San Joaquin County Behavioral Health Services
2019-20 Annual Update to the 2010 Cultural Competency Plan

San Joaquin County Behavioral Health Services (BHS) continuously seeks to improve by evaluating, strategizing and enhancing service delivery in a broad range of behavioral health services that include mental health and substance use disorder services in a culturally competent and linguistic appropriate manner to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.

This document serves as a brief annual update, reviewing the efforts of Fiscal Year 2018-2019 and to provide strategic guidance and baseline development on upcoming efforts for 2019-20. The Brief Annual update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010, reflective of the current Medi-Cal population to provide strategies on improvement and enhancement of Culturally Competent and Linguistically Appropriate Services, for agency staff, community partners and consumers.

Criterion 1: Commitment to Cultural Competence
(CLAS Standard 2, 3, 4, 9, 15)

BHS continues its efforts to expand and enhance its Cultural Competency efforts. BHS began tracking, monitoring and measuring strategies via the BHS QI Work Plan. The addition of this process allowed for accountability to review measurable objectives throughout the 2018-19 Cultural Competency Plan Update.

A new four to five hour online training entitled, "Improving Cultural Competency for Behavioral Health Professionals", released in May 2019, was introduced to the cultural competency committee. The training's learning objectives are to: 1) Describe how culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care; 2) Describe the principles of cultural competency and cultural humility; 3) Discuss how our bias, power, and privilege can affect the therapeutic relationship; 4) Discuss ways to learn more about a client's cultural identity; 5) Describe how stereotypes and microaggressions can affect the therapeutic relationship; 6) Explain how culture and stigma can influence help-seeking behaviors; 7) Describe how communication styles can differ across cultures; 8) Identify strategies to reduce bias during assessment and diagnosis; and, 9) Explain how to elicit a client's explanatory model. After review by the Cultural Competency Committee, the training was selected as agency-wide online training course to replace the former online training.

2018-19 Accomplishments: Two significant strategies were implemented to enhance agency commitment to Cultural Competency. These were:

- Measured and monitored cultural competency standards through the 2018-19 Quality Improvement Work Plan (See Attachment 1)
- Adopted a new, updated online training entitled "Improving Cultural Competency for Behavioral Health Professionals" by the Federal Office of Minority Health to replace an older training. (See Attachment 2)

2019-20 Strategies: BHS plans to further enhance its cultural competence by:

- Developing measurable standards for culturally competent services for substance use disorder (SUD) services by December 31, 2019.

- Developing a plan to measure and monitor the cultural competency standards for SUD services through the data dashboard and/ or the Quality Improvement Work Plan by December 31, 2019.
- Conducting a division-wide and program-specific inventory of Cultural Competency knowledge via the California Brief Multicultural Competence Scale (CMCBS) to identify gaps in the knowledge base of BHS Staff members and partners by March 30, 2020.
- Strategizing and developing an action plan to address findings of the CBMCS Survey by June 30, 2020

Criterion 2: Updated Assessment of Service Needs

(CLAS Standard 2)

BHS conducted assessments of service needs through two methods:

1. Mental Health Services Act (MHSA) Community Planning Process on the needs and gaps in services to diverse communities in the County. The assessment of service needs is detailed in the 2019-20 Annual Update to the Three Year Program and Expenditure Plan, pages 7 through 18 (See attachment 3).
2. Review of county-specific Medi-Cal Approved Claims Data for both mental health (MH) and SUD utilization provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity and penetration rates by age, gender and ethnicity (See attachment 4).

Through its MHSA Planning Needs Assessment, BHS found that the diversity of its consumers was similar to the distribution in prior years.

- African Americans are disproportionately represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County).
- Latinos are enrolled as lower rates compared to their proportion of the general population (26% of participants while comprising 42% of the population) – though this rate is up slightly from prior years.
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs more services are reaching the younger populations.
- Survey Input and Stakeholder feedback displayed race/ethnicity data reflective of the BHS client population. Notably children and youth are more likely to be Hispanic/Latino than adult survey respondents. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population.
- Feedback from self-reported demographics found that Adult Consumers represented 11% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Amongst children and youth 12% self-identified as LGBTQQI.

Data provided by CALEQRO for MH Medi-Cal Beneficiaries showed that:

- The penetration rate for individuals 60+ is higher than the statewide average.
- The penetration rate for Asian/Pacific Islanders is higher than the statewide average.
- The penetration rate for Latino/Hispanic communities (2.65%) is lower than the statewide average of 3.78%

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries showed that:

- The penetration rate for individuals 65+ is higher than statewide average
- The penetration rate for African-American group is higher than statewide and medium sized counties average
- The penetration rate for Latino/Hispanic communities (.8%) is higher that the statewide average.

From this data, the BHS Cultural Competency Committee has laid out recommendations for strategies to increase Latino/Hispanic Communities within San Joaquin County (See Attachment 5).

2018-19 Accomplishments: BHS implemented a comprehensive community planning process that included:

- Six community discussions and about the needs and challenges experienced by MH consumers with a focus on the diverse range of consumers served.
- Five targeted discussion groups with MH consumers, family members and community stakeholders.
- Assessment of program services, including utilization, timeliness and client satisfaction.
- Cultural Competency Committee presentation to multiple stakeholder groups throughout the BHS System.
- California Brief Multicultural Competency Survey (CBMCS) online survey developed for distribution to both MH and SUD direct hire staff.

2019-20 Strategies:

- Conduct a series of MHSA community planning discussions on the needs and challenges experienced by MH consumers with a focus on the diverse range of consumers served by January 31, 2020.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by January 31, 2020.
- Distribute and collect needs assessment surveys by February 15, 2020.
- Complete an annual MHSA assessment of needs by February 29, 2020.
- Conduct a series of planning discussions on the needs and challenges experienced by SUD consumers with a focus on the diverse range of consumers served by May 31, 2020.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by May 31, 2020.
- Distribute and collect needs assessment surveys by June 1, 2020.
- Complete an annual SUD assessment of needs by June 30, 2020.
- To follow-up on its CLAS survey with a more robust survey to be administered to all staff, a division-wide and program-specific inventory of Cultural Competency knowledge via the CBMCS to identify gaps in the knowledge base of both MH and SUD staff members and community partners will be administered to all staff by March 30, 2020,
- Develop strategies and an action plan to address CBMCS findings by June 30, 2020.

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Disparities

(CLAS Standard 1, 10, 14)

The new Behavioral Health Assessment and Respite Center, which opened in June 2018, is designed as a "friendly front door" to services for individuals who are unlikely to access MH and SUD services from the public behavioral health system. Community Medical Centers (CMC), a local non-profit community health care provider and a Federally Qualified Health Center (FQHC), was selected as the lead project partner because it has a long standing reputation in the community for serving racial and ethnic minorities, having started over forty years ago providing health care services in the fields to migrant farm workers. Over the years it has grown to a network of 12 community clinics serving over 80,000 patients. Ninety-seven percent of patients are low-income and 83% identify as ethnic or racial minorities.

As of 5/30/2019, a total of 445 individuals have either been referred or self-referred to receive services delivered as of part of the Homeward Bound Initiative.

