foundation Douglas Young BPSR Ctr.	North Central Region Adults/Older Adults Bio-Psychosocial Rehabilitation Wellness Recovery Center	Increase the number of SMI TAY receiving integrated, culturally specific mental health services countywide	Adults/Older Adults who have a SMI, including those with co-occurring substance abuse disorder, and Medi-Cal eligible or indigent	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support for seriously mentally ill clients aged 18+ including those who may have a co-occurring substance abuse disorder	CRF - Douglas Young 10717 Camino Ruiz Suite 207 San Diego, CA 92126 (858) 695-2211	1,4
TAOA-SD	Telecare Corp In Home Outreach Team IHOT Central/East/ South	Mobile In Home Outreach Teams (IHOT) in the South Regions	The goal of this program is to reduce the effects of untreated mental illness in individuals with SMI and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults who are reluctant to seek treatment	• In Home Mobile Outreach for Adults/Older Adults with a serious mental illness	Telecare Corp - IHOT 1080 Marina Village Pkwy. Suite 100 Alameda, CA 94501 (619) 961-2120	1,2,4
TAOA-SD	Mental Health Systems, Inc. In Home Outreach Team IHOT - North Inland, North Central	In-home Outreach Team - Mobile Outreach and Linkage North Coastal, North Inland, North Central	The goal of this program is to reduce the effects of untreated mental illness in individuals with SMI and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment	• In Home Mobile Outreach for Adults/Older Adults with a serious mental illness	MHS - IHOT North Coastal, North Inland, North Central 365 Rancho Santa Fe Rd. Suite 100 San Marcos, CA 92078 (760) 591-0100	5
TAOA-SD	Exodus Recovery Inc. Walk in Assessment Center Vista Exodus North County Walk in Assessment Center - Escondido	Walk-in services assessment center	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	TAY, Adults/Older Adults	• Walk-In center providing treatment, rehabilitation, and recovery services to adults age 18+ who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	North County Walk In Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 796-7760 Vista Walk In Assessment Center 524 & 500 W. Vista Way Vista, CA 92083 (760) 758-1150	5
TAOA-SD	Mental Health Systems, Inc. Serial Inebriate Program	Serial Inebriate Program (SIP) Non-residential alcohol and other drug (AOD) treatment and recovery services	Support integrated treatment of chronic serial inebriants. Stabilization, recovery and reducing stigma associated with mental health concerns and provides additional support or referrals	Adults/Older Adults SIP clients referred by SDPD SIP Liaison Officer	• Non-residential AOD treatment and recovery service center focus of court sentenced chronic public inebriates as an alternative to custody. Serves those who may have a co-occurring mental health disorder and chronic inebriants working in conjunction with the SDPD Homeless Outreach Team (HOT) • Services include individual and group counseling, case management, housing and linkages to other relevant services	MHS SIP Program 3340 Kemper St. San Diego, CA 92118 (619) 523-8121	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Neighborhood House Association, Inc. Project Enable Outpatient Program	Provides a Short-Doyle Medi-Cal (SD/MC) certified Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Provide outpatient mental health rehabilitation, recovery services, an urgent walk-in component, and case management brokerage. Transitions TAY and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other TAY providers	Seriously mentally ill (SMI) clients Transition Age Youth (TAY) aged 18-25; Adults aged 26-59 and Older Adults aged 60+ older including those who may have a co-occurring substance abuse disorder; Adults/Older Adults who are low income or Medi-Cal eligible	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage • Transitions TAY and coordinates transitional services between its outpatient program and HHSA Children, Youth and Family Mental Health Services and other TAY providers	Project Enable 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1,4
TAOA-SD	Neighborhood House Association, Inc. Project In-Reach	Provide in-reach, engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance abuse issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and community aftercare	The program is focused on serving at-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth (TAY) incarcerated at designated facilities, with an additional focus on inmates with serious mental illness (SMI)	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a SMI to assist in connecting clients with community-based treatment once released	Project In-Reach 286 Euclid Ave. Suite 102 San Diego, CA 92114 (619) 266-9400	All
TAOA-SD	Community Research Foundation South Bay Guidance Wellness and Recovery Center	South Region (Northern Area) strengths-based case management	Provides strengths-based case management services to persons with SMI	Adults 18+ who have a SMI, including those who may have a co-occurring substance abuse disorder	• Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM to adults age 18+ who have a SMI, including those who may have a co-occurring substance use disorder	South Bay Guidance Wellness and Recovery Center 835 3rd Ave. Suite C Chula Vista, CA 91911 (619) 429-1937	1
TAOA-SD	Ruby's House Independent Living	Emergency shelter services for mentally ill adults	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	6 Women: Voluntary adults who have SMI, have no stable income, and are homeless	• Provide shelter and food in a residential setting that has staff available during all operating hours • Provide safe and sanitary quarters on a nightly basis and in a location acceptable to the County • Coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-CSS	Homefinder - Alpha Project for the Homeless	Housing support for adult clinics of BHS clinics	Identify and secure safe and affordable housing	Adults who are enrolled in COR designated BHS programs with SMI who are homeless or at risk	• The Home Finder program serves clients, who are age 18 and above, in identifying and securing safe and affordable housing. Clients must be enrolled in designated Behavioral Health Services (BHS) contracted or county outpatient mental health clinic, have housing instability due to being homeless or at-risk of homelessness • Housing options may include both single and shared occupancy. The Home Finder program will create, update and provide BHS designated program access to a centralized hub for housing resources and roommate matching services • The program provides flex funds to support resident retention. The program also provides housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness (SMI)	Alpha Project for the Homeless 3860 Calle Fortunada San Diego, CA 92113 (619) 542-1877	4
TAOA-SD	Tri-City Medical Center Crisis Stabilization Unit	Crisis Stabilization	Impact unnecessary and lengthy involuntary inpatient treatment, as well as to promote care in voluntary recovery oriented treatment settings.	Adult SMI (voluntary and involuntary)	• Provide a twenty-four (24) hour, seven (7) days a week hospital-based Crisis Stabilization Unit (CSU) in the North Coastal Health and Human Services Agency (HHSA) region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug induced problems	Tri-City Medical Center 4002 Vista Way Oceanside, CA 92056 (760) 724-8411	3,5
TAOA-SD	Palomar Health Crisis Stabilization Unit	Crisis Stabilization	Provide a 24 hour, seven days a week hospital-based Crisis Stabilization Unit in the North Inland Health and Human Services Agency region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug induced problems	Adult SMI (voluntary and involuntary)	• Provide a twenty-four (24) hour, seven (7) days a week hospital-based Crisis Stabilization Unit (CSU) in the North Coastal Health and Human Services Agency (HHSA) region of North County for adult and older adult Medi-Cal beneficiaries who are residents of San Diego County; who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug induced problems	Palomar Health 555 E. Valley Pkwy. Escondido, CA 92025 (760) 739-3000	3,5
TAOA-SD	Episcopal Community Services Downtown Safe Haven	Adult mental health emergency shelter beds	Increase client-driven services to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Voluntary adults who have a SMI, have no stable income, and are homeless	• Provides shelter and food in a residential setting that has staff available during all operating hours • Provides safe and sanitary quarters on a nightly basis and in a location acceptable to the County, work with, and coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Downtown Safe Haven 1425 C St. San Diego, CA 92101 (619) 238-8300	

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Telecare Corp Assisted Outpatient Treatment (AOT)	Intensive community-based services for persons who establish an AOT court settlement agreement, persons who are court-ordered to receive AOT, and for persons who otherwise meet the AOT eligibility criteria and voluntarily accept AOT-alternative services prior to an AOT petition being filed	Integrate behavioral health and rehabilitation treatment and recovery services for adults who are seriously mentally ill and have been identified as potential AOT candidates by the County-identified entity which serves potential AOT candidates (IHOT), have agreed to an AOT court settlement, or have AOT status resulting from a contested court hearing	Only individuals 18+ meeting 9 criteria as established under Laura's Law	• ACT services with a rehabilitation and recovery focus to Adults/Older Adults with a serious mental illness or co-accruing substance abuse disorder	Telecare Corp 1660 Hotel Circle N. Suite 101 San Diego, CA 92108 (619) 481-3840	All
TAOA- SD	UCSD IHOT and AOT Services Evaluation	Conduct outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services by: 1) conducting client, family and staff focus groups 2) evaluating program and outcome data 3) preparing and submitting to County periodic and final reports of findings and recommendations	Provide outcome and program evaluations of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services	Support for the two IHOT programs (IHOT North & TC IHOT) and AOT programs	• Data analysis/ evaluation of serviced provided by In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT)	Regents of the University of California 9500 Gilman Dr. La Jolla, CA 92093 (619) 619-471 ext. 9396	All
TAOA-SD	Mental Health Systems, Inc. North Inland RRC	Regional Recovery Center - Non-residential alcohol and other drug (AOD) treatment and recovery services	To assist individuals in becoming and remaining free of alcohol and other drug problems. For co-occurring clients, the goal is to ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	Adults with alcohol and other drug-induced problems, including co-occurring disorders	• Screening for mental health issues • Linkage to mental health services	North Inland RRC 200 E. Washington Ave. Suite 100 Escondido, CA 92025 (760) 741-7708	5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	MITE Adolescent Group Homes	North County, East County, and South Bay Adolescent Group Homes	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals according to need	Individuals residing in contracted residential and outpatient substance abuse programs with or exhibiting mental health concerns	• Screening • Education • Brief counseling • Referral and linkage • Prevention groups • Family education	MITE - East 2219 Odessa Crt. Lemon Grove, CA 91945 (619) 442-0277 MITE - North County 3744 Santa Ynez Way Oceanside, CA 92054 (760) 806-1495 MITE - South 2315 Bar Bit Rd. Spring Valley, CA 91978 (619) 442-0277	All
CO-02	Phoenix House of San Diego, Inc.	AOD Residential Services for Adolescents	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Individuals residing in contracted residential substance abuse programs with or exhibiting mental health concerns	• Screening • Education • Brief counseling • Referral and linkage • Prevention groups • Family education	Phoenix House 11600 Eldridge Ave. Lake View Terrace,CA 91342 (818) 686-3000	All
CO-02	UCSD Regents Behavioral Health Services COD Program	Outpatient clinic providing Short-Doyle Medi-Cal certified treatment, rehabilitation & recovery services	Provide fully integrated dual diagnosis enhanced mental health services to include individual & group psychotherapy, case management linkages to health, housing, financial, educational & vocational supports, psycho-educational recovery & relapse services consistent with the CCISC model adopted by AOABHS	Adults 18+ with serious mental illness and co-occurring substance use disorder	• Individual & group psychotherapy, • Case management • Linkages to health, housing, financial, educational & vocational supports • Psycho-educational recovery & relapse services consistent with the CCISC model adopted by AOABHS	Regents of UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All
CO-02	Catholic Charities Rachel's Women's Center	Non-residential alcohol and other drug recovery services that are non-institutional and non-medical	Deliver a safe, non-threatening AOD-free environment for homeless women that supports and encourages recovery by providing supportive interventions that address both alcohol and drug and mental health issues, and to assist the clients' efforts to attain and maintain AOD and Mental Health Recovery	AOD recovery services in downtown San Diego to homeless women age eighteen (18) and over who are recovering from alcohol and drug abuse	• Non-residential services shall include educational groups, process groups, and recovery supportive activities. Recovery services may include, but not necessarily be limited to: relapse prevention; recovery planning groups; self-help group participation	Catholic Charities Homeless Women's Recovery Center 349 Cedar St. San Diego, CA 92101 (619) 236-9074	1,4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	AOD treatment and recovery for pregnant adolescents	Adolescent Perinatal Non-Residential Alcohol and Other Drug Treatment and Recovery Services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Substance Abusing pregnant & parenting adolescent girls	• Outpatient, individual, group, and family Therapy • Case Management • Rehabilitative Services/Skill Building • AOD Counseling	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	1, 2, 4
CO-02	North County Serenity House	Long Term Residential Women & Perinatal AOD Treatment Program	Long-term housing, recovery, and wellness	Substance abusing pregnant and parenting women and their children	• Residential	Health Right 360 1735 Mission St. Suite 2051 San Francisco, CA 94103 (415) 762-1558	All
CO-02	MITE Teen Recovery Center-North Coastal	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	• Non-Residential AOD treatment and recovery services	MITE-Teen Recovery Center 3923 Waring Rd. Suite D Oceanside, CA 92056 (760) 726-4451	5
CO-02	MHS North Inland TRC	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	• Non-Residential AOD treatment and recovery services	Mental Health Systems Inc. 508 North Mission Ave. Suites 104 & 105 Escondido, CA 92025	2
CO-02	Central Region Teen Recovery Center (TRC)	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	•Non-Residential AOD treatment and recovery services	UPAC Central 1031 25th St. San Diego, CA 92102 (619) 232-6454 ext. 801	1,4
CO-02	VHF Central Southeastern TRC	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	• Non-residential alcohol and other drug treatment and recovery services for adolescents	Vista Hill Foundation 220 North Euclid Ave. Suite 40 San Diego, CA 92114 (619) 795-7232	1,4
CO-02	MITE East Teen Recovery Center	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	• Non-residential alcohol and drug treatment and recovery services	MITE Teen Recovery Center 7800 University Ave. Suite A1 La Mesa, CA 91942 (619) 465-4349	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	MITE South Teen Recovery Center	Non residential AOD treatment and recovery services	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Adolescents ages 12 to 17 with alcohol and other drug-induced problems	• Non-residential alcohol and other drug treatment and recovery services for adolescents	MITE Teen Recovery Center 2429 Fenton St. Bldg. 5 Chula Vista, CA 91914 (619) 482-9300	1
TAOA-OE	UPAC	Non-Residential Alcohol and Drug Treatment and Recovery for Adults and TAY	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Asian and Pacific Islander adults, 18+	• Non-residential AOD • Family education	UPAC 3288 El Cajon Blvd. Suites 3,6,10,11,12 & 13 San Diego, CA 92104 (619) 521-5720	4
CO-02	MITE KIVA	Perinatal Detox, KIVA-Women and Children Residential	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Individuals residing in contracted residential and substance abuse programs with or exhibiting mental health concerns	• Screening • Education • Brief counseling • Referral and linkage • Prevention groups • Family education	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	All
CO-02	Women & Perinatal Long Term Residential Treatment	Alcohol and Drug Women's and Children's Residential AOD Treatment Services Family Recovery Center	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Pregnant and parenting women who have alcohol or other drug problems, and behavioral health issues	• Outpatient, individual, group, and family Therapy • Case Management • Rehabilitative Services/Skill Building • AOD Counseling	Mental Health Systems Inc. Family Recovery Center-Residential 1100 Sportfisher Dr. Oceanside, CA 92054 (760) 439-6702	5
CO-02	South Bay Women's Recovery Center	Substance Use Disorder treatment for perinatal women and adolescents	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Pregnant and parenting women and adolescents over age 15	• Non-residential Services • Educational sessions process groups •Individual counseling sessions • Recovery activities • Day Care Habilitative and Outpatient Drug Free services	McAlister Institute for Treatment and Education 400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	TBD
CO-02	VHF	Women's Non-Residential Alcohol and other Drug Treatment and Recovery Services - Central Region	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Substance abusing women, including pregnant, parenting, perinatal, and dependent children to age 17	• Non-residential Services • Educational sessions process groups •Individual counseling sessions • Recovery activities • Day Care Habilitative and Outpatient Drug Free services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5121	4

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	VHF	Women's Non-Residential Perinatal - AOD Treatment Services Parentcare Family Recovery Center; East Region	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Substance abusing women, including pregnant, parenting, perinatal, and dependent children to age 17	• Non-residential Services • Educational sessions process groups •Individual counseling sessions • Recovery activities • Day Care Habilitative and Outpatient Drug Free services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego,CA 92123 (858) 514-5121	2
CO-02	North Inland Women's and Adolescent's Recovery Center	Substance Use Disorder treatment for perinatal women and adolescents	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Pregnant and parenting women and adolescents over age 15	SUD treatment for perinatal women and adolescents	McAlister Institute for Treatment and Education 1400 North Johnson Ave. Suite 101 El Cajon, CA 92020 (619) 442-2012	2, 3, 5
CO-02	Women's and Adolescent Girl's Perinatal OP SUD treatment	AOD treatment and recovery for pregnant and parenting women & adolescents	Support integrated treatment of co-occurring disorder issues for those enrolled in substance abuse treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals	Substance Abusing pregnant & parenting women & adolescent girls	• Outpatient, individual, group, and family Therapy • Case Management • Rehabilitative Services/Skill Building • AOD Counseling	TBD	3, 5
CO-02	Stepping Stone of San Diego, Inc. Alcohol and Drug Residential AOD Treatment and Recovery Services	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Reduce and/or eliminate the use of illicit drugs, abuse of prescription medications, and/or alcohol abuse to improve the overall health and social wellness of adults and HIV/AIDS positive adults; to promote participation in substance abuse treatment and recovery programs; and if needed, foster client capability to address medical needs related to HIV/AIDS and adhere to complex medication regimens	Drug and alcohol using adults	• Residential AOD structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week	Stepping Stone Residential 3767 Central Ave. San Diego, CA 92105 (619) 278-0777	All
CO-02	House of Metamorphosis, Inc.	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assist adult adults to become and remain free of alcohol and other drug problems	Drug and alcohol using adults	• Residential AOD structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week	House of Metamorphosis, Inc. 2970 Market St. San Diego, CA 92102 (619) 236-9492	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	CRASH Inc. BDRRP, Short Term I, Short Term II	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assist adults to become and remain free of alcohol and other drug problems	Drug- and alcohol-using adults	• Residential AOD structured program with treatment and/or recovery services available 24 hours per day, 7 days a week	CRASH BDRRP 726 F. St. San Diego, CA 92101 (619) 239-9691 Short Term I 4161 Marlborough Ave. San Diego, CA 92105 (619) 282-7274 Short Term II 1081 Camino Del Rio S. Suite 129 San Diego, CA 92108 (619) 297-5131	All
CO-02	The Fellowship Center	24 hour social model recovery services that are non-institutional and non-medical within state-licensed and -certified residential facilities to individuals with alcohol and other drug problems	Assist adult males to become and remain free of alcohol and other drug problems.	Adult/older adult (age 18 and up) men who have a primary alcohol or other drug dependency problem other than tobacco or ordinary caffeine containing beverages	• Educational groups, process groups, individual sessions • Recovery supportive activities. • Structured program available 24 hours per day, 7 days per week to residents	Fellowship Center 737 East Grand Ave. Escondido, CA 92025 (760) 745-8478	All
CO-02	Alpha Project for the Homeless - Casa Raphael	Residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs	Assist males who have a history of using or abusing alcohol and other drugs to become free of alcohol and other drugs	Adult/older adult (age 18 and up) men who use drugs and alcohol	AOD services to individuals with substance abuse problems, structured program with treatment and/or recovery services available twenty-four hours per day, seven days a week	Alpha Project 993 Postal Way Vista, CA 92083 (760) 630-9922	All
CO-02	Volunteers of America - Renaissance Treatment Center (includes detox and long term)	Alcohol and other drug residential treatment, recovery and ancillary services that are non-institutional and non-medical within licensed and certified residential programs, and non-institutional and non-medical detoxification services	Assist adults to become and remain free of alcohol and other drug problems and assist adults who are using, misusing, or abusing alcohol or other drugs (AOD) to withdraw from chemicals and to be oriented and referred to AOD treatment or recovery programs	Adults 18 years and older with Alcohol and Drug induced problems, including those who may have co-occurring MH disorder	• Residential adult alcohol and other drug (AOD) social model recovery services and detoxification program, combining detoxification and pre-treatment/referral services to individuals as they withdraw from alcohol and drugs	Volunteers of America 2300 E. 7th St. National City, CA 91950 (619) 791-2730	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
SA-01	School Based PEI Central and North Central	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and Culturally-appropriate Family Community Partnership services	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 627-7598	3, 4
SA-01	School Based PEI Central and Southeastern	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and culturally appropriate Family Community Partnership services	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 627-7598	4
SA-01	School Based PEI Central and Southeastern	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and Culturally-appropriate Family Community Partnership services	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 627-7598	1

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
SA-01	School Based PEI Central and Southeastern	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and culturally appropriate Family Community Partnership services	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 627-7598	3
SA-01	School Based PEI North Coastal Region	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and culturally appropriate Family Community Partnership services	Palomar Family Counseling Services, Inc 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	5
SA-01	School-based PEI East	Family-focused approach that engages families in their child's school success. School-based interventions coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and culturally appropriate Family Community Partnership services	San Diego Unified School District 2351 Cardinal Ln. Annex B San Diego, CA 92123 (858) 627-7598	2
CO-02	MHS Adult Drug Court - North County Center for Change	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to be alcohol and other drug free.	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of alcohol and other drugs	• Non-residential AOD treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services	North County Center For Change 504 W. Vista Way Vista CA 92083 (760) 940-1836	3, 5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	MHS Adult Drug Court - South County Center for Change	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to be alcohol and other drug free	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of alcohol and other drugs	• Non-residential AOD treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services	South County Center For Change 1172 3rd Ave. Chula Vista,CA 91911 (619) 691-1662	1, 4
CO-02	MHS Adult Drug Court - East County Center for Change	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to be alcohol and other drug free	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake	• Non-residential AOD treatment, recovery, and ancillary services. • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) service in an environment free of alcohol and other drugs	East County Center For Change 545 N. Magnolia Ave. El Cajon, CA 92020 (619) 579-0947	2
CO-02	MITE RRC South	Non residential alcohol and other drug (AOD) treatment and recovery service center	To ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	18 and older with AOD induced problems, including those who may have co-occurring MH disorder	• Rehabilitative Services/Skill Building • Evidence-based treatment and recovery service incorporating both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	MITE RC South 1180 Third Ave. Suite C3 Chula Vista, CA 91911 (619) 691-8164	1
CO-02	MITE- East Regional Recovery Center	Non residential alcohol and other drug (AOD) treatment and recovery service center	Assist individuals to become and remain free of alcohol and other drug problems addressing both disorders for adults experiencing co-occurring substance abuse and mental health problems	18 and older with AOD induced problems, including those who may have co-occurring MH disorder	• Non-residential AOD • Treatment and recovery service center AOD clients including co-occuring mental health diorders	MITE East Regional Recovery Center 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
CO-02	McAlister Institute for Treatment and Education North Coastal Regional Recovery Center	Non residential alcohol and other drug (AOD) treatment and recovery service center for adults	Assist individuals to become and remain free of alcohol and other drug problems. For client siwth co-occuring disorders, the goal is to ensure that adults experiencing co-occuring substance abuse and mental health problems receive services that comprehensively address both disorders	18 and older with AOD induced problems, including those who may have co-occurring MH disorder	• Evidence-based treatment and recovery service approaches • 12-step models (e.g., AA, NA) • Non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety. • PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	3, 5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	Episcopal Community Services Regional Recovery Center - Central	Non residential alcohol and other drug (AOD) treatment and recovery service center for adults	Provide outpatient treatment and recovery services to adults with alcohol and other drug-induced problems, including co-occurring disorders. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	18 and older with AOD induced problems, including those who may have co-occurring MH disorder	• AOD treatment and recovery services. Adults receive PC 1000 (Deferred Entry of Judgment) drug diversion services	Episcopal Community Services 401 Mile of Cars Way Suite 350 National City, CA, 91950 (619) 228-2800 4660 El Cajon Blvd. Suite 210 San Diego, CA 92115 (619) 597-7335	1, 2
TAOA-OE	Solutions for Recovery	Non residential alcohol and other drug (AOD) treatment and recovery service center for adults age 18+ with alcohol and/or other drug-induced problems, including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of alcohol and other drug problems. Ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	Transition Age Youth (TAY) (18-25 y.o.), adults (26-59 y.o.) and older adults (60 y.o. and above) with alcohol and other drug-induced problems, including co-occurring mental health disorders. LGBTQ adults (as a priority). Adults who have any mental health disorder of sufficient severity, disability and persistence that it would interfere with the person participating successfully in a traditional program	• Contractor shall provide non-residential alcohol and other drug (AOD) treatment and recovery services. • Evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety	Family Health Centers of San Diego 3928 Illinois St. San Diego, CA 92104 (619)515-2588	4
CO-03	Next Steps	Comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and /or substance abuse issues	Mental Health screening and services provided to youth with substance abuse	• Adult aged 18 years or older	• On call either in person or via mobile devices • Screening tool for mental health substance abuse client	NAMI SD 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 643-6580	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
DV-03	Alliance for Community Empowerment	Provide trauma informed, community centered, family driven and evidenced based Community Violence Response services. Central Region, but may serve clients outside the region Middle school aged boys and girls affected by violence	Increase in resilience; improvement in parenting knowledge; increase problem-solving and coping skills; reduced stigma and suicidal rsik factors; reduced psycho-social impact of trauma	Middle school aged boys and girls	• Direct counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities 5348 University Ave. Suites 101 and 102 San Diego CA 92105 (619) 232-6454	4
DV-04	CSF - South Region	Services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establish a community safety net to ensure the safety and wellbeing of children and their families	Families at highest risk of child abuse & neglect; Children, 0 to 17 years	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
DV-04	CSF Central & North Central Regions	Services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establish a community safety net to ensure the safety and wellbeing of children and their families	Families at highest risk of child abuse & neglect; Children, 0 to 17 years	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	Social Advocates for Youth 8755 Aero Dr. Suite 100 San Diego, CA 92123 (858) 565-4148	4
DV-04	CSF East Region	CSF program provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and wellbeing of children and their families	Families at highest risk of child abuse & neglect; Children, 0 to 17 years	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	Home Start 5005 Texas St. Suite 203 San Diego, CA 92108 (619) 692-0727	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
DV-04	CSF - North Coastal/North Inland	Services and engagement with community resources and supports for families in order to assist in maintaining a safe home for children and reducing the effects of trauma exposure	Establish a community safety net to ensure the safety and wellbeing of children and their families	Families at highest risk of child abuse & neglect; Children, 0 to 17 years	• Case management • In-Home Parent Education • Safe Care • STEP Training • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	5
EC-01	Triple P	Provide mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum	A specialized culturally and developmentally appropriate mental health PEI service to promote social and emotional welless for children and thier families	Countywide parents and families; parents and Gurdians of children enrolled in Head Start, Early Head Start, Elementary School and Communty Center locations	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Services 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
FB-01	Pathways Community Services-Kickstart	Provide Prevention and Early Intervention (PEI) services for persons age 10-25 who have emerging 'prodromal' symptoms of psychosis	Reduce incidence and severity of mental illness and increase awareness and usage of services	Countywide Youth ages 10-25 in San Diego County and their families & substantial public component on psychosis Serve 800 community members and 300 At Risk Mental State (ARMS) youth each fiscal year	• Prevention, through public education • Early Intervention, through screening potentially at risk youth • Intensive Treatment, with treatment of youth who are identified as at risk and their families	Pathways Community Services, LLC 4281 Katella Ave. Suite 201 Los Alamitos, CA 90720 (562) 467-5532 6160 Mission Gorge Rd. Suite 400 San Diego, CA 92120 (858) 637-3030	All
NA-01	Southern Indian Health Council, Inc.	PEI and substance use treatment services to Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives;tribal members of South and East San Diego region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• PEI services •AOD services • Child abuse prevention case management to Native Americans in South and East County	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
NA-01	Indian Health Council, Inc.	PEI and substance use treatment services to Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives;tribal members of South and East San Diego region tribes; and qualified family members residing on reservations; All age groups; North region of San Diego County	• PEI services • AOD services • Child abuse prevention • Case management to Native Americans in North County	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5
NA-01	SD American Indian Health Center	PEI services to Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	At risk and high risk urban American Indian and Alaska Natives children and Transitional Age Youth	• Provide specialized culturally appropriate PEI services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave. Suite 105 San Diego, CA 92103 (619) 234-1525	4
NA-01	Sycuan Medical/Dental Center	Provide specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the Sycuan tribal community	Reduce ethnic disparities in service access and use. Increase access to care	East Regions At-risk and high-risk children, youth, Transitional Age Youth, adults and older adults	• Provides specialized culturally appropriate behavioral health PEI services	Sycuan Band of Kumeyaay Nation 5442 Sycuan Rd. El Cajon, CA 92019 (619) 445-0707 ext. 114	2
OA-01	Elder Multicultural Access & Support Services (EMASS)	Elder Multi-cultural Access and Support Services providing outreach and support to older adults, especially non-Caucasian/non-English speaking	Reduce ethnic disparities in service access and use. Increase access to care	Multi-cultural Seniors, refugees, age 60+ at risk of developing mental health problems	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community based services	Union of Pan Asian Communities 525 14th St. Suite 200 San Diego, CA 92101 (619) 238-1783 ext. 30	All
OA-02	Positive Solutions - UPAC	Outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduce stigma associated with mental health concerns and disparities in access to services	Homebound older adults (60+ years) at risk for depression or suicide	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities 525 14th St. Suite 200 San Diego, CA 92101 (619) 238-1783 ext. 30	1,4,5

