COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due August 31, 2010 to:

Department of Mental Health
Office of Multicultural Services
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PLACER COUNTY

1IA. Placer County’s Mental Health System Commitment to Cultural Competence

Placer County Department of Health and Human Services Systems of Care has been engaged in a collaborative, community-based process of reassessing our service capacities and gaps in services for our unserved and underserved populations and creating plans for system improvement for the past 5 years through both the MHSA planning process and our SAMHSA Cooperative Agreement for children’s mental health. In the past 18 months we have conducted a county-wide web-based survey of over 230 System of Care (Adult System of Care and Children’s System of Care) staff, conducted 10 focus groups for diverse populations and conducted 19 confidential key informant interviews for diverse staff and consumers. The data that was obtained has been organized by themes as it corresponds to the eight (8) Domains, and the Domains document developed by the CLC Workgroup. The Domains are broken out as follows:

- Organizational Values
- Policies, Procedures, Governance
- Planning, Monitoring, Evaluation
- Communication
- Human Resource Development
- Community and Consumer Participation
- Facilitation of a Broad Service Array
- Organizational Resources.

A copy of the Summary of the CLC Workgroup Recommendations is as follow in its entirety:

DOMAINS

PLACER COUNTY SYSTEMS OF CARE
CULTURAL AND LINGUISTIC COMPETENCY PLAN

Summary of CLC Workgroup Recommendations

1) Organizational Values

Goal: To engage executive leadership, management and line staff in a joint effort to embrace cultural curiosity and competency as a core value across the system of care.

In order to adopt a core value of cultural curiosity, the System of Care (SOC) will need to create a culture of safety and comfort to facilitate cross-cultural exchange. Towards this end, the CLC workgroup recommends the following activities:

1.1. SOC Leadership will employ a strengths-based approach that role models and rewards the growth of cultural curiosity as a value across the system of care.
   - Identify leaders to be visible agents of change in organizational values.
   - Review charter/governance documents to strengthen values statement.
Include increasing diversity of leadership as topic in next year’s retreat.
Engage forums within organization to facilitate safe and open dialogue.
Motivate change by rewarding positive cultural inquiry and actions.
Institute “Guiding Principle Awards” to honor risk taking and growth.

1.2. SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.
- Create information guide to provide strategies and guidance on how to open dialogue with leadership, management and peers around cultural awareness.
- Set standards for core staff competencies related to cultural awareness.
- Develop a training team to assist staff with integrating values and behaviors.
- Include cultural awareness as part of staff orientation and evaluation.
- Integrate culture-based discussion as a routine component of supervision.

1.3. SOC Staff will support their peers in an effort to increase the level of cultural curiosity and awareness across the system of care.
- Set norms with peers around how to engage in cultural dialogue.
- Encourage staff to bring their cultural experiences as an asset.
- Foster mentoring relationships that facilitate cultural curiosity.
- Create avenues for diverse staff to serve as resources for learning.
- Engage community members as resources for cultural exchange.
- Integrate cultural curiosity into ongoing change agent efforts.

2) Policy and Governance

Goal: To strengthen System of Care policy making and governance processes by increasing the access and inclusion of SOC management, staff and consumers.

Towards the goal of increasing participation of diverse communities in System of Care policy making and governance processes, the following activities are recommended:

2.1. SOC Leadership will review current policy making and governance processes, and develop a plan for facilitating participation from diverse constituent groups.
- Clarify values and purpose of policy groups in relation to being “stewards” of process that guides the administration of funds on behalf of all consumer groups.
- Review current structure and membership of SPEAC and SMART Policy.
- Set goals for increasing diversity of membership of key policy making groups.
- Define a cross-systems policy making and governance approach that supports active engagement of SOC management, staff, and consumers at all levels.
- Initiate the development of policies that promote culturally relevant practices, including intake, assessment, care planning, service delivery, and staff training.
- Support leadership development and education for diverse consumer groups to encourage active participation in policy making and governance activities.

2.2. SOC Managers and Supervisors will take a strengths-based approach to policy development, providing a bridge for staff and consumers to be involved in process.
- Create central source for access to policy information across SOC.
- Provide training and ongoing information on organizational policies.
- Address the barriers in current policies that limit culturally relevant practices.
- Develop and implement policies to guide culturally competent practices.
- Develop guidance for working with un-documented/un-recognized groups.
- Monitor adherence to policies that guide culturally competent practices.
- Enhance CQI and evaluation activities to include peer/consumer review.
- Create cross-systems structure to review cultural and linguistic policies for consistency, i.e., need to implement policies against racism in the schools.

2.3. SOC Staff will support their peers and consumers in being more informed and active in the development, implementation, and evaluation of policies that guide cultural and linguistic competence.

- Encourage staff to participate in policy making groups and processes.
- Empower peers to bring forward policy needs and recommendations.
- Educate each other on current policies that guide cultural competence.
- Set a group value and problem solve to improve adherence to policies.
- Keep consumers informed on policy making and grievance processes.
- Engage community members as resources for implementing policies.

3) Communication and Collaboration

Goal: To increase the capacity of SOC to engage diverse communities in mental health services through enhanced multi-cultural and multi-lingual communication.

In order to increase access for diverse communities to appropriate services, strategies for strengthening SOC capacity for multi-cultural and multi-lingual communication include:

3.1. SOC Leaders will establish the value of and create mechanisms for increasing organizational capacity for multi-cultural and multi-lingual communication.

- Establish the value of competent communication with diverse communities.
- Engage members of diverse communities in leadership and planning groups to better understand the needs and potential collaboration with these communities.
- Validate a shift in perspectives from system-based to community-based care.
- Prioritize the development of resources for increased communication capacity.
- Work with PCOE to develop a plan for increasing community collaboration.
- Authorize administrative flexibility to creatively engage resources to improve cultural and linguistically competent services.

3.2. SOC Managers will develop resources for effective community-based strategies to increase multi-cultural and multi-lingual communication and collaboration.

- Develop resources for increasing multi-cultural/lingual materials and services.
- Support a team approach towards community-based services, which includes engaging community liaisons, advocates, and peer mentors as valued members.
- Develop an assets directory of staff/cultural brokers, with tiered language skills.
- Create flexibility around current role/time constraints that limit the capacity of diverse/multi-lingual staff serve as a language resources and cultural brokers.
- Provide training and support staff to develop skills for engaging members of
diverse communities as resources in care planning and service provision.

- Create a clearinghouse resource for translation of essential forms and materials.
- Establish collaborative communication mechanisms for working with PCOE.

3.3. SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.

- Honor cultural curiosity and communication as a community wellness tool.
- Develop a team approach to better utilize staff cultural and linguistic skill sets.
- Create mechanisms for sharing resource information among staff/departments.
- Shift from provider-based service model to community-based wellness model.
- Increase collaboration with schools to create a multi-cultural community base.
- Assist schools in conducting an assessment of youth and family wellness needs.
- Create a list of cultural supports and mentors for schools and organizations.
- Assist schools to order culturally appropriate materials and develop resources for school-based cultural activities that match state education standards.

4) Human Resource Development

Goal: To expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities.

Towards the goal of improving services for diverse consumers, strategies for expanding the skills, experiences and composition of the SOC work force include:

4.1 SOC Leadership will promote the expansion of the skills, experiences, diversity of resources within SOC to provide culturally relevant and responsive services.

- Role model changing attitudes, beliefs and behaviors by participating in “courageous conversations” to address systemic privileges and biases.
- Create policies to facilitate the integration of diverse staff and cultural brokers.
- Work with cultural brokers to develop staff training and education resources.
- Expand funding streams to create pathways for hiring diverse staff members.
- Prioritize diversity in succession planning in leadership positions and processes.
- Allocate resources for training through a variety of venues, including e-learning, experiential opportunities, and local trainers from specific cultural backgrounds.
- Validate participatory learning opportunities by authorizing the use of flex time.
- Create language to ensure the hiring of diverse staff and the use of appropriate practices for contracts with community partners serving diverse communities.

4.2 SOC Managers will create tools, training materials, and procedures for expanding the diversity of staff, community resources, and service models.

- Integrate consumers and community representatives into management teams.
- Facilitate “courageous conversations” to promote intercultural learning.
- Add cultural competency to staff supervision, evaluation and development plans.
- Mentor diverse staff to utilize cultural experiences as assets in service delivery.
- Engage cultural brokers to provide experiential training opportunities for staff.
- Support staff attending cultural events and community education opportunities.
- Integrate cultural brokers into PRT/SMT as a linkage to community resources.
• Create a team to review intake, assessment forms, planning tools and practices.
• Implement best practice practices through cultural-specific service teams.

4.3 SOC staff will expand their skills, knowledge and ability to collaborate with community resources to provide culturally relevant and responsive services.
• Participate in training opportunities to expand awareness of diverse cultures.
• Engage in experiential training, attending cultural and community events.
• Integrate personal experiences and culture as an asset in the workplace.
• Work on professional and personal biases in supervision and practice.
• Set goals for expanding skills for working with diverse community members.
• Apply culturally appropriate modalities and best practices in the field.
• Seek partnerships and consultation with diverse staff and cultural brokers.

5) Consumer/Community Development

Goal: To create pathways for consumers and diverse community partners to participate in SOC policy development, service planning, delivery and evaluation.

The following strategies are recommended to successfully integrate diverse consumers and community members as partners in all levels of service planning and delivery:

5.1 SOC Leadership will develop policies and procedures to support the successful integration of consumers and diverse community members in the levels of service.
• Promote the value of equal and authentic inclusion of diverse consumers and community partners in SOC governance groups and policy making processes.
• Participate in processes to recognize and address own biases that may present barriers to working with consumers as equal partners in decision making groups.
• Serve as role models for reducing stigma, institutionalized discrimination and power differentials in working with community partners with lived experiences.
• Allow for flexibility of meeting times, locations and formats to facilitate the participation of diverse consumers and communities in governance processes.
• Engage consumers and community partners in a revision of policies to better accommodate cultural needs and diverse levels of ability in the workplace.

5.2 SOC Managers will develop resources, workplace practices and partnerships to support the preparation and integration of consumers and community members.
• Assist with the development of resources for building consumer and community capacity to participate comfortably at all levels of service planning and delivery.
• Provide skills training, supervision, and venues for peer support to assist people with lived experience entering and working effectively in the SOC workforce.
• Provide training, supervision, and venues for peer support to assist staff without lived experiences to learn how to share power and work with community partners.
• Provide training on recognizing stigma, discrimination, and behaviors that are designed to maintain power differentials; and tools for addressing these behaviors.
• Work with supervisors and staff to develop practices to ensure workplace parity.
- Assist supervisors to assess and develop appropriate accommodations to allow for the integration of workers with diverse levels of ability in the workforce.

5.3 SOC Staff will work in partnership to maximize skills and experiences.
- Create a welcoming environment that values the lived experiences of peers.
- Participate in changing workplace dynamics, working to share power with members of the workforce who have alternative pathways into the workforce.
- Support ongoing discussion on issues of culture, stigma, and discrimination.
- Support the leadership and advocacy skills of workers with lived experience.
- Develop partnerships to combine the assets of professional training with the assets of lived experience, working in community settings when appropriate.

6) Facilitating a Broad Array of Services

Goal: To create a county-wide model for providing community-based, culturally-relevant services through the expansion of the community advocacy program.

Towards the goal of creating community-based, culturally relevant services for diverse communities, SOC will develop a county-wide community peer advocacy program.

6.1 SOC Leadership will develop working relationships with community-based organizations in order to implement a culturally-relevant advocacy programs.
- Develop relationships with diverse communities and consumer groups to expand the community advocate/cultural broker model across underserved communities (i.e., Transition Age Youth, Native, Latino county-wide, Older Adults, GLBT).
- Work in partnership with diverse communities to develop a framework for community-based education and advocacy model for underserved communities.
- Facilitate a working group to guide the development of advocacy services.
- Provide guidelines for standard contract language to ensure that contracting organizations have the capacity to provide culturally-relevant services.
- Hire managers and supervisors who are members of diverse communities and have experience developing peer-based education and advocacy programs.

6.2 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.
- Develop resources for implementing best practices in community advocacy through training, technical assistance, and comprehensive program evaluation.
- Outline clear goals and objectives for community-based advocacy programs.
- Develop contract guidelines to ensure that community-based organizations conduct cultural and linguistic competency self-assessment and planning.
- Meet in quarterly working sessions with managers of community organizations.
- Develop training/orientation materials in partnership with managers of CBOs.
- Facilitate cross-cultural roundtables and workgroups to guide best practices.
- Develop evaluation protocols to measure outcomes of advocacy services.

6.3 SOC staff and community-based organizations will work together to ensure a high level of community satisfaction and ownership of mental health services.
- Build relationships with community advocates to share resources and skills.
- Participate in cross cultural roundtables and ongoing best practices workgroups.
- Participate in training on how to engage in cultural conversations effectively.
- Solicit feedback from service recipients on the success of advocacy services.
- Create forums for community members to participate in the development of mental health supports and services tailored to the needs of their community.
- Facilitate community wellness through community ownership of services.

7) Organizational Resources for CLC Activities

Goal: To develop a budget and plan for resources to dedicated to support the implementation of a comprehensive CLC plan across the system of care.

The following activities are recommended to support the development of a dedicated budget and resource development plan to support a system-wide CLC plan:

7.1 SOC leadership will develop a dedicated budget and resource development plan to support the implementation of a comprehensive CLC plan for the organization.
  - Review CLC resources and requirements across SOC programs to ensure resources are appropriately allocated and integrated in a coordinated effort.
  - Develop a budget dedicated to implementing the activities of the CLC plan.
  - Implement a fund development plan to increase resources for CLC activities.
  - Invest in partnerships with diverse communities to maximize SOC resources.

7.2 SOC Managers will engage in resource development activities to support the implementation of the CLC plan.

Recommendations from previous domains:
  - Develop resources for increasing multi-cultural/lingual materials and services.
  - Expand funding streams to create pathways for hiring diverse staff/advocates.
  - Allocate resources for training through a variety of venues including e-learning, experiential opportunities, and local trainers from specific cultural backgrounds.
  - Support the resource development capacity of community-based organizations.
  - Assist with the development of resources for building consumer and community capacity to participate comfortably at all levels of service planning and delivery.
  - Develop resources for implementing best practices for community advocacy through training, technical assistance, and comprehensive program evaluation.

Placer County’s three (3) year Strategic Plan for CLC is included, in its entirety, in Appendix D-5 of this document. Policies, procedures, tables, and/or practices are also included in Appendix A-H and are so noted throughout this plan.

1IB. Compliance Review Deliverables

All compliance review deliverables are available on site for compliance reviews.

1IIA. Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System
Placer County SOC has developed the following paragraph regarding the provision of culturally and linguistically competent services for inclusion in every contract:

**CULTURAL COMPETENCE:** PROVIDER shall provide services pursuant to this Agreement in accordance with current State statutory, regulatory and policy provisions related to cultural and linguistic competence as defined in California State Department of Mental Health (DMH) Information Notice No:10-02, The 2010 Cultural Competence Plan Requirements, which establishes new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. The Cultural Competence Plan Requirements (CCPR) standards and criteria are spelled out in the California Code of Regulations, Title 9, Section 1810.410. The standards and criteria are applicable to organizations/agencies that provide mental health services via Medi-Cal, MHSA and/or Realignment.

**Community Outreach, Engagement and Involvement**

In 2004 Placer County HHS conducted a Latino Access Study in the North Tahoe area of Kings Beach to assess the penetration and retention rates of Latino MediCal beneficiaries. The study consisted of data collection and evaluation, focus groups with the Latino Kings Beach community, individual interviews with community members including school staff and the faith-based community and HHS staff and community provider surveys.

The study resulted in the following recommendations: Create a local community-based Latino Access Study (LAS) Implementation Team which will report quarterly and annually to HHS Administration; sponsor training specific to the Latino culture for HHS and community provider staff; hire a bicultural/bilingual therapist for the Tahoe office; develop and disseminate information on mental health services to the Latino community in Spanish; improve Spanish communication systems (e.g., voice mail) and translation services; co-locate Mental Health services in Kings Beach; and provide outreach and education to reduce stigma and fear.

The following year in October of 2005 Placer HHS Children’s System of Care was awarded a 6-year Substance Abuse and Mental Health Services Administration (SAMHSA) Children’s Mental Health Initiative (CMHI) cooperative agreement. The focus of this grant was to transform the Children’s System of Care to embrace family and youth voice at every level of the system, to become culturally competent and to improve access and services to the Latino, Native American and Transition Age Youth communities. The SAMHSA grant Steering Committee joined with the LAS Implementation Team to improve services for the Latino community of Kings Beach. Through the grant initiative eight Latino community members from a variety of non-profit agencies received nine days of training in implementing wraparound services to the Latino community using RAICES (meaning “roots”), the promotora model developed in part by the University of South Florida. These individuals were certified as trainers and renamed the program “CREER” (which means “to believe” in Spanish), which stands for “Creating Resiliency through Empowerment, Education and Respect”. Trained promotoras are now assisting Latino families in South Placer County as well at Kings Beach to navigate the Mental Health and Child Welfare Systems.

A bilingual/bicultural therapist was hired utilizing grant dollars for North Tahoe. In addition, a bilingual Community Educator was hired through grant dollars to provide
outreach, education, and support to Latino families and their youth. Services of the Community Educator are provided in Kings Beach and at the local middle and high schools for the youth. Thus far we have not been able to co-locate the therapist due to lack of adequate confidential office space in Kings Beach.

Through the SAMHSA Steering Committee and the Campaign for Community Wellness Steering Committee (established in 2006 as the community planning and advisory committee to MHSA), we engaged consultants from the Native American and Latino communities to assist in outreach to these communities as well as in designing services that were culturally relevant to these communities. The Native Network (now known as the Sierra Native Alliance (SNA) and the Latino Leadership Council (LLC) were formed as community advisory groups to the HHS Systems of Care (Adult and Children’s Systems of Care). Participants in both groups include community members, non-profit providers as well as county staff. These groups have been meeting monthly for nearly four years and each is now an established 501(c)3 non-profit. Leaders of both groups participate in the SAMHSA Steering Committee and the Campaign for Community Wellness Steering Committee (CCW). The CCW was initially established as the community planning body for the MHSA initiatives, however, the SNA and LLC representatives were not yet part of the CCW when the CSS Plan was approved. The CCW continues to meet monthly to act in an advisory and planning function for system improvement.

As a result of the SAMHSA Steering Committee, the MHSA planning process, and the CCW, Placer HHS has hosted, in collaboration with our community partners, numerous trainings and community events. In 2008 Roberto Dansie, PhD., an indigenous healer, provided a 6-hour training in Spanish for over 200 Latino parents entitled “Healthy Families, Strong Communities”. Child care with activities, a catered lunch, raffle, and a survey asking parents to identify other topics of interest and need were also a part of this event. Based on results from the survey responses, two Health Fairs were held for the Latino communities, one in Lincoln in 2009 and one in Roseville in 2010. Combined over 400 adults were screened for diabetes, chronic conditions, vision, hearing, substance abuse and mental health issues by physicians and health professionals who donated their time. In conjunction with the Health Fair in Roseville, Roberto Dansie, PhD., was again invited to speak to the Latino community in Spanish on the role of the Latino culture in health and wellness.

In collaboration with the Sierra Native Alliance, Placer HHS contributed to the revival, after a nine year absence, of the Auburn Big Time Pow Wow in 2008. This event drew over 200 dancers, 50 drummers, numerous art and food vendors and over 4000 visitors from Placer and surrounding communities and states. The event brought awareness of our local Native federally recognized and unrecognized tribes and renewed pride in the Native traditions. The Auburn Big Time Pow Wow has been an annual event since 2008. Placer has also been a sponsor/sponsor of the Indigenous People’s Day in Nevada County and the Leafing Out of Spring Celebration at the Maidu Interpretive Center in Roseville.

As a result of the CCW planning process for PEI the steering committee recommended awarding funding to the Latino community through the LLC, and the Native community through the SNA for programs and services chosen specifically by those communities. The SNA is implementing Positive Indian Parenting, Families of Tradition, Youth Leadership Development and Mentoring Services, a Youth Culture Camp and community concert and sustaining the Auburn Big Time Pow Wow. The LLC is implementing the Promotora Program, the Parent Project in Spanish, Parent/Family Counseling, Youth Cultural Arts Programs, and Educational Forums.

Since 2007 Placer County HHS has implemented the Community Readiness
Assessment (CRA), a best practice model for community assessment and evaluation developed by Colorado State University. This tool has been used widely by SAMHSA and the Center for Disease Control (CDC) funded projects as a community capacity building and development tool. The CRA is a process by which the community identifies an issue or concern that they would like to change (e.g., lack of culturally appropriate services) and the outcome of the assessment informs the strategies that would most likely create a successful change. Phase I of our CRA was to assess the System of Care capacity for readiness to address cultural competence for our three populations of focus, Latino, Native and Transition Age Youth. Phase II assessed the awareness and readiness of these three communities. We are launching Phase III this fall which will be a point in time evaluation of any progress we have made toward cultural competence since 2007.

11B. Current Relationship with Racially Diverse Families, Policy Boards, and Community Business Partners

Placer County System of Care (SOC) are governed by the Mental Health and Alcohol and Drug Board (MHADB) and, specifically for the Children’s System of Care, the SMART (Systems Management Advocacy and Resource Team) Policy Board. The current composition of these governance boards is not reflective of the diversity in our communities. However, Placer SOC has begun to integrate consumer, family, youth and members of diverse communities into our quality improvement committee structure and in our management and leadership structure. This integration is identified in the descriptions below:

- **SMART Policy Executive Advisory Committee**: The SMART Policy Executive Advisory Committee (SPEAC), appointed by the SMART Policy Board, is composed of the Juvenile Court Commissioner/Referee, the Director of the Children’s System of Care, the Director of Prevention Services for the County Office of Education and the **Family Advocate Program Director**. SPEAC is responsible for completing assigned tasks, analyzing projects and making recommendations, and implementing policies, procedures and programs.
- **Client/Family Relations Committee**: The committee reviews aggregate statistical data and information on access to services; implements Client Sensitivity Training; develops and/or reviews client informational materials and monitors their distribution; develops and monitors consumer satisfaction surveys; reviews documentation submitted to it on client-related problem resolution activities. The Client/Family Relations Committee includes an SOC Program Manager; Service Providers and Partners; the Patient’s Rights Advocate; the CWS Ombudsman; and representatives for both children and adults receiving mental health, substance abuse, child welfare and other SOC services such as: clients, former clients, **Consumer Employees, Family and Peer Advocates, Youth Advocates, Navigators**; and their family or community representatives including United Advocates for Children and Families, National Alliance for the Mentally Ill, and/or Mental Health Alcohol and other Drug Board Advisory Members. An SOC Program Manager or their designee chairs the Client/Family Relations Committee.
- **Cultural and Linguistic Competence Committee**: The purpose of the Cultural and Linguistic Competence Committee (CLCC) is to ensure the development of the necessary skills, knowledge, attitudes, behaviors and policies within Placer
County’s System of Care, in order to provide culturally responsive and effective care to members of diverse cultural groups.

- Towards this goal, Placer County System of Care will engage representatives of diverse communities and consumer groups in a collaborative planning process that is informed by the diverse interests, expertise and needs of these groups.
- The membership of CLCC shall reflect the communities served by Placer County System of Care; including county management level and line staff, clients and family members from diverse cultural groups, providers, and community partners.
- The CLCC will be co-chaired by a System of Care staff person and a community representative, with agenda preparation and meeting facilitation responsibilities being shared between county staff and community representatives. The SOC Co-Chair will be appointed by SOC Leadership, the Community Co-Chair will be elected by the community representatives of the CLCC on an annual basis.
- Currently members of the CLC Committee include Systems of Care staff, as well as provider staff and community members who each represent the diversity of our communities including Native, Latino, youth, family, consumers, older adults and LGBTQI2S. The CLC is currently co-chaired by a SOC Program Manager and a community provider from the Sierra Native Alliance.

**SAMHSA Steering Committee:** The SAMHSA Steering Committee is the body responsible for operationalizing the goals of the federal grant awarded to transform children’s mental health services. The primary goals are: to assure services and approaches are culturally competent, to infuse family and youth voice in the Children’s System of Care (CSOC) and to improve services and outcomes for Latino, Native, and Transition Age Youth. The Steering Committee is comprised of the following members: CSOC Program Manager, CSOC Technical Assistance Coordinator, Youth Coordinator, Family Advocate Program Director, Native Community Liaison, Latino Community Liaison/Social Marketer, Lead Evaluator and representatives from three Family Resource Centers in the communities. Through this work we have established two pilot projects: a Native Services Team and a Latino Services Workgroup. Both of those entities are comprised of both county staff and cultural brokers from the community. Together these teams assure that the families and youth who are served by these teams receive culturally and linguistically appropriate services for the life of the case. Our intention is to continually evaluate the effectiveness of these service models and then expand the team to provide these services county wide.

**Campaign for Community Wellness:** The Campaign for Community Wellness (CCW) is the steering committee formed in 2006 in order to engage community members in planning and implementing the seven major components of the California Mental Health Services Act. This Steering Committee is composed of 50 community members, advocates, providers, youth, consumers and family members. Representatives of the Latino Leadership Council (LLC) and the Sierra Native Alliance (SNA) are also active members of the CCW. As a result of the MHSA planning process dollars were awarded through MHSA PEI to the LLC and SNA to begin implementing programs and services specifically designed to improve the health and wellness of the Latino and Native populations in Placer
County.

- **CSOC Managers Team**: Placer County Children’s System of Care Managers meet weekly to review all the publically funded services for children, youth and families in Placer County. Monthly the Youth Coordinator, Family Advocate Program Director, Sierra Native Alliance Executive Director and facilitator of the Latino Leadership Council join the managers’ team to focus specifically on the needs and outcomes for youth, families, and Native and Latino communities.

- **SOC Leadership Team**: The management and leadership teams of the Adult System of Care and the Children’s System of Care meet quarterly to keep each other informed of services, barriers, gaps and successes. The Youth Coordinator, Family Advocate Program Director, Executive Director of the Sierra Native Alliance, and facilitator of the Latino Leadership Council are now standing members of this leadership team and have equal voice in system and program improvement review and planning.

- Some of SOC’s Latino staff are members of the Latino Leadership Council and some have also been chosen to serve as Board Members.

**11C. Skills Development and Strengthening of Community Organizations**

In 1998 Placer County HHS initiated the **Placer Greater Collaborative** which was an informal association of all child serving agencies and individuals throughout the county whose purpose was to communicate, collaborate, evaluate and collectively plan a community-based continuum of care for all children, youth and families in the county. At its inception the Greater Collaborative launched a county-wide assessment of services and needs which resulted in the identification of five ‘pocket areas’ located throughout the county with the greatest need and to a large extent the greatest difficulty in accessing services. These five pocket areas are Kings Beach, Foresthill, North Auburn, Lincoln and Central Roseville. The assessment revealed higher levels of poverty, crime and domestic violence, and poorer school attendance and achievement rates. Together the county and the community began to plan services and supports to bridge the identified needs and gaps in service. For example, today Placer County has four Family Resource Centers located in four of the ‘pocket areas’.

In 2005 the Placer Greater Collaborative became the **Placer Collaborative Network** (PCN), a project of the Placer Community Foundation. As stated on the PCN website, the purpose is to “be “a creative, results driven organization striving to improve the lives of children, adults and families by collaborating and building the resources of the organizations that serve them.” The over 40 member agencies are committed to five core values, which are: 1) Belief in and commitment to the collaborative process; 2) Respect, integrity, honesty; 3) Strength-based and family-centered approaches; 4) Diversity; and 5) Holistic view of children, adults and family. PCN continues to meet quarterly to share information, plan to eliminate service gaps, participate in trainings to benefit the entire community and to assist one another in capacity building. For example over the past eighteen months, PCN has participated in a Learning Conversation with John Ott, a CiMH consultant, on grassroots community capacity building. Case examples focused on expanding our Native and Latino communities’ service capacity.

The **Campaign for Community Wellness (CCW)** was created in the fall of 2006, in an effort to coordinate and leverage key mental health initiatives and ultimately improve mental health care in Placer County for all people. The CCW with a steering committee of over 50 community members, advocates, providers, consumers, youth and family members,
was the planning and advisory group for the implementation of the MHSA initiatives in Placer County. Meeting monthly, the CCW Steering Committee approved the plans for the Full Service Partnerships, Prevention and Early Intervention, the Workforce, Education and Training Plan, the Innovations Plan and the Capitol Improvements Plan. Members of PCN, including representatives from the Latino Leadership Council and the Sierra Native Alliance, serve on the CCW representing their communities.

Over the past few years the ASOC Change Agents have developed a strategy to educate informal providers, particularly those most impacted by recent changes in service levels. They determined that churches were especially impacted as they are approached by increasing numbers of individuals suffering from depression and addictions. The Change Agents strategically contacted the Mosaic Church in Rocklin, a relatively new medium sized congregation, and received a positive response from the Pastoral Care Team, headed by Pastor Mark Ferreira, who oversees requests for assistance including individuals with mental health and or substance abuse disorders.

The multi-disciplinary Change Agent team developed a brief presentation and resource packet which explained Co-Occurring Disorders and public and private services provided to this population and presented this to the leadership at Mosaic church. The church saw this as a way to continue their service and community involvement and asked for a list of things that the church can do to help and that seem to “fall through the cracks”, i.e., transportation, listening skills, auto repairs, visitation and phone calls.

The pastor is currently working on organizing and forming teams within his church to support these activities. The goal is to re-instill community and hope for individuals currently receiving services as well as to support individuals prior to their need for services. The Church is very excited to give back by implementing change within their community.

This is truly a mutually beneficial relationship as ASOC staff continues to offer educational, training and resource information to the pastoral team, and the church reaches out to the community more confident in their ability to understand the needs and supports for individuals with mental health and/or substance abuse concerns.

Tables noting culturally competent trainings that have been offered by HHS are located in Appendix E-1 through E-3.

11D. Lessons Learned on Items A, B, and C Above

Placer County has been working toward system transformation for many years. First, we reorganized our children’s services system to combine our children’s mental health services with child welfare services and juvenile probation (the Children’s’ System of Care) under one roof, one organizational structure and one budget. Next, we were given the opportunity to create a Department of Health and Human Services by combining our Welfare Department and Health Department and created the Adult System of Care. Then, within the last 5+ years we have taken on the challenge of transforming our System of Care to be reflective of the values and principles of both the MHSA and SAMHSA Children’s Mental Health Initiative.

The following are some of our lessons learned:

- Developing structures and mechanisms for ensuring authentic community, family, youth and consumer voice and participation in decision making is essential;
- Recognizing the time, energy and commitment that is needed to transform a 30 year old system/bureaucracy;
• Recognizing/acknowledging the mistakes that are part of the learning process;
• Shared power, shared decision making and transparency are concepts that are foreign to the bureaucracy and not easily attained;
• Making room for critical or courageous conversations is imperative;
• Intentional and active listening and follow through on commitments are essential to building trust.

11IE. County Technical Assistance Needs

Placer County desires assistance with identifying a neutral facilitator for engaging leadership and line staff in “Courageous Conversations” with our community partners, families, youth and consumers;

111A. Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Responsible for Cultural Competence

The Cultural Competency/Ethnic Services Manager is currently Cynthia Brundage, LCSW, one of the Program Managers in the System of Care assigned to the Children’s System of Care. In this role she reports directly to the Director of the Children’s System of Care and to the Director of the Adult System of Care, who is also the Mental Health Director for Placer County. Ms. Brundage is a member of the Quality Improvement Committee, the Project Lead for the SAMHSA Steering Committee, a staff representative on the Campaign for Community Wellness Steering Committee, a member of the SOC Staff Development Committee and the Chair of the Client Family Relations Committee. Ms. Brundage co-chairs the Cultural and Linguistic Competency Committee along with Anno Nakai, Executive Director of the Sierra Native Alliance, a community-based non profit.

111B. Written Description of Cultural Competence Responsibilities of Designated CC/ESM

The Cultural Competency/Ethnic Services Manager has the following responsibilities:
• Lead responsibility for the development and implementation of cultural competence planning within HHS SOC;
• Advises all SOC Managers in the monitoring of county services and contracts with regard to the delivery of services in accordance with local and State mandates as they affect underserved populations;
• Promotes the development of appropriate mental health services that will meet the needs of the county’s racial and ethnic populations;
• Participates in the development of documents, contracts, proposals and grants with regard to the delivery of mental health services to ethnic minorities and other diverse groups;
• Participates as a member of the SOC management/leadership team;
• Actively participates in the Campaign for Community Wellness and the Placer Collaborative Network to promote an array of mental health programs and activities that are specific to underserved and unserved populations;
• Participates in the Staff Development Committee and advises the WET Advisory
Group with regard to training and workforce development issues to improve the quality of care for all communities and reduce mental health disparities;

- Attends trainings that inform, educate and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system.

**1IVA. Identify Budget Resources for Culturally Competent Activities**

Placer County’s budget for culturally competent activities is detailed in the CLC Budget Breakdown chart below. Of this budget of $1,696,732 only $14,500 remains as discretionary funds for FY 2010-2011 for use by the CLC Committee for implementing CLC activities.

**FY10-11 CLC BUDGET BREAKDOWN**

<table>
<thead>
<tr>
<th>Programs/Services</th>
<th>Budgeted Amount</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Advocate Program (Including Friends &amp; Family Supports)</td>
<td>$352,781</td>
<td>SB 163</td>
</tr>
<tr>
<td></td>
<td>$188,738</td>
<td>MHSA CSS</td>
</tr>
<tr>
<td>Youth Empowerment Services Program</td>
<td>$128,250</td>
<td>SB 163</td>
</tr>
<tr>
<td></td>
<td>$61,800</td>
<td>MHSA CSS</td>
</tr>
<tr>
<td></td>
<td>$25,000</td>
<td>MHSA PEI</td>
</tr>
<tr>
<td>Peer Advocates</td>
<td>$30,000</td>
<td>MHSA CSS</td>
</tr>
<tr>
<td>System Navigators</td>
<td>$50,000</td>
<td>MHSA CSS</td>
</tr>
<tr>
<td>Interpreter/Translation Services</td>
<td>$40,000</td>
<td>SAMHSA/CWS</td>
</tr>
<tr>
<td>Latino Leadership Council/Herrera</td>
<td>$47,071</td>
<td>MHSA PEI</td>
</tr>
<tr>
<td></td>
<td>$27,890</td>
<td>MHSA CSS</td>
</tr>
<tr>
<td></td>
<td>$121,000</td>
<td>SAMHSA</td>
</tr>
<tr>
<td>Sierra Native Alliance</td>
<td>$231,846</td>
<td>MHSA PEI</td>
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<tr>
<td></td>
<td>$63,824</td>
<td>SB 163</td>
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<tr>
<td></td>
<td>$123,950</td>
<td>SAMHSA</td>
</tr>
<tr>
<td>Circle Point – Social Marketing</td>
<td>$50,000</td>
<td>MHSA PEI</td>
</tr>
<tr>
<td>Tahoe System Enhancement</td>
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<td>MHSA CSS/PEI</td>
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<tr>
<td><strong>Training:</strong></td>
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<tr>
<td>Trilogy</td>
<td>$1,858</td>
<td>MHSA CSS</td>
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<tr>
<td>UCD Extension</td>
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<td>CWS</td>
</tr>
<tr>
<td>ADP</td>
<td>$6,500</td>
<td>In-kind</td>
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<tr>
<td>Discretionary Funds</td>
<td>$14,500</td>
<td>SAMHSA</td>
</tr>
<tr>
<td><strong>County Positions</strong></td>
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<tr>
<td>CLC/ES Manager .30 FTE</td>
<td>$58,364</td>
<td>MHSA PEI</td>
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<tr>
<td>WET Coordinator .30 FTE</td>
<td>$38,080</td>
<td>MHSA WET</td>
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<tr>
<td><strong>TOTAL:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$1,696,732</strong></td>
<td></td>
</tr>
</tbody>
</table>

**1IVB. Funding Allocations for Interpreter and Translation Services, Reduction of MH Disparities, etc.**

Placer County SOC has a current budget of $40,000 for written translation services, which includes $10,000 in SAMHSA funding ($4,500 for FY 2009-10 and $5,500 for FY 2010-11) and $30,000 in Child Welfare Services funding. This funding has been set aside to insure the accurate translation of written forms and documents such as treatment authorization and consent documents, treatment plans, and court documents. Interpreter services have been provided via existing staff who are certified by Placer County’s’
Personnel Department after passing an oral and written examination. When a local ‘live’ interpreter is not available the ATT Language Line or Language World Services are available.

Recently a survey conducted by the Latino Leadership Council has brought to light grave concerns about the ‘real’ availability of staff as translators. The survey revealed that staff are often not ‘allowed’ to offer their skills for translation because of the high demands of their primary work assignment. In the current budget climate both Systems of Care (Adult and Children) are holding several vacancies and overtime is prohibited except in the direst emergencies. An additional concern highlighted by the LLC, which was developed through their hands-on experiences in advocating for families, is the perceived lack of sensitivity by some SOC employees as to the need for any translator. What often happens is families are encouraged to bring their own translators (friends or family) and in some situations, the youth translate. This practice of using youth as translators is especially prevalent within the probation arena.

Examining the results of the LLC survey and exploring better options of providing effective translation services must be a priority of both the CLC Committee and the SOC Leadership Team in this fiscal year, 2010-11.

Outreach to racially and ethnically diverse populations and developing culturally appropriate services has been a priority for Placer County SOC during the past 5+ years as discussed above. After 5 years of outreach and engagement planning, training and activities Placer’s approved PEI plan includes population specific treatment services for our Native and Latino communities. Placer HHS has contracted with the Sierra Native Alliance to provide culturally-based, “non-traditional” mental health services such as Positive Indian Parenting, Sons and Daughters of Tradition, cross-generational Mentoring, Culture Camps and community events. Likewise we have contracted with the Latino Leadership Council to provide the Parent Project in Spanish, bilingual/bicultural counseling, educational forums for parents and cultural arts programs for youth. Funds have also been dedicated to addressing the needs of the Latino population in the Kings Beach community in Tahoe and for expanding the Promotoras program county-wide. All of the services and programs were determined and requested by the communities themselves.

In addition to our culturally and ethnically specific populations, Placer has demonstrated our commitment to consumer, youth and family cultures by funding, through a variety of mechanisms, consumer, youth and family advocate positions. The Family Advocate Program team consists of a Family Program Director, six Family Advocates (including two bicultural/bilingual) dedicated to CSOC, two Family and Friends Supporters dedicated to ASOC and one full-time Administrative Clerk. The Youth Empowerment Services program includes one Youth Program Manager, two full-time Youth Coordinators and one .5 FTE Youth Coordinator. Currently there are 14 consumers who are paid Navigators and 2 who are Peer Advocates working along side staff in the Adult System of Care. These persons with lived system experience are now able to help others navigate the system, seek outside support and opportunities and empower each individual to advocate on their own or a loved one’s behalf.

2IA. Summary of General Population by Race, Ethnicity, Age, and Gender

Placer County, California, is located 100 miles northeast of San Francisco and 20 miles west of Reno, Nevada. Auburn, the County Seat, is 30 miles northeast of the state capital, Sacramento, and eight miles north of the epicenter of the 1849 Gold Rush. The county extends east to the Nevada border and includes the north shore of Lake Tahoe. Physically, the majority
of the county is rural and mountainous, which limits accessibility to many services in the more rural parts of the county. There are five incorporated cities with the following 2008 population figures: Roseville (109,154); Rocklin (53,843); Lincoln (39,758); Auburn (13,273); and Colfax (1,855); and one incorporated town, Loomis (6,624) (Placer County Profile, 2009). Placer County’s population was an estimated 341,945 in 2008 (US Census). Placer County’s per capita income in 2007 was $27,963.

U. S. Census estimates for 2008 indicate 78.4% non-Hispanic whites, 11.7% Latino, 5.5% Asian/Pacific Islander, 2.6% multiracial, 1.7% African American and 0.9% American Indian/Alaska Native (AI/AN). However, an estimated 2.7% of individuals in the County self-identify as having some AI/AN heritage, according to the 2007 California Health Interview Survey (CHIS, 2007).

Placer County has six geographic areas with high rates of poverty. These areas are central Roseville, Lincoln, North Auburn, Colfax and the unincorporated communities of Foresthill and Kings Beach, These areas include neighborhoods with a high population of Latino families and Native American families (Campaign for Community Wellness).
IIA. Summary of Medi-Cal Population Service Needs (current CAEQRO data if available)

Overall, Placer County continues to be above the State’s penetration rates in virtually every category, with one exception this year being White beneficiaries. And even at that, the percentages are nearly identical – 11.45% vs. 11.72%. Overall, Placer County is above the State penetration rates for the following targeted categories listed on the attached table: Total, Male, Female, Hispanic, Native American, African-American, Ages 6-17, and Ages 18-59. You can also see that Placer County’s penetration rate is often
significantly higher than the State’s rate. Total, 49% higher, Male, 39% higher; Female, 58% higher; Native American, 22% higher; Ages 6-17, 33% higher; and Ages 18-59, 71% higher. Conversely, one can see that Placer County is often below the State average for Approved Claims per Beneficiary, with the exceptions of the 60+, Native American, and Asian/Pacific Islander categories. Also, Placer County is very close to the State average in two other categories – Male, within 1%; and Hispanic, within 6%.