Population rate of selected Races and Ethnicities in San Joaquin County, and Service Utilization Rates across BHS and the Homeward Bound Initiative :

Race and Ethnicity in San Joaquin County	Population rate across San Joaquin County[1]	San Joaquin BHS Service Utilization	Homeward Bound Service Utilization
White (non-Hispanic)	34%	38%	46%
Latinx	41%	24%	26%
Asian	15%	11%	5%
African American	7%	19%	12%
Other	4%	8%	13%

Increasing engagement across different racial and ethnic groups has been more challenging, assuming the need for Homeward Bound services across these groups is somewhat similar. As highlighted in the original proposal, the proportion of Latinx consumers who utilize San Joaquin County BHS is significantly lower than the San Joaquin population average (24% of BHS consumers are Latinx, relative to 41% of the San Joaquin population).The preliminary findings presented here suggest that the Homeward Bound Initiative is experiencing comparable levels of under-engagement (26% of consumers reporting being of Latinx ethnicity). Based on the feedback from CMC providers it is possible that at least part of this difference may be attributable to a greater number of Latinx consumers refusing to answer questions regarding their race and ethnicity, and limitations in how the data was captured. However, even factoring this into consideration, engagement with Latinx populations appears relatively low. Additionally, the proportion of consumers of Latinx ethnicity who were assessed but declined services was slightly higher relative to other racial and ethnic groups. These differences were evident despite 10 of the 15 members who deliver SUD services at CMC being Spanish speaking (67%); translation services being available where necessary; CMC's historical track record of providing physical, behavioral, and social care to migrant farm workers and their families dating back to the 1960's; and extensive current outreach efforts. One example of such outreach efforts includes a questionnaire distributed to the local community to better understand the needs of the population. Notably, a number of individuals of Latinx ethnicity initially requested additional information, but when called back either declined to engage or denied requesting such information. The engagement rates reported were calculated on relatively small sample sizes, so at this stage no firm conclusions can be drawn. Nevertheless, these findings suggest that even more extensive outreach efforts to engage a greater number of people of Latinx (and Asian) race and ethnicity may be warranted.

2018-19 Accomplishments

- First Year Evaluation Report was completed by the UC Davis Behavioral Health Center for Excellence to highlight successes, deficiencies and recommendations for upcoming year.

2019-20 Strategies

- Cultural Competency Committee to Review data from First Year Evaluation Report related to race and ethnicity and provide recommendations for further engagement of the Latinx and Asian population by April 30, 2020
- Implement adjustments to the activities of the Assessment and Respite Center in the annual contract review process by June 30, 2020.

Criterion 4: County Systems Client/Family Member/Community Committee:

(CLAS Standard 13)

BHS has two avenues to discuss the cultural competence of its staff and services:

- A Cultural Competency Committee comprised of BHS staff, consumers/family members, and other stakeholders.
- The Consortium, established in 2007, comprised of a variety of stakeholders: representatives of community based organizations, consumers and family members, community members and BHS staff.

The Cultural Competency committee was developed in accordance with the requirements of Title IX, CA Code of Regulations, Chap. 11, Article 4 Section 1810.410, (b). BHS policy states that:

1. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community
2. The Cultural Competence Committee shall meet regularly to review the BHS adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services.
3. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.
4. The Cultural Competence Committee will collaborate with the MHSA Consortium and organizations representing various groups within the community.

The Consortium meets monthly to discuss community-wide behavioral health services in a framework of cultural diversity. Many meetings include presentations on services for diverse racial and ethnic communities and focus on cultural competence and language proficiency. The Co-Chair of the Cultural Competency Committee is responsible for planning the Consortium activities along with community stakeholders. The Consortium has become a vehicle through which the Cultural Competency Committee informs our stakeholders of continuous Cultural Competency efforts.

2018-19 Accomplishments: The Cultural Competency committee achieved significant successes with the development of three major projects:

- Integrated SUD services staff into the Cultural Competency Committee
- Introduced a new mandatory online staff training on Cultural Competence (see attachment 2)

2019-20 Strategies

- Hold at least eight meetings involving representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community by June 30, 2020.
- Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups by June 30, 2020.
- Recruit additional representation from SUD Services to the Cultural Competency Committee
- Collaborate with the Consortium by disseminating Cultural Competency information and strategies at five Consortium meetings by June 30, 2020.

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

To ensure that the cultural competence training is widely available and to track employee compliance with training participation, BHS developed an online training that could be taken at each employee's convenience, and for which participation could be tracked electronically. In an effort to enhance cultural competency training, the cultural competency committee reviewed and recommended a new online training for BHS

entitled, “Improving Cultural Competency for Behavioral Health Professionals,” developed by the U.S. Department of Health and Human Services – Office of Minority Health.

The e-learning program covers:

1. Connections between culture and behavioral health
2. The impact of cultural identity on interactions with clients
3. Ways to engage, access, and treat clients from diverse backgrounds
4. Teaches how to better respond to client’s unique cultural and communication needs

2018-19 Accomplishments:

- Adopted new online course curriculum entitled, “Improving Cultural Competency for Behavioral Health Professionals”
- BHS has also continued its efforts in providing cultural competency presentations via the Consortium as outlined in Criterion 4.

2019-20 Strategies:

- Implement new online Cultural Competency Training by November 30, 2019.
- Expand Cultural Competency Training agency wide by providing Train-the-Trainers for the Health Equity Multicultural Diversity Training by (Ca. Institute for Behavioral Health Services (CIBHS)).

Criterion 6: County Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

(CLAS Standard 7)

BHS conducted a system Workforce Needs Assessment in February 2019 (Attachment 6). The results of the Workforce Needs Assessment are included in attachment 6. The table below compares proportional data on BHS employees to client data from CALEQRO and the United States Census data:

	BHS staff (Number)	BHS staff %	MH Medi-Cal Beneficiaries % (CALEQRO)	SUD Medi-Cal Beneficiaries % (CALEQRO)	County % (Census)
Caucasian/White	225	33.4%	17.2%	19%	31.8%
Hispanic	197	29.2%	45.7%	44%	41.6%
Asian	115	17.0%	9.7%	16%	16.7%
Black/African American	79	11.7%	9.7%	10%	8.2%
Other	57	8.4%	13.0%	10%	1.7%
Total	673	100%	100%	100%	100%

Data shows that BHS staff continue to be underrepresented in staff that are Hispanic, a decrease in African-American Beneficiaries shows that BHS Staff % is now just slightly above representation. Data also shows that Asian SUD Beneficiaries match BHS representation.

2018-19 Accomplishments

- Conducted system-wide Workforce Needs Assessment in February 2019.
- Reviewed staff data to determine areas in which the BHS staff was over or under-represented.

2019-20 Strategies

- The BHS Cultural Competency Committee in partnership with the Recruitment and Retention Committee will develop strategies for increasing the recruitment of staff from the Latinx/Hispanic communities and by June 30, 2020.