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
OA-06	Caregivers of Alzheimer's Disease and Other Dementia Clients Support Services	Caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers	Reduce incidence of mental health concerns in caregivers of Alzheimer's patients. Improve the quality of well-being for caregivers and families. Provide services to an underserved/unserved population	Adult Caregivers	• Outreach • Information Dissemination • Early Intervention • Education	Southern Caregiver Resource Center 3675 Ruffin Rd. San Diego, CA 92123 (858) 268-4432	All
SA-01	Project In-Reach	Provide in-reach, engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance abuse issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and community aftercare	The program is focused on serving at-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth (TAY) incarcerated at designated facilities, with an additional focus on inmates with serious mental illness (SMI)	• Pre- and-post-release case management, • Pre-release evidence based cognitive behavioral therapy (CBT) • Group interventions • Peer support • Post service linkages and follow up and transportation	NHA - Project In Reach 286 Euclid Ave. Suite 207 San Diego, CA 92114 (619) 684-9065	All
PS-01	Supported Employment Technical Consultant Services	Technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated through BHS to develop new employment resources	Employment is an essential element of comprehensive mental health services for adults with serious mental illness (SMI). Supported Employment is a key strategy for meeting both the employment and service needs of adults with SMI and the MHSA target populations. These services should improve access to employment opportunities for adults with SMI	Service providers, employers, agencies, government organizations, and other stakeholders	• Consultant Services	San Diego Workforce Partnership, Inc. 3910 University Ave. Suite 400 San Diego, CA 92105 (619) 228-2952	All
PS-01	Suicide Prevention & Stigma Reduction Media Campaign - Civilian	Countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increase awareness of available mental health services	County-wide Individuals with mental illness; Families of individuals with mental illness; General public	• Public media campaign to education and promote mental health concerns • Print, radio, and TV ads • Printed materials	Civilian Inc. 170 Laurel St. San Diego, CA 92101 (619) 243-2290	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
PS-01	Suicide Prevention Action Plan	Facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies	Provides support and increase knowledge of mental illness and related issues. Reduce stigma and harmful outcomes	General population, mental health service consumers, local planners, and mental health organizations	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives	TBD	All
PS-01	Family Peer Support Program (In Our Own Voice & Friends in the Lobby)	Provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue	Provides support and increase knowledge of mental illness and related issues. Reduce stigma and harmful outcomes	Family members and friends of psychiatric inpatients	• Resources and support to family friend's visiting loved ones in psychiatric inpatient units in San Diego area • Public education	NAMI of San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6597	All
PS-01	Breaking Down Barriers & Father2Child	Conducts outreach and engagement to ethnic and non-ethnic groups throughout the county. Father2Child is a parenting program for African American fathers/caregivers in southeastern San Diego	Reduce mental health stigma to culturally diverse, un-served and underserved populations	Un-served and underserved populations; Latino; Native American; African; LGBTQ; African-American	• Outreach and education to reduce mental health stigma to culturally diverse, un-served and underserved populations • Collaboration with community based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Breaking Down Barriers Mental Health Association of SD County 4069 30th St. San Diego, CA 92104 (619) 543-0412 ext. 102	All
PS-01	Mental Health First Aid	Mental Health First Aid is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Provides community-based mental health literacy education and training services, countywide	Adults and Adults who work with Youth	• Community-based mental health literacy education and training services, countywide	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
RC-01	Integrated Behavioral Health and Primary Care Services in Rural Communites	Provides Rural Integrated Behavioral Health and Primary Care Services for prevention and early intervention services	Increased access to and usage of services	Adults *Older Adults; Children; TAY	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5122	All
RE-01	CHIP Independent Living Association (ILA)	This program will create an Independent Living Facility (ILA) Association with voluntary membership	The goal of this program is to promote the highest quality home environments for adults with severe mental illness	ILA Operators Individuals, families, discharge planners and care coordination who are seeking quality housing resources	• Brief intervention	Community Health Improvement Partners 5095 Murphy Canyon Rd. Suite 105 San Diego, CA 92123 (858) 609-7974	All
SA-01	School Based PEI North Coastal Region	Family-focused approach that engages families in their child's school success. School-based interventions are coordinated and designed to improve school climate, educational success and child/parent social and emotional skills	Reduce family isolation and stigma associated with seeking behavioral health services. Increase resiliency and protective factors for children. Reduce parental stress. Improve school climate for children to thrive at school	Pre-school through 3rd grade, cultural population burdened with poverty, illiteracy, limited, education, and homelessness	• Social-emotional early intervention utilizing evidenced based program, Incredible Years (IY) and culturally appropriate Family Community Partnership services	Palomar Family Counseling Services, Inc 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
SA-02	HERE Now	School based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth (TAY)	Reduce suicides and the negative impact of suicide in schools. Increase education of education community and families	Middle school, high school, and Transition Age Youth (TAY).	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All
VF-01	Courage to Call Mental Health Systems, Inc.	Confidential, peer-staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increase awareness of the prevalence of mental illness in this community. Reduce mental health risk factors or stressors. Improve access to mental health and PEI services, information, and support	Veterans, active duty military, Reservists, National Guard, family members	• Education • Peer counseling • Linkage to mental health services • Mental health information • Support Hotline	Mental Health Systems, Inc. 9445 Farnham St. Suite 100 San Diego, CA 02123 (858) 636-3604	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	MHS Adult Drug Court - San Diego Center for Change	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to be alcohol and other drug free	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of alcohol and other drugs	• Non-residential AOD treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services	San Diego Center For Change 3340 Kemper St. Suite 103 San Diego,CA 92110 (619) 758-1433	4
CO-02	San Diego Second Chance Program - Re-Entry Court	Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	To attain employment and stable housing, to be alcohol and other drug free and complying with law, not committing new criminal offenses	Non-violent male and female offenders, with a history of substance use and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of alcohol and other drugs	• Non-residential AOD treatment, recovery, and ancillary services • Outpatient Drug-Free (ODF) treatment and intensive Day Care Habilitative (DCH) services	Second Chance 6145 Imperial Ave. San Diego, CA 92114 (619) 839-0931	All
CO-02	MHS San Diego Re-Entry Court	Case management and non-residential alcohol and other drug (AOD) treatment and testing program services for non-violent adult male and female offenders with histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems who have been referred to Reentry Court	To increase self-sufficiency and reduce recidivism	Parolees referred through the Reentry Court who are San Diego County residents and have high risk to recidivate, high criminogenic issues, AOD problems, excluding tobacco or ordinary caffeine-containing beverages, and who are experiencing social, psychological, physical and/or behavioral problems resulting from current or previous substance abuse	• Case management and non-residential treatment services • Screening • Psychosocial assessment • Non-residential substance abuse treatment • Drug testing • Recovery placement services • Vocational and educational services, and linkages to ancillary support services such as physical health or social support services	Mental Health Systems, Inc. 9465 Farnham St. Suite 100 San Diego, CA 92123 (858) 573-2600	All

Work Plan	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
CO-02	MHS, Inc. North Central RRC (Mid-Coast)	Non-residential alcohol and drug treatment and recovery services for adults- regional recovery center in the North Central region service area	Assist individuals to become and remain free of alcohol and other drug problems. Adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	Drug and alcohol-using Transition Age Youth (TAY) (18-25 y.o.), adults (25-59 y.o.), and older adults (60 y.o. and above), including those with co-occurring mental health issues	• Core functions of a Regional Recovery Center (RRC) • Treatment and recovery services for adults referred from a variety of sources, which may include HHSA Child Welfare Services, mental health programs, the Superior Court, CalWORKs Welfare-to-Work Employment Case Management and Substance Abuse Case Management programs, and the Probation Department, among others	Mid-Coast RRC 3340 Kemper St. San Diego, CA 92110 (619) 523-8121	4
CO-02	N. Inland RRC	Regional Recovery Center - Non-residential alcohol and other drug (AOD) treatment and recovery services	To assist individuals to become and remain free of alcohol and other drug problems. For co-occurring clients, the goal is to ensure that adults experiencing co-occurring substance abuse and mental health problems receive services that comprehensively address both disorders, so the individual may achieve an alcohol and drug free life style	Adults with alcohol and other drug-induced problems, including co-occurring disorders	• Screening for mental health issues; linkage to mental health services if indicated	North Inland RRC 200 E. Washington Ave. Suite 100 Escondido, CA 92025 (760) 741-7708	3, 5

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-11	Care Giver Connection to Treatment	KidSTART	Certified outpatient mental health program will provide a full range of Title 9 outpatient diagnostic and treatment services	Support the mental health of the caregivers of young children to increase the mental health and support family care	Children ages 0 through 5 in Countywide regions	• Care coordination • Link caregivers to their own services • Clinical groups specific to caregiver needs	Rady KidStart 3665 Kearny Villa Rd. Suite 500 San Diego, CA 92123 (858) 966-5990	All
INN-12	Family Therapy Participation Enhancement	Community Research Foundation - Crossroads	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Priority efforts shall be made to engage underserved populations such as Latinos and African Americans. Children and TAY up to age 21	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2
INN-12	Family Therapy Participation Enhancement	Community Research Foundation	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Priority efforts shall be made to engage underserved populations such as Latinos and African Americans. Children and TAY up to age 21	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd. Suite 100 San Diego, CA 92110 (619) 398-3261	All
INN-12	Family Therapy Participation Enhancement	North County Life Line	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Priority efforts shall be made to engage underserved populations such as Latinos and African Americans. Children and TAY up to age 21	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	North County Lifeline Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	5
INN-12	Family Therapy Participation Enhancement	Vista Hill Foundation	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Priority efforts shall be made to engage underserved populations such as Latinos and African Americans. Children and TAY up to age 21	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Escondido Vista Hill Foundation 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 North Inland Ramona Vista Hill Foundation 1012 Main St. Suite 101 Ramona, CA 92065 (760) 788-9724	2,3

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-12	Family Therapy Participation Enhancement	Family Health Center	Utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in treatment process and addressing barriers on individualized levels	The goal is to clarify, teach, and motivate the caregiver of the value of their involvement in treatment and how it will directly support the success and outcome of the family unit	Priority efforts shall be made to engage underserved populations such as Latinos and African Americans. Children and TAY up to age 21	• Outreach and engagement of caregivers in family therapy via a parent partner • Motivational Interviewing	Community Circle: Logan Heights Family Health Centers 2204 National Ave. San Diego, CA 92113 (619) 515-2355 Community Circle:Spring Valley Family Health Centers 3845 Spring Dr. Spring Valley, CA 91977 (619) 515-2380	1,2,4
INN-13	Faith Based Initiative	Community Health Improvement Partners Faith Based Initiative	Faith Based Initiatives Outreach, Engagement & Training Community Education	Faith Based Initiative	Children, TAY, adults, older adults in Central & North Inland Regions	• Outreach • Education • Training services	Community Health Improvement Partners 5095 Murphy Canyon Rd. Suite 105 San Diego, CA 92123 (858) 609-7968	4
INN-13	Faith Based Initiative	Harmonium, Inc. Faith Based Initiative	Faith-Based Initiatives Outreach/Engagement & Training Community Education Ministry Development Crisis Response	Collaboration, Partnerships and Faith-based Academy (Outreach, Engagement, and Training): Outreach and engage faith-based congregations and develop collaboration and partnership between faith based leaders and behavioral health providers	TAY, AOA, youth and familes	• Outreach / Engagement & Training • Community Education • Ministry Development • Crisis Response	Harmonium, Inc. 9245 Activity Rd. Suite 200 San Diego, CA 92126 (858) 684-3080	4
INN-13	Faith Based Initiative	Total Deliverance Worship Faith Based Initiative	Faith Based Initiatives Outreach, Engagement & Training Community Education	To provide faith based outreach, education, and training, and community education ministry development. Also to provide crisis response services	Children, TAY, adults, older adults in Central & North Inland Regions	• Outreach / Engagement & Training • Community Education • Ministry Development • Crisis Response	Total Deliverance Worship PO Box 1698 Spring Valley, CA 91979	2
INN-13	Faith Based Initiative	Interfaith Community Services Faith-based Academy in the North Inland Region	Faith Based Initiatives Outreach, Engagement & Training Community Education; Design, develop and implement a Faith Based Academy (FBA): develop an educational curriculum and joint training that includes material to address faith/spirituality principles and values, wellness, mental health conditions, and resource information to the Latino communities in designated regions	The goal of the Interfaith's FBA is to provide useful information, resources, and educational training for faith based and community leaders in regard to wellness and mental health with an emphasis on the Latino community. The FBA will provide information as well as educational resources that will ultimately connect behavioral health providers with faith leaders. The training classes will be designed to break through the judgment and shame affiliated with substance abuse and mental health conditions	Mental Health professionals and clergy in the North Inland Region	• Outreach / Engagement & Training • Community Education • Ministry Development • Crisis Response	Interfaith Community Services 550 W. Washington Ave. Suite B Escondido, CA 92025 (760) 489-6380 ext. 230	3, 5

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-13	Faith Based Initiative	Training Center Ministry Development in the Central Region	Develop a Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a Serious Mental Illness (SMI) while in jail	This Ministry outreaches individuals while in detention at Central Jail and Las Colinas Detention Facility and assists them in transitioning into the community. Services shall be provided for up to 90 days post release	Incarcerated adults diagnosed with a serious mental illness in the Central Jail and Las Colinas	• Support services consistent with pastoral counseling and the individual's faith • Information, linkage and education about community based resources	Training Center 525 Grand Ave. Spring Valley, CA 91977 (619) 267-1066	4
INN-13	Faith Based Initiative	Training Center Ephesians	A Wellness and Mental Health In-reach Ministry that focuses on Adults diagnosed with a Serious Mental Illness (SMI) while in jail. Program services include: engaging individuals with SMI; providing spiritual support; mental and physical health wellness; information and counseling on the impact and effects of untreated mental illness, co-occurring disorders; linkage and community based resources for re-integration back into the community; support services consistent with pastoral counseling and the individual's faith in addition to information. This Ministry will outreach individuals while in detention and assist them in transitioning into the community	Engage adults diagnosed with serious mental illness (SMI) and a severe level of impairment while incarcerated. promote the mental wellness, spiritual support, physical health and emotional stability of inmates while in custody and post release, assist inmates with SMI to transition and connect effectively to behavioral health and faith resources in their community. increase access to behavioral healthcare and faith communities by providing case management, support, referrals, and connections to the community behavioral health system and community supports, identify and promote individual resilience within their community post release, identify and overcome barriers, including socio-cultural barriers, that challenge connectedness to community behavioral and faith support, develop and increase partnerships between faith communities and behavioral health providers, reduce stigma and increase knowledge about mental health conditions, mental wellness, and substance use disorders	Adult/Older Adult	• Support services consistent with pastoral counseling and the individual's faith. • Information, linkage and education about community based resources	Training Center 525 Grand Ave. Spring Valley, CA 91977 (619) 267-1066	3,5
INN-13	Faith Based Initiative	NAMI San Diego Faith Based Initiative	Faith Based Initiative, outreach and engagement, and community education	The purpose is to educate clergy and congregations about mental illness so that they can create stronger safety nets and welcoming communities of faith for people living with serious mental illness	Faith Leaders and Mental Health Professionals	• Outreach / Engagement & Training • Community Education • Ministry Development • Crisis Response	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6586	4
INN-13	Faith Based Initiative	Urban Leage of San Diego County Faith Based Academy-Central	Faith Based Initiative--Outreach/Engagement & Training	Faith Based leaders and Behavioral Health providers to collaborate in developing an educational curriculum and joint training that includes material to address faith/spirituality principles and values, wellness, mental health conditions, and resource information to the African-American and Latino communities	Mental Health professionals and clergy in the North Inland Region	• Facilitator training and education • Curriculum for faith leaders, community leaders, and behavioral health providers	Urban League of San Diego County 4305 University Ave. Suite 360 San Diego, CA 92105 (619) 263-3660	1,4

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-13	Faith Based Initiative	Faith Based Crisis Response Team-Central	Faith Based Mental Health Crisis Response Central	Mobile community-based program that pairs licensed mental health clinicians and clergy to respond to individual and family crisis situations 24/7	Families in the Central region, with a focus on African American and Latino communities	• Crisis Response	Total Deliverance Worship Center 7373 University Ave. Suite 201 La Mesa, CA 91942 (619) 825-3930	2
INN-13	Faith Based Initiative	Training of Facilitators	Faith Based Mental Health Community Education North Inland	Collaborate and participate with identified Faith Based and Behavioral Health Champions from Faith Based Academies. To facilitate community education presentations to faith communities and behavioral health providers with HHSA North Island region	Faith leaders, behaviroal health providers and members of congregations and community	• Community Education	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (619) 543-1434	2,3,5
INN-13	Faith Based Initiative	Community Education Central	Faith Based Mental Health Community Education North Inland	Collaborate and participate with identified Faith Based and Behavioral Health Champions from Faith Based Academies. To facilitate community education presentations to faith communities and behavioral health providers with HHSA Central region	Families in the Central region, with a focus on African American and Latino communities	• Community Education	Total Deliverence Worship Center 7373 University Ave. Suite 201 La Mesa, CA 91942 (619) 825 3930	4
INN-13	Faith Based Initiative	Mental Health Association of San Diego County	Faith Based Initiatives Community Education Mnistry Development	To provide faith based education, ministry development to children, youth, families and TAY	Faith based organizations, children, youth, families, TAY	• Community Education • Ministry Development	MHA San Diego 4069 30th St. San Diego, CA 92104 (619) 543-0412	4
INN-13	Faith Based Initiative	Neighborhood House Association Faith Based Initiative	Faith Based Initiatives Community Education Mnistry Development	To provide Faith Based Initiatives, Outreach/Engagement & Training, Community Education, Ministry Development, Crisis Response to TAY, Adults and Older Adults who have SMI	Faith based organizations, children, youth, families, TAY	• Community Education • Crisis Response • Ministry Development	Neighborhood House Association 5560 Copley Dr. San Diego, CA 92114 (858) 715-2642	4
INN-14	Supported Employment Initiative	Union of Pan Asian Communities (UPAC) Ramp Up 2 Work	Engages and retains employment opportunities for transitionl age youth (TAY) and Adults and Older Adults (AOA) with Serious Mental Illness (SMI) in the behavioral health system through an enhanced array of supported and competitive employment options	The goal is too expand employment opportunities for TAY and AOA with SMI and to promote self-determination and empowerment. The program helps clients overcome barriers to employment	TAY, Adults and Older Adults who have SMI	• Client functional Assessment • Employment reediness Assessment • Job coaches • Computer skills support	UPAC 1031 25th St. San Diego, CA 92102 (619) 232-6454	All

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-15	Peer Assisted Transitions	NAMI San Diego Peer Assisted Transition	Provision of peer specialist coaching, incorporating shared decision-making and active social supports, to increase the depth and breadth of services to person diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected to community resources. This program shall be focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services	Increase depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports	TAY, Adults and Older Adults in Central, North Coastal & North Inland regions	• Peer specialist coaching • Conneting to relevant services	NAMI San Diego 5095 Murphy Canyon Rd. Suite 320 San Diego, CA 92123 (858) 634-6586	1
INN-16	Innovative Artistic Expression Focused Engagement Program (Urban Beats)	Pathways Community Services Urban Beats	Program provides an artistic expression that includes the use of multiple models of artistic expression including visual arts, spoken word, music, videos and performances and social media created and developed by TAY	Increase the engagement and retention rates in mental health treatment of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) and at risk TAY by incorporating a TAY focused recovery message into an artistic expression and social marketing	TAY who are clients of the mental health system SED/SMI or at-risk of mental health challenges	• Develop youth leaders within TAY community • Increase access to services • Whole health and prevention services	Program Site: 3330 Market St. San Diego, CA 92101 (858) 227-9051	1
INN-17	Innovative Mobile Hoarding Intervention Program	UCSD CREST (IMHIP)	Diminishes long term hoarding behaviors in Older Adults	Improves health, safety, quality of life, and housing stability through provision of comprehensive hoarding treatment	Older Adults 60+ with hoarding disorder and SMI	• Community Outreach and Engagement • In-home Therapy • Family Support	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	1,5
INN-18	Peripartum	TBD	Identifies at-risk peripartum women for engagement and provides services for women and spouses	Reduce incidence and impact of postpartum depression	Peripartum women and partners, especially in communities at-risk of trauma	• Outreach and engagement through Public Health Nurses • Interventions to prevent and treat postpartum depression	TBD	All

Work Plan	Program	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	District
INN-19	Telemental Health	TBD	Provides post institutuionalization follow-up treatment and stabilization via electronic devices	Prevents re-institutionalization and destabilization and encourages successful re-integration following institutionalization	Tranistion Age Youth	• Outreach and engagement • Follow-up psychiatric treatment and stabilization via telemedicine • Digital telemedicine training and engagement • Counseling, therapy, tele-psychiatry	TBD	All
INN-20	ROAM Services	Roaming Outpatient Access Mobile Services	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County	• Outreach and Engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Program approved May 25, 2017; RFP Pending.	2,5
INN-21	ReST	Recuperative Services Treatment	Provides post-institutuionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevents re-institutionalization and homelessness; encourages successful re-integration following institutionalization	Transition Age Youth	• Wrap-around services • Case management • Voluntary residential services • Employment and permanent housing support	Program approved May 25, 2017; RFP Pending.	4
INN-22	Medication Clinic	TBD	Provides ongoing medication management by pediatric psychiatrists for youth following clinical discharge	Promotes stabilization and improvement by providing accessible follow up for complex psychiatric and medical situations	Children and Youth 17 and under	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	Program approved May 25, 2017; RFP Pending.	All

Work Plan	Program	Program Name & Contract Agency	Program Description	Contract Information	District Page 215
WET-02	Training and Technical Assistance	Regional Training Center (RTC)	RTC will provide administrative and fiscal training support services to HHSA Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop and execute training contracts between RTC and trainers/consultants, coordinate with HHSA BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.	Regional Training Center 6155 Cornerstone Ct, Suite 130 San Diego, CA 92121 (858) 550-0040	All
WET-03	Public Mental Health Academy	Alliant International University Community Academy, Public Mental Health Academy	The Community Academy is a partnership between NAMI San Diego, RI International, the Family Youth Round Table and the California School of Professional Psychology (CSPP) at Alliant International University. It provides training and employment assistance for individuals with lived experience of mental illness and/or family members.	Alliant Educational Foundation 10455 Pomerado Rd San Diego CA 92131 (858) 635-4357	4
WET-03	Recovery Innovations, Inc.	Consumer/Family Academy, TAY/Adult/Older Adult Peer Specialist Training	Provide training for Adult Peer Support Specialist, parent Peer Support Specialist, TAY Peer Support Specialist, and Family Member Peer Support Specialist	Recovery Innovations, Inc. 2701 North 16th St Phoenix Arizona 85006 (602) 650-1212	All
WET-04	Residency, Internship Programs; Community Psychiatry Program	Regents of the University of California, UCSD Community Psychiatry Program	The UCSD School of Medicine will provide two programs for physicians- one for adult psychiatry residents and fellows and the second for child and adolescent psychiatry residents and fellows. The program will foster the development of leaders in Community Psychiatry and provide all residents with exposure to the unique challenges and opportunities within this context. Targeted approaches to ethnically and linguistically diverse populations	Regents of the University of California, UCSD 200 West Arbor Drive San Diego CA 92103 619-471-9396	All

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-3	Personal Health Record	The Personal Health Record (PHR) embedded in the InteliChart Patient Portal enables patients to both securely view and update their records in a timely manner	All ages	• PHR is constructed from patients existing behavioral health medical record. InteliChart provides and supports mobile apps that enable patients to make appointments, view lab results, and securely communicate with their healthcare providers conveniently using mobile technology	TBD	All
SD-5	CRF Heartland	Provides technological support for telemedicine at Heartland Bio-Psychosocial Rehabilitation (BPSR) WRC	Adults 18+ who have a SMI, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have a SMI, including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	CRF Heartland Center 460 N. Magnolia Ave. El Cajon, CA 92020 (619) 440-5133	2
SD-5	CRF Maria Sardinas	Provides technological support for telemedicine at South Region Biopsychosocial Rehabilitation Wellness Recovery Center	Adults 18+ who have a SMI, including those who may have a co-occurring substance abuse disorder. TAY population and Probation-funded AB109 component	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults age 18+, TAY & AB109 who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	Maria Sardiñas Wellness & Recovery Center 1465 30th St. Suite K San Diego, CA 92154 (619) 428-1000	1
SD-5	CRF South Bay Guidance Center	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18+ older who have SMI, including those who may have a co-occurring substance abuse disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults age 18+, TAY & AB109 who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder	CRF - South Bay Guidance Wellness and Recovery Center 835 3rd Ave. Suite C Chula Vista, CA 91911 (619) 427-4661	1
SD-5	UPAC Mid City/UPAC Serra Mesa	Provides technological support for telemedicine at UPAC	Monolingual and/or limited English proficient Asian/Pacific Islander adults 18+ with SMI	• Clinic services supported: Outpatient case management, vocational support services for indigent clients with a SMI who may have a co-occurring substance abuse disorder	UPAC Mid-City BPSR 5348 University Ave. Suites 101 & 120 San Diego, CA 92105 (619) 229-2999 UPAC Serra Mesa 8745 Aero Dr. Suite 330 San Diego, CA 92123 (619) 268-0244	1,4

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-5	Community Research Foundation Douglas Young	Provides technological support for telemedicine at North Central Region Adult/Older Adult Bio-Psychosocial Rehabilitation Wellness Recovery Center	Adults 18+ who have a SMI including those with co-occurring and Medi-Cal eligible or indigent	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	CRF Douglas Young Center 10717 Camino Ruiz Suite 207 San Diego, CA 92126 (858) 695-2211	4
SD-5	Neighborhood House Association Project Enable	Provides technological support for telemedicine at Project Enable	Transition Age Youth, Adults and Older Adults aged 60+ older including those who may have a co-occurring substance abuse disorder	• Clinic services supported: Stabilization and recovery services with the expectation that with treatment, clients will effectively recover and graduate from the program	Neighborhood House Association 286 Euclid Ave. Suite 102 San Diego, CA 92114 (619) 266-9400	All
SD-5	County-Operated Southeast Mental Health Clinic	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18+ who have a SMI	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have a SMI, including those who may have a co-occurring substance use disorder	Southeast Mental Health Center 3177 Ocean View Blvd. San Diego, CA 92113 (619) 595-4400	1,4
SD-5	MHS North Inland MHC MHS Kinesis North MHS Kinesis Fallbrook MHS Kinesis Ramona	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	TAY, Adults and Older Adults	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have a SMI, including those who may have a co-occurring substance use disorder	MHS, Inc. North Inland Mental Health Center 125 W. Mission Ave. Suite 103 Escondido, CA 92025 (760) 747-3424 Kinesis Wellness & Recovery Center 474 W. Vermont Ave. Suite 101 Escondido, CA 92025 (760) 480-2255 Fallbrook Satellite 1328 S. Mission Rd. Fallbrook, CA 92028 (760) 451-4720 Ramona Satellite 1521 Main St. Ramona, CA 92065 (760) 736-2429	3,5

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-5	MHS North Coastal MHC MHS BPSR Vista	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	TAY, Adults and Older Adults.	Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18+ who have a SMI, including those who may have a co-occurring substance use disorder	MHS, Inc. North Coastal Mental Health Center 1701 Mission Ave. Oceanside, CA 92058 (760) 967-4475 MHS, Inc. Vista 550 West Vista Way Suite 407 Vista, CA 92083 (760) 758-1092	4
SD-5	Deaf Community Services	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Children, adults and older adults who are deaf or hard of hearing and who have a SMI or alcohol and other drugs (AOD) use or abuse problems	• Clinic services supported: Outpatient mental health services, case management and substance abuse services are provided for deaf and hard of hearing adults	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S. Suite 300 San Diego, CA 92108 (619) 398-2437	All
SD-5	Exodus NC/NI (hub)	Provides technological support for telemedicine at an outpatient psychiatric medication services clinic	Children, TAY, adults and older adults via telehealth technology	• Clinic services supported: Outpatient psychiatric medication services for children, TAY, adults and older adults mental health consumers utilizing Telehealth practices and technology	Exodus Recovery, Inc. 524 W. Vista Way Vista, CA 92083 (760) 758-1150 1520 S. Escondido Blvd. Escondido, CA 92025 (760) 796-7760	All
SD-5	Community Research Foundation (CRF) Jane Westin	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18+ who have a SMI	• Clinic services supported: Walk-in outpatient mental health assessments and psychiatric consultation, medication management services; crisis intervention and case management brokerage	Jane Westin Wellness & Recovery Center Walk In Services Assessment Center 1045 9th Ave. San Diego, CA 92101 (619) 235-2600	1,4
SD-5	County-Operated East County Mental Health Clinic	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18+ who have a SMI.	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services, including those who may have a co-occurring substance use disorder	East County Mental Health Center 1000 Broadway Suite 210 El Cajon, CA 92021 (619) 401-5500	2

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-5	County-Operated North Central Mental Health Clinic (Hub)	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18+ who have a SMI	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services, including those who may have a co-occurring substance use disorder	North Central Mental Health Clinic 1250 Morena Blvd. San Diego, CA 92110 (619) 692-8750	4
SD-5	CRF-Mobile Adolescent Service Team (MAST)	Provides technological support for telemedicine at a Children and youth outpatient mental health clinic, including video, secure email, and phone consultation	Children and youth	• Clinic services supported: Outpatient school based mental health services for SED Children and youth	CRF MAST, Mobile Adolescent Service Team 1202 Morena Blvd. Suite 203 San Diego, CA 92110 (619) 398-3261	All
SD-5	CRF-Nueva Vista Family Services	Provides technological support for telemedicine at a Children and youth Outpatient mental health clinic, including video, secure email, and phone consultation in a mental health walk-in outpatient clinic within the County of San Diego	Children and youth	• Clinic services supported: Individual/group/family treatment, case management and rehabilitative services, Intensive Care Coordination, Intensive Home-Based Services, crisis intervention, medical management, outreach at schools and in the community. Services are provided at schools, home or office/clinic	CRF Nueva Vista Family Services 1161 Bay Blvd. Suite B Chula Vista, CA 91911 (619) 585-7686	1
SD-5	CRF-Crossroads Family Center	Provides technological support for telemedicine at Children and youth outpatient mental health clinic provides video, secure email, and phone consultation	Children and youth	• Clinic services supported: Individual/group/family treatment, case management and rehabilitative services, Intensive Care Coordination, Intensive Home-Based Services, crisis intervention, medical management, outreach at schools and in the community. Services are provided at schools, home or office/clinic	CRF Crossroads Family Center 1679 E. Main St. Suite 102 El Cajon, CA 92021 (619) 441-1907	2
SD-5	School-Based Douglas Young Youth and Family Services Outpatient Children's Mental Health Services	Provides technological support for telemedicine at Douglas Young Youth and Family Services Outpatient Children's Mental Health Services	Children and youth	• Clinic services supported: Outpatient school based mental health services for SED Children and youth	Community Research Foundation 1202 Morena Blvd. Suite 300 San Diego, CA 92110 (619) 275-0822	4

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-5	START Community Research Foundation CRF Vista Balboa, CRF New Vistas, CRF Halcyon, Crisis Center, CRF Turning Point, CRF Jary Barreto, CRF Isis Crisis Center	Provides technological support for telemedicine at short-term, acute residential treatment clinics	Voluntary adults who have a SMI/Co-Occurring Disorder experiencing a mental health crisis, in need of intensive, non-hospital intervention	• Clinic services supported: 24 hour, 7-day a week 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions, and are residents of San Diego County	Vista Balboa 545 Laurel Ave. San Diego, CA 92101 (619) 233-4399 New Vistas 734 10th Ave. San Diego, CA 92101 (619) 239-4663 Halcyon 1664 Broadway El Cajon, CA 92021 (619) 579-8685 Turning Point 1738 S. Tremont St. Oceanside, CA 92054 (760) 439-2800 Jary Barreto 2865 Logan Ave. San Diego, CA 92113 (619) 232-4357 Del Sur (formerly Isis) 892 27th St. San Diego, CA 92154 (619) 575-4687	All
SD-5	Community Research Foundation Areta Crowell Clinic, ACC	Provides technological support for telemedicine at Areta Crowell	Seriously mentally ill (SMI) clients aged 18 and older	Clinic services supported: Outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support, including those who may have a co-occurring substance abuse disorder	Community Research Foundation 1963 4th Ave. San Diego, CA 92101 (619) 233-3432	
SD-5	Esperanza Crisis Center-CRF	Provides technological support for telemedicine at Esperanza Crisis Center	Voluntary adults 18 and older with acute and serious mental illness (SMI) including those who may have a Co-Occurring substance abuse Disorder and are residents of San Diego County	Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All

Work Plan	Program Name	Program Description	Population Focus	Services Offered	Contact Information	District
SD-6	Road Map into the Millennium	This project replaced the core information system used by virtually all providers in the extended system of care, including all clinical and billing information. The new Practice Management and Managed Care System replaces in their entirety the legacy applications that were in use	The main users of the system will be County of San Diego employees, County Service Providers, Administrative Support Organizations (ASO's) and Fee For Service Providers may collectively be referred to herein as Third Party Service Providers	• InSyst application – supported by Echo Management, Inc. and resides on VAX hardware. It is a client and service tracking and billing application that is used by CoSD and contract mental health providers to coordinate client care, perform required State reporting requirements and bill Medi-Cal and other payers; eCura application – supported by InfoMC and used for Managed Care. The end users are United Behavioral Health (UBH) Administrative Services Organization (ASO) employees	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All
SD-8	Connect Well San Diego	Program identifies opportunities for interoperable management information systems between the County and partners. This may include expenses related to the use of the HealtheIntent, Ultra-Sensitive Exchange, Personal Health Record and the potential development of information technology interfaces	TBD	• TBD	TBD	All
SD-9	Financial Management System	The Financial Management System will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, contract tracking and business analytics tools, including standard reporting, dashboards and queries	The business areas and programs served including the following: Registration/Administration; Service Recording; Electronic Health Record; Medi-Cal Billing; Other Billing; Managed Care Functionality	• This system will streamline financial data collection and reporting, including potentially assisting with the annual MHSA Revenue & Expenditure Report (RER), maintain the integrity of data with system securities and prevent duplication of effort to ensure resources are fully maximized	Behavioral Health Services 3255 Camino del Rio S. San Diego, CA 92120 (619) 563-2700	All

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
Key Words: (CCRT, Cultural Competency)

SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
		PAGE:	1 OF 3
		DATE:	**02/24/2014**
REFERENCE			

PURPOSE
To establish a Behavioral Health Services (BHS) Cultural Competence Resource Team (CCRT) to advise the BHS Executive Team of Adult/Older Adult (AOA) and Children, Youth, and Family (CYF) BHS Systems of Care (SOC) on issues of cultural competency.

BACKGROUND
None

DEFINITIONS
None

POLICY
It is the policy of BHS to promote mental health, wellness and recovery, eliminate the debilitating effects of psychiatric and alcohol and other drug conditions in a culturally centered manner and to promote cultural competence. To accomplish this goal, the CCRT was established and will be maintained within the BHS. The purpose and structure of this team supports the local Cultural Competence Plan as mandated by the California Department of Public Health's Office of Health Equity.

PROCEDURES
The CCRT was established and charged as follows:

1. Members of the CCRT shall be appointed by the Deputy Directors of BHS. Appointees will be from various organizational units and disciplines within BHS as well as member-at-large appointees from the community to include consumers and family representatives. Representation from key groups, such as BHS, Quality Improvement (QI), the Mental Health Contractors Association (MHCA), the Mental Health Board (MHB) and the Alcohol and Drug Advisory Board (ADAB) will be requested.