For Transition Age Youth, Placer County not only saw an increase in the penetration rates for Total, Male, Female, White, Hispanic, and Native American, all of these rates were above the State average for each category, and oftentimes significantly so (Total, 62% higher; Male, 57% higher; Hispanic, 45% higher; Native American, 82% higher).

In the Foster Care category, whereas Placer County was above the State average for penetration rate in CY 2007, it is now below for CY 2008. Placer County does remain above the State average for White and Native American categories. For almost all Race/Ethnicity categories other than White, the sample sizes are very small and do not lend themselves to make informed conclusions. For example, for Asian/Pacific Islander, the average number of eligibles per month was 4, and for Other, the number was 6. One can see from the data that Placer County is below the statewide penetration rate for the age group 0-5.

According to the overall data provided, over 65% of the average number of Medi-Cal eligibles per month fall in either the Ages 6-17 or the Ages 18-59 category (17,801 of the 27,241 total eligibles per month.) Placer County shows penetration rates significantly higher in these two categories compared to the rest of the State. In the 0-17 category, Placer’s penetration rate of 10.37% is 33% higher than the State’s penetration rate of 7.81% And in the 18-59 age group category, Placer’s rate of 14.61% is an incredible 71% higher than the State’s average penetration rate of 8.56%. The 0-5 age group is discussed in the paragraph above. Even though Placer County’s penetration rate of .85% is lower than the State’s rate of 1.4%, clients in this age group are receiving services outside of the formal County system through its community partners. The penetration rate for the 60+ age group is nearly the same for Placer County (3.3%) as it is for the State (3.4%).

Regarding TBS services, Placer County at least appears to have a very low TBS penetration rate. But this data does not take into account the TBS-like services that are provided.

Placer County is above the State average in 21 of the 36 reported penetration rate categories on the attached table. In addition to this, Placer County also saw percentage increases in 13 of these categories from the prior calendar year.

### Placer/Sierra MediCal Population/Penetration Rate for Calendar Year 2008

<table>
<thead>
<tr>
<th>CY08 Total</th>
<th>PLACER/SIERRA</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Number of Eligibles/ Month</td>
<td>Number of Beneficiaries Served/Yr</td>
<td>Approved Claims</td>
<td>Penetration Rate</td>
<td>Approved Claims/ Beneficiary Served/Yr</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27,240</td>
<td>2,510</td>
<td>$9,919,481</td>
<td>9.21%</td>
<td>$3,952</td>
</tr>
<tr>
<td>AGE GROUP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>4,901</td>
<td>42</td>
<td>$57,302</td>
<td>0.86%</td>
<td>$1,364</td>
</tr>
<tr>
<td>6-17</td>
<td>6,681</td>
<td>693</td>
<td>$3,481,662</td>
<td>10.37%</td>
<td>$5,024</td>
</tr>
</tbody>
</table>
### 2IIB. Analysis of Disparities in Medi-Cal Population

Looking at the overall data, it appears to be consistent with the Placer County’s overall means of dealing with the recent economic downturn and subsequent diminishing resources around the State. Placer County has been very aggressive in its planning over the past few years, trying to keep as many different services and programs available to clients as possible. Placer County, for the most part, and due to this early and ongoing planning, fortunately has not yet been in the situation to have to implement these types of programmatic cuts. Instead of seeing the state-wide trend of providing more intensive services to a small portion of beneficiaries, which is shown in the attached table, Placer County has been working to partner with the community based organizations who tend to better serve the underserved and unserved clients of our population, especially the Latino/Hispanic and Native American populations, in a more culturally appropriate manner.

Placer County’s penetration rate of .85% for the 0-5 age category is lower than the State’s rate of 1.4%. Clients in this age group have been receiving services outside of the formal County system through various community partners for a while, so this may explain the lower penetration rate.

It is very difficult to draw conclusions in the Foster Care category with so few clients in these categories. We believe that there may be several explanations for this due to the way that these particular services are provided in Placer County. To begin with, Placer
County utilizes the Differential Response paradigm for its children’s welfare emergency services, as do many counties. This means that families, in an attempt to keep children in their most natural environment, are referred to community partners for services rather than have them enter into the formal system. These community partners are even involved in going out on the initial investigations as this practice is imbedded into Differential Response philosophy. Often times the result of this is that children and families begin to receive services from one of Placer County’s several Family Resource Centers, or through Families First. Simply because Placer County’s “penetration rate” may be lower in comparison to other like-sized counties or to Statewide averages, it does not mean that children are not receiving services using these other community resources.

The increases for Transition Age Youth are seen as being consistent with Placer County’s strong relationship with and dedication to the various Youth Advocates that it employs. These Youth Advocates have been solidifying their roles within the existing CSOC service delivery teams, educating this hard to reach population of clients about services that are available to them. The rationale for having a generally lower rate for approved claims per beneficiary would be the same as is described above.

According to the overall data provided, Placer County shows penetration rates significantly higher in these two categories compared to the rest of the State. In the 0-17 category, Placer’s penetration rate of 10.37% is 33% higher than the State’s penetration rate of 7.81%. And in the 18-59 age group category, Placer’s rate of 14.61% is an incredible 71% higher than the State’s average penetration rate of 8.56%. The penetration rate for the 60+ age group is nearly the same for Placer County (3.3%) as it is for the State (3.4%).

Regarding TBS services, Placer County at least appears to have a very low TBS penetration rate. But this data does not take into account the TBS-like services that are provided. TBS-like services have been defined by DMH and have been sanctioned by DMH as being a legitimate and appropriate alternative to formal TBS services. Since this data does not take this into account, no final conclusions will be made here. Placer County continues to remain in compliance with the Emily Q. Exit Plan as outlined by DMH, and will continue to report these outcomes to DMH as further analysis is completed.

Placer County has been tracking the number of authorizations written to Network Providers to see what trends have emerged because of this, and the number of service authorizations written to Network Providers went from 1,135 in Q1 2008 to 959 in Q4 2008. We anticipate this trend to continue into the future. Also, Network Providers during this time period have been required to improve their documentation of Medi-Cal Necessity for ongoing services. If the provider is not able to document that services are necessary, the services are not authorized. This is also consistent with the data provided by APS for Number of Services Approved per Beneficiary Served.

In summary, Placer County is above the State average in 21 of the 36 reported penetration rate categories on the attached table. In addition to this, Placer County also saw percentage increases in 13 of these categories from the prior calendar year. Placer County has been able to serve a much higher percentage of its Medi-Cal beneficiaries compared to the rest of the State, although at a lower approved claims rate per beneficiary. Placer County views this data as being consistent with the goals it has set to maintain the services and programs that are available to its beneficiaries, and will continue to strive for similar results in the coming years.

2IIIA. 200% of Poverty (minus Medi-Cal) Population and Service Needs

In calendar year 2008 (latest available data), it was estimated that 57,638 persons
were below 200% poverty in Placer County. A portion of this population would have a need for mental health services. In order to estimate that need for services, Placer used the Holzer prevalence rates as developed for the California Department of Mental Health through a contract with Dr. Charles Holzer, Ph.D., an epidemiologist at the University of Texas, Medical Branch). According to the Holzer formulas, approximately 4,891 persons, 8.5% of the estimated 57,638 persons below 200% of poverty in Placer County, would need mental health services. According to this data, the Latino/Hispanic population represents 25% (396) of the approximately 4,891 persons needing mental health services. Placer County Latino/Hispanic mental health staff comprise an estimated 5.4% of the staff. The data is summarized in the following charts:
### Calendar Year 2008 – Placer County Estimate of Mental Health Services Needs <200% Poverty (Minus MediCal) (estimated) – Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Cases &lt;200% Poverty Needing Services*</th>
<th>Total Population &lt;200% Poverty*</th>
<th>Percent &lt;200% Needing Services</th>
<th>Difference &lt;200% (Not Served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3,397</td>
<td>38,238</td>
<td>8.9%</td>
<td>1,429</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1,225</td>
<td>15,663</td>
<td>7.8%</td>
<td>1,003</td>
</tr>
<tr>
<td>African-American</td>
<td>20</td>
<td>197</td>
<td>10.2%</td>
<td>-52</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>89</td>
<td>1,859</td>
<td>8.7%</td>
<td>50</td>
</tr>
<tr>
<td>Native American</td>
<td>24</td>
<td>232</td>
<td>10.3%</td>
<td>-17</td>
</tr>
<tr>
<td>Multi</td>
<td>136</td>
<td>1,449</td>
<td>9.4%</td>
<td>-32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,891</strong></td>
<td><strong>57,638</strong></td>
<td><strong>8.5%</strong></td>
<td><strong>2,381</strong></td>
</tr>
</tbody>
</table>
*CPES Estimate of Need for Mental Health Services: CA Department of Mental Health

Calendar Year 2008 – Placer County Estimate of Mental Health Services Needs <200% Poverty (Minus MediCal) (estimated) - Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Cases &lt;200% Poverty Needing Services*</th>
<th>Total Population &lt;200% Poverty*</th>
<th>Percent &lt;200% Needing Services</th>
<th>Difference &lt;200% (Not Served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>517</td>
<td>5,964</td>
<td>8.7%</td>
<td>475</td>
</tr>
<tr>
<td>6-11</td>
<td>1,015</td>
<td>11,632</td>
<td>8.7%</td>
<td>322</td>
</tr>
<tr>
<td>18-20</td>
<td>3,359</td>
<td>40,044</td>
<td>8.4%</td>
<td>1,584</td>
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<tr>
<td>Total</td>
<td>4,891</td>
<td>57,640</td>
<td>8.5%</td>
<td>2,381</td>
</tr>
</tbody>
</table>

*CPES Estimate of Need for Mental Health Services: CA Department of Mental Health

Calendar Year 2008 – Placer County Estimate of Mental Health Services Needs <200% Poverty (Minus MediCal) (estimated) - Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Cases &lt;200% Poverty Needing Services*</th>
<th>Total Population &lt;200% Poverty*</th>
<th>Percent &lt;200% Needing Services</th>
<th>Difference &lt;200% (Not Served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,800</td>
<td>24,655</td>
<td>7.3%</td>
<td>694</td>
</tr>
<tr>
<td>Female</td>
<td>3,091</td>
<td>32,982</td>
<td>9.4%</td>
<td>1,687</td>
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<tr>
<td>Total</td>
<td>4,891</td>
<td>57,637</td>
<td>8.5%</td>
<td>2,381</td>
</tr>
</tbody>
</table>

*CPES Estimate of Need for Mental Health Services: CA Department of Mental Health

Placer and Sierra Counties’ 200% of Poverty - Race/Ethnicity Analysis:
- In 2008, 8.9% (3,397) cases of Placer County’s 200% of Poverty white population (38,238) were needing services. 42% (1,429) were not served.
- A total of 7.8% (1,225) cases of Placer County’s 200% of Poverty Hispanic population (15,663) were needing services. 82% (1,003) were not served.
- Statistics show that 10.2% (20) cases of Placer County’s 200% of Poverty black or African American population (197) were needing services. 52 additional cases being served.
- An estimated 8.7% (89) cases of Placer County’s 200% of Poverty Asian/Pacific Islander population (1,859) were needing services. 56.2% (50) were not served.
- For Placer County’s 200% of Poverty Native American population, 10.3% (24) cases of (232) were needing services. 17 additional cases being served.
- In 2008, 9.4% (136) cases of Placer County’s 200% of Poverty multi-racial population (1,449) were needing services. 32 additional cases being served.
- An estimated 8.5% (4,891) cases of Placer County’s 200% of Poverty overall population (57,638) were needing services. 48.7% (2,381) were not served.
Placer and Sierra Counties’ 200% of Poverty – Age Group Analysis:
- In 2008, 8.7% (517) cases of Placer County’s 200% of Poverty 0-5 age group (5,964) were needing services. 91.9% (475) were not served.
- For Placer County’s 200% of Poverty 6-11 age group, 8.7% (1,015) cases of the population (11,632) were needing services. 31.7% (322) were not served.
- An estimated 8.4% (3,359) cases of Placer County’s 200% of Poverty 0-5 age group (40,044) were needing services. 47.2% (1,584) were not served.

Placer and Sierra Counties’ 200% Poverty – Gender Analysis:
- Male - In 2008, 7.3% (1,800) cases of Placer County’s 200% of male population (24,655) were needing services. 38.6% (694) were not served.
- In 2008, 9.4% (3,091) cases of Placer County’s 200% of female population (32,982) were needing services. 54.6% (1,687) were not served.

2IIIB. Analysis of Disparities From Above Summary

The focus of the SAMHSA project and a large portion of the MHSA PEI Program is to increase accessibility and culturally appropriate services for the Transitional Age Youth (TAY) population, Hispanics and American Indian/Native Americans. As noted in the above data, services to the American Indian/Native American and Black/African American populations exceeded predicted penetration rates. However, services to the 0-5 age, transition age youth, Asian/Pacific Islander and Latino/Hispanic populations did not meet expected penetration rates and were quite low in some instances. Outreach to many of these populations has already begun and will continue to be a priority in the coming years.

The Holzer formula for calculation of need for mental health services provides target penetration rates by ethnicity, gender and age. The formula is based upon a series of weighted environmental factors, which, if present, suggests a greater need for services. It is acknowledged that not everyone who needs a service will avail themselves of that service. In fact, if the demand for mental health services equaled the predicted need for the service, it would exceed the capacity of any county system.

It is a priority for Placer County that anyone who is eligible for and who needs County mental health services is aware of the various types of service available and feels comfortable in accessing those services, either from the county or from a community partner, as they desire and/or the situation demands. Subsequently, provision of services to our underserved populations remain a high priority. The ability to increase the number of bicultural and bilingual staff to meet the needs of our population continues to be a challenge in the current budget crisis.

2IVA. Summary of MHSA Community Services and Supports (CSS) Population Assessment and Service Needs

Below is the population assessment from Placer’s approved CSS Plan:

Placer County MHSA Plan for Community Services and Supports (2005 Plan Revised November 2006)
Section II: Analyzing Mental Health Needs In The Community

Un-served Populations
   Population and Utilization Assessments. Chart 5\(^1\) shows Placer County’s updated population assessments.

\(^1\) Data Source: CA Dept of Finance
<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Children 0-17</th>
<th>Transitional Age Youth 16-24</th>
<th>Adults 18-59</th>
<th>Older Adults 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Total</td>
<td>303,595</td>
<td>75,538</td>
<td>36,213</td>
<td>171,483</td>
<td>56,574</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>148,727 (49.0)</td>
<td>38,613 (51.1)</td>
<td>18,714 (51.7)</td>
<td>84,692 (49.4)</td>
<td>25,422 (44.9)</td>
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<tr>
<td>Female</td>
<td>154,868 (51.0)</td>
<td>36,925 (48.9)</td>
<td>17,499 (48.3)</td>
<td>86,791 (50.6)</td>
<td>31,152 (55.1)</td>
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<td>Race/Ethnicity</td>
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<td></td>
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<tr>
<td>African American</td>
<td>4,908 (1.6)</td>
<td>1,137 (1.5)</td>
<td>747 (2.1)</td>
<td>2,420 (1.4)</td>
<td>1,351 (2.4)</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>10,804 (3.6)</td>
<td>2,765 (3.7)</td>
<td>1,186 (3.3)</td>
<td>6,534 (3.8)</td>
<td>1,505 (2.7)</td>
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<tr>
<td>Latino</td>
<td>31,528 (10.4)</td>
<td>11,047 (14.6)</td>
<td>4,089 (11.3)</td>
<td>17,530 (10.2)</td>
<td>2,951 (5.2)</td>
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<tr>
<td>Native American</td>
<td>2,622 (0.9)</td>
<td>754 (1.0)</td>
<td>407 (1.1)</td>
<td>1,564 (0.9)</td>
<td>304 (0.5)</td>
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<tr>
<td>White</td>
<td>247,927 (81.7)</td>
<td>57,166 (75.7)</td>
<td>28,775 (79.5)</td>
<td>140,820 (82.1)</td>
<td>49,941 (88.3)</td>
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<tr>
<td>Other</td>
<td>5,806 (1.9)</td>
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<td>1,007 (2.8)</td>
<td>2,615 (1.5)</td>
<td>522 (0.9)</td>
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<tr>
<td>Males</td>
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</tr>
<tr>
<td>African American</td>
<td>2,476 (0.8)</td>
<td>564 (0.7)</td>
<td>372 (1.0)</td>
<td>1,227 (0.7)</td>
<td>685 (1.2)</td>
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<tr>
<td>Asian/Pacific Islander</td>
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<td>1,413 (1.9)</td>
<td>580 (1.6)</td>
<td>3,035 (1.8)</td>
<td>606 (1.1)</td>
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<tr>
<td>Latino</td>
<td>16,231 (5.3)</td>
<td>5707 (7.6)</td>
<td>2229 (6.2)</td>
<td>9114 (5.3)</td>
<td>1410 (2.5)</td>
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<tr>
<td>Native American</td>
<td>1,337 (0.4)</td>
<td>389 (0.5)</td>
<td>231 (0.6)</td>
<td>788 (0.5)</td>
<td>160 (0.3)</td>
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<tr>
<td>White</td>
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<td>29,176 (38.6)</td>
<td>14,812 (40.9)</td>
<td>69,268 (40.4)</td>
<td>22,317 (39.4)</td>
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<td>Other</td>
<td>2,868 (0.9)</td>
<td>1364 (1.8)</td>
<td>490 (1.4)</td>
<td>1260 (0.7)</td>
<td>244 (0.4)</td>
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<td>Females</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2,432 (0.8)</td>
<td>573 (0.8)</td>
<td>375 (1.0)</td>
<td>1,193 (0.7)</td>
<td>666 (1.2)</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>5,750 (1.9)</td>
<td>1,352 (1.8)</td>
<td>608 (1.7)</td>
<td>3,499 (2.0)</td>
<td>899 (1.6)</td>
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<tr>
<td>Latino</td>
<td>15,297 (5.0)</td>
<td>5340 (7.1)</td>
<td>1860 (5.1)</td>
<td>8,416 (4.9)</td>
<td>1,541 (2.7)</td>
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<td>1,285 (0.4)</td>
<td>365 (0.5)</td>
<td>176 (0.5)</td>
<td>776 (0.5)</td>
<td>144 (0.3)</td>
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<tr>
<td>White</td>
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<td>27,990 (37.1)</td>
<td>13,963 (38.6)</td>
<td>71,552 (41.7)</td>
<td>27,624 (48.8)</td>
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<td>517 (1.4)</td>
<td>1355 (0.8)</td>
<td>278 (0.5)</td>
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<td>Age Group</td>
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<tr>
<td>Children 0-17</td>
<td>75,538 (24.9)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Transitional Age Youth 16-24</td>
<td>36,213 (11.9)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults 18-59</td>
<td>171,483 (56.5)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Adults 60+</td>
<td>56,574 (18.6)</td>
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</table>
## Chart 6

### Estimated Un-served

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Children 0-17</th>
<th>TAY 16-24</th>
<th>Adults 18-59</th>
<th>Older Adults 60+</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>(%)</td>
<td>n</td>
<td>(%)</td>
<td>n</td>
</tr>
<tr>
<td>Total</td>
<td>2,296</td>
<td>(33.0)</td>
<td>758</td>
<td>(33.0)</td>
<td>379</td>
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<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>758</td>
<td>(33.0)</td>
<td>295</td>
<td>(38.9)</td>
<td>195</td>
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<tr>
<td>Female</td>
<td>1,564</td>
<td>(68.1)</td>
<td>465</td>
<td>(61.4)</td>
<td>191</td>
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<td><strong>Race/Ethnicity</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>African American</td>
<td>15</td>
<td>(0.6)</td>
<td>-2</td>
<td>- (0.3)</td>
<td>4</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>139</td>
<td>(6.1)</td>
<td>47</td>
<td>(6.2)</td>
<td>26</td>
</tr>
<tr>
<td>Latino</td>
<td>332</td>
<td>(14.5)</td>
<td>163</td>
<td>(21.5)</td>
<td>54</td>
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<tr>
<td>Native American</td>
<td>-32</td>
<td>(-1.4)</td>
<td>5</td>
<td>(0.7)</td>
<td>-3</td>
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<tr>
<td>White</td>
<td>1,577</td>
<td>(68.7)</td>
<td>436</td>
<td>(57.5)</td>
<td>247</td>
</tr>
<tr>
<td>Other</td>
<td>-62</td>
<td>(-2.7)</td>
<td>7</td>
<td>(0.9)</td>
<td>-11</td>
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<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>5</td>
<td>(0.2)</td>
<td>3</td>
<td>(0.4)</td>
<td>3</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>63</td>
<td>(2.7)</td>
<td>19</td>
<td>(2.6)</td>
<td>14</td>
</tr>
<tr>
<td>Latino</td>
<td>115</td>
<td>(5.0)</td>
<td>68</td>
<td>(8.9)</td>
<td>26</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>(0.1)</td>
<td>2</td>
<td>(0.2)</td>
<td>-2</td>
</tr>
<tr>
<td>White</td>
<td>1,198</td>
<td>(52.2)</td>
<td>132</td>
<td>(17.4)</td>
<td>121</td>
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<tr>
<td>Other</td>
<td>-3</td>
<td>(-0.1)</td>
<td>3</td>
<td>(0.4)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>22</td>
<td>(0.9)</td>
<td>-4</td>
<td>- (0.6)</td>
<td>1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>81</td>
<td>(3.5)</td>
<td>28</td>
<td>(3.6)</td>
<td>12</td>
</tr>
<tr>
<td>Latino</td>
<td>220</td>
<td>(9.6)</td>
<td>95</td>
<td>(12.5)</td>
<td>27</td>
</tr>
<tr>
<td>Native American</td>
<td>-32</td>
<td>(-1.4)</td>
<td>3</td>
<td>(0.4)</td>
<td>-1</td>
</tr>
<tr>
<td>White</td>
<td>593</td>
<td>(25.8)</td>
<td>305</td>
<td>(40.2)</td>
<td>134</td>
</tr>
<tr>
<td>Other</td>
<td>-46</td>
<td>(-2.0)</td>
<td>4</td>
<td>(0.5)</td>
<td>-11</td>
</tr>
</tbody>
</table>

### Note

- Estimates do not add up to 100% of the total.
- Because of the manner in which the estimates were calculated, estimates do not add up to 100% or the column totals.
- Cells in which small numbers produced unstable estimates are removed from display.

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2 Estimates are based on data from CA Dept of Finance
Ethnicity and Language Disparities

The residents of Placer County are predominantly white and English speaking. Eighty-two percent of residents are white, 10.4% Latino, 3.6% Asian/Pacific Islander, 1.9% other, 1.6% African American, and 0.9% Native American. Latinos comprise the largest non-white population group, ranging from 5.2% of the population over 60 to 14.6% of children 0-17. No other non-white ethnic group represents over 5% of the population. Among children under 18, non-white ethnicity was slightly higher: 75.8% were white, 14.6% Latino, 3.7% Asian/Pacific Islander, 1.5% African American, 1% Native American, and 3.5% Other. 2003 school enrollment data (Chart 7) shows more ethnic diversity, with concentrations of Latino children in Kings Beach, Lincoln/Sheridan, Auburn, and Colfax; and small American Indian clusters in Foresthill and Colfax. In the last few years, small groups have Ukrainians have moved to the southern region of Placer County.

<table>
<thead>
<tr>
<th></th>
<th>Placer County</th>
<th>Auburn Area</th>
<th>Colfax</th>
<th>Foresthill</th>
<th>Lincoln/Sheridan</th>
<th>Rocklin</th>
<th>Roseville</th>
<th>Kings Beach</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>78.5%</td>
<td>74.0%</td>
<td>86.0%</td>
<td>90.8%</td>
<td>74.6%</td>
<td>80.5%</td>
<td>73.7%</td>
<td>%31.2%</td>
</tr>
<tr>
<td>Latino</td>
<td>10.0%</td>
<td>9.6%</td>
<td>7.2%</td>
<td>3.7%</td>
<td>15.5%</td>
<td>7.1%</td>
<td>14.2%</td>
<td>%67.7%</td>
</tr>
<tr>
<td>African American</td>
<td>2.2%</td>
<td>1.5%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>2.0%</td>
<td>1.6%</td>
<td>3.2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.5%</td>
<td>2.1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>3.9%</td>
<td>5.2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>American Indian</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>2.8%</td>
<td>3.7%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2.0%</td>
<td>1.6%</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>1.0%</td>
<td>3.1%</td>
<td>2.7%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Multiracial/ no response</td>
<td>1.9%</td>
<td>&lt;1%</td>
<td>2.9%</td>
<td>&lt;1%</td>
<td>5.0%</td>
<td>2.8%</td>
<td>&lt;1%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Among all residents age 5 or older, 89% speak only English at home; among the ten percent who speak a language other than English, over half speak English “very well.”

In 2004, the Placer County undertook an in-depth study of the mental health needs and utilization of services of the Latino population in Kings Beach at Lake Tahoe. Although the study was restricted to a single community, many of the findings can be used to inform other Latino “pocket areas” in Placer County. The study found that the Kings Beach Latino population grew significantly between the 1990 and 2000 census, increasing from 30% of the population in 1990 to 54% in 1999. According to the 2000 census, 47.5% of the Kings Beach population speaks a language other than English, and among Spanish speaking residents, 55.5% reported not speaking English well to not at all. In 2000, 30% of Kings Beach children under 6 lived below the poverty line.

Use of mental health services by Latinos in Placer County is much lower than the white population. The Latino Access Study reported that in 2003-04, Placer County’s Latino population represented 18.5% of the county’s Medi-Cal eligible residents, compared to 68% for the white population. Only 2.9% of Latinos eligible for Medi-Cal countywide receive specialty mental health services compared to 7.8% of Whites. In Kings Beach, the disparity

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was even greater; 9.3% of white residents received mental health services, compared to only 1.2% of Latinos.

To some extent, the under-utilization of county mental health services by the county’s Latino population may be mitigated by services provided by community-based organizations. According to the 2003-04 Cultural Competence Plan Update, a significant number of target population clientele are served by community-based organizations including the family resource centers and the Lincoln Lighthouse. In some cases, Placer County SOC provides funding for these programs and in all cases we actively collaborate with them to serve target populations. Many of the individuals served by these community-based organizations would be reluctant to participate in government services, yet they seek out and participate in services in their own neighborhood in a non-threatening setting. Our support of these programs is based on our understanding of this issue and the belief that many individuals are served best in local, non-institutional settings where they feel most comfortable.⁴

**Income Disparities**

Placer County has a relatively high median household income of $57,535, compared to the state ($47,535), and a much lower level of poverty. According to the 2000 census, 2,118 Placer families (6.0%) with 4,317 children under 18 had incomes below the federal poverty line, and 5,472 (8.0%) had incomes below 185% of the poverty line. Income and poverty levels are not consistent throughout the county. Lower income families are concentrated in six “pocket” areas of Placer County, including North Auburn, Lincoln, Colfax, central Roseville, Foresthill and Kings Beach. (Chart 8)

<table>
<thead>
<tr>
<th>Area</th>
<th>California</th>
<th>Placer County</th>
<th>Auburn</th>
<th>Colfax Area</th>
<th>Foresthill</th>
<th>Kings Beach</th>
<th>Lincoln/Sheridan</th>
<th>Rocklin</th>
<th>Roseville</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Median Income ($)</td>
<td>47,493</td>
<td>57,535</td>
<td>48,188</td>
<td>47,711</td>
<td>51,000</td>
<td>38,366</td>
<td>46,591</td>
<td>68,603</td>
<td>57,048</td>
</tr>
<tr>
<td>Families below federal poverty line (#, %)</td>
<td>845,991</td>
<td>10.6%</td>
<td>2118</td>
<td>6.0%</td>
<td>422</td>
<td>7.6%</td>
<td>106</td>
<td>4.9%</td>
<td>54</td>
</tr>
<tr>
<td>Families below 185% of poverty (#, %)</td>
<td>1,939,982</td>
<td>24.3%</td>
<td>5472</td>
<td>8%</td>
<td>1146</td>
<td>9.7%</td>
<td>360</td>
<td>8.1%</td>
<td>180</td>
</tr>
</tbody>
</table>

Countywide, 1,225 families participate in TANF, including over 1,440 children. Among these, 840 families (1,140 children) are served in Roseville, 363 families (249 children) in Auburn, and 20 families (29 children) in Tahoe.

**Criminal Justice Data**

The California Forensic Medical Group, which contracts with Placer County to

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⁴ Placer County Health and Human Services Cultural Competence Plan Update, 2004, page 18
provide medical and psychiatric services to inmates in the Placer County Jail and wards in the juvenile hall, report that in Placer County, approximately 25% of the jail population have mental health diagnoses. This estimate is based on utilization of specific psychiatric medications in the jail, as well as, services provided to persons with severe mental disorders in the jail by both a psychiatrist and a psychiatric social worker.

Homelessness

In January of 2005, a count of the homeless population in Placer County (except the Lake Tahoe region) was conducted by the Placer Consortium on Homelessness and Affordable Housing. The survey counted 483 persons, 60% male and 40% female. Thirty-two percent (153) were children under the age of 18. About three quarters were white, 10% Latino, 5% American Indian and 5% African American. Approximately a quarter was chronically homeless and 45% lived in transitional housing. All children were sheltered. Among those surveyed, 28% reported having a mental illness and 59% reported having a substance abuse problem.5

Gay, Lesbian, Bi-sexual and Transgender Individuals (GLBT)

Based on the assumption that 10% of the overall population is GLBT, it is reasonable to assume that at least the same proportion of mental health clients are GLBT. Placer County, however, is a conservative county, many persons who are GLBT do not always feel comfortable to be “out” in the community and there are few local supports or opportunities to communicate, network or socialize. Some clients have found Sacramento GLBT organizations to be less than friendly to persons with mental health needs; they also note that many social activities within these organizations involve alcohol, which is harmful to many mental health clients.

Some Placer County mental health clients have also reported that they have been reluctant to disclose their gender identity issues for fear of being treated badly or receiving inappropriate services. Currently there are no services or supports specifically directed to mental health/GLBT clients. Several clients, however, have requested that SOC sponsor non-alcoholic support groups for lesbian and gay clients that will provide a safe place to network, discuss gender identity and mental health issues, and socialize.

Individuals with Co-Occurring Substance Abuse Disorders

There are no statistics on the number of individuals with co-occurring substance abuse disorders in Placer County, but anecdotal accounts from practitioners suggest that the numbers are significant. National estimates report that about 40% of mental health clients also have substance abuse disorders.

Individuals with Multiple Disabilities

Placer County providers serving clients with SMI and other disabilities, such as physical, visual, hearing or developmental disabilities report that these clients are unserved, under-served, and inadequately served. Placer Independent Resource Services reports that 10% of their clients have multiple disabilities, many of which are not able to obtain services due to physical or programmatic barriers. Alta Regional Center reports serving 94 adults with developmental disabilities and SMI, only 21 of whom are receiving county services.

5 Placer Coalition on Ending Homelessness, Placer County Homeless Survey Summary 2005
Estimates of Fully Served, Under-Served/Inappropriately Served by Race Ethnicity
Charts 9-12 provide Placer County’s estimates of persons who are fully served, under-served or inappropriately served by age group, race ethnicity and gender. Estimates based on Placer County Mental Health Practice Management System (Avatar PM),

Chart 9
Estimates-Children and Youth 0-17

<table>
<thead>
<tr>
<th>Children/Youth</th>
<th>Fully Served</th>
<th>Under-served or Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Number</td>
</tr>
<tr>
<td>Total</td>
<td>186</td>
<td>119</td>
<td>433</td>
<td>279</td>
<td>1,017</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Latino</td>
<td>23</td>
<td>12</td>
<td>53</td>
<td>29</td>
<td>117</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>White</td>
<td>165</td>
<td>102</td>
<td>384</td>
<td>237</td>
<td>888</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8</td>
<td>21</td>
<td>19</td>
<td>57</td>
</tr>
</tbody>
</table>

Chart 10
Estimates-Transition Age Youth 16-24

<table>
<thead>
<tr>
<th>TAY</th>
<th>Fully Served</th>
<th>Under-served or Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Number</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>105</td>
<td>270</td>
<td>246</td>
<td>736</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Latino</td>
<td>12</td>
<td>10</td>
<td>27</td>
<td>24</td>
<td>73</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>White</td>
<td>102</td>
<td>89</td>
<td>238</td>
<td>208</td>
<td>637</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>8</td>
<td>11</td>
<td>18</td>
<td>42</td>
</tr>
</tbody>
</table>
### Chart 11
#### Estimates-Adults 18-59

<table>
<thead>
<tr>
<th>Adults</th>
<th>Fully Served</th>
<th>Under-served or Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male Female</td>
<td>Male Female</td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
</tr>
<tr>
<td>Total</td>
<td>332 478</td>
<td>776 1,115</td>
<td>2,701 100</td>
<td>15,056 100</td>
<td>171,483 100</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>5 7</td>
<td>12 15</td>
<td>39 1.4</td>
<td>151 1.0</td>
<td>2,420 1.4</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>4 7</td>
<td>10 15</td>
<td>36 1.3</td>
<td>391 2.6</td>
<td>6,534 3.8</td>
</tr>
<tr>
<td>Latino</td>
<td>28 44</td>
<td>66 103</td>
<td>241 8.9</td>
<td>1,466 9.7</td>
<td>17,530 10.2</td>
</tr>
<tr>
<td>Native American</td>
<td>7 10</td>
<td>16 23</td>
<td>56 2.1</td>
<td>72 0.5</td>
<td>1,564 0.9</td>
</tr>
<tr>
<td>White</td>
<td>299 424</td>
<td>698 990</td>
<td>2,411 89.3</td>
<td>12,829 85.2</td>
<td>140,820 82.1</td>
</tr>
<tr>
<td>Other</td>
<td>12 25</td>
<td>28 59</td>
<td>124 4.6</td>
<td>297 2.0</td>
<td>2,615 1.5</td>
</tr>
</tbody>
</table>

### Chart 12
#### Estimates-Older Adults 60+

<table>
<thead>
<tr>
<th>Older Adults</th>
<th>Fully Served</th>
<th>Under-served or Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population</th>
<th>County Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male Female</td>
<td>Male Female</td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
</tr>
<tr>
<td>Total</td>
<td>23 47</td>
<td>53 110</td>
<td>233 100</td>
<td>3,349 100</td>
<td>56,574 100</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>1 1</td>
<td>1 2</td>
<td>5 2.1</td>
<td>80 2.4</td>
<td>1,351 2.4</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>1 1</td>
<td>1 1</td>
<td>4 1.7</td>
<td>89 2.7</td>
<td>1,505 2.7</td>
</tr>
<tr>
<td>Latino</td>
<td>1 3</td>
<td>1 12</td>
<td>12 5.2</td>
<td>175 5.2</td>
<td>2,951 5.2</td>
</tr>
<tr>
<td>Native American</td>
<td>0 1</td>
<td>0 2</td>
<td>3 1.3</td>
<td>18 0.5</td>
<td>304 0.5</td>
</tr>
<tr>
<td>White</td>
<td>20 42</td>
<td>46 98</td>
<td>206 88.4</td>
<td>2,957 88.3</td>
<td>49,941 88.3</td>
</tr>
<tr>
<td>Other</td>
<td>1 2</td>
<td>3 6</td>
<td>12 5.2</td>
<td>31 0.9</td>
<td>522 0.9</td>
</tr>
</tbody>
</table>

Charts 9-12 display ethnic and gender disparities in those served and under-served by mental health services.⁶

- **Among children 0-17**, boys receive services at a much higher rate than girls among whites, Latinos, and Asian/Pacific Islanders. African American girls receive services at a higher rate than boys and Native American boys and girls receive services at approximately the same rate. Latino and Asian/Pacific Islander children are served at a lower rate and white children are served at a higher rate relative to their proportion of the total population. Children who are under-served or inappropriately served typically receive medication, often from their pediatrician or limited outpatient services. If they need more intense services, they are often placed in out-of-home placement. Frequently, they do not have access to mid-level services such as family services or alternative programs such as wrap-around.

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⁶ Note that the small numbers in these cells make interpretation of these data less reliable.
• **Among Transition Age Youth 16-24**, as a whole, the rate of youth receiving services drops off precipitously at ages 19 and 20, and starts to recover about ages 23 and 24. The gender gaps noted for children dissipate, with males overall receiving services at a rate more equal to girls. Ethnic disparities for Latino and Asian/Pacific Islander youth remain. Under-served and inappropriately served youth include those who have inadequate support to make the transition between the CSOC and ASOC, and those in transition who “fall between the cracks”. Youth with SED/SMI in transition between children’s and adult services need more than medication or outpatient services; they need age appropriate support and services, such as housing, employment, education, and life skills. Without these services, there is a higher probability of dropping out services and re-enter with more critical mental health needs as an adult.

• **Among adults 18-59**, the gender gap identified among children reverses; among all ethnic populations, females receive services at a much higher rate than males. The ethnic disparities identified above remain. Individuals who are under-served or inappropriately served include those who leave hospitals or IMDs without follow-up services or who cannot be accommodated at lower levels of care, and those who seek crisis services but do not receive them. In addition, those not served are seen disproportionately in the criminal justice system and in the streets a clear consequence of the lack of mental health services.

• **Among adults older than 60**, the number of individuals among all ethnic groups and genders is strikingly low relative to their representation in the overall population. Because of the very low numbers served, conclusions regarding disparities are very uncertain, except that females continue to be served at a much higher rate than males. Under-served and inappropriately served individuals, in addition to those described for younger adults, include those who do not receive age-appropriate services, have inadequate transportation to access ongoing services, are housed inappropriately in institutions, and most likely will not seek services without outreach.

Section III: Identifying Initial Populations for Full Service Partnerships

Chart 13 shows the populations selected as the top priority for initial full service partnerships funded by the MHSA. These populations were chosen from the groups described below for each age group.

<table>
<thead>
<tr>
<th>Full Service Population</th>
<th># Served 05-06</th>
<th># Served 06-07</th>
<th># Served 07-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with SED identified by county, ineligible for 26.5 services, not being served</td>
<td>12</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>TAY: 17-18 with SED/SMI aging out of CSOC, who do not subsequently receive services from ASOC</td>
<td>19</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Adults 18-59 with SMI with 5150 assessment, leaving jails, hospitals or</td>
<td>18</td>
<td>36</td>
<td>32</td>
</tr>
</tbody>
</table>
Children

- The MHSA Children’s Work Group and the Steering Committee identified three high priority groups of children for Full Service Partnerships, to be served in the following order:
  1. Children with SED identified by county, ineligible for 26.5 services, not being served by Placer County; 2) children with SED with 5150 assessments, whose cases were not opened for intensive services; and 3) children with SED ages 0-5.

Criteria used to select the top priority groups among children and youth included:
- Estimates of the number of children in need, by age, gender and ethnicity
- Expertise brought to the work group by educators, parents, providers, clients and county staff
- Feedback on children’s needs from the Information and Feedback Groups
- Client/family survey data
- MHSA guidance to “start small”
- Data on service utilization
- Are at risk of out-of-home placement, hospitalization, out-of-county placement, and/or homelessness
- The population selected is expected to be over-represented with persons from ethnic communities
- Exhibit aggressive, volatile or self-injurious behaviors

Identification of initial population

- Children with SED identified by county, ineligible for 26.5 services, not being served. Based on county utilization and prevalence data, it is estimated that 135 children (22%) with SED deemed to be eligible for county Medi-Cal mental health services have not yet been identified, have not/do not meet the Government Code Section 26.5 requirements for special education services, and thus were not receiving needed services through either the school or the county to treat their SED. In the event of significant change to the current Government Code 26.5 or its state level of funding (as presumed to otherwise be continuing in the original proposition 63), the Committee recommends that, as soon as such change is known to this community, a stakeholder group of children’s representatives be reconvened to address the impact on this plan’s current priorities, and to update recommendations for change to the priorities and plan as currently proposed.

Transition Age Youth

TAY is, defined here for CSS purposes, as youth 18-24 years. However, the Steering Committee identified a subgroup for intervention. Based on county utilization and prevalence data, it is estimated that 98 (34%) of the 17 and 18-year-old youth with SED/SMI who have been served in the CSOC do not successfully make the transition to adult mental health services in the ASOC. A recognition that 17 and 18 year olds in Placer County are particularly vulnerable, and highly likely to drop out of mental health services and supports, due to:
• Inadequate age-appropriate planning or assistance to transition out of CSOC into ASOC.
• Inadequate and uncoordinated and do not meet their needs for education, housing, employment, family/peer support, etc.