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

The BHS Cultural Competency Committee reviewed the language capacity of its staff collected with an in-house database. The data, provided below, shows improvement in language capacity from previous fiscal year in Cambodian, Vietnamese and Laotian Languages. Other unrepresented languages are American Sign Language and Korean.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (2017-18)	Staff to client ratio (2017-18)	# of Clients	# of BHS Staff Providing Direct Services (2018-19)	Staff to client ratio
English	13,782	705	1:20	13717	736	1:19
Spanish	830	80	1:10	818	80	1:10
Cambodian	391	4	1:98	391	7	1:56
Vietnamese	193	0	n/a	192	7	1:27
Laotian	89	0	n/a	87	6	1:15
Hmong	78	8	1:10	78	8	1:10
Tagalog	47	42	1:1	6	42	1:1
Arabic and Farsi	30	2	1:15	20	2	1:10
Chinese (Mandarin and Cantonese)	18	1	1:18	16	1	1:16
American Sign Language	10	0	n/a	7	0	n/a
Korean	3	0	n/a	3	0	n/a

2018-19 Accomplishments:

- Maintained an in-house database of language capacity of BHS staff.
- Completed Workforce Needs Assessment in 2018-19
- Improvement in language capacity in Cambodian, Vietnamese and Laotian.

2019-20 Strategies:

- The BHS Cultural Competency Committee will partner with Recruitment and Retention Committee to develop strategies for increasing the recruitment of staff that speak Cambodian, Vietnamese, and Laotian by June 30, 2020.

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

BHS documented the necessity of cultural and linguistic competency in its contractual requirements and monitors contractors to ensure that services are being implemented accordingly. BHS has included the requirement for cultural and linguistic competence in each of the project descriptions in its Requests for Proposals (RFP).

2018-19 Accomplishments:

- BHS contracts document the requirement for cultural and linguistic competence. (Attachment Boilerplate Contract)

- BHS created monitoring item in contracting document that will monitor contractors to ensure that

new services are being implemented with cultural and linguistic competence. (Attachment Contract Monitoring Tool)

2019-20- Strategies:

- Work with training coordinator to enhance access to Cultural Competency Training for BHS Contractors

Attachments:

1. BHS MH QAPI Work Plan
2. BHS SUD QAPI Work Plan
3. Online Cultural Competence Training
4. 2019-20 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 10-21
5. San Joaquin County-specific Data provided by CALEQRO for MH and SUD
6. Cultural Competency Committee Recommendations
7. 2019 Workforce Needs Assessment
8. Boilerplate Contract – Cultural Competency Language
9. Contract Monitoring Tool

5. Structure and Operations										
5.H. Cultural Competency- The MHP incorporates cultural competency principles in the systems of care to		18/19 Work Plan Reference	Goals	Target	Baseline	Data Source	Department Responsible	Review Committee	Frequency of Review	Action Plan
5.H.2	The MHP identifies strategies and resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	6.c.i.	Create workforce that is representative of the population.	By 6/30/2020, BHS will increase the Hispanic/Latino proportion of staff to 45%.	31% FY18/19	Human Resources	Cultural Competence Committee	Cultural Competence Committee	Quarterly	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies.
5.H.3	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	6.a.	Improve cultural competency of staff	As described in the Cultural Competence Plan, 100% of staff and contractors hired during FY18/19 will receive online Cultural Competency Training within 12 months of employment	66% FY18/19 for FY17/18	Department Managers	Training	Cultural Competence	Quarterly	Managers and supervisors will require new staff to complete online cultural competence training during the initial probationary period.

Initiative 6: Develop Staff and Enhance Cultural Competency

#	Goal	FY18/19 Strategic Actions and Objectives	FY18/19 Strategic Actions and Objectives
6a	Linguistically and culturally diverse staff	Document the linguistic capabilities of SAS staff and compare to Medi-Cal eligible populations to determine capacity of existing staff to meet linguistic needs of the population.	Review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.
6b	Staff and leadership trained in cultural responsiveness	Implement a train the trainer cultural responsiveness training initiative throughout the behavioral health department	Trained trainers provide ongoing training and coaching to all SJCBHS staff.
6c	Promotion of culturally and linguistically appropriate services, policies, and practices	SJCBHS's Cultural Competency Committee (CCC) recruits 3 new SUD members from diverse cultural backgrounds and from different disciplines within the department and community.	Cultural Competency Committee reviews service utilization and outcome data disaggregated by key demographic categories, and provides input on culturally relevant performance objectives, performance improvement strategies, programs, and organizational policies.
6d	American Society of Addiction Medicine (ASAM) training	All SUD staff complete 2-day in-person ASAM training, which provides participants with opportunities for skill practice at every stage of the treatment process; assessment, engagement, treatment planning, continuing care and discharge or transfer.". Two forensics mental health clinicians and three mental health adult outpatient clinicians receive ASAM training as well, to support integration of services and ensure that mental health services support clients with co-occurring disorders.	All SUD staff will receive five on-line ASAM training modules, including "ASAM Multidimensional Assessment", "From Assessment to Service Planning and Level of Care" and "Introduction to the SAM Criteria (p384 of STCs).

Attachment 3:

NEW!

Improving Cultural Competency for

Behavioral Health Professionals

Improving Cultural Competency for Behavioral Health Professionals is a FREE e-learning program designed to help behavioral health providers build knowledge and skills related to culturally and linguistically appropriate services (CLAS).

This e-learning program covers:

- Connections between culture and behavioral health
- The impact of cultural identity on interactions with clients
- Ways to engage, assess, and treat clients from diverse backgrounds

AT A GLANCE

- Learn how to better respect and respond to your client's unique cultural and communication needs
- Complete the program on your own time
- Earn up to 5 contact hours at no cost
- Accredited for Licensed Alcohol and Drug Counselors, Nurses, Psychiatrists, Psychologists, and Social Workers

READ MORE:
ThinkCulturalHealth.hhs.gov/education/behavioral-health

U.S. Department of Health and Human Services Office of Minority Health

Attachment 4: 2019-20 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 10-21

Community Program Planning Process

The community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis:

- BHS Program Service Assessment: September – March
  - Utilization Analysis
  - Penetration and Retention Reports
  - External Quality Review
- Workforce Needs Assessment
- Evaluation of Prevention and Early Intervention Programs for 2017/18

Community Discussions:

- MHSA Showcase of Programs and Services
  - October 10, 2018
- Behavioral Health Board:
  - October 2018 – Discussion of Homelessness, Housing, and the Mentally Ill
  - November 2018 – MHSA, Community Planning Meeting
- General Public Forums
  - November 5, 2018 at Behavioral Health Services in Stockton, CA
  - November 7, 2018 at the Larch Clover Community Center in Tracy, CA
  - November 8, 2018 at the Lodi Public Library in Lodi, CA

Targeted Discussion Groups

- Consumer Focus Groups
  - November 8, 2018 at the Wellness Center
  - November 15, 2018 at the Martin Gipson Socialization Center
- Consortium of MHSA Providers and Stakeholders
  - December 5, 2018

Consumer and Family Member Surveys

- 2018-19 MHSA Youth or Family Member of Children and Youth Survey
- 2018-19 MHSA Adult consumer Survey

Assessment of Mental Health Needs

Population Served

San Joaquin County Behavioral Health Services (BHS) provides behavioral health services, including mental health and substance use disorder treatments to nearly 15,900 consumers annually. In general program access is reflective of the diverse population of San Joaquin County; with a roughly even division of male and female clients. An analysis of services provided in fiscal year 2017-18, provides a general overview of program participation and county population.