2. The charge of the CCRT is:

    a. To serve as the "eyes, ears and conscience" of the County of San Diego's A/OA and CYF systems regarding the development and integration of cultural competence in the delivery of behavioral health services to culturally diverse populations and

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
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SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
		PAGE:	2 OF 3
		DATE:	**02/24/2014**
REFERENCE			

system-wide adherence to the local Cultural Competency Plan. The CCRT is a formal mechanism for providing to the Behavioral Health Administration, to County and contracted individual providers input and feedback to:

1) Monitor and evaluate the cultural competence of the BHS system of care.
2) Recommend performance outcomes and standards for assessing the behavioral health system's cultural competence in serving culturally diverse populations.
3) Review performance outcomes and recommend strategies to address gaps.
4) Recommend corrective action when the system's performance does not meet expected standards of cultural competence.
5) Recommend system of care training to address gaps.

3. BHS primary staff support to the CCRT will include the Ethnic Services **Coordinator** (currently the Director of the A/OA SOC). Other support necessary for the CCRT to fulfill its charge will be made available to the extent feasible.

4. The CCRT chair shall be appointed by the Behavioral Health Director and shall be at a Chief or Program Coordinator level or above. CCRT members will also be appointed by the Director upon recommendation of the Chair. The Chair will serve as the link between the CCRT and the BHS Deputy Directors.

5. Formal actions of the CCRT will occur under Robert's Rules of Order.

6. Members will be expected to participate in a subcommittee where work assignments will be completed.

7. CCRT members are expected to observe confidentiality in regard to information obtained during the work of the Team.

QUESTIONS / INFORMATION
Piedad Garcia, Director
BHS Adult Older Adult System of Care
(619) 563-2757

ATTACHMENTS/RELATED DOCUMENTS
None

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult Older Adult System of Care
Key Words: (CCRT, Cultural Competency)

SUBJECT:	**Cultural Competence Resource Team**	**REFERENCE #**	5946
		PAGE:	3 OF 3
		DATE:	**02/24/2014**
REFERENCE			

SUNSET DATE: This policy will be reviewed for continuance on or before April 30, 2017.

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	1 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

PURPOSE
To assure improvements in the access and availability of culturally and linguistically competent services in County Behavioral Health Services (BHS).

BACKGROUND
For detail information, please see the most recent update of the Cultural Competence Plan. The Mental Health Plan (MHP) Cultural Competence Plan is available from the Quality Improvement (QI) Unit.

DEFINITIONS
None

POLICY
Cultural competence is a key element in providing high-quality behavioral health care to the diverse population of San Diego County. The County BHS will make ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of San Diego residents.

PROCEDURES
The MHP, with the guidance of the Cultural Competence Resource Team (CCRT), will ensure ongoing progress toward meeting service access and availability based on the cultural and linguistic needs of the population of San Diego County requiring mental health services by:

1. Analyzing County demographic information changes periodically, to determine or identify gaps in service provision.

2. Reflecting cultural and linguistic needs in strategic plans, policies and procedures, human resource training and recruitment, and contracting requirements.

3. Ensuring involvement of diverse populations in planning processes.

4. Periodically analyzing the human resources composition of MHP and provider staff in comparison to the cultural, ethnic, and linguistic characteristics of Medi-Cal beneficiaries and adjusting training, recruitment, and retention efforts accordingly.

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	2 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

5. Ensuring Clinical Practice Standards for Cultural Competence will be incorporated in the mental health service provision.

6. Ensuring that programs adhere to the guidelines and requirements of the most recent Cultural Competence Handbook.

7. Periodically assessing and adjusting contract language to reflect changing cultural competence needs in the selection of contract providers.

8. Providing and fostering the provision of training and staff development in cultural competence on a wide variety of cultures and diverse communities, including client culture for provider staff, support staff, administration, and interpreter services.

9. Analyzing consumer and staff satisfaction survey results, and grievances and appeals, to determine areas of needed cultural and linguistic service improvement.

10. Evaluating site review and medical record review findings to ensure: 1) that all provider sites are able to assist consumers with diverse threshold and non-threshold language needs, through in-house staff capabilities or interpreter services; and 2) that there is an array of written materials at provider sites in the threshold languages of the County.

11. Evaluating progress in the development of a program or system to evaluate the cultural competence of staff and interpreters and making interventions, as needed.

12. Analyzing outreach and engagement strategies, results of culture-specific staff recruitment efforts, and the effectiveness of providing culture-specific provider listings in reaching underserved populations.

QUESTIONS / INFORMATION
Piedad Garcia, Director
Adult Older Adult System of Care
(619) 563-2757

ATTACHMENTS/RELATED DOCUMENTS
A - Cultural Competence Clinical Practice Standards Attach-A, Cult Comp Clinical Standards

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Adult and Older Adult Behavioral Health Services
Key Words: (Cultural Competence)

SUBJECT:	**Culturally and Linguistically Competent Services: Assuring Access and Availability** **Formerly: Culturally and Linguistically Competent Services**	**REFERENCE #**	5994
		PAGE:	3 OF 3
		DATE:	**02/28/2013**
REFERENCE	**San Diego County Mental Health Plan and San Diego County Cultural Competence Handbook**		

B - Cultural Competence Handbook link:
http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetenceHandbook11-1-11.pdf

This handbook outlines cultural competence guidelines and requirements in implementing programs and systems of care that are culturally competent.

SUNSET DATE: This policy will be reviewed for continuance on or before February 28, 2016.

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Cultural Competence Resource Team
MEETING NOTES

Friday, FEBRUARY 5, 2016 10:00-11:30 AM

3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In attendance: Piedad Garcia (BHS), Abdullahi, Ismahan (BHS), Altamirano, Leon (NCHS), Laura Andrews (MHA), Elisa Barnett (BHETA), Juan Camarena (SDSU), Lauren Chin (BHS), Dasha Dahdouh (BHS), Rick Heller (HSRC), Celeste Hunter(CASRC), Michelle Ly (UPAC), Liz Miles (BHS), Edith Mohler (BHS), Joe Reimann (BHS), Chandrea Taylor (BHS), Gary Ulmer-Goodrich (BHS), Mercedes Webber (RI), Charity White-Voth,

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions (Piedad Garcia)	• Meeting was called to order at 10:05 AM	
II. Approval of December 4, 2015 Minutes	• Approval of December 4, 2015 meeting was moved and second with noted changes. Recovery Innovations has relocated to 3838 Camino Del Rio N. #308 San Diego, CA 92108 (Laura Andrews and Leon Altamirano)	
III. Chair's Report (Piedad Garcia)	• **Mid-Year Enhancements** – AOA and TAY will increase Homeless FSP slots by 200 clients • Outreach and Engagement funding has been enhanced for PEI programs which will follow a new model of outreach and engagement that is designed to establish relationships and build trust to positively impact the homeless population potentially in need of mental health or substance abuse services • Behavioral Health Court slots have been increased by 10. • *1 for All* is a new Homeless initiative for persons with serious mental illness that the Board of Supervisors has approved and plans on its implementation are due to the Board of Supervisors in 120 days. • BHS is continuing work on the FY 2016-2017 Operation Plan with allocation letters due to contractors on 4/1/16.	
IV. QI Updates (Liz Miles)	• QI completed their annual audit, there no results to provide at this time and anticipate feedback from their auditors within a few months	
V. Cultural Competence Tool Discussion (Dasha Dahdouh)	• An in depth review of alternative cultural competency tools was discussed. The tools discussed are alternative options to the Cultural Competent Program Annual Self Evaluation (CCPAS) California Brief Multicultural Competent Scale (CBMCS) which are currently utilized by the system.	**Action Item:** • QI will forward electronic copies for review. • Education and Training Workgroup will assemble to discuss in more detail and report in March.

ITEM	SUMMARY	ACTION
VI. Children's Update (Edith Mohler)	• CYF provided summary on the mid-year enhancements. • The County operated Emergency Screening Unit (ESU) offers Crisis Stabilization services to children and youth will fully transition from County operations to New Alternatives, Inc. effective 7-1-16. The program will continue to provide 24-hour services at its current location in Chula Vista, CA. The County will retain administrative oversight of these critical mental health services, and current County staff assigned to the program will be deployed to other programs. • CYF has identified those selected for their nine slots for the upcoming CADRE XVI	
VII. MHSA Plan Update (Gary Ulmer-Goodrich)	• MHSA Fiscal Year 2016-17 Annual Update will include the new BHS budget and is scheduled for public viewing to begin on 3/7/16.	
VIII. CCRT Membership	• Meeting attendees were asked to check their information listed on the sign-in sheet for accuracy	**Action Item:** • Membership list will be updated. • CCRT policies and bylaws will be addressed during March 2016 meeting
IX. Announcements	• None	

NEXT MEETING IS SCHEDULED FOR
FRIDAY, MARCH 5, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team

MEETING NOTES

Friday, March 4, 2016

10:00-11:30 AM

3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

Attendees: Alfredo Aguirre (BHS), Piedad Garcia (BHS), Heather Alesch (UPAC), Leon Altamirano (NCHS), Laura Andrew (MHA), Elisa Barnett (BHETA), Lauren Chin (HPPS), Dasha Dahdouh (QI), Dixie Galapon (UPAC), Wanjiru Golly (PCWTA), Rick Heller (HSRC), Celeste Hunter (CASRC), Jackie Hurtado (BHS), Michelle Ly (UPAC), Jose Mallari (BHS), Liz Miles (QI), Edith Mohler (CYF), Nancy Rodriguez (HHSA), Maria Samayoa (BHS), Ann Vilmenay (BHS), Mercedes Webber(RI), Adrienne Yancey (MHSA)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Piedad called the meeting to order at 10:00 AM.	
II. Approval of February 2016 Minutes	• Approval of February 5, 2016 minutes was moved and second with noted changes. (Leon Altamirano, Mercedes Webber)	
III. Chair's Report (Piedad Garcia)	• Neighborhood House Association did a presentation for Project In-Reach at the Behavioral Health Advisory Board. The data presented was for 2012 – 2015, in the presentation the recidivism for the program showed positive low rates for clients served in the County. • Faith Based Task Order I and II have been released. The contractors are Urban League of San Diego and Interfaith Community Services (North Inland). They are to develop a training manual for the FB Academy that will focus on the underserve population mainly African-American and Latino community. Contractors will also be providing , community and stakeholder education, and increasing awareness to Behavioral Health Service and ministries for the Central and North Inland region communities. • Faith Based Task Orders III and IV are currently released for response. . Children System of Care will take the lead for the III task order which will pair a licensed mental health clinician with a clergy to respond to individual and family crisis situations on a 24/7 on-call system. The AOA assigned COR will take the lead for Task order IV which will focus on Adults diagnosed with a Serious Mental Illness (SMI) while in jail that are in the acute care unit and provide mental health and support services and short term case management as clients integrate back into the community. • Contractor Allocation letters are planned to be released the first week of April and will include FY 2016 - 2017 enhancements for the selected program pending Board approval.	
IV. Teen Recovery Centers Presentation (Wendy Maramba)	• Teen Recovery Center (TRC) provides outpatient substance abuse to adolescents ages 12-17. • There are 7 TRCs in the County of San Diego the Services include:	

ITEM	SUMMARY	ACTION
	➢ Assessments ➢ group and individual counseling ➢ addressing of co-occurring disorders ➢ crisis intervention ➢ case management ➢ education ➢ drug testing ➢ coordination of services, and support • Program Goals: – Provide developmentally appropriate substance abuse treatment services for adolescents throughout the County – Assure access to care – Help youth reach their full potential by achieving a substance free lifestyle – Promote self-sufficiency though education or employment – Contribute to the decrease in crime by ensuring that participants have no arrest	
V. Behavioral Health CoCare Initiative Recruitment (Alfredo Aguirre)	• A newly established Behavioral Health Steering Continuum Care Initiative (BHCCI) is establishing workgroups to address outpatient mental health services in the system of care. Representatives were requested to provide input and recommendations for each of the workgroups: ▪ Pre-Service – will address services in the community for acute care and/or reduce criminal activity. ▪ Point of Service – will address issues that impact long term care patients in acute care facilities or behavioral health patients in emergency rooms. ▪ Post-Service – will address how people are linked to community care upon release from a hospital or incarceration to prevent re-hospitalization and/or recidivism. • BHCCI Steering Committee will be coordinating with workgroups to provide the Committee with input. The workgroup are not yet active. Anticipated to commence May or June. • Dr. Leon Altamirano volunteered to participate in a workgroup.	***Action Item:*** • Piedad to f/u with CoCare workgroup representatives and select a workgroup for each rep.
VI. QI Updates (Liz Miles on behalf of Tabatha Lang)	• The CC-PAS will be administered from 4/4/16 - 4/15/16 giving program managers 2 weeks to complete. An email reminder will be sent out on 3/21/16. • External Quality Review (EQR) has provided a draft report for the annual audit in January. QI is waiting for the final report to present to CCRT. • The Cultural Competence Plan to DHCS is currently being finalized, QI to present to CCRT in May for review and input.	***Action Item:*** • Dr. Todd Gilmer to present – Recovery Culture Progress Report • QI to send Cultural Competence Plan in April.

ITEM	SUMMARY	ACTION
VII. Committee Updates • **Children's** (Edith Mohler) • **Education and Training** (Charity White-Voth)	**Children Update:** • Pathways to Well-Being is working with TAY to develop focus groups that will discuss and evaluate the needs within the system. • Children, Youth & Families is preparing for their 2nd Annual Children Mental Health celebration on May 4, 2016 at BHS from 4:00 – 6:00 PM, more information will be provided. **Education and Training:** • The Committee met on February 24, 2016 reviewed and discussed existing tools and research new tools for organizational and individual assessment. The implementation will not take effect until April 2017. • The Cultural and Linguistic Competence Assessment is being reviewed to ensure it is grouped and matched with the CLAS Standards.	***Action Item:*** • Provide Education & Training membership sign-in sheet – Charity
VIII. MHSA Plan Update (Adrienne Yancey)	• BHS 2015 Community Forums Analysis summary of Tier I and Tier II were distributed. Tier II data was considered when determining MHSA programming for Fiscal Year 2016-2017. • CCRT requested Forum information by region. Adrienne informed this request is in progress.	
IX. Cultural Competence Resource Team (CCRT) Membership	• CCRT is in the process of revising and updating the membership list, policy and procedures. • Members are to review information and inform of any changes. Further discussion regarding membership and policies at the April CCRT meeting.	***Action Item:*** • Provide members sign-in sheet and recruitment procedures - Maria
X. Policy and Program • **Disparity Report 2013**	• Piedad reminded CCRT members to bring their own copy of the Disparity Report provided via email or on Technical Resource Library (TRL) to the CCRT meetings as this is an ongoing item for discussion as we moved forward in the MHSA plan and BHS Ops Plan. • The Disparity Report will be cross referenced with BHS Community Forum data summary and the Cultural Competence plan for recommendation and input to align the budget process.	
XI. Announcements	• No announcements at the time.	

NEXT MEETING IS SCHEDULED FOR
FRIDAY, APRIL 1, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team

MINUTES

Friday, April 1, 2016
10:00-11:30 AM
3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

Andrews, Laura(MHA); Barnett, Elisa(BHETA); Blair, Natalie(AOT); Camarena, Juan(SDSU); Dahdouh, Dasha(BHS-QI); Garcia, Piedad(BHS-AOA); Gilmer, Todd(UCSD); Heller, Rick(HSRC); Hunter, Celeste(CASRC); Katsanis-Semel, Kat(MHA); Ly, Michelle(UPAC); Mohler, Edith(BHS-CYF); Rodriguez, Nancy(HHSA); Taylor, Chandrea(BHS-AOA); Webber, Mercedes(RI); White-Voth, Charity(BHS-AOA); Yancey, Adrienne(BHS-MHSA)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	Piedad Garcia called the meeting to order at 10:08AM.	
II. Approval of March 2016 Minutes	Laura Andrews moved to approve the 3/4/16 summary notes as amended. This motion was seconded by Juan Camarena.	
III. Chair's Report (Piedad Garcia)	Contractors are scheduled to receive the allocation letters for FY 16-17 budget on 4/11/16. In July 2016 a request for the approval of the implementation of the 1115 Waiver will be presented to the Board of Supervisors.	
IV. AOT/Laura's Law Update (Charity White-Voth)	The Assisted Outpatient Treatment (AOT) contract was officially awarded on January, 1 2016; the program began accepting clients on 3/28/16. Natalie Blair reiterated that referrals for AOT come through the In Home Outreach Team (IHOT) programs. Ms. Blair provided an overview of the nine criteria that must be met in order for clients to qualify for AOT.	
V. Recovery Culture Progress Report (Dr. Todd Gilmer)	Dr. Gilmer discussed the Recovery Culture Progress Report (RCPR), a provider evaluation survey tool funded by Mental Health Services Act Oversight and Accountability Commission (MHSAOAC) that focuses on the recovery orientation of programs implemented by the Mental Health Services Act (MHSA).	Piedad Garcia will discuss the RCPR with the BHS Director of Operations and Executive Team and will report their feedback to CCRT at the May 2016 meeting.
VI. QI Updates (Dasha Dahdouh)	All program managers will be given two weeks to complete the Cultural Competence Program Annual Self Evaluation (CC-PAS) starting on Monday, April 4, 2016 through Friday, April 15, 2016. Cultural Competence Plan updates will be finalized and the document will be sent for review in April 2016. The final EQR report was received and will be posted on the Technical Resource Library (TRL)	

ITEM	SUMMARY	ACTION
VII. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update** (Edith Mohler)	**<u>Education and Training:</u>** Charity invited CCRT members to join the committee. The committee is currently reviewing various evaluation tools that measure cultural competence. **<u>Children's Update:</u>** Children's Mental Health celebration will be held on May 4, 2016 between 4-6PM.	**<u>Education and Training:</u>** Review the RCPR and compare and contrast with the RSA, CC-PAS and CBMCS **<u>Children's Update:</u>** Edith Mohler will request Suzanne Ford to lead a portion at the celebration
VIII. MHSA Plan Update (Adrienne Yancey)	Adrienne Yancey provided a transcription of the specific comments from the Fall 2015 BHS Community Engagement Forums that are directly related to Cultural Competency.	CCRT members will review and provide comments at the May 2016 meeting.
IX. Announcements	Cara Evans Murray has researched the definition of *Underserved* as defined by MHSA Innovations program and the OAC. Representatives are still needed to participate in the Behavioral Health Continuum of Care committees. • PRE-SERVICE WORKGROUP • POINT OF SERVICE WORKGROUP • POST SERVICE WORKGROUP	*Underserved* definition will be sent to CCRT members

NEXT MEETING IS SCHEDULED FOR
FRIDAY, MAY 6, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team MINUTES

Friday, May 6, 2016

10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In Attendance: Piedad Garcia (BHS), Leon Altamirano (NCHS), Lauren Chin (BHS), Minola Clark Manson (BHETA), Dasha Dahdouh (BHS), Dave Devries (BHS), Carlos Gutierrez (BHS), Kat Katsanis-Semel (MHA), Tabatha Lang (BHS), Edith Mohler (BHS), Shiva Motahari (BHETA), Maria Samayoa (BHS), Charity White-Voth (BHS), Adrienne Yancey (BHS)

ITEM	SUMMARY	ACTION
I. Welcome/ Introduction	• Piedad called the meeting order at 10:03 AM.	
II. Approval of April 2016 Minutes	• Approval of April 1, 2016 minutes was moved as written. (Dasha Dahdouh)	
III. Chair's Report (Piedad Garcia)	• Board of Supervisors (BOS) approved the preliminary budget plan for Fiscal year 2016 – 2017, which will expand the programs and staffing for Behavioral Health Services (BHS). Including Project One for All. • Project One for All is a homeless project for SMI and was directed by the BOS and directs the HHSA to develop an implementation plan which will be presented to the Behavioral Health Advisory Board and the BOS in May. The Plan will include work with HCD and other housing authorities to leverage housing subsidies with services. • Allocation letters were sent out to contractors by BHS, to be reviewed and discussed with program monitors. • BHS Adult & Older Adult team will began workgroups with AOD providers and Narcotic Treatment Providers for recommendations, input and feedback. • AOA is working with the City of San Diego on SMART Pilot project for clients with primary drug addiction for Recovery Center services, linkages and connections to Residential Treatment and Sober Living. • The Faith Based Task Order 3 & 4 – North Inland did not receive any proposal response. Suggestion for a reaching out strategy and proving further information to possible providers.	
IV. QI Updates (Tabatha Lang)	• Notice was sent via email regarding State Surveys (YSS & MHSIP) that will take place from May 16 – 20. A few added data questions were added, for all CYF clinicians about their use of homework with clients and the knowledge of grievance and appeals process. • THE CYF Clinician survey was sent on May 4, 2016 with deadline of May 13, 2016. • Cultural Competence Plan Updates were emailed April 29, 2016 for team to review and provide feedback by May 13, 2016. Recommendations and comments will be provided at the June 2016 CCRT meeting. • The Health Outcomes Management System (HOMS) has been enhanced and trainings will be provided. Further information will be sent via email. • The state has contracted the CA Institute for Behavioral Health Solutions (CHIBS) to provide training on the 1115 Waiver (DMC) state and countywide. San Diego is currently waiting for a training timeline.	

ITEM	SUMMARY	ACTION
V. MHSA Plan Update (Adrienne Yancey)	• The MHSA Annual Update for 2016 – 2017 has been released for review. To download go to **http://sandiego.camhsa.org/**. If you have any comment or questions please see link for contact information. BHS community forums for 2017 – 2018 planning to start in August. • MHSA has its own process for addressing issues, complaints and grievances about MHSA planning and process. The Department of Health Care Services (DHCS) requires that the local issue resolution process be exhausted before accessing State venues. San Diego County BHS MHSA Issue Resolution Process handout was distributed.	
VI. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update** (Edith Mohler)	**Education and Training:** • Committee has been meeting monthly to review and discussed existing tools and research new tools for organizational and individual assessment prior to presenting it to the team. **Children Update:** • Currently developing a new specialized treatment program that will provide services to LGBTQ for Fiscal year 2016 - 2017. The program will provide mental health counseling, assistance with permanent supportive housing, sexual health education, life skills training, employment development and education support. • Children's Mental Health Well-Being Celebration on Tuesday, May 4, 2016 was very successful.	
VII. WET Update	• Workforce Education and Training (WET) was a one-time funding for a maximum of 10 years to spend and the funds have been steadily decreasing. Further review into using unspent funds is in the process, a recommendation to extend certain programs that are close to achieving sustainability. • For Fiscal year 2016 – 2017, approximately $2,200,000 in CSS funds will be transferred to MHSA WET component to continue funding and the need for additional WET Funds will be evaluated annually.	
VIII. Announcements	• Mental Health of America will be hosting an event featuring author Ms. Laura Fenamore on May 19, 2016. • BHETA Learning Management System (LMS) will be upgrading and unavailable on May 24, 2016, email notification have been sent and will continue weekly.	

NEXT MEETING IS SCHEDULED FOR
FRIDAY, JUNE 3, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

CULTURAL COMPETENCE RESOURCE TEAM MINUTES

Friday, June 3, 2016

10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In Attendance: Juan Camarena (SDSU), Dasha Dahdouh (BHS), Dixie Galapon (FHC), Celeste Hunter (CASRC), Kat Katsanis-Semel (MHA), Tabatha Lang (BHS), Liz, Miles (BHS), Edith Mohler (BHS), Maria Samayoa (BHS), Charity White-Voth (BHS), Adrienne Yancey (BHS)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Charity called the meeting to order at 10:06 AM.	
II. Approval of May 2016 Minutes	• Approval of May 6, 2016 minutes was moved and second as written. (Celeste Hunter and Juan Camarena)	
III. Chair's Report (Charity White-Voth on behalf of Piedad Garcia)	• BHS is working on linking individuals with 15 housing vouchers in the East Region by using the HMIS and VI-SPDATS resource. • Laura's Law/AOT currently has a few candidates for the program and 1 under petition.	
IV. QI Updates (Tabatha Lang)	• Recommendation and feedback was received for the draft Cultural Competence Plan (CCP) and are being reviewed to incorporate in the final version that will be submitted to the state in July. • The CCP will continue to be updated annually however a 3 year plan will also be incorporated in 2017. QI will be working with CCRT for input and recommendations. • CBMCS Surveys data is being compiled and will be presented to CCRT in August. • CC-PAS and State Survey (YSS & MHSIP) data will also be reviewed and compiled to present at a future meeting. • Starting July 1, 2016 there will be new State Regulations for Prevention and Early Intervention (PEI) that all PEI programs must adhere. • PEI Program-specific HOMS trainings will be provided and is recommended that at least 1 staff member for each program attend. Further detailed information will be provided via email and flyer for training dates and information. • In anticipation of the County opting-in to the 1115 Waiver a memo will be presented to the BOS for implementation. BHS is working with Narcotic Treatment and AOD Providers for recommendations and input.	***Action Items:*** • QI – CBMCS Data presentation. • Maria – Email PEI Regulation and Training information.
V. MHSA Plan Update (Adrienne Yancey)	• The MHSA Annual update 30 day public comment period closed and is now being finalized to submit to the state.	

ITEM	SUMMARY	ACTION
VI. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update** (Edith Mohler)	**Education and Training:** • CCBMCS and CC-PAS are being reviewed and compared to George Town University's Linguistic tool. Committee's goal is to finalize material before December. **Children** • The new Family Youth Liaison contractor is NAMI San Diego, contact will be Sue Skube. • Pathways to Well-Being will be hosting training on the expansion of Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). Handout with information was distributed. • CYF is working with CWS and Probation on Continuum of Care Reform which draws together a series of existing and new reforms to CWS program designed to ensure services and support for children, youth and the family while the child or youth are apart from their biological parents.	
VII. Announcements	• **Due to holiday CCRT will be going dark in July**.	

NEXT MEETING IS SCHEDULED FOR
AUGUST 5, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team

MINUTES

Friday, August 5, 2016

10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In Attendance: Piedad Garcia (BHS), Laura Andrews (MHA), Lauren Chin (BHS), Fran Cooper (BHS), Dasha Dahdouh (BHS), Celeste Hunter (CASRC), Kat Katsanis-Semel (MHA), Michelle Ly (UPAC), Nicole McAleer (TKC), Liz, Miles (BHS), Edith Mohler (BHS), Joe Reimann(BHS), Maria Samayoa (BHS), Ann Vilmenay (BHS), Charity White-Voth (BHS), Rose Wood (BHETA), Adrienne Yancey (BHS), Jessica Young (PE)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Piedad called the meeting to order at 10:04 AM.	
II. Approval of June 2016 Minutes	• June 3, 2016 minutes were moved and second as written. (Joe Reimann) • July Meeting – Dark due to holiday	
III. Chair's Report (Piedad Garcia)	• Project One For All (POFA) was submitted to the BOS for review and is targeted to commence April 1, 2017. • The 1115 Waiver draft plan will be presented to the BHAB and BOS in September 2016 for recommendation and support. • Charity informed the 100 Homeless Person Project Request for Proposal (RFP) was sent out. The hybrid model integrates 2 service components in 1 contract. One component for individuals with SMI with co-occurring and the 2nd component for AOD clients with primary diagnosis of substance use.	***Action Item:*** • Piedad - Contact George Scolari to attend CCRT for Health Plan discussion.
IV. QI Updates (Liz Miles)	• The Cultural Competence Plan (CCP) was submitted to the state on July 1, 2016. • The 3-Year Strategic CCP will commence development in October or November with input and recommendation from the CCRT. • The Mental Health Services Oversight and Accountability Commission (MHSOAC) will be conducting a site visit to get feedback on the implementation of the PEI regulations that went into effect July 1, 2016. • A state ADS audit revealed that CLAS standards within ADS programs are not being monitored. A CLAS component was distributed for CCRT members to review and provide feedback for ADS programs to use.	
V. Committee Updates • **Education and Training** (Charity White-Voth)	**Education and Training:** • Cultural and Linguistic Competence Policy Assessment (CLCPA) from George Town University has been reviewed and modified to best serve San Diego County. The modification would need to be approved by George Town University. • The goal is for CLCPA to replace the annual CC-PAS. CCRT to discuss recommendations and presentation to BHS executive team.	

ITEM	SUMMARY	ACTION
• **Children's Update** (Edith Mohler)	• Piedad requested feedback from the CCRT regarding the Cultural Competence Academy. Action: Members recommended reducing trainings hours, having a training Academy that integrates diverse populations versus specific population. Other specific CC Academies include: Refugees and LGBTQI. A motion was moved and second (Laura Andrews & Joe Reimann) to present recommendations to the Behavioral Health Services Training & Education Committee. **Children's Update:** • A Multi-Cultural Fair was held on May 11, 2016 by the San Diego Unified School District. This event is held annually for the community and families to enjoy and engage in learning.	Action: CCRT recommendations to be presented at BHSTEC at next meeting. Piedad to present recommendations
VI. MHSA Plan Update (Adrienne Yancey)	• BHS Community Forums will commence at the end of August, detailed information to dates and times will be provided when it is finalized.	
VII. LGBTQ Programs (Fran Cooper)	• CYF is currently working on the components for an RFP that will provide county-wide services to LGBTQ. CCRT recommended services for youth and families of immigrants.	
VIII. Announcements	• No Announcements.	

NEXT MEETING IS SCHEDULED FOR
SEPTEMBER 2, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team

MINUTES

Friday, September 2, 2016

10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In Attendance: Piedad Garcia (BHS), Elizabeth Acuff (BHS), Elisa Barnett (BHETA), Juan Camarena (SDSU), Dasha Dahdouh (BHS), Danielle Dorrington (BHS), Dixie Galapon (FHC), Kat Katsanis-Semel (MHA), Tabatha Lang (QI), Michelle Ly (UPAC), Samuel Murray (BHS), Diana Rubio (BHS), Maria Samayoa (BHS), Elaine Sanders (BHS), Krystle Umanzor (BHS), Mimi Viets (BHS), Ann Vilmenay (BHS), Charity White-Voth (BHS), Rose Wood (BHETA), Adrienne Yancey (BHS), Jessica Young (PE)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Piedad called the meeting to order at 10:06 AM.	
II. Approval of August 2016 Minutes	• Approval of August 5, 2016 minutes was moved and second with edits in section IV. (Elisa Barnett, Kat Katsanis-Semel)	
III. Chair's Report (Piedad Garcia)	• BHS Community Engagement forums have commenced to allow community members to share their opinions and recommendations regarding the variety of behavioral health programs and services. • Project One for All (P.O.F.A.), is a comprehensive strategy to ensure individuals with serious mental illness have access to treatment services paired with permanent supportive housing. • The P.O.F.A implementation plan has some components to accomplish the goal: ➢ Outreach and Engagement – Establish active outreach to homeless individuals to engage them in housing and services. ➢ Treatment Services – expansion of FSP/ACT wraparound treatment services that are easily accessible to improve individuals ability to function and sustain housing. ➢ Housing Resources – Identify and prioritize housing resources with a collective approach and commitment from housing authorities, local cities, providers and stakeholders. ➢ Outcomes – track progress and effectiveness at the individual and system to provide feedback for adjustments.	
IV. QI Updates (Tabatha Lang)	• The CC-PAS survey data has been compiled and result were distributed for CCRT to review. The results showed a decrease in technical assistance requests, furthermore the portion of the clinical program managers who indicated that they have met the standard has decreased for all but 2 standards. Programs are encouraged to continue enhancing knowledge of tools, resources and trainings. • CBMCS survey data was also compiles and distributed. Based on the results the most self-identify training needs amongst staff were in the area of Awareness of Cultural Barriers and Socio-Cultural Diversities. • Development of 3-Year Cultural Competence Plan for input and recommendations from CCRT to be added in as standing agenda item starting November.	***Action Item:*** • **Maria** - Add 3-Year Cultural Competence Plan to agenda for November.