The MHSA TAY Work Group and the Steering Committee identified three high priority groups of youth for Full Service Partnerships. The following are the priorities in order:

1. Youth 17 and 18 years olds with SED/SMI, in transition from the CSOC to the ASOC
2. Youth 17 and 18 years olds with SED/SMI in the juvenile justice system on formal probation, including youth in substance abuse treatment
3. Youth 17 and 18 years old with SED/SMI identified by county, ineligible for 26.5 services, not being served by Placer County.

Criteria used to select the top priority transition age youth groups included:
• Estimates of the number of TAY in need, by age, gender and ethnicity
• Expertise brought to the work group by youth, parents, educators, law enforcement, providers, clients, and county staff
• Feedback on TAY needs from the Information and Feedback Groups
• Client/family survey data
• Data on service utilization
• MHSA guidance to “start small”
• Evidence that youth in the juvenile justice system have inadequate services and supports for mental health treatment and support, once they leave juvenile hall
• Evidence that these youth are liable to drop out of school without adequate support and services
• Co-occurring disorder
• At risk of deep end services/homelessness/hospitalization
  • The population selected is expected to be over-represented with persons from ethnic communities.

Identification of initial population
• TAY: 17-18 with SED/SMI aging out of CSOC, who do not subsequently receive services from ASOC.

Adults
The MHSA Adult Work Group and the Steering Committee identified three high priority groups of adults age 18-59 for Full Service Partnerships, to be served in the following order:

1. Adults with SMI with at risk of psychiatric hospitalization leaving jails, hospitals and IMDs without additional services
2. Adults with SMI, identified but not receiving services
3. Adults with SMI, homeless

Criteria used to select the top priority groups included:
• Estimates of the number of adults in need, by age, gender and ethnicity
• Expertise brought to the work group by clients, providers, county staff, law enforcement, faith community advocates for the homeless
• Feedback on adult needs from the Information and Feedback Groups
• Client/family survey data
Data on service utilization
MHSA guidance to “start small”
Evidence that services are highly inadequate to meet the need and that adults often must fail before they are enrolled in services
Evidence that a significant number of adults leave hospitals without adequate, or any, urgently needed follow-up supports and services. These individuals have a high likelihood of relapse
Evidence that many individuals with SMI who are involved in the criminal justice system, or who are homeless, do not receive needed services
The population selected is expected to be over-represented with persons from ethnic communities
Co-occurring disorders
Homeless or at risk or homelessness

Identification of initial population

Adults 18-59 with SMI, leaving jails, hospitals or Institutes for Mental Disease (IMD), without aftercare or other services.

Based on county utilization and prevalence data, it is estimated that 713 (54%) of adults with SMI leaving hospitals and IMDs who meet county eligibility standards do not receive follow-up services.

Older Adults

The MHSA Older Adult Work Group and the Steering Committee identified three high priority groups of older adults for Full Service Partnerships, to be served in the following order:

1. Older adults age 65-84 newly identified with SMI, un-served
2. Older adults with SMI, age 55+, in transition from the ASOC to the Older ASOC
3. Older adults age 65-84 with SMI in nursing homes.

Criteria used to select the top priority groups included:

- Estimates of the number of older adults in need, by prevalence, age, gender and ethnicity
- Expertise brought to the work group by clients, providers, advocates, county staff
- Feedback on older adult needs from the Information and Feedback Groups
- Client/family survey data
- Data on service utilization
- MHSA guidance to “start small”
- Evidence that services are highly inadequate to meet the need so that adults often must fail before they are enrolled in services
- Have physical ailments and disabilities
- Have suffered losses of family and friends
- Have lost or fear losing their driver’s licenses
- Evidence that age-appropriate services are not available for older adults, and recommendations to implement an Older ASOC in Placer County
- Co-occurring disorders
- Risk of institutionalization
- Homeless or at risk of homelessness
• The population selected is expected to be over-represented with persons from ethnic communities.

**Identification of initial population**

- Older Adults 65-84 with SMI, newly identified by county, un-served

Based on county utilization and prevalence data, it is estimated that 86 (66%) of older adults newly identified with SMI are not receiving services.

Placer County’s Community Planning Process was designed to go beyond MHSA funding and services to develop a long-term countywide plan for mental health services. The county’s Children and Adult System of Care (CSOC/ASOC) recognize that a transformed system involves much more than new funding sources and that changes to the mental health system will be achieved through collaboration and shared resources among public and private partners, as well as, through the redesign of services. Further, the Placer System of Care (SOC) is committed to reaching county residents who are not getting their share of services and to improving outcomes for individuals in the mental health system.

The plan for community supports and services includes all community and systems issues and Full Service Partnership populations identified through the planning process. It establishes priorities among system development and outreach strategies to serve the Full Service Partnership populations and others receiving mental health services. Finally, the plan identifies how MHSA funds will be spent to address the priorities in the plan.

**2IVB. Analysis of Disparities from Above Summary**

Placer County’s MHSA Plan for Community Services and Supports focuses on implementing, improving or expanding services for four age groups: children, transition age youth, adults and older adults. The data does reflect that there are unserved and inappropriately served persons in these age groups. However, the plan does not take into account the needs of the diverse populations in these age groups. Other than acknowledging the gap in services that are specific to the needs of the transition age youth, the plan does not address disparities. Clearly the plan assessment data identifies the complete lack of services for LGBT individuals and high estimates of individuals with co-occurring disorders. In addition, in spite of penetration rates higher than or equal to the state averages for Native American, Latino and African American individuals, the plan does not address the cultural differences that may impede the effectiveness of being offered and receiving “one size fits all” services which are not culturally competent nor proven at all useful for diverse populations.

**3IA. Identified Unserved/Underserved Medi-Cal, CSS, WET and PEI Focus populations (with disparities)**

Placer’s priority populations with disparities within the Medi-Cal, CSS, WET and PEI priority populations are detailed below:

**Medi-Cal:**

In recent years Placer County has been partnering with community partners who are able to provide more culturally appropriate services for the Latino and Native American Population. In addition, community partners have recently started to provide services for the 0-5 year population and mothers of those youth who may suffer from maternal
depression.
The underserved/unserved populations in the MediCal population are as follows:
- Latino population
- Asian/Pacific Islander population
- 0-5 age population
- foster care population
- transition age youth population

CSS Priority Populations: (The following statements have been extracted from the population assessment within the CSS Plan.)
- According to the 2000 census, 47.5% of the Kings Beach population speaks a language other than English, and among Spanish speaking residents, 55.5% reported not speaking English well to not at all.
- In 2000, 30% of Kings Beach children under 6 lived below the poverty line.
- Only 2.9% of Latinos eligible for Medi-Cal countywide receive specialty mental health services compared to 7.8% of Whites.
- In Kings Beach, the disparity was even greater; 9.3% of white residents received mental health services, compared to only 1.2% of Latinos.
- The survey on homelessness counted 483 persons, 60% male and 40% female. Among those surveyed, 28% reported having a mental illness and 59% reported having a substance abuse problem.\(^7\)
- Based on the assumption that 10% of the overall population is GLBT, it is reasonable to assume that at least the same proportion of mental health clients are GLBT. Placer County, however, is a conservative county, many persons who are GLBT do not always feel comfortable to be “out” in the community and there are few local supports or opportunities to communicate, network or socialize.
- Currently there are no services or supports specifically directed to mental health/GLBT clients.
- There are no statistics on the number of individuals with co-occurring substance abuse disorders in Placer County, but anecdotal accounts from practitioners suggest that the numbers are significant. National estimates report that about 40% of mental health clients also have substance abuse disorders.
- Placer County providers serving clients with SMI and other disabilities, such as physical, visual, hearing or developmental disabilities report that these clients are un-served, under-served, and inadequately served.
- Latino and Asian/Pacific Islander children are served at a lower rate and white children are served at a higher rate relative to their proportion of the total population.
- Among Transition Age Youth 16-24, as a whole, the rate of youth receiving services drops off precipitously at ages 19 and 20, and starts to recover about ages 23 and 24. The gender gaps noted for children dissipate, with males overall receiving services at a rate more equal to girls. Ethnic disparities for Latino and Asian/Pacific Islander youth remain.
- Underserved and inappropriately served youth include those who have inadequate support to make the transition between the CSOC and ASOC, and those in transition who “fall between the cracks”.
- Among adults 18-59, the gender gap identified among children reverses; among all

\(^7\) Placer Coalition on Ending Homelessness, *Placer County Homeless Survey Summary 2005*
ethnic populations, females receive services at a much higher rate than males. The ethnic disparities identified above remain.

- **Among adults older than 60**, the number of individuals among all ethnic groups and genders is strikingly low relative to their representation in the overall population. Because of the very low numbers served, conclusions regarding disparities are very uncertain, except that females continue to be served at a much higher rate than males.

- Based on county utilization and prevalence data, it is estimated that 135 children (22%) with SED deemed to be eligible for county Medi-Cal mental health services have not yet been identified, have not/do not meet the Government Code Section 26.5 requirements for special education services, and thus were not receiving needed services through either the school or the county to treat their SED.

- TAY: 17-18 year olds with SED/SMI aging out of CSOC, who do not subsequently receive services from ASOC.

- Based on county utilization and prevalence data, it is estimated that 713 (54%) of adults with SMI leaving hospitals and IMDs who meet county eligibility standards do not receive follow-up services.

- Based on county utilization and prevalence data, it is estimated that 86 (66%) of older adults newly identified with SMI are not receiving services.

**WET Priority Populations:**

- Service providers in all areas of the county recognize the need for more bi-lingual mental health workers.

- While the need is high throughout the county, due to geographic and demographic distribution, there is particular need in Kings Beach and Lincoln.

- With regard to the Tahoe Kings Beach area, there are shortages in all mental health positions. The cost of living is high and transportation can be difficult.

- There is a large Latino population in the area, many who are monolingual Spanish speaking. The need for mental health workers (particularly Spanish speaking) is great.

- The need to attract and retain bilingual/bicultural staff exists in both the public and private sectors.

- While Placer has not met any other threshold language requirements yet, there is a large Ukrainian population in the Roseville (West Placer) area. Residents and county employees have recognized an unmet need for increased ability to serve this population. Outreach and employees who speak their native language are necessary to meet this need.

- Diversity
  1. Consider culture to include ethnicity, but also culture beyond it (e.g. LGBT, deaf, consumer, religion, etc.)
  2. Diversify workforce in order to pair clients with staff of same culture
  3. Create career pathways (from high school through college)

**MHSA PEI Priority Populations:** (Underserved racial/ethnic and cultural populations)

**Ready For Success Priority Populations:**

- Trauma Exposed Individuals (Children and Youth, Transition Age Youth and Adult)

- Individuals Experiencing Onset of Serious Psychiatric Illness (Children and Youth
and Transition Age Youth
• Children and Youth in Stressed Families (Children and Youth and Transition Age Youth)
• Children and Youth at Risk for School Failure (Children and Youth and Transition Age Youth)
• Children and Youth at Risk of or Experiencing Juvenile Justice Involvement (Children and Youth and Transition Age Youth)

Bye Bye Blues Priority Populations:
• Trauma Exposed Individuals (Transition Age Youth, Adult, and Older Adult)
• Individuals Experiencing Onset of Serious Psychiatric Illness (Transition Age Youth, Adult, and Older Adult)
• Children and Youth in Stressed Families (Transition Age Youth, Adult, and Older Adult)

Bye Bye Blues - Key Data Points for Priority Populations (Source: DMH, OAC)
• Mothers: Parents with depression is the most consistent and well-replicated risk factor for children; those with a depressed parent have a 2-3 times increased risk of having a major depressive disorder and are 4-6 times overall more likely to receive a psychiatric diagnosis. Typically, a third of children with depressed mothers have a current psychiatric disorder. An estimated 1 in 4 mothers suffer from depression at some point during their lifetime. Sixty-eight percent of women who experience a mental disorder are parents.
• Older Adults: Older adults have the highest rate of suicide in Placer County. Of older adults who committed suicide, 75% saw their primary care doctors the week prior to their death.
• Native American: Nationally, suicide is the number one cause of death in males aged 15-24.

Bridges to Wellness Priority Population:
• Trauma Exposed Individuals (Children and Youth, Transition Age Youth, Adults, and Older Adults)
• Individuals Experiencing Onset of Serious Psychiatric Illness (Children and Youth, Transition Age Youth, Adults, and Older Adults)
• Children and Youth in Stressed Families (Children and Youth, Transition Age Youth)
• Children and Youth at Risk for School Failure (Children and Youth, Transition Age Youth)
• Children and Youth at Risk of or Experiencing Juvenile Justice Involvement (Children and Youth, Transition Age Youth)

A copy of the final WET Plan can be found in Appendix C-2. A portion of the MHSA PEI Plan detailing the Ready for Success, Bye Bye Blues, and Bridges to Wellness priority populations can be found in Appendix F-13.

3IA1. Describe Process and Rationale Used to Identify and Focus PEI Priority Populations (with disparities)

A. The Overall Community Program Planning Process
In late 1996, Placer County System of Care (Adult and Children’s) joined forces to launch a campaign to transform mental health services. Believing that the key to transforming mental health care in Placer County was to involve the community, the Campaign for Community Wellness was born. Phase I of the Campaign for Community Wellness has been to coordinate key mental health initiatives in the county -- MHSA and SAMHSA. It was thought that there is great leverage and synergy between the two initiatives and that tighter coordination will expand the resources available to better serve a wide range of people. The Campaign for Community Wellness core values align with transformational concepts inherent in the MHSA and PEI policies adopted by the Mental Health Services Oversight and Accountability Commission (OAC). These core values include:

- Community collaboration
- Cultural competence
- Consumer/Family driven planning and programs
- Wellness focus including concepts of resiliency and recovery
- Integrated services
- Outcome-based program design

The Placer MHSA PEI Community Planning Process was conducted under the umbrella of the Campaign for Community Wellness. Several Placer County Health and Human Services (HHS) personnel supported the planning process. The main role of HHS staff was to provide the content information, including data statistics and MHSA background, to the process.

Additionally, five work group chairs supported the planning process. The work group chairs included a wide range of perspectives including: Latino, Native American, Asian-American, Faith, gay and lesbian. Additionally, the backgrounds of the chairs varied across socio-economic, cultural and educational spectrums. The role of the work group chairs was to link the voice of their constituency to the process and vice versa.

To support all of the above, Placer County retained professional planners and facilitators from Streamline Consulting Group to provide the neutral facilitation required to gain trust with the planning process and create a true community-based plan. (www.streamlineconsultingroup.com)

For content expertise in the area of mental health prevention and early intervention, Lynne Marsenich from the California Institute of Mental Health provided a one-day training for the Steering Committee that guided the group to a greater understanding of prevention and early intervention, support factors and risk factors. This one day training really helped the diverse Steering Committee and participants create a set of common vocabulary around prevention and early intervention that served them well over the nine month planning period. Lynn also provided on-going feedback and suggestions during the planning process and identified evidenced based and cultural relevant programs that mapped to group desired outcomes. Lynne provided support, as needed, to each of the work group as they developed their recommendations.

B. Coordination and Management of the Community Program Planning Process

Coordination and management of the Community Program Planning process was provided by HHS staff and work group chairs noted above, as well as Streamline Consulting Group.
C. Insurance that Stakeholders Have the Opportunity to Participate in the Community Program Planning Process

The Campaign for Community Wellness was, and still is guided by a steering committee of 35 voting stakeholders including approximately 20 community-based members from numerous constituencies as listed below. Regular attendees to the monthly Campaign Steering meetings include people from all walks of life making for lively and authentic conversations and plans. A variety of perspectives come from the fact that our meeting attendees include a wide range of people with different means, educational backgrounds, religious beliefs and experiences. We have mothers who have lost adult children to suicide, homeless adults, youth, city employees, etc. Gay, straight, Native American, Latino, Asian-American, African American also define our group—which, at the end of the day—is a true reflection of the Placer community. This group meets monthly and provided key recommendations into the PEI planning process and plan.

For the PEI planning process, the Steering Committee identified the risk and supportive factors in the community as well as the assets and gaps in services. The Steering reviewed the key demographics of Placer, noting the underserved population groups such as: Latino, Native American, Asian American, African American and homeless. Additionally, they reviewed key statistics related to risk and protective factors in Placer as well as feedback from the several community meetings that were conducted in Lincoln, Roseville and Tahoe.

Participants in these meetings included a wide range of community members and consumers of mental health services. Additionally, we held forums and solicited feedback from the Latino Leadership Council, the Native American Network and the Campaign for Community Wellness Steering Committee. In all of these outreach efforts we gave a brief overview of prevention and intervention in a power point format, and then asked the following questions in a brainstorming format:

- Who is most at risk?
- What are they at risk for?
- What are the current protective factors/assets these groups currently have?
- What new ideas or programs are suggested?

Below is a summary of input gathered from the various input forums that informed the work group and Steering Committee determination of priority populations:

Forum Input: Who are at risk? / Input: What are they at risk for?

CCW Steering Committee Input -
- Children & Youth: Poverty, uninsured, abuse, depression, disability, poor school performance, substance abuse, incarceration
- Adults: Trauma, depression
- Seniors: Depression, substance abuse

Community Input – Kings Beach, Auburn, and Lincoln
- Children: Neglect, lack of care and security, substance abuse
- Youth: Isolation, inverted family structure, substance abuse, gang involvement, aggression, lack of job skills, incarceration
- Adults: Women: Depression, poverty, transportation; Men: Poverty, unemployment, discrimination
- Families: Substance abuse, early sex, bullying, domestic violence, divorce
- Seniors: Isolation, depression, elder abuse, substance abuse, poor health

Latino Leadership Council
- Children
- Women, men and family
- Children: School failure, domestic violence
- Women, men and family: Substance abuse, isolation, depression, fear of immigration, lack of medical care, incarceration, unemployment

Native Network
- All ages and gender who are at-risk
- Historical trauma, discrimination, poverty, homelessness, low educational attainment, lack of access to care

3IIA. Identified Disparities Within Medi-Cal, CSS, WET and PEI Focus Populations

The list of the identified populations with disparities noted within MediCal, CSS, WET, and PEI’s priority populations is as follows:
- Native families, children and youth
- Latino families, children and youth
- Transition Age Youth
- Older Adults
- Mothers of children 0-5 years with depression
- Children and youth at-risk for school failure, incarceration
- Recruitment/retention of bilingual/bicultural staff
- Bilingual/bicultural services to Tahoe and Lincoln
- Stigma and bias in the workforce regarding mental health issues
- Need for better understanding of the role and benefit of consumers, families and youth in the workforce
- LGBTQI2S
- Co-Occurring
- Multiple Disabilities
- Homeless Individuals

3IIIA. Identified Strategies/Objectives/Actions/Timelines in CSS, WET, and PEI Plans for Reducing Identified Disparities

Strategies, objectives, actions, and/or timelines in CSS, WET and PEI plans for reducing disparities are as follows:

CSS Plan

Objectives to Reduce Disparities in Access and Services
Placer County is committed to addressing the discrepancies and disparities in
access and service delivery related to race ethnicity, gender and age. MHSA objectives to reduce these disparities include:

- Reducing service disparities to Latino residents through increased outreach and new culturally appropriate services.
- Reducing the gender gap in services for children by exploring why boys (0-17) are served at a higher rate than girls.
- Reducing the gender gap in services for adults and older adults through increased outreach and more sensitivity to the needs of males.
- Increasing and improving services to transition age youth through increased outreach, development of a TAY system of care (see PTAY Wrap below), increasing cross-system collaboration among Probation, Adult System of Care and Children’s System of Care, and tailoring services to meet the age-appropriate needs of this population.
- Increasing services to Older Adults through increased outreach and development of an Older Adult System of Care

**WET Goals and Strategies:**

**TRAINING AND TECHNICAL ASSISTANCE:**

**Consumer and Staff Development**

- The WET subcommittee will identify effective evidenced-based models for each topic area and determine trainers and most cost effective manner to provide these trainings
- Provide annual trainings and ongoing consultations to develop staff competencies in the areas identified by our stakeholders.
- Incorporate the client and family voice into trainings to expand beyond the clinical perspective of the trainee (e.g. Listening Well being led by Placer consumer’s who have been trained to train consumer/family members and staff).
- Provide trainings/ technical assistance with diversified methods (e.g. interactive, classroom style, group learning, etc.)

**Objectives:**

- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula
- Incorporate into each of these trainings, specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse minority population of our County.
- Evaluate internal versus external resources for proposed trainings
- Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula
- Provide training, as appropriate, to employed consumers / family members with the goal of training all within 5 years
- Incorporate outcome measures to ensure efficacy of training programs
- Continue offering trainings for incoming staff, contracted providers and employed consumers / family members
• Develop a resource library available to all providers and consumers
• Address the issues of stigma and discrimination faced by mental health consumers and by family members.
• Ensure that staff is exposed to various client and family member viewpoints and to better understand the client and family experience.
• Employees, including consumers and family members, will evaluate via evaluation forms, survey’s, and by committee, the effectiveness of their training experiences to allow them to:
  • Understand the public mental health system
  • How to navigate the system more easily
  • Develop skills to reduce stigma and discrimination

Leadership Development Activities:
• Establish a leadership academy of 10-20 mental health staff (consumer and family trainers will be identified).
• Bring in trainings and/or consultants who will train staff in recovery oriented leadership skills including: meeting facilitation, community outreach, professional presentations, technical writing, team motivation, etc.
• Develop a mental health speaker’s bureau who train/speak about MHSA core values to partner agencies, in classroom settings, or other community venues.
• Provide 5 stipends at $500 each to members who provide relevant recovery oriented trainings to partner’s agencies (as determined eligible by WET workgroup). *To be funded in Action 9.

Objectives:
• Evaluate internal versus external resources for proposed trainings
• Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
• Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula
• Provide leadership development training, as appropriate, to employed consumers / family members with the goal of training all within 5 years
• Incorporate outcome measures to ensure efficacy of training programs
• Continue offering trainings for incoming staff, contracted providers and employed consumers / family members
• Develop a resource library available to all providers and consumers
• Address the issues of stigma and discrimination faced by mental health consumers and by family members.
• Ensure that staff and community is exposed to various client and family member viewpoints and to better understand the client and family experience.
• Develop opportunities for leadership to grow through member’s of the leadership academy being allowed to discuss wellness, recovery, and resiliency as well as introduce students/community members to the mental health field.

E-Learning Contract Objectives:
• Provide greater ease for staff, community providers, consumers and family members to access training and educational courses which meet license requirements and/or provide career path development, as well as rehabilitation and consumer employment courses.
• Explore providing a community access portal for consumers and family members and key stakeholders to meet their training and information needs.
• Increase quality and availability of diverse training offerings while reducing cost.
• Provide compliance and quality control for legal requirements by linking to the County’s existing education and licensing tracking system.
• Research existing training modules that offer established credibility
• All staff will be trained in a set of core wellness, recovery, and resiliency oriented classes within 5 years.

MENTAL HEALTH CAREER PATHWAY PROGRAMS
Psychosocial Rehabilitation Certification Program Activities:
• Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
• Purchase a Psychosocial Rehabilitation Curriculum (e.g. CASRA, META) along with necessary call-specific resource materials to provide training.
• Train Placer County Staff to “train the trainer” to teach course curriculum to current/potential mental health staff (including consumers/family members).
• Research and outreach to local Junior colleges to explore offering the recovery oriented mental health courses as a class for credit.
• Pursue stipends/scholarships toward USPRA certification and class enrollment if outreach to Junior colleges is successful.

Objectives:
• Address the issues of stigma and discrimination faced by mental health consumers and by family members.
• Ensure that staff and community is exposed to various client and family member viewpoints and to better understand the client and family experience.
• Enhance the skill level of consumers/family members working in the mental health field.
• Provide opportunities to enhance job skills and educational advancement.
• Encourage consumers and family members to further pursue the mental health field.
• Increase consumer voice within mental health organizations.
• Train all staff in relevant course material within 5 years.

Outreach and Enhanced High School Career Tracts Activities:
• Develop a contract with at least 1 school district with the outcome of starting a Mental Health Professions Academy or similar program by September 2009.
• Conduct a minimum of 4 speaking engagements annually. Target health care professionals, youth, consumers and their families from and within diverse communities.
• Attend Job Fairs and develop new ways of recruiting for hard to fill positions (e.g. utilize Nursing employees to help with recruitment, etc.)
• Provide 2 paid internships for high school students annually
• Provide opportunities for high school age volunteers within the public mental health system.

Objectives:
• Identify early and facilitate mental health career information
• Educate early learners in wellness, recovery, and wellness principles
• Increase “hard to fill” positions by increasing opportunities and knowledge about how to enter the mental health field.

Increased Retention Efforts Activities:
• Newsletters for county employees and make contributions to Placer’s community newsletter (Campaign for Community Wellness).
• Develop appreciation strategies to create welcoming and appreciative organizational cultures.
• Further collaboration with community partners
• Develop and implement a recovery oriented new employee orientation

Objectives:
• Support cultural differences and stories to help decrease stigma
• Develop new and innovative strategies to decrease stigma and increase cultural competence in the workforce
• All staff develop skills to reduce stigma and discrimination
• Maintain/retain quality employees in the Mental Health Workforce
• Increase productivity of employees by creating a welcoming environment.

RESIDENCY, INTERNSHIP PROGRAMS
Internship Programs
Objectives:
• Expand internships to consumer/family members, the medical field, as well as diverse master’s level interns who meet Placer’s identified needs.
• Provide recovery oriented supervision (meeting necessary requirements for individualized intern).
• Provide (if possible) needed interns to target areas specified in needs assessment (e.g. bi-lingual/bi-cultural in Tahoe and/or Lincoln).
• Expand internships on the career ladder to include non-master’s level students/potential students and provide supervision and support.

FINANCIAL INCENTIVE PROGRAMS
Stipends and/or Scholarships and Grants Actions:
• Provide stipends/and or scholarships each year to individuals wishing to pursue higher education / career pathway opportunities in Mental Health Service.
• Establish an application process that would determine eligible individuals for a stipend or scholarship.
• Establish a process with key stakeholders for reviewing applications and recommendations for stipends, scholarships or grants.
• Provide accountability and support to the individuals approved to receive stipends, scholarships, or grants.
• Allocate funds for Speaker’s Bureau participants.
• Allocate funds for consumers and family members to attend relevant trainings, classes, or conferences each year. *beginning FY 2010-11
• Allocate stipends for 5 new interns as outlined in Action 8 *beginning FY 2010-11.
• Allocate stipends for 2 HS student interns *beginning FY 2010-11

Objectives:
• Community (e.g., HS students) hear from a variety of local leaders about being in and entering the Mental Health Field
• Decrease stigma and bias around consumer/family members and increase consumer voice.
• Decrease workforce shortages by creating incentives for hard to fill positions in difficult to recruit areas.
• Increase consumer and family member participation in trainings and classes
• Increase interns trained and receiving work experience in a mental health setting and design strategies to retain interns and/or encourage hard to fill staff to continue toward the mental health field.

MHSA PEI Programs, Goals and Strategies:

Incredible Years (Expansion)
Across the board, the Incredible Years training program has the best outcomes for improving family functioning across a variety of ethnic demographics. To reach the priority population of young children, this program was selected as the most desirable.

The Incredible Years parent training intervention is a 12-week program focused on strengthening parenting competencies (monitoring, positive discipline, confidence) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competencies, and reduce conduct problems. The parent programs are grouped according to age. The programs in Placer will be delivered in a culturally competent, safe, nurturing setting at local Family Resource Centers. It is expected that 40% of the families served that are enrolled in this program will be Latino due to the demographics of the Family Resource Centers.

Functional Family Therapy (Expansion)
To reach the targeted youth population at risk of involvement with Juvenile Justice, we identified a program called Functional Family Therapy that is currently working very well in Placer County for a diverse set of youth. Functional Family Therapy is yielding positive outcomes such as: reduced school failure, improved relationships with school community and family, and prevention of relapses. Functional Family Therapy, targets youth from 10-18 at high risk of involvement with the Juvenile Justice System. It is conducted in partnership with Placer System of Care, Placer Juvenile Detention and various community partners. Recently, additional community agencies, such as the Sierra Council on Alcoholism and Drug Dependence approached the County to expand the program through collaboration. It was thought that providing funds to expand this program would enable more youth to be served with leveraged funds.

Recently, Placer Juvenile Detention Facility collected responses to a survey on
mental health in 2008 from 49, 12-18 year olds. Survey respondents stated that individual and family counseling was what they most needed to get themselves on the right track. They also mentioned needs for life skill training and help with dealing with depression and anxiety issues. Family Functional Therapy addresses both these concerns in a culturally competent manner. Sexual orientation, race, gender, religious background and other needs are part of the over-all awareness and understandings that make this program work well across diverse populations of youth in Placer County.

Functional Family Therapy is an empirically grounded, well-documented and highly successful family intervention for at-risk and juvenile justice involved youth. The target population is youth ages 10-18 and their families, whose problems range from acting out, conduct disorder, and alcohol/substance abuse. The focus of the program is to work to resolve the underlying family dysfunction that leads to these issues. By doing such, the outcome is a more resilient, healthier youth who chooses better pathways to adulthood.

The program will focus on a two-pronged approach of preventing youth with the first onset of mental health and family issues from progressing to out of home placement situations as well as focusing on preventing youth from entering into deeper end services through Probation, Mental Health and Child Welfare due to their mental health and family dysfunction.

Evaluation for this program will be conducted by the Placer PEI Coordinator in partnership with the program partners and in accordance with the methodology laid out in this report. This program was chosen as the best fit for the needs of local youth and their parents by community partners who work directly with this population.

Positive Indian Parenting: NEW, Alternative

Representing 1.4% of the Placer County population, the Native American community is overrepresented in the Children System of Care and school failure rates are significantly higher than their Anglo peers (37%).

According to the California Health Information Survey of 2005, Native American residents in Placer County reported the highest level of mental health distress and the lowest level of access to health services, with 67% of Native American respondents reporting that they do not have health insurance and 57% reporting that they had no usual point of access to health care.

It has been noted that one of the impacts historical trauma has had on Native American communities is the loss of a positive cultural identity, which places Native American youth at risk for substance use, depression, suicide, and school failure. Another impact is the erosion of family structures and lack of transmission of cultural knowledge that promotes protective factors for Native American youth.

In order to provide greater access to cultural knowledge and increase mental wellbeing for youth, the Native American work group proposed the prevention strategy based on the PEI logic model, of strengthening the family unit through a program called Positive Indian Parenting.

Parent Project (NEW)

The Latino Leadership Council (LLC) was formed to better identify Latino health needs and concerns. Since its inception, LLC members have both participated in and conducted a number of surveys to ensure their needs were heard and could be adequately addressed. Currently, the LLC is moving towards the formation of their own, independent advocacy organization with the ability to manage financial and organization needs.
association with serving the needs of their community.

After several meetings with community members in Lincoln, Roseville and Auburn, LLC members have recommended that a pilot program of the Parent Project be initiated in Lincoln to divert youth from at-risk behaviors and to give parents the skills they need to raise their children in a new culture.

Based on the logic model, this alternative program is being proposed as the best model to serve the unique needs of the unique Latino families in the unique city of Lincoln. This program will be evaluated as part of the over-all PEI evaluation process and will lend important data to the field of promising practices for the Latino community. Additionally, a part-time bi-lingual/bi-cultural therapist will be serving children, youth and parents enrolled in the Parent Project program as deeper-end needs arise. This therapist will be available for session 1-2 days per week at a location naturally frequented by the Latino population in Lincoln such a church, school or other partner agency.

Youth Development
The PEI process brought to the surface the need to provide positive social skill training for a diverse set of youth at risk of school failure, living in stressed families and at risk of involvement in the juvenile justice system so that they would learn how to make positive decisions for themselves. In a national teen survey conducted by the Boys and Girls Club of America in 2002, of 46,000 youth, 40% stated that problems with drugs and alcohol were their number one issues. In the same survey, 45% stated that parents have the biggest influence on their decision-making and 37% stated that their relationship with their parents is the most important to them. Based on this data, as well as numerous other sources, the Children and Youth work group wanted to choose programs that had both pro-social and parenting components. Listed below are the youth development programs chosen that best fit the local needs of strengthening the whole family unit while building protective factors for youth at risk for multiple issues.

Life Skills Training: NEW, Alternate
Life Skills Training (LST) is a program based on more than 20 years of rigorous scientific research and is one of the most effective evidence-based programs used in schools today. LST is proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive and exciting program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations. Partnered with this program is a parent education component that takes place simultaneously to the youth’s involvement in school. The parent sessions take place in the evening and work to support the efforts of the students in the program.

Life Skills training has been tested over the years to a diverse set of youth, including Anglo, African-American and Latino youth. Life Skills Training will help to:
- Teach a diverse set of students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs
- Help students to develop greater self-esteem and self-confidence recognizing their uniqueness
- Enable students to effectively cope with anxiety
- Increase their knowledge of the immediate consequences of substance abuse
- Enhance cognitive and behavioral competency to reduce and prevent a variety of
health risk behaviors

In Placer, Life Skills Training will be offered in middle and high school to youth identified as being at risk of school drop-out due to a variety of issues. In Tahoe the program could be offered through a partnership between Tahoe Women’s Services and Tahoe Truckee Unified School District that already exists. These partners are currently operating other youth programs in the local middle and high schools. It is expected that 50% of the participants in this program will be Latino. Programs will be offered with-in the school day, for 8 weeks, 45 minutes per session.

In Western Placer County, 3 schools have been identified for the Life Skills training. The Placer Unified School District will partner with these schools to implement the program with-in the context of services already supporting the at risk youth in middle and high school. It is expected that approximately 30% of the students in this program will be Latino based on local demographics of the 4 schools.

The Life Skills program will be delivered by trained counselors who can support and identify mental health needs as they surface. Additional supports for this program include: coordinating, materials, supplies, room rental and program evaluation. Evaluation, coordination for these programs will be handled through a partnership between the Placer PEI Coordinator and a Tahoe-based community educator.

Though this is not an evidence-based program as outlined in the PEI State Resources, youth, particularly Latino at-risk youth. (Source: Independent multi-year evaluation studies posted on [www.lifeskillstraining.com](http://www.lifeskillstraining.com).) Additionally, it was felt that this type of program best responds to the needs of this specific population---something that no other program is doing at this time.

Tahoe Enhancement Programs – NEW, Expanded, Alternative Program

In order to meet the unique needs of the rural Kings Beach community, the Steering Committee recommended that additional funds be made available to add supplemental training to the Life Skills program. The supplemental training will focus on delivering successful violence prevention and acculturation programs. A small portion of funding was also recommended for local oversight of PEI programs, due to the remote location from the rest of the County.

Adventure Risk Challenge (ARC) – NEW, Expanded, Alternative Program

Additionally, it was recommended that a local program, Adventure Risk Challenge (ARC) be supported. ARC teaches at-risk students literacy and leadership skills through a rigorous academic and outdoor education curriculum with a six-week intensive summer immersion program and subsequent follow-up support. The program focuses on highly motivated English Language Learners in the eight, ninth and tenth grade.

The six-week summer immersion program is a combination of intensive academic curriculum and a series of backcountry expeditions focused on leadership and self-sufficiency skills. The stress is on the adventure, risks and challenges faced in the outdoors, in personal growth, in social interactions, and in academic learning. Local research has found that this program raises student performance by two grade levels over a six-week session. Three subjects are intertwined throughout the summer program:

1) Language Arts curriculum
2) Science – Environmental and Wilderness Medicine, and
3) Leadership and Physical Fitness.

Each course focuses on improving English language reading, writing, and public speaking. The curriculum is aligned with California State Standards, service-learning
guidelines, and meets requirements for high school credits. Ongoing additional support includes year-round mentoring, tutoring, college counseling and community service participation.

Of the last 32 students who participated in the ARC program, 28 or 88% passed the California High School Proficiency test. The statewide average for English Language learners is 36% and 40% in Placer County. ARC students generally pass at a rate of more than 2 times the State and County average.

This program has several funding and collaborative partners including: Sagehen Creek Field Station, UC Berkeley, Tahoe Truckee Unified School District, local high school ESL programs, the Tahoe National Forest Service, Summer Search, King’s Beach Boys & Girls Club, Sierra Watershed Education Partners (SWEP), Truckee River Watershed Council (TRWC), Teichert mines, California State Parks, Creciendo Unidos, Project Discovery, Kayak Tahoe, Placer County’s Health and Human Services, Project MANA, Tahoe Women’s Services, The Truckee Family Resource Center and Summer Search.

Native American Youth Development Programs

In order to provide greater access to cultural knowledge and increase mental well-being for youth, the Native American work group proposed the prevention strategy, based on the PEI logic model, of strengthening the family unit through two programs: Project Eagle and Across the Ages.

Project Eagle (Leadership Development): NEW, Alternative Program

Culturally relevant group psycho-education for Native American youth and their families that promotes positive cultural identity, self-esteem, self-disclosure, positive parent/youth interactions and leadership skills. Targeted risk factors include teen suicide, depression, anxiety, alcohol and substance abuse, low self-esteem, alienation, running away and dropping out from school.

Across Ages Program: New

Native American adaptation of an intergenerational mentorship program that pairs elders (55+) with youth ages 9 to 13 years and supports the formation of positive cultural identity through the transmission of traditional skills and knowledge. The program employs mentoring, community service, social competence training, and family activities to build personal responsibility for self and community. The goal is to increase the resiliency of youth and therefore reduce their risks of substance abuse, early sexual activity, violence, or school failure.

Placer’s Native Network Liaison and a hired coordinator/community organizer will deliver these two programs. The program will be supported by TANF or comparable organization that will also provide the room for the trainings and help with outreach. The County anticipates that by 2011, a Native Family Resource Center could exist to host these and similar trainings. Partnering with an established Native-serving organization will improve access for this underserved population. Outreach for this program will be conducted by the Native Network and Native TANF (or similar organizations) who both have natural links and established trust in the local Native communities. Additional supports for these two programs include childcare, supplies, materials and staff coordination.

Transition to Independence Program: Expansion, Alternate

The Transition to Independence Process (TIP) model was developed to engage a wide range of youth and young adults in the process of their own future planning, provide
them with developmentally-appropriate services and supports, and involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains – employment, career-building education, living situation, personal-effectiveness and quality of life, and community-life functioning.

Currently, the Transition to Independence Program is being used by local service provider, Whole Person Learning, Inc. Whole Person Learning currently does not have the capacity or resources to serve youth and transition-aged youth who have additional needs in the mental health arena. The Transition to Independence Program is designed to add in the mental health service element that some of these transitioning youth need to take the next step into adulthood.

This program will be managed and evaluated by the Placer PEI coordinator who will ensure that desired PEI outcomes are monitored.

**Depression Screening and Resources: NEW**

Working in partnership with the Women, Infants and Children (WIC) offices and the five Family Resource Centers in the county, as well as other organizations serving mothers with young children, referrals will be made from the depression screening tool. The depression screening for the referred mothers will be conducted by county public health nurses in the community clinics and by Family Resource Center staff (or similar place). Referrals will be made for group or short-term individual therapy as needed. A full-time bilingual therapist (funded by PEI funds) will be available to provide therapy for mothers screened and needing immediate short-term intervention support for depression in the Auburn/Roseville/Lincoln area, and a half-time health educator will be hired to serve the Tahoe region.

Resources will be given to each depression-screening participant including information about a web-based resource. All resources and materials will be available in English and Spanish and delivered in a culturally and linguistically relevant manner. Older adults will be referred for depression screening by primary care doctors and social workers. Screening and treatment will take place with-in primary care settings at Placer County Community Clinic. Those deemed in need of immediate short-term group or individual therapy will be referred to the new full-time therapist (funded by PEI funds) who will conduct 12-week individual sessions at the community clinic or other location naturally used by the older adults.

The depression-screening tool for the Project would be the Edinburgh or Beck Depression inventory tools. Training on how to use the screening tool will be conducted annually for 30 community service providers.

**12-Week Short-term Intervention Therapy for Depression: NEW**

Two therapy modalities will be used for the short-term individual and or group therapy offering to consumers screened and deemed in need of an intervention: 1) Cognitive Behavioral Therapy, and 2) Interpersonal Talk Therapy. Both modalities were chosen for their successful outcomes for depression for a short-term intervention period and because it was felt that these approaches work best for the specific needs of our community. Both the Native and Latino communities felt that the IPT therapy approach was a better fit for their cultural needs.

- *Cognitive Behavioral Therapy (CBT)* is a brief form of psychotherapy used in the treatment of adults and children with depression. Its focus is on cognitive...
Restructuring and behavioral activation, and methods involving current issues and symptoms versus more traditional forms of therapy, which tend to focus on a person’s past history. The usual format is weekly therapy sessions coupled with daily practice exercises designed to help the patient apply CBT skills in their home environment. CBT is a scientifically well-established and effective treatment for depression; with over 75% of patients showing significant improvements (National Association of Cognitive-Behavioral Therapists, nacbt.org).