Mental Health Services provided FY 2017-18

Services provided by Age	Number of BHS Clients*	Percent of BHS Clients
Children	3022	19.0%
Transitional Age Youth	3087	19.5%
Adults	8104	51.0%
Older Adults	1661	10.5%
Total	**15,874**	**100%**

*Source: BHS Client Services Data

Program participation is reflective of anticipated demand for services, with the majority of services being delivered to adults, ages 25-59 years of age. The participation amongst other age groups is consistent with their percentage within the total population.

Race/Ethnicity	County Population by Race/Ethnicity*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
White	235,440	32%		5,908	37%
Latino	310,067	42%		4,086	26%
African American	50,693	7%		2,953	19%
Asian	111,968	15%		1,642	10%
Other	31,932	4%		745	5%
Native American	1,337	0%		479	3%
Pacific Islander	3,987	1%		61	0%
Total	**745,424**	**100%**		**15,874**	**100%**

*Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American) and data indicates that nearly one-third of the Native American's in the County received services from BHS at least one time during the past year. Latinos are enrolled in mental health treatment services at rates lower than is be expected compared to

their proportion of the general population (26% of participants though comprising 42% of the population). Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impede access for Latino adults with behavioral health needs more services are reaching the younger populations.

City	County Population by City*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
Stockton	315,103	42%		10,591	67%
Lodi	67,121	9%		1,313	8%
Tracy	92,553	12%		966	6%
Manteca	81,345	11%		1,000	6%
Lathrop	24,268	3%		282	2%
Ripon	15,847	2%		107	1%
Escalon	7,558	1%		89	1%
Balance of County	154,949	20%		1,526	10%
Total	**758,744**	**100%**		**15,874**	**100%**

*Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

The majority of clients are residents of the City of Stockton. Stockton is the County seat and largest city in the region, accounting for 42% of the county population. The majority of services and supports for individuals receiving public support benefits (including mental health) are located in Stockton.

Discussion Group Input and Stakeholder Feedback

Several different types of community forums and discussion groups were convened in the Fall of 2018 to provide opportunities for a range of community stakeholders to participate in the Community Program Planning Process.

Community Program Planning for 2019-20 began in October 2018. The first set of activities included

1. MHSA Showcase.
   The purpose of the MHSA Showcase was to provide a venue for consumers, family members, stakeholders and interested community members to learn more about the programs and services funded in San Joaquin County through MHSA Program funds. The Showcase Event featured individual program booths for all MHSA funded programs – both those operated by BHS as well as those managed by contracted community partners.

   The MHSA Planning Booth at the Showcase included a poster and flyer of upcoming community planning meetings and included surveys, comment cards, and additional information about how to participate in the Community Program Planning Process.

2. Announcement at the October 2018 Behavioral Health Board

An announcement was made during the public comments portion of the October Behavioral Health Board Meeting that community program planning discussion groups were convening in November. The Director's Report included additional details regarding the proposed methodology and timeline for the community program planning process conducted to inform the 2019/20 Annual Update to the Three Year Program and Expenditure Plan. Meeting flyers for upcoming Community and Consumer Discussion Groups were distributed.

Community and Consumer Discussion Groups were held during the first two weeks of November and included three community forums and two groups specifically targeting participation by consumers ages 18 and older. The final Community Discussion Group was held in conjunction with the Behavioral Health Board Meeting, providing an opportunity for stakeholders to directly provide input to the members of the Behavioral Health Board.

All community discussion groups begin with a brief training on the Mental Health Services Act, a summary of the five components, and information about the intent and purpose of the different components including:

- Funding Priorities
- Populations of Interest
- Regulations guiding the use of MHSA funding

Stakeholder participation at these groups was tracked through meeting sign-in sheets and through the collection of anonymous demographic forms. Findings from the Demographic Form suggest that a diverse group of stakeholders participated in the community program planning process, including representatives of unserved and underserved populations.

One hundred and seventy-one individuals (N=171) participated in the community meetings and focus groups. Of these over half, (N=57%) self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59 however 22% were older adults and 5% were youth ages 18-25.

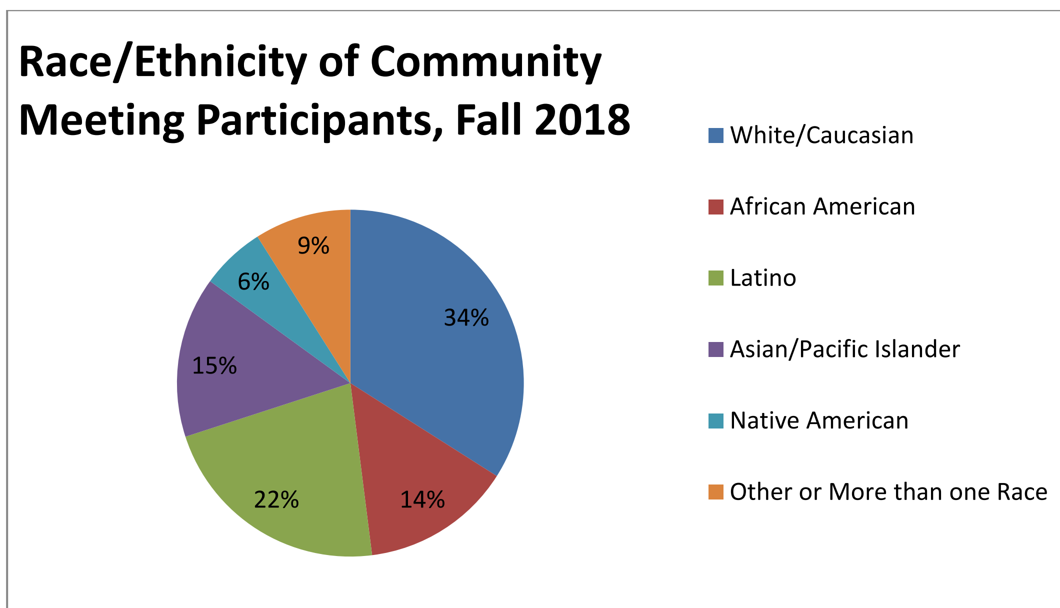
Community Meetings were also attended by the following types of individuals:

- County mental health department staff
- Substance use disorder treatment provider
- Community-based organization staff
- Children and Family Services
- Law Enforcement
- Veterans Services
- Senior Services
- Housing Providers
- Health care Providers
- Advocates for people with Serious Mental Illness

Community meetings included a diverse array of stakeholder participants. Sixteen percent (16%) of meeting participants reported speaking a language other than English at home; this compares favorably to the overall BHS population served during FY 2017/18, in which 13% of clients served spoke a language other than English.

This year also saw a greater proportion of individuals self-identifying as transgender (n=4) than in previous years which typically only included one or two individuals self-identifying as transgender. It is unknown if these increases are due to improved outreach efforts or due to community-wide reductions in stigma allowing more people the safety to self-disclose.

Community meetings were attended by a broad range of individuals representing diverse racial/ethnic backgrounds. Similar to the County population and BHS services, no one racial or ethnic group comprised a majority of participants. Also, in line with BHS service delivery patterns, there was a slight overrepresentation of African American participants, compared to the County population, and a slight underrepresentation of Latinos. These rates are consistent with service utilization at BHS.