ITEM	SUMMARY	ACTION
V. MHSA Plan Update (Adrienne Yancey)	• Innovations Projects concepts have been discussed at the BHS Community forums. The following are the concepts: o Postpartum Prevention & Early Intervention o Tele-Health o Roaming Outpatient Access Mobile o Recuperative Housing Development	
VI. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update**	**Education & Training:** • CCA recommendations discussed at the August CCRT meeting were sent to Lauren Chin lead for BHSTEC. Lauren will include recommendation for next BHSTEC meeting. • As discussed in recent meetings the workgroup has been reviewing tools for a more accurate assessment across the system. The revised CLCPA was distributed the intent is to measure organizational cultural competency and is to be completed by Program Managers. • CCRT was asked to review revised CLCPA to provide input and recommendation by September 7, 2016, so it can be submitted to George Town University for approval. • The workgroup will be working on reviewing tools for CBMCS from George Town University called Promoting Cultural Diversity and Cultural Competency which is also a Self-Assessment checklist. Future review of the RSA will also be included. • To participate in the Education and Training workgroup contact Charity White Voth and/or Ann Vilmenay. **Children's Update:** • Piedad provided update for CYF which is one of the focus areas addressed in the current BHS forums. Children behavioral health needs focus groups are being conducted as part of the annual information/input gathering.	***Action Item:*** • Dasha – Provide CLCPA/CLAS comparison grid
VII. Announcements	• The San Diego LGBT Community Center will be hosting 2 Senior Housing Informational Sessions on September 8, 2016 and October 5, 2016, for further information contact: seniors@thecentersd.org	

NEXT MEETING IS SCHEDULED FOR
OCTOBER 7, 2016
10:00 AM-11:30 AM
BHS – LA JOLLA ROOM

Cultural Competence Resource Team

MINUTES

Friday, October 7, 2016 - 10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – La Jolla Room

In Attendance: Piedad Garcia (BHS), Elizabeth Acuff (BHS), Leon Altamirano (NCMH), Irena Anguelov (BHS), Elisa Barnett (BHETA), Juan Camarena (SDSU), Dasha Dahdouh (BHS), Dixie Galapon (FHC), Matthew Hargrove (BHS), Rick Heller (HSRC), Celeste Hunter (CASRC), Kat Katsanis-Semel (MHA), Tabatha Lang (QI), Amanda Lee (UPAC), Liz Miles (BHS), Edith Mohler (BHS), Dave Post (BHS), Martha Rodriguez (BHS), Maria Samayoa (BHS), Krystle Umanzor (BHS), Mimi Viets (BHS), Ann Vilmenay (BHS), Charity White-Voth (BHS), Rose Wood (BHETA), Adrienne Yancey (BHS), Jessica Young (PE)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Piedad called the meeting to order at 10:03 AM.	
II. Approval of September 2016 Minutes	• Approval of September 2, 2016 minutes was moved and second with edits in items IV and V. (Jessica Young and Leon Altamirano)	
III. Chair's Report (Piedad Garcia)	**POFA Update** • BHS has been working with Housing and Community Development Services (HCD) and the San Diego Housing (SDHC) Commission to implement housing subsidies for clients enrolled in the FSP for homeless clients. . • FSP mid-year enhancements were made which has been helpful, but housing still remains a challenge with limited availability and ensuring clients meet requirements. HCD is working on partnering with landlords and property managers and providing incentives to increase housing availability. **BHS** • BHS is expanding staffing positions to monitor and administer multiple new programs and initiatives. **1115 Waiver Update** • The 1115 waiver draft plan was sent to AOD providers for review and their input, if the County decides to opt-in, the BHAB will receive the plan in October 2016. BHS continues to meet with AOD providers for input and recommendations to develop an organized delivery system.	
IV. QI Updates (Tabatha Lang)	• The MHSIP & YSS will be out November 14 – 18, 2016. • Reminder of Cultural Competence Requirements will be sent out to the COR's to share with needed programs. • 3-year Cultural Competence Plan input and recommendation meeting will commence in November.	***Action Item:*** • TAY Workgroup representative requested the CC-PAS and CBMCS report for TAY Programs only.
V. MHSA Plan Update (Adrienne Yancey)	• BHS Community Forums have concluded, recommendations and input from all forums will be analyzed and reviewed by Consultant. Results expected in November 2016, which will be considered for the budget build of FY 2017-2018. • One challenge that is being improved for the community forums is more participation from the diverse population being served by BHS. This year 6 focus groups have been added to specific regions in hopes to receive the response from diverse groups.	

ITEM	SUMMARY	ACTION
VI. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update** (Edith Mohler)	**Education and Training:** • Assessment Tool has been sent to George Town University for approval. Next tool is the Self-assessment Tool that is being reviewed to bring to CCRT for input and recommendations. • Dasha provided the team a comparison grid that crosswalks the questions in the CLCPA with the 15 CLAS Standards to ensure it reflect the CLAS Standards. **Children's Update:** • CYF is working with the Continuum of Care Collaboratives to apply for the Youth Homelessness Demonstration Program (YHDP) which is a new initiative designed to assist communities in building a system of care to prevent and end youth homelessness. Application deadline is November 30, 2016; the selected communities will be announced in the winter of 2017.	
VII. Other	• In light of the tragedy that occurred in El Cajon on September 27, 2016, Juan Camarena inquired about the role CCRT may have to examine and possibly provide recommendations for P.E.R.T curriculum. • Elisa mentioned how vital the Cultural Competence Component is for Mental Health trainings and should be in the P.E.R.T curriculum if not already included. • Celeste Hunter noted as a member of the P.E.R.T Advisory Committee, that immediately after the incident a meeting was held to address the needs and GAPs to improve services. The committee is in the beginning stages of overview. One of the concerns of members not only from the committee but from the community is law enforcement outside of P.E.R.T, what is there training in Cultural Competence. • A recommendation to reach-out to Commanding Officers and their community relations staff within the regions to establish a working relation and help them understand the patient population that programs work with. A great resource to assist with these meetings is Marla Kingkade with P.E.R.T.	***Action Items:*** • Piedad to request Mark Marvin for a copy of the training curriculum. **Next Steps:** – Contact Mark Marvin and/or Marla Kingkade regarding Cultural Competence. – Discuss information with Holly and Alfredo and provide any input or information back to CCRT. – Request Mark or Marla to present at December or future meeting.
VIII. Announcements	• CYF, AOA and TAY will be having a Joint Council meeting on October 18, 2016.	.

NEXT MEETING IS SCHEDULED FOR
NOVEMBER 4, 2016
10:00 AM-11:30 AM
BHS – GARDEN ROOM

Cultural Competence Resource Team

MINUTES

Friday, November 4, 2016 10:00-11:30 AM - 3255 Camino Del Rio South San Diego, CA 92108 BHS – GARDEN ROOM

In Attendance: Piedad Garcia (BHS), Elisa Barnett (BHETA), Juan Camarena (SDSU), Dasha Dahdouh (BHS), Gebaynesh Gashaw-Gant (Guest)Susan Hagos (NSDI), Rick Heller (HSRC), Celeste Hunter (CASRC), Kat Katsanis-Semel (MHA), Michelle Ly (UPAC), Liz Miles (BHS), Edith Mohler (BHS), Nancy Rodriguez (CM), Maria Samayoa (BHS), Krystle Umanzor (BHS), Ann Vilmenay (BHS), Charity White-Voth (BHS), Rose Wood (BHETA), Jessica Young (PE)

ITEM	SUMMARY	ACTION
I. Welcome/ Introductions	• Piedad called the meeting to order at 10:08 AM.	
II. Approval of October 2016 Minutes	• Approval of October 7, 2016 was moved and second with edit to item IV. (Elisa Barnett and Kat Katsanis-Semel)	
III. Chair's Report & Action Items (Piedad Garcia) **Action Item Updates** ➢ Discuss Next Step recommendations from CCRT in evaluating PERT Curriculum w/ BHS Execs. ➢ Request a copy of PERT Training Curriculum. ➢ Cultural Competence Training – PERT Curriculum	**Action Item Updates:** • As agreed in October CCRT meeting, Piedad discussed with BHS Executives the recommendation of evaluating PERT training curriculum and CCRT's participation. • The Director of P.E.R.T provided their training curriculum outlines, which included: – 3-day POST Certified P.E.R.T Academy – Crisis Response Training – 8-Hour Post Certified Pert Academy • Piedad informed after review of the curriculum, that there was minimal Cultural Competence components integrated for the training. BHS Staff will consult with PERT Director regarding CCRT's recommendation to collaborate and provide input for P.E.R.T Curriculum. • Charity, Betsy and Piedad had a conference call meeting with Dr. Marvin to discuss opportunities to enhance the curriculum and have invited Dr. Marvin to come to the CCRT meeting to discuss integration of Cultural Competence in the curriculum. • Liz Miles mentioned there is a First Responder Training that was created in the past and can be used for reference. **Chair Report:** • After thoughtful consideration, data analysis, community conversations, and stakeholder input, the HHSA-BHS will be closing the County operated Children's South East Mental Health Clinic (SEMHC). The closure will occur over time to allow the children, youth and families currently served to complete their treatment. New referrals will be routed to other behavioral health programs. • A concern was raised from other CYF Programs regarding the process requirement when SEMHC referrals are received and will they be identified as referrals from SEMHC. A request for further information or directions regarding the concerns was made. • MHSA added 6 smaller focus groups in specific regions for the unique population being served by BHS to receive some input and response. A consumer, an in-jail and justice related focus group were included.	***Action Item:*** • Betsy to contact P.E.R.T for a presentation in the near future. • Liz Miles to forward Piedad a BHS First Responder Training Manual from a past year. • Edith to f/u with CYF on the request for further direction on SEMHC referrals expectation process and identification. • Piedad – Ask MHSA to present recommendation and input from Focus Groups at future meeting.

ITEM	SUMMARY	ACTION
	• In addition Piedad and other BHS staff members met with a Special Focus Group that included the County, resettlement agencies, (United Women of East Africa and Nile Sisters), Survivors of Torture Intl. and consumers to discuss Refugee Behavioral Health. • One of the main concerns that was mentioned at this meeting was that refugee children under the age of 16 are not assessed for mental health or trauma issues when they arrive from their countries. • BHS is reviewing children's assessments at schools and resources understanding it is a multifaceted issue, such as expertise of clinicians, medical social workers, school assessments, etc.	
IV. Nile Sisters Development Initiative	• Susan Hagos the Health Advocacy Coordinator with the Nile Sisters Development Initiative provided an overview of the program to the CCRT. • The Nile Sisters Development Initiatives works with community leaders to assess the primary needs for and barriers within the communities. The program assist migrants, refugees and their families by offering support, education in social and economic self-reliance and employment skills.	
V. Committee Updates • **Education and Training** (Charity White-Voth) • **Children's Update** (Edith Mohler)	**Education & Training:** • Georgetown University sent notice they have approved the modified CLCPA that was submitted, they have also stated the CC-PAS can be modified without a formal request as it is not an assessment. **Children's Update:** • The Critical issues in Child & Adolescent Mental Health Conference will be held in March 2017, further information will be provided when finalized.	
VI. QI Updates (Liz Miles) **Action Item Updates** ➢ CC-PAS and CBMCS report for TAY Programs only.	• CC-PAS and CBMCS specific to TAY programs request is being finalized and will be presented at the TAY Workgroup meeting on November 16, 2016 and then at the December 2, 2016 CCRT meeting. • State Survey and Consumer results were sent out on November 2, 2016, please note the handouts are in English and Spanish per previous year recommendations. • 2016 Program Level CC-PAS results have been provided to the Program Coordinators and they will be discussing them with individual programs.	
VII. 3- Year Cultural Competence Plan (Liz Miles)	**Criterion I – Commitment to Cultural Competence:** I. The County of San Diego Behavioral Health Services' commitment to cultural competence *(Policies, procedures, or practices that reflect steps taken to dully incorporate the recognition and value of racial, ethnic, and cultural diversity within SDCBHS.* **Suggestions:** Tools to better reflect CLAS Standards, establish a library of ethnics and cultural specific group assessment tools providers can access, LGBTQ drop-in Center, standardized language for MHSA	***Action Item:*** • QI to provide CCP information & updates to CCRT prior to meetings.

ITEM	SUMMARY	ACTION
	II. County recognition, value, and inclusion of racial, ethnic, cultural and linguistic diversity within the system *(description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system)* ***Suggestions:*** Training for all staff in programs (support staff, administrative staff etc.), advertisement awareness III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence *(Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations)* ***Liz to f/u with Piedad.*** IV. Identify budget resources targeted for culturally competent activities *(Evidence of budget dedicated to cultural competence activities)* ***Suggestions:*** drop-n centers and shelters for homeless youth and TAY, Single parenting men, outreach for more programs and community **<u>Criterion II - Updated Assessment Of Service Needs</u>** I. General Population *(Summary of the county's general population by race, ethnicity, age, gender, and other social/cultural groups)* ***Input:*** Increase in Caribbean's, Haitians, Cubans, west Africans migrants and refugees; Adult and Older with dementia and related mental health; Asian population is also increasing II. Medi-Cal population service needs *(Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, gender, and other social/cultural groups)* ***No input*** III. 200% of Poverty (minus Medi-Cal) population and service needs *(Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other social/cultural groups)* ***Suggestions***: Increase community based treatments and clinics, include and train community leaders IV. MHSA Community Services and Supports (CSS) population assessment and service needs *(What target population and services would you recommend the Community Services and Supports (CSS) Plan focus on in the next three years?)* ***No input*** V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations *(Would you recommend any changes to the identified PEI priority population(s)? (underserved cultural populations, individuals experiencing onset of serious psychiatric illness,*	

ITEM	SUMMARY	ACTION
	children/youth in stressed families, trauma exposed, children/youth at risk of school failure, and children/youth at risk of experiencing juvenile justice involvement) ***Out of time to continue discussion at next meeting.***	
VIII. Announcements	• The in-person Cultural Competence Academy trainings through BHETA have ended on October 31, 2016, online trainings will continue to be provided.	

NEXT MEETING IS SCHEDULED FOR
DECEMBER 2, 2016
10:00 AM-11:30 AM
EAST AFRICAN CULTURAL COMMUNITY CENTER

BHETA

Behavioral Health Education and Training Academy

BHETA (Behavioral Health Education and Training Academy) provides the County of San Diego Behavioral Health System with staff development services that increase competency in health integration, culture, co-occurring disorders, and the provision of resilience, family-focused, trauma informed, and recovery-based services. BHETA coordinates classes, conferences, and trainings; provides curriculum and trainer development; develops eLearning courses; and offers consultation, research, and staffing needs assessments in the area of mental health and substance abuse. Additionally, BHETA provides peer education groups for people new to recovery. Services are provided to county and contract staff, consumers, peers, and family members.

Training Delivery

Overall, 50 different classes were offered, 17 of them were new. BHETA provided a total of 475 training hours to the County of San Diego Behavioral Health System, including county and contracted staff. BHETA hosted a conference focused on sexuality in children and adolescents, *Let's Talk About Sex*, that helped participants gain comfort and develop the trust, rapport, and skills to discuss sex and sexuality with children and adolescents. Eight training series were delivered; *CADRE, Introduction to Geriatric Mental Health, Dialectical Behavior Therapy, Solution Focused Brief Therapy, Pathways to Well-Being, Transition to Independence Process, Interpreter Training,* and *Trauma Focused-Cognitive Behavioral Therapy*. In total, training was delivered to 8,389 trainees. A total of 446 Roadmap to Recovery (R2R) education groups for people living with mental health challenges were held in clubhouses throughout San Diego County. Of the 1,929 participants who attended R2R groups, 1,334 were unique individuals; 27 people graduated having completed all 13 R2R class sessions. The Cultural Competency Academy (CCA) has completed its fourth cohort. The fourth cohort focused on African American and Native American populations.

Curriculum Development

Created six eLearnings: *Introduction to Filial Therapy, Comprehensive Continuous Integrated System of Care: An Introduction (rev.), Pathways to Well-Being, Children Youth Families Overview (rev.) DSM5-ICD 10, Transition to Independence Process Overview,* and *American Society of Addiction Medicine Assessments: An Introduction.* Curriculum was developed for Child Family Team Facilitation training. The training curriculum for facilitators of the R2R Program was updated.

Key Priorities for the Future

BHETA priorities in the coming year are two-fold: to expand Roadmap for Recovery's education services both with San Diego County Behavioral Health Services and in the for-profit healthcare arena, and to diversify BHETA's funding.

50
training sessions

17
new

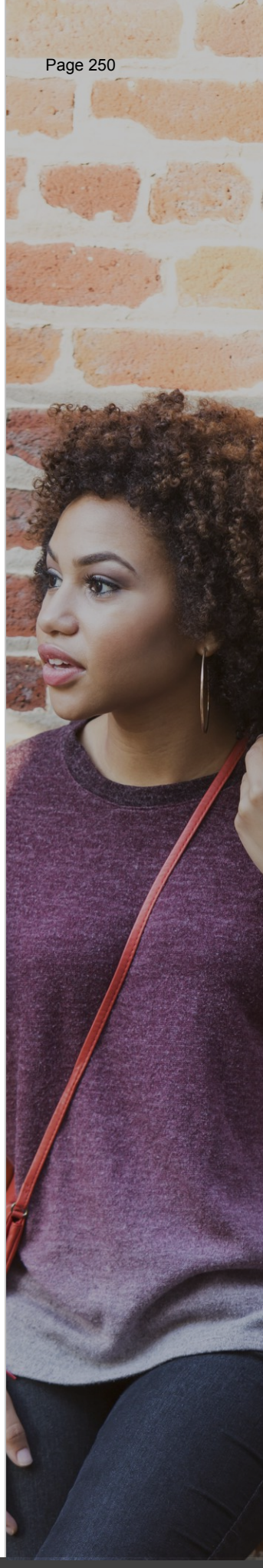
475
training hours

8,389
trainees

1,929
attendees of R2R groups

27
R2R graduates

6 new
eLearnings developed



SDIGEC

San Diego/Imperial Geriatric Education Center

SDIGEC (San Diego/Imperial Geriatric Education Center) has completed its first of three years as part of the Geriatrics Workforce Enhancement Program, a $35.7 million effort by the U.S. Department of Health and Human Services (DHHS), that aims to improve the quality of healthcare for older Americans by developing the healthcare workforce serving older adults. SDIGEC builds on The Alzheimer's Project, a regional initiative of the County of San Diego, that through the leadership of Chairwoman Dianne Jacob (now County Supervisor) and the County Board of Supervisors, brought together community partners to develop plans to address the growing health concern of Alzheimer's disease.

Community Training Development and Delivery

- Trained over 6,500 caregivers on topics that address the needs of older adults with Alzheimer's disease and other related dementias (ADRD).
- Trained over 200 primary care providers on assessment and resources for those with ADRD.
- Provided a Caregiver Conference offered in Spanish.
- Created a training insert that now reaches over 500 Public Authority training participants each month, providing them with resource information for assisting someone with Alzheimer's.
- A public education campaign was developed to increase awareness of Alzheimer's featuring personal stories including that of Tony Hawk, whose mother is affected by Alzheimer's. The campaign included 8 ads in the San Diego Union Tribune newspaper and 153 TV spots on Alzheimer's awareness.

Student Training and Stipend Program

- In order to reach the next generation of care providers, training stipends are being offered: 15 UCSD medical students, fellows, and residents received stipends for conferences to engage them in geriatrics, two SDSU Adult/Gerontological Nurse Practitioners have been awarded training stipends, and 10 SDSU School of Social Work students have been identified to receive stipend awards.
- Additional clinical training environments have been identified to provide experiences in integrated geriatrics for social work students.
- UCSD Division of Geriatrics developed a Geriatrics Grand Rounds to improve knowledge, competence, and goal performance for physicians and health care providers. Over 50 providers have participated.

Key Priorities for the Future

In addition to maintaining its current efforts, SDIGEC plans to expand its training to reach law enforcement by collaborating and offering a mobile app for law enforcement with: warning signs, resources, and easy access to the *Take Me Home Registry*. SDIGEC will also offer training on memory care to residential care workers and county staff providing direct services to older adults. SDIGEC will focus on relationship building in Imperial County for future expansion of services.

6,500 caregivers
trained on ADRD

200 primary care providers
trained on resources for those with ADRD

500 Public Authority
training participants received resource information on ADRD

153 TV spots
in public education campaign

GUIDELINES FOR BHETA TRAINERS

(Ethics, Standards & Performance)

The following guidelines encompass the guiding ethics, values, and training principles applicable to the trainers with BHETA. BHETA holds all trainers and coordinators accountable to these principles in our work of delivering training to behavioral health staff, clients, and their families.

1. **CORE VALUES**:
    a. Every effort should be made to ensure the physical and emotional safety of all trainees.
    b. Learning and development: facilitate knowledge acquisition; skill demonstration and practice; utilize strategies to promote transfer of learning; and, advocate for the development of learning organizations/communities.
    c. Cultural Competence: promote competence in understanding the uniqueness of individuals within their environment and recovery.
    d. Integrity: Promote a climate of trust and mutual respect.

2. **ETHICAL STANDARDS**:
    A. **Consumer/Client or Family Focused**:
        a. Advocate for the well-being of people being served and their families.
        b. Preserve and promote the dignity of people discussed in training and development activities.
        c. Maintain the confidentiality during training activities.
        d. Provide training activities that help trainees better understand and promote recovery of people living with mental illness and their families.
        e. Promote the philosophy of resilience and self-reliance.

    B. **Participant/Trainee Focused**:
        a. Recognize, protect and where possible, enhance the dignity and worth of all trainees.
        b. Clarify expectations regarding:
            - training goals
            - roles of those involved in training activity
            - rules/policies impacting trainee:
            - interpersonal behavior in the classroom
        c. Provide a safe learning environment:
            - where content areas have the potential for causing emotional reactions, have a plan on how to handle reactions that support the trainee without distracting other trainees from their learning process.
            - to promote a climate of trust and mutual respect in training so that trainees feel supported enough to take risks to promote their learning and development.

d. Promote trainee acquisition of knowledge and skills.
e. Help trainees plan for application of learning to the job.

3. TRAINER PERFORMANCE

A. **Training Design**:

a. Demonstrate ability to write appropriate content for the instructional objectives
b. Demonstrate ability to organize instructional material in sequencing, integration of theory and practice, pacing of material, and depth of material in relation to audience
c. Demonstrate the information to be delivered is relevant, current, based on evidence based practice, current research, literature and/or law review and best practice
d. Demonstrate the ability to integrate BHS specific information and/or values.
e. Demonstrate understanding of adult learning theory in designing curriculum.
f. Incorporate a variety of methodologies to enhance learning
g. Demonstrate the ability to use feedback and evaluation data to revise training curriculum

B. **Integration of BHS**

Themes:

a. cultural competence
b. resilience
c. recovery
d. integrated co-occurring treatment
e. wrap-around

4. Competencies During Presentation of Training:

A. **Training Delivery:**

a. Demonstrate mastery of subject matter to be presented in curriculum
b. Make effective use of multiple presentation styles (lecture, facilitated discussion, small group breakouts, role plays, case examples, technology, and handouts) to illustrate key points in training.

NOTE:

- Not all presentation styles need to be incorporated during the training day.
- Technology may include the use of video clips, music, power point presentation, etc.

c. Clearly state identified competencies and learning objectives
d. Manage conflict
e. Encourage audience participation
f. Create an environment where participants feel safe to explore ideas and disagree
g. Provide clear instructions for activities
h. Provide learning opportunities for the variety of learning styles defined by Adult Learning Theory

Culturally Competent Program Annual Self-Evaluation (CC-PAS)

September 2016

County of San Diego Behavioral Health Services

Introduction

One of the Quality Improvement strategies in the County of San Diego Behavioral Health Services (SDCBHS) Cultural Competence Plan is to survey all programs to assess for culturally competent service provisions. Accordingly, all County and County-contracted programs are required to complete the Culturally Competent Program Annual Self-Evaluation (CC-PAS). In April 2016, the SDCBHS Quality Improvement Unit requested that each contracted Mental Health Services (MHS) and Alcohol and Drug Services (ADS) Program Manager complete the survey. A total of 221 programs responded to the survey: 128 clinical (20 ADS and 108 MHS programs) and 93 non-clinical (43 ADS and 50 MHS programs). The CC-PAS supports the SDCBHS' commitment to a culturally competent workforce and the guidelines described in the Cultural Competence Plan and Handbook. These documents can be located in the SDCBHS Technical Resource Library at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.

For more information contact the Quality Improvement, Performance Improvement Team at BHSQIPOG@sdcounty.ca.gov.

Background and Method

The CC-PAS tool was developed by the SDCBHS to be used by programs to rate themselves on their current perception of competence for providing culturally competent services. The CC-PAS protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC).

Clinical and Non-Clinical Google surveys were distributed via email to all County and County-Contracted Program Managers on April 1, 2016. The e-mail recipients were asked to complete the survey—one response per unique contract—by reviewing 20 cultural competence standards and determining if their program has Met, Partially Met, or Not Met each standard using the description of the standard noted for each category. The Program Managers also had the opportunity to indicate if they would like to receive technical assistance on any cultural competence standard. The responses were assigned a score (5 points for Met Standard, 3 points for Partially Met Standard, 1 point for Standard Not Met) and summed up for each program. The highest possible survey score was 100. For example, if a program responded 'Met' on all 20 standards, the total score was 100. This report summarizes the clinical and non-clinical MHS and ADS program responses and compares the results to the previous year.

What Does the Data Mean?

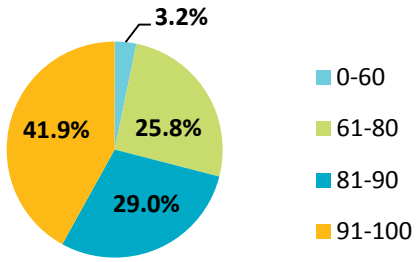
The CC-PAS results show that while the requests for technical assistance among the non-clinical programs have decreased for all cultural competence standards since the previous year, only two standards have been met by 100% of the program managers who responded. Furthermore, compared to the previous year, the proportion of the clinical program managers who indicated that they have met the standard has decreased for all but two standards. The program monitors are encouraged to continue enhancing the program managers' knowledge of the tools, resources, and trainings available through continuous discussion.

Non-Clinical CC-PAS Results and Technical Assistance Requests

There were **93 Non-Clinical CC-PAS surveys** submitted between April 4 and April 15, 2016.

- Scores ranged from **52** to **100**, out of a possible **100**. The average score was **85.4** (81.2 in 2015).
- **14.0%** (13.2% in 2015) of non-clinical programs reported that they met **ALL** cultural competence standards on the CC-PAS.
- **56.0%** (46.2% in 2015) of non-clinical programs reported that they met or partially met **ALL** cultural competence standards on the CC-PAS.
- **84.9%** (86.8% in 2015) reported that they partially met at least one of the standards (a total of 440 "partially met" responses).
- Similar to last year, the top 3 most unmet standards among non-clinical programs were:
  - o "*The program/facility has conducted a survey amongst its clients/target population to determine if the program is perceived as being culturally competent*" (**22 programs, 23.7%**).
  - o "*The program/facility has conducted a survey amongst its clients/target population to determine if the program's services are perceived as being culturally competent*" (**19 programs, 20.4%**).
  - o *"The program/facility supports/provides all staff training on the use of interpreters"* (**11 programs, 11.8%**).

Non-Clinical Programs - CC-PAS Scores†



† A high score on the CC-PAS does not always indicate a high level of cultural competence. When interpreting the scores, please consider that the results are based on the program managers' perception of program competence.

CC-PAS 2015 Results – Non-Clinical Programs N = 93 in 2016 (106 in 2015)	Programs that *Met or Partially Met* Standard			Technical Assistance Requests		
	2015	2016	Results Change	2015	2016	Results Change
1. The program/facility has developed a Cultural Competence Plan.	100.0%	98.9%	▼	10.4%	8.6%	▼
2. The program/facility has assessed the strengths and needs for services in its community.	100.0%	98.9%	▼	14.2%	6.5%	▼
3. The staff in the program/facility reflects the diversity within the community.	100.0%	100.0%	–	3.8%	0.0%	▼
4. The program/facility has a process in place for ensuring language competence of administrative services staff who identify themselves as bi- or multi-lingual.	89.6%	90.3%	▲	12.3%	4.3%	▼
5. The program/facility has a process in place for ensuring language competence of support staff who identify themselves as bi- or multi-lingual.	88.7%	93.5%	▲	14.2%	4.3%	▼
6. The program/facility supports/provides all staff training on the use of interpreters.	77.4%	88.2%	▲	20.8%	7.5%	▼
7. The program/facility uses language interpreters as needed.	88.7%	90.3%	▲	14.2%	4.3%	▼
8. The program/facility has a process in place for assessing cultural competence of all staff.	86.8%	94.6%	▲	18.9%	5.4%	▼
9. The program/facility has a process and a tool in place for all staff to self-assess cultural competence.	81.1%	90.3%	▲	21.7%	6.5%	▼
10. The program/facility has conducted a survey amongst its clients/target population to determine if the program is perceived as being culturally competent.	74.5%	76.3%	▲	15.1%	10.8%	▼
11. The program/facility conducted a survey amongst its clients/target population to determine if the program's services are perceived as being culturally competent.	76.4%	79.6%	▲	16.0%	9.7%	▼
12. The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards.	88.7%	93.5%	▲	23.6%	10.8%	▼
13. The program/facility supports cultural competence training of administrative services staff.	93.4%	95.7%	▲	8.5%	0.0%	▼
14. The program/facility supports cultural competence training of support services staff.	91.5%	98.9%	▲	8.5%	1.1%	▼
15. Services provided are designed to meet the needs of the community.	98.1%	94.6%	▼	5.7%	1.1%	▼
16. The program has implemented the use of any evidence-based practices or best practice guidelines appropriate for the populations served.	99.1%	98.9%	▼	12.3%	4.3%	▼
17. The program collects client outcomes appropriate for the populations served.	86.8%	91.4%	▲	4.7%	2.2%	▼
18. The program conducts outreach efforts appropriate for the populations in the community.	97.2%	100.0%	▲	7.5%	3.2%	▼
19. The program is responsive to the variety of stressors that may impact the communities served.	100.0%	98.9%	▼	11.3%	1.1%	▼
20. The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.	94.3%	98.9%	▲	14.2%	1.1%	▼

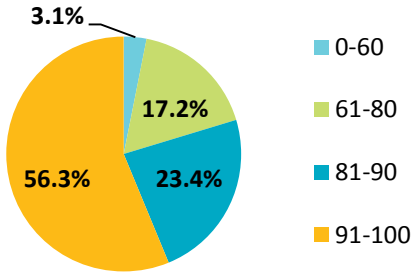
Please note: Red arrows mean negative change, while green arrows mean positive change. The direction of the arrows indicates increase/decrease in responses.

Clinical CC-PAS Results and Technical Assistance Requests

There were **128 Clinical CC-PAS surveys** submitted between April 4 and April 15, 2016.

- Scores ranged from **48** to **100**, out of a possible 100. The average score was **89.3** (89.6 in 2015).
- **20.3%** (13.1% in 2015) of clinical programs reported that they met **ALL** cultural competence standards on the CC-PAS.
- **82.8%** (81.5% in 2015) of clinical programs reported that they met or partially met **ALL** cultural competence standards on the CC-PAS.
- **79.7%** (86.8% in 2015) reported that they partially met at least one of the standards (a total of 506 "partially met" responses).
- The top 4 most unmet standards among clinical programs were:
  - "*The program/facility has a process and a tool in place for direct and support services staff to self-assess cultural competence*" (**12 programs, 9.4%**).
  - *"The program/facility supports/provides direct and indirect services staff training on the use of interpreters"* (**9 programs, 7.0%**).
  - "*The program/facility has conducted a survey amongst its clients to determine if the program is perceived as being culturally competent*" (**9 programs, 7.0%**).
  - *"The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards"* (**9 programs, 7.0%**).

Clinical Programs - CC-PAS Scores†



† A high score on the CC-PAS does not always indicate a high level of cultural competence. When interpreting scores, please consider that the results are based on the program managers' perception of program competence.