- **Interpersonal “talk” Therapy (IPT)** is a short-term form of psychotherapy that focuses on interpersonal interactions and the development of interpersonal skills. Research by Joiner, Brown and Kistler through Lawrence Erlbaum Associates have shown that IPT is effective in treating depression. IPT utilizes structured interviews, known as “talk therapy,” and home assignments relating to interpersonal interaction (International Society for Interpersonal Therapy, interpersonalpsychotherapy.org).

Two full-time therapists and one part-time health educator will be hired to support the mothers and older adults screened for depression. The hired therapists will be trained in Cognitive Behavioral Therapy (CBT) at the onset of their start date.

1. The full-time bilingual therapist will serve mothers in the Auburn, Roseville, and Lincoln region at locations frequented by this population such as the Family Resource Centers and Women, Infant and Children (WIC) offices.
2. One part-time Tahoe health educator will work to serve mothers in partnership with Sierra Family Services and North Tahoe Family Resource Center in a bilingual capacity.
3. One full-time therapist will serve the older adult population in the Auburn, Roseville, and Lincoln region at locations frequented by this population such as community clinics for primary care and senior centers.

**Native American Healing: NEW, Alternate**

The Native American population uses a cultural healing approach to build protective factors in their community for mental health needs. To this end, their approach to reducing depression and suicide involves celebrating their cultural heritage through events and gatherings. Annually, the Native Network plans to host a community concert and cultural camp to build cultural pride that produces outcomes of improved mental health.

**Social Marketing/Anti-stigma: NEW**

Most children and adults with mental health problems seek help from their primary care physicians rather than a mental health specialist. Primary care providers are a natural and non-stigmatized point of contact for families, with the capacity to identify mental health problems and intervene early (source: OAC, 1.8.08). The strategy planned to reach primary care providers about mental health issues with the Bye Bye Blues program is threefold:

1) Conference: One-day conference on topics of suicide, depression, and other common mental health topics, including panels by consumers, family members.
2) Depression screening training: Primary care staff will be solicited to take part in the annual depression screening training.
3) Awareness campaign and link to a 211 or Network of Care type of resource: All Placer-based primary care providers will be sent information about available
mental health services and programs including key messages that reflect the importance of their role in early intervention

3IIIB. Identified Strategies in Medi-Cal, 200% of poverty population, MHSA/CSS, and PEI Priority Populations

Medi-Cal:
Placer County will strive to continue to improve the Medi-Cal penetration rate for the following age, gender, race/ethnic populations through the following strategies:
- Latino/Hispanic population by contracting with Latino Leadership Council and KidsFirst to improve outreach to the Latino community through community based services and health fairs (promotoras, Parent Project, Maternal Depression and Incredible Years)
- 0-5 age population by contracting with community partner KidsFirst to provide Incredible Years and Maternal Depression programs
- Foster Care youth population by contracting with community partner UACF to provide youth advocates/coordinators who work directly with TAY foster youth and juvenile justice youth to increase knowledge of rights and available services
- Older adult (60+ years) population by increasing services through outreach and development of Older Adult System of Care
- Asian/Pacific Islander population by increasing staff awareness and training in cultural sensitivity and cultural competency when working with this population

200% of Poverty Population:
The priority populations are very similar for both the MediCal population and the <200% of Poverty population. As stated in the paragraph above, Placer’s strategies for serving the unserved and underserved populations has been to partner with agencies, organizations and individuals through our Private Provider Network who are capable of providing services in a culturally competent manner and who have proven to be trusted resources to the communities. The focus of the SAMHSA Cooperative Agreement and subsequent planning through MHSA PEI also reflects this approach as well. However, it must be said that this approach has been short-sighted, in that persons with serious and persistent mental health issues will also need county services and we must be capable of providing appropriate assessments, interventions and long term support.

Placer County will continue to improve the <200% of Poverty population penetration rate for the following underserved/unserved age, gender, race/ethnic populations through the following strategies:
- Latino/Hispanic population by contracting with Latino Leadership Council and KidsFirst to improve outreach to the Latino community through community based services and health fairs (promotoras, Parent Project, Maternal Depression and Incredible Years)
- 0-5 age population by contracting with community partner KidsFirst to provide Incredible Years and Maternal Depression programs
- Transition age youth population by contracting with community partner UACF to provide youth advocates/coordinators who work directly with TAY foster youth and juvenile justice youth to increase knowledge of rights and available services
services

- Asian/Pacific Islander population by increasing staff awareness and training in cultural sensitivity and cultural competency when working with this population

**MHSA CSS Objectives to Reduce Disparities in Access and Services**

Placer’s MHSA CSS Plan primarily focuses on serving unserved or underserved children, transition age youth, adult and older adults. The disparity is being unserved or underserved, not necessarily being culturally, ethnically or otherwise “diverse”. The following statements, extracted from the CSS Plan, are the objectives to reduce disparities:

- Placer County is committed to addressing the discrepancies and disparities in access and service delivery related to race ethnicity, gender and age. MHSA objectives to reduce these disparities include:
  - Reducing service disparities to Latino residents through increased outreach and new culturally appropriate services.
  - Reducing the gender gap in services for children by exploring why boys (0-17) are served at a higher rate than girls.
  - Reducing the gender gap in services for adults and older adults through increased outreach and more sensitivity to the needs of males.
  - Increasing and improving services to transition age youth through increased outreach, development of a TAY system of care (see PTAY Wrap below), increasing cross-system collaboration among Probation, Adult System of Care and Children’s System of Care, and tailoring services to meet the age-appropriate needs of this population.
  - Increasing services to Older Adults through increased outreach and development of an Older Adult System of Care

The ASOC Priority Population Policy can be found in Appendix C-1.

**PEI Priority Populations:**

The strategies included in the PEI Plan to reduce disparities are again primarily focused on partnering with the various communities and their trusted providers to expand services specifically tailored to the unserved and underserved populations. (The specific services are detailed in Section 3IIIA above). However, also included in the PEI Plan are strategies to begin to transform the county mental health system. These strategies include providing training and information to existing staff through social marketing, cultural immersion activities and formal training. In addition, the utilization of Promotoras and cultural brokers in partnership with SOC staff will provide opportunities for hands-on learning and better collaboration between the community and the system.

Please refer to the tables under Criterion 3VA for the various plans (CSS, PEI, and MediCal) with strategies, objectives, actions, milestones listed.

**3IVA. Additional strategies/objectives/actions/timelines and lessons learned**

Currently there is some contradiction on the actual vs. perceived disparities among our Native and Latino communities. In some instances it appears as though Placer County
is serving the Native and Latino communities at the same or a greater rate as reflected in the populations within our county. For example, by reviewing actual case records, Native families are served in CSOC at a much higher rate (25%) than is their percentage of the total population (1.4%). However, the outcomes for these families continue to be poor and to reinforce and repeat the historical trauma by removing children from Native homes. Data for our Latino community appear to show greater disparity in the number of families and children served and the large number of Latino youth served in our Juvenile Justice population is an indicator of poorer and more disparate outcomes.

Though the PEI Plan is beginning to address these disparities by making available culturally appropriate services and supports (see Lessons Learned below), the missing strategy in the WET Plan appears to be implementing a recruitment, training, education and incentives program for local Native and Latino youth and adults to work toward social service, mental health, substance abuse and prevention careers. Anecdotally, we are seeing early signs of recovery and success as a result of services provided by culturally matched providers for Natives and Latinos that warrant additional attention.

In addition, we recognize that Transition Age Youth often exit CSOC without a planned or successful transition to ASOC. At times these youth, who are now adults and in charge of their own decisions, want nothing to do with any service system. At times, these youth have significant needs, but may not meet the priority population criteria for MediCal recipients for inclusion in ASOC. Despite our efforts to provide a Youth Coordinator to support youth and link them to community supports some fall through the cracks. An additional strategy would be to develop a plan for increasing our pool of youth advocates with lived experience. We are witnessing many youth whose transition is successful when they are able to be supported by a youth who has also experienced their transition from the system.

Finally, Placer SOC needs to develop services and supports specific to the LGBTQI, Ukrainian, and Co-Occurring communities as well as individuals who are homeless or who have multiple disabilities.

### 3IVA1. Share What has been Working Well and Lessons Learned While Working to Reduce Disparities on Identified Populations of Medi-Cal, CSS, WET, and PEI

**What’s Working Well:**

Placer has had many successes to note. Beginning with SAMHSA funding and enhanced by SB 163 and MHSA CSS funding, Placer has grown from one Family Advocate in 1999 to nine current advocates (and 2 vacancies). The advocates serve families in CSOC and friends and families in ASOC. The advocates are invaluable in engaging families, explaining the system, its processes and rules, helping the families to be empowered and find their voice to get involved in the service planning and outcomes for their family. Likewise, with SB163 and MHSA CSS funding, Placer now has three full-time and one half time Youth Advocates. They are providing direct services and working to shape policies, procedures and program development to be responsive and respectful of youth culture. Three youth and 4 adult supporters were recently trained by the Youth Development Network in positive youth development. Their goal in the coming year is to teach all county staff and providers in the Youth Development Initiative model in order to continue to transform our work within the youth culture.

Thanks to the formation of the Sierra Native Alliance and the Latino Leadership Council, culture specific services are being provided throughout the county. In addition, Placer has formed a Native Services Team and a Latino Services Workgroup within CSOC.
These two pilot teams are a combination of identified county staff and cultural brokers/promotoras who work together to provide culturally appropriate services to these diverse families. As stated above, though our evaluation is incomplete, families are more engaged in their service planning, demonstrating better follow through and they are reporting greater satisfaction with services. Staff are also reporting a workload reduction in that the cultural brokers/promotoras are providing additional support and linkages to services that allows them to focus on other aspects of service delivery.

Finally, Placer is employing 16 consumers, 14 as part-time Navigators and 2 as full-time Peer Advocates. In addition to direct service the consumers have created a Consumer Council, continue to operate a vibrant Welcome Center, have begun active fund raising, participate in the Campaign for Community Wellness Steering Committee and provide Listening Well Workshops. Consumers’ voices are being heard and their ideas are further transforming the system.

Lessons Learned:

Placer SOC has stumbled many times in the process of becoming inclusive of authentic community voice, creating and maintaining trust, sharing decision making and demonstrating transparency. Our missteps were not caused by a lack of good intentions, but of our inexperience and inability to navigate the bureaucratic barriers (and explain, multiple times, in layperson’s terms what the barriers are) that will continue to exist. For example, Placer had completed the PEI Planning process with the Steering Committee and we reached consensus with the plan, which populations would be served and what services were needed. We took the step of calling for Letters of Intent for each population/program area. Because, in most cases, multiple Letters of Intent were submitted, we were ‘forced’ by county, state and federal regulations to move into a Request for Proposal process. In spite of Placer SOC’s attempts to prepare everyone with the potential options, many members of the community who were participating did not understand the RFP process or the reasons behind it or how it applied to the MHSA process and our credibility was damaged. We have since realized a need to take more time, explain in greater detail and be more thoughtful about educating our community members on the complexities of the bureaucratic culture we live in.

3VA. Planning and Monitoring of Identified Strategies/Objectives/Actions/ Timelines to Reduce Mental Health Disparities

Below is Placer’s progress toward implementing and monitoring identified strategies for reducing mental health disparities through the CSS, WET and PEI approved plans:

<table>
<thead>
<tr>
<th>PLAN TO REDUCE MENTAL HEALTH DISPARITIES</th>
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<tbody>
<tr>
<td>CSS Plan</td>
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<thead>
<tr>
<th>STRATEGIES</th>
<th>OBJECTIVES</th>
<th>ACTION</th>
<th>MILESTONES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase outreach to Latino Communities</td>
<td>• Reduce service disparities</td>
<td>• The LLC has continued to provide outreach</td>
<td>Two Health Fairs drew over 400 Latino</td>
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<td></td>
<td>through two</td>
<td>adults who received free</td>
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<tr>
<td>2. Establish culturally appropriate services</td>
<td>Reduce service disparities</td>
<td>Contracted with the LLC to provide culturally appropriate services to Latino communities</td>
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<td></td>
<td></td>
<td>LLC is implementing the Promotoras Program, the Parent Project in Spanish, bilingual counseling, youth cultural arts activities and educational forums</td>
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<tr>
<td>3. Increase outreach and sensitivity to the needs of males</td>
<td>Reduce the gender gap in services for adults and older adults</td>
<td>No action</td>
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<tr>
<td>4. Increase outreach to TAY</td>
<td>Increase and improve services to TAY</td>
<td>Hired 1 FTE Youth Coordinator</td>
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<td>Youth Coordinator has provided linkage and support services to 388 TAY individuals</td>
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<tr>
<td>5. Develop a TAY System of Care</td>
<td>Increase and improve services to TAY</td>
<td>TAY staff have developed the YES, Youth Empowerment Support program model</td>
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<td></td>
<td></td>
<td>Have hired 3.5 FTE TAY staff, YES model includes direct service, training, support groups and leadership training</td>
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</tr>
<tr>
<td>6. Increase outreach to Older Adults</td>
<td>Increase services to Older Adults</td>
<td>Hired 1 FTE Older Adult clinician</td>
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<tr>
<td></td>
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<td>Outreach has been provided to 173 older adults</td>
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</tr>
<tr>
<td>7. Develop an Older Adult System of Care</td>
<td>Increase services to Older Adults</td>
<td>Hired 1 FTE Older Adult clinician</td>
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<td></td>
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<td>22 older adults have received Mental Health interventions</td>
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</table>
## PLAN TO REDUCE MENTAL HEALTH DISPARITIES

### PEI Plan

<table>
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<tr>
<th>STRATEGIES</th>
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<th>ACTION</th>
<th>MILESTONES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement the Incredible Years Program</td>
<td>• Strengthen the parenting skills of parents with children ages 3-8</td>
<td>• Awarded IY contract to KidsFirst, a local CBO</td>
<td>First IY class is enrolled by Aug 27, 2010  Classes start September 2, 2010</td>
</tr>
<tr>
<td>2. Implement Positive Indian Parenting</td>
<td>• Increase cultural knowledge and the mental well-being of Native youth  • Strengthen the Native family unit</td>
<td>• Awarded contract for Positive Indian Parenting to Sierra Native Alliance</td>
<td>First class of Parents completed on August 24, 2010  Second class of 6 parents began on August 30, 2010</td>
</tr>
<tr>
<td>3. Implement the Parent Project in Spanish and offer bilingual/bicultural counseling when needed to Parent Project participants</td>
<td>• Help Latino parents to divert youth from at-risk behaviors  • Give Latino parents new skills to raise a family in a new culture</td>
<td>• Awarded contract for Parent Project in Spanish to the Latino Leadership Council</td>
<td>First class of 12 parents completed in the City of Lincoln. Second class in the City of Roseville begins on September 2, 2010</td>
</tr>
<tr>
<td>4. Offer LifeSkills Training to Tahoe youth</td>
<td>• Provide leadership training and positive development program to at-risk youth in Tahoe (at least 50% Latino)</td>
<td>• Awarded contract for LifeSkills to Tahoe Women’s Services</td>
<td>Curriculum has been obtained and staff are trained  Program to start in September of 2010</td>
</tr>
<tr>
<td>5.</td>
<td>• Provide supplemental training to at-risk Tahoe youth on violence prevention and acculturation</td>
<td>• N/A</td>
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<tr>
<td>6. Enhance funding for Adventure Risk challenge to serve additional at-risk youth in Tahoe</td>
<td>• Improve literacy and leadership skills through ARC (a rigorous academic and outdoor education curriculum)</td>
<td>• Preparing to implement this school year and next summer</td>
<td></td>
</tr>
<tr>
<td>7. Implement Sons and Daughters of Tradition (formerly Project Eagle)</td>
<td>• Provides culturally relevant group education for Native youth and their families</td>
<td>• Awarded contract to Sierra Native Alliance</td>
<td>Family night occurs every Wednesday since March 2010 and serves approx. 30 families each week</td>
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<tr>
<td>8. Strengthening Native Community Commitment through Mentoring (formerly Across the Ages)</td>
<td>• Strengthen personal and cultural resiliency factors through intergenerational mentoring</td>
<td>• Awarded contract to Sierra Native Alliance</td>
<td></td>
</tr>
<tr>
<td>9. Implement Transition to Independence Program</td>
<td>• Increase and improve successful transition to adulthood for youth with mental health and other challenges</td>
<td>• Awarded contract to Unity Care Group</td>
<td>Staff have been hired and trained in this model and the referral process has begun</td>
</tr>
<tr>
<td>10. Depression screening and short term therapy for mothers with children 0-5</td>
<td>• Reduce risks of the effects of prolonged depression, such as suicide, for post-partum mothers and mothers of young children</td>
<td>• Awarded contract to KidsFirst for bilingual/bicultural therapist</td>
<td>Therapist has been hired and trained</td>
</tr>
<tr>
<td>11. Depression screening and short term therapy for Older Adults</td>
<td>• Reduce risks of prolonged depression and suicide for Older Adults</td>
<td>• ASOC has assigned a bilingual and bicultural therapist</td>
<td>Older Adult outreach has begun</td>
</tr>
<tr>
<td>12. Provide Native youth culture camp and community concert</td>
<td>• Improve mental health outcomes for Native youth by building cultural pride and celebrating cultural heritage</td>
<td>• Awarded contract to the Sierra Native Alliance</td>
<td>Eighteen youth participated in a six week summer conservation program</td>
</tr>
<tr>
<td>13. Create an effective social marketing campaign in order to address stigma and discrimination</td>
<td>• Increase awareness and understanding of persons with mental health issues and increase responsiveness in a positive way</td>
<td>• Awarded contract to Circle Point Marketing</td>
<td>An eight element social marketing plan has been developed and is being implemented</td>
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</tbody>
</table>
### PLAN TO REDUCE MENTAL HEALTH DISPARITIES

#### WET Plan

<table>
<thead>
<tr>
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<th>ACTION</th>
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</tr>
</thead>
</table>
| 1. Provide staffing and support to the WET component to enhance Placer’s training infrastructure | • Increase capability to meet special needs of clients  
• Enhance staff development (e.g., EBP’s, leadership and management practices  
• Promote the integration of wellness, recovery and resiliency concepts  
• Develop cultural and co-occurring competent staff  
• Increase capacity and capability for the provision of clinical supervision  
• Improve the coordination and streamlining of training efforts in SOC  
• Ensure that consumers, family members and underserved and underrepresented communities are included as both trainers and participants | • Hire Consumer Navigator to work with WET Coordinator  
• Host trainings specific to Wellness, recovery and resiliency.  
• Participate in the SOC Staff Development Committee  
• Provide Recovery focused clinical supervision support for staff | • Established WET Advisory Committee  
• All ASOC staff, many CSOC and community partners trained in Welcoming, Resiliency and Cultural Competency  
• Monthly Clinical Consultation supports all ASOC staff providing supervision. |
| 2. Work with Placer Personnel to review and revise existing job descriptions | • Reduce barriers to hiring consumers, family members including those from diverse communities | • Revise existing job descriptions  
• Add entry level position | • Initial conversations on requirements and process to revise job descriptions |
| 3. Participate in and support regional and state education and training efforts | • Ensure coordination and reduce duplication of services | • WET Coordinator attends regional and state meetings  
• Host regional Trainings | • Hosted Regional Trainings on Recovery Oriented Leadership and Creative Problem |
| 4. Provide trainings | • Increase client/family member skill development in social rehabilitation, wellness recovery, record keeping, data management and/or peer counseling | • Wellness Recovery Action Plan (WRAP) training and Listening Well presented by Consumer Trainers  
• Research best peer counseling training curriculum  
• Hire consumer employees | • 10 consumer employees trained in WRAP.  
• 8 consumer employees assisting in various roles while gaining record keeping and data management skills |
| | | | |
| 5. Assist in the development/implementation of courses at the community college level | • Increase supervisors of client/family member employees knowledge of covered benefits, reasonable accommodations, supporting consumer employees and recovery oriented work | • Provide training for staff in recovery oriented work  
• Provide training for supervisors on reasonable accommodations and supporting consumer employees. | • 150 staff attended recovery oriented trainings  
• 3 supervisors participated in webinar on accommodations and supporting consumer employees and share learning with colleagues. |
<table>
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<tbody>
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<td>1. Update Cultural Competence Plan</td>
<td>• Utilize results from the Community Readiness Assessment and the Survey Monkey, focus groups and key informant interviews to update the CLC Plan</td>
<td>• Sort findings by themes according to domains</td>
<td>• Plan written and submitted to DMH 9/3/10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Translate findings into goals and objectives</td>
<td></td>
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<td>2. Ensure Access to Services telephone lines are providing linguistically appropriate services to callers.</td>
<td>• Test the Adult and Children’s phone lines annually to ensure appropriate services are being provided to callers.</td>
<td>• MHDAB tested the phone lines</td>
<td>• Provide training to intake staff by 10/10</td>
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<td></td>
<td>• Remedial training is n is needed</td>
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<tr>
<td>3. Implement the recommendations of the Latino Access Study</td>
<td>• Prepare an Annual Report on the status of the implementation</td>
<td>• Mike Pyzak at SFS completed the report</td>
<td>• Draft report should be available by 09/10</td>
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<tr>
<td>4. Reduce disproportionate out-of-home placements of Native children</td>
<td>• Create a Native Services Workgroup and Native Services Team to improve the cultural appropriateness of</td>
<td>• Native cultural brokers and CSOC staff are working together as a team.</td>
<td>• Native Family Liaison is serving 30 families who are also</td>
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**PLAN TO REDUCE MENTAL HEALTH DISPARITIES**

**MediCal**

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| 5. Provide trainings based on cultural competence needs assessment | • Improve the cultural awareness and cultural knowledge of staff by providing a variety of training experiences on different cultures  
• Develop 3-year CLC Training Plan | • Provided 6 Cultural Immersion Brown Bag Lunches  
• Provided training on “The Role of Culture in Healing”, Lesbian, Gay Bisexual, Transgender Youth and Identifying gifts, Talents and Skills: Using Powerful New Capacity Assessment Tools | • Over 200 staff participated in one or more cultural competence trainings. |
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<tbody>
<tr>
<td>6. Increase consumer, family and youth involvement in SOC Programs and Activities</td>
<td>• Consumer Navigators, Family Advocates and Youth Coordinators will attend and participate in QI Committees and other program development and evaluation activities</td>
<td>• Consumer, family and youth advocates are members of the Client/Family Relations Committee, Cultural Competence Committee, the Consumer Council, CCW</td>
<td>• Family Advocate Program Director and Youth Program Manager are attending Management and SOC Leadership meetings</td>
</tr>
<tr>
<td>7. Implement a training tracking system through Trilogy</td>
<td>• Track staff participation in trainings</td>
<td>• Training through the Trilogy catalogue is accessible to all SOC staff</td>
<td>• First locally developed training, “Compliance” has been uploaded to Trilogy</td>
</tr>
</tbody>
</table>
3VB. Mechanism in Place to Measure and Monitor Effect of Identified Strategies, Objectives, Actions, and Timelines on Reducing Disparities. Discuss Measure and Activities Used to Monitor Reduction or Elimination of Disparities

Placer County has created an Evaluation Advisory Workgroup which is charged with developing a comprehensive plan to evaluate the effectiveness of our SAMSHA Cooperative Agreement strategies as well as our PEI strategies. In spite of the State requirement that a county must only evaluate one of the programs it is implementing under PEI, Placer has decided to evaluate all components in order to: 1.) Assure that all components and contractors are reaching and serving the populations and the numbers of participants recommended; 2.) Assure the we can measure outcomes for each of the components; 3.) Determine if the outcomes are consistent with our intentions to create positive change and reduce disparities.

Placer intends to identify strategies, objectives, actions and timelines for evaluation by December 31, 2010. As stated elsewhere, Placer is also amending our contract monitoring tool to more accurately assess each contract provider for overall organizational and programmatic cultural competence. Contractors are responsible for reporting to the county each quarter on their deliverables as well as their movement toward cultural competence and the reduction of disparities.

3VC. Identify Placer County’s Technical Assistance Needs

Placer would be interested in models others county’s are using to assess the effectiveness of their cultural competence efforts and MHSA implementation.

4IA. Brief Description of Cultural Competence Committee (structure, meeting frequency, functions, and role)

Placer SOC’s CLC Committee Charter has been inserted below:

**Placer County System of Care**
**Cultural and Linguistic Competence Committee**

**CLC Committee Charter**

**Committee Purpose**
The purpose of the Cultural and Linguistic Competence Committee (CLCC) is to ensure the development of the necessary skills, knowledge, attitudes, behaviors and policies within Placer County’s System of Care, in order to provide culturally responsive and effective care to members of diverse cultural groups.

Towards this goal, Placer County System of Care will engage representatives of diverse communities and consumer groups in a collaborative planning process that is informed by the diverse interests, expertise and needs of these groups.

**Committee Function**
In accordance with the CA Department of Mental Health Cultural Competence Plan requirements, the function of the CLCC shall be to:
- Identify unmet needs and mental health disparities in Placer County;
Review all System of Care (SOC) programs, services, and plans and respond and/or make recommendations with respect to cultural and linguistic competence needs and issues;

Provide a bridge for communication and accountability between the county and diverse cultural groups and community partners;

Participate in the development of and monitor the effectiveness an integrated CLC training plan for county staff and contractors;

Participate in the overall planning and implementation of services, including review of MHSA plans and client developed programs;

Provide reports to Quality Assurance/Quality Improvement programs;

Provide recommendations directly to the executive level; and

Prepare an annual report of committee activities

**Composition and Structure**

The membership of CLCC shall reflect the communities served by Placer County System of Care; including county management level and line staff, clients and family members from diverse cultural groups, providers, and community partners.

The CLCC will be co-chaired by a System of Care staff person and a community representative, with agenda preparation and meeting facilitation responsibilities being shared between county staff and community representatives. The SOC Co-Chair will be appointed by SOC leadership, the Community Co-Chair will be elected by the community representatives of the CLCC on an annual basis.

In order to facilitate an integrated role of the CLCC into System of Care planning, leadership and quality assurance processes:

- The CLCC shall designate a member to represent this committee on SOC planning, leadership and quality assurance committees (including but not limited to the SOC Leadership Committee, Quality Improvement Committee, SOC Staff Development, Workforce Education and Training, and the Mental Health, Alcohol and Drug Board);
- Representatives will provide reports of relevant SOC committee activities on a monthly basis through a standing CLCC agenda item;
- Items needing CLCC attention and review will be brought to the general meeting and sub-committees as needed to prepare recommendations;
- The CLCC shall also provide reports to the Campaign for Community Wellness, SMART Policy Board, Mental Health Director, the Board of Supervisors, and other decision making groups within system of care.

**Roles**

**Committee Co-Chairs:** The committee co-chairs will prepare meeting agendas, review minutes, and ensure that necessary materials are copied and provided at the beginning of each meeting. The co-chairs will facilitate meetings to assure collaborative, sequential and timely accomplishment of the committee's work.

**Committee Members:** Committee members will commit to staying current with CLCC business, including documents and activities missed due to absences from meetings. Members will also serve as designated representatives to the various system of care decision making groups and committees, and will be responsible for reporting back key issues and activities that are relevant to the work of the CLCC. Members are asked to
notify the co-chairs when they are unable to attend a meeting and/or designate a representative to report on any activities that the member may be responsible for at the meeting.

**Decision Making**
Decisions on committee recommendations, reports and actions are to be made by consensus among those in attendance. If a consensus cannot be reached, the committee use a simple majority vote, table the item until the next meeting, or refer the item for input from the SOC Leadership Committee.

**Committee Meetings and Resources**
The CLCC shall hold a general meeting at least once a month, and may meet as a group or in sub-committees more frequently to fulfill committee functions.

Placer SOC will provide the CLCC with access to meeting space, documents and appropriate information needed to accomplish the goals of the committee. The CLCC will accomplish their work with a budget specified in the annual CLC Plan.

**4IB. Policies, Procedures and Practices to Assure Members of CCC will be Reflective of the Community**
As stated in the CLC Committee Charter above, the members of the committee will “reflect the communities served by Placer County Systems of Care.” This commitment is also reflected in the composition of the current CLC Committee members by the roster included in Section 41D below.

**4IC. Organizational Chart**
The SOC organization chart indicating the CLC Committee connection to other decision making committees is below:
### 4ID. Committee Membership Roster Listing Member Affiliation

The CLCC committee membership roster is listed below:

**CULTURAL COMPETENCY COMMITTEE MEMBERSHIP ROSTER**

<table>
<thead>
<tr>
<th>COMMITTEE MEMBER</th>
<th>AFFILIATION/POSITION</th>
<th>VOICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynthia Brundage</td>
<td>Program Manager CSOC</td>
<td>Co-Chair</td>
</tr>
<tr>
<td>Anno Nakai</td>
<td>Exec Director Sierra Native Alliance</td>
<td>Co-Chair/Native Voice</td>
</tr>
<tr>
<td>Cyndy Bigbee</td>
<td>Supervisor ASOC</td>
<td>WET Coordinator</td>
</tr>
<tr>
<td>Christi Meng</td>
<td>UACF Program Director</td>
<td>Family Voice</td>
</tr>
<tr>
<td>Tammy Cherry</td>
<td>UACF Youth Program Coordinator</td>
<td>Youth (TAY) Voice</td>
</tr>
<tr>
<td>Elisa Herrera</td>
<td>LLC Facilitator</td>
<td>Latino Voice</td>
</tr>
<tr>
<td>Tink Miller</td>
<td>PIRS Director</td>
<td>Disabled Community</td>
</tr>
<tr>
<td>Melyssa Hollitz</td>
<td>In Home Support Services</td>
<td>Older Adults</td>
</tr>
<tr>
<td>Steven Surgener</td>
<td>Peer Advocate</td>
<td>Consumer Voice</td>
</tr>
<tr>
<td>Kalisa Johnson</td>
<td>Youth Coordinator</td>
<td>Youth (TAY) Voice</td>
</tr>
<tr>
<td>Cassandra Luera</td>
<td>Family Advocate</td>
<td>Latino Voice</td>
</tr>
<tr>
<td>Katrina Moser</td>
<td>Family Advocate</td>
<td>Family Voice (ASOC)</td>
</tr>
<tr>
<td>LeeAnna Miller</td>
<td>Youth Coordinator</td>
<td>Youth (TAY) Voice</td>
</tr>
<tr>
<td>Rebecca Huntley</td>
<td>Family Advocate</td>
<td>Family Voice (ASOC)</td>
</tr>
<tr>
<td>Jainell Gaitan</td>
<td>Clinician – ASOC</td>
<td>Older Adult/Latino Voice</td>
</tr>
<tr>
<td>Csilla Csizsar</td>
<td>Program Supervisor ASOC</td>
<td>Navigator/Consumers</td>
</tr>
<tr>
<td>Emilio Vaca</td>
<td>ED North Tahoe Family Resource Ctr</td>
<td>Latino Voice/Tahoe Voice</td>
</tr>
</tbody>
</table>

### 4IIA. Evidence of How the Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System

The CLC Committee Charter confirms the role and responsibility of the committee as restated below:

**Committee Function**

In accordance with the CA Department of Mental Health Cultural Competence Plan requirements, the function of the CLCC shall be to:

- Identify unmet needs and mental health disparities in Placer County;
- Review all System of Care (SOC) programs, services, and plans and respond and/or make recommendations with respect to cultural and linguistic competence needs and issues;
- Provide a bridge for communication and accountability between the county and diverse cultural groups and community partners;
- Participate in the development of and monitor the effectiveness an integrated CLC training plan for county staff and contractors;
- Participate in the overall planning and implementation of services, including review of MHSA plans and client developed programs;
- Provide reports to Quality Assurance/Quality Improvement programs;
- Provide recommendations directly to the executive level; and
• Prepare an annual report of committee activities.

4IIB. Evidence Showing the CCC Participates in the Above Review Process

Members of the CLC Committee have participated in the following:
• Preparation of and implementation of the Community Readiness Assessment, Phase I, II and III (described on page 4 of this document).
• Preparation and analysis of the Cultural and Linguistic Competence Policy Assessment of SOC staff through a Survey Monkey, focus groups and key informant interviews.
• Participation and approval of the various MHSA Plans.
• Semi-Annual reports to the QI Committee.

In 2010-2011 members of the CLC Committee will:
• Begin reviewing all SOC programs, services and plans and make recommendations with respect to cultural and linguistic competence needs and issues.
• Monitor the effectiveness of an integrated CLC training plan for county staff and contractors;
• Provide a bridge for communication and accountability between the county and diverse cultural groups and community partners.

4IIC. Annual Report of CCC Activities

The latest Annual CLC Report can be found in Appendix D-4. For 2009-2010 Placer’s CLC Committee’s goals were as follows:
1. Complete an assessment of the cultural and linguistic competence of our system of Care using an adapted version of Georgetown University’s Cultural and Linguistic Competence Policy Assessment (CLCPA).
2. Provide training on cultural competence to SOC staff and community providers.
3. Continue to implement the recommendations of the Latino Access Study.
4. Implement culture specific services for the Latino communities.
5. Implement culture specific services for the Native communities.
6. Increase the diversity of the CLC Committee
7. Develop Annual CLC Cultural and Linguistic Competency CQI Plan

Goal #1 was met successfully. The CLCPA was modified and sent to all staff via Survey Monkey. Over 230 SOC staff completed the survey. Ten focus groups and 19 key informant interviews were also conducted with members of diverse communities. The results were organized according to themes and the findings summarized (See Appendix D-4 for complete results).

Goal #2: Placer SOC has continued to provide cultural competence training to staff. This year 50 staff attended Roberto Dansie’s, “The Role of Culture in Healing”. Staff have also received Nurtured Heart Training, LGBTQ training, Recovery Oriented Leadership training and training via e-learning through Trilogy. While we were successful in training over 200 staff and community partners, our goal over the next 3 years is to ensure that all staff receive at least 8 hours of culturally specific training every year. To reach this goal we
will be utilizing the Trilogy system to track and monitor our results.

Goal #3: Placer SOC has continued to implement the recommendations of the Latino Access Study in Tahoe. To this end, we have a bilingual/bicultural therapist and a bilingual community educator. Through MHSA PEI our community-based partner agencies are providing transportation assistance and child care assistance as well as Life Skills training and leadership development opportunities for our Latino youth. In addition, our Family Advocate Program has most recently hired a bilingual/bicultural Family Advocate for Tahoe.

Goal #4: Through the Latino Leadership Council the promotora program continues to expand county-wide. The LLC has begun providing the Parent Project in Spanish in Lincoln and Roseville. Parents and children participating in the Parent Project who need additional counseling are referred to a bilingual/bicultural therapist (and the therapy is covered by MHSA PEI dollars). The LLC has also provided educational forums, a health fair with free health screenings, cultural arts and activities for the Latino community. In conjunction with CSOC staff a promotora is a member of a CSOC services team. The Promotora provides support services to Latino families who are receiving CSOC services to assure that the family receives culturally and linguistically appropriate services.

Goal #5: The Sierra Native Alliance incorporated as a 501c3 non-profit this past year. As of August 1, 2010, Placer SOC has contracted with the Sierra Native Alliance to operate Native specific programs for Placer County. These programs are: The White Bison program, Sons and Daughters of Tradition, Positive Indian Parenting, Intergenerational Mentoring, Native Culture Camp, and community and cultural events such as the Big Time Pow Wow. In addition, CSOC has formed a Native Services Team with staff from the Sierra Native Alliance and our staff, in order to provide for a Native cultural assessment and services for native children and their families who are being served in our system.

Goal #6: Placer SOC has broadened and deepened the membership of the CLC Committee to include Native, Latino, consumer, family, youth, older adult, disability, and community provider voice. In the next year we will add additional voices from the LGBTQI2S community and the Ukraine community.

Goal #7: Placer CLC has developed FY2010-2011 Annual Cultural and Linguistic Competency CQI Plan. The CLC plan in its entirety is as follows:

Appendix D-5

Placer County Systems of Care

Annual Cultural and Linguistic Competency CQI Plan
Fiscal Year 2010-2011

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Annual Cultural and Linguistic Competency Plan (Current Objectives from Overall SOC Annual QI Work Plan)

Population Assessment and Utilization Data Objectives

<table>
<thead>
<tr>
<th>Overall Goal/Objective</th>
<th>Planned Steps and Activities to Reach Goal/Objective</th>
<th>Responsible Entity and/or Lead Person</th>
<th>Auditing Tool</th>
<th>Due Date / Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Cultural Competence</td>
<td>Use results from the Community Readiness</td>
<td>CLC Committee/ Lead: CLC Manager (Cindy):</td>
<td>Cultural Competence</td>
<td>Due: 8/31/10 Completed:</td>
</tr>
<tr>
<td>Plan</td>
<td>Assessment to inform and update the 2010 version of the Cultural Competence Plan.</td>
<td>Native Liaison (Anno Nakai)</td>
<td>Plan update</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Ensure Access to Services telephone lines are providing linguistically appropriate services to callers. Provide training as needed.</td>
<td>Test the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the AT&amp;T Translation Line Service. Provide remedial training as deemed necessary.</td>
<td>CLC Committee/Lead: CLC Manager (Cindy)/MHAOD Board QIC/Lead: QI/MCU Manager (Twylla)</td>
<td>MHAOD Board Access to Services Test Line Report; Training sign in</td>
<td>Due: Annually, by 6/30/10 Completed:</td>
</tr>
<tr>
<td>Implement the recommendation s of the completed Latino Access Study</td>
<td>The specific objectives of the Latino Access Study developed to improve services to the Kings Beach Community are described in the Study. Latino Access Study report to be generated annually.</td>
<td>Lead: SOC Directors (Richard/Maureen)/CLC Manager (Cindy)</td>
<td>Written Educational Information</td>
<td>This is an ongoing activity. Annual report due 6/30/10</td>
</tr>
<tr>
<td>Reduce disproportionate out-of-home placements in the Placer County Native Community</td>
<td>Participate in the Disproportionality Project sponsored by the Annie E Casey Foundation and CDSS. 1) Attend learning conversations in 09-10. 2) Explore CWS Native Services Team Development (collaboration of Native county staff in CWS and Ongoing teams and Native Liaison for Best Practices implementation).</td>
<td>CLC Committee/Lead: CLC Manager (Cindy); Native Liaison (Anno Nakai)</td>
<td>Avatar Minutes and project development document</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
<tr>
<td>Provide trainings based on the cultural competence needs assessment</td>
<td>To continue to improve cultural competence and experiences of SOC staff through trainings based on the needs assessment. Trainings for 2009-2010 to be held include: Improving Outcomes for Native Youth and Families (March 3); Big Time Pow Wow - Honoring Family and Children of Yesterday and Today (Oct 17); Recovery Happens (Sept 19); Leafing Out of Spring (April 25); Lesbian, Gay, Bisexual, Trans-gender, and</td>
<td>CLC Committee/Lead: CLC Manager (Cindy)</td>
<td>CLC Minutes and List of Trainings</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
<tr>
<td>Human Resources Composition Objectives</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td>Assess bilingual staff and interpreter skills and provide appropriate training</td>
<td>Provide annual training for interpreters and use of interpreters.</td>
<td>CLC Committee/Lead: CLC Manager (Cindy)</td>
<td>CC Minutes Training Flyer, sign-in sheet</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
<tr>
<td>Increase consumer involvement in SOC Programs and Activities</td>
<td>Ensure attendance of Consumer Navigator (county employee) and/or Consumer/Family Member or Youth Advocate employee of UACF to attend System of Care QI meetings, participate in improvement activities, and give feedback to the SOC about program satisfaction and enhancement.</td>
<td>Client &amp; Family Relations/Lead: CLC Manager, QI Manager, and UACF Director</td>
<td>QIC rosters; Welcome Center feedback; workgroup membership</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
<tr>
<td>Increase consumer involvement in SOC Programs and Activities</td>
<td>Ensure attendance of Consumer Navigator (county employee) and/or Consumer/Family Member or Youth Advocate employee of UACF to attend System of Care QI meetings, participate in improvement activities, and give feedback to the SOC about program satisfaction and enhancement.</td>
<td>Client &amp; Family Relations/Lead: CLC Manager, QI Manager, and UACF Director</td>
<td>QIC rosters; Welcome Center feedback; workgroup membership</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
<tr>
<td>Track staff participation in trainings and presentations</td>
<td>Develop, add local trainings, and implement training tracking system through Trilogy Inc., with the E-Learning training module for HHS System of Care (ASOC and CSOC staff).</td>
<td>CLC Committee/Lead: Training supervisors Jennifer Cook and Cindy Bigbee</td>
<td>Manager reports of staff attendance - baseline year</td>
<td>Due: 6/30/10 Completed:</td>
</tr>
</tbody>
</table>

**Cultural and Linguistic Competency Plan Work Group (Items and Goals developed from Summary Recommendations)**

| 1.1 Organizational Values: To engage executive leadership, management, and line staff in a joint effort to embrace cultural curiosity and competency as a core value across the | 1) Review CLC Charter and to strengthen values statement. | Lead: CLC Committee | Charter Review |
|----------------------------------------|----------------------------------------------------------|------------------|------------------|------------------|
| 2) Review and revise CSOC and ASOC Mission Statements to include cultural competence. | Lead: ASOC Managers, CSOC Managers | Mission Statement Review | Due: 9/30/10 |
| | | | Due: 12/30/10 |
| 1.2. SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice. | 1) Institute “Guiding Principles Awards” across the SOC to honor cultural curiosity and growth.  
2) Develop a training team to assist staff with integrating values and behaviors.  
3) Include cultural awareness as part of staff orientation and evaluation.  
4) Educate managers and supervisors on the expectation to evaluate cultural competence of all employees in annual performance evaluation. | Lead: HHS-Director (Richard Burton) and CSOC Director (Richard Knecht) | Review of Retreat Minutes | Due: 3/30/10 |
| | 1) Institute “Guiding Principles Awards” across the SOC to honor cultural curiosity and growth.  
2) Develop a training team to assist staff with integrating values and behaviors.  
3) Include cultural awareness as part of staff orientation and evaluation.  
4) Educate managers and supervisors on the expectation to evaluate cultural competence of all employees in annual performance evaluation. | Lead: ASOC Director (Maureen Bauman); CSOC Director (Richard Knecht) | Review Awards | Due: 12/30/10 |
| | 1) Institute “Guiding Principles Awards” across the SOC to honor cultural curiosity and growth.  
2) Develop a training team to assist staff with integrating values and behaviors.  
3) Include cultural awareness as part of staff orientation and evaluation.  
4) Educate managers and supervisors on the expectation to evaluate cultural competence of all employees in annual performance evaluation. | Lead: QI Manager (Twylla Abrahamson); ASOC Program Manager (Cheryl Trenwith) | Appoint coordinator for training activities | Due: 9/30/10 |
| | 1) Institute “Guiding Principles Awards” across the SOC to honor cultural curiosity and growth.  
2) Develop a training team to assist staff with integrating values and behaviors.  
3) Include cultural awareness as part of staff orientation and evaluation.  
4) Educate managers and supervisors on the expectation to evaluate cultural competence of all employees in annual performance evaluation. | Lead: ? | Plan for Staff Training | Due: 12/30/10 |
| | 1) Institute “Guiding Principles Awards” across the SOC to honor cultural curiosity and growth.  
2) Develop a training team to assist staff with integrating values and behaviors.  
3) Include cultural awareness as part of staff orientation and evaluation.  
4) Educate managers and supervisors on the expectation to evaluate cultural competence of all employees in annual performance evaluation. | Lead: ? | Managers Minutes | Due: 6/30/10 |
| 1.3. SOC staff will create avenues for diverse staff and community members to serve as resources for learning. | 1) Construct and administer a survey to determine diversity resources among staff, contract providers and community partners, and willingness of same to become resources for others.  
2) From survey results above, create resource list for distribution.  
3) Construct and administer survey to determine if persons listed as resources were contacted throughout the year, and whether those that contacted same resources felt they had been assisted in a competent manner. | Lead: CLC Committee | Completion of Survey | Due: 9/30/10 |
| | 1) Construct and administer a survey to determine diversity resources among staff, contract providers and community partners, and willingness of same to become resources for others.  
2) From survey results above, create resource list for distribution.  
3) Construct and administer survey to determine if persons listed as resources were contacted throughout the year, and whether those that contacted same resources felt they had been assisted in a competent manner. | Lead: QI/MCU Manager (Twylla Abrahamson) | Submit report and distribute resource list | Due: 12/30/10 |
| | 1) Construct and administer a survey to determine diversity resources among staff, contract providers and community partners, and willingness of same to become resources for others.  
2) From survey results above, create resource list for distribution.  
3) Construct and administer survey to determine if persons listed as resources were contacted throughout the year, and whether those that contacted same resources felt they had been assisted in a competent manner. | Lead: QI/MCU Manager (Twylla Abrahamson) | Completion of Survey; Report results to QIC | Due: 6/30/11 |
| 2.1 SOC leadership will increase cultural diversity in policy | 1) (2.1.3) Increase diversity of membership in SOC Quality | Lead: QI/MCU Manager (Twylla Abrahamson) | Percentage of membership and cultural | Due: 6/30/11 |
### Improvement Committee.