Survey Input and Stakeholder Feedback

BHS distributed two surveys to consumers and family members in January 2019 to learn more about the perspectives, needs, and lives of the clients served through mental health programs. Over 800 individuals completed the surveys. The ***MHSA Adult Consumer Survey*** was distributed through BHS Crisis Services and various Outpatient Clinics; 501 adults completed this survey. An additional 335 family members or youth completed the ***MHSA Youth or Family Member of Children and Youth Survey*** in conjunction with services received through BHS Children and Youth Services. Survey questions were relatively the same across both questionnaires, with slight differences in the phrasing of the questions depending on the target audience. Surveys were paper-based surveys with limited choice answers. Responses were scanned into a software program that uses a proprietary technology to match checked answers with corresponding data fields. Survey instruments can be reviewed in the Appendix.

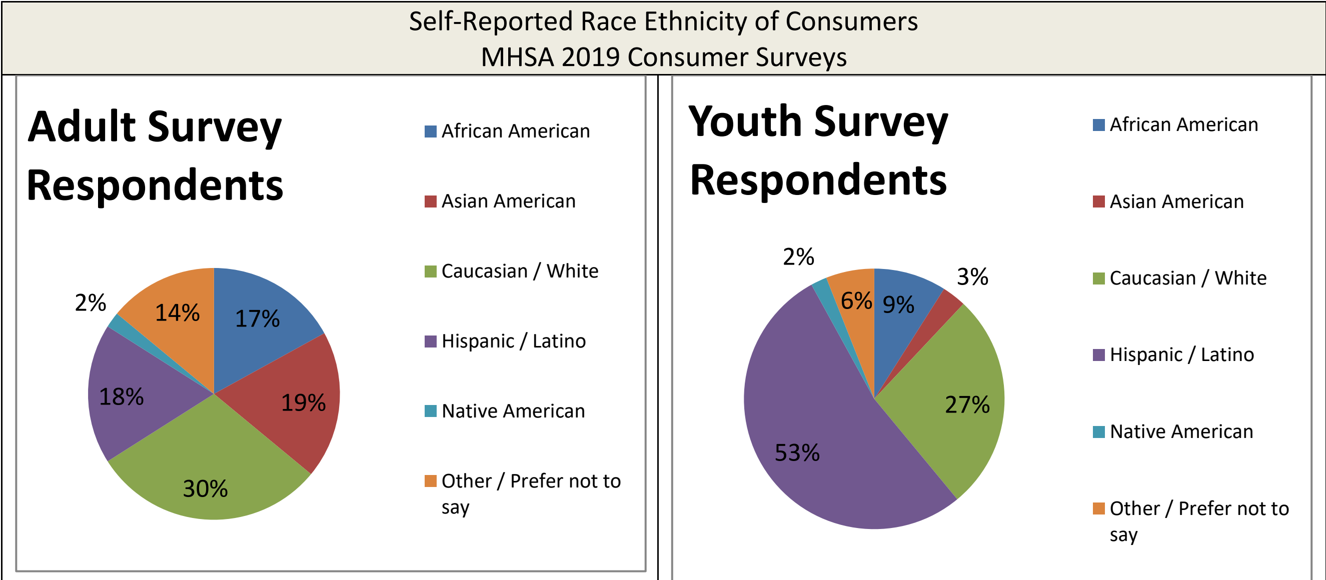
Overall BHS consumers and their family members report high levels of satisfaction with the services provided to address mental health and/or substance use disorder concerns with 85% of the respondents reporting that they would recommend BHS services for others. In terms of challenges, respondents from both surveys

reported that the greatest service challenge is the length of time it takes to get an appointment. Satisfaction for all respondents was highest in the area of thoroughness of services provided. In terms of cultural competency respondents of both surveys reported that the more work is needed to make the lobbies and reception areas feel welcoming and friendly; but report the highest levels of agreement with statements regarding staff courtesy and professionalism, respect of cultural heritage, and capacity to explain things in an easily understood manner. In one area of discrepancy between the respondents, consumers in the adult system of care were far more likely to describe BHS interpretation services as needing improvement than those served in the children and youth system of care (amongst those that have ever used interpretation services). Within the children and youth system, 92% of respondents described interpretation services as good or better, vs. only 76% of those served in the adult system of care. More work is needed to understand this discrepancy as BHS has just one set of protocols to respond to interpretation needs of clients, regardless of the system of care.

BHS was also interested in learning more about the types of people that use mental health services and used the survey tool as a way to ask clients to anonymously self-report demographic information, in the hope of getting a more nuanced understanding of the clients served separate from the data stored and reported in standardized intake forms. Survey data revealed interesting findings about client demographics, criminal justice experiences, and living situations that has not been consistently reported elsewhere.

Race/ethnicity data for the two surveys is depicted below. Race/ethnicity data is reflective of the BHS client population. Notably children and youth are more likely to be Hispanic /Latino than adult survey respondents. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population. Again, this aligns with the population served by BHS.

More detailed summaries for each population subset follows.



Summary of Adult Consumer Demographic Data (as self-reported on the survey) N=501

Age Range	Percent
18-25	11%
26-59	63%
60 and over	23%
Other or decline to state	3%

Gender	Percent
Male	42%
Female	56%
Non-binary	1%
Transgender	1%

The 500 Adult consumers surveyed represent the broad diversity of clients served by Behavioral Health Services. Most consumers have children, with 55% describing themselves as parents. Consistent with the general population, 11% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Many have a disability, with 48% describing themselves as having a physical or developmental disability. Few are military veterans, with only 6% reporting that they had served in the US armed forces. Finally a quarter of clients reported experiencing homelessness more than four times or being homeless for a at least a year (25%); and a significant portion (40%) reported having been arrested or detained by the police.

Summary of Children and Youth Consumer Demographic Data (as self-reported or declared by a parent or guardian on the survey) N=335

Age Range	Percent
0-5	5%
6-11	29%
12-15	31%
16-21	17%
22-25	7%
Prefer not to say	10%

Gender	Percent
Male	33%
Female	60%
Non-binary	0%
Transgender	1%
Prefer not to say	5%

The child's parent or guardian completed approximately half of the Children and Youth Surveys. Parents were instructed to complete surveys from the perspective of their child, but there may be some error in asking parents to complete surveys on behalf of their children. Amongst children and youth 12% self-identified at LGBTQQI and 24% reported having a disability. Veteran status was not asked on the children and youth survey. Children and youth served by Behavioral Health Services also face challenges with their living situation and in their interactions with the criminal justice system; several had been homelessness (n=31) or been detained by the police (N=40).

Community Mental Health Issues

Key Issues for Children and Youth

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County. Stakeholders recognize the increase coordination between Behavioral Health Services and Child Welfare Services in addressing the needs of children and youth touched by the foster care system, but argue that more needs to be done to support and strengthen families, particularly those where risk factors for mental illness are present. In several of the community meetings convened, stakeholders discussed the importance of uniform screening processes and earlier interventions for children and families.

- Early Education providers and schools appear to be doing a sufficient job at conducting early screening and detection for social emotional concerns among young children. However additional work is needed to engage family practice physicians and pediatricians in identifying children and families in need of additional support services.
- The biggest gap in services are early interventions for children and families following the identification of a social-emotional risk factor. Schools are seeking more behavioral health consultations in the classroom to assist teachers in working with students (including pre-school age students) that are displaying behaviors suggestive of an emerging emotional disorder.
- Many stakeholders also identified family supports such as parenting classes, family strengthening activities, and family peer partners as being pivotal early interventions to help empower parents, stabilize families, and reduce tension/anxiety among children. In particular, stakeholders suggested targeting resources towards (1) parents with self-identified behavioral health concerns of their own, and (2) young parents, particularly young parents with more than one child under 5 in the home.