CC-PAS 2015 Results – Clinical Programs N = 128 in 2016 (130 in 2015)	Programs that *Met or Partially Met* Standard			Technical Assistance Requests		
	2015	2016	Results Change	2015	2016	Results Change
1. The program/facility has developed a Cultural Competence Plan.	100.0%	98.4%	▼	1.5%	3.9%	▲
2. The program/facility has assessed the strengths and needs for services in its community.	99.2%	98.4%	▼	4.6%	4.7%	▲
3. The staff in the program/facility reflects the diversity within the community.	100.0%	100.0%	–	2.3%	3.1%	▲
4. The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi- or multi-lingual.	98.5%	98.4%	▼	3.1%	6.3%	▲
5. The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi- or multi-lingual.	99.2%	98.4%	▼	2.3%	6.3%	▲
6. The program/facility supports/provides direct and indirect services staff training on the use of interpreters.	96.2%	93.0%	▼	6.9%	7.8%	▲
7. The program/facility uses language interpreters as needed.	96.9%	94.5%	▼	2.3%	3.1%	▲
8. The program/facility has a process in place for assessing cultural competence of direct and support services staff.	95.4%	95.3%	▼	4.6%	7.8%	▲
9. The program/facility has a process and a tool in place for direct and support services staff to self-assess cultural competence.	92.3%	90.6%	▼	5.4%	9.4%	▲
10. The program/facility has conducted a survey amongst its clients to determine if the program is perceived as being culturally competent.	93.8%	93.0%	▼	5.4%	5.5%	▲
11. The program/facility conducted a survey amongst its clients to determine if the program's clinical services are perceived as being culturally competent.	94.6%	93.8%	▼	5.4%	6.3%	▲
12. The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards.	96.9%	93.0%	▼	6.2%	6.3%	▲
13. The program/facility supports cultural competence training of direct services staff.	100.0%	98.4%	▼	0.8%	3.1%	▲
14. The program/facility supports cultural competence training of support services staff.	100.0%	96.9%	▼	1.5%	2.3%	▲
15. Services provided are designed to meet the needs of the community.	98.5%	98.4%	▼	2.3%	3.1%	▲
16. The program has implemented the use of any evidence-based practices or best practice guidelines appropriate for the populations served.	100.0%	98.4%	▼	3.1%	3.1%	–
17. The program collects client outcomes appropriate for the populations served.	96.9%	96.9%	▼	0.0%	3.9%	▲
18. The program conducts outreach efforts appropriate for the populations in the community.	96.2%	97.7%	▲	0.0%	3.1%	▲
19. The program is responsive to the variety of stressors that may impact the communities served.	100.0%	98.4%	▼	0.0%	6.3%	▲
20. The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.	100.0%	99.2%	▼	2.3%	7.0%	▲

Please note: Red arrows mean negative change while green arrows mean positive change. The direction of the arrows indicates increase/decrease in responses.

Technical Assistance Requests

Programs were asked to identify any standards for which their program would require technical assistance: 29.0% of all non-clinical programs (17 MHS and 10 ADS programs out of 93) and 21.1% of all clinical programs (21 MHS and 6 ADS programs out of 128) identified at least one cultural competence standard in which they would like technical assistance.

	1-5 standards		6-10 standards		11-15 standards		16+ standards	
	MHS	ADS	MHS	ADS	MHS	ADS	MHS	ADS
Non-clinical programs *(50 MHS and 43 ADS)*	17 34.0%	8 18.6%	– 0.0%	1 2.3%	– 0.0%	1 2.3%	– 0.0%	– 0.0%
Clinical programs *(108 MHS and 20 ADS)*	15 13.9%	6 30.0%	– 0.0%	– 0.0%	4 3.7%	– 0.0%	2 1.9%	– 0.0%

Requests among non-clinical programs for technical assistance in utilizing CLAS Standards have decreased since last year from 23.6% to 10.8%; requests among clinical programs for technical assistance have gone up for all but one Standard. *Program monitors will receive individual program reports and will discuss technical assistance requests with the program managers.*

Technical Assistance Requests – Cultural Competency Domains

The four Cultural Competency Domains are:

STANDARD GUIDELINES AND PROCEDURES	CLIENTS AND THE COMMUNITY	STAFF COMPETENCIES AND TRAINING	EVALUATION AND DATA COLLECTION

The Cultural Competency Domain where the clinical programs requested technical assistance (in order of the most need) was '**Staff Competencies and Training**'. The top three requests for technical assistance were:

STAFF COMPETENCIES AND TRAINING	Would you like Technical Assistance with providing a tool for staff to self-assess cultural competence? Would you like Technical Assistance with supporting/providing training on the use of interpreters? Would you like Technical Assistance with assessing cultural competence of staff?

The Cultural Competency Domain where the non-clinical programs requested technical assistance (in order of the most need) was '**Standard Guidelines and Procedures**'. The top three requests for technical assistance were:

STANDARD GUIDELINES AND PROCEDURES	Would you like Technical Assistance with surveying clients/target population about the program's cultural competence? Would you like Technical Assistance about utilizing CLAS Standards? Would you like Technical Assistance with surveying clients/target population about cultural competence of the program's services?

Conclusions/Next Steps

Next steps in the CC-PAS administration include:

- Disseminating results to interested parties and stakeholders such as the SDCBHS leadership, CCRT, the BHS Training and Education Committee (BHSTEC), Behavioral Health Education and Training Committee (BHETA), and QRC.

Next steps in CC-PAS analysis and review include:

- Providing individual program results to program monitors for contract monitoring activities.
- Continuing to track trends in technical assistance needs and CC-PAS scores.

Next steps also include linking the CC-PAS with other cultural competence measures and information for a snapshot of cultural competence. Narratives, scores, and responses on the State-mandated California Brief Multicultural Competence Scale (CBMCS)—which identifies individual training needs in the delivery of culturally competent behavioral health services—and the submitted Cultural Competence Plans will be used in conjunction with the CC-PAS to measure systemwide cultural competence and cultural competency strengths and areas for improvement.

The California Brief Multicultural Competence Scale (CBMCS) Report

July 2016

Prepared by Behavioral Health Services Quality Improvement,
Performance Improvement Team
Data Source: CBMCS Survey, 2015
Date: 7/22/2016

CBMCS Report

July 2016

BACKGROUND

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumers, and family members to work effectively in cross-cultural situations.

In alignment with the *Live Well San Diego* vision, the Health and Human Services Agency Behavioral Health Services (BHS) Division continually works toward the complete integration of mental health and alcohol and other drug services. Within this integration, BHS is working to fully incorporate the recognition and value of racial, ethnic, and cultural diversity, and sees the creation of a truly culturally competent and trauma-informed Behavioral Health System as a developmental process. These efforts are demonstrated through BHS' commitment to cultural competence and the trauma-informed systems' efforts to continuously enhance strategies in: reducing racial, ethnic, cultural, and linguistic disparities; strengthening cultural competence evaluation and training activities; developing a multi-cultural workforce; and integrating BHS. To support the needs of our diverse populations, the County of San Diego Behavioral Health Services (SDCBHS) recommends that all providers be committed to prioritizing cultural competence by: incorporating cultural competence throughout the providers' mission statements, guiding principles, and policies and procedures; developing or enhancing the Cultural Competence Plan; periodically evaluating staff and programs; and ensuring that clinical practice is based on cultural awareness, knowledge, and skills.

To assist programs with developing a plan to enhance the cultural competence of their staff and their current capability for providing culturally competent services, the SDCBHS has developed a Cultural Competence Handbook. The Handbook contains resources, tools, and assessments to assist the programs with the efforts to enhance cultural competence levels among staff. The CBMCS survey is one of the tools in the Handbook and was developed in response to the request of the California Mental Health Directors Association for a standardized cultural competency assessment tool. The evidence-based, replicable 21-item scale measures individual, self-reported multi-cultural competency and training needs of behavioral health staff in the following four areas: multicultural knowledge; awareness of cultural barriers; sensitivity and responsiveness to consumers; and socio-cultural diversities. This report analyzes data from the CBMCS survey that was distributed to BHS' Children, Youth, and Families (CYF) and Adult/Older Adult (A/OA) program staff in the fall of fiscal year 2015-16.

KEY FINDINGS

CYF Programs

- A total of 849 staff from 115 CYF programs responded to the CBMCS survey – a slight decrease from the previous survey period in 2013. The number of respondents per program ranged from one to 60. The majority of the staff who responded to the survey provide direct services, and the greatest proportion of all respondents has been in the behavioral health field between two and five years.
- More than half of the respondents indicated proficiency in all four areas of cultural competence, with the largest proportion of the respondents' scores indicating proficiency in the area of Sensitivity & Responsiveness to Consumers.
- Socio-Cultural Diversities was the area of the greatest need for additional training among the respondents.
- Similarly, the analysis of the aggregate program scores (versus individual respondent scores) shows the greatest proficiency in the area of Sensitivity & Responsiveness to Consumers, while the greatest need for additional training in the area of Socio-Cultural Diversities. This is consistent with the previous survey period in 2013.

A/OA Programs

- A total of 829 staff from 138 A/OA programs responded to the CBMCS survey – a decrease from the previous survey period in 2013. The number of respondents per program ranged from one to 30. The majority of the staff who responded to the survey provide direct services, and the greatest proportion of all respondents has been in the behavioral health field between two and five years.
- Nearly half of the respondents indicated proficiency in all four areas of cultural competence; with the largest proportion of the respondents' scores indicating proficiency in the area of Sensitivity & Responsiveness to Consumers.
- Awareness of Cultural Barriers was the area of the greatest need for additional training among the respondents.
- The analysis of the aggregate program scores (versus individual respondent scores) shows the greatest proficiency in the area of Sensitivity & Responsiveness to Consumers, with the greatest need for additional training in the area of Socio-Cultural Diversities. This is consistent with the previous survey period in 2013.

What Do The Results Mean?

- The aggregate survey results suggest the most need for additional training among all behavioral health staff in the areas of Awareness of Cultural Barriers and Socio-Cultural Diversities, consistent with the previous survey period in 2013. However, a closer look at the score distribution of individual responses shows a need for additional training in all four areas of cultural competence.
- While the largest proportion of the respondents whose scores indicated a need for additional training in cultural competence have been working in the field of behavioral health for more than five years, the training should focus on all staff regardless of experience in the field.

SURVEY METHOD

The areas of the CBMCS measure the following aspects of cultural competence:

Multicultural Knowledge	Includes recognizing deficiencies in research conducted on minorities; psychosocial factors to consider when providing services to a culturally diverse consumer population; providing a culturally competent mental health assessment; diagnosis and understanding; and evaluating wellness, recovery, and resilience.
Awareness of Cultural Barriers	Includes awareness of self (cultural self-awareness, worldview, racial/ethnic identity) and awareness of others (oppression, racism, privilege, gender differences, sexual orientation).
Sensitivity & Responsiveness to Consumers	Includes acknowledgement and understanding of divergent social values; communication styles; and ability to understand consumers' experiences of racism, oppression and discrimination.
Socio-cultural Diversities	Includes knowledge of socio-cultural groups in which ethnicity may not be the major or immediate focus of professional attention (i.e., age, gender, sexual orientation, social class, physical-mental intactness, and disability status); awareness of bias, oppression and discrimination experienced by members of socio-cultural groups; and knowledge about best practices and treatment considerations for members of socio-cultural groups.

SCORING

The answers to each of the 21 survey questions were assigned a number and totaled according to the pre-determined areas of cultural competence. The scores were then analyzed based on thresholds to identify proficiency levels and training needs among the respondents.

Area of Cultural Competence	Rating Scale	Score Range	Result Thresholds
Multicultural Knowledge	4-point Likert Scale: 1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree	5 – 20	5-11 = in need of training 12-20 = proficient
Awareness of Cultural Barriers		6 – 24	6-17 = in need of training 18-24 = proficient
Sensitivity & Responsiveness to Consumers		3 – 12	2-8 = in need of training 9-12 = proficient
Socio-cultural Diversities		7 – 28	7-19 = in need of training 20-28 = proficient

GENERAL RESPONDENT INFORMATION

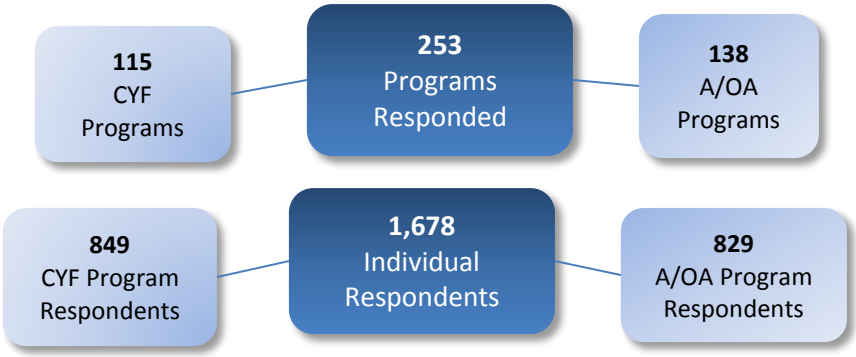
1,678 staff from 253 behavioral health programs completed the survey, (*39 individuals did not indicate a program name*).

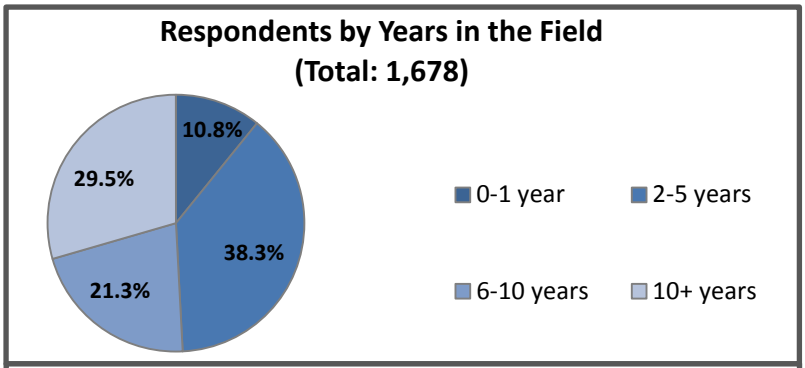
While a large proportion of the respondents were born in the United States (81.6%), staff indicated 59 countries of origin on the survey. Furthermore, the respondents indicated a total of 49 spoken languages and/or dialects, with a large number of respondents indicating that they speak between two and six languages. The majority of the respondents (58.2% or 977) indicated English as the only spoken language.

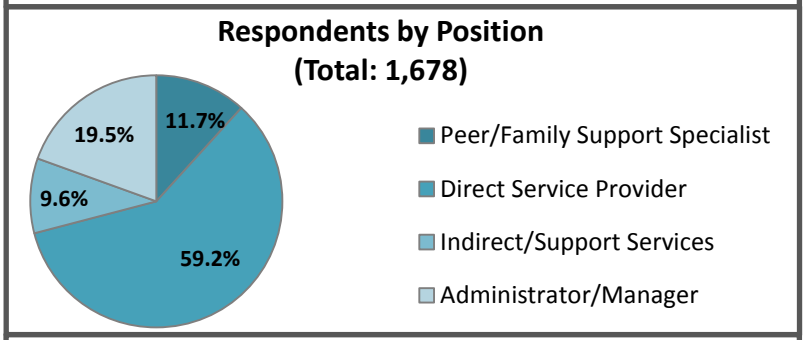
The largest proportion of the respondents have between two and five years of experience working in the behavioral health field (38.3% or 643), followed by the respondents with 10 or more years of experience (29.5% or 495).

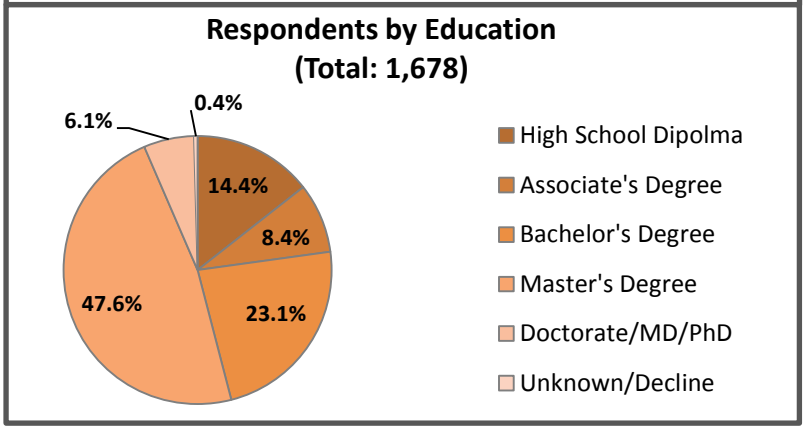
Direct service providers represent the majority of the respondents (59.2% or 993).

Additionally, when looking at education level, individuals with a Master's degree represent the largest proportion of the respondents (47.6% or 798).









Data Source: CBMCS Survey, 2015
BHS QI PIT (DD, CG) | 7/22/16

PROFICIENCY AMONG RESPONDENTS: AGGREGATE RESULTS

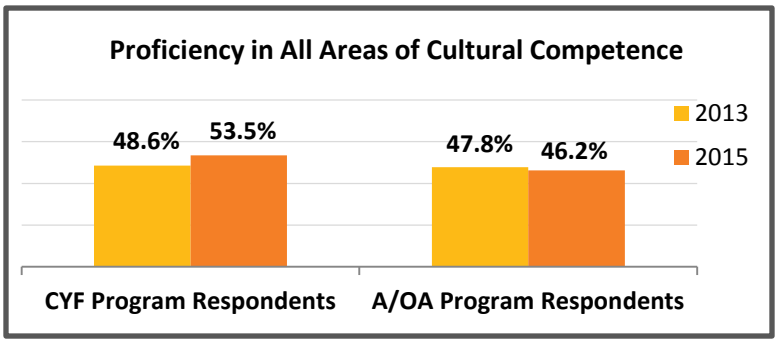
Scores for nearly half of all respondents (9.9% or 837) indicate proficiency in all four areas of cultural competence – a 10% decrease from the last CBMCS survey period.

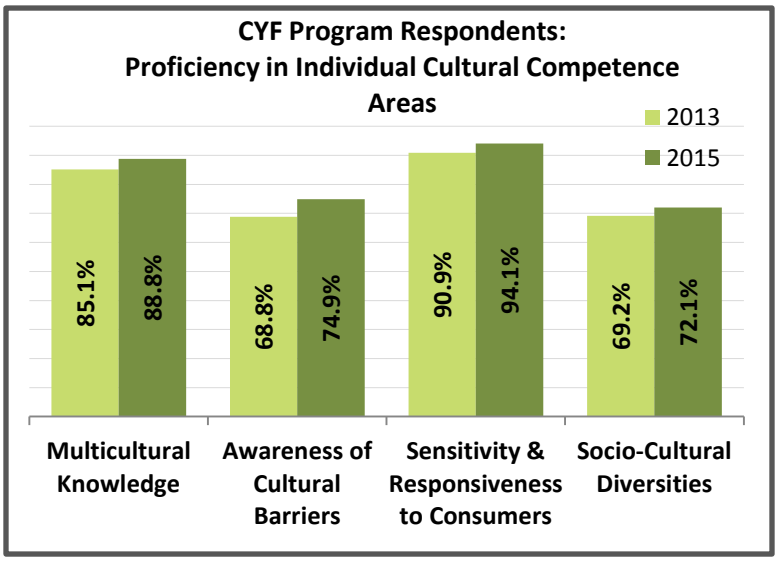
More than half of CYF program respondents' (53.5%) and nearly half of A/OA program respondents' (46.2%) scores indicate proficiency in all four areas of cultural competence. Compared to the previous survey period, there was a 5% increase in the overall proficiency among the CYF program respondents and a slight decrease (1.5%) in the overall proficiency among the A/OA program respondents. Additionally, more than half of all MHS program respondents (51.4% or 715) and slightly under half of ADS program respondents (41.5% or 110) indicated proficiency in all four areas of cultural competence.

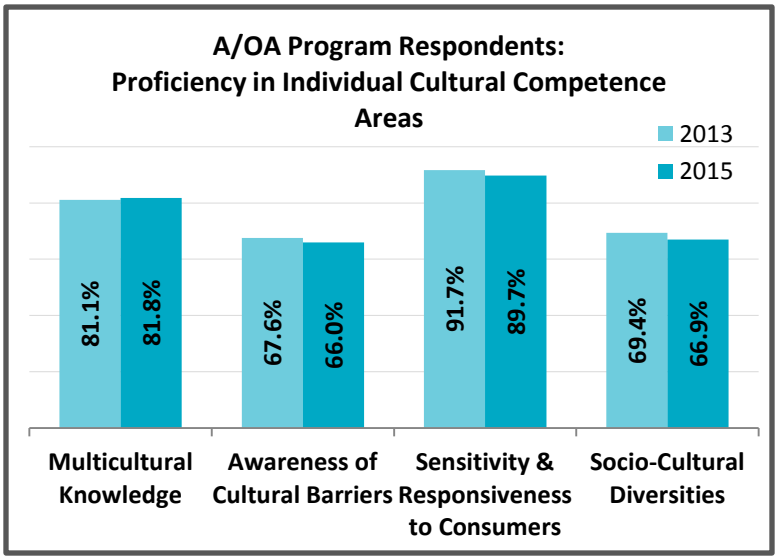
One third of the respondents (37.2%) have 6-10 years of experience in the behavioral health field, followed by the respondents with 2-5 years of experience (32.3%). When looking at education level, individuals with a Master's degree represent the majority of the respondents (63.9%), followed by the respondents with a Bachelor's degree (17.7%).

Compared to the previous survey period, the proficiency among the CYF program respondents has increased for all four individual areas of cultural competence, with the largest increase (6.1%) in the area of Awareness of Cultural Barriers. In contrast, the proficiency among the A/OA program respondents has decreased slightly with an exception of the area of Multicultural Knowledge which has remained the same.

It is important to note that the areas of Awareness of Cultural Barriers and Socio-Cultural Diversities had the least number of the respondents whose scores indicated proficiency among CYF and A/OA program respondents.





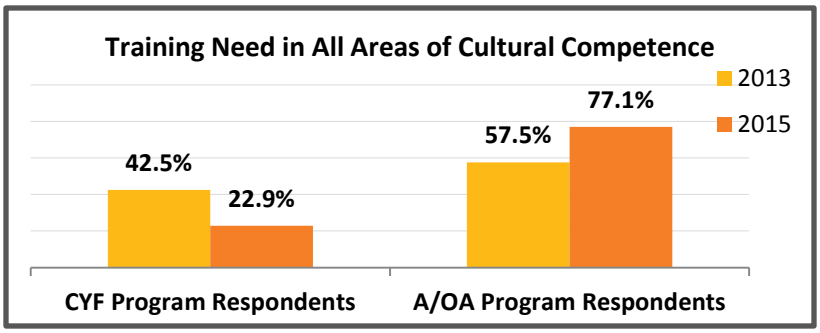


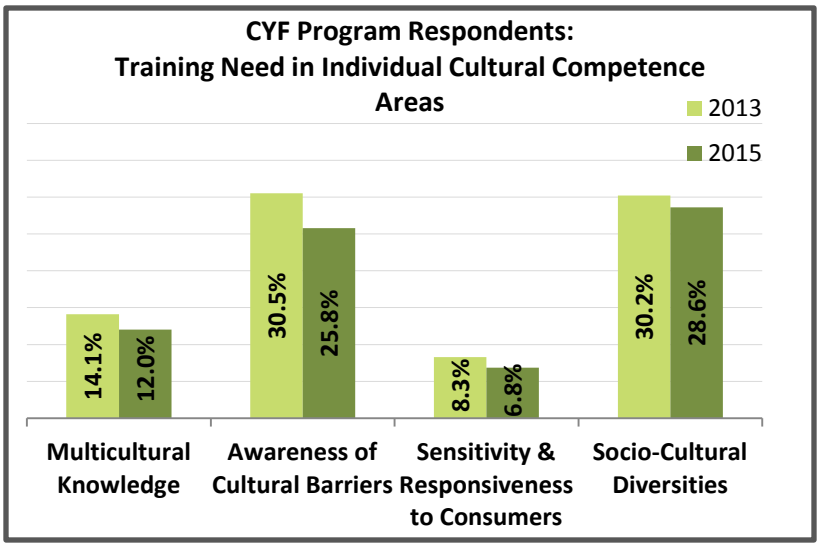
TRAINING NEEDS AMONG RESPONDENTS: AGGREGATE RESULTS

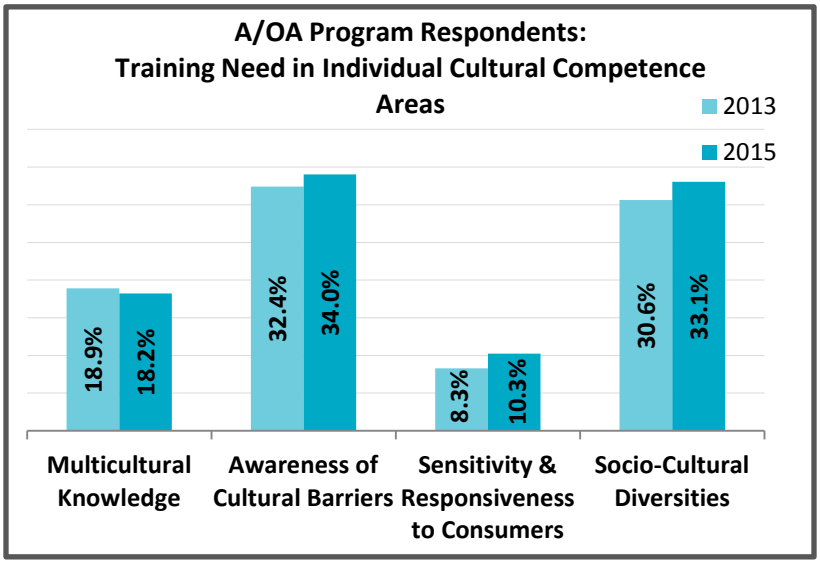
Overall, a very small proportion of the respondents' scores indicate a need for additional training in all four areas of cultural competence (2.9% or 48) – a 20% increase from the last CBMCS survey period in 2013. Compared to the previous survey period, there was a 20% decrease in the proportion of the CYF program respondents and a 20% increase in the proportion of A/OA program respondents whose scores indicate a need for additional training.

One third of the respondents (35.4%) have 2-5 years of experience in the behavioral health field, followed by the respondents with 6-10 years of experience (22.9%). When looking at education level, individuals with a high school diploma represent the majority of the respondents whose scores indicate a need for additional training (52.1%), followed by the respondents with an Associate's degree (16.7%). It is also important to note that the proportion of the respondents with a Bachelor's degree whose scores indicate a need for additional training has decreased by nearly 16% (from 32.5% to 16.7%).

Compared to the previous survey period, additional training needs among the CYF program respondents have decreased for all four individual areas of cultural competence, with the most significant increase (4.7%) in the area of Awareness of Cultural Barriers. In contrast, additional training needs among the A/OA program respondents for the individual areas of cultural competence have increased with an exception of the areas of Multicultural Knowledge which decreased very slightly.







CBMCS Report

July 2016

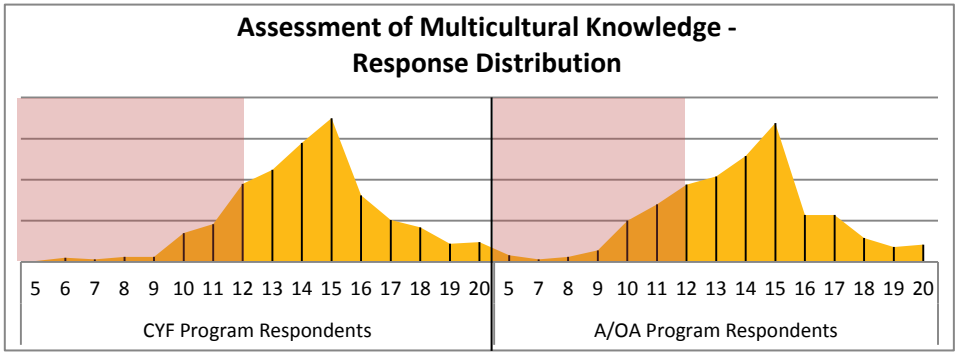
ASSESSMENT OF INDIVIDUAL RESPONSE DISTRIBUTION

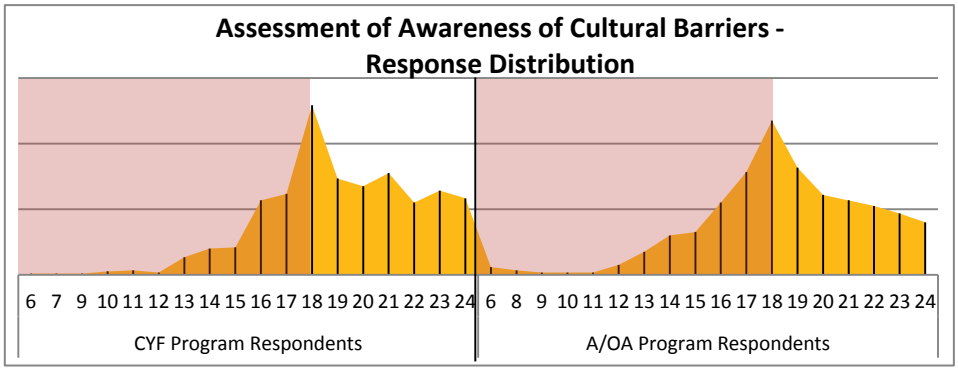
Assessment of Response Distribution

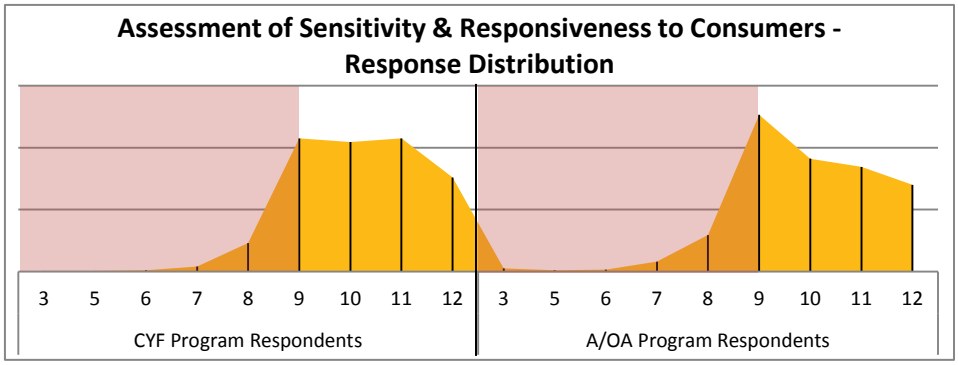
The CBMCS scoring tool definitively categorizes the respondents into two predetermined groups (proficiency or training need); however, the distribution of individual responses in these charts shows that many respondents scored closer to the cut-off between proficiency and training need (with an exception of the area of Multicultural Knowledge).

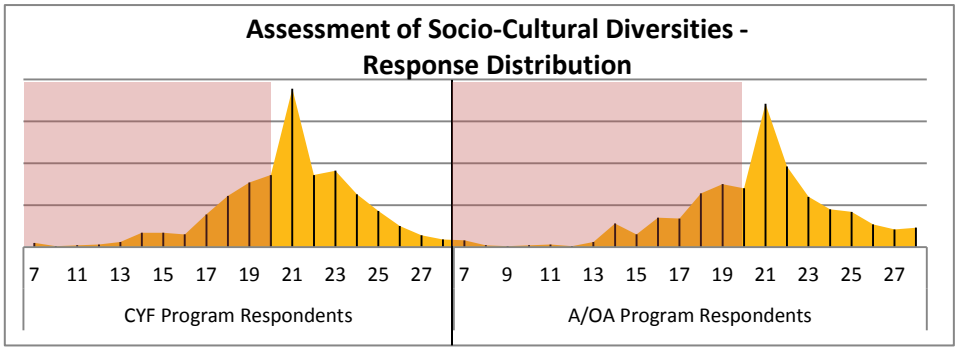
The shaded area highlights the scores that fall below the threshold (see page 3) and indicate a training need. **This breakdown demonstrates that the results of the survey might not be as conclusive as they appear from aggregate data, indicating a greater need for additional training in all areas of cultural competence regardless of the aggregate results that place the scores on either side of the scoring threshold.**

Multicultural Knowledge: a large proportion of CYF and A/OA program respondents scored between 12 and 16.
Awareness of Cultural Barriers: the largest number of CYF and A/OA respondents scored 18 – the cut-off number between proficiency and training need.
Sensitivity & Responsiveness to Consumers: the largest number of respondents scored 9 – the cut-off score.
Socio-Cultural Diversities: the largest number of CYF and A/OA respondents scored 21 – one point above the cut-off score.









See page 3 of the report for the breakdown of the scores.

Data Source: CBMCS Survey, 2015
BHS QI PIT (DD, CG) | 7/22/16

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Beneficiary Packet Materials Order Request Form

This form is for hard copy requests only.

All forms are available in the electronic format on www.optumsandiego.com.