1. **(2.1.3)** Review membership in SPEAC with Placer County SMART Policy Board and set goals for increasing the cultural diversity of membership.

   - **Lead:** CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)
   - **Due:** 6/30/11

2. **(2.2.3)** Address the barriers in current policies that limit culturally relevant practices via creation of an inclusive policy revision committee that includes community partners and consumers.

   - **Lead:** CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)
   - **Due:** 6/30/11

3. **(2.1.4)** Create a diagram and process description that reflects a cross system approach to staff and consumer participation in policy development and system governance.

   - **Lead:** QI/MCU Manager (Twylla Abrahamson); Cultural Liaison Anno Nakai
   - **Due:** 9/30/11

### 2.2 SOC Managers and Supervisors will take a strengths based approach to policy development that promotes involvement of consumers and line staff.

1. **(2.1.1)** Store all SOC policies in a folder on the T: Drive that is accessible by all staff.

   - **Lead:** CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)
   - **Due:** 12/30/10

2. **(2.2.2)** Provide training and education on this central source for access to policy information across SOC.

   - **Lead:** Training supervisors Jennifer Cook and Cindy Bigbee
   - **Due:** 6/30/11

3. **(2.2.2)** Conduct two (2) leadership development classes in FY2010-11 focusing on use of a participatory management style and inclusion of staff and consumers in policy development.

   - **Lead:** CLC Committee and Community Resources
   - **Due:** 6/30/11

4. **(2.2.2)** Increase accuracy of indicators for cultural representation of consumers in mental health services by using the latest CSI data report from the Department of Mental Health.

   - **Lead:** QI/MCU Manager (Twylla Abrahamson)
   - **Due:** 7/30/11
<table>
<thead>
<tr>
<th>2.3 The Change Agents for Co-occurring Disorders Workgroup will provide a framework, guidance, inspiration and accountability and encourage system transformation and improvement efforts for private and government service providers</th>
<th>The Change Agents for Co-Occurring Disorders Workgroup will keep Social and community providers informed and involved in their transformational efforts</th>
<th>Change Agents Workgroup, CLC Committee, QI Committee</th>
<th>E newsletters, Progress reports, Staff training</th>
<th>6-30-11</th>
</tr>
</thead>
</table>
| 3.1 Communication and Collaboration: SOC Managers will develop resources for effective community-based strategies to increase multicultural and multilingual communication and collaboration. | 1) Develop resources for increasing multicultural/lingual materials and services and create a list of local or community cultural supports and mentors.  
2) Provide training and support staff to develop skills for working with diverse community partners in care planning and service provision. | Lead: SAMHSA Manager (Cindy Brundage) and Native Liaison anno Nakai  
Lead: CLC Committee and SOC Development Committee | Evaluation Reports on PEI services; White Bison activities; Pow Wow; Expansion of Promotoras; Reports on SAMHSA contract services; NP specialized services list | Baseline Due: 6/30/10 |
| 3.2 SOC Staff will integrate multicultural and multilingual communication strategies into a community-based model of care. | 1) Integrate Native American/American Indian and Latino services Team into CSOC through 90% of appropriate referrals ending up on the service correct team.  
2) (4.3) Include culturally diverse community partners in review of service plans for appropriate families in Smart Management Team and Placement Review Team.  
3) Assist schools in creating a list of local | Lead: CSOC Service Program Managers (Debbie Drake and Candyce Skinner)  
Lead: ?  
Lead: CLC Committee | Report on involvement of community based resources in family team process.  
Resource List | Development of measurement tool by 9/30/10. Report due 6/20/11  
Due: |
<table>
<thead>
<tr>
<th>3.3 Add a section to the Guide to MediCal Services Member Handbook that addresses culturally diverse service options</th>
<th>Convene a sub-committee of the CLC Committee and the QI Committee to develop an addendum to the Member Handbook detailing the information on the culturally diverse service options in Placer County</th>
<th>CLC Committee, CFR Committee, QI Committee</th>
<th>Copy of the Addendum</th>
<th>6-30-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4 Develop an expanded budget for CLC translation and interpretation services</td>
<td>Develop a contract with a certified translator for translation of all materials. Assure translation and interpretation is accurate and at the appropriate reading level.</td>
<td>Mental Health Director, CSOC Director, SOC leadership, CLC Committee</td>
<td>Engage the LLC in developing a tool and monitoring process to assure accuracy and appropriateness</td>
<td>6-30-11</td>
</tr>
<tr>
<td>3.5 Review LLC survey findings regarding unavailability of interpreters and develop a solution</td>
<td>Convene a sub-committee of the CLC Committee and members of the LLC to review survey findings and create a proposal for solution</td>
<td>CLC Committee, the LLC, SOC Leadership</td>
<td>Engage Soc staff and LLC in developing a proposal for resolution</td>
<td>6-30-11</td>
</tr>
<tr>
<td>4.1 Human Resource Development: Expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities</td>
<td>1) Promote attendance in the Cultural Awareness Activities.</td>
<td>Lead: SAMHSA Manager (Cindy Brundage)</td>
<td>Increase average monthly participation by 50%. Report on number of cultural trainings included.</td>
<td>Baseline established June 2010. Report due 6/30/11</td>
</tr>
<tr>
<td></td>
<td>2) Film all cultural trainings, including Cultural Awareness Fridays, for inclusion in the SOC e-Learning library.</td>
<td>Lead: SAMHSA Manager (Cindy Brundage)</td>
<td>Report on percent participation</td>
<td>Due: 6/30/11</td>
</tr>
<tr>
<td></td>
<td>3) Require service delivery, supervisory and management staff to participate in a minimum of one (1) training on cultural diversity per year.</td>
<td>Lead: ASOC Director (Maureen Bauman) and CSOC Director (Richard Knecht)</td>
<td>Review of trainings held</td>
<td>Due: 6/30/11</td>
</tr>
<tr>
<td></td>
<td>4) Allocate resources for trainings through a variety of venues, including e-learning.</td>
<td>Lead: CLC Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2 Assure that cultural and linguistic competence strategies are addressed as the WET Plan is operationalized</td>
<td>Members of the CLC Committee also serve on the WET Advisory Committee. CLC Representatives will inform the decisions of the WET Advisory Committee on the need to address cultural competence</td>
<td>CLC Members, WET Advisory Committee</td>
<td>WET Plan Updates</td>
<td>6-30-11</td>
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<td>---</td>
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<tr>
<td>4.3 Train staff to request, obtain and document translated clinical findings and reports</td>
<td>Develop a contract with a certified translator in order to translate clinical findings and reports for consumers and their families</td>
<td>SOC Leadership, CLC Committee, QI Committee</td>
<td>Copies of translated clinical documents</td>
<td>6-30-11</td>
</tr>
<tr>
<td>4.4 Provide all staff the opportunity of engaging in “Courageous Conversations”</td>
<td>Provide training to all leadership staff on the Power Wheel Dynamics and Courageous Conversations Provide opportunities for Courageous Conversations</td>
<td>SOC Leadership</td>
<td>Training Rosters</td>
<td>6-30-11</td>
</tr>
<tr>
<td>4.5 Client Sensitivity Training is an annual required training for</td>
<td>Placer Client/Family Relations Committee will provide opportunities for</td>
<td>CFR Manager and Committee, SOC Leadership and</td>
<td>Quarterly training opportunities</td>
<td>6-30-11</td>
</tr>
</tbody>
</table>

- **experiential opportunities and local trainings from specific cultural backgrounds through CLC.**
- **5) Integrate cultural brokers into SMT as a linkage to community resources via invitation to SMT when a Native or Latino youth/family is involved.**
- **6) Review Intake, assessment forms, planning tools and practices.**
- **7) Workers will document efforts to engage cultural brokers and community partners when working with families of diverse cultures.**

**Lead:** SMT Scheduler

**Lead:** MCU Auditor (Derek Holley)

**Due:** 12/31/10

**Due:** 6/30/11
<table>
<thead>
<tr>
<th>5.1 Consumer/Community Development: SOC management will create pathways for consumers and diverse community partners to participate in SOC policy development, service planning, delivery and evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> Redesign two (2) management team meetings per month to be Community Service and Support Teams with full decision making ability.</td>
</tr>
<tr>
<td><strong>2)</strong> Increase cultural diversity in the membership of the Mental Health, Alcohol and Other Drug Advisory Board.</td>
</tr>
<tr>
<td><strong>3)</strong> Increase culturally diverse membership in the Quality Improvement Committee</td>
</tr>
<tr>
<td>Lead: CSOC Director (Richard Knecht)</td>
</tr>
<tr>
<td>Lead: ASOC Director (Maureen Bauman)</td>
</tr>
<tr>
<td>Lead: QI/MCU Manager (Twylla Abrahamson)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2 SOC Managers will develop resources, workplace practices and partnerships to support the preparation and integration of consumers and community members.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> (5.2.2) Increase culturally diverse Peer Advocate and Navigator positions in the Welcome Center to advance the consumer Employment Career Ladder.</td>
</tr>
<tr>
<td>Lead: ASOC Director (Maureen Bauman)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.3 Improve service sites and waiting areas to be more welcoming of diverse populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convene a workgroup of Clerical leads, CLC Committee members and CFR Committee members to assess the improvement needs and implement the necessary changes</td>
</tr>
<tr>
<td>Clerical Leads, CLC Committee, CFR Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> (6.2.2) Create a community-based evaluation process for the Mental Health Services Act – Prevention and Early Intervention tract.</td>
</tr>
<tr>
<td><strong>2)</strong> (6.2.7) Work with community partners to redesign the Placer County Outcome Screen to include culturally relevant measures of family and consumer skills.</td>
</tr>
<tr>
<td>Lead: CSOC Supervisor (Jennifer Cook); PEI Evaluation Team</td>
</tr>
<tr>
<td>Lead: CSOC Supervisor (Jennifer Cook); PEI Evaluation Team</td>
</tr>
</tbody>
</table>
3) Develop contract guidelines to ensure that community-based organizations conduct cultural and linguistic competency self-assessment and planning.

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Lead:</th>
<th>Included in contract “boiler plate” language</th>
<th>Due:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop guidelines</td>
<td>Contract monitors (Doreen Drake and Steve Martinson)</td>
<td></td>
<td>12/31/10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Lead:</th>
<th>Specifics</th>
<th>Due:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placer SOC will hold contractors accountable for the recruitment, training and retention of a culturally and linguistically competent staff. In addition, contract providers will strive for culturally competent organizational structures, environments and Boards of Directors.</td>
<td>CLC Committee, QI Coordinator; Contract leads</td>
<td>Quarterly and annual provider reports; site visits</td>
<td>6-30-11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Lead:</th>
<th>Specifics</th>
<th>Due:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) (6.2.2) Create a community-based evaluation process for the Mental Health Services Act – Prevention and Early Intervention tract.</td>
<td>PEI Evaluation Team</td>
<td>Implementation of community-based and culturally diverse evaluation process</td>
<td>12/30/10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Lead:</th>
<th>Specifics</th>
<th>Due:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Create cross systems strategies to review racism in the education system, by Inviting school representatives to attend Campaign for Community Wellness meetings in targeted areas.</td>
<td>Family Advocate (Christi Meng); Consumer Advocate (Katrina Moser)</td>
<td>Documentation of Invitations</td>
<td>12/30/10</td>
</tr>
</tbody>
</table>

The Annual Report of the Cultural Competence Committee can be found in Appendix D-4.

5IA. Three Year Training CLC Plan Requirement for Staff and Stakeholders to Receive Annual Cultural Competence Training

Placer SOC CLC Committee has developed a comprehensive Cultural and Linguistic Competence Plan (See Appendix D-5 for the 3-year CLC plan) that is inclusive of organizational, staff and provider development. This Plan was based on our organizational self-assessment, our previous Community Readiness Assessment, our MHSA PEI planning process and our understanding of our current demographics and disparities.

Placer’s SOC CLC Committee will, by January of 2011, have developed a comprehensive, stand alone CLC Training Plan to serve as a guide to further
implementation of our strategies.

The projected number of staff who will be mandated to take at least 8 hours of cultural competence training per year and 6 hours of required Client Sensitivity Training per year includes 132 ASOC staff and 199 CSOC staff. We will open up our trainings to contract and community provider staff whenever possible.

Placer’s Staff Development Committee, along with the CLC Committee, will be responsible for ensuring that every training includes a cultural competence focus. We will accomplish this through pre and post testing, careful review of trainer qualifications and training syllabuses, review of learning objectives and training evaluations. See Appendix D-5 for the 3-year CLC plan.

5IIA. Report on Cultural Competence Trainings for Staff, Community Members, etc

The listing of cultural competency trainings for staff and community partners can be found in Appendix E-1 through E-3.

5IIB. Cultural Competence Training Topics

The list of training topics includes:

Youth: Working with Adolescents, Youth and Gang Violence, Foster Youth and Homelessness, Nurtured Heart, Preparing foster Youth for Reunification


Population Specific: Culturally Competent Approaches to Serving LGBT Populations, Hooked on Gambling: The New Addiction, Engaging Non-Voluntary and Working with Resistance, Foster Parent Empowerment, Tribal STAR Training: Improving Outcomes for Native Youth and Families, Strong Families and Great Communities (Latino focus) RAICES/Promotoras Training, The Role of Culture in Healing (Latino focus), Aging and Long Term Care


General: Community Mental Health: Wellness, Recovery and Belonging, Hope and Resiliency, Identifying Gifts, Talents and Skills: Using Powerful New Capacity Assessment Tools, Hope at Work, Creative Problem Solving. The listing of cultural competency trainings for staff and community partners can be found in Appendix E-1 through E-3.

In addition to the above list of in-person trainings that have been offered to SOC staff, SOC has purchased training software and is now able to offer on-line trainings to all staff. The Trilogy description is below:

Trilogy (e-learning)

Placer County SOC purchased the license to Trilogy’s e-learning catalog and Learning Management System (LMS) in 2008. The SOC utilized January 1, 2009 through June 30, 2009 to verify accuracy of the records by comparison data runs to their regular tracking systems. On July 1, 2009 Placer County SOC operationalized Trilogy LMS as their primary tracking software for all SOC employee training records.

Trilogy e-learning offers an extensive catalog of trainings which staff members can
access and use right from their computer desk tops. This catalog offers a variety of clinical, cultural, ethical, legal, and office skills enhancement trainings. Thus, it can be used for program and support staff. In addition, SOC can and has uploaded county specific training for staff members to access. The Trilogy product has an excellent tracking and notification method whereby not only can we pull reports on which staff has taken what training, but supervisors can log into the system and assign a training to a particular staff member or members and then be told whether they have taken it or not, but the staff member can also be reminded that they need to take the training.

5IIIA. Relevance and Effectiveness of All Cultural Competence Trainings

Placer’s SOC has recently created a cross-system Staff Development Committee. Members of the committee include the Adult System of Care (ASOC) Training Manager; Children’s System of Care Training Manager; ASOC Training Coordinator; CSOC Training Coordinator, CLC/SAMHSA Manager; WET Advisory Committee Supervisor; ASOC Training Administrative Support; and CSOC Training Administrative Support. The purpose of the committee is to respond to, and operationalize, the vision and concepts of the Workforce and Education Training (WET) Advisory Committee, Cultural and Linguistic Competence Committee (CLC), and Client Family Relations Committee (CFR). To that end the committee reviews input, suggestions, feedback, and recommendations from the WET Advisory Committee, CLC Committee, and CFR Committee in order to ensure staff development and training occurs according to the mission, vision, and values of the System of Care (SOC). The committee will be responsible for an annual report on its activities, findings, and recommendations to the Quality Improvement Committee. This committee was formed six months ago as the need arose to better coordinate training and resources across systems, to assure that MHSA deliverables were met and to inform the continuous quality improvement of our training and staff development goals.

Prior to the formation of this committee, Placer SOC did not have a formalized and centralized mechanism for oversight of training and its effectiveness. As a result of this committee’s preliminary work, we have begun to implement consistent training evaluations and we are creating templates for pre and post tests, which will be required. We are now capable of tracking and monitoring staff attendance at trainings through the Trilogy system and we will be able to produce reports for all supervisors to assist them with monitoring staff progress toward their goals.

Evaluation summaries can be found in Appendix E-4 through E-10.

5IVA. Evidence of the County Process for the Incorporation of Client Culture Training Throughout the Mental Health System

In Placer County the Client/Family Relations Committee, a sub-committee of the Quality Improvement Committee is responsible for assuring that Client Sensitivity trainings are provided to staff annually. The committee is responsible for working with the consumers, family members and youth who are willing and ready to tell their stories to prepare them for the event and to debrief after the event. Committee members volunteer to assist in determining the panel of presenters, securing a location and marketing the event. Client Sensitivity training events are staffed by committee members who are also
responsible for facilitating the discussions between the panel and the staff.

In March of 2009 Placer CSOC hosted an “All Staff Meeting” for its 180 staff. The entire meeting was focused on youth and family voice and stories. A short video was produced at one of our SED school sites by youth who shared about their experience in that educational/mental health setting. Two Family Advocates shared, one through a written story and one through a video she produced, their stories of navigating multiple systems to help meet the needs of their children. Finally two Youth Advocates spoke about their system experiences and how that has prepared them for their current roles as advocates.

However, in this past fiscal year this committee has struggled to provide Client Sensitivity training to a broad SOC audience. Because of feedback from previous trainings about the potential for consumers, etc., to re-experience their trauma the committee decided to pursue other avenues, such as having the presentations video taped. This option became time and cost prohibitive.

At present there is a sub-committee of Family and Youth Advocates, Navigators and Peer Advocates as well as consumers who are revamping the Client Sensitivity training model. SOC anticipates providing a new and revised Client Sensitivity training to all staff the fall of 2010.

However, consumer, family and youth have been sharing stories of their experiences in the system on a monthly basis at the Campaign for Community Wellness meetings to approximately 50 people who are either staff or community providers/members. In addition, stories, reports and information related to consumer, family and youth experiences have been highlighted in staff e-newsletters and the Campaign for Community Wellness newsletter.

5IVB. Inclusion of Personal Experiences of Children, Adolescents, Transition Age Youth, Parents, and Caretakers on Family Focused Treatment, Navigating Multiple Agency Services, and Resiliency

See 5IVA above.

6IA. Recruitment, Hiring and Retention of a Multicultural Workforce From, or Experienced With, the Identified Unserved and Underserved Populations

A copy of Placer County’s MHSA WET Workforce Assessment can be found in Appendix F-1. The WET Advisory Committee Charter is as follows:

**Placer County**

**Mental Health Services Act**

**Workforce and Education Training (WET) Advisory Committee Charter**

**MHSA WET Mission**

The WET mission is to develop and support a workforce capable of providing client and family driven, culturally competent services, that promote wellness, recovery and resiliency, and lead to evidenced-based, value-driven outcomes.

**Vision**

A workforce which delivers culturally and co-occurring appropriate services for individuals wanting wellness and recovery for themselves and their families.
• A community of care that is an environment of learning, diversity, cultural competence, co-occurring competence and skill sets that match the needs of those served.
• A community of care that collaborates and works together for the well-being of its members
• A community of care that embraces recovery as its responsibility

Strategies
• Training – building skills and developing competencies of staff, community and partners
• Outreach/Recruitment – consumer and culturally represented systems and programs, qualified staff that understands and applies recovery and wellness principles
• Service Delivery – coordinated, integrated, client and/or family-centered, recovery focused, co-occurring, culturally and linguistically competent

Goals/Outcomes
• Improved and cost-effective mental health services
• More consumers on the road to recovery through a diverse, culturally competent, recovery oriented staff.
• People with mental health issues and their families feel heard, empowered and are given opportunities for employment in the mental health field if desired.
• All services are provided in a welcoming, co-occurring and culturally competent manner
• Stigma towards those with mental illness no longer exists

ROLE
The WET Advisory Committee will:
• Function in advisory capacity, regarding WET implementation, to the Campaign for Community Wellness (CCW) Steering Committee;
• Collaborate with Placer County HHS System of Care (SOC) to seek out consultants and partnerships to maximize the efficiency of WET programs;
• Provide input to HHS SOC on the WET plan implementation as needed;
• Provide feedback regarding implementation strategies;
• Review, analyze and inform the CCW Steering Committee regarding results of WET strategies and report on effectiveness.
• Provide periodic updates to the CCW Steering Committee;
• Abide by the timelines and guidelines established by the CCW Steering Committee, the State, and Placer’s Mental Health Director;

MEMBERSHIP
The WET Advisory Committee will strive to include stakeholder representatives from the following groups identified in the WET Component Guidelines (or others identified by the Advisory Committee) including but not limited to:
• Program, administrative, human resource, training and line staff from the county and community based organizations providing public mental health services, to include those organizations serving unserved, underserved, immigrant, Native American and rural and urban communities;
• Representatives who can speak to workforce diversity needs and solutions, to include organizations representing underserved racial/ethnic communities; those who identify themselves as gay, lesbian, bisexual, and/or transgender; children youth and older adults; and urban and rural communities;
• Educational entities, to include high schools, adult education, regional occupational programs, community colleges, universities, private schools, trainers, consultants, and professional organizations;
• Community partners who assist in the delivery of public mental health services, such as social services, behavioral health and vocational rehabilitation services.

The WET Coordinator will provide support and MHSA subject matter expertise to the Advisory Committee.

ADVISORY COMMITTEE ROLES AND RESPONSIBILITIES
1. The WET Coordinator will chair the WET Advisory Committee.
2. Advisory Committee members are asked to make a 1 year commitment to the effort.
3. Adhere to the Advisory Committee and Member roles and responsibilities.
4. Secure and maintain the support of their stakeholder group or organization for full participation in Advisory Committee efforts.
5. Devote the necessary time to fulfill Advisory Committee obligations. Advisory Committee members are expected to prepare for and attend, at minimum, two-thirds of all Advisory Committee meetings. Meetings will be held quarterly or as needed based on group determination.
6. Contact the Advisory Committee Chair to inform them when they will not be attending a meeting.
7. Read pre-meeting materials and come to meeting prepared to discuss and make decisions.
8. Actively seek out and represent the broadest needs and concerns of your constituents and community of service ensuring outreach to the unserved and underserved communities.
9. Identify other stakeholders to participate in MHSA efforts.
10. Update Advisory Committee members on the status and changes occurring in their field of expertise.
11. The WET Coordinator is responsible for convening meetings, helping develop meeting agendas, and ensuring adherence to the process and DMH requirements.

MEETING PROCESS GUIDELINES AND GROUND RULES
• The meetings will start on time and end on time. Participants are asked to come to the meetings a few minutes ahead of time, prepared and ready to begin.
• Whoever is present at the meeting will make decisions. Absent members must be willing to support the decisions made in their absence.
• The preferential process for decision making will be consensus. If that is not possible, than a vote may be required.
• Votes will be taken on Advisory Committee items under a simple majority by raise of hands. All Advisory Committee members shall be entitled to vote at any Advisory Committee meeting.
• Members will take responsibility for excusing themselves from voting if there is a conflict regarding a particular issue. Other members may politely point out a
possible conflict that a member might not perceive, and the group will collaboratively
decide whether a conflict exists.
- The Advisory Committee will use available data to inform its decisions.
- Each person will have an opportunity to speak and time to listen; please self monitor
your participation.
- Meeting minutes will be taken by MHSA staff and e-mailed to Advisory Committee
members prior to subsequent meetings. Items that have been agreed upon and
implemented will be posted to the Campaign for Community Wellness website at
http://www.campaignforcommunitywellness.org/wet.html

Arrangements for an interpreter, translation or reasonable accommodations will be
made as needed for each meeting. Requests should be submitted to Cyndy Bigbee,
Workforce Education and Training Coordinator @ 530-889-7229 at least one week prior to
the meeting.

6IB. Comparison of WET Plan Assessment Data with General Population, Medi-Cal,
and 200% of Poverty Data

When the WET Plan was being developed the focus was primarily on staffing and
did note the need of bicultural/bilingual staff to serve the growing Latino population
throughout Placer County. The Latino population is a priority population identified in all
areas (MediCal, 200% of poverty, PEI, and CSS). The other race/ethnic focus noted in the
WET plan was on the multi-race, Native American, and African American populations which
acknowledged that the general population was more diverse than the current workforce.
Noted as well was the immereing Ukranian population in Western Placer County (Roseville
area) and the unmet need there for bilingual staff. The focus of the WET Plan was largely
on staffing and not on the underserved/unserved population.

6IC. Specific Actions Taken in Response to Cultural Consultant Technical
Assistance Recommendations Provided During Review of WET Plan
Submission to State (if applicable)

There are not any technical assistance recommendations provided. Some members of
the CLCC did request feedback on a number of questions. A copy of the questions and
responses are located in Appendix F-2.

6ID. Provide Summary of Targets Reached to Grow a Multicultural Workforce in
Rolling Out WET Planning and Implementation Efforts

While Placer’s WET plan does include some targets related to growing a
multicultural workforce including outreach to specific high schools, consumer development
activities and small scholarship and stipend amounts, we are still in the preliminary stage in
the implementation of our WET plan and have not implemented any of these specific
strategies at this time. Actions to date have focused on trainings to increase cultural
competencies of all staff, the development of a WET Advisory Committee representing
multiple constituencies to assist in the implementation of our plan strategies, and efforts to
retain current staff. Training data is included in Criterion 5, and Staff Development
information can be found in 5IIIA.
6IE. Share lessons Learned in Rolling Out County WET Planning and Implementation Efforts

While rolling out county WET planning and implementation efforts, we learned the following:

- The value and importance of taking time to include community stakeholders in the planning and implementation efforts.
- The need for trust building and involvement of trusted community leaders to assist in outreach and implementation.
- Public mental health systems involve implementation processes that have become more complicated due to the need to design and develop adequate and appropriate community stakeholder mechanisms for input. Ways to effectively capture this valuable and necessary input are still a work in progress.
- Having a desire and intention to train and hire diverse staff is not sufficient. There must be diverse individuals seeking the positions and/or seeking to gain the qualifications.
- Unexpected economic and social situations can impede the ability to progress as planned.
- Stakeholders may not always understand their role in the development of a competent and diverse workforce.

6IF. Identify County Technical Assistance Needs

Placer County SOC will identify any technical assistance needs at the next SOC Staff Development meeting. Input from the WET Advisory Committee will be reviewed.

7IA1. Evidence of Efforts to Increase Bilingual Workforce Capacity Through Dedicated Resources and Strategies

Placer SOC has not been able to increase our bilingual workforce in the past four years due to our mandatory hiring freeze. We have lost staff, including bilingual staff, due to resignations, retirements and relocations. We have not needed to lay off staff, but we have not been allowed to fill vacancies. We have grown in our utilization of promotoras and cultural brokers who are culture and language proficient which is how we have been able to meet some of the need. The MHSA WET Plan regarding bilingual staff members can be found in Appendix F-1.

The following are excerpts from the WET Plan which focus on the need for more bilingual and bicultural staff:

Program #2 Consumer/Staff Development/ Date: 3/26/10/ CSS and WET Objectives:

- …Training topics may include: Clinical skills in best practices (e.g. motivational interviewing, welcoming), Recovery/Wellness training, co-occurring competency, suicide assessment/treatment, Listening Well, and Cultural Competence.
Program #8 Internship Programs/ Date: 3/26/10 /CSS and WET
Objectives:
Four to eight interns will be offered recovery oriented supervision (particularly bi-
lingual/bicultural and those with lived experience). We will look for a combination of
Bachelors and Masters level students. Students will be offered a comprehensive internship
that allows them to experience various aspects of Placer’s integrated system.

# 4 Transforming Services through Co-Occurring, Resiliency/Recovery, Cultural
Competency and Family/Client-driven System (Systems Development Strategy)/ Date:
3/26/10/CSS and WET Placer Systems of Care will continue to improve the system capacity
for co-occurring competent, culturally competent, recovery/resiliency oriented and
client/family driven services through the use of evidence-based models that promote
recovery and increase the level of participation of clients and families. In collaboration with
the WET plan Placer will continue to provide: Opportunities for training for staff, providers,
consumers and families on the principles of the recovery model; Leadership development
for consumers, families and the Consumer Council; Peer support programming through the
Welcome Center; Latino Leadership Counsel growth; Consumer Navigators and Peer
Advocate programs; the Youth Coalition; Change Agents for co-occurring systemic
transformation efforts.

CSS and WET Plan Program #2 Consumer/Staff Development can be found in
Appendix F-6; CSS and WET Program Plan #7 Retention Efforts can be found in Appendix
F-7; CSS and WET Plan Program #8 – Internship Programs can be found in Appendix F-8;
CSS and WET Plan/Objectives can be found in Appendix F-9. CSS and WET Plan
Program #4 – Transform Services through Co-Occurring Resiliency/Recovery, Cultural
Competency and Family/Client-Driven System can be found in Appendix F-10.

Excerpt from Placer County CLC Domain #4 is as follows: (The Domains document
in its entirety can be found in Appendix D-4.)

4) Human Resource Development

Goal: To expand the skills, experiences and composition of SOC human resources
to better serve consumers from diverse cultures and communities.

Towards the goal of improving services for diverse consumers, strategies for expanding the
skills, experiences and composition of the SOC work force include:

4.1 SOC Leadership will promote the expansion of the skills, experiences, diversity of
resources within SOC to provide culturally relevant and responsive services.

- Role model changing attitudes, beliefs and behaviors by participating in
  “courageous conversations” to address systemic privileges and biases.
- Create policies to facilitate the integration of diverse staff and cultural brokers.
- Work with cultural brokers to develop staff training and education resources.
- Expand funding streams to create pathways for hiring diverse staff members.
- Prioritize diversity in succession planning in leadership positions and processes.
- Allocate resources for training through a variety of venues, including e-learning,
  experiential opportunities, and local trainers from specific cultural backgrounds.
- Validate participatory learning opportunities by authorizing the use of flex time.
- Create language to ensure the hiring of diverse staff and the use of appropriate.
practices for contracts with community partners serving diverse communities.

4.2 SOC Managers will create tools, training materials, and procedures for expanding the diversity of staff, community resources, and service models.

- Integrate consumers and community representatives into management teams.
- Facilitate “courageous conversations” to promote intercultural learning.
- Add cultural competency to staff supervision, evaluation and development plans.
- Mentor diverse staff to utilize cultural experiences as assets in service delivery.
- Engage cultural brokers to provide experiential training opportunities for staff.
- Support staff attending cultural events and community education opportunities.
- Integrate cultural brokers into PRT/SMT as a linkage to community resources.
- Create a team to review intake, assessment forms, planning tools and practices.
- Implement best practice practices through cultural-specific service teams.

4.3 SOC staff will expand their skills, knowledge and ability to collaborate with community resources to provide culturally relevant and responsive services.

- Participate in training opportunities to expand awareness of diverse cultures.
- Engage in experiential training, attending cultural and community events.
- Integrate personal experiences and culture as an asset in the workplace.
- Work on professional and personal biases in supervision and practice.
- Set goals for expanding skills for working with diverse community members.
- Apply culturally appropriate modalities and best practices in the field.
- Seek partnerships and consultation with diverse staff and cultural brokers.

7IA2. Updates from MHSA, CSS, or WET Plans on Increasing Bilingual Workforce Who Speak the Languages of Target Populations

Placer SOC has not been able to increase our bilingual workforce in the past four years due to our mandatory hiring freeze. We have lost staff, including bilingual staff, due to resignations, retirements and relocations. We have not needed to lay off staff, but we have not been allowed to fill vacancies. We have grown in our utilization of promotoras and cultural brokers who are culture and language proficient which is how we have been able to meet some of the need. The MHSA WET Plan regarding bilingual staff members can be found in Appendix F-1.

7IA3. Total Annual Dedicated Resources for Interpreter Services

Placer County does not have an annual budget for interpreter services, per se. Our bilingual staff are paid a 5% differential for providing these services after they are certified by our Personnel Department through a written and oral testing process. Currently Placer SOC has a total of 11 staff certified as interpreters in Spanish, our only threshold language. (See discussion of this item in Section 1IVB above)

Interpreters are available through a Blanket Purchase Order Placer County Human Services division has established with Language World, a Sacramento area company, which will provide in-person translation or translation of written documents. However, Placer SOC is billed by Language World for each service.

Placer SOC Leadership will be responsible for determining a budget for interpreter services in FY 2010-11.
7IIA1. Evidence of Policies, Procedures, and Practices in Place to Provide Services to Persons Having Limited English Proficiency (LEP) by using interpreter services

Placer County uses the AT&T Language Line Translation Service. The complete policy, Accessing Interpreter Services, is located in Appendix G-9. It is an over-the-phone interpretation service, which allows a provider to access over 140 different languages from any county extension. This service is available 24 hours a day, seven days a week.

California Relay Service (CRS) is a free telephone assistance service available 24 hours a day, seven days a week. This service provides human voicers for people who have difficulty being understood by the public. CRS enables those who are deaf, hard of hearing, or speech impaired/disabled to use Text Telephones (TDDs) or Personal Computers (PCs) to use voice telephone through a professionally trained relay operator.

“Speech-To-Speech” is a part of the California Relay Service (CRS) and is provided through the Deaf and Disabled Telephone Program. This service was developed for consumers with speech disabilities. The policy and procedure, Accessing Interpreter Services, can be found in Appendix G-1.

7IIA2. Use of New Technologies Such as Video Language Conference and Capacity to Grow Language Access

Placer County has acquired video conferencing equipment at our Auburn CSOC office and our Carnelian Bay (Tahoe) office. This equipment has been used extensively for conferencing with staff and families in our Tahoe catchment area, the majority of whom are Latino, for service planning and placement decisions.

7IIA3. Protocol Used for Implementing Language Access Through County’s 24-hour Phone Line with Statewide Toll-Free Access

The Placer County SOC policy, Accessing Interpreter Services, can be found in Appendix G-9.

7IIA4. Staff Training to Access 24-hour Phone Line to Meet Client’s Linguistic Capability

During New Employee Orientation staff receive training on use of the 24-hour toll-free phone line for accessing interpreter services and the California Relay Service. The SOC policy for Accessing Interpreter Services, which is included in Appendix G-1, gives step by step instructions for those services. Also included in Appendix G-2 is the SOC policy, Key Point of Contact Language Proficiency, which gives additional instructions for staff on the use of interpreters.

7IIE. Identify County Technical Assistance Needs

Placer County has been unable to participate in the Interpreter and Translation Training sponsored by CiMH due to the cost and time commitment required. Placer County wants our staff and clinicians to be adequately trained in these areas, but our current budget constraints make the current model prohibitive. We would welcome a low cost,
accessible Interpreter and Translation Training, including an e-learning module we could have access to on Trilogy, our web-based training system.

7IIIA. Evidence of Availability of Interpreter (e.g. posters/bulletins) and/or Bilingual Staff for Languages Spoken by Community

Placer SOC offices display written information on our programs and services, including interpreter services in both English and Spanish, our only threshold language.

7IIIB. Documented Evidence Showing Interpreter Services are Offered and Provided to Clients and Response to Offer is Recorded

Two samples of documented evidence showing interpreter services were offered and provided in two separate languages are located in Appendix G-6.

7IIIC. Evidence of Providing Contract or Agency Staff Linguistically Proficient in Threshold Languages During Regular Operating Hours

Eleven SOC staff are proficient in Spanish as evidenced by passing the oral and written examination provided by Placer’s Personnel Department. Spanish is currently the only threshold language. Proficiency testing is administered through the Placer County Personnel Department.

7IIID. Evidence of County Process in Place to Ensure Interpreters are Trained and Monitored for Language Competence

Placer SOC staff with bilingual capabilities must pass a written and an oral test through Placer’s Personnel Department in order to be authorized to provide bilingual services. Once employees pass both tests the policy cited below applies.

Chapter 3.12.020 of the County Personnel Code reads:

Bi-Lingual Pay: a. General, Professional and Management. Effective 5:01 p.m. pay period 15, December 29, 2000, upon request of the department head, and approval by the personnel director, designated employees shall be paid an additional five percent for the use of a second language in the normal course and scope of work.

7IVA. Services Provided to All LEP Clients Not Meeting the Threshold Language Criteria Who Encounter the Mental Health System at All Points of Contact

See the SOC policy for Key Points of Contact Language Proficiency, which is located in Appendix G-2. The CDSS Your Rights Pamphlet, which has been translated into various languages, is located in Appendix G-10.

7IVB. Written Plan for How Non-Threshold Meeting Clients are Assisted to Secure, or Linked to Culturally and Linguistically Appropriate Services

See policies Key Points of Contact Language Proficiency and Accessing Interpreter
Services in Appendix G-2. In addition, we have included in Appendix G-8, a copy of the Language Identification Card and the booklet, Your Guide to Language Line Translation Service (Appendix G-7), which is given to every staff for easy desk reference.