Recommendations to Strengthen Services for Children and Youth:

- All adults, with children in the home, who are receiving services from BHS Adult Outpatient Clinics should be offered services or supports pertaining to family strengthening; and referred to PEI funded parenting classes.
- BHS should work with San Joaquin Child Welfare Services to review case files of young families with multiple children under 5 in the home; offer parenting classes, services, or supports; engage families and make referrals to existing parenting classes funded through PEI programming.
- The PEI school-based interventions program providing behavioral health interventions on school campuses should be available to all children, including those in pre-school or transitional kindergarten programs.

Key Issues for Transitional Age Youth

In general, stakeholders expressed the most concern for transition age youth who are easily missed by system partners – including those that have been in the military, have exited the foster care system, are college age, or are from communities that are historically unserved or underserved by mental health services. Stakeholders identified some existing resources for transition age youth, but overall stated that outside of a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- Both UOP and Delta College have student mental health programs. However, programs are not well articulated to off-campus services and supports, especially those available through the primary health care system to address mild to moderate behavioral health concerns. More linkages and articulating are needed to prevent the escalation of illnesses that can benefit from early interventions such as depression and anxiety.
- Numerous partners are working to reach returning veterans, and new services such as the veteran's court are identifying at-risk veterans and engaging them into services and supports, including alcohol and drug treatment programs.

- Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or allied youth were also identified as being at higher risk for untreated behavioral health concerns, including using alcohol of other substances as a coping mechanism for depression or anxiety related to social stigma and discrimination towards their sexual identity. LGBTQI youth have few resources or supports in San Joaquin County, though an emerging allies movement is increasing awareness of the need for more deliberate and integrated approaches to supporting LGBTQI youth in San Joaquin county.

Recommendations to strengthen services for transition age youth 16-25

- More and more apps for smart devices are emerging on the marketplace. Solicit the assistance of young people to identify which apps and tools that are being used to support mindfulness, wellness, and mental health.
- Work with local colleges to develop a pathway for referrals for student mental health concerns. Convene workshop for college mental health professionals on the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Work with Veterans Services to support young adults exiting the military and returning to San Joaquin County. Convene workshops for veterans services counselors in the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Develop smart graphics poster, in English and local threshold languages, which provides navigation guidance and advice in accessing behavioral health services for self or friends. Include risk for suicide ideation, and suicide ideation through gun violence.
- In 2017/18 BHS reserved funding for programs to address the behavioral health needs of transition age youth and adults experiencing or recovering from traumatic situations. Program services for Transitional Age Youth should demonstrate capacity for delivering culturally competent and trauma informed services, including services for transition age youth who do not have English as a first language, and for youth that are especially vulnerable to stigma, discrimination, and marginalization such as LGBTQI youth.

Key Issues for Adults

Consumers and community allies discussed the challenges of being homeless while seeking recovery from a mental illness and the need to develop more housing opportunities for people with mental illnesses. Criminal justice partners played an active role in the community program planning meetings and echoed the frustrations of consumers and family members regarding the need for better housing options to avert homelessness. Consumers also expressed frustration that it is still difficult to find reliable information on the services and supports that are available and asked BHS to consider different approaches to talking about mental health and the services available in the community.

- Too many clients are homeless and/or justice involved. BHS needs to work collaboratively to develop comprehensive treatment approaches to prevent the criminalization of the mentally ill. This should include a focus on strengthening services for those dually diagnosed with both a mental illness and a substance use disorder.

- Individuals with mental illnesses, who have been arrested and charged with offenses, are at high risk of homelessness and re-offending upon re-entry in the absence of coordinated services and supports. More efforts are needed to strengthen re-entry services for people with serious mental illnesses to avert homelessness and prevent decompensation from an untreated illness. More coordination is needed to assess all individuals exiting custody for mental illnesses and link them to existing community services prior to release.
- More information is needed regarding access to services. Public information messages should be tailored for consumers, family members, and partner service providers. Information should be developed that is responsive to diverse cultural communities – understanding that clients come from diverse backgrounds and have a range of experiences – many are parents, many are LGBTQ, and many have a first language other than English.
- More education is needed regarding mental health in general. Veterans and Latino communities are underrepresented in the adult mental health service system. Education is needed to reduce stigma towards mental illness that may prevent help seeking behavior. Education is also needed to address suicide risk and ideation – especially targeting adult men.
- BHS should work with community partners to better serve Southeast Asian clients as there is low language proficiency among BHS staff to serve some Southeast Asian clients in their native languages. BHS has 42 staff that are proficient in Tagalog, 8 who are proficient in Hmong, and 4 who are proficient in Cambodian. However there are no direct service staff that are proficient in either Laotian or Vietnamese.

Recommendations to strengthen services for Adults.

- Continue to strengthen the housing continuum for people with serious mental illnesses.
- Strengthen outreach and engagement to underserved populations including Latinos and military veterans. Consider adopting new public information and education strategies that are more broadly received and more specifically target stigma and discrimination.
- Expand suicide prevention efforts (beyond school-based prevention efforts). Develop public information and education campaign for adults with a focus on adult men and veterans.
- Create more treatment teams or residential programs that work specifically with individuals diagnosed as having co-occurring disorders.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior centers and other programs serving older adults to provide specialty interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is also needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Stakeholders identify increase use of alcohol as a coping mechanism for depression and suggest that behavioral health programming should be (1) better targeted to older adults, (2) more urgently address alcohol and depression as co-morbid conditions, (3) provide meaningful alternatives for daily living that combat depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning. Finally stakeholders identified the biggest risk to be among older adults living independently and who are socially isolated. Community members in the Tracy area stated that there are few resources for older

adults in South County. The director of the Larch Clover Community Center in Tracy, which hosted the meeting, encouraged more behavioral health services being co-located at local community centers which provide arrange of senior activities, services, and supports in locations throughout the County.

- There are few behavioral health prevention services for older adults in San Joaquin County.
- There are few evidence based substance use disorder treatment programs designed for older adults in San Joaquin County, this is of serious concern because alcohol abuse is strongly correlated with older adult depression.
- Expanded prevention services should work in partnership with local community centers.
- Vulnerable older adults include those that are homeless (which account for 10% of the total homeless population) and those that are isolated and living alone.

Recommendations to strengthen services for Older Adults:

- Co-locating senior peer counseling program in local community centers one day a week to provide information on the mental health services and supports available to older adults in the community. Ensure that senior peer partners have training in recognizing signs and symptoms of alcohol abuse and have an array of tools and resources to offer older adults requesting assistance with behavioral health concerns, including co-occurring disorders.
- Work with Adult Protective Services to identify older adults with escalating mental health symptoms. Convene workshops for Adult Protective services counselors in the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Strengthen and enhance suicide prevention efforts to target the entire community. Include targeted prevention information for middle age and older adult men. Include a focus on handguns and firearm safety precautions when living with loved ones experiencing depression.