To request a **hard copy** of Mental Health Plan materials, please complete the form below by indicating the number of copies you would like to receive in the designated box for your preferred language. If you would like to receive the materials in the **audio** or **large print** formats, please contact BHSQIPIT@sdcounty.ca.gov.

Program Name:						
Contact Person:		Phone Number:				
PLEASE CHECK:	☐ Inpatient or 24 hour care facility	☐ Outpatient				
County of San Diego Mental Health Plan Materials		*Specify amount needed in the preferred language box*				
		English	Spanish	Vietnamese	Arabic	Tagalog
County of San Diego Guide to Medi-Cal Mental Health Services (8/2013)						
Quick Guide to Mental Health Services for Adults, Older Adults, and Children brochure (7/2014)						
Grievance and Appeal Procedures brochure (3/2012)						
Grievance and Appeal Client Form (1/2016)						
Self-Addressed envelopes for grievances and appeals (1/2016)						
Grievance and Appeal poster (4/2012)						
MHP's Notice of Privacy Practices (MHP-NPP) (12/2014)						
Advance Directive brochure (3/2012)						
Access and Crisis Line posters (2015)						
Limited English Proficiency (LEP) posters (12/2002)						
Recovery Brochures (Eng: 8/2013 | Sp: 9/2011)						
Fee-For-Services Provider List (8/2015)						
Behavioral Health Services Provider Directory (8/2015)						
California Regulation-Physicians Notice to Patients						

SUBMIT FORM

Mail or fax requests to ATTN: Reception Desk

Mailing Address	Interoffice Mail	Fax
Health and Human Services Agency Behavioral Health Services Division 3255 Camino del Rio South San Diego, CA 92108	Mail Stop P531-J	(619) 584-5080

Questions? (619) 563-2700

Name: [redacted] Case#: [redacted] Page: 1 of 2
Type: Client Plan Date: 07/06/2015 - 07/05/2016
Printed on 04/08/2016 at 09:46 AM (Final Approved)

Individual Progress Note (08/11/2015)

			Start	Duration
Form#:	[redacted] Date: 08/11/2015	Service:		1:32
		Travel:		0:21
Unit:	UPAC MULTI COMM COUNSEL MHSA	Documentation:		0:16
SubUnit:	UPAC MCC MHSA			
Server:	PAT, CARMEN (00131)	Total Server Time:	2 Hours, 9 Minutes	
Supervisor:		Participants:	0	
Service:	PSYCHOTHERAPY- FAMILY 32	Days:	0	
Lab:		Quantity:	0	

Provided To:	Client and Family	Provided At:	Home
Outside Facility:		Contact Type:	Face to Face
Appointment Type:	Scheduled	Billing Type:	Not Applicable
Intensity Type:	NOT APPLICABLE		

Progress Note

7440/7441
FAMILY THERAPY PROGRESS NOTE

FAMILY CURRENT PRESENTING PROBLEM/S AS RELATED TO CLIENT'S TREATMENT (May include client's potential for harm, changes from previous visits, cognitive capacity, complaints, precipitators, strengths, appearance):
[redacted] traveled from Golden Hill neighborhood to Lincoln Park neighborhood for a scheduled session. Both clt and mo presented with euthymic mood and were engaged with each other and T throughout the session. Mo exhibited a tendency to speak tangentially and at length, and clt was observed to get frustrated in response, as evidenced by fidgeting, sighing, and raising her voice slightly in order to clarify questions for mo or attempt to redirect mo.

THERAPEUTIC INTERVENTION:
1) T informed clt and mo about the limits of confidentiality, T's role as a mandated reporter, and T's status as a trainee under the supervision of a licensed therapist.

2) T inquired about the strengths that clt and mo observe in each other and in their relationship for the purpose of identifying the positives in their family situation.

3) T used circular questions in order to identify clt and mo's interactional pattern when communicating about mo's boyfriend. T utilized a cognitive-behavioral chart for the purpose of highlighting clt's and mo's thoughts, feelings, and behaviors related to their interactional pattern.

4) T used open-ended and close-ended questions for the purpose of exploring clt's and mo's relational history. T listened empathetically and validated clt's and mo's feelings in order to build rapport and to encourage further emotional expression.

5) T utilized a miracle question for the purpose of identifying clt's and mo's solutions to the problem. T provided psychoeducation regarding the goals and format of therapy for the purpose of addressing mo's expectations regarding therapy and increasing mo's motivation to participate in therapy with clt.

RESPONSE TO TREATMENT:
1) Clt and mo verbally expressed understanding of the limits of confidentiality, T's role as a mandated reporter, and T's status as a trainee under supervision.

2) Mo stated that clt is a "good daughter" and reported that she and daughter have not had any

Individual Progress Note (08/11/2015)

arguments in the last week. Mo enjoyed coordinating clt's quinceanera and dancing with clt last week. Clt stated that mo is a hard worker and that she and mo are close. Clt expressed appreciation for her mo's efforts in coordinating her quinceanera for her.

3) Clt and mo reported that they have arguments when mo wants to spend time with her boyfriend. They also have arguments related to mo's decision-making related to marrying boyfriend. Clt reported that she thinks, "She would rather spend time with me" and "I'm afraid of losing my mom," feels sad, and responds by ignoring mo and talking instead to her sister. Mo reported that, in response, she thinks, "Maybe she's right, maybe I should wait," feels confused, and responds by putting off decisions related to boyfriend. Mo expressed her worry that clt and boyfriend's son will not get along and identified this concern as a major hindrance to making decisions in her relationship with boyfriend.

4) Mo reported that clt previously lived with her father in Tijuana while mo lived and worked in the US; therefore they had limited contact with each other. When clt first came to live with mo, she behaved aggressively and would yell at mo. Clt stated that she was angry that mo worked so much instead of spending time with her. Clt identified her father's death as a turning point for her relationship with mo, stating, "It was just us. There was no one else." Clt reportedly realized then that mo worked hard in order to care for her. Mo stated that her own experience of getting very sick has led her to believe that she needs to "stay strong and be there" for her family. Mo stated, "I don't stop working." Clt and mo have now lived together for 2 years. Clt's older sister and child joined the household 4 months ago.

5) Mo reported that she does not want to see any change, stating, "We're okay. There are no problems. Everything has been good since the party." Mo stated that she appreciates that clt has been able to value her more since the party. Clt reported that she would like mo to notice when she does not like something or does not want to do something and to accept it instead of trying to force her to like it (e.g., getting along with the son of mo's boyfriend). Both clt and mo expressed understanding of the goals and format of therapy and agreed to alternating weekly individual and family therapy sessions for the remainder of the month.

CLIENT'S PROGRESS TOWARD MEASURABLE GOALS/OBJECTIVES:
Clt has not had anger outbursts or arguments with mo in the past week. Clt and mo both express a need for more effective conflict management and communication skills.

PLAN OF CARE (Include indicated client plan changes, next steps, referrals given):
T will continue to meet with clt for individual and family therapy sessions. T will work with clt and mo to develop and improve emotion regulation, conflict management, and communication skills so as to promote satisfactory levels of individuality and cohesion between clt and mo.

OTHER INFORMATION:
Session #5 of 13
This session was provided in English and Spanish using an interpreter.

Obj: 1.1.1 Learn/Practice Coping Skills

Name: PAT, CARMEN (00131), TRAINEE 12277 Electronically Signed	Date: 08/18/2015	Time:	Electronic
Name: JUSTICE, LINDA (00131), MFT 10840 Electronically Signed	Date: 08/25/2015	Time:	Electronic

County of San Diego Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT

Program Name: CRF IMPACT FSP

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: ⊙ None ○ LPS ○ Probate ○ Temporary

Case Manager: ○ None ○ SBCM ⊙ FSP ○ Institutional ○ Regional Center ○ Other

Payee: none

Probation Officer:

SOURCE OF INFORMATION:
Client
Previous Assessment

If a source other than listed on the "Source of Information" table, specify:

Reports Reviewed:

Previous Assessment Bayview Hospital dated 12/28/2015, 11/12/2015, 11/13/2015, and 12/14/2015. San Diego County Criminal Backgound Check and Warrant Search dated 1/4/2016.

Referral Source: FFS Hospital

If Other, specify: BAYVIEW HOSPITAL

PRESENTING PROBLEMS/NEEDS:

Client is a 39 y.o. Hispanic, spanish speaking, heterosexual, unemployed, single female with a long hx of chronic mental illness. Client was referred by Bayview Hospital for intensive case management, psychiatric care, and housing support services. Client is not currently conserved, and is homeless due to severity of her mental health sx's. Clinician met with Client at her B+C to complete this assessment. Client was discharged today from Bayview to her B+C. Clinician utilized a spanish speaking interpreter, as Client speaks spanish only at this time.

Spanish + PN.

During today's assessment, Client presents AAO x 2, fair hygiene, and casually dressed. Client presents as a poor historian, intellect was difficult to assess, as Client provided minimal information, and she did not appear to be internally pre-occupied. Client presented in child-like manner, with labile affect, and anxious mood, as she would be very calm, and quiet, and then suddenly begin to cry loudly, bang her fists on the table, and then abruptly stand up and walk out of the house and down the street. Client appeared to be easily stimulated/overwhelmed by completing paperwork, as she would often get up and leave when Clinician would review paperwork and ask her to complete forms/sign paperwork. Client maintained minimal eye contact throughout the assessment, and she needed constant redirection from Clinician, to complete this initial assessment.

Presenting Problem: Client has been hospitalized for the past 82 days for grave disability, as she was BIB SDPD/PERT on a 5150 hold for danger to others. Client presented as extremly disorganized in her thought process and unable to verbalize the context of her current hospitalization, and she was heavily responding to internal stimuli. Client was on a 5150 hold because she had a physical/verbal altercation directed towards her mother and sister for unknown reasons. Client is currently homeless, as she was living with family in San Diego, however due to her psychotic sx's and hx of aggressive bx when she is not stable, Client's

Individual Progress Note (02/01/2016)

Form#:	[redacted] Date: 02/01/2016		Start / Duration
		Service:	0:41
		Travel:	0:00
Unit:	CRF IMPACT FSP	Documentation:	2:54
SubUnit:	CRF IMPACT FSP MHSA		
Server:	RINAS, KERRI (00142)	Total Server Time:	3 Hours, 35 Minutes
Supervisor:		Participants:	0
Service:	PLAN DEVELOPMENT 13	Days:	0
Lab:		Quantity:	0

Diagnoses: F20.3 - Undifferentiated schizophrenia

Provided To:	Client	Provided At:	Home
Outside Facility:		Contact Type:	Face to Face
Appointment Type:	Scheduled	Billing Type:	Not Applicable
Intensity Type:	NOT APPLICABLE		

Progress Note

3400/3401

PLAN DEVELOPMENT PROGRESS NOTE

CURRENT CONDITION (Include complaints, symptoms, appearance, cognitive capacity, changes from previous visits, potential for harm, precipitators, strengths): Clinician met with CLT at B+C to complete her Client Plan. CLT did not endorse or present with SI/HI. CLT presents AO x 2, anxious mood, cooperative, evasive at times, and minimally engaged. Client appears to minimal/no insight into her mental illness. During today's session CLT did not appear to be responding to internal stimuli. CLT's strength during session: Client was unable to identify her goal for today.

THERAPEUTIC INTERVENTION: Clinician assessed for SI/HI. Clinician utilized motivational interviewing skills to engage client in discussion about her coping skills and strengths, and build rapport with CLT. Clinician spent most of the time walking side by side with Client (and Interpreter) to complete her Client Plan, as she struggles to sit for more than a few minutes at a time. Clinician engaged CLT in discussion of her areas of need, goals, strengths, and objectives to begin her Client Plan. Clinician validated her depressed mood, as this is a change from being in the hospital for the past 82 days. Clinician used Mot Int to elicit change talk, and increase her motivation to provide more detailed/clear responses to identifying her strengths and objectives in her Client Plan, as she often provided unclear answers/bizarre answers, or replied "no."

RESPONSE TO TREATMENT: CLT was fairly cooperative and appeared to have minimal/no insight into her mental health sx's, struggled to identify her strengths of alert, support system and hobbies and she identified (with assistance from Clinician) her future oriented goals during session to maintain long term housing, avoid hospitalization, work towards med compliance, and utilize her support system. CLT struggled to identify specific examples or measurable objectives in her client plan. Client would often eat paper napkins, when she felt anxious sitting down.

PROGRESS TOWARDS GOALS: CLT has minimal progress towards her goals, without assistance from intensive case management services, such as IMPACT.

PLAN OF CARE (include indicated client plan changes, next steps, referrals given): refer to Client Plan for additional information

Individual Progress Note (02/01/2016)

OTHER INFORMATION: Please refer to client plan for additional information. No travel time accounted for, as this was completed same day as psychiatric assessment. Client was provided with Spanish speaking interpreter, as Client's primary language is Spanish.

Obj: 1.1.1 Learn to Identify Symptoms

Name: RINAS, KERRI (00142), LCSW 10944 Electronically Signed	Date: 02/08/2016	Time:	Electronic
Name:	Date:	Time:	N/A

County of San Diego Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT

Program Name: UPAC MIDTOWN CENTER

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: ⊙ None ○ LPS ○ Probate ○ Temporary

Case Manager: ⊙ None ○ SBCM ○ FSP ○ Institutional ○ Regional Center ○ Other N/A

Vietnamese ✓

Payee: None

Probation Officer: None

SOURCE OF INFORMATION:
Client
Previous Assessment

If a source other than listed on the "Source of Information" table, specify: N/A

Reports Reviewed:

N/A

Referral Source: Self/Family

If Other, specify: N/A

PRESENTING PROBLEMS/NEEDS:

3000/3002, 11/19/2015, Annual Update

Client is a 61 y/o monolingual, separated, unemployed, 2 adult children, Vietnamese male who has been receiving MH services from UPAC-CTC since 2011. CLT diagnosed with PTSD and MDD moderate. CLT mainly received medication management services over the past 12 months.

CLT arrived on time for his annual update appointment with this writer. CLT appeared good hygiene with gray jacket, black pants, and black shoes with baseball cap. CLT was alert, oriented 4x, speech was pressured, thought process was coherent, behavior was cooperative, intellect was average, mood was depressed and anxious, memory was normal. CLt motor was slowed, judgment and insight were age appropriate. CLT denied AH/VH/SI/HI at this time. No psychiatric hospitalized over the past 12 months.

There are not so many changes from last year, CLT still experiencing follow sxs; anxiety, depressed mood, anhedonia, nightmares, AH, lack of energy, feeling of irritability and agitation, back pain and headaches, flash backs, hypervigilance, loss of motivation, fatigue. CLT reported he was imprisoned 8 years and tortured during the Vietnam War, still having nightmares related it such as tortured , and related AH such as people are calling his names and talking. CLT complained lots of physical pain and reported "communist tortured me, and broken my spine". When asked what would happen if CLT skipped the medication from UPAC-CTC for 3 days, CLT answered, "My mind will not clear, I will be angry, I won't sleep". Client denies CAH, VH, SI, HI.

CLT currently lives with younger brother, who provide client with financial supports as well as ADL support. CLT reported his daily schedule as eat, sleep, going to catholic church every week, exercise which is walking 2 times a day, 40 minutes each time with his nephew. CLT

denied history/current use of alcohol, drugs and smoking at this time.

CLT prescribed on Doxepin 50mg, Ambien 10mg. CLT takes meds as prescribed. CLT reported no side effect from the meds.
CLT next NP appointment scheduled on 02/09/2015 at 9:30am.
The session was conducted in Vietnamese with the help from an interpter.

PAST PSYCHIATRIC HISTORY:

3000/3002, 11/19/2015, Annual Update

No psychiatric hospitalized over the past 12 months.

FAMILY HISTORY:

Living Arrangement: House or Apt w/ Support

Those living in the home with client:

Client lives with a brother and brother's family. Client lives with younger brother, who provide client with financial supports as well as ADL support (cooking, cleaning, ensuring client gets into the bath safely).

Have any relatives ever been impacted by the following:
(Select from Relatives table listed in the Instructions Sheet): Expand below if applicable.

Suicidal thoughts, attempts:

Violence:

Domestic violence:

Substance abuse or addiction:

Other addictions:

Gang involvement:

Emotional/mental health issues:

Physical health conditions:

Intellectual developmental disorder:

Developmental delays:

Arrests:

Abuse:

Abuse reported: ⊙ N/A O No O Yes O Refuse/Cannot Assess

Include relevant family information impacting the client:

Clietn reprots he is the third oldest of his siblings. Clietn has a total of 10 brothers. His two oldest brothers died in the war before 1975; they were both in the military. Client reports three sisters. Client reports mother is mother 92 y/o and father fied at age 87 y/o. Client reports he and wife have been separated for nearly 10 years; client reports he does not know where is ex-wife or adult children are living. Client reports he belives his daughter is in her 30s and his son is 19 y/o. Client reports he speaks to childrens limitedly, noting he

Name: [redacted] Case#: [redacted] Page: 1 of 2
Type: Client Plan Date: 11/12/2015 - 03/31/2016
Printed on 04/08/2016 at 10:03 AM (Final Approved)

Individual Progress Note (01/19/2016)

			Start	Duration
Form#:	[redacted] Date: 01/19/2016	Service:		1:12
		Travel:		
Unit:	UPAC MULTI COMM COUNSEL MHSA	Documentation:		0:17
SubUnit:	UPAC MCC MHSA			
Server:	DU, YEN (00131)	Total Server Time:	1 Hour, 29 Minutes	
Supervisor:		Participants:	0	
Service:	COLLATERAL 33	Days:	0	
Lab:		Quantity:	0	

Diagnoses: F20.9 - Schizophrenia, unspecified

Provided To:	Family / Legal Guardian	Provided At:	Office
Outside Facility:		Contact Type:	Face to Face
Appointment Type:	Scheduled	Billing Type:	Not Applicable
Intensity Type:	NOT APPLICABLE		

Progress Note

7440/7441:
Mo drove to MCC's office to meet with T for the scheduled appt, T met with Mo immediately after her appt. with FSP. Meeting was held in one of the therapy room.

Therapeutic Interventions:
1) T provided Mo the space and time to reflect and discuss about clt's recent "cycle" of sxs, for the purpose of tracking the severity of sxs. In addition, T asked additional questions to assess the onset of new sxs that clt exhibited during this recent "cycle".
2) T spent an extensive amount of time providing Mo culturally appropriate psychoeducation about Schizophrenia and related sxs, to help Mo better understand the challenges and bxs that clt exhibits. T provided examples of how sxs of Schizophrenia can affect one's level of functioning, to help Mo understand limitations and identify appropriate expectations for clt. T utilized different metaphors to explain and help Mo understand the bxs that clt exhibit due to the lack of appropriate coping skills and/or sxs management skills, for the purpose of exploring effective ways that Mo can support clt's needs. T also utilized validation throughout the session to give Mo a sense of support and keep Mo motivated to support the clt with managing his sxs.
3) T followed up with Mo about clt's medication adherence; T explained to Mo the importance of clt being medication compliant; T recommended Mo or a caregiver (clt's maternal grandparents) supervises clt to ensure that clt takes his medication as prescribed. In addition, T encouraged Mo to schedule an appt. with the psychiatrist when severity of clt's sxs worsen, to allow psychiatrist to monitor and adjust medication as clinically appropriate.
4) T also discussed with Mo about completing a referral for clt to be transfer to UPAC CTC, to ensure that clt continue to receive medication management and therapeutic services, as a discharge care plan for clt/family. T reminded Mo that clt was towards the discharge phase of treatment and encouraged family to start the referral soon, to ensure enough time for clt to adjust with new treatment provider and provide family with a smooth transfer.

Family's Responses:
1) Mo reflected and spent an extensive amount of time providing T detailed examples of clt's bxs in the past 2 weeks; however explained that clt's sxs have become more stable at this moment. Mo reported that in the past 2 weeks clt exhibited unusual bxs: not sleeping, leaving the house at late hours and coming home in the morning (refused to inform home his whereabout), disoriented, delusional (believing and wanting to be a superhero), illogical, etc... In addition, Mo reported that during "this cycle" clt became aggressive towards Mo; Mo explained that clt was throwing objects,

Individual Progress Note (01/19/2016)

impulsive and was disobedient towards Mo. Mo highlighted that clt's only aggressive towards Mo.
2) Mo understood the information that T provided and acknowledged that although clt is 19y/o that he is developmentally a lot younger; Mo stated that clt "may be starting his teenager years." Mo was receptive to the metaphors that T provided and understood the challenges that clt experiences on a daily basis; Mo appeared motivated to continue learning effective ways to support the clt's needs, especially how to communicate with clt to establish/maintain a healthy relationship.
3) Mo reported that she does not currently supervises clt with taking his meds, therefore is unable to report on clt's medication adherence. Mo was receptive to the information that T provided and stated that she plans to or have grandparents ensure that clt takes his medication daily, as prescribed.
4) Mo expressed that she would like to stay with UPAC MCC in the meantime, to support clt with managing and stablizing clt's current sxs prior to the referring clt to UPAC CTC. Mo requested to start the process of referral next month.

Plan of Care: T will continue to meet with clt and Mo to monitor clt's sxs. In addition, T will assist family with completing referrals for CTC, to ensure that clt will received continue medication management and therapeutic services.

Additional information: Services were provided in Vietnamese.

Obj: 1.1.2 Learn/Practice Social Skills
Obj: 1.1.1 Learn/Practice Symptom Management

Name: DU, YEN (00131), IMF 10871 Electronically Signed	Date: 02/01/2016	Time:	Electronic
Name:	Date:	Time:	N/A

Name: [redacted] Case#: [redacted] Page 1 of 8
Type: Initial Screening Date 04/06/2016
Printed on 04/07 2016 at 03 28 PM (Final Approved on 04/07 2016 at 01 59 PM)

County of San Diego Mental Health Services
INITIAL SCREENING

Type of Contact: ○ Telephone ⊙ Face-to-Face Program: CRF HEARTLAND CENTER

Informant Name: Relation to Client: Sibling

Is the client under 18? ○ Yes ⊙ No Client's Age Today: 43 Date of Birth: [redacted]

PARENTAL INFORMATION

Parent Name: N/A Relationship:

Address: Phone:

City/State/Zip:

Employment Phone: Other Information:

LEGAL INFORMATION

Legal Consent: Self/Not Applicable If other:

Responsible Person: Relationship

Address: Phone·

City/State Zip·

Employment Phone· Other Information

ic

no PN -

CLIENT INFORMATION

Whom can we call back

Presenting Problem

3040/3043 4 6/16
[redacted] is a 43 y.o., single monolingual Arabic speaking Iraqi male who presented for an Initial screening accompanied by his brother who was also requesting services CLT was seen separately and interviewed with the assistance of Heartland Interpreter. CLT was casually dressed, appear well-groomed affect flat, mood depressed. CLT's responses to questions were simple and not always logical. It appeared that CLT had some cognitive deficits. CLT denies SA/SI/HI and psychosis although he seems to have a hx of some paranoia possibly

CLT reports that he has "depression all the time" and he is "always tired". He reported being exposed to trauma "back home in Iraq". CLT reported being on a "bunch of different meds" but could not say what they were for. He was able to say that he has some "sleeping medicine". CLT was a poor historian and upon closer look at past collateral, he had been at Maria Sardinas and the Chaldean and Middle Easter program in the past. CLT was not able to recall much of his experiences with other providers nor medication efficacy.. CLT apparently lives with his mother who helps to care for him. According to CLT's brother and past collateral, CLT lives in a type of fantasy world..."superhero world". He also endorses a great deal of physical concerns (e.g. impaired hearing, kidney stones, visual probelms and said he had blocked arteries).

CLT is requesting groups and individual therapy because he "feels lonely", "has no friends" and feels "no one loves me". CLT is also interested in taking care of his depression and is open to medications.

3180/3181 11/19/12
REVIEW WITH EDITS
[redacted] is a 40y.o single, heterosexual Iraqi male, Arabic speaking; whom is accompanied by his brother [redacted]. [redacted] stated that [redacted] suffers from depression. He discussed that [redacted] is often inside of his home, watching TV, and wishing that he was a superhero like Superman and Spider Man. He is waiting for the time when he could save the world. When he goes outside he is disturbed and bothered by the reality of the world. He often states, according to brother, that if he was the president or some other big figure that he would do differently. However, he cannot do this and this saddens him. [redacted] also discussed that Client someitmes feels as though people are laughing at him or talking about him. [redacted]'s sleeping patterns are normal, eating is normal, but he is confused with things, and his dreams get in the way of his reality, so he is unable to do much. Clt denies SI/HI and [redacted] states that [redacted] sometimes hears people calling his name, denies VH. These sx have lasted since 2007 when several family members passed away acoording to [redacted]. Client is taking Thyroxine, hydroclorothyrazide, amlodipin, potassium Citrate. These medications are to treat the thyroid and kidney issues. He has had 3 surgeries for kidney stones and one surgery to remove a hernia. According to Client's brother, renal failure runs in the family, and Client has been very concerned about the possibilty of renal failure in his own life, especially because he has had 3 surgeries for kidney stones. Client's brother [redacted] states that [redacted] sometimes has trouble remembering how to do things and this upsets him and he becomes angry because he can not complete certain tasks on his own.

3040/3043 [redacted] is a 39 y.o Iraqi, Arabic speaking gentleman whom is accompanied by his brother whom is acting as interpreter today. [redacted] suffers from depression. Brother states that he is often inside of his home, watching TV, and wishing that he was a superhero like Superman and Spider Man. He is waiting for the time when he could save the world. When he goes outside he is disturbed and bothered by the reality of the world. He often states, according to brother, that if he was the president or some other big figure that he would do differently. Howevwer, he cannot do this and this saddens him. Clt is sleeping patterns are normal, eating is normal, but he is confused with things, and his dreams get in the way of his reality, so he is unable to do much. Clt denies SI/HI/AH/VH. Brother states that clt states that he wishes he was not here. These sx have lasted 5-6 yrs acoording to clt. Clt states that he is unsure of what he wants from the center at this time, but he does request med mgmt. Clt is taking Thyroxine, hydroclorothyrazide, amlodipin, potassium Citrate. These medications are to treat the thyroid, kidneys. He has had 3 surgeries for kidney stones and one surgery to remove a hernia.

Urgency Level: ⊙ Routine ○ Emergency ○ Urgent ○ Unspecified/Unknown

☐ Initiate Second Effort Assigned Staff:

Date Second Effort Initiated:

Stages of Change: Mental Health Recovery

- ○ Pre-Contemplation
- ○ Contemplation
- ○ Preparation/Determination
- ○ Action
- ◉ Maintenance
- ○ Not applicable

CLINICAL FORMULATION:

3000/3002, 12/28/2015:
**An interpreter was present for the session*

The previous diagnosis of Schizophrenia, unspecified is being upheld due to CLT's reports of VH/AH. Resulting from his condition, the CLT is impaired at home, socially and occupationally. Such impairment consists of interrupted sleep, in which CLT reports frequently "waking up in the middle of the night and driving to the business center." Additionally, CLT is often disorganized, as he endorsed "walking around aimlessly."
CLT lacks insight of his current condition. CLT's sister, who is diagnosed similarly, also receives services at the current clinic; however, CLT fails to realize any likeness between his condition and his sibling's. CLT's reports that sister is "praning" (translated as crazy) results in distress and is assumed to inhibit their relationship and living situation. Additionally, the CLT's tangential thought process impacts his ability to engage in reciprocated conversation.
No SI/HI reported - CLT reported, "I feel safe."

DN present

Tag Alog

CLT meets medical necessity for continued admittance in the current clinic.

The clinician recommends that CLT continue his medication regime, and participate in group therapy sessions intended to emphasize the importance of medication and to equip CLT with education regarding his condition.

MEDICAL NECESSITY MET:

○ No ◉ Yes

When "No", note date NOA-A issued (Medi-Cal clients only):

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☒ Yes Date: 12/28/2015

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☒ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☒ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimburseable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☒ **Guide to Medi-Cal Mental Health Services was explained and offered on:**	12/28/2015
☒ **Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**	12/28/2015
☒ **Provider List explained and offered on:**	12/28/2015
☒ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:**	12/28/2015
☒ **Language/Interpretation services availability reviewed and offered when applicable on:**	12/28/2015

County of San Diego Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT

Program Name: UPAC MIDTOWN CENTER

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: ⊙ None ○ LPS ○ Probate ○ Temporary

Case Manager: ○ None ⊙ SBCM ○ FSP ○ Institutional ○ Regional Center ○ Other None

Payee: None

Probation Officer: None

SOURCE OF INFORMATION:
Client

If a source other than listed on the "Source of Information" table, specify: N/A

Reports Reviewed:

3000/3002, 12/28/2015:

None

Referral Source: Self/Family

If Other, specify: NONE

PRESENTING PROBLEMS/NEEDS:

3000/3002, 12/28/2015:
**An interpreter was present for the session*

CLT is a 49 year old, never married limited English-speaking Filipino male. CLT arrived on time and drove to the clinic. Upon being greeted by the clinician, CLT appeared alert, and remained so for the duration of the session. CLT was appropriately dressed, wearing a red SDSU jacket, brown denim pants, and black "Croc"-style slip on shoes with black socks. CLT's speech was normal, although CLT frequently spoke over the interpreter present. In response, the writing clinician acknowlaged the intricacies of having 3 individuals speaking in 2 languages, and asked the CLT to not speak out of turn. CLT presented with tangential thought process, and frequently answered questions, followed by responses that did not fit the context of the preceding question; at times, CLT would speak about the government and its budgets for the current clinic and other healthcare and social service resources. Additionally, the CLT presented with cooperative behavior, appropriate affect, euthymic mood, and normal memory. CLT maintains eye contact, almost intense, and the writing clinician noticed that CLT slighlty swishes his mouth when listening to the clinician.

CLT endorsed "6-8 hours" of interrupted sleep. When CLT awakens in the middle of the night, he reported "walking outside or driving to the business center," which CLT reported is open "24 hours." Upon inquiry from the clinician, CLT did not endorse driving while groggy or sleepy. When inquired about previously endorsed VH/AH, CLT answered vaguely. CLT reported that he frequently meets people "on the corner." According to CLT, "an American lady" recently invited him over for Christmas dinner; CLT reported only meeting the "American lady" once, and denied anyone else's presence during this encounter. CLT also reported an interaction with "2 people from New York." CLT reported these individuals as being sad, based on their "facial expressions," and that they approached him and expressed concern

Individual Progress Note (12/28/2015)

Form#:	[redacted] Date: 12/28/2015		Start / Duration
		Service:	1:05
		Travel:	
Unit:	UPAC MIDTOWN CENTER	Documentation:	0:56
SubUnit:	UPAC MIDTOWN CENTER MHSA		
Server:	METCALFE, RICHARD (00131)	Total Server Time:	2 Hours, 1 Minute
Supervisor:		Participants:	0
Service:	ASSESSMNT PSYCHSOC INTERACT 9	Days:	0
Lab:		Quantity:	0

Diagnoses: F20.9 - Schizophrenia, unspecified

Provided To:	Client	Provided At:	Office
Outside Facility:		Contact Type:	Face to Face
Appointment Type:	Scheduled	Billing Type:	Not Applicable
Intensity Type:	NOT APPLICABLE		

Progress Note

3000/3002, 12/28/2015:

Clinician met with CLT for annual assessment. During this session, presenting problems and client stressors were assessed. CLT did not endorse SI/HI. Please refer to the Behavioral Health Assessment for further detail.
Interpreter present for the assessment.

Obj: 2.1.1 Reduce Frequency/Intensity of Symptoms

Name: METCALFE, RICHARD (00131), MHRS 120 Date: 12/31/2015 Time: Electronic
Electronically Signed

Name: LEE, AMANDA (00131), ASW 2353 Date: 12/31/2015 Time: Electronic
Electronically Signed

Name: [redacted] Case#: [redacted] Page: 1 of 1
Type: Interim Folder Date: 02/01/2016 - 02/24/2016
Printed on 04/08/2016 at 09:52 AM (Final Approved)

Individual Progress Note (02/22/2016)

			Start	Duration
Form#:	[redacted] Date: 02/22/2016	Service:		0:45
		Travel:		0:25
Unit:	UPAC MULTI COMM COUNSEL HSA	Documentation:		0:06
SubUnit:	UPAC MCC MHSA			
Server:	DELOSREYES, KRISTINE (00131	Total Server Time:	1 Hour, 16 Minutes	
Supervisor:		Participants:	0	
Service:	CASE MGT/ BROKERAGE 50	Days:	0	
Lab:		Quantity:	0	

Diagnoses: F33.2 - Major depressive disorder, recurrent severe without psychotic features
F41.9 - Anxiety disorder, unspecified
Z62.820 - Parent-biological child conflict
Z60.3 - Acculturation difficulty

Provided To:	Family / Legal Guardian	Provided At:	Other Community/Field Unspec
Outside Facility:		Contact Type:	Face to Face
Appointment Type:	Scheduled	Billing Type:	Not Applicable
Intensity Type:	NOT APPLICABLE		

Progress Note

7440/7441

FSP met with Mo for this scheduled session within the community of Mira Mesa. FSP provided services for this session in the Tagalog language, which is Mo's preferred language.