7IVC. Policies, Procedures and Practices Showing Evidence of Complying with Title VI of the Civil Rights Act of 1964

Placer County Human Services Division of HHS last provided training on Title VI of the Civil Rights Act of 1964 to all SOC staff in September of 2007. The Human Services division has since converted this training to a power point presentation and post test, which an employee must pass with 90% proficiency. This training will be uploaded onto our Trilogy website by October of 2010 (the training is currently undergoing a second revision) and all staff will be required to complete the training by June 30, 2011.

7VB. Documented Evidence in Clinical Chart Showing Clinical Findings/Reports are Communicated in Clients’ Preferred Language

Placer County contracts with Sierra Family Services in the Tahoe area to provide 26.5 mental health services to the Latino community as they employ a bicultural/bilingual therapist, Ephram Estrada. Mr. Estrada has prepared reports for the Spanish speaking clients in some instances. However, this is an area that has room for improvement as there is a large need for Spanish translation of various documents and reports. (See Findings Report in Spanish in Appendix G-5.)

7VC. Consumer Satisfaction Survey Translated in Threshold Languages, Including Summary Report of the Results

A consumer satisfaction survey was conducted over the phone with See the Results of Spanish Speaking Phone Satisfaction Survey located in Appendix G-4.

7VD. Describe Mechanism for Ensuring Accuracy of Translated Materials in Terms of Language and Culture

Placer County currently does not have a formal policy or mechanism to ensure the accuracy of translated materials. We have informally used our bi-lingual/bi-cultural staff and bi-lingual/bi-cultural community partners to review documents and provide feedback. Placer will add an objective to our CLC Plan to formally address this issue in the coming year. We will outreach to our Latino Leadership Council to ensure their input in resolving this issue.

7VE. Mechanism for Ensuring Translated Materials are at Appropriate Reading Level (6th Grade)

Placer SOC currently has no formal mechanism for ensuring translated materials are at an appropriate 6th grade reading level. However, we currently rely on our bilingual staff and community partners to inform us of the appropriateness and effectiveness of our translated materials. Our Beneficiary Handbook, Satisfaction Surveys, Fair Hearing materials, Informed Consent for Medication, Confidentiality and Release Forms have all been translated into Spanish. Mental Health education materials have been obtained
through trusted sources such a CI MH.

81A. List and Describe County’s/Agency’s Client Driven/Operated Recovery and Wellness Programs

In 2005 Placer County’s Adult System of Care (ASOC) opened the Welcome Center, a consumer lead drop-in resource and support center in Auburn. The Welcome Center is a volunteer organization that offers programs that recognize individual strengths and encourage opportunities to develop those skills. The philosophy of the Welcome Center is: “Participants of the Welcome Center believe each individual can grow in confidence and ability, develop and utilize healthy relationships, and discover abilities and talents. By working together, we benefit each other and the larger community.” The Welcome Center offers groups, activities, and outings. Consumers can get individualized support to address a wide variety of issues from housing to employment and beyond.

Beginning in 2007, ASOC began implementing several other strategies to engage consumers and staff in system transformation. These strategies include Listening Well, employment of Navigators, establishing a Change Agents group and a Consumer Council. Listening Well is a peer led intensive workshop aimed at assisting consumers in telling their story of recovery and, in doing so, learning to identify and honor their individual gifts that aided in the recovery process. The Navigator program hires consumers as peers who participate in all areas of ASOC to assist other consumers on their journey through recovery and work with staff on system improvement. The Navigator position is unique in that consumer employees work side-by-side with ASOC staff. Through collaboration with AMI Housing and Sierra Family Service ASOC has been able to expand the Navigator program to employ 14 consumers on a part-time basis. In 2010, the position of Peer Advocate was added. This position created a stepping stone for Navigators, who have demonstrated an ability to work full-time in an office/community environment. Change Agents is a group of staff and consumers who are dedicated to transforming the mental health and substance abuse serving systems in Placer County from the ground up to be more co-occurring competent, to eliminate disparities in service delivery, to be wellness focused and recovery oriented. The Consumer Council was established in order to assure continuous quality improvement in all aspects of system change and peer-led programs.

In 1997 Placer County CSOC hired our first Family Advocate, a parent with lived-experience of having a child in a system of care. Not until our SAMHSA Cooperative Agreement was awarded in 2005, were we able to grow this program. To date CSOC has a Family Advocacy Program consisting of consisting of 1 Program Director, 7 Family Advocates and one full-time Administrative Assistant dedicated to CSOC. Families currently receiving deep-end wraparound services are assigned a Family Advocate to educate them about the system and the services, to empower them to have their own voice and to encourage them as they learn and grow in their abilities to help their own family reach their potential. These Family Advocates become members of the child and family team which meets regularly to develop, review and implement the child and family services plan. Family Advocates are available to accompany the family to court, to IEP’s and other meetings.

Likewise, in 2007 through the MHSA CSS funding two Family and Friend Supporters, family members with lived-experience of adult consumers, joined the Family Advocate team to assist the friends and families of adult consumers. These Supporters are available to meet families at the hospital during the 5150/involuntary hospitalization process as well as to support and educate post-hospitalization or crises. In addition, support groups
are offered to family and friends to educate, empower and encourage them as their loved one recovers.

Since 2005 Placer CSOC and ASOC have been developing a youth advocacy program, which is now called Y.E.S., Youth Empowerment Support. Placer currently has one full-time Youth Program Manager, two full-time Youth Coordinators and one half-time Youth Coordinator. All of our youth advocates are employees of our contract agencies but stationed along side ASOC and CSOC staff within our service locations. Likewise, all have lived experience as children who received system of care services. One of the full-time Youth Coordinators is assigned to the MHSA TAY program at ASOC and the remaining advocates are assigned to CSOC. The Youth Coordinators provide direct services to youth and like the Family Advocates, become members of the youth’s team and accompany them to court, IEP’s, etc. In addition to direct service, our Youth Coordinators are serving on numerous program and policy committees (such as the Cultural Competency Committee, the Campaign for Community Wellness Steering Committee, the SAMHSA Steering Committee, the Client/Family Relations Committee, the CSOC Management Team and quarterly on the System of Care Leadership Team) and providing valuable input into system transformation. In the near future they will be initiating support groups for and by youth as well as training staff and providers on positive youth development and youth culture.

For the past 15 years Placer county has provided training, coaching and support for a Senior Peer Counseling Program. We currently have 18 professionally trained and certified volunteers who go into the homes of seniors to provide counseling around depression, anxiety, loneliness, isolation, grief and loss, phase of life issues, family conflicts and a number of other issues. We serve residents of Placer County who are 55 and older and the service is free. Individuals are referred to this program by contacting the program coordinator, who conducts a confidential screening over the phone.

The Program Coordinator also does outreach in the community by participating in local Health Fairs, featured media articles, and radio interviews. We are currently conducting a recruitment for additional Senior Peer Counselors and the training for these individuals will begin in September.

8IB. Evidence County has Alternatives and Options Available Within Above Programs to Accommodate Individual Preference and Racially, Ethnically, Culturally, and Linguistically Diverse Differences

The programs listed in “A” above are open to consumers currently served by ASOC and CSOC respectively. In addition, the Welcome Center is open to all adults seeking services or information, including the homeless population. And Senior Peer Counseling is provided upon request. If other individual preferences are requested or identified as a current need, consumers would be referred to programs within the community. See 8IIA Below.

8IC. Briefly Describe from “A” List Above Client-Drive/Operated Programs that are Racially, Ethnically, Culturally, and Linguistically Specific

Placer County ASOC and CSOC do not currently operate Client-Driven programs that are racially, ethnically, culturally and linguistically specific except for their focus on either consumer, family or youth culture.

8IIA. Documented Evidence of County/Contractor Alternatives and Options for
Accommodating Individual Preference, Cultural and Linguistic Preferences, Demonstrated by Culture-Specific Programs Provided

Placer County HHS has entered into contracts with the Sierra Native Alliance to provide culturally specific services to the Native American communities and the Latino Leadership Council to provide culturally specific services to the Latino communities throughout the county.

The Sierra Native Alliance (also known as the Native Alliance of the Sierra Nevada Foothills) is a non-profit agency serving El Dorado, Placer and Nevada counties. Their offices are located in Auburn at 173 Oak St., Room 7, in the old Alta Vista School. Below is a description of their programs and services. In addition, more information is located on their website, www.sierranativealliance.org.

**Native Family Advocacy:** The Native Family Advocacy program provides outreach, family support, advocacy, family visitation and case management services for Native youth and families at risk for involvement in child welfare, juvenile justice, mental health, and substance abuse services. White Bison recovery groups, traditional health services, and family wellness counseling sessions will be provided to families in need of support.

**Positive Indian Parenting:** Parenting support will be provided through Families of Tradition nights and Positive Indian Parenting (PIP) education classes. Families of Tradition activity nights provide Native families a community venue for sharing parenting skills and cultural knowledge. The PIP curriculum focuses on traditional cultural parenting values and practices to promote cultural resiliency factors such as mutual respect, communication, extended family networks, and access to cultural knowledge.

**Sons and Daughters of Tradition:** Provides culturally relevant group education for Native American youth and their families. The group promotes cultural resiliency factors such as positive cultural identity, self-esteem, intergenerational connections, and leadership skills. The youth group will be facilitated by youth leaders, and will plan community service and recreational events with the support of the Youth Coordinator to support peer-mentoring and leadership skills development.

**Strengthening Native Community Commitment through Mentoring:** Using a mentoring guidebook developed by HUD's Office of Native American Programs, this mentoring program will facilitate intergenerational mentoring and advocacy for Native youth. Using a curriculum based on the medicine wheel, this program is designed to strengthen personal and cultural resiliency factors for youth reducing their risks of substance abuse, depression, violence, justice involvement, out of home placement, and school failure.

**Native American Culture Camp/Community Concert:** The purpose of the culture camp and the community concert/art shows is both to raise awareness of the Native American community within Placer County for the general population and to develop leadership skills, strengthen resiliency and increase cultural pride and self-esteem for Native youth. The camp and the concert will expose Native youth and their families to positive Native role models and to Native traditions and activities that are the basis for wellness and recovery in the Native culture.

**Community/Cultural Events:** SNA will sponsor cultural and community events in collaboration with community partners, to build social support and networks in the region. The Big Time-Pow Wow is one of the annual community cultural events that was revived in Placer County in 2008, after a nine year absence. This event brings awareness and education to the general public on Native American traditions, art and culture. The Native community benefits by honoring Native peoples from diverse Tribes and showcasing the dance, art, music and food of diverse Native communities and local California Tribal
traditions.

The Latino Leadership Council has recently become a 501c3 non-profit. Unlike the Sierra Native Alliance which has established its own office site, the programs and services sponsored by the LLC are delivered in partnership with existing community-based organizations, such as the Lincoln Lighthouse and Counseling Center and various schools within the community. Below is a description of the services currently being offered:

**Promotora Program:** A promotora is, in essence, a bilingual/bicultural community educator, who is trained to bring information to Latino families on a variety of health and mental health issues. The pormotora is not a therapist or a counselor, but an educator who can offer support and link families to information and services. In CSOC the Promotora is a cultural bridge between the social worker and the family, educating the family about the system and the services as well as the rules and regulations and educating the staff on the mores, values and beliefs of the family. Together, the family team, creates a meaningful and appropriate service plan.

**Parent Project:** After several meetings with community members in Lincoln, Roseville and Auburn, Latino Leadership Council members have recommended that a pilot program of The Parent Project ® be initiated in Lincoln to divert youth from at-risk behaviors and to give parents the skills they need to raise their children in a new culture.

Latino leadership Council will assure staff are trained to implement the Parent Project in order to serve a maximum of 150 Latino families in Placer County. The program consists of adult education, social and cultural groups and classes for the children and youth. The implementation requires that the Parent Project® be offered in 3 sessions per year. Each session shall run for 10 weeks and shall include weekly 3-hour classes. Each session shall enroll up to 50 families, for a total of 150 families served annually.

**Bi-Lingual Counseling:** A part-time bilingual/bicultural licensed therapist will be sub-contracted through the Latino leadership Council to provide short term therapy to the children, youth and families enrolled in the Parent Project as deeper-end needs are identified. The therapist shall be available 1-2 days per week at a location acceptable and accessible to the Latino population in Lincoln. Each course of therapy shall include 8 to twelve sessions and shall include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy or a similar modality. The therapist is expected to serve 25-30 families per year.

**Educational Forums:** The LLC will continue to host Educational Forums for the Latino communities of Placer based on the results of the surveys completed at the Roberto Dansie training and two Health Fairs.

**Youth Cultural Arts Activities:** Based on the numerous requests from Latino families, the LLC will sponsor cultural arts classes for Latino families and their children so that families can pass on their cultural traditions to their children. Classes may include food, music, dance and visual arts.

**Cultural Immersion Experiences:** The LLC will offer cultural immersion experiences to county and provider staff in order to increase sensitivity and awareness of the Latino culture as well as their experience of immigration and acculturation.

**8IIA1. Option of Developing Listing of Available Alternatives and Options**

Placer SOC has been successful in outreaching to and including consumer, family and youth voice within the System of Care. We have contracted with specialty service providers to assure culturally and linguistically appropriate service options are available to consumers, families and youth through the United Advocates for Children and Families, the Sierra Native Alliance and the Latino Leadership Council contracts. However, we have
more work to do.

Community outreach and the development of specific programs and service options for the following populations are among our future goals:

- LGBTQI2S
- Faith-based
- Ukrainian culture and community
- Rural communities

In addition, Placer is committed to continuing efforts to transform our county operated services, to the extent possible, to meet the unique needs of our diverse populations such as expanding the Native Services Team and the Latino Services Workgroup from pilot projects to county-wide service teams.

8II.B. Evidence of County Informing Clients of Availability of Above Listing in Member Services Brochure

Placer County’s member services brochure is available in the lobby’s at all mental health service locations and is available in English and Spanish. The services being provided by the Sierra Native Alliance, the Latino Leadership Council, the Youth Empowerment Program and the Family Advocacy Program are not yet included in the brochure. Amending the brochure to be inclusive of the new programs will be an action item for the 2010-2011 FY. Likewise, while the Welcome Center displays their own brochure in every lobby, which provides information on adult consumer run programs, the information needs to be included in the larger member brochure.

8II.C. County Policies, Procedures, and Practices to Inform all Medi-Cal Beneficiaries of Available Services Under Consolidation of Specialty Mental Health Services

Placer SOC has a Guide to Medi-Cal Services that is available in English and Spanish which explains the availability of Specialty Mental Health Services. The guide is available in each waiting area and is given to clients at the first intake appointment. The Client Family Relations Committee is charged with developing a more current and relevant tri-fold brochure by February 2011.

8II.C. Include b) Evidence of Outreach for Informing Under-Served Populations of the Availability of Cultural and Linguistic Services and Programs

Placer County SOC has recently (as of January of 2010) contracted with CirclePoint, a social marketing firm, to assist us with better informing our staff, community providers, consumers and the general public of the availability of new services and resources, many of which are culture specific, as well as to begin to address issues of stigma, discrimination and disparities. During the first six months, the staff of Circle Point met individually with each ‘community’ (Native, Latino, youth, family and consumer) to identify needs, goals and objectives for each population. The resulting Social Marketing Plan includes eight elements: Website Development (rebranding and updating of the Campaign for Community Wellness website), Trusted Advisors Coordination, Marketing Materials Development, Event Handouts, Media Relations, Cultural Competency Materials Development, Consumer Rights’ Materials and Staff e-Newsletter Coordination. A ninth component for outreach to
youth is still under discussion. A sub-committee has formed for each element and detailed work plans are being developed to address each area. Most of the elements are designed to address each communities needs separately, but in a coordinated fashion. By January of 2011, materials (brochures, handouts, posters, etc.) for each population should be available.

The Sierra Native Alliance has created a brochure of their services and has established a website. In addition, the Native Services Team has begun to provide in-service trainings at CSOC team meetings and in September we have a training scheduled with the Officers of the Courts and CSOC staff, to further everyone’s understanding of the services available and the benefit to Native families.

The Latino Leadership Council has made flyers and referrals forms available in English and Spanish for CSOC staff and the community, which are posted in all CSOC locations. Their website and brochure are under development.

Likewise a Family Advocacy and a Y.E.S. Program brochure are under development.

As mentioned above, the Welcome Center brochure is available in all mental health lobbies.

8IID. Evidence County has Assessed Factors and Developed Plans to Facilitate the Ease with which Culturally and Linguistically Diverse Populations can Obtain Services

Placer SOC provides mental health services in Roseville, (serving south Placer County), Auburn (serving the central Placer County foothill communities) and Tahoe City (serving the North Shore of Lake Tahoe). Crisis Services are offered 24/7 to the entire county. Our Psychiatric Health Facility is located in Roseville and operated through a contract with Telecare. Outpatient services are generally offered from 8 AM to 5 PM. CSOC Mental Health staff offer evening appointments to families receiving wraparound services and on a case-by-case basis. CSOC also operates three day treatment programs, one located in Roseville and two located in Newcastle, just west of Auburn. Mental Health services provided via Education Code 26.5 are offered in the schools, at the home or in the office. Transportation can be a barrier. While bus transportation is available, depending on the route or the need to make a transfer, the length of time this may take is an issue.

All of the facilities utilized by Placer SOC are ADA compliant. Mental Health staffs, a psychiatrist and nurse, are co-located in our county operated rural health clinic in Auburn. Adult consumers who need medication reviews can be seen in that setting. CSOC has two office locations, one in an office complex in Roseville near a residential neighborhood and one in Auburn in a store front complex. The waiting rooms contain child friendly art, books and games. ASOC also operates out of two locations. The Roseville location is in the old Charter Hospital complex in Roseville and the Auburn location is at the DeWitt Center which was a state hospital and is now a government center. Before the economic downturn, Placer was beginning to develop a facility master plan for relocating and revitalizing service sites. That plan is on hold indefinitely.

In Tahoe, our services are provided through a contract with Sierra Family Services (SFS), which is located in Tahoe City. That site is a long bus ride away from our Latino community in Kings Beach. This resulted in the recommendation from the Latino Access Study to co-locate a Community Educator in Kings Beach. SFS is also offering to pay for a taxi from Kings Beach to and from appointments.

Placer SOC also contracts with four Family Resource Centers (FRC), all of whom are located in our ‘pocket areas’ near our Latino neighborhoods. Counseling and or linkage
to a variety of services are available in the FRC’s.

An action item for the Cultural and Linguistic Competence Committee is to look at how to improve our service sites and waiting rooms to be more comfortable and inviting to persons of diverse backgrounds.

8IIIA. Quality of Care - Evidence of How Contractor Providers’ Ability to Provide Culturally Competent Mental Health Services is Utilized in Selection of Contract Providers, Including Identification of any Cultural Language Competence Conditions in Contracts with Mental Health Providers

As stated previously, as of August 2010, all contracts will include the following language:

**CULTURAL COMPETENCE:** PROVIDER shall provide services pursuant to this Agreement in accordance with current State statutory, regulatory and policy provisions related to cultural and linguistic competence as defined in California State Department of Mental Health (DMH) Information Notice No:10-02, The 2010 Cultural Competence Plan Requirements, which establishes new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. The Cultural Competence Plan Requirements (CCPR) standards and criteria are spelled out in the California Code of Regulations, Title 9, Section 1810.410. The standards and criteria are applicable to organizations/agencies that provide mental health services via Medi-Cal, MHSA and/or Realignment.

8IV. Quality Assurance - Description of Current or Planned Processes to Assess Quality of Care Provided For All Customers

Placer SOC has engaged our contract providers through the Placer Collaborative Network and through the Campaign for Community Wellness as well as by opening up our trainings to provider staff. Our emphasis on becoming increasingly culturally competent has been made clear. We have established an Evaluation Team whose charge is to design and implement an evaluation of the effectiveness of every PEI component that was recommended in our MHSA PEI Plan. We are also in the process of developing a contract monitoring tool that will capture the implementation timelines, staffing, training, and deliverables of each contract. See sample Contract Monitoring Tool in Appendix H-4 and H-5.

8IVA. Outcome Measures, Identification and Descriptions of Culturally Relevant Consumer Outcomes Measured Used

As state previously, Placer SOC has recently formed an Evaluation Team. This team is beginning to identify outcome measures and review existing tools for capturing the data. We are working closely with our partner agencies, the Sierra Native Alliance and the Latino Leadership Council, as well as consumers, family and youth advocates to assure we develop a respectful and culturally sensitive process for collecting data. We anticipate having a matrix of outcomes measures and the corresponding tools available by January of 2011.
8IVB. Outcome Measures Used to Measure Staff Experience or Opinion Regarding the Organization’s Ability to Value Cultural Diversity in the Workforce and CLC

In Placer County, 230 SOC staff completed the on-line survey of the Cultural and Linguistic Competence Policy Self-Assessment which was modified from the guide developed by Georgetown University. In addition, diverse staff had the opportunity to participate in focus groups or to participate in confidential Key Informant interviews.

The document created by the CLC Committee based on the feedback from staff and consumers entitled, Placer County Systems of Care Cultural and Linguistic Competency Plan: Summary of CLC Workgroup Recommendations is included in Appendix D-4. From the recommendations in this document the team created the objectives and action items that form the 3 year CLC Plan for Placer, which can be found in Appendix D-5.

See staff survey results under Workforce Needs Assessment (c) noting the workforce’s own stigma related to acknowledging mental health in their own family unit in Appendix F-1.

8IVC. Description of How Medi-Cal and non-Medi-Cal Client Grievance and Complaint/Issues Resolution Process Data is Analyzed and Comparison Rates between General Population and Ethnic Beneficiaries

Placer’s grievances and complaints for MediCal and non-MediCal populations are monitored and analyzed by our Patient’s Rights Advocate. When a grievance or complaint is received, it is forwarded to the Patient’s Rights Advocate, who investigates and works with all parties to resolve. She keeps a confidential record of each instance and quarterly reports back to the Client/Family Relations Committee and the Quality Improvement Committee. She analyzes and monitors all grievances and complaints and issues two reports, one for MediCal only and one for the total number of grievances and complaints in that quarter. The complete SOC policy on Appeal and Grievance (including forms) can be found in Appendix H-2.
APPENDICES
APPENDIX A-1

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APPENDIX B
DATA & DATA ANALYSIS
APPENDIX C
STRATEGIES TO ADDRESS DISPARITIES

APPENDIX C-1  ASOC Priority Population
APPENDIX C-2  Final Placer County WET Plan
POLICY

The Placer County Adult System of Care is dedicated to providing quality services to the priority populations identified in California Mental Health Act and to all Placer County Medi-Cal beneficiaries who meet the State Department of Mental Health medical necessity criteria.

Reference: California Welfare and Institutions Code Sections 5777, 5600.1, 5600.2; and 5600.6; California Code of Regulations Section 1830.205 of Title 9; Government Code Section, Title 1, Division 7, Chapter 26.5

PURPOSE

The purpose of this policy is to:

1. Identify and define the priority populations to which the local mental health program is legally obligated to provide mental health services.

2. Identify the Medi-Cal beneficiary population to which the Adult System of Care are obligated to provide mental health specialty services under contract with DMH as a Managed Mental Health Plan.

DEFINITIONS

Priority Target Populations:

In accordance to Sections 5600.1 and 5600.2 of the California Welfare and Institutions Code, the Systems of Care is obligated to provide mental health services to residents of the County who have severe and disabling mental illness, or children who are emotionally disturbed (ED), regardless of financial means. (Attachment A)
The Adult System of Care will make special efforts to engage the severely disabled mentally ill who are homeless and/or who have co-occurring substance dependence.

**Medi-Cal Medical Necessity Definitions:**
In accordance medical necessity definition found referred to in Section 5777 of the California Welfare and Institutions Code and Section 1830.205 of Title 9 of the California Code of Regulations County residents who are Medi-Cal beneficiaries are entitled to receive an appropriate array of mental health services. (Attachment B)

**SERVICE PRIORITIES:**
The Adult System of Care mental health program's first priority will be to provide an array and intensity of services to County residents who have a severe and persistent mental illness and Medi-Cal beneficiaries who meet the criteria established by the State Department of Mental Health.

**Services to Target Populations:**
In accordance with Section 5600.6 of the California Welfare and Institutions Code, the Adult System of Care mental health services will provide a minimum array of services for residents, who as a result of their mental disorder, have substantial functional impairments or symptoms, or a psychiatric history demonstrating that, without treatment, there is an imminent risk of increasing impairment and/or increasing symptoms. The minimum array of services should include: Crisis Services, Assessment, Medication Education and Management, Case Management, Twenty-four-hour Treatment Services, Rehabilitation and Support Services, Vocational Services, and Residential Services. Individuals with a severe and persistent mental illness are to be treated within a coordinated and integrated system of care approach.

**Services to Medi-Cal Beneficiaries:**
Specialty mental health services are to be provided at a level of intensity and duration to adequately address the beneficiary's medically necessary mental health condition. These services will be furnished primarily through a provider network utilizing a brief therapy model. Beneficiaries requiring medications will first be evaluated for appropriateness of prescription by their primary care providers. Psychiatric consultation will be available to primary health care providers. Primary care providers may refer for on-going psychiatric care.

**Crisis Intervention Services:**
County residents, regardless of financial means, who, as a result of a mental illness, are determined to be a danger to self, a danger to others or gravely disabled, are eligible to receive crisis intervention services offered by the Systems of Care to address their emergent mental health condition.
Attachment A

PRIORITY POPULATION FOR
ADULT SERVICES

PRIORITY POPULATION CRITERIA

The priority target population is comprised of individuals with a severe and persistent mental illness. The criteria utilized are that the individual suffers from (1) a severe psychiatric impairment, (2) exhibit an impaired level of functioning that prevents them from sustaining themselves in the community without treatment, supervision, rehabilitation and supports, and (3) whose illness and impaired level of functioning is persistent in duration. Excluded from this criterion are individuals who have a primary diagnosis of substance abuse and those individuals with a sole diagnosis of developmental disabilities. The criteria also exclude individuals with a primary diagnosis of organic brain syndrome.

OPERATIONAL DEFINITION

Individual who are considered to be severe and persistently mentally ill must meet the following criteria to be eligible for services:

Criteria A

At least one of the following diagnoses as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorder IV-TR:

**Schizophrenia**
- 295.1 Disorganized
- 295.2 Catatonic
- 295.3 Paranoid
- 295.4 Residual
- 295.9 Undifferentiated

**Schizoaffective Disorder**
- 295.70

**Bipolar Disorders**
- 296.0x Bipolar I
- 296.4x Manic
- 296.5x Depressed
- 296.6x Mixed
- 296.7 Most Recent Episode, Unspecified
296.80  Bipolar Disorder Not Otherwise Specified
296.89  Bipolar II Disorder

Major Depression
296.2x  Single Episode
296.3x  Recurrent

Delusional Disorder
297.1

Psychotic Disorder Not Otherwise Specified
298.9

Criteria B:
A Global Assessment Functioning Scale with a score of 60 or lower

Criteria C:
The client’s actual Functional Impairment(s) must be specifically identified and documented in writing in the chart and the notation must indicated how they have limited or impacted the individuals daily functioning.
Attachment B

STATE DEPARTMENT OF MENTAL HEALTH
MEDI-CAL MANAGED CARE
MEDICAL NECESSITY CRITERIA

Medical necessity for managed care specialty mental health services which are the responsibility of the County mental health plan must meet the three following criteria:

ELIGIBILITY

To be eligible for Medi-Cal reimbursement for Outpatient/Specialty Mental Health Services, clients must meet all three criteria (diagnostic, impairment & intervention)

DIAGNOSES

Must have one of the following DSM IV-TR diagnoses, which will be the focus of any treatment intervention which is provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorders which are excluded
- Attention Deficit and Disruptive Behavioral Disorders
- Elimination Disorders
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders, Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorder, excluding Antisocial Personality Disorders
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Communication Disorders
- Autistic Disorders
• Tic Disorders
• Delirium, Dementia, Amnestic and Other Cognitive Disorders
• Mental Disorders due to a general medical condition
• Substance-Related Disorders
• Sexual Dysfunctions
• Sleep Disorders
• Antisocial Personality Disorders

A beneficiary may receive services for an included diagnosis even when an excluded diagnosis is also present.

**IMPAIRED CRITERIA**

Must have one of the following as a result of a mental disorder(s) identified in the diagnostic criteria and must have one of 1, 2, or 3 below

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

**INTERVENTION RELATED CRITERIA**

Must have **all** 1, 2, and 3 below:

1. The focus of the proposed intervention must address the condition identified as part of the impairment criteria above and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and
   The condition would not be responsive to physical based health care treatment.
Placer does not have particular challenges recruiting mental health employees (except in rural areas of the county). Due to the large number of master’s programs in the area, we have many applicants for our master’s level positions in both the County and the local non-profit agencies. The area has less social work schools than Marriage and Family Therapy programs; therefore, we have fewer social workers. Social Worker’s headed toward licensure must be supervised by a Licensed Clinical Social Worker (LCSW), and this creates additional demands.

Experienced Supervisor’s and Management staff in the Mental Health field (particularly licensed staff) are very difficult to fill. In Lake Tahoe (the most eastern part of the county) there has been an open recruitment for a qualified Manager for over a year. The Manager needs to be qualified in Mental Health and all other social services because the area is far removed from other services and is required to operate independently.

Service providers in all areas of the county recognize the need for more bi-lingual mental health workers. While the need is high throughout the county, due to geographic and demographic distribution, there is particular need in Kings Beach and Lincoln. With regard to the Tahoe Kings Beach area, there are shortages in all mental health positions. The cost of living is high and transportation can be difficult. There is a large Latino population in the area, many who are monolingual Spanish speaking. The need for mental health workers (particularly Spanish speaking) is great. There are also a significant number of monolingual Spanish speakers, with limited access to service in the Lincoln area (see section D below).

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

Placer’s largest variance of workforce to target population is Latino/Hispanic (5.5% variance). On closer examination, the variance was not as significant when comparing only County Client’s to Staff (3.3% variance), however, the variance is greater when evaluating community based organizations’ staff and client case loads. The need to attract and retain bi-lingual/bi-cultural staff exists in both the public and private sectors.

Other areas of note include: 4.5% variance of Multi-Race/Other, 0.8% variance of Native American, and 0.6% variance of African American staff to client ratios. We have slightly more diversity among the population being served than in our workforce. Concurrently with the WET planning, Placer is in the process of gathering more data to create a cultural competency plan.

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

An interesting finding was discovered in the surveys completed by all the Mental Health Workforce in Placer County. When the entire workforce was asked whether they were a consumer/family member of public mental health services, 32% of the workforce indicated yes they were, and 17.6% of the workforce declined to answer this question. From this it can be surmised that there continues to exist considerable concern regarding stigma and bias in the workforce.

Placer has employed consumer and family member staff for several years. The county has increased the number of consumer designated positions significantly in the last 1 ½ years. The recent large increase of consumers in the workforce has helped transform
the system. The community agencies interviewed do not have “designated” consumer/family member employees (although there are some employees who disclose this as part of their identity after hire).

County HHS Adult System of Care has 14 part-time consumer “Navigator” employees. Applications are received on-going and there is a large interest in this program. Navigator positions are considered entry-level, extra-help positions. Minimum requirements for the position are to currently be a consumer of public mental health services. Adult System of Care has 3 full-time consumer employees who qualified for the “Client Service Assistant” positions. These are fully benefited, competitively offered positions. The county typically receives several applications for this classification. While everyone who meets the minimum standards (HS diploma) can apply, these consumers were hired in 3 of the available spots. We have had 1 consumer employee who works on site at Adult System of Care but is hired through a contract with Best Step Tech.

Placer has 12 full time “family member” positions titled “Parent Partner’s”. One works in adult services and eleven work in the Children’s System of Care; they are hired through a contract with United Advocates for Children and Families. One of these positions is a Manager for the County; the others are considered extra help, entry level positions.

Input from Consumers/Family members as well as experts in consumer employment see an additional need in this area: training and development of current and new consumer/family member employees, workforce training to help understand the benefits of consumer employment, decreased stigma in the workforce, and advancement opportunities. Family members expressed a need to improve staff understanding of the role of advocates. The outcome family advocates hope to see is the consumer/family member voice empowered and continued transformation of the workforce in the model of Recovery.

D. Language proficiency:

Placer County has 23.1 FTE staff who are able to offer services in Spanish. 11% (682) of our total mental health population is Latino/Hispanic. Of that 11% (682), approximately 17.41% (119) are monolingual. The Kings Beach area (East Placer County in the rural Tahoe area) and Lincoln (North/West Placer with no County buildings) have the largest concentration of monolingual Spanish speaking clients. The need for more Spanish speaking Mental Health employees (particularly in these areas) still exists.

While Placer has not met any other threshold language requirements yet, there is a large Ukrainian population in the Roseville (West Placer) area. Residents and county employees have recognized an unmet need for increased ability to serve this population. Outreach and employees who speak their native language are necessary to meet this need.

Diversity
1. Consider culture to include ethnicity, but also culture beyond it (e.g., LGBT, deaf, consumer, religion, etc.)
2. Diversify workforce in order to pair clients with staff of same culture
3. Create career pathways (from high school through college)
APPENDIX D

CLC INTEGRATION

APPENDIX D-1  SOC Cultural Competency Charter
APPENDIX D-2  CLCC Committee Biennial Report (8/09 to 12/09
APPENDIX D-3  CLCC Committee Biennial Report (1/10 to 6/10
APPENDIX D-4  Summary of CLCC Workgroup Recommendations
APPENDIX D-5  FY2010-2011 Annual CLC CQI Plan
APPENDIX D-1

PLACER COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

SYSTEMS OF CARE
CULTURAL COMPETENCY COMMITTEE

CHARTER

PURPOSE:
In order to promote and assure accessibility and competence in service delivery in a way that is inclusive and sensitive to individuals’ and families’ needs, the Cultural Competency Committee will: identify unmet needs for cross-cultural services, facilitate the implementation of procedures, policies and programs which enhance effective cross-cultural service delivery, promote understanding and appreciation of diversity, and provide continuing cross-cultural training to all staff and service providers. The committee recognizes the development of cultural competence to be an on-going process, and acknowledges that the values and principles of cultural competence impact all interactions with consumers and community.

FUNCTION:
The Cultural Competency Committee will act to review and provide oversight responsibilities with California Department of Mental Health and Department of Social Services regulations pertaining to cross-cultural service delivery. The Committee will regularly develop, implement and support cross-cultural training. Committee members will prioritize identified needs with regard to cross-cultural services, develop protocols for addressing those needs, submit those plans of action to the SOC Managers for review and to the Q. I. Committee for approval and then carry out the designated tasks in order to provide optimal service to individuals representing multiple cultures. The Committee, additionally, will develop strategies for outreach to underserved groups within the larger community to enable those individuals to access Systems of Care programs and services.

Specific duties include the Quality Improvement Work Plan, the Mental Health Audit/Cultural Competence Requirements, the Cultural Competence Plan Update and the Latino Access Study.

MEMBERSHIP:
The Committee recognizes the need for broad representation of, and input from, our county’s diverse cultures in order to meet the goals outlined above. The Committee will include both line and management staff from ASOC and CSOC, consumer representatives and community members with special interest in, and knowledge of, cultural competency issues. The SOC Management representative will serve as the Liaison between the Cultural Competency and Q. I. Committees.
ROLES:
Committee Chair: To lead the Committee at each meeting to assure orderly, collaborative, sequential and timely accomplishments of the Committee’s work. The committee is chaired by one of the SOC Program Managers serving on it.

Committee Members: To take responsibility for staying current on Committee business, including the activities missed due to absences from meetings and following through on action items. When unable to attend a meeting, Members are asked to advise the Committee Chair in advance.

DECISION MAKING:
Decisions on recommended actions, products and formats are to be made by consensus among those in attendance. If a consensus cannot be reached, decisions will be made based upon a mutually agreed-upon process determined to be the best approach at the time.

CONSTRAINTS:
The products and accomplishments of the Committee must be based upon the discussions and agreements made in the Committee’s meetings.

RESOURCES:
Committee Members will utilize Placer County Systems of Care resources for preparatory and follow-up work, to assure the timely and complete accomplishment of the Committee’s goals.

If the Committee determines that occasional County office support is needed, reasonable requests will be made for assistance, utilizing established supervisory and/or management approval methods.

COMMITTEE MEETINGS:
The Cultural Competency Committee will meet on a monthly basis, at a time and location designated as convenient to Committee members. The Committee Chair will prepare meeting agendas and action-tracking materials in advance, and will provide sufficient copies at the beginning of the meeting.
This is the semi-annual report of the SOC CLC Committee.

Committee Purpose

In order to promote and assure accessibility and competence in service delivery in a way that is inclusive and sensitive to individuals’ and families’ needs, the Cultural and Linguistic Competence Committee will: identify unmet needs for cross-cultural services, facilitate the implementation of procedures, policies and programs which enhance effective cross-cultural service delivery, promote understanding and appreciation of diversity and provide continuing cross-cultural training to all staff and service providers. The committee recognizes the development of cultural competence to be an on-going process, and acknowledges that the values and principles of cultural competence impact all interactions with consumers and community.

Committee Composition

The Cultural and Linguistic Competence Committee is currently composed of seven SOC staff including one Manager, one Supervisor, five staff (two from CSOC, three from ASOC and one from the managed Care Unit), two Family Advocates and one Native Community Consultant and one Latino community Consultant. Currently there are no Transition Age Youth on this committee.

Training

Building on the successes of 2008 (Tom Lidot and Matthew Mock) CSOC plans to host a training for key staff and partners on “Working with Non-Fed Eligible Youth”. This will be in March. E Learning/Trilogy is up and running, and more than 20 staff have completed culturally related training elements since July 2009.

CLC Plan Development

The final CLC plan is complete and attached for review. This is the result of an 18-month analysis and staff survey.

Latino Access Study Implementation/Tahoe

Our Bilingual Community Educator, Patrick Bolinger, continues to be out-stationed to the North Tahoe Family Resource Center one day a week. In addition, he provides self-esteem and problem solving groups to Latino youth on the campus of the North Tahoe High School and leads the Mountain Prevention Coalition. This key position was recently funded in part
by MHSA, making it more secure.

Sierra Family Services continues to manage a ‘flex fund’ for families who are at-risk and to use as incentives for youth involvement.

Through the Mental Health Services Act planning process at the Campaign for Community Wellness Steering Committee, a Tahoe Enhancement Plan was approved with the goal of implementing a Community Services and Supports- Full Service Partnership at Tahoe. Likewise, a Prevention Early Intervention Plan was approved for Tahoe to include: Life Skills Training for children and youth; enhancement of the Adventure Risk Challenge program for English language learners; and a part-time therapist/community educator to be housed in King’s Beach. These services are soon to be under contract, as of February 1, 2010.

There are now 7 promontoras volunteers functioning in the Kings Beach community of Lake Tahoe. This is the result of much effort and partnership with the NTFRC and others. More than 2 dozen families have been served already.

**Latino Leadership Council Update**

The Latino Leadership Council continues to meet monthly at the Sutter Roseville Medical Center.

The LLC continues to take leadership in assessing the Latino community’s needs and planning for the implementation of the various services approved through the MHSA planning process. These services will include support groups, cultural immersion dinners with SOC staff, parenting classes and counseling. The council is planning an additional Health Faire, and is exploring a return engagement with Roberto Danzie, PhD.

**Native American Collaboration Update**

The Native Network conducted a Strategic Planning meeting in January of 2009 and agreed to become the Native Alliance of the Sierra Nevada Foothills, a tri-county non-profit organization involving El Dorado, Placer and Nevada Counties. This is significant in that these three counties plus Sierra County make up the traditional home of the local tribal peoples.

The Native Alliance continues to meet monthly and recently celebrated occupancy of their permanent location at the old Alta Vista public school site. Attendance continues to grow and several youth are involved regularly. The alliance is already offering:

- Native Language Classes
- White Bison Classes

Anno Nakai, our Native Community Liaison, on behalf of the Native Alliance, continues to participate in the Campaign for Community Wellness Steering Committee. Through one-time and ongoing MHSA dollars, several programs specific for the Native community have begun. These include Positive Indian Parenting, Native American Eagle, and Across the Ages. In addition, there will be on-going support for the annual Big Time Pow Wow, support
to develop a local Native Gathering place and start up funds for the non-profit.

Sierra Family Services has agreed to be the fiscal sponsor to ‘hold these dollars and programs until the Native Alliance is up and running. The annual Pow Wow Big Time was held in October and was a huge success. More than 500 residents enjoyed dancing, singers, crafts and a host of other activities.

Challenges/Opportunities

1. **Increasing the Diversity of the CLC:** We have increased the diversity of the CLC in the last 6 months and there is more balance between the representation of ASOC and CSOC staff. We currently have no youth, consumer or community/Network providers of the committee.