Attachment 5: San Joaquin County Specific Data provided by CALEQRO for MH and SUD

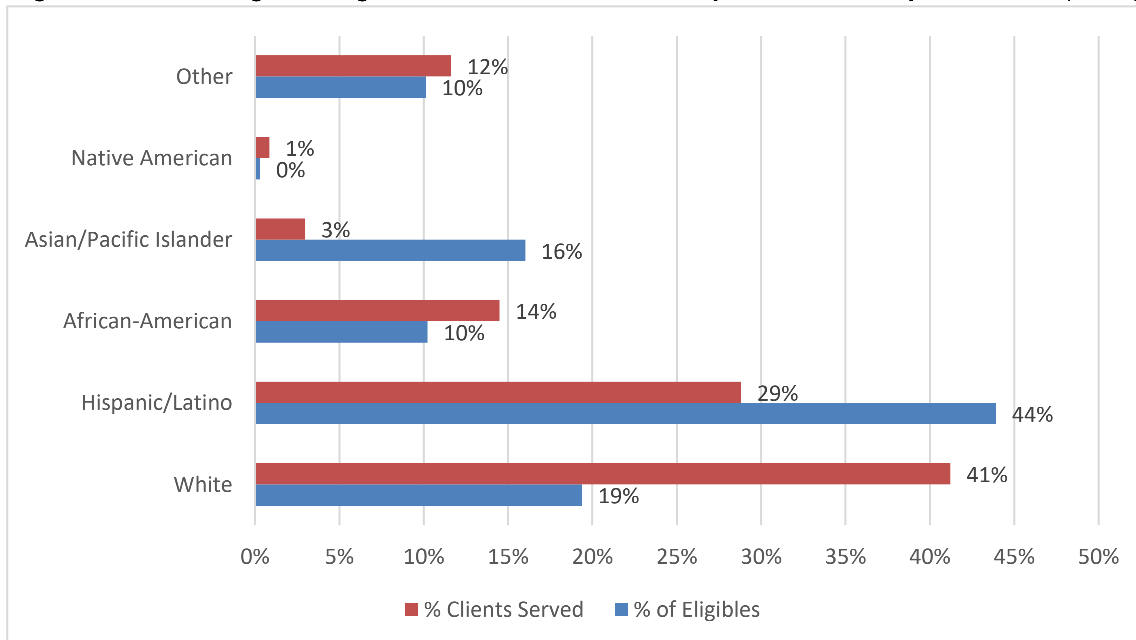
CALEQRO PERFORMANCE MEASURES FY19-20 – SAN JOAQUIN MHP

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018, by Race/Ethnicity San Joaquin MHP

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	50,914	17.2%	3,526	29.7%
Latino/Hispanic	135,669	45.7%	3,590	30.2%
African-American	28,654	9.7%	1,779	15.0%
Asian/Pacific Islander	42,745	14.4%	1,106	9.3%
Native American	813	0.3%	54	0.5%
Other	37,817	12.7%	1,833	15.4%
Total	**296,611**	**100%**	**11,888**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it.
The averages are calculated independently.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 2018 (SUD)



Attachment 6: Cultural Competency Committee Recommendations

Cultural Competency Committee – Latino Subcommittee Focus Group – Notes from Subcommittee Meeting(s)

June 3rd, June 10th, July 2nd

Cultural Competency Plan Strategies:

1. *Criterion 3 – Dedicate efforts of the BHS – Cultural Competency Committee to the development of additional strategies for outreach and engagement to Latino/Hispanic Communities by making it a permanent agenda item on monthly meetings.*
2. *Criterion 4 – Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups.*

Attendees:

Antonio Gutierrez – CYS
Lucy Lopez – Golden Valley Health
Jennifer De Polanco – Whole Person Care/JDD
Angelo Balmaceda – Administration

*Additional Feedback from general Cultural Competency Committee on July 9th.

Recommendations:

1. Alternative/Extended clinic hours to meet the needs of Latino Families that are currently working.
    a. Explore option of 4/10's to accommodate this effort.
2. Outreach Information Tables:
    a. Universities (for recruitment efforts)
    b. Flea Market
    c. Activate/Education Leaders in the Latino Community
    d. Advertising Campaign targeted to Latino Population
    e. Working with the Health Plans (HPSJ and HealthNet) on Community Events
    f. Faith Based Communities (Latino)
3. Outreach Team from each Program (Are Outreach Workers going out to community events?) –
    a. Pilot Outreach Team from 2 programs to provide Outreach and Engagement Services in a targeted Latino Community Outreach approach
4. Explore the option of expanding BHS Prevention Program:
    a. Create an In-House Cultural Broker Team (Lead Outreach Team/Community Health Workers) similar to the Promotoras Model for Latino Community Engagement
        i. Community Education (MH First Aid, Suicide Prevention)
        ii. Community Presentations
        iii. Linkage to Services
        iv. Awareness of Historical Trauma
5. Collaboration with Public Health for Community Engagement and Outreach

SAN JOAQUIN COUNTY
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Attachment 7: 2019 Workforce Needs Assessment -

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT:

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	5.75	0	0							
Case Manager/Service Coordinator	103.75	1	30							
Employment Services Staff	1.00	0	0							

Housing Services Staff	1.00	0	0							
Consumer Support Staff	44.75	1	8							
Family Member Support Staff	8.75	1	4	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only)						
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	87.25	1	0							
Sub-total, A (County)	**252.25**	**4**	**42**	**61.75**	**78.00**	**34.25**	**20.25**	**1.00**	**15.50**	**210.75**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	24.35	0	3							
Case Manager/Service Coordinator	35.25	0	5							
Employment Services Staff	1.00	0	0							

Housing Services Staff	4.50	0	0							
Consumer Support Staff	38.00	0	0							
Family Member Support Staff	2.00	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)						
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	38.27	0	0							
Sub-total, A (All Other)	**143.37**	**0**	**0**	**40.74**	**55.24**	**15.38**	**21.70**	**2.75**	**7.56**	**143.37**
Total, A (County & All Other):	**395.62**	**4**	**42**	**102.49**	**133.24**	**49.63**	**41.95**	**3.75**	**23.06**	**354.12**

I. By Occupational Category - page 2

Major Group and Positions	Esti- mated # FTE author- ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His- panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri- can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	14.63	1	9							
Psychiatrist, child/adolescent........	5.12	1	6							
Psychiatrist, geriatric	2.00									
Psychiatric or Family Nurse Practitioner	2.75	1	0							
Clinical Nurse Specialist										
Licensed Psychiatric Technician........	68.25	1	8							
Licensed Clinical Psychologist........										
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	14.75	1	8							
MSW, registered intern (or waivered)	27.25	1	14							
Marriage and Family Therapist (MFT)........	27.00	1	8							
MFT registered intern (or waivered)........	42.25	1	13	(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)						

Other *Licensed* MH Staff (direct service)	6.75	1	6							
Sub-total, B (County)	**210.75**	**9**	**72**	**56.35**	**50.50**	**19.75**	**51.75**	**0**	**19.10**	**197.45**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	3.25	1	2							
Psychiatrist, child/adolescent...	.20	1	3							
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner		1								
Clinical Nurse Specialist										
Licensed Psychiatric Technician..	3.75	1	4							
Licensed Clinical Psychologist...	2.10									
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	5.85	1	2							
MSW, registered intern (or waivered)	4.65	1	4							
Marriage and Family Therapist (MFT).....................................	21.70	1	2							
MFT registered intern (or waivered)..	13.85	1	4							
Other *Licensed* MH Staff (direct service)	0	1	2	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)						
Sub-total, B (All Other)	**55.35**	**9**	**23**	**15.79**	**14.15**	**5.55**	**14.51**	**0**	**5.35**	**55.35**
Total, B (County & All Other):	**266.10**	**18**	**95**	**72.14**	**64.65**	**25.30**	**66.26**	**0**	**24.45**	**252.80**