FSP provided support by talking to Mo about section 8, in order to provide stability of housing for the CLT. Mo informed FSP that she has submitted an application at the county office for this more than 5 years ago, but that she didn't quite understand the process then, because she and the CLT were still new to the country. Mo said she has not kept up with her application for section 8 since. FSP discussed with Mo about creating an online account and updating information on her application, so that Mo does not lose her spot on the waitlist. FSP was able to retrieve the section 8 application with Mo and update information. FSP helped Mo understand how to navigate the online site, so that she can access this on her own to make changes to information as needed.

Plan of care:
SP will follow up with Mo regarding accessing section 8 information on her own.

Name: DELOSREYES, KRISTINE (00131), MHRS 1	Date: 02/24/2016	Time:	Electronic
Electronically Signed			
Name:	Date:	Time:	N/A

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (cultural, linguistic)

SUBJECT:	**Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services**	**REFERENCE #**	5977
		PAGE:	1 OF 4
		DATE:	**NOT SET**
REFERENCE	**42 Code of Federal Regulations 438.10, CCR, Title 9, Chapter 11, §1810.41(a); DMH Information Notice 02-03, Pages 13, 17, DHCS All County Welfare Directors Letter No.: 10-03, and Title VI Civil Rights Act of 1964 (42 U.S.C., §2000(d), 45 C.F.R., Part 80)**		

PURPOSE

To ensure that all individuals requesting services at Mental Health Plan (MHP) programs providing Specialty Mental Health Services have been evaluated for needing culturally/linguistically specialized services and linked with services or referred appropriately.

BACKGROUND

Based on the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410(a); DMH Notice No. 97-14, Page 18, Civil Rights Act of 1964 (42 U.S.C., Section 2000(d), 45 CFR, Part 80), when a need is determined, the County of San Diego Health and Human Services Agency (HHSA) – Behavioral Health Services (BHS) shall ensure that a process is in place for accommodating and referring clients to available culturally and/or linguistically appropriate services. Title VI of the Civil Rights Act of 1964 prohibits the denial of access to federally assisted programs and activities because of limited English proficiency. Providers are required to provide language assistance to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

The MHP Cultural Competence Clinical Practice Standards (found in Section H of the Organizational Provider Operations Handbook (OPOH)) help ensure culturally sensitive practice in assessments, referrals, treatment, testing, staffing, and community outreach.

DEFINITIONS

None

POLICY

Clients have a right to a choice of providers whenever possible, and cultural and linguistic issues shall be considered in making appropriate referrals. At the point of entry into a program, the cultural and/or linguistic needs of an individual shall be assessed and all reasonable efforts made to accommodate, refer and/or link them to appropriate services reflecting those preferences. In this context, cultural needs may include special referral needs, such as homelessness, dual diagnosis, and children under the age of six (6). Clients shall be informed of the availability and how to access free interpretation

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (cultural, linguistic)

SUBJECT:	**Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services**	**REFERENCE #**	5977
		PAGE:	2 OF 4
		DATE:	**NOT SET**
REFERENCE	**42 Code of Federal Regulations 438.10, CCR, Title 9, Chapter 11, §1810.41(a); DMH Information Notice 02-03, Pages 13, 17, DHCS All County Welfare Directors Letter No.: 10-03, and Title VI Civil Rights Act of 1964 (42 U.S.C., §2000(d), 45 C.F.R., Part 80)**		

services which shall be available in threshold and non-threshold languages. Written materials specified by state and federal regulations shall be available in threshold languages.

PROCEDURES

All persons with LEP speaking threshold or non-threshold languages shall be informed in a language they understand that they have a right to free oral interpretation assistance and that there is no expectation that family members provide interpreter services. Please call the BHS Administration Front Office at 619-563-2700 for LEP Posters in the five threshold languages. A consumer may choose to use a family member or friend as an interpreter, after being informed of the availability of free interpreter services. Other than in extenuating circumstances, minors (under the age of 18) may not be used as interpreters even if the applicant/beneficiary requests to do so, although at the applicant's/beneficiary's request the minor may be present in addition to the County provided interpreter. The availability of free interpretation assistance will be publicized in the Guide to Medi-Cal Mental Health Services and the Quick Guide to Mental Health Services and reinforced by signs that will be provided by the county for display in behavioral health service waiting areas.

Providers will log all contacts (phone, walk-in) on a Request for Services Log (See Section-C of the OPOH) that will be kept on-site and stored to maintain the confidentiality of the individual.

<u>For Individuals Walking in or Telephoning Provider Sites with Language Needs that Cannot Be Determined</u>

- If the provider has no on-site staff that can provide appropriate language assistance in the threshold or non-threshold language spoken by the individual, the staff should call OptumHealth (OH) Access & Crisis Line at **1-888-724-7240** for assistance.
- OptumHealth will utilize its staff when a member has the appropriate language expertise, or connect with the Language Line to facilitate a brief assessment of the individual's problem and cultural and/or linguistic needs.
- Based on the brief assessment, OH, the provider, and the individual will reach a consensus about the plan of action to best address the individual's problem and consider any cultural and linguistic needs. This may include, but not be limited to, a referral for mental health assessment and/or, as appropriate, a referral to a community organization or social service agency.

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (cultural, linguistic)

SUBJECT:	**Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services**	**REFERENCE #**	5977
		PAGE:	3 OF 4
		DATE:	**NOT SET**
REFERENCE	**42 Code of Federal Regulations 438.10, CCR, Title 9, Chapter 11, §1810.41(a); DMH Information Notice 02-03, Pages 13, 17, DHCS All County Welfare Directors Letter No.: 10-03, and Title VI Civil Rights Act of 1964 (42 U.S.C., §2000(d), 45 C.F.R., Part 80)**		

- If a mental health assessment is indicated, an appointment or referral will be made, making all reasonable effort to accommodate the individual's linguistic and/or cultural preferences as soon as possible.

If there are no providers who can provide services in the primary language of the client, the site staff providing the assessment or referral will arrange with the County's Interpreter Services to provide needed language assistance for the subsequent appointments (see Section-C of the OPOH).

For Person Seeking Services with Language Needs Which Can Be Determined

- If the provider has staff that speaks the individual's language, the provider will utilize this staff to determine service needs. The individual will also be asked about cultural preferences.
- Based on a brief assessment, the staff person will work with the individual to determine a plan of action to best address the individual's problem, in view of any cultural and linguistic needs. This may include, but not be limited to, setting up an appointment or referral for a mental health assessment, and/or, as appropriate, a referral to a needed community or social service(s). The staff member will make all reasonable efforts to meet the individual's cultural and linguistic preferences.
- If there is no staff or other providers who can provide services in the primary language of the client, the provider will arrange with the County's Interpreter Services Contractors to provide needed, free, language assistance for the subsequent appointments (see Section-C of the OPOH for details). Individuals speaking threshold languages will also be informed about the availability of written information in threshold languages and how to access that material.

Documentation of the Provision of Culturally/Linguistically Appropriate Services

- Offers of interpreter services shall also be documented.
- Suggestions and Transfer Forms (as reported in the Monthly Status Report (MSR) or Quarterly Status Report (QSR) will reflect requests for transfer to a different provider because of cultural or linguistic issues.

Monitoring Provision of Culturally/Linguistically Appropriate Services

- The BHS-Quality Improvement (QI) Unit will review the Request for Services Log periodically to ensure referrals are being made and logged.
- The BHS-QI Unit will periodically review the reported usage of interpreter services from Interpreter's Unlimited and Network Interpreting.

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (cultural, linguistic)

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QUESTIONS / INFORMATION
Liz Miles, PAA
BHS Quality Improvement
(619) 584-5015

ATTACHMENTS/RELATED DOCUMENTS
None

SUNSET DATE: This policy will be reviewed for continuance on or before October 31, 2016.

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Youth Services Survey (YSS)

May 2016 Survey Period

San Diego County

Children, Youth & Families Behavioral Health Services

Report prepared by the
Child & Adolescent Services Research Center (CASRC)

October 2016

Overview

One way to ensure that services are responsive to consumer needs is to collect information from youth and families about their satisfaction with services and their perspectives on the quality of services. In San Diego County, data on consumer satisfaction was collected through the Youth Services Survey (YSS), which is completed by **all youth (ages 13+)** and **all available parents/caregivers**, regardless of the youth/client age. The majority of questions on the YSS focus on satisfaction with the provision and results of services.

This report focuses on results of the YSS from the May 16-20, 2016 survey administration period. Two YSS measures were independently evaluated: **YSS compliance** and **YSS results.**

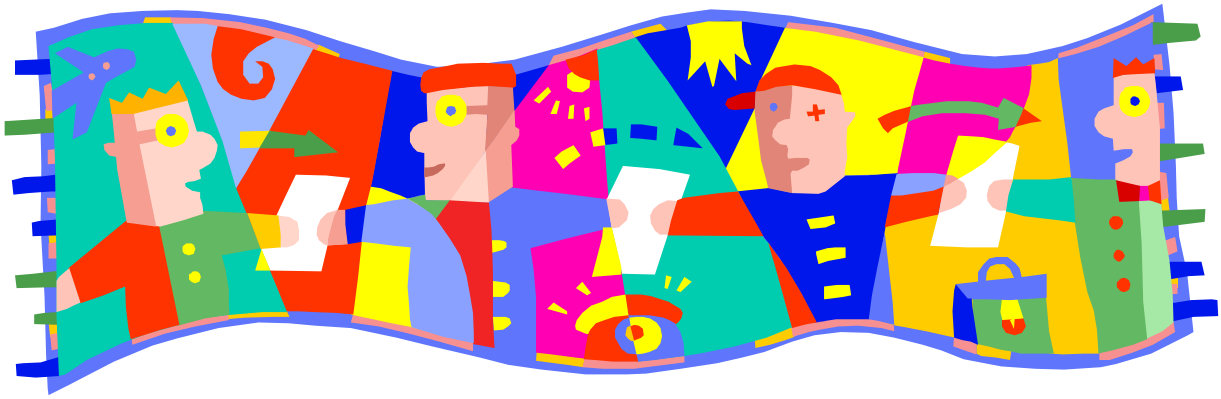
YSS compliance is determined by using Client ID numbers to compare the number of clients receiving services (as reported in Cerner Community Behavioral Health [CCBH]) to the number of clients who submitted surveys during the May 2016 YSS period. During the survey period, 377 (10.9%) of the 3,449 completed forms did not match to a client with a billed service. There are several reasons why this may have occurred: 1) Client ID number error on the survey, 2) delays in billing data entered into CCBH; i.e., client got a billed service, but it had not yet been entered in CCBH at the time of data download, or 3) client should not have been given a survey (client had an open episode, but did not receive a billed service during the YSS period).

YSS results are calculated directly from submitted surveys. The YSS gives a snapshot in time of youth receiving behavioral health services, and whether client data changes with duration of services received. Specifically, the YSS provides data regarding three outcome areas of interest: consumer satisfaction, recent substance use, and recent arrests.

Individual items on the YSS are grouped into seven domains for analysis:

1. General Satisfaction
2. Perception of Access
3. Perception of Cultural Sensitivity
4. Perception of Participation in Treatment Planning
5. Perception of Outcomes of Services
6. Perception of Functioning
7. Perception of Social Connectedness

Clients may receive multiple services from more than one program during the YSS period; therefore, a single client may submit multiple forms. Results are evaluated by item and by domain, at the systemwide, level of care, and program levels.



Key Findings—May 2016

1. The County process objective of 80% of clients submitting a YSS form was met and exceeded in May 2016: 93% of the 3,413 clients receiving a service submitted a YSS form. Submission rates remain at at their highest since the process objective was set.
2. The County outcome objective of 80% of clients responding "agree" or "strongly agree" for at least 75% of the satisfaction survey items was met for parents/caregivers and youth.
3. Both parents/caregivers and youth were most satisfied with the *Perception of Cultural Sensitivity* domain. Parents/caregivers and youth were least satisfied with the *Perception of Outcomes of Services* domain.
4. Parents/caregivers were more satisfied than youth on every domain; youth were nearly as satisfied as parents/caregivers on the *Perception of Functioning* domain.
5. The greatest disparity in satisfaction between youth and parents/caregivers was found on the *Perception of Participation in Treatment Planning* domain.
6. Satisfaction and perception of outcomes varied substantially among different levels of care in the Children, Youth and Families Behavioral Health Services (CYFBHS) system. On average, youth receiving TBS services, and parents/caregivers of youth receiving Outpatient or TBS services, were most satisfied. Youth and parents/caregivers of youth receiving Day Treatment services were least satisfied.
7. Satisfaction and perception of outcomes also varied widely among different racial/ethnic groups. Overall, Asian/Pacific Islander clients and their parents/caregivers reported the highest satisfaction averaged across domains. Clients of mixed race/ethnicity and their parents/caregivers reported the lowest satisfaction averaged across domains. Native American clients and their parents/caregivers reported the highest levels of satisfaction across racial/ethnic groups on the *Perception of Outcomes of Services* and *Perception of Functioning* domains; however, only 13 completed surveys were submitted for Native American youth and their parents/caregivers, which means the averages may not be generalizable to the population.
8. On average, satisfaction and perception of outcomes were highest among parents/caregivers of children ages 0 to 11 years.
9. Twenty percent of youth who responded to the recent substance use question on the YSS reported substance use within the past month; this is a decrease from 24% of youth who reported recent substance use on the November 2015 YSS. The most commonly used substances remain consistent: marijuana, cigarettes, and alcohol.
10. Four percent of youth who responded to the recent arrest question on the YSS reported an arrest within the past month. Overall, clients in services more than one year had fewer arrests than clients who received less than one year of treatment services.

CYFBHS Process Objective

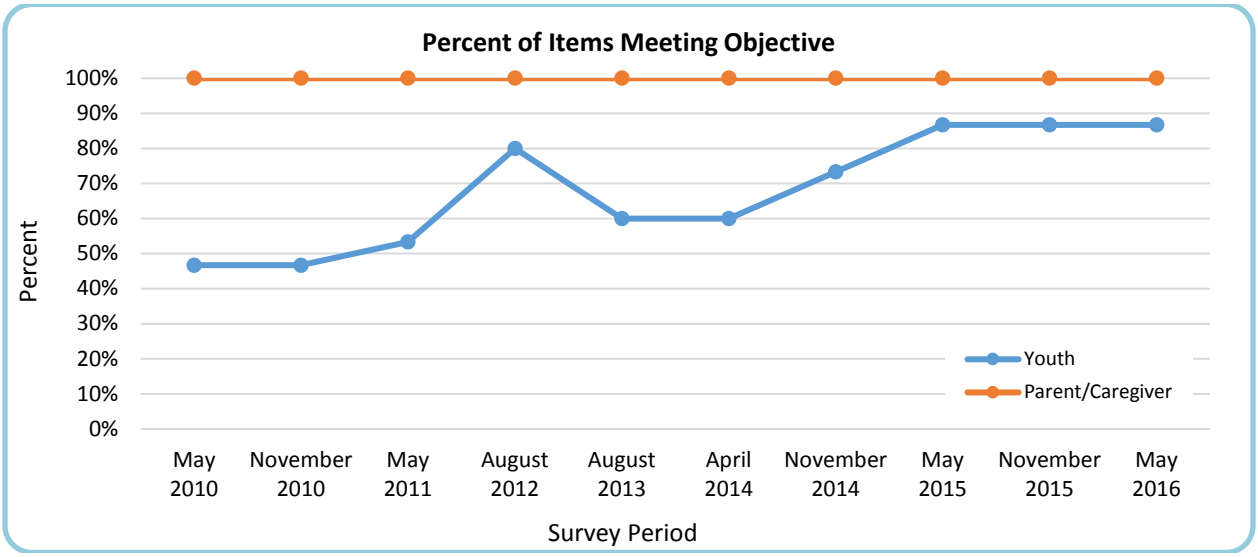
Providers are tasked with the administration of a YSS survey to every client (and/or parent/caregiver) receiving a service during the survey period. The process objective set by the County is 80% of eligible clients submitting a YSS form; this objective has been met and exceeded during every survey period since November 2006. The process objective is calculated using the number of clients served during the survey period, as opposed to the number of forms received. In the current survey period, **3,168 (93%) of 3,413 clients receiving a service *submitted* a YSS form,** and 2,414 (71%) of 3,413 clients receiving a service *completed* a YSS form.

CYFBHS Outcomes Objective

More than 5,400 survey forms were submitted for the May 2016 YSS (3,669 forms from parents/caregivers and 1,772 forms from youth). More than 3,400 of the forms were completed and had useable data (2,220 forms from parents/caregivers and 1,229 forms from youth). Overall, **63% of the forms that were turned in were completed.** Reasons for non-completion include refusals, parent/caregiver not available (e.g., for a child in out-of-home care), and parent/caregiver or child not showing up for a scheduled appointment.

The first 15 items on the YSS address satisfaction, while the remaining items cover client demographics, outcomes of services, and involvement with police and schools. The County has established an **outcome objective for the satisfaction items** which applies to all contractors: Aggregated scores on the Youth Services Survey (YSS) and the Youth Services Survey Family (YSS-F) shall show an average of 80% or more of clients responding in the two most favorable categories (Agree and Strongly Agree) for at least 75% of the individual survey items. Countywide data on the outcomes objective are presented in this report.

Parents/caregivers were more satisfied with services than Youth respondents. Since the outcomes objective was initiated in November 2006, **parent/caregiver scores have been above 80% for all of the satisfaction items on the survey**, and the objective has been satisfied. For youth respondents, the scores are lower; this has been true since the inception of these YSS measures. The County's objective was met during the May 2016 YSS; at least 80% of youth responded in the two most favorable categories for 87% of the individual survey items. Only two individual items fell below the threshold: "I helped to choose my services" and "I got as much help as I needed."



Survey Response Rate

	Parent/Caregiver	Youth	TOTAL
Forms Submitted	3,669	1,772	5,441
Forms Completed	2,220	1,229	3,449

Satisfaction by Item Response: Systemwide

Parent/Caregiver Satisfaction by Item*		
Questions based on services received in last 6 months:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. Overall, I am satisfied with the services my child received	2.0%	93.3%
2. I helped to choose my child's services	4.6%	90.6%
3. I helped to choose my child's treatment goals	2.6%	93.5%
4. The people helping my child stuck with us no matter what	3.0%	92.0%
5. I felt my child had someone to talk to when he/she was troubled	2.2%	92.0%
6. I participated in my child's treatment	1.8%	96.1%
7. The services my child and/or family received were right for us	2.1%	90.5%
8. The location of services was convenient for us	4.2%	92.7%
9. Services were available at times that were convenient for us	3.4%	93.7%
10. My family got the help we wanted for my child	2.5%	88.5%
11. My family got as much help as we needed for my child	3.4%	84.3%
12. Staff treated me with respect	1.2%	98.1%
13. Staff respected my family's religious/spiritual beliefs	1.3%	96.6%
14. Staff spoke with me in a way that I understood	1.4%	97.7%
15. Staff were sensitive to my cultural/ethnic background	1.7%	96.0%
At least 80% of clients responded "Agree" or "Strongly Agree" to 15 of 15 questions – 100%		
As a result of the services received:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
16. My child is better at handling daily life	5.4%	72.9%
17. My child gets along better with family members	6.2%	73.7%
18. My child gets along better with friends and other people	5.5%	73.5%
19. My child is doing better in school and/or work	7.0%	71.4%
20. My child is better able to cope when things go wrong	8.2%	67.1%
21. I am satisfied with our family life right now	12.1%	68.0%
22. My child is better able to do things he or she wants to do	6.5%	71.2%
23. I know people who will listen and understand me when I need to talk	2.5%	91.9%
24. I have people that I am comfortable talking with about my child's problem(s)	2.8%	92.9%
25. In a crisis, I would have the support I need from family or friends	4.0%	89.2%
26. I have people with whom I can do enjoyable things	3.0%	91.9%

**Percent may not add up to 100, as "Undecided" response is not reported here.*

Youth Satisfaction by Item*		
Questions based on services received in last 6 months:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
1. Overall, I am satisfied with the services I received	5.4%	85.9%
2. I helped to choose my services	12.5%	69.6%
3. I helped to choose my treatment goals	6.5%	83.3%
4. The people helping me stuck with me no matter what	4.6%	80.7%
5. I felt I had someone to talk to when I was troubled	5.9%	81.9%
6. I participated in my own treatment	3.8%	85.6%
7. I received services that were right for me	4.8%	84.1%
8. The location of services was convenient for me	5.7%	83.9%
9. Services were available at times that were convenient for me	5.8%	81.2%
10. I got the help I wanted	5.6%	81.5%
11. I got as much help as I needed	6.5%	77.8%
12. Staff treated me with respect	3.9%	87.8%
13. Staff respected my religious/spiritual beliefs	3.1%	87.9%
14. Staff spoke with me in a way that I understood	3.4%	90.5%
15. Staff were sensitive to my cultural/ethnic background	5.5%	82.8%
At least 80% of clients responded "Agree" or "Strongly Agree" to 13 of 15 questions – 87%		
As a result of the services received:	% Strongly Disagree/Disagree	% Strongly Agree/Agree
16. I am better at handling daily life	7.0%	70.7%
17. I get along better with family members	9.1%	66.4%
18. I get along better with friends and other people	5.6%	74.6%
19. I am doing better in school and/or work	10.4%	67.6%
20. I am better able to cope when things go wrong	7.5%	71.4%
21. I am satisfied with my family life right now	12.2%	65.7%
22. I am better able to do things I want to do	8.7%	70.3%
23. I know people who will listen and understand me when I need to talk	3.7%	86.0%
24. I have people that I am comfortable talking with about my problem(s)	5.6%	83.3%
25. In a crisis, I would have the support I need from family or friends	4.8%	81.8%
26. I have people with whom I can do enjoyable things	4.2%	86.5%

**Percent may not add up to 100, as "Undecided" response is not reported here.*

Satisfaction by Domain: Systemwide

DOMAIN	Percent Stating Agree or Strongly Agree	
	Parent/Caregiver (N=2,220)	Youth (N=1,229)
General Satisfaction (Items 1, 4, 5, 7, 10, 11)	91.1%	82.4%
Perception of Access (Items 8, 9)	91.1%	77.0%
Perception of Cultural Sensitivity (Items 12, 13, 14, 15)	97.4%	87.0%
Perception of Participation in Treatment Planning (Items 2, 3, 6)	93.9%	78.8%
Perception of Outcomes of Services (Items 16, 17, 18, 19, 20, 21)	68.8%	67.3%
Perception of Functioning (Items 16, 17, 18, 20, 22)	71.9%	71.8%
Perception of Social Connectedness (Items 23, 24, 25, 26)	91.9%	83.3%

Satisfaction by Level of Care

Parent/Caregiver Satisfaction by Level of Care			
DOMAIN	Percent Stating Agree or Strongly Agree		
	Outpatient (N=1,999)	Day Treatment (N=115)	TBS (N=106)
General Satisfaction	91.1%	91.2%	90.3%
Perception of Access	91.4%	80.2%	96.0%
Perception of Cultural Sensitivity	97.3%	98.0%	99.0%
Perception of Participation in Treatment Planning	94.5%	82.6%	95.1%
Perception of Outcomes of Services	68.8%	69.6%	67.3%
Perception of Functioning	72.0%	69.7%	73.0%
Perception of Social Connectedness	92.0%	91.9%	89.0%

Youth Satisfaction by Level of Care			
DOMAIN	Percent Stating Agree or Strongly Agree		
	Outpatient (N=941)	Day Treatment (N=259)	TBS (N=29)
General Satisfaction	86.9%	65.3%	89.7%
Perception of Access	81.8%	58.5%	86.2%
Perception of Cultural Sensitivity	91.4%	70.1%	96.4%
Perception of Participation in Treatment Planning	81.9%	67.2%	82.8%
Perception of Outcomes of Services	66.8%	68.2%	75.9%
Perception of Functioning	71.7%	72.0%	75.9%
Perception of Social Connectedness	86.3%	72.2%	86.2%

NOTE: Not every youth/caregiver completed responses for every domain.

Satisfaction by Client Race/Ethnicity

DOMAIN	Percent Stating Agree or Strongly Agree							
	White (N=577)	Hispanic (N=2,087)	African-American (N=210)	Asian/ Pacific Islander (N=72)	Native American (N=13)	Mixed Race/ Ethnicity (N=221)	Other (N=44)	Unknown /Missing (N=225)
General Satisfaction	85.9%	90.0%	82.4%	92.6%	81.8%	84.1%	86.4%	81.6%
Perception of Access	82.9%	88.4%	84.2%	89.7%	75.0%	78.9%	74.4%	82.8%
Perception of Cultural Sensitivity	95.4%	94.7%	89.8%	92.2%	90.0%	90.0%	88.1%	87.4%
Perception of Participation in Treatment Planning	89.8%	89.2%	87.3%	89.7%	81.8%	86.1%	85.7%	81.3%
Perception of Outcomes of Services	59.1%	71.8%	66.5%	77.9%	100.0%	60.1%	66.7%	63.5%
Perception of Functioning	64.7%	75.3%	67.2%	82.4%	100.0%	65.3%	73.2%	62.5%
Perception of Social Connectedness	85.8%	90.7%	84.8%	92.8%	91.7%	88.7%	79.5%	81.0%

Satisfaction by Client Age

DOMAIN	Percent Stating Agree or Strongly Agree				
	0-5 years (N=269)	6-11 years (N=934)	12-15 years (N=1,383)	16-17 years (N=728)	18-25 years (N=135)
General Satisfaction	89.1%	91.0%	87.4%	85.5%	85.0%
Perception of Access	87.8%	91.8%	84.0%	82.6%	83.2%
Perception of Cultural Sensitivity	95.5%	97.6%	92.4%	90.6%	91.2%
Perception of Participation in Treatment Planning	91.7%	95.4%	85.3%	84.7%	86.6%
Perception of Outcomes of Services	72.8%	68.6%	66.8%	68.8%	69.5%
Perception of Functioning	76.2%	71.4%	70.2%	73.4%	74.8%
Perception of Social Connectedness	94.1%	91.8%	87.2%	87.2%	83.1%

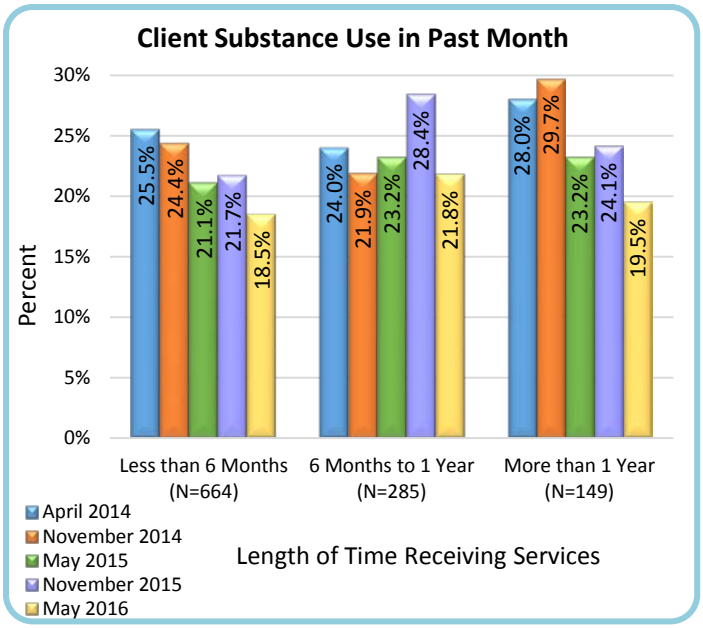
NOTE: Not every youth/caregiver completed responses for every domain.

Substance Use by Length of Service

On the YSS, youth ages 13+ were asked whether they had used any of a list of substances (alcohol, cigarettes, ecstasy, cocaine, marijuana, crystal meth, inhalants, hallucinogens, opiates, injected drugs) in the past month. 1,140 youth survey responses to the substance use question were submitted for the May 2016 survey period.

Overall, 20% of youth stated that they had used one of these substances at least once in the past month.

The three most commonly used substances in the past month were: Marijuana (13.7%), Alcohol (9.0%), and Cigarettes (8.6%).

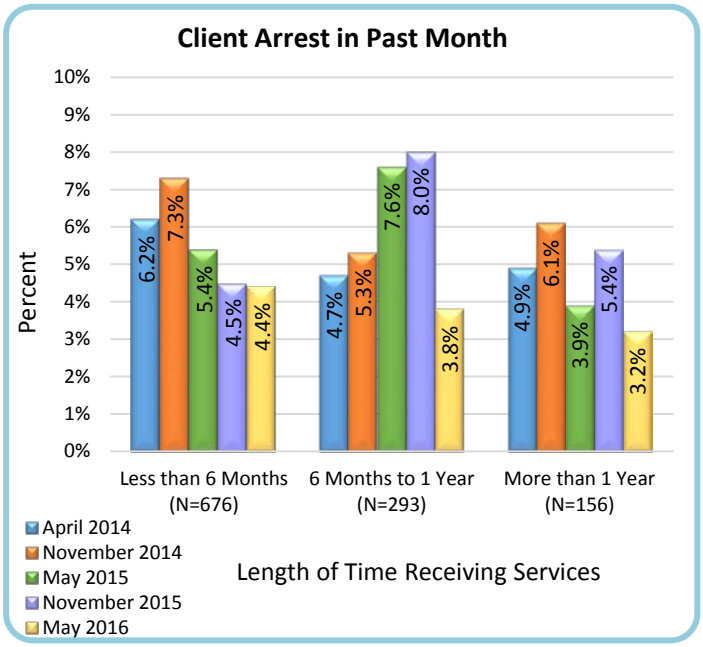


Arrests by Length of Service

On the YSS, youth ages 13+ were asked to report on whether they had been arrested for any crimes in the past month. 1,173 youth survey responses to the arrest question were submitted for the May 2016 survey period.

Overall, clients in services more than one year had fewer arrests than clients who received less than one year of treatment. It is important to note that due to the small number of clients systemwide (N=51 in May 2016) who reported arrests, small changes in numbers can have large effects on proportion.

50 of 51 youth who reported arrests also responded to the substance use question; of these, 20 (40%) reported use of a substance in the past month.



The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded behavioral health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

Consumer Satisfaction Survey Results

Survey Period: May 16-20, 2016

The County of San Diego's Adult and Older Adult Behavioral Health Services (AOABHS): Adult Mental Health Services

Consumer Satisfaction Survey Results

Survey Period: May 16-20, 2016

Summary

Consumer Satisfaction

- 89% of consumers were generally satisfied with services received (as indicated by either having agreed or strongly agreed with general satisfaction domain).

Consumer Satisfaction: Trends Across Time

- Consumer satisfaction scores were slightly lower across all domains in the Spring 2016 survey period as compared to the Fall 2015 survey period, except for Perception of Functioning.

Satisfaction by Level of Care

- Across all levels of care, means were higher for the General Satisfaction domain, with individuals receiving Other and Outpatient (OP) services giving the highest ratings.
- Consumers who received Crisis Residential (CR) services reported higher percentages of dissatisfaction in the following three domains than consumers receiving Outpatient (OP), Assertive Community Treatment (ACT), Case Management (CM), or Other services:
  - √ Perceptions of Outcome Services
  - √ Perception of Functioning
  - √ Perception of Social Connectedness

Satisfaction by Race/Ethnicity

- Native American persons had higher mean scores than any other racial/ethnic group for the Perception of Quality and Appropriateness, and Perception of Social Connectedness domains.
- Native American persons reported the highest proportion of satisfaction among all racial/ethnic groups in Perception of Access, Perception of Quality and Appropriateness, and Perception of Participation in Treatment Planning.