2. **Training Expectations:** The Cultural Competency Committee supports continuing to provide training for staff and providers on all aspects of cultural competency as we have just begun to touch the surface of many important issues. To this end we recommend establishing an annual budget for training and related activities. Because we are operating with fewer resources, it is difficult for staff to balance training and other mandates at this time.

3. **Cultural Competency Budget:** Likewise, the draft Cultural and Linguistic Competency guidelines from DMH, include establishing an annual budget and dedicated staff for those purposes.

   *This is a possible discussion item for the Workforce Development and Training Plan*

4. **Office in King’s Beach:** To participate in Mental Health treatment services in the Tahoe area currently requires travel to the Sierra Family Services Offices in Carnelian Bay. For residents of King’s Beach this almost always requires a long bus ride over several hours for one hour of therapy. Establishing an office space in King’s Beach would make these services more accessible and visible to the individuals that need these services.

   *This issue is currently on the Capital/Facilities Improvement list of priorities and also in the MHSA Tahoe PEI Plan.*

5. **State MHSA Budget Challenge:** The Governor’s recent budget projection calls for significant cuts to core Mental Health services and/or supplanting those services with MHSA dollars. This significantly imperils the PEI and Innovation planning that the community has accomplished over the last 3 years.

Respectfully Submitted,

Richard S. Knecht, M.S.
Director, Children’s System of Care
Placer County Health and Human Services
This is the semi-annual report of the SOC CLC Committee.

Committee Purpose

In order to promote and assure accessibility and competence in service delivery in a way that is inclusive and sensitive to individuals’ and families’ needs, the Cultural and Linguistic Competence Committee will: identify unmet needs for cross-cultural services, facilitate the implementation of procedures, policies and programs which enhance effective cross-cultural service delivery, promote understanding and appreciation of diversity and provide continuing cross-cultural training to all staff and service providers. The committee recognizes the development of cultural competence to be an on-going process, and acknowledges that the values and principles of cultural competence impact all interactions with consumers and community.

Committee Composition

The Cultural and Linguistic Competence Committee is currently composed of seven SOC staff including one Manager, one Supervisor, five staff (two from CSOC, three from ASOC and one from the managed Care Unit), two Family Advocates, one Native Community Consultant, one Latino Community Consultant, one Youth mentor and the Youth Coordinator.

Training

During the past six months 265 staff, providers and community partners have received Nurtured Heart Training, a strengths and asset-based approach to serving children and families in all settings. Thirty-two staff, providers and community members attended Culturally Competent Approaches to Serving LGBT Populations. A training on Foster youth and Homeless Education was attended by 61 participants. A training, Recovery Oriented Leadership, by Bruce Anderson, was attended by 9 staff. Thanks to the Latino Leadership Council, Roberto Dansie, PhD. returned to train 50 staff and providers on The Role of Culture in Healing.

CLC Plan Development

The CLC Plan is currently being written. A rough draft will be available for review on August 1, 2010. The final plan is due to the State by August, 31, 2010.

Latino Access Study Implementation/Tahoe
Our Bilingual Community Educator, Patrick Bolinger, resigned his position in March. Sierra Family Services, our Tahoe Mental Health and Substance Abuse vendor, hired Mike Pysak as the Bilingual Community Educator to replace him. Mr. Pysak continues to be out-stationed to the North Tahoe Family Resource Center one day a week. In addition, he provides self-esteem and problem solving groups to Latino youth on the campus of the North Tahoe High School. Sixty percent of the funding for this position is from MHSA PEI dollars.

Mike Pysak is currently compiling a written report on the progress thus far in implementing the recommendations of the 2003 Latino Access Study.

**Latino Leadership Council Update**

The Latino Leadership Council continues to meet monthly at the Sutter Roseville Medical Center.

The LLC continues to take leadership in assessing the Latino community’s needs and implementing of the various services approved through the MHSA planning process. The LLC implemented its second annual Health Fair in Roseville in May. Again over two hundred adults were screened by health care volunteers for a variety of health and medical issues. During the Health Fair Roberto Dansie spoke on health and wellness in the Latino culture. The LLC was awarded a $25,000 grant from Kaiser Permanente to help provide medical care to Latino adults in need. As a follow up to the Health Fair, the LLC is currently linking these adults with medical care providers.

The LLC has conducted and completed the first set of Parent Project classes for Latino families in Lincoln. This fall they will provide the Parent Project in Roseville.

A contract with the LLC is being finalized and additional services will be provided. These services will include support groups, cultural immersion dinners with SOC staff, and youth cultural activities.

A Latino Services Workgroup Pilot Project has been formed between the LLC and CSOC. One Social Worker in Roseville and one Promotora are assigned to each Latino family coming into the system. The Promotora provides support and education to the family and, in turn, educates the Social Worker on the families culture, beliefs and needs. Together they provide culturally effective services. Early reports indicate higher satisfaction with services and a likelihood for greater success.

Elisa Herrera, facilitator for the Latino Leadership Council serves on the SAMHSA Steering Committee, the Campaign for Community Wellness Steering Committee, the Cultural Competency Committee and a monthly Children’s System of Care manager’s Meeting and the quarterly SOC Leadership Meeting.

**Native American Collaboration Update**

The Native Network transitioned into the Native Alliance of the Sierra Nevada Foothills (aka
Sierra Native Alliance), a tri-county non-profit organization involving El Dorado, Placer and Nevada Counties last fall. This is significant in that these three counties plus Sierra County make up the traditional home of the local tribal peoples.

The Sierra Native Alliance continues to meet monthly at their permanent location at the old Alta Vista public school site. Through MHSA PEI dollars the Sierra Native Alliance hired a Youth Coordinator and through SB 163 funding (wraparound) they hired a Native Family Liaison.

Anno Nakai, our Native Community Liaison and the Executive Director of the Sierra Native Alliance, continues to participate in the Campaign for Community Wellness Steering Committee, the SAMHSA Steering Committee and acts as co-chair of the Cultural Competency Committee. She also is a participant in a monthly Children’s System of Care manager’s Meeting and a quarterly SOC Leadership Meeting.

Through our inclusion in the CA Disproportionality Project (an 18 month process to improve child welfare outcomes for Native youth and families) CSOC and the Sierra Native Alliance has formed the Native Services Team. This team consists of two CSOC social workers and two staff from the Sierra Native Alliance, who work together to provide culturally appropriate wraparound services to Native families. Currently the Native Family Liaison has a caseload of thirty Native families. There are 20 Native youth participating in the youth program at SNA.

Through one-time and ongoing MHSA dollars, several programs specific for the Native community have begun.

Native Family Advocacy: The Native Family Advocacy program provides outreach, family support, advocacy, family visitation and case management services for Native youth and families at risk for involvement in child welfare, juvenile justice, mental health, and substance abuse services. White Bison recovery groups, traditional health services, and family wellness counseling sessions will be provided to families in need of support.

Positive Indian Parenting: Parenting support will be provided through Families of Tradition nights and Positive Indian Parenting (PIP) education classes. Families of Tradition activity nights provide Native families a community venue for sharing parenting skills and cultural knowledge. The PIP curriculum focuses on traditional cultural parenting values and practices to promote cultural resiliency factors such as mutual respect, communication, extended family networks, and access to cultural knowledge.

Sons and Daughters of Tradition (formerly listed as Project Eagle): Provides culturally relevant group education for Native American youth and their families. The group promotes cultural resiliency factors such as positive cultural identity, self-esteem, intergenerational connections, and leadership skills. The youth group will be facilitated by youth leaders, and will plan community service and recreational events with the support of the Youth Coordinator to support peer-mentoring and leadership skills development.

Strengthening Native Community Commitment through Mentoring (formerly listed as Across the Ages): Using a mentoring guidebook developed by HUD’s Office of Native American Programs, this mentoring program will facilitate intergenerational mentoring and advocacy for Native youth. Using a curriculum based on the medicine wheel, this program is designed to strengthen personal and cultural resiliency factors for reducing their risks of
substance abuse, depression, violence, justice involvement, out of home placement, or school failure.

Sierra Family Services has been the fiscal sponsor for the Sierra Native Alliance this past year. However, on July 27, 2010, HHS is requesting approval from the Board of Supervisors to award a contract directly with the Sierra Native Alliance.

SAMHSA awarded the Sierra Native Alliance an ECCO (Excellence in Communication and Community Outreach) Award for SNA’s website.

Challenges/Opportunities

1. **Increasing the Diversity of the CLC:** We have increased the diversity of the CLC in the last 6 months and there is more balance between the representation of ASOC and CSOC staff. We currently have two youth, one consumer employee and one community/network provider on the committee. The current Cultural Competency plan requirements urge participation from family, youth and consumers and diverse community members who are not currently employed by the system.

2. **Training Expectations:** The Cultural Competency Committee supports continuing to provide training for staff and providers on all aspects of cultural competency as we have just begun to touch the surface of many important issues. To this end we recommend establishing an annual budget for training and related activities. Because we are operating with fewer resources, it is difficult for staff to balance training and other mandates at this time.

3. **Cultural Competency Budget:** Likewise, the draft Cultural and Linguistic Competency guidelines from DMH, include establishing an annual budget and dedicated staff for those purposes.

   *This is a possible discussion item for the Workforce Development and Training Plan*

4. **Office in Kings Beach:** To participate in Mental Health treatment services in the Tahoe area currently requires travel to the Sierra Family Services Offices in Carnelian Bay. For residents of King’s Beach this almost always requires a long bus ride over several hours for one hour of therapy. Establishing an office space in King’s Beach would make these services more accessible and visible to the individuals that need these services.

   *This issue is currently on the Capital/Facilities Improvement list of priorities and also in the MHSA Tahoe PEI Plan.*

5. **State MHSA Budget Challenge:** The Governor’s recent budget projection calls for significant cuts to core Mental Health services and/or supplanting those services with MHSA dollars. This significantly imperils the PEI and Innovation planning that the community has accomplished over the last 3 years.

Respectfully Submitted,
Cynthia Brundage, LCSW  
Program Manager, Children’s System of Care  
Placer County Health and Human Services
APPENDIX D-4

DOMAINS

PLACER COUNTY SYSTEMS OF CARE
CULTURAL AND LINGUISTIC COMPETENCY PLAN

Summary of CLC Workgroup Recommendations

1) Organizational Values

Goal: To engage executive leadership, management and line staff in a joint effort to embrace cultural curiosity and competency as a core value across the system of care.

In order to adopt a core value of cultural curiosity, the System of Care (SOC) will need to create a culture of safety and comfort to facilitate cross-cultural exchange. Towards this end, the CLC workgroup recommends the following activities:

1.1. SOC Leadership will employ a strengths-based approach that role models and rewards the growth of cultural curiosity as a value across the system of care.
   - Identify leaders to be visible agents of change in organizational values.
   - Review charter/governance documents to strengthen values statement.
   - Include increasing diversity of leadership as topic in next year’s retreat.
   - Engage forums within organization to facilitate safe and open dialogue.
   - Motivate change by rewarding positive cultural inquiry and actions.
   - Institute “Guiding Principle Awards” to honor risk taking and growth.

1.2. SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.
   - Create information guide to provide strategies and guidance on how to open dialogue with leadership, management and peers around cultural awareness.
   - Set standards for core staff competencies related to cultural awareness.
   - Develop a training team to assist staff with integrating values and behaviors.
   - Include cultural awareness as part of staff orientation and evaluation.
   - Integrate culture-based discussion as a routine component of supervision.

1.3. SOC Staff will support their peers in an effort to increase the level of cultural curiosity and awareness across the system of care.
   - Set norms with peers around how to engage in cultural dialogue.
   - Encourage staff to bring their cultural experiences as an asset.
   - Foster mentoring relationships that facilitate cultural curiosity.
   - Create avenues for diverse staff to serve as resources for learning.
   - Engage community members as resources for cultural exchange.
   - Integrate cultural curiosity into ongoing change agent efforts.

2) Policy and Governance
Goal: To strengthen System of Care policy making and governance processes by increasing the access and inclusion of SOC management, staff and consumers.

Towards the goal of increasing participation of diverse communities in System of Care policy making and governance processes, the following activities are recommended:

2.1. SOC Leadership will review current policy making and governance processes, and develop a plan for facilitating participation from diverse constituent groups.
   - Clarify values and purpose of policy groups in relation to being “stewards” of process that guides the administration of funds on behalf of all consumer groups.
   - Review current structure and membership of SPEAC and SMART Policy.
   - Set goals for increasing diversity of membership of key policy making groups.
   - Define a cross-systems policy making and governance approach that supports active engagement of SOC management, staff, and consumers at all levels.
   - Initiate the development of policies that promote culturally relevant practices, including intake, assessment, care planning, service delivery, and staff training.
   - Support leadership development and education for diverse consumer groups to encourage active participation in policy making and governance activities.

2.2. SOC Managers and Supervisors will take a strengths-based approach to policy development, providing a bridge for staff and consumers to be involved in process.
   - Create central source for access to policy information across SOC.
   - Provide training and ongoing information on organizational policies.
   - Address the barriers in current policies that limit culturally relevant practices.
   - Develop and implement policies to guide culturally competent practices.
   - Develop guidance for working with un-document/un-recognized groups.
   - Monitor adherence to policies that guide culturally competent practices.
   - Enhance CQI and evaluation activities to include peer/consumer review.
   - Create cross-systems structure to review cultural and linguistic policies for consistency, i.e., need to implement policies against racism in the schools.

2.3. SOC Staff will support their peers and consumers in being more informed and active in the development, implementation, and evaluation of policies that guide cultural and linguistic competence.
   - Encourage staff to participate in policy making groups and processes.
   - Empower peers to bring forward policy needs and recommendations.
   - Educate each other on current policies that guide cultural competence.
   - Set a group value and problem solve to improve adherence to policies.
   - Keep consumers informed on policy making and grievance processes.
   - Engage community members as resources for implementing policies.

3) Communication and Collaboration

Goal: To increase the capacity of SOC to engage diverse communities in mental health services through enhanced multi-cultural and multi-lingual communication.

In order to increase access for diverse communities to appropriate services, strategies for
strengthening SOC capacity for multi-cultural and multi-lingual communication include:

3.1. SOC Leaders will establish the value of and create mechanisms for increasing organizational capacity for multi-cultural and multi-lingual communication.
   - Establish the value of competent communication with diverse communities.
   - Engage members of diverse communities in leadership and planning groups to better understand the needs and potential collaboration with these communities.
   - Validate a shift in perspectives from system-based to community-based care.
   - Prioritize the development of resources for increased communication capacity.
   - Work with PCOE to develop a plan for increasing community collaboration.
   - Authorize administrative flexibility to creatively engage resources to improve cultural and linguistically competent services.

3.2. SOC Managers will develop resources for effective community-based strategies to increase multi-cultural and multi-lingual communication and collaboration.
   - Develop resources for increasing multi-cultural/lingual materials and services.
   - Support a team approach towards community-based services, which includes engaging community liaisons, advocates, and peer mentors as valued members.
   - Develop an assets directory of staff/cultural brokers, with tiered language skills.
   - Create flexibility around current role/time constraints that limit the capacity of diverse/multi-lingual staff serve as a language resources and cultural brokers.
   - Provide training and support staff to develop skills for engaging members of diverse communities as resources in care planning and service provision.
   - Create a clearinghouse resource for translation of essential forms and materials.
   - Establish collaborative communication mechanisms for working with PCOE.

3.3. SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.
   - Honor cultural curiosity and communication as a community wellness tool.
   - Develop a team approach to better utilize staff cultural and linguistic skill sets.
   - Create mechanisms for sharing resource information among staff/departments.
   - Shift from provider-based service model to community-based wellness model.
   - Increase collaboration with schools to create a multi-cultural community base.
   - Assist schools in conducting an assessment of youth and family wellness needs.
   - Create a list of cultural supports and mentors for schools and organizations.
   - Assist schools to order culturally appropriate materials and develop resources for school-based cultural activities that match state education standards.

4) Human Resource Development

Goal: To expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities.

Towards the goal of improving services for diverse consumers, strategies for expanding the skills, experiences and composition of the SOC work force include:

4.1 SOC Leadership will promote the expansion of the skills, experiences, diversity of
resources within SOC to provide culturally relevant and responsive services.

- Role model changing attitudes, beliefs and behaviors by participating in “courageous conversations” to address systemic privileges and biases.
- Create policies to facilitate the integration of diverse staff and cultural brokers.
- Work with cultural brokers to develop staff training and education resources.
- Expand funding streams to create pathways for hiring diverse staff members.
- Prioritize diversity in succession planning in leadership positions and processes.
- Allocate resources for training through a variety of venues, including e-learning, experiential opportunities, and local trainers from specific cultural backgrounds.
- Validate participatory learning opportunities by authorizing the use of flex time.
- Create language to ensure the hiring of diverse staff and the use of appropriate practices for contracts with community partners serving diverse communities.

4.2 SOC Managers will create tools, training materials, and procedures for expanding the diversity of staff, community resources, and service models.

- Integrate consumers and community representatives into management teams.
- Facilitate “courageous conversations” to promote intercultural learning.
- Add cultural competency to staff supervision, evaluation and development plans.
- Mentor diverse staff to utilize cultural experiences as assets in service delivery.
- Engage cultural brokers to provide experiential training opportunities for staff.
- Support staff attending cultural events and community education opportunities.
- Integrate cultural brokers into PRT/SMT as a linkage to community resources.
- Create a team to review intake, assessment forms, planning tools and practices.
- Implement best practice practices through cultural-specific service teams.

4.3 SOC staff will expand their skills, knowledge and ability to collaborate with community resources to provide culturally relevant and responsive services.

- Participate in training opportunities to expand awareness of diverse cultures.
- Engage in experiential training, attending cultural and community events.
- Integrate personal experiences and culture as an asset in the workplace.
- Work on professional and personal biases in supervision and practice.
- Set goals for expanding skills for working with diverse community members.
- Apply culturally appropriate modalities and best practices in the field.
- Seek partnerships and consultation with diverse staff and cultural brokers.

5) Consumer/Community Development

Goal: To create pathways for consumers and diverse community partners to participate in SOC policy development, service planning, delivery and evaluation.

The following strategies are recommended to successfully integrate diverse consumers and community members as partners in all levels of service planning and delivery:

5.1 SOC Leadership will develop policies and procedures to support the successful integration of consumers and diverse community members in the levels of service.

- Promote the value of equal and authentic inclusion of diverse consumers and community partners in SOC governance groups and policy making processes.
Participate in processes to recognize and address own biases that may present barriers to working with consumers as equal partners in decision making groups.

Serve as role models for reducing stigma, institutionalized discrimination and power differentials in working with community partners with lived experiences.

Allow for flexibility of meeting times, locations and formats to facilitate the participation of diverse consumers and communities in governance processes.

Engage consumers and community partners in a revision of policies to better accommodate cultural needs and diverse levels of ability in the workplace.

5.2 SOC Managers will develop resources, workplace practices and partnerships to support the preparation and integration of consumers and community members.

- Assist with the development of resources for building consumer and community capacity to participate comfortably at all levels of service planning and delivery.
- Provide skills training, supervision, and venues for peer support to assist people with lived experience entering and working effectively in the SOC workforce.
- Provide training, supervision, and venues for peer support to assist staff without lived experiences to learn how to share power and work with community partners.
- Provide training on recognizing stigma, discrimination, and behaviors that are designed to maintain power differentials; and tools for addressing these behaviors.
- Work with supervisors and staff to develop practices to ensure workplace parity.
- Assist supervisors to assess and develop appropriate accommodations to allow for the integration of workers with diverse levels of ability in the workforce.

5.3 SOC Staff will work in partnership to maximize skills and experiences.

- Create a welcoming environment that values the lived experiences of peers.
- Participate in changing workplace dynamics, working to share power with members of the workforce who have alternative pathways into the workforce.
- Support ongoing discussion on issues of culture, stigma, and discrimination.
- Support the leadership and advocacy skills of workers with lived experience.
- Develop partnerships to combine the assets of professional training with the assets of lived experience, working in community settings when appropriate.

6) Facilitating a Broad Array of Services

Goal: To create a county-wide model for providing community-based, culturally-relevant services through the expansion of the community advocacy program.

Towards the goal of creating community-based, culturally relevant services for diverse communities, SOC will develop a county-wide community peer advocacy program.

6.1 SOC Leadership will develop working relationships with community-based organizations in order to implement a culturally-relevant advocacy programs.

- Develop relationships with diverse communities and consumer groups to expand the community advocate/cultural broker model across underserved communities (i.e., Transition Age Youth, Native, Latino county-wide, Older Adults, GLBT).
- Work in partnership with diverse communities to develop a framework for
community-based education and advocacy model for underserved communities.

- Facilitate a working group to guide the development of advocacy services.
- Provide guidelines for standard contract language to ensure that contracting organizations have the capacity to provide culturally-relevant services.
- Hire managers and supervisors who are members of diverse communities and have experience developing peer-based education and advocacy programs.

6.2 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.

- Develop resources for implementing best practices in community advocacy through training, technical assistance, and comprehensive program evaluation.
- Outline clear goals and objectives for community-based advocacy programs.
- Develop contract guidelines to ensure that community-based organizations conduct cultural and linguistic competency self-assessment and planning.
- Meet in quarterly working sessions with managers of community organizations.
- Develop training/orientation materials in partnership with managers of CBOs.
- Facilitate cross-cultural roundtables and workgroups to guide best practices.
- Develop evaluation protocols to measure outcomes of advocacy services.

6.3 SOC staff and community-based organizations will work together to ensure a high level of community satisfaction and ownership of mental health services.

- Build relationships with community advocates to share resources and skills.
- Participate in cross-cultural roundtables and ongoing best practices workgroups.
- Participate in training on how to engage in cultural conversations effectively.
- Solicit feedback from service recipients on the success of advocacy services.
- Create forums for community members to participate in the development of mental health supports and services tailored to the needs of their community.
- Facilitate community wellness through community ownership of services.

7) Organizational Resources for CLC Activities

Goal: To develop a budget and plan for resources to dedicated to support the implementation of a comprehensive CLC plan across the system of care.

The following activities are recommended to support the development of a dedicated budget and resource development plan to support a system-wide CLC plan:

7.1 SOC leadership will develop a dedicated budget and resource development plan to support the implementation of a comprehensive CLC plan for the organization.

- Review CLC resources and requirements across SOC programs to ensure resources are appropriately allocated and integrated in a coordinated effort.
- Develop a budget dedicated to implementing the activities of the CLC plan.
- Implement a fund development plan to increase resources for CLC activities.
- Invest in partnerships with diverse communities to maximize SOC resources.

7.2 SOC Managers will engage in resource development activities to support the implementation of the CLC plan.
Recommendations from previous domains:

- Develop resources for increasing multi-cultural/lingual materials and services.
- Expand funding streams to create pathways for hiring diverse staff/advocates.
- Allocate resources for training through a variety of venues including e-learning, experiential opportunities, and local trainers from specific cultural backgrounds.
- Support the resource development capacity of community-based organizations.
- Assist with the development of resources for building consumer and community capacity to participate comfortably at all levels of service planning and delivery.
- Develop resources for implementing best practices for community advocacy through training, technical assistance, and comprehensive program evaluation.
# Appendix D-5

Placer County Systems of Care

Annual Cultural and Linguistic Competency CQI Plan
Fiscal Year 2010-2011

## Annual Cultural and Linguistic Competency Plan (Current Objectives from Overall SOC Annual QI Work Plan)

### Population Assessment and Utilization Data Objectives

<table>
<thead>
<tr>
<th>Overall Goal/Objective</th>
<th>Planned Steps and Activities to Reach Goal/Objective</th>
<th>Responsible Entity and/or Lead Person</th>
<th>Auditing Tool</th>
<th>Due Date / Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Cultural Competence Plan</td>
<td>Use results from the Community Readiness Assessment to inform and update the 2010 version of the Cultural Competence Plan.</td>
<td>CLC Committee/ Lead: CLC Manager (Cindy); Native Liaison (Anno Nakai)</td>
<td>Cultural Competence Plan update</td>
<td>Due: 8/31/10 Completed:</td>
</tr>
<tr>
<td>Ensure Access to Services telephone lines are providing linguistically appropriate services to callers. Provide training as needed.</td>
<td>Test the Adult Intake Services and Family and Children’s Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the AT&amp;T Translation Line Service. Provide remedial training as deemed necessary.</td>
<td>CLC Committee/ Lead: CLC Manager (Cindy)/MHAOD Board QIC/Lead: QI/MCU Manager (Twylla)</td>
<td>MHAOD Board Access to Services Test Line Report; Training sign in</td>
<td>Due: Annually, by 6/30/10 Completed:</td>
</tr>
<tr>
<td>Implement the recommendation s of the completed Latino Access Study</td>
<td>The specific objectives of the Latino Access Study developed to improve services to the Kings Beach Community are described in the Study. Latino Access Study report to be generated annually.</td>
<td>Lead: SOC Directors (Richard/Maureen)/CLC Manager (Cindy)</td>
<td>Written Educational Information</td>
<td>This is an ongoing activity. Annual report due 6/30/10</td>
</tr>
<tr>
<td>Reduce disproportionate out-of-home placements in the Placer County Native Community</td>
<td>Participate in the Disproportionality Project sponsored by the Annie E Casey Foundation and CDSS. 1) Attend learning conversations in 09-10. 2) Explore CWS Native Services Team Development (collaboration of Native county staff in CWS and On-</td>
<td>CLC Committee/Lead: CLC Manager (Cindy); Native Liaison (Anno Nakai)</td>
<td>Avatar Minutes and project development document</td>
<td>Due: 6/30/10 Completed:</td>
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</tbody>
</table>
going teams and Native Liaison for Best Practices implementation).

| Provide trainings based on the cultural competence needs assessment | To continue to improve cultural competence and experiences of SOC staff through trainings based on the needs assessment. Trainings for 2009-2010 to be held include: Improving Outcomes for Native Youth and Families (March 3); Big Time Pow Wow - Honoring Family and Children of Yesterday and Today (Oct 17); Recovery Happens (Sept 19); Leaing Out of Spring (April 25); Lesbian, Gay, Bisexual, Trans-gender, and Questioning Youth (Jan 12); Identifying Gifts, Talents, and Skills: Using Powerful New Capacity Assessment Tools (March 11). | CLC Committee/Lead: CLC Manager (Cindy) | CLC Minutes and List of Trainings | Due: 6/30/10 Completed: |

| Assess bilingual staff and interpreter skills and provide appropriate training | Provide annual training for interpreters and use of interpreters. | CLC Committee/Lead: CLC Manager (Cindy) | CC Minutes Training Flyer, sign-in sheet | Due: 6/30/10 Completed: |

| Increase consumer involvement in SOC Programs and Activities | Ensure attendance of Consumer Navigator (county employee) and/or Consumer/Family Member or Youth Advocate employee of UACF to attend System of Care QI meetings, participate in improvement activities, and give feedback to the SOC about program satisfaction and enhancement. | Client & Family Relations/Lead: CLC Manager, QI Manager, and UACF Director | QIC rosters; Welcome Center feedback; workgroup membership | Due: 6/30/10 Completed: |
### Increase consumer involvement in SOC Programs and Activities
Ensure attendance of Consumer Navigator (county employee) and/or Consumer/Family Member or Youth Advocate employee of UACF to attend System of Care QI meetings, participate in improvement activities, and give feedback to the SOC about program satisfaction and enhancement.  
Client & Family Relations/Lead: CLC Manager, QI Manager, and UACF Director  
QIC rosters; Welcome Center feedback; workgroup membership  
Due: 6/30/10  
Completed:

### Track staff participation in trainings and presentations
Develop, add local trainings, and implement training tracking system through Trilogy Inc., with the E-Learning training module for HHS System of Care (ASOC and CSOC staff).  
CLC Committee/Lead: Training supervisors Jennifer Cook and Cindy Bigbee  
Manager reports of staff attendance - baseline year  
Due: 6/30/10  
Completed:

### Cultural and Linguistic Competency Plan Work Group (Items and Goals developed from Summary Recommendations)

#### 1.1 Organizational Values: To engage executive leadership, management, and line staff in a joint effort to embrace cultural curiosity and competency as a core value across the system of care.

1. Review CLC Charter and to strengthen values statement.  
   Lead: CLC Committee  
   Charter Review  
   Due: 9/30/10

2. Review and revise CSOC and ASOC Mission Statements to include cultural competence.  
   Lead: ASOC Managers, CSOC Managers  
   Mission Statement Review  
   Due: 12/30/10

3. Include increasing diversity of leadership as topic in FY 10-11 SMART Policy Board retreat.  
   Lead: HHS-Director (Richard Burton) and CSOC Director (Richard Knecht)  
   Review of Retreat Minutes  
   Due: 3/30/10

#### 1.2. SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.

1. Institute "Guiding Principles Awards" across the SOC to honor cultural curiosity and growth.  
   Lead: ASOC Director (Maureen Bauman); CSOC Director (Richard Knecht)  
   Review Awards  
   Due: 12/30/10

2. Develop a training team to assist staff with integrating values and behaviors.  
   Lead: QI Manager (Twylla Abrahamson); ASOC Program Manager (Cheryl Trenwith)  
   Appoint coordinator for training activities  
   Due: 9/30/10

3. Include cultural awareness as part of staff orientation and evaluation.  
   Lead: ?  
   Plan for Staff Training  
   Due: 12/30/10

4. Educate managers and supervisors on the  
   Lead: ?  
   Managers Minutes  
   Due: 6/30/10
| 1.3. SOC staff will create avenues for diverse staff and community members to serve as resources for learning. | 1) Construct and administer a survey to determine diversity resources among staff, contract providers and community partners, and willingness of same to become resources for others.  
2) From survey results above, create resource list for distribution.  
3) Construct and administer survey to determine if persons listed as resources were contacted throughout the year, and whether those that contacted same resources felt they had been assisted in a competent manner. | Lead: CLC Committee  
Lead: QI/MCU Manager (Twylla Abrahamson)  
Lead: QI/MCU Manager (Twylla Abrahamson) | Completion of Survey  
Submit report and distribute resource list  
Completion of Survey; Report results to QIC | Due: 9/30/10  
Due: 12/30/10  
Due: 6/30/11 |
| 2.1 SOC leadership will increase cultural diversity in policy making and governance processes. | 1) (2.1.3) Increase diversity of membership in SOC Quality Improvement Committee.  
2) (2.1.3) Review membership in SPEAC with Placer County SMART Policy Board and set goals for increasing the cultural diversity of membership.  
3) (2.2.3) Address the barriers in current policies that limit culturally relevant practices via creation of an inclusive policy revision committee that includes community partners and consumers.  
4) (2.1.4) Create a diagram and process description that reflects a cross system approach to staff and consumer | Lead: QI/MCU Manager (Twylla Abrahamson)  
Lead: CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)  
Lead: CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman)  
Lead: QI/MCU Manager (Twylla Abrahamson); Cultural Liaison Anno Nakai | Percentage of membership and cultural diversity  
Documentation of goals set for membership  
Creation of Committee and report on cultural membership  
Completion of diagram/process description | Due: 6/30/11  
Due: 6/30/11  
Due: 6/30/11  
Due: 9/30/11 |
<p>| 2.2 SOC Managers and Supervisors will take a strengths based approach to policy development that promotes involvement of consumers and line staff. | 1) (2.1.1) Store all SOC policies in a folder on the T: Drive that is accessible by all staff. | Lead: CSOC Director (Richard Knecht) and ASOC Director (Maureen Bauman) | Creation and organization of folder | Due: 12/30/10 |
| | 2) Provide training and education on this central source for access to policy information across SOC. | Lead: Training supervisors Jennifer Cook and Cindy Bigbee | Training materials notifying staff of policy location | Due: 6/30/11 |
| | 3) (2.2.2) Conduct two (2) leadership development classes in FY2010-11 focusing on use of a participatory management style and inclusion of staff and consumers in policy development. | Lead: CLC Committee and Community Resources | Scheduling of trainings | Due: 6/30/11 |
| | 4) (2.2.2) Increase accuracy of indicators for cultural representation of consumers in mental health services by ensuring completion of the CSI fields in AVATAR. This may be a problem. The delay date in DMH CSI data is about 2 years | Lead: QI/MCU Manager (Twylla Abrahamson) | Use latest CSI data report from Department of Mental Health (FY06-07) as baseline. | Due: 7/30/11 |
| 2.3 The Change Agents for Co-occurring Disorders Workgroup will provide a framework, guidance, inspiration and accountability and encourage system transformation and improvement efforts for private and government service providers | The Change Agents for Co-Occurring Disorders Workgroup will keep Soc and community providers informed and involved in their transformational efforts | Change Agents Workgroup, CLC Committee, QI Committee | E newsletters, Progress reports, Staff training | 6-30-11 |
| 3.1 Communication and Collaboration: SOC Managers will develop resources for increasing multi-cultural/lingual materials and services and create | 1) Develop resources for increasing multi-cultural/lingual materials and services and create | Lead: SAMHSA Manager (Cindy Brundage) and Native Liaison anno Nakai | Evaluation Reports on PEI services; White Bison activities; | Baseline Due: 6/30/10 |</p>
<table>
<thead>
<tr>
<th>Effective community-based strategies to increase multicultural and multilingual communication and collaboration.</th>
<th>a list of local or community cultural supports and mentors.</th>
<th>Lead: CLC Committee and SOC Development Committee</th>
<th>Pow Wow; Expansion of Promotoras; Reports on SAMHSA contract services; NP specialized services list</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Assist schools in creating a list of local community cultural supports and mentors for schools and organizations.</td>
<td>2) (4.3) Include culturally diverse community partners in review of service plans for appropriate families in Smart Management Team and Placement Review Team.</td>
<td>Lead: ?</td>
<td>Report on involvement of community based resources in family team process.</td>
</tr>
<tr>
<td>3.2 SOC Staff will integrate multicultural and multilingual communication strategies into a community-based model of care.</td>
<td>1) Integrate Native American/American Indian and Latino services Team into CSOC through 90% of appropriate referrals ending up on the service correct team.</td>
<td>Lead: CSOC Service Program Managers (Debbie Drake and Candyce Skinner)</td>
<td>Development of measurement tool by 9/30/10. Report due 6/20/11</td>
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<td>Due: 6/30/10</td>
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<tr>
<td>3.3 Add a section to the Guide to MediCal Services Member Handbook that addresses culturally diverse service options</td>
<td>Convene a sub-committee of the CLC Committee and the QI Committee to develop an addendum to the Member Handbook detailing the information on the culturally diverse service options in Placer County.</td>
<td>CLC Committee, CFR Committee, QI Committee</td>
<td>Copy of the Addendum 6-30-11</td>
</tr>
<tr>
<td>3.4 Develop an expanded budget for CLC translation and interpretation services</td>
<td>Develop a contract with a certified translator for translation of all materials. Assure translation and interpretation is accurate and at the appropriate reading level.</td>
<td>Mental Health Director, CSOC Director, SOC leadership, CLC Committee</td>
<td>Engage the LLC in developing a tool and monitoring process to assure accuracy and appropriateness 6-30-11</td>
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<tr>
<td>3.5 Review LLC</td>
<td>Convene a sub-</td>
<td>CLC Committee, the</td>
<td>Engage Soc 6-30-11</td>
</tr>
<tr>
<td>Survey Findings Regarding Unavailability of Interpreters and Develop a Solution</td>
<td>Committee of the CLC Committee and Members of the LLC to Review Survey Findings and Create a Proposal for Solution</td>
<td>LLC, SOC Leadership and Staff and LLC in Developing a Proposal for Resolution</td>
<td></td>
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</tbody>
</table>
| **4.1 Human Resource Development:** Expand the Skills, Experiences and Composition of SOC Human Resources to Better Serve Consumers from Diverse Cultures and Communities | **1) Promote Attendance in the Cultural Awareness Activities.** | **Lead:** SAMHSA Manager (Cindy Brundage) **Increase Average Monthly Participation by 50%**  
**Report on Number of Cultural Trainings Included.**  
**Due:** 6/30/11 |
| 2) Film All Cultural Trainings, Including Cultural Awareness Fridays, for Inclusion in the SOC e-Learning Library. | **Lead:** SAMHSA Manager (Cindy Brundage) | **Report on Percent Participation**  
**Due:** 6/30/11 |
| 3) Require Service Delivery, Supervisory and Management Staff to Participate in a Minimum of One (1) Training on Cultural Diversity Per Year. | **Lead:** ASOC Director (Maureen Bauman) and CSOC Director (Richard Knecht) | **Review of Trainings Held**  
**Due:** 6/30/11 |
| 4) Allocate Resources for Trainings Through a Variety of Venues, Including e-Learning, Experiential Opportunities and Local Trainings from Specific Cultural Backgrounds Through CLC. | **Lead:** CLC Committee | **SMT Minutes Review**  
**Due:** 12/31/10 |
| 5) Integrate Cultural Brokers into SMT as a Linkage to Community Resources via Invitation to SMT When a Native or Latino Youth/Family Is Involved. | **Lead:** SMT Scheduler | **Incorporate into Standard Review of Charts**  
**Due:** 6/30/11 |
<p>| 6) Review Intake, Assessment Forms, Planning Tools and Practices. | <strong>Lead:</strong> ? | <strong>Due:</strong> 6/30/11 |
| 7) Workers Will Document Efforts to Engage Cultural Brokers and Community Partners When Working with Families of Diverse Cultures. | <strong>Lead:</strong> MCU Auditor (Derek Holley) | <strong>Due:</strong> 6/30/11 |</p>
<table>
<thead>
<tr>
<th>4.2 Assure that cultural and linguistic competence strategies are addressed as the WET Plan is operationalized</th>
<th>Members of the CLC Committee also serve on the WET Advisory Committee. CLC Representatives will inform the decisions of the WET Advisory Committee on the need to address cultural competence</th>
<th>CLC Members, WET Advisory Committee</th>
<th>WET Plan Updates</th>
<th>6-30-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3 Train staff to request, obtain and document translated clinical findings and reports</td>
<td>Develop a contract with a certified translator in order to translate clinical findings and reports for consumers and their families</td>
<td>SOC Leadership, CLC Committee, QI Committee</td>
<td>Copies of translated clinical documents</td>
<td>6-30-11</td>
</tr>
<tr>
<td>4.4 Provide all staff the opportunity of engaging in “Courageous Conversations”</td>
<td>Provide training to all leadership staff on the Power Wheel Dynamics and Courageous Conversations. Provide opportunities for Courageous Conversations</td>
<td>SOC Leadership</td>
<td>Training Rosters</td>
<td>6-30-11</td>
</tr>
<tr>
<td>4.5 Client Sensitivity Training is an annual required training for all staff</td>
<td>Placer Client/Family Relations Committee will provide opportunities for Client Sensitivity Training 4 times a year</td>
<td>CFR Manager and Committee, SOC Leadership and Supervisors</td>
<td>Quarterly training opportunities and rosters, Trilogy tracking system</td>
<td>6-30-11</td>
</tr>
<tr>
<td>5. 1 Consumer/Community Development: SOC management will create pathways for consumers and diverse community partners to participate in SOC policy development, service planning, delivery and evaluation</td>
<td>1) Redesign two (2) management team meetings per month to be Community Service and Support Teams with full decision making ability. 2) Increase cultural diversity in the membership of the Mental Health, Alcohol and Other Drug Advisory Board. 3) Increase culturally diverse membership in the Quality Improvement Committee</td>
<td>Lead: CSOC Director (Richard Knecht) Lead: ASOC Director (Maureen Bauman) Lead: QI/MCU Manager (Twylia Abrahamson)</td>
<td>Set ongoing time for meeting Survey of cultural diversity Report on membership</td>
<td>Due: 9/30/10 Due: 9/30/10 Due: 6/30/11</td>
</tr>
<tr>
<td>5.2 SOC Managers will develop resources, workplace practices and</td>
<td>1) (5.2.2) Increase culturally diverse Peer Advocate and Navigator positions in the Welcome</td>
<td>Lead: ASOC Director (Maureen Bauman)</td>
<td>Report on added culturally diverse</td>
<td>Due: 6/30/11</td>
</tr>
<tr>
<td>6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.</td>
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<tr>
<td>1) (6.2.2) Create a community-based evaluation process for the Mental Health Services Act – Prevention and Early Intervention tract.</td>
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<td>Lead: CSOC Supervisor (Jennifer Cook); PEI Evaluation Team</td>
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<tr>
<td>Implementation of community-based and culturally diverse evaluation process</td>
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<td>Due: 9/30/10</td>
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<td>2) (6.2.7) Work with community partners to redesign the Placer County Outcome Screen to include culturally relevant measures of family and consumer skills.</td>
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<td>Lead: CSOC Supervisor (Jennifer Cook); PEI Evaluation Team</td>
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<td>Implementation of new Outcome Screen</td>
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<td>Due: 6/30/11</td>
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<td>3) Develop contract guidelines to ensure that community-based organizations conduct cultural and linguistic competency self-assessment and planning.</td>
<td></td>
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<tr>
<td>Lead: Contract monitors (Doreen Drake and Steve Martinson)</td>
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<tr>
<td>Included in contract &quot;boiler plate&quot; language</td>
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<td>Due: 12/31/10</td>
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</tbody>
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<table>
<thead>
<tr>
<th>6.2 Contract providers will be culturally competent</th>
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</thead>
<tbody>
<tr>
<td>Placer SOC will hold contractors accountable for the recruitment, training and retention of a culturally and linguistically competent staff. In addition, contract providers will strive for culturally competent organizational structures, environments and Boards of Directors.</td>
</tr>
<tr>
<td>CLC Committee, QI Coordinator; Contract leads</td>
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<tr>
<td>Quarterly and annual provider reports; site visits</td>
</tr>
<tr>
<td>6-30-11</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>6.3 SOC staff and community-based organizations will work together to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) (6.2.2) Create a community-based evaluation process for the Mental Health</td>
</tr>
<tr>
<td>Lead: PEI Evaluation Team</td>
</tr>
<tr>
<td>Implementation of community-based and culturally</td>
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<tr>
<td>Due 12/30/10</td>
</tr>
</tbody>
</table>
Ensure a high level of community satisfaction and ownership of mental health services.