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0									
Registered Nurse	23.50	1	3							
Licensed Vocational Nurse	1.0									
Physician Assistant..	0									
Occupational Therapist...	1.0									
Other Therapist (e.g., physical, recreation, art, dance)	0									

Other Health Care Staff (direct service, to include traditional cultural healers)	25.0	1	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ↓						
Sub-total, C (County)	**50.50**	**2**	**3**	**19.75**	**7.0**	**4.50**	**13.25**	**0**	**3.75**	**48.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0									
Registered Nurse	0	1	0							
Licensed Vocational Nurse.......................................	1.50	1	0							
Physician Assistant...	0									
Occupational Therapist...	0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	1.20			(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ↓						
Sub-total, C (All Other)	**2.70**	**2**	**0**	**1.20**	**1.50**					**2.70**

Total, C (County & All Other):	53.20	4	3	20.95	8.50	4.50	13.25	0	3.75	50.95

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor	13.00			(Managerial and Supervisory; Sub-Totals Only)						
Supervising psychiatrist (or other physician)	1.00									
Licensed supervising clinician	23.00	1	4							
Other managers and supervisors	33.00	1	4							
Sub-total, D (County)	**70.00**	**2**	**8**	**33.00**	**11.00**	**5.00**	**11.00**	**2.00**	**2.00**	**64.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	6.72									

Supervising psychiatrist (or other physician)	0			(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Licensed supervising clinician	4.25	1	4							
Other managers and supervisors	9.98									
Sub-total, D (All Other)	**20.95**	**1**	**4**	**7.96**	**5.00**	**4.73**	**2.26**	**0**	**1.00**	**20.95**
Total, D (County & All Other):	**90.95**	**3**	**12**	**40.96**	**16.00**	**9.73**	**13.26**	**2.00**	**3.00**	**84.95**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	**27.75**	**1**	**15**	(Support Staff; Sub-Totals Only) ↓						
Education, training, research	**0**									
Clerical, secretary, administrative assistants.....	**142.25**									
Other support staff (non-direct services)	**28.75**									
Sub-total, E (County)	**198.75**	**1**	**15**	**54.00**	**50.75**	**15.25**	**18.50**	**.75**	**12.75**	**152.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	**1.45**			(Support Staff; Sub-Totals and Total Only) ↓						
Education, training, research	**0**									
Clerical, secretary, administrative assistants.....	**12.95**									
Other support staff (non-direct services)	**2.0**									
Sub-total, E (All Other)	**16.40**	**0**	**0**	**6.15**	**2.37**	**1.00**	**1.43**	**0**	**5.45**	**16.40**

Total, E (County & All Other):	215.15	1	15	60.15	53.12	16.25	19.93	.75	18.20	168.40

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE

(A+B+C+D+E)

Major Group and Positions	Esti- mated # FTE author- ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau- casian	Hispanic/ Latino	African- Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri- can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).......**	**782.25**	**18**	**140.00**	**224.85**	**197.25**	**78.75**	**114.75**	**3.75**	**53.10**	**672.45**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) ....**	**238.77**	**12**	**27.00**	**71.84**	**78.26**	**26.66**	**39.90**	**2.75**	**19.36**	**238.77**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**1,021.02**	**30**	**167.00**	**296.69**	**275.51**	**105.41**	**154.65**	**6.50**	**72.46**	**911.22**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**6,827**	**4,609**	**3,270**	**1,814**	**518**	**791**	**17,829**

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	63.85	1	8
Family Member Support Staff	11.75	1	4
Other *Unlicensed* MH Direct Service Staff.....................	0	1	

Sub-Total, A:	**75.60**	**3**	**12**
B. ***Licensed*** **Mental Health Staff (direct service).............**	**0**	**0**	
C. Other Health Care Staff (direct service)	**0**	**0**	
D. Managerial and Supervisory	**2.50**	**0**	
E. Support Staff (non-direct services)	**9.15**	**0**	
GRAND TOTAL (A+B+C+D+E)	**87.25**	**0**	**12**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL** **(2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish (threshold)	Direct Service Staff 126 Others 39	Direct Service Staff 52 Others 0	Direct Service Staff 178 Others 39
2. Cambodian (threshold)	Direct Service Staff 8 Others 2	Direct Service Staff 1 Others 0	Direct Service Staff 9 Others 2
3. Vietnamese	Direct Service Staff 11 Others 1	Direct Service Staff 0 Others 0	Direct Service Staff 11 Others 1

4. Hmong	Direct Service Staff 9 Others 5	Direct Service Staff 0 Others 0	Direct Service Staff 9 Others 5	
5. Lao	Direct Service Staff:1 Others: 0	Direct Service Staff: 2 Others 0	Direct Service Staff: 3 Others 0	
6.Thai	Direct Service Staff: 3 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 3 Ohers: 0 Others	Direct Servic C
7 Tagalog/Filipino	Direct Service Staff 23 Others 7	Direct Service Staff 0 Others 0____	Direct Service Staff 23 Others 7__	

Attachment 8: 2019-20 Boilerplate Contract – Cultural Competency Language - Item #15

15. Cultural and Linguistic Proficiency:

a. To ensure equal access to quality care by diverse populations, CONTRACTOR shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

b. When the consumer served by CONTRACTOR is a non-English or limited-English speaking person, CONTRACTOR shall take all steps necessary to develop and maintain an appropriate capability for communicating in that consumer's primary or preferred language to ensure full and effective communication between the consumer and CONTRACTOR staff. CONTRACTOR shall provide immediate translation to non-English or limited-English speaking consumers whose conditions are such that failure to immediately translate would risk serious impairment. CONTRACTOR shall provide notices in prominent places in the facility of the availability of free translation in necessary other languages.

c. CONTRACTOR shall make available forms, documents and brochures in the San Joaquin County threshold languages of English and Spanish to reflect the cultural needs of the community.

d. CONTRACTOR is responsible for providing culturally and linguistically appropriate services. Services are to be provided by professional and paraprofessional staff with similar cultural and linguistic backgrounds to the consumers being served.

Attachment 9: Contract Monitoring Tool – Annual Site Review Checklist – 6d.

6. Review sample documentation for evidence of compliance with other contract requirements:
a. Employee HIPAA training and confidentiality statements;
b. Employee training including BHS Compliance Training, CANSA, cultural competency and limited English proficiency, and clinical documentation
c. Compliance Sanction Checks up to date (applicable to Medi-Cal providers)
d. Notice of Adverse Benefit Determination (NOABD) practices of agency (applicable to Medi-Cal providers)
e. Adoption of the Federal Office of Minority Health CLAS Standards; policy and practice examples
f. Timeliness standards
g. Presence of required postings and forms available for consumers; free interpretation services, HIPAA Rights, Mon-Discrimination notices, forms for suggestions and satisfaction surveys, Notice of Adverse Benefit Determination, Medi-Cal Beneficiary Brochure