Total Number of Surveys Returned: 2,626

- **2,178 completed**
- **448 incomplete***

To calculate response rates, surveys were counted as incomplete if the survey had insufficient data to compute the "General Satisfaction" domain score of the MHSIP which meant that all three of the first three items of the questionnaire were missing.

NOTE: All surveys (complete and incomplete) were included in the aggregate analyses.

- As compared to persons of other racial/ethnic backgrounds, African American persons reported the highest proportions of dissatisfaction for five out of the seven domains: Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcome Services, Perception of Functioning, and Perception of Social Connectedness.

Satisfaction by Age

- All age ranges have equally as high mean scores for three out of the seven domains: Perception of Access, Perception of Outcome Services, and Perception of Functioning.
- Older Adults reported the highest (or equally as high) proportion of satisfaction in six out of the seven domains: General Satisfaction, Perception of Access, Perception of Participation in Treatment Planning, Perception of Outcome Services, Perception of Functioning, and Perception of Social Connectedness.

Length of Services

- 62% of consumers who participated in the survey had been receiving mental health services with AOABHS for more than one year.

Arrests

- Among the 38% of consumers who received services for one year or less, 70% reported reduced encounters with police since they began receiving mental health services.
- Among the 62% of consumers who received services for more than one year, 61% reported reduced encounters with police since they began receiving mental health services.

Consumer Demographics

- About half (52%) of the consumers that participated in the Spring 2016 survey were male.
- Each racial/ethnic group was represented in the Spring 2016 survey period, with White, Hispanic, and African American persons representing 86% of the total population surveyed (44%, 28%, and 14%, respectively).

Language Availability

- 97% of consumers reported that services were provided in the language they prefer.

Reason for Involvement with Program

- The majority (59%) of persons who received mental health services reported that someone else recommended that they go.

Response Rates

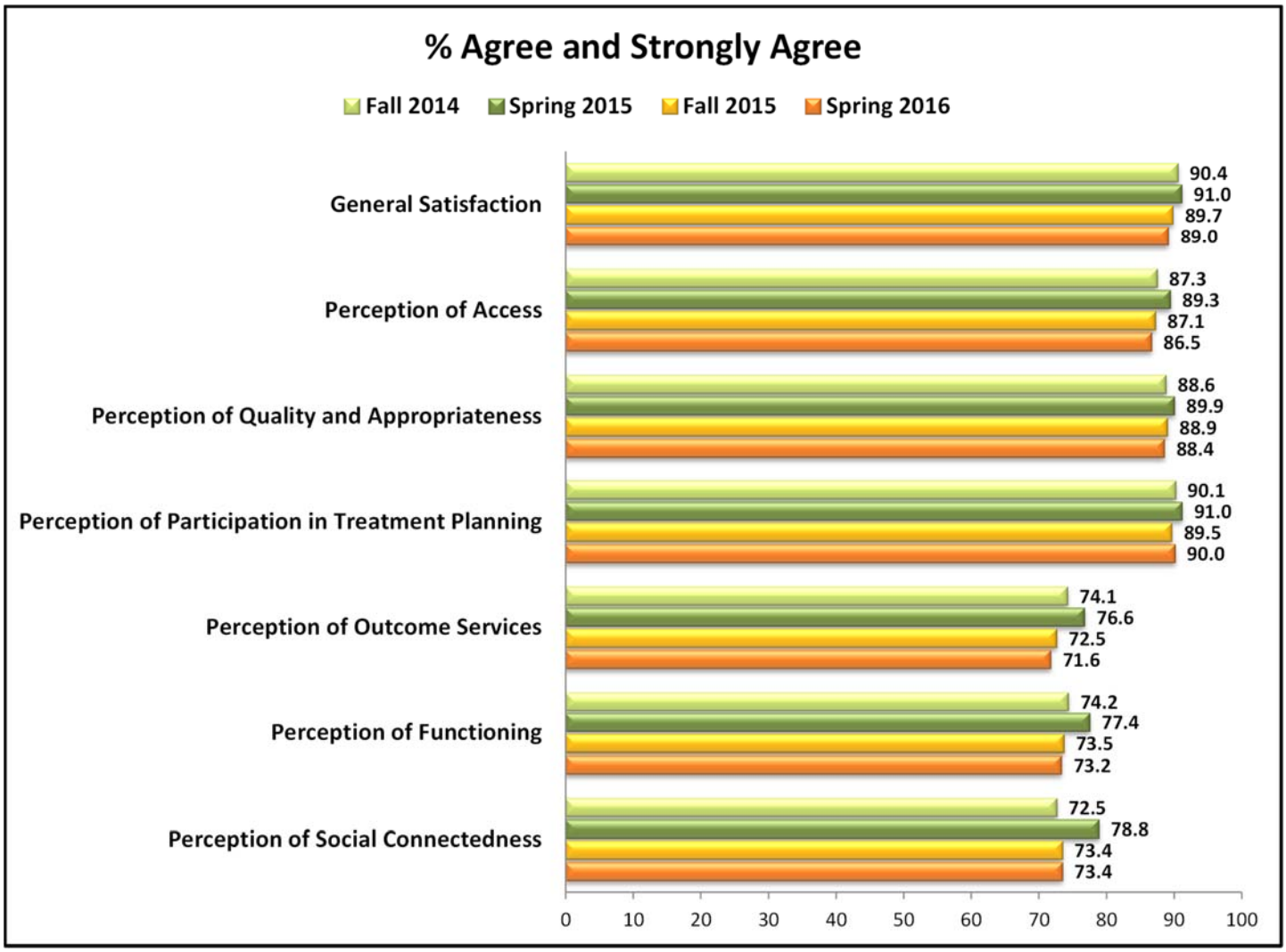
- 83% of clients who received “face to face” services during the survey period completed a survey (NOTE: this calculation excludes incomplete surveys).

Consumer Satisfaction (Domains: All Programs)

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree (N = 2,178*)

DOMAIN	% below 3.5	% over 3.5	Mean
General Satisfaction (Items: 1-3)	11.0	89.0	4.4
Perception of Access (Items: 4-9)	13.5	86.5	4.2
Perception of Quality and Appropriateness (Items: 10, 12-16, 18-20)	11.6	88.4	4.3
Perception of Participation in Treatment Planning (Items: 11, 17)	10.0	90.0	4.2
Perception of Outcome Services (Items: 21-28)	28.4	71.6	3.9
Perception of Functioning (Items: 29-32)	26.8	73.2	3.9
Perception of Social Connectedness (Items: 33-36)	26.6	73.4	3.9

Consumer Satisfaction: Trends Across Time



** The total number of responses for domain scores may be less than the reported number of completed surveys as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.*

Consumer Satisfaction (Item Responses: All Programs)

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree (N = 2,178*)

Questions based on services received in last 6 months	% Disagree/ Strongly Disagree	% Agree/ Strongly Agree
1. I like the services that I received here.	1.9	89.7
2. If I had other choices, I would still get services from this agency.	4.7	85.3
3. I would recommend this agency to a friend or family member.	3.3	87.5
4. The location of services was convenient (parking, public transportation, distance, etc.).	6.0	82.7
5. Staff were willing to see me as often as I felt it was necessary.	4.5	85.7
6. Staff returned my calls within 24 hours.	8.4	78.1
7. Services were available at times that were good for me.	3.8	87.9
8. I was able to get all the services I thought I needed.	5.5	84.2
9. I was able to see a psychiatrist when I wanted to.	7.3	78.8
10. Staff here believe that I can grow, change, and recover.	2.2	88.3
11. I felt comfortable asking questions about my treatment and medication.	3.2	89.6
12. I felt free to complain.	4.8	80.7
13. I was given information about my rights.	3.0	87.4
14. Staff encouraged me to take responsibility for how I live my life.	2.9	87.5
15. Staff told me what side effects to watch out for.	8.5	78.1
16. Staff respected my wishes about who is, and who is not to be given information about my treatment.	3.3	87.7
17. I, not staff, decided my treatment goals.	5.4	79.7
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	3.1	84.4
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	3.4	85.3
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	3.8	84.4

As a direct result of the services I received:	% Disagree/ Strongly Disagree	% Agree/ Strongly Agree
21. I deal more effectively with daily problems.	4.4	78.4
22. I am better able to control my life.	5.1	75.8
23. I am better able to deal with crisis.	6.1	74.8
24. I am getting along better with my family.	8.2	70.4
25. I do better in social situations.	9.4	66.4
26. I do better in school and/or work.	12.5	55.6
27. My housing situation has improved.	13.9	62.2
28. My symptoms are not bothering me as much.	13.6	63.0
29. I do things that are more meaningful to me.	8.0	69.8
30. I am better able to take care of my needs.	7.4	72.7
31. I am better able to handle things when they go wrong.	9.5	68.7
32. I am better able to do things that I want to do.	10.3	68.6
33. I am happy with the friendships I have.	9.0	71.0
34. I have people with whom I can do enjoyable things.	9.6	71.4
35. I feel I belong in my community.	12.8	63.2
36. In a crisis, I would have the support I need from family or friends.	9.6	73.7

** The total number of responses for domain scores may be less than the reported number of completed surveys as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.*

NOTE: The 3 highest percentages of "% Agree/Strongly Agree" are highlighted green. The 3 highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Level of Care

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

DOMAIN	Means				
	OP (N=1,184)	ACT (N=716)	CM (N=183)	CR (N=79)	Other (N=464)
General Satisfaction	4.5	4.2	4.3	4.2	4.6
Perception of Access	4.3	4.0	4.3	4.0	4.3
Perception of Quality and Appropriateness	4.3	4.1	4.3	4.2	4.5
Perception of Participation in Treatment Planning	4.3	4.1	4.3	4.3	4.4
Perception of Outcome Services	3.9	3.9	4.0	3.7	4.1
Perception of Functioning	3.8	3.9	4.0	3.7	4.1
Perception of Social Connectedness	3.9	3.9	3.9	3.7	4.0

DOMAIN	% over 3.5				
	OP	ACT	CM	CR	Other
General Satisfaction	92.7	83.8	88.0	83.5	90.0
Perception of Access	89.9	81.1	89.6	75.9	90.0
Perception of Quality and Appropriateness	91.4	83.8	90.6	78.5	95.0
Perception of Participation in Treatment Planning	91.7	87.4	90.4	86.1	95.0
Perception of Outcome Services	70.4	72.9	79.9	56.4	80.0
Perception of Functioning	71.0	77.2	77.9	57.1	84.2
Perception of Social Connectedness	73.1	74.2	78.4	61.0	72.2

DOMAIN	% below 3.5				
	OP	ACT	CM	CR	Other
General Satisfaction	7.3	16.2	12.0	16.5	10.0
Perception of Access	10.1	18.9	10.4	24.1	10.0
Perception of Quality and Appropriateness	8.6	16.2	9.4	21.5	5.0
Perception of Participation in Treatment Planning	8.3	12.6	9.6	13.9	5.0
Perception of Outcome Services	29.6	27.1	20.1	43.6	20.0
Perception of Functioning	29.0	22.8	22.1	42.9	15.8
Perception of Social Connectedness	26.9	25.8	21.6	39.0	27.8

Legend	
OP	Outpatient
ACT	Assertive Community Treatment
CM	Case Management
CR	Crisis Residential
Other	Includes: Residential, Behavioral Health Court, and Prevention

NOTES: The total number of responses for domain scores may be less than the reported number of completed surveys as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The highest percentages of "% Agree/Strongly Agree" are highlighted green. The 3 highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Race/Ethnicity

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

	Means				
DOMAIN	White (N=1,164)	Hispanic (N=725)	African American (N=364)	Asian/ Pacific Is. (N=185)	Native American (N=28)
General Satisfaction	4.3	4.4	4.3	4.5	4.4
Perception of Access	4.1	4.3	4.2	4.3	4.5
Perception of Quality and Appropriateness	4.2	4.3	4.2	4.3	4.6
Perception of Participation in Treatment Planning	3.9	4.0	3.8	4.0	4.1
Perception of Outcome Services	3.8	4.0	3.8	4.0	4.2
Perception of Functioning	3.8	4.0	3.8	4.0	4.2
Perception of Social Connectedness	4.2	4.3	4.2	4.3	4.6

	% over 3.5				
DOMAIN	White	Hispanic	African American	Asian/ Pacific Is.	Native American
General Satisfaction	87.0	92.0	88.2	91.9	88.0
Perception of Access	83.8	89.5	84.2	90.0	100.0
Perception of Quality and Appropriateness	88.2	89.7	83.9	90.5	100.0
Perception of Participation in Treatment Planning	89.0	91.4	87.9	92.4	96.0
Perception of Outcome Services	70.0	75.4	67.5	77.7	72.0
Perception of Functioning	72.3	76.0	71.6	78.4	87.5
Perception of Social Connectedness	71.7	78.7	67.2	79.5	75.0

	% below 3.5				
DOMAIN	White	Hispanic	African American	Asian/ Pacific Is.	Native American
General Satisfaction	13.0	8.0	11.8	8.1	12.0
Perception of Access	16.2	10.5	15.8	10.0	0.0
Perception of Quality and Appropriateness	11.8	10.3	16.1	9.5	0.0
Perception of Participation in Treatment Planning	11.0	8.6	12.1	7.6	4.0
Perception of Outcome Services	30.0	24.6	32.5	22.3	28.0
Perception of Functioning	27.7	24.0	28.4	21.6	12.5
Perception of Social Connectedness	28.3	21.3	32.8	20.5	25.0

NOTES: Other (N = 112) and Unknown (N = 31) racial/ethnic categories are not displayed above.

The total number of responses for domain scores may be less than the reported number of completed surveys as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The 3 highest percentages of "% Agree/Strongly Agree" are highlighted green. The 3 highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Satisfaction by Age

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

DOMAIN	Means		
	18-25 (N=336)	26-59 (N=1,931)	60+ (N=359)
General Satisfaction	4.3	4.4	4.4
Perception of Access	4.2	4.2	4.2
Perception of Quality and Appropriateness	4.3	4.3	4.2
Perception of Participation in Treatment Planning	4.3	4.2	4.3
Perception of Outcome Services	3.9	3.9	3.9
Perception of Functioning	3.9	3.9	3.9
Perception of Social Connectedness	3.9	3.9	3.8

DOMAIN	% over 3.5		
	18-25	26-59	60+
General Satisfaction	88.9	88.7	91.1
Perception of Access	86.3	86.5	86.5
Perception of Quality and Appropriateness	89.7	88.2	88.3
Perception of Participation in Treatment Planning	90.1	89.7	91.8
Perception of Outcome Services	73.7	70.6	75.0
Perception of Functioning	76.7	72.0	77.1
Perception of Social Connectedness	75.1	72.9	75.1

DOMAIN	% below 3.5		
	18-25	26-59	60+
General Satisfaction	11.1	11.3	8.9
Perception of Access	13.7	13.5	13.5
Perception of Quality and Appropriateness	10.3	11.8	11.7
Perception of Participation in Treatment Planning	9.9	10.3	8.2
Perception of Outcome Services	26.3	29.4	25.0
Perception of Functioning	23.3	28.0	22.9
Perception of Social Connectedness	24.9	27.1	24.9

NOTES: The total number of responses for domain scores may be less than the reported number of completed surveys as a completed survey was defined as any survey having sufficient data to calculate the first (General Satisfaction) domain. While some respondents may have completed this requirement, sufficient data to calculate the other domain scores may not have been available for all respondents.

The 3 highest percentages of "% Agree/Strongly Agree" are highlighted green. The 3 highest percentages of "% Disagree/Strongly Disagree" are highlighted red.

Length of Services

How long have you received services here? (N=2,003)	%	N
This is my first visit here.	4%	71
I have had more than one visit but I have received services for less than one month.	5%	106
1 - 2 months.	8%	167
3 - 5 months.	9%	172
6 months to 1 year.	12%	241
More than 1 year.	62%	1,246

Arrests: Services One Year or Less

Were you arrested since you began to receive mental health services?	%	N
Yes.	11%	71
No.	89%	553
Were you arrested during the 12 months prior to that?	**%**	**N**
Yes.	18%	111
No.	82%	505
Since you began to receive mental health services, have your encounters with the police . . .?	**%**	**N**
Been reduced.	70%	176
Stayed the same.	23%	58
Increased.	7%	18

Arrests: Services More than One Year

Were you arrested since you began to receive mental health services?	%	N
Yes.	7%	79
No.	93%	1,118
Were you arrested during the 12 months prior to that?	**%**	**N**
Yes.	10%	114
No.	90%	1,081
Since you began to receive mental health services, have your encounters with the police . . . ?	**%**	**N**
Been reduced.	61%	173
Stayed the same.	29%	82
Increased.	10%	27

NOTE: Percentages in the tables above may not add up to 100% due to rounding.

Consumer Demographics

AOABHS Spring 2016 Survey Takers

Gender	%	N
Female	47%	1,244
Male	52%	1,363
Other/Unknown	<1%	2

All AOABHS Consumers in FY 2015-16

Gender	%	N
Female	49%	5,471
Male	50%	5,567
Other/Unknown	<1%	47

AOABHS Spring 2016 Survey Takers

Race/Ethnicity	%	N
White	45%	1,164
Hispanic	28%	725
African American	14%	364
Asian/Pacific Islander	7%	185
Native American	1%	28
Other	4%	112
Unknown	1%	31

Data above includes all returned surveys from clients with valid Race/Ethnicity or Gender data in CCBH (N=2,609).

All AOABHS Consumers in FY 2015-16

Race/Ethnicity	%	N
White	44%	4,871
Hispanic	26%	2,844
African American	12%	1,313
Asian/Pacific Islander	9%	968
Native American	1%	83
Other	5%	559
Unknown	4%	447

Data Source: CCBH download (7/2016)
NOTE: These data are preliminary and subject to change in the publication of the AOABHS Databook for FY 2015-16.

Language Availability

Were the services you received provided in the language you prefer?	%	N
Yes.	97%	1,874
No.	3%	56

Reason for Involvement with Program

What was the primary reason you became involved with this program?	%	N
I decided to come in on my own.	36%	706
Someone else recommended that I come in.	59%	1,157
I came in against my will.	5%	97

NOTE: Percentages in the tables above may not add up to 100% due to rounding.

Response Rates

SPRING 2016 SURVEY	
Total Number of Visits Reported Across Programs (during survey period)	4,430
Total Number of Clients Who Received Services Across Programs (during survey period)	3,554
Total Number of Surveys Received	2,626
Number of Incomplete Surveys Received	448
Number of Completed Surveys Received	2,178
Proportion of Returned Surveys Completed	83%
Proportion of Returned Surveys Incomplete*	17%
BY VISIT Response Rate Including Incompletes	59%
BY VISIT Response Rate NOT Including Incompletes	49%
BY CLIENT Response Rate Including Incompletes	74%
BY CLIENT Response Rate NOT Including Incompletes	61%

**To calculate response rates, surveys were counted as incomplete if the survey had insufficient data to compute the "General Satisfaction" domain score of the MHSIP which meant that all 3 of the first 3 items of the questionnaire were missing.*

NOTE: All surveys (complete and incomplete) were included in the aggregate analyses.

Health and Human Services Agency
Behavioral Health Services

Do you have input on Mental Health and Alcohol & Other Drug Services in your community? If yes, please plan to attend one of the Community Engagement Forums below. With your input we can improve the path to better health! All forums will be the same format and it is only necessary to attend one.

Please visit BHSforums.eventbrite.com to register online or you may register by calling Gina Brown at (619) 563-2762. Please RSVP for interpreter services, if needed. Facilities are ADA accessible.

Community Engagement Forums

8/29/16 Park Ave. Community Center
210 Park Avenue
Escondido, CA 92025
1 p.m. – 4 p.m.

8/30/16 Scottish Rite Center
1895 Camino del Rio South
San Diego, CA 92108
9 a.m. – 12 p.m.

8/31/16 Clarion Hotel National City
700 National City Boulevard
National City, CA 91950
1 p.m. – 4 p.m.

9/1/16 QLN Conference Center
1938 Avenida del Oro
Oceanside, CA 92056
9 a.m. – 12 p.m.

9/12/16 Marina Village Center
1936 Quivira Way
San Diego, CA 92109
9 a.m. – 12 p.m.

9/14/16 Office of Education
6401 Linda Vista Road
San Diego, CA 92111
6 p.m. – 9 p.m.

9/20/16 Alpine Community Center
1830 Alpine Boulevard
Alpine, CA 91901
2 p.m. – 5 p.m.

9/21/16 Clarion Hotel National City
700 National City Boulevard
National City, CA 91950
6 p.m. – 9 p.m.

9/26/16 North Inland Live Well Center
649 W. Mission Avenue
Escondido, CA 92025
6 p.m. – 9 p.m.

9/28/16 Scottish Rite Center
1895 Camino del Rio South
San Diego, CA 92108
6 p.m. – 9 p.m.

9/29/16 QLN Conference Center
1938 Avenida del Oro
Oceanside, CA 92056
6 p.m. – 9 p.m.

10/4/16 La Mesa Community Center
4975 Memorial Drive
La Mesa, CA 91942
6 p.m. – 9 p.m.

light meal will be served, pre-registration required. **childcare services will be available, pre-registration required.**

MHS Cultural Competence Plan Review Guidelines

MHS Program/Legal Entity_____

Current Status of Program				
The Cultural Competence Plan includes:	**Included**		**Quality**	**Strengths/Needs**
	Yes	**No**	**1-adequate 2-good 3-exemplary**	
How the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.				
How program administration prioritizes cultural competence in the delivery of services.				
Goals accomplished regarding reducing health care disparities.				
Barriers to quality improvement.				

Service Assessment Update and Data Analysis				
The Cultural Competence Plan includes:	**Included**		**Quality**	**Strengths/Needs**
	Yes	**No**	**1-adequate 2-good 3-exemplary**	
An assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.				
Comparison of staff to diversity in community.				
A universal awareness of trauma that is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.				
Use of interpreter services.				
Service utilization by ethnicity, race, language usage, and cultural groups.				
Client outcomes that are meaningful to client's social ecological needs.				

Objectives				
The Cultural Competence Plan includes:	**Included**		**Quality**	**Strengths/Needs**
	Yes	**No**	**1-adequate 2-good 3-exemplary**	
Goals for improvements.				
Processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practices in service delivery.				
a) Trauma-informed principles and concepts integrated.				
b) Faith-based services.				

Culturally and Linguistically Appropriate Services (CLAS) Standards				
CLAS Standards are embedded into the Cultural Competence Plan.				

Notes

_____

_____

_____

_____

_____

_____

_____ _____

Reviewer Name **Review Date**

Supplemental Information			
	Yes	**No**	**COMMENTS**
Cultural Competence – Program Annual Self-Evaluation (CC-PAS)			
California Brief Multicultural Competence Scale (CBMCS)			
Certification of Language Competence			
Cultural Competence Focus Groups for Program Clients			
Training Needs Survey			
Other:			
Other:			
Other:			

Culturally and Linguistically Appropriate Services (CLAS) Standards					
The Cultural Competence Plan includes:	**Included**		**The extent to which this CLAS Standard is being implemented** (check applicable box)		
	Yes	**No**	**Not implemented**	**Partially implemented**	**Fully implemented**
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.					
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.					
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.					
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.					
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.					
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.					
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.					
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.					
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.					
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.					
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.					
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.					
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.					
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.					
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.					

Additional CLAS-specific notes: _____

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (problem resolution, appeal, grievance)

SUBJECT:	**Grievances, Appeals, Expedited Appeals and State Fair Hearings: Monitoring the Beneficiary and Client Problem Resolution Process**	**REFERENCE #**	6037
		PAGE:	1 OF 6
		DATE:	**01/23/2012**
REFERENCE	**CFR Title 42, Subpart F, §438.400; Title 9, CCR, Chapter 11, §1850.205, 1850.210 and 1810.375; DMH Information Notice No.: 01-05, and DMH Letter 05-03, County Mental Health Beneficiary & Client Problem Resolution Policy and Process**		

PURPOSE

- To establish procedures for the monitoring of the Mental Health Plan (MHP) Beneficiary and Client Problem Resolution Process,
- To ensure that client rights are maintained to their fullest extent, and
- To ensure MHP compliance with federal, state and contract regulations.

BACKGROUND

Title 42, Section (§) 438.400 of the Code of Federal Regulations details the requirements for grievance systems and the handling of grievances and appeals. Title 9 of the California Code of Regulations, Chapter 11, §1850.205 details the requirements for problem resolution processes as required in California. These include regulations regarding access to State Fair Hearings for Medi-Cal beneficiaries who want to have a ruling on an MHP service decision by an Administrative Law Judge.

The MHP maintains a process for addressing and resolving the grievances, appeals, expedited appeals, and requests for State Fair Hearings of all consumers utilizing county and contracted mental health services in accordance with applicable federal and state regulations. This process is included as part of the Organizational Provider Operations Handbook, and as such, is a part of every provider contract.

DEFINITIONS

None

POLICY

The MHP Quality Improvement (QI) Unit shall be responsible for monitoring grievances, appeals, expedited appeals, and State Fair Hearings emanating from usage of the Beneficiary and Client Problem Resolution Process in order to identify trends and issues and make recommendations for needed system improvements. The QI Unit shall submit any required reports on grievances, appeals, expedited appeals and State Fair Hearings to the Department of Mental Health (DMH).

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

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PROCEDURES

The QI Unit shall keep a centralized record of all grievances, appeals and expedited appeals from advocacy contractors. The QI Unit shall also keep a record of all State Fair Hearings. The Beneficiary and Client Problem Resolution Process shall reflect the following:

1. County clinics and each contracted organizational provider shall have processes in place for informal, quick resolution of client concerns and suggestions. These shall be reviewed by QI staff during the annual site visit and upon request.

2. The county shall contract with an advocacy program to provide services to consumers in MHP inpatient and residential facilities and with a second advocacy program to provide services for consumers in outpatient and all other types of mental health programs, hereafter referred to as “advocacy organizations.” These organizations shall be designated and publicized as points of contact for clients experiencing problems with the MHP. The MHP shall ensure that all provider staff, beneficiaries and clients have adequate information explaining the Grievances, Appeals and Expedited Appeals procedures through the processes detailed in Title 9, CCR, Chapter 11, §1850.205(1).

3. The advocacy organizations shall complete and submit the required Grievance and Appeal Log to the QI Unit within the required time frame each month. The logs shall include the client name or other identifier, date of receipt of the grievance or appeal, date logged, description of the problem, and date and description of the resolution. Grievances and appeals pertaining to children shall be differentiated from those pertaining to adults.

4. QI Unit staff shall review logs and verify that the above required information is present and compile the log information into a QI Unit database.

5. Since timeliness of resolution is a key issue for beneficiaries, QI Unit staff shall monitor the timeliness of the advocacy organization’s resolution of grievances and appeals, and make recommendations for improvements where needed. This shall include ensuring that:

    - Grievances and appeals are recorded in the log within one (1) working day of the date of receipt;

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COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
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- The advocacy organization provides the client with written acknowledgement of receipt of grievance or standard appeal within three (3) working days, and expedited appeal within two (2) working days. A reasonable effort shall be made to provide clients with prompt oral notice of expedited appeal resolution;

- The advocacy organization contacts the provider within three (3) working days of the receipt of the client's written permission to represent the client for a grievance or standard appeal, and within no longer than two (2) working days of the receipt of an expedited appeal;

- The advocacy organization contacts the QI Unit within three (3) working days of receipt of a standard appeal, and immediately upon receipt of an expedited appeal;

- The grievance disposition is provided by the advocacy organization to the client, the provider and the QI Unit within 60 calendar days of receipt. If an extension was made (up to maximum of 14 calendar days) for good cause, documentation is present showing the client's agreement to that extension; and if a timeframe extension was not at the request of the client, the advocate shall provide the client written notice of the reason for the delay, using a Notice of Action-D form (NOA-D);

- The appeal disposition is provided by the advocacy organization to the client, the provider, and the QI Unit within 45 calendar days of receipt. If an extension was made (up to maximum of 14 calendar days) for good cause, documentation is present showing the client's agreement to that extension; and if a timeframe extension was not at the request of the client, the advocate shall provide the client written notice of the reason for the delay;

- Concurrence of the MHP shall be obtained by the advocacy organization prior to denying classification of any appeal as an "expedited appeal"; expedited appeal denials shall be provided by the advocacy organization to the client, the provider, and the QI Unit within two (2) calendar days of denial; and

- The expedited appeal disposition shall be provided by the advocacy organization to the client, the provider, and the QI Unit within three (3) working days of receipt. If an extension was made (up to maximum of 14 calendar days) for good cause, documentation is present

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH ADMINISTRATION

Chapter: Quality Improvement
Key Words: (problem resolution, appeal, grievance)

SUBJECT:	**Grievances, Appeals, Expedited Appeals and State Fair Hearings: Monitoring the Beneficiary and Client Problem Resolution Process**	**REFERENCE #**	6037
		PAGE:	4 OF 6
		DATE:	**01/23/2012**
REFERENCE	**CFR Title 42, Subpart F, §438.400; Title 9, CCR, Chapter 11, §1850.205, 1850.210 and 1810.375; DMH Information Notice No.: 01-05, and DMH Letter 05-03, County Mental Health Beneficiary & Client Problem Resolution Policy and Process**		

showing the client's agreement to that extension; and if a timeframe extension was not at the request of the client, the advocate shall provide the client written notice of the reason for the delay.

Each advocacy organization shall ensure that clients are able to check the status of a grievance, appeal or expedited appeal. The Program Managers for these organizations shall be the designated contact persons, with the understanding that all staff can provide status reports through usage of a computerized case activity logs.

MHP Quality Improvement Monitoring Process

1. QI Unit staff shall monitor documentation by the advocacy organization showing that the client and provider was notified in writing of the resolution of any grievance. The documentation shall include the date of notification of the parties involved. If the advocacy organization was unable to successfully contact the client with this information, the advocacy organization shall show evidence of efforts to do so.

2. QI Unit staff shall monitor all aspects of the Beneficiary Problem Resolution Process through oversight of the advocacy organization, including on-site audits and review of files, to ensure the client's rights are safeguarded. This shall include ensuring that the utmost level of client confidentiality is maintained. It shall also include ensuring that:

   - A client may authorize another person to act on his/her behalf and that this representative may use the grievance or appeal process at the client's request;

   - A client may choose a support person to accompany him or her to any meetings or hearings regarding a grievance or appeal;

   - A client or his or her representative may examine the case file, including medical records and any other documents or records considered during the grievance or appeal process, before and during the process;

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- A client is not subject to any penalty for filing a grievance, appeal or expedited appeal, nor does any provider have punitive action taken against it for supporting/requesting an expedited appeal;

- A client is not required to file a grievance or appeal in writing, and will be assisted, if necessary, in completing the required written appeal; no written copy is necessary for an expedited appeal;

- A Medi-Cal beneficiary has the right to request a fair hearing when dissatisfied with the resolution of an appeal or when the grievance or appeal has not been completed within mandated timelines. Beneficiaries must otherwise exhaust the MHP's appeal process prior to filing for a State Fair Hearing;

- The grievance or appeal decision maker shall be a health care professional with the appropriate clinical expertise in treating the client's condition, when the grievance or appeal is about a clinical issue;

- The grievance or appeal decision maker shall be an outside contractor staff person not involved in any previous level of review or decision making;

- Personnel have been identified to assist the client with these processes at the client's request;

- Personnel have been identified to provide information regarding the status of a client's grievance or appeal; and

- All aspects of the grievance and appeals processes protect the beneficiary's right to confidentiality.

3. A pattern of non-compliance with regulations regarding processing of client grievances and appeals may result in QI staff instituting a Quality Improvement Plan or Plan of Correction with the advocacy organization or provider.

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4. QI Unit staff shall prepare a summary of grievances, appeals, expedited appeals, and State Fair Hearings on a semi-annual basis. In addition, QI Unit staff shall prepare any required reports on grievances, appeals, and expedited appeals and State Fair Hearings for DMH.

5. Trends including the frequency of occurrence of a particular issue and the frequency of involvement of a particular provider or client in grievances, appeals, expedited appeals, and State Fair Hearings will be analyzed. Identified issues will be reported to the Quality Review Council, the MHP Director, Behavioral Health Administration, and other oversight committees for recommendations or action, as needed.

QUESTIONS / INFORMATION
Steven Jones, Program Manager
Quality Improvement
(619) 641-8802

ATTACHMENTS/RELATED DOCUMENTS
None

SUNSET DATE: This policy will be reviewed for continuance on or before March 31, 2015.

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