2) Create cross systems strategies to review racism in the education system, by inviting school representatives to attend Campaign for Community Wellness meetings in targeted areas.

| Services Act – Prevention and Early Intervention tract. | Lead: Family Advocate (Christi Meng); Consumer Advocate (Katrina Moser) | Documentation of Invitations | Due: 12/30/10 |
APPENDIX E
CC TRAINING ACTIVITIES

APPENDIX E-1  CLC Training Activities 2008/2009
APPENDIX E-2  CLC Training Activities 2009/2009
APPENDIX E-3  CLC Training Activities 2007/2008/2009
APPENDIX E-4  Training Eval Summary
APPENDIX E-5  Training Eval Summary
APPENDIX E-6  Training Eval Summary
APPENDIX E-7  Training Eval Summary
APPENDIX E-8  Training Eval Summary
APPENDIX E-9  Training Eval Summary
APPENDIX E-10  Training Eval Summary
APPENDIX E-11  Training Eval Summary
# APPENDIX E-1

## Placer County Systems of Care

*Culturally Competent Training Activities*

**2008/2009**

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>Length/Frequency</th>
<th>Attendance by Function</th>
<th>No. of Attendees (and Total)</th>
<th>Date of Training</th>
<th>Name of Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurtured Heart</td>
<td>Teaching an extraordinary approach that has extraordinary results with ADHD and other challenging behaviors. An approach that helps all children to flourish beyond normal expectations.</td>
<td>7 hours</td>
<td>Admin./Mgmt</td>
<td>1/31/9</td>
<td>8/13/08</td>
<td>Tom Grove and Gabrielli LaChiara</td>
</tr>
<tr>
<td>5150 Certification</td>
<td>An overview of LPS law and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt</td>
<td>3/3</td>
<td>8/20/08</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Community Mental Health - Wellness, Recovery, Belonging</td>
<td>Helping staff understand some of the underlying analysis and principles for community mental health as it relates to Placer County and working with our community partners</td>
<td>3 hours</td>
<td>Admin./Mgmt</td>
<td>9/85/17</td>
<td>9/17/08</td>
<td>John Ott</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
<td>Date of Training</td>
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<tr>
<td><strong>Motivating &amp; Empowering Parents</strong></td>
<td>Examination of: (1) the concept of motivation and its application in working with abusive and neglectful parents (2) process of change (3) ways to help client's feel empowered to make changes</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>Total:7</td>
<td>11/18/08</td>
<td>UCD - Ed Pieczneik, LCSW</td>
</tr>
<tr>
<td><strong>5150 Certification</strong></td>
<td>An overview of LPS law and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>Total:11</td>
<td>11/19/08</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Tools for</td>
<td>7 hours</td>
<td>Admin./Mgmt</td>
<td>1</td>
<td>12/11/08</td>
<td>Sharon Kuehn</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
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<tr>
<td>Wellness - Client's Perspective</td>
<td>understanding the client culture and perspective and developing a Wellness Recovery Action Plan (WRAP)</td>
<td></td>
<td>Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>15</td>
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<td>Total:16</td>
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<tr>
<td>Suicide Prevention Assessment</td>
<td>Risk factors – Which ones are the highest priority? Assessment process tasks which ones not to leave out! When to hospitalize, when to do a safety plan. Considering collateral information and cultural context. Use of probable cause. Working with the families, (including after a suicide).</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>1</td>
<td>1/5/09</td>
<td>Ben Lopez</td>
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<tr>
<td></td>
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<td>Total:21</td>
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<td>Risk factors – Which ones are the highest priority? Assessment process tasks which ones not to leave out! When to hospitalize, when to do a safety plan. Considering collateral information and cultural context. Use of probable cause. Working with the families, (including after a suicide).</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>41</td>
<td></td>
<td>Ben Lopez</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Total:41</td>
<td></td>
<td>1/12/09</td>
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<tr>
<td>Training Event</td>
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<td>Risk factors – Which ones are the highest priority? Assessment process tasks which ones not to leave out! When to hospitalize, when to do a safety plan. Considering collateral information and cultural context. Use of probable cause. Working with the families, (including after a suicide).</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>33 Total:33</td>
<td>2/21/09</td>
<td>Ben Lopez</td>
</tr>
<tr>
<td>Benificiary Protection Training</td>
<td>Managed Care Overview: Update on audits, Q&amp;A. Medi-Cal regs governing our responsibility to beneficiaries. Medi-Cal regs regarding documentation. Info on NOA req. Info on Ombudsman services</td>
<td>3 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>1 2 15 Total:22</td>
<td>2/27/09</td>
<td>Tom Lind, Michelle Johnson, Linda Helling</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
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<tr>
<td>5150 Certification</td>
<td>Overview of LPS and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>3 Total:3</td>
<td>3/10/09</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Working with Adolescents</td>
<td>Examines developmental issues of adolescence; impact of foster care; strategies for helping teens, parents, and foster parents cope with adolescents</td>
<td>6 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>25 3 Total:32</td>
<td>4/29/09</td>
<td>ICD - Margaret Cordero, MA</td>
</tr>
<tr>
<td>5150 Certification</td>
<td>An overview of LPS law and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>3 Total:3</td>
<td>5/6/09</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Job Retention for clients in Employment</td>
<td>Workshop provides training and technical assistance covering the basics of traditional job coaching while emphasizing</td>
<td>7 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>6 3 Total:9</td>
<td>5/14/09</td>
<td>Michele Lewis, Christa Reed, and Stephen Simmonson - Crossroads Employment Services</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
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<tr>
<td>Aging and long-Term Care</td>
<td>the importance of developing a system of supports and barrier resolution throughout the provision of services. Participants receive instruction regarding techniques for on-site intervention as well as off-site strategies beyond the traditional mental health and rehabilitation systems</td>
<td>6 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>15 Total:15</td>
<td>5/14/09</td>
<td>UCD-Douglas Kaplan</td>
</tr>
<tr>
<td>Youth and Gang Violence</td>
<td>Addresses the growing concern with youth and gang violence. Topics customized to fit unique needs of individual counties and</td>
<td>6 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>19 5 Total:24</td>
<td>5/27/09</td>
<td>UCD - Kenneth Bell</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
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</tr>
<tr>
<td>Training Event</td>
<td>communities. Gain a better understanding of etiology of youth and gang violence, and prevention and intervention</td>
<td></td>
<td>Comm. CBO/Agcy. B of Dir.</td>
<td></td>
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</tr>
<tr>
<td>Connecting Employment with Recovery</td>
<td>Changing the way we engage with those we serve and the communities they live in in order to support client-focused, culturally, and co-occurring competent practice</td>
<td>8 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>2 23 8</td>
<td>6/4/09</td>
<td>Mark Ragins, LCSW</td>
</tr>
</tbody>
</table>
## APPENDIX E-2

### Placer County Systems of Care

**Culturally Competent Training Activities**

**FY2009/2010**

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>Length/ Frequency</th>
<th>Attendance by Function</th>
<th>No. of Attendees (and Total)</th>
<th>Date of Training</th>
<th>Name of Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5150 Certification</td>
<td>An overview of LPS law and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>5 1 1 Total:7</td>
<td>7/22/09</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Nurtured Heart</td>
<td>Teaching an extraordinary approach that has extraordinary results with ADHD and other challenging behaviors. An approach that helps all children to flourish beyond normal expectations.</td>
<td>7 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>95 6 2 48 4 Total:155</td>
<td>8/13/09</td>
<td>Tom Grove, MFT</td>
</tr>
<tr>
<td>Nurtured Heart</td>
<td>Teaching an extraordinary approach that has extraordinary results with ADHD and other challenging behaviors. An approach that helps all children to flourish beyond normal expectations.</td>
<td>7 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>28 82 Total:110</td>
<td>8/14/09</td>
<td>Tom Grove, MFT</td>
</tr>
<tr>
<td>Beneficiary Protection</td>
<td>Understanding: The role of the Patient's Rights Advocate. The role of Ombudsman.</td>
<td>3 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services</td>
<td>3 4</td>
<td>8/20/09</td>
<td>Tom Lind, Linda Helling, Derek Holley</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
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<tr>
<td>Our appeal and grievance process and basic Patient's Rights. Knowledge about Notice of Action and Advanced Health Care Directives.</td>
<td>5.5 hours</td>
<td>General Public Interpreter, MH Board &amp; Comm., CBO/Agcy. B of Dir.</td>
<td>3 2 1</td>
<td>Total: 7</td>
<td>12/23/09</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>5150 Certification</td>
<td>An overview of LPS law and Patient's rights</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services, General Public Interpreter, MH Board &amp; Comm., CBO/Agcy. B of Dir.</td>
<td>1 23 8</td>
<td>1/20/10 and 1/21/10</td>
<td>Willy Wilkinson</td>
</tr>
<tr>
<td>Culturally Competent Approaches to serving LGBT Populations</td>
<td>Topics covered include: terms and concepts associated with the LGBT community, the myriad socioeconomic, health-related, and legal issues that LGBT people face, how to show respect to the LGBT community through culturally appropriate language and behavior, treatment strategies and service approaches for working with LGBT individuals, methods for identifying and utilizing LGBT resources and referrals,</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Supp. Svcs., Gen. Public Interpreter, MH Board &amp; Comm., CBO/Agcy. B of Dir.</td>
<td>1 23 8</td>
<td>1/20/10 and 1/21/10</td>
<td>Willy Wilkinson</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
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<tr>
<td>Hope Lives HIV/AIDS HED/STD 101</td>
<td>This is a basic HIV/AIDS/HEP/STD training for providers to use for harm reduction and prevention messages with their clients. Consideration for specific norms of homeless, youth and drug cultures are discussed.</td>
<td>3 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Supp. Svs., Gen. Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>17 18</td>
<td>1/26/10</td>
<td>Candace Jones</td>
</tr>
<tr>
<td>Foster Youth and Homeless Education</td>
<td>Laws intended to improve educational opportunities, stability, and outcomes for Foster youth with a particular focus on recent legislation</td>
<td>3 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Supp. Svs., Gen. Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>4 13 2 40 2 Total:61</td>
<td>3/2/10</td>
<td>Marisol Avina, Jesse Hahnel, and Lenore Silverman</td>
</tr>
<tr>
<td>Identifying Gifts, Talents, and Skills: Using Powerful New Capacity Assessment Tools</td>
<td>Recognizing that a strength is not simply a strength, but a skill. Learning the difference and using each of these qualities in the appropriate way is vital to laying a foundation for planning, problem-solving and support</td>
<td>6 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>39 2 Total:41</td>
<td>3/11/10</td>
<td>Bruce Anderson</td>
</tr>
<tr>
<td>Wraparound</td>
<td>Teaching the</td>
<td>12 hours</td>
<td>Admin./Mgmt</td>
<td></td>
<td>3/24/10</td>
<td>Sharon</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
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<tr>
<td>In Action: Skill Building for Guiding the Wraparound Process</td>
<td>Wraparound process includes using planning strategies, understanding and negotiation team dynamics, and using excellent people skills. Assisting in providing the foundations for facilitators, child and family specialists, and parent-partners to implement the Wraparound philosophy and processes.</td>
<td>total</td>
<td>Dir. Svvs., County Dir. Svvs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>25 5</td>
<td>3/25/10</td>
<td>Morrison-Velasco, Margaret Maxwell</td>
</tr>
<tr>
<td>5150 Certification</td>
<td>An overview of LPS law and Patient's rights</td>
<td>5.5 hours</td>
<td>Admin./Mgmt Dir. Svvs., County Dir. Svvs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>3 10</td>
<td>3/26/10</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>5150 Recertification (only)</td>
<td>A review of LPS law and Patient's rights</td>
<td>1.5 hours</td>
<td>Admin./Mgmt Dir. Svvs., County Dir. Svvs., Contract Support Services</td>
<td>3</td>
<td>4/21/10</td>
<td>Linda Helling</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
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<td>Date of Training</td>
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<tr>
<td>Hope at Work</td>
<td>This training focuses on 3 critical areas for building a hopeful and resilient work culture.</td>
<td>6 hours</td>
<td>Admin./Mgmt Dir. Svvs., County Dir. Svvs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>Total:3</td>
<td>4/22/10</td>
<td>Bruce Anderson</td>
</tr>
<tr>
<td>Law Enforcement Crisis Intervention Training Academy</td>
<td>4-day training curriculum designed to enable participants to recognize symptoms of mental illness, need for treatment and proper treatment resources and referrals. Cultural Awareness is a specific course section aothough cultural considerations are included in all sections</td>
<td>4 days/ once a year</td>
<td>Admin./Mgmt Dir. Svvs., County Dir. Svvs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>Total:24</td>
<td>5/20/10</td>
<td>Sgt Carlos Ponce taught the Cultural Awareness Section. 15 other trainers also involved in the 4 day series.</td>
</tr>
<tr>
<td>Hope at Work</td>
<td>This training focuses on 3 critical areas for building a hopeful and resilient work culture.</td>
<td>4 hours</td>
<td>Admin./Mgmt Dir. Svvs., County Dir. Svvs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>Total:86</td>
<td>5/25/10</td>
<td>Bruce Anderson</td>
</tr>
<tr>
<td>Creative</td>
<td>The session is a</td>
<td>6 hours</td>
<td>Admin./Mgmt</td>
<td></td>
<td>5/26/10</td>
<td>Bruce</td>
</tr>
</tbody>
</table>

159
<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>Length/ Frequency</th>
<th>Attendance by Function</th>
<th>No. of Attendees (and Total)</th>
<th>Date of Training</th>
<th>Name of Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving</td>
<td>mixture of presentation, reflection on personal styles and attributes, and practice in small groups solving real-life issues. The focus is on building skills for time-limited focused problem solving with individuals and groups taking into context culture, context and objective.</td>
<td>9 hours</td>
<td>Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>9 1</td>
<td></td>
<td>Anderson</td>
</tr>
<tr>
<td>Recovery Oriented Leadership</td>
<td>The purpose of this event is to provide leaders with reflective and action-planning time to expand their awareness of how the principles of Recovery can be used within a leadership framework to increase the hopefulness, productivity, and health of the leader, other employees, and the organization they work in. Outcomes for the seminar include increased leadership understanding and commitment to Recovery values and principles, and practical plans for using the principles of</td>
<td>9 hours</td>
<td>Admin./Mgmt Dir. Svs., County Dir. Svs., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>3 3 2 1</td>
<td>6/8/10</td>
<td>Bruce Anderson</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>Length/ Frequency</td>
<td>Attendance by Function</td>
<td>No. of Attendees (and Total)</td>
<td>Date of Training</td>
<td>Name of Presenter(s)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Hooked on Gambling: The new Addiction</td>
<td>Recovery to create hope, commitment, and action in your organization.</td>
<td>3 hours</td>
<td>Admin./Mgmt Dir. Sv., County Dir. Sv., Contract Support Services General Public Interpreter MH Board &amp; Comm. CBO/Agcy. B of Dir.</td>
<td>11 8 2</td>
<td>6/16/10</td>
<td>Peggy Thomas, Ontrack Consulting</td>
</tr>
</tbody>
</table>
Old records need to be retrieved and reviewed to ascertain the pertinent training attendance information on the following trainings. Information will be provided to DMH by 9/30/2010.

<table>
<thead>
<tr>
<th>Topics</th>
<th>Date(s)</th>
<th>Check box if staff from each agency/organization attended that training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family-Driven Care</strong></td>
<td></td>
<td><strong>Grant staff</strong></td>
</tr>
<tr>
<td>1. Attachment, Separation &amp; Loss</td>
<td>1/17/08</td>
<td>X</td>
</tr>
<tr>
<td>2. Creating Successful Alliances with Birth Families</td>
<td>2/06/08</td>
<td>X</td>
</tr>
<tr>
<td>3. Working with Adolescents</td>
<td>2/7/08</td>
<td>X</td>
</tr>
<tr>
<td>4. Behavior Intervention Strategies</td>
<td>6/18/08</td>
<td>X</td>
</tr>
<tr>
<td>5. Stage Matched Treatment Planning</td>
<td>6/19/08</td>
<td>X</td>
</tr>
<tr>
<td>7. Engaging Nonvoluntary &amp; Working with Resistance</td>
<td>9/16/08</td>
<td>X</td>
</tr>
<tr>
<td>9. Social Work Values &amp; Ethics</td>
<td>10/22/08</td>
<td>X</td>
</tr>
<tr>
<td>10. Motivating &amp; Empowering Parents</td>
<td>11/18/08</td>
<td>X</td>
</tr>
<tr>
<td>11. Family Systems Practice</td>
<td>12/16/08</td>
<td>X</td>
</tr>
<tr>
<td>12. Preparing Foster Youth for Reunification</td>
<td>2/06/29</td>
<td>X</td>
</tr>
<tr>
<td>13. Foster Parent Empowerment</td>
<td>2/06/09</td>
<td>X</td>
</tr>
<tr>
<td>#</td>
<td>Topic</td>
<td>Date</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>15.</td>
<td>Advocacy in Education</td>
<td>3/5/09</td>
</tr>
<tr>
<td>16.</td>
<td>Structured Decision Making</td>
<td>10/17/07</td>
</tr>
<tr>
<td></td>
<td><strong>Cultural Competence</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Tribal Star Training – Train the Trainer</td>
<td>7/25&amp;26/07</td>
</tr>
<tr>
<td>2.</td>
<td>Working with Families as a Translator</td>
<td>9/05/07</td>
</tr>
<tr>
<td>3.</td>
<td>Cultural Competency in BH – Leadership</td>
<td>9/19/07</td>
</tr>
<tr>
<td>6.</td>
<td>Strong Families &amp; Great Communities – Roberto Dansie</td>
<td>3/30/08</td>
</tr>
<tr>
<td>7.</td>
<td>The Role of Culture in Healing – Roberto Dansie</td>
<td>3/31/08</td>
</tr>
<tr>
<td>8.</td>
<td>RAICES/Promotoras MH Training – Train the Trainer</td>
<td>9/15-19/08</td>
</tr>
<tr>
<td>11.</td>
<td>Culturally Competent Case Management</td>
<td>09/25/07</td>
</tr>
</tbody>
</table>
APPENDIX E-4

TRAINING EVALUATION SUMMARY

TRAINING TITLE  Mental Health Wellness- Client’s Perspective
                Dec 11, 2008

INSTRUCTOR(S)  Sharon Kuehn / Williams
FACILITY        Auburn Memorial Hall

RATING SYSTEM – average of ratings
1= YES          0= NO

NUMBER OF PARTICIPANTS:  15 attending / 14 evaluations

1) Was the session interesting?  1.0
2) Was the presenter(s) well informed and organized?  1.0
3) How effective was the trainer in presenting the information?
   Worked well together
   Extremely
   They knew what they were reping and they had great smiles.
   The trainers and written material was very effective in teaching about the
   WRAP.
   Very effective.
   Informative & uplifting & educational.
   Very effective.
   Excellent – poignant – relevant & engaging.
   Very well.
   Good Presentation.
   Good.
   Great!
   Most Effective.
   Very effective and fun.

4) How was the topic relevant to your job/responsibilities?
   Very relevant now & always.
   Future responsibilities – considering NAVIGATOR PROGRAM.
   I had a problem and I was able to get rid of the problem.
   It’s relevant in staying well on the job.
   Very relevant.
   My wellness affects my work – when I’m well, I work well.
   NA
   Relevant & overdue !!!
   Fairly relevant.
   Work daily with those in recovery and/or co-occurring.
   Good to pass on.
Great to my mental health. This came at a perfect time for me as I currently have a client in crisis. However it is also very relevant for clients not in crisis. As a consumer it will be very helpful for me to write a WRAP.

5) Were the materials easy to follow and informative? 1.0

6) How did the session energize, stimulate or motivate you to try something new or different? 
This is very helpful in giving me ideas for individual & group counseling. Great!
OK
How to help clients take more involvement in their recovery.
I’d like to meet with some friends & co-workers after work and have a support group & start possibly WRAP plans.
With engaging interactive presentation of relevant & new information.
It motivated me to make a wellness tool box and action and crisis plan.
The crisis plan & inclusion of people I trust is very important & something I need to do.
On a scale of 1 to 10 – 10.
Trying new things in managing my symptoms in dance.
Very good.
Learning the points exercise & doing the yoga & dancing & laughter.
Absolutely.
With a lot of new information.

7) What suggestions do you have for improving the session?
Less need to focus on follow-up schedule (other than Murphy’s override.)
Well done! Thanks.
I don’t think it can be improved.
It’s great the way it is.
Have another one.
Always having a toilet available; total commitment on part of facilitators/building management.
Work with improving the projector.

8) Was there something in the session that you’d like more information or a follow up session on?
All of it – especially Ron to teach the subject.
No.
Very interesting & peaceful – very inspiring.
No – all great wi/me.
No.
Completing the plan.
The dance.
It was sufficient.
Acupuncture & movement in general.
List of resources.
I wish we had more time.
APPENDIX E-5

TRAINING EVALUATION SUMMARY

TRAINING TITLE    Suicide Prevention Assessment
January 5, 2009  8:00 AM – 12:30

INSTRUCTOR(S)    Ben Lopez

FACILITY    PCOE Annex, Auburn
RATING SYSTEM  1=Not applicable   2=Unsatisfactory   3=Fair   4=Good   5=Excellent

NUMBER OF PARTICIPANTS    21 attending / 18 evaluations

CONTENT
The information presented met or exceeded my expectations  4.83
The information was presented clearly  4.89
The information was relevant  4.89
The information presented provided a broad overview  4.89

QUALITY
The written materials were helpful  4.83
Presenter had a thorough knowledge of subject matter  5.00
Presenter had ability to relate subject in a meaningful way  4.94
Presenter answered questions clearly and concisely  4.89

VALUE
The training increased my understanding  4.83
The training provided insights that are relevant to my work  4.83
I will be able to apply what I learned at work  4.78

TRAINING FACILITY
The facility was comfortable  4.44
The facility was a good learning environment  4.22

PARTICIPANT’S OVERALL RATING    4.88

COMMENTS/SUGGESTIONS

Needed a day. Too much noise.
Excellent with beginning with questions. Also vignette provided a great beginning process. Surprised to learn more here from previous crisis sources.
Very good.
Jan 5th class shared partition noisy experience. Speaker handled challenge well. Very good class, thank you.
Aside from the noise in the room next door, the facility was adequate. I really enjoy the style of the opening. It was very informal, as was the presenter/ but also professional. Excellent training covering important elements of assessing for suicide within a half day training.
I really enjoyed Ben’s presentation. He has a wealth of knowledge experience applicable to my area of study.
Great training, Ben Lopez’s teachings rings true, the voice of experience, thanks.
Not much room for improvement. Best training I have had on subject, thanks.
Thank you.
Very useful in real life situations. Ben has a wonderful presentation style.
I would like more trainings of this type. Where else could we get more training from Ben?
Great training.
Room was really noisy due to group next door.
Very concise and realistic presentation of topic, very good.
Worth the time to discuss on important topic in our career. Thank you very much.
APPENDIX E-6

TRAINING EVALUATION SUMMARY

TRAINING TITLE: Culturally Competent Approaches LGBT
January 20, 2010 – Cirby Hills, Roseville
January 21, 2010 – DeWitt, Auburn

INSTRUCTOR(S): Willy Wilkinson MPH

FACILITY: Cirby Hills Cafeteria & Community Room – Justice Center

RATING SYSTEM
1=Not applicable  2=Unsatisfactory  3=Fair  4=Good  5=Excellent

NUMBER OF PARTICIPANTS  34 attending / 26 evaluations

CONTENT
The information presented met or exceeded my expectations  4.50
The information was presented clearly  4.58
The information was relevant  4.65
The information presented provided a broad overview  4.81

QUALITY
The written materials were helpful  4.50
Presenter had a thorough knowledge of subject matter  4.92
Presenter had ability to relate subject in a meaningful way  4.69
Presenter answered questions clearly and concisely  4.88

VALUE
The training increased my understanding  4.50
The training provided insights that are relevant to my work  4.42
I will be able to apply what I learned at work  4.35

TRAINING FACILITY
The facility was comfortable  4.12
The facility was a good learning environment  4.27

PARTICIPANT’S OVERALL RATING  4.50

COMMENTS/SUGGESTIONS

- I learned a lot that I can immediately use on my job.
- Very knowledgeable and approachable trainer. Very good exposure and
discussion. Might have been helpful to review handouts and do a bit more “nuts
and bolts” of techniques and skill development.
➤ Need further resources. Great training.
➤ Cafeteria always cold with very uncomfortable chairs.
➤ Great training. Thank you!
➤ Surprised about the lack of information within the group of people attending the training which leads to the need for more training for our employees.
➤ Excellent. Thanks Willy!
➤ All of Placer County employees should be required to take.
➤ Regarding the facility – provide access to refreshments.
➤ Thank you Willy! Great job – good luck to you.
APPENDIX E-7

TRAINING EVALUATION SUMMARY

TRAINING TITLE: Community Health HIV/HEP/STD Education
January 26, 2010

INSTRUCTOR(S): Candace Jones

FACILITY: Auburn CDRA Building

RATING SYSTEM
1=Not applicable  2=Unsatisfactory  3=Fair  4=Good  5=Excellent

NUMBER OF PARTICIPANTS 18 attending / 18 evaluations

CONTENT
The information presented met or exceeded my expectations 4.28
The information was presented clearly 4.33
The information was relevant 4.44
The information presented provided a broad overview 4.28

QUALITY
The written materials were helpful 4.50
Presenter had a thorough knowledge of subject matter 4.72
Presenter had ability to relate subject in a meaningful way 4.39
Presenter answered questions clearly and concisely 4.39

VALUE
The training increased my understanding 4.22
The training provided insights that are relevant to my work 4.22
I will be able to apply what I learned at work 4.22

TRAINING FACILITY
The facility was comfortable 4.72
The facility was a good learning environment 4.77

PARTICIPANT’S OVERALL RATING 4.44

COMMENTS/SUGGESTIONS

➢ Hi Cyndy – we miss you at CSC.
➢ Candace was amazing. Thanks for the great info.
➢ I love Candace and her honest, upfront approach to this subject matter. She is a great benefit to Placer County.
➢ Love the energy.
- Excellent!
- Just needed better directions to the training location.
- Would have liked more specific information - mostly anecdotes about trainers' past.
- Best training I've been to in a long time! I learned so much.
- Thank You!
- Great presentation.
APPENDIX E-8

TRAINING EVALUATION SUMMARY

TRAINING TITLE  
Suicide Prevention Assessment  
February 21, 2009  8:30 – 12:30

INSTRUCTOR(S)  
Ben Lopez

FACILITY  
Cirby Hills Cafeteria, Roseville

RATING SYSTEM  
1=Not applicable  2=Unsatisfactory  3=Fair  4=Good  5=Excellent

NUMBER OF PARTICIPANTS  -- attending / -- evaluations

CONTENT  
The information presented met or exceeded my expectations  4.50  
The information was presented clearly  4.50  
The information was relevant  4.83  
The information presented provided a broad overview  4.17

QUALITY  
The written materials were helpful  4.00  
Presenter had a thorough knowledge of subject matter  4.67  
Presenter had ability to relate subject in a meaningful way  4.67  
Presenter answered questions clearly and concisely  4.67

VALUE  
The training increased my understanding  4.17  
The training provided insights that are relevant to my work  4.50  
I will be able to apply what I learned at work  4.33

TRAINING FACILITY  
The facility was comfortable  3.5  
The facility was a good learning environment  3.5

PARTICIPANT’S OVERALL RATING  4.80

COMMENTS/SUGGESTIONS

I have been to a number of suicide prevention workshops, this is the best one I have attended.  
Good info.  
It was fun and informative.  
The training was very good. Ben is very knowledgeable.
I was ten minutes late and did not receive a handout. The training was very insightful and directly applies to crisis work, thank you.
TRAINING EVALUATION SUMMARY

TRAINING TITLE  Suicide Prevention Assessment
February 21, 2009  8:30 – 12:30

INSTRUCTOR(S)  Ben Lopez

FACILITY  Cirby Hills Cafeteria, Roseville

RATING SYSTEM
1=Not applicable  2=Unsatisfactory  3=Fair  4=Good  5=Excellent

NUMBER OF PARTICIPANTS  -- attending / -- evaluations

CONTENT
The information presented met or exceeded my expectations  4.28
The information was presented clearly  4.49
The information was relevant  4.56
The information presented provided a broad overview  4.44

QUALITY
The written materials were helpful  4.38
Presenter had a thorough knowledge of subject matter  4.79
Presenter had ability to relate subject in a meaningful way  4.64
Presenter answered questions clearly and concisely  4.62

VALUE
The training increased my understanding  4.21
The training provided insights that are relevant to my work  4.41
I will be able to apply what I learned at work  4.33

TRAINING FACILITY
The facility was comfortable  3.64
The facility was a good learning environment  3.71

PARTICIPANT'S OVERALL RATING  4.45

COMMENTS/SUGGESTIONS
Always enjoy and appreciate Bens experience and easy manner. He instills trust and confidence. Good discussion and others that added a lot to the training.
Mr Lopez was excellent. I enjoyed the training and it will help me.
Nice work.
Bens delivered well and I learned a lot.
Some confusion regarding which document was being referred to.
Great info, offer more regarding if possible as a refresher.
Helpful, professional presentation.
Thank you.
Way too long. It could have been done in 2 hours. Material was very basic, repetitive, I lost interest. Feel like some of the discussion should have been stopped (legal issues) hard to hear. He should have had the material to follow guidelines of the county. Material seemed too basic and very drawn out. Could have been covered in 2 hours. Put handouts in order.
I wish there had been a little more time for Ben to take random questions. However all the material presented was very helpful.
Thank you.
Difficult to hear.
Break on the hour, little long.
Bit too long. It seemed like he was stretching. Could have done this in three hours. Wikipedia as a reference?
APPENDIX E-10

TRAINING EVALUATION SUMMARY

TRAINING TITLE  Connecting Employment with Recovery

March --, 2009  9:00 AM – 4:30

INSTRUCTOR(S)  Mark Ragins

FACILITY  PCOE Annex, Auburn

RATING SYSTEM
1=Not applicable  2=Unsatisfactory  3=Fair  4=Good  5=Excellent

NUMBER OF PARTICIPANTS  -- attending / -- evaluations

CONTENT
The information presented met or exceeded my expectations 4.18
The information was presented clearly 4.49
The information was relevant 4.41
The information presented provided a broad overview 4.48

QUALITY
The written materials were helpful 4.02
Presenter had a thorough knowledge of subject matter 4.70
Presenter had ability to relate subject in a meaningful way 4.73
Presenter answered questions clearly and concisely 4.64

VALUE
The training increased my understanding 4.11
The training provided insights that are relevant to my work 4.07
I will be able to apply what I learned at work 3.93

TRAINING FACILITY
The facility was comfortable 3.23
The facility was a good learning environment 3.6

PARTICIPANT'S OVERALL RATING 4.27

COMMENTS/SUGGESTIONS
APPENDIX E-11

2010 CIT ACADEMY EVALUATION SUMMARY

TRAINING TITLE: 12 Cultural Awareness

INSTRUCTOR(S): Sgt. Carlos Ponce

FACILITY: Sheriff’s Training Facility - Auburn

RATING SYSTEM
1=Not applicable 2=Unsatisfactory 3=Fair 4=Good 5=Excellent

NUMBER OF PARTICIPANTS 24 attending / 24 evaluations

2. WAS THE INSTRUCTOR PREPARED? 4.8

3. DID THE INSTRUCTOR FACILITATE THE LEARNING PROCESS? 4.8

4. DID THE TOPIC SEEM RELEVANT? 4.8

5. WAS THE INSTRUCTOR KNOWLEDGEABLE? 4.8

COMMENTS/SUGGESTIONS

- Excellent presenter. Very useful info for L.E. Too bad this course is not a high school requirement.
- Great class. Racial profiling and hate crimes should be a STC/POST class for everyone.
- Good instructor.
- Great use of video footage/P.P. slides.
- Great combination with video and lecture.
APPENDIX F

WORKFORCE ASSESSMENT

APPENDIX F-1  WET Workforce Needs Assessment
APPENDIX F-2  Placer County Points of Clarification on WET Plan
APPENDIX F-3  CSS, WET, PEI Plans
APPENDIX F-4  CSS WET – Lake Tahoe System Development
APPENDIX F-5  CSS WET - Wraparound
APPENDIX F-6  CSS WET - Consumer/Staff Development
APPENDIX F-7  CSS WET - Retention Efforts
APPENDIX F-8  CSS WET – Internship Programs
APPENDIX F-9  WET Training and Technical Assistance
APPENDIX F-10 CSS WET – Transforming Services
APPENDIX F-11 PEI – Youth and Family Support Program
APPENDIX F-12 PEI – Reducing Depression & Suicide
APPENDIX F-13 PEI – Bridges to Wellness

APPENDIX F-14
EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT (continued)

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

Information below includes responses from both the directly operated programs, personnel administrators, and the contract providers who completed the survey.

A. Shortages by occupational category:

1. Psychiatrists
2. Nursing Staff
3. Licensed Social Workers
4. Experience Supervisor and Management Staff

Given the competitive market, recruitment of psychiatrists (especially those trained in the Recovery Model) is very difficult. Retention of psychiatrists is also difficult. The geographic distance, and in some areas, rural nature of this county, limits access to care. While Placer has done an excellent job of redesigning its procedures to shorten the wait time to see a doctor, limited resources can, at times, force a wait time of 2-4 weeks.

Placer is experiencing a shortage of nursing staff. While it is difficult to recruit all nursing staff, recruitments for psychiatric nurses are frequently open for up to a year before being filled. Also, the difficulty in hiring teachers for nursing programs limits the number of students that graduate each year.

Placer does not have particular challenges recruiting mental health employees (except in rural areas of the county). Due to the large number of master’s programs in the area, we have many applicants for our master’s level positions in both the County and the local non-profit agencies. The area has less Social Work Schools than Marriage and Family Therapy programs, therefore, we have fewer Social Workers. Social Worker’s headed toward licensure must be supervised by a Licensed Clinical Social Worker (LCSW), and this creates additional demands.

Experienced Supervisor’s and Management staff in the Mental Health Field (particularly licensed staff) are very difficult to fill. In Lake Tahoe (the most eastern part of the county) there has been an open recruitment for a qualified Manager for over a year. The Manager needs to be qualified in Mental Health and all other social services because the area is far removed from other services and is required to operate independently.

Service providers in all areas of the county recognize the need for more bi-lingual mental health workers. While the need is high throughout the county, due to geographic and demographic distribution, there is particular need in Kings Beach and Lincoln.
With regard to the Tahoe Kings Beach area, there are shortages in all mental health positions. The cost of living is high and transportation can be difficult. There is a large Latino population in the area, many who are monolingual Spanish speaking. The need for mental health workers (particularly Spanish speaking) is great. There are also a significant number of monolingual Spanish speakers, with limited access to service in the Lincoln area (see section D below).

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

Placer’s largest variance of workforce to target population is Latino/Hispanic (5.5% variance). On closer examination, the variance was not as significant when comparing only County Client’s to Staff (3.3% variance), however, the variance is greater when evaluating community based organizations’ staff and client case loads. The need to attract and retain bi-lingual/bi-cultural staff exists in both the public and private sectors.

Other areas of note include: 4.5% variance of Multi-Race/Other, 0.8% variance of Native American, and 0.6% variance of African American staff to client ratios. We have slightly more diversity among the population being served than in our workforce. Concurrently with the WET planning, Placer is in the process of gathering more data to create a cultural competency plan.

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

An interesting finding was discovered in the surveys completed by all the Mental Health Workforce in Placer County. When the entire workforce was asked whether they were a consumer/family member of public mental health services, 32% of the workforce indicated yes they were, and 17.6% of the workforce declined to answer this question. From this it can be surmised that there continues to exist considerable concern regarding stigma and bias in the workforce.

Placer has employed consumer and family member staff for several years. The county has increased the number of consumer designated positions significantly in the last 1 ½ years. The recent large increase of consumers in the workforce has helped transform the system. The community agencies interviewed do not have “designated" consumer/family member employees (although there are some employees who disclose this as part of their identity after hire).

County HHS Adult System of Care has 14 part-time consumer “Navigator” employees. Applications are received on-going and there is a large interest in this program. Navigator positions are considered entry-level, extra-help positions. Minimum requirements for the position are to currently be a consumer of public mental health services. Adult System of Care has 3 full-time consumer employees who qualified for the “Client Service Assistant” positions. These are fully benefited, competitively offered positions. The county typically receives several applications for this classification. While everyone who meets the minimum standards (HS diploma) can apply, these
consumers were hired in 3 of the available spots. We have had 1 consumer employee who works on site at Adult System of Care but is hired through a contract with Best Step Tech.

Placer has 12 full time “family member” positions titled “Parent Partner’s”. One works in adult services and eleven work in the Children’s System of Care; they are hired through a contract with United Advocates for Children and Families. One of these positions is a Manager for the County; the others are considered extra help, entry level positions.

Input from Consumers/Family members as well as experts in consumer employment see an additional need in this area: training and development of current and new consumer/family member employees, workforce training to help understand the benefits of consumer employment, decreased stigma in the workforce, and advancement opportunities. Family members expressed a need to improve staff understanding of the role of advocates. The outcome family advocates hope to see is the consumer/family member voice empowered and continued transformation of the workforce in the model of Recovery.

D. Language proficiency:
Placer County has 23.1 FTE staff who are able to offer services in Spanish. 11% (682) of our total mental health population is Latino/Hispanic. Of that 11% (682), approximately 17.41% (119) are monolingual. The Kings Beach area (East Placer County in the rural Tahoe area) and Lincoln (North/West Placer with no County buildings) have the largest concentration of monolingual Spanish speaking clients. The need for more Spanish speaking Mental Health employees (particularly in these areas) still exists.

While Placer has not met any other threshold language requirements yet, there is a large Ukrainian population in the Roseville (West Placer) area. Residents and county employees have recognized an unmet need for increased ability to serve this population. Outreach and employees who speak their native language are necessary to meet this need.

E. Other, miscellaneous:
Co-occurring competent staff was an identified need through the stakeholder process. We believe that the majority of clients served in Placer mental health organizations have co-occurring disorders. Community members and experts in co-occurring issues agree that more training and staff development around co-occurring capability is required to meet this consumer population’s needs, as well as reduce the unique stigma and bias this population experiences.

After combining all qualitative data received by the stakeholder process and then allowing the WET workgroup to rank the needs/ strategies proposed, these were the top ranked priorities:

Diversity

1- Consider culture to include ethnicity, but also culture beyond it (e.g. LGBT, deaf, consumer, religion, etc.)

182
2- Diversify workforce in order to pair clients with staff of same culture
3- Create career pathways (from high school through college)

Consumers/Family Members
1- Reduce/eliminate stigma in the existing workforce
2- Support existing staff and consumers to help consumers be successful in the workforce
3- Increase appreciation among existing staff for more consumer/family involvement in the workforce
4- Provide staff support (e.g. training, mentors, child care, flexible schedules, job shares, etc.)
5- Provide specialized training and certification programs

Staff Development/Training
1- Develop clinical skills in best practices (e.g. motivational interviewing, etc.)
2- Train in Recovery principles and practices
3- Continue developing co-occurring competency
4- Training with and for community partners (e.g. law enforcement, etc.)

EXHIBIT 4: WORK DETAIL
Please provide a brief narrative of each proposed Action. Include a Title, short description, objectives on an annualized basis, a budget justification, and an amount budgeted for each of the fiscal years included in this Three-Year Plan. The amount budgeted is to include only those funds that are included as part of the County’s Planning Estimate for the Workforce Education and Training component. The following is provided as a format to enable a description of proposed Action(s):
APPENDIX F-2

Placer County’s “Points of Clarification” on WET Plan
Questions with Answers attached
December 17, 2008

Exhibit 2

Were specific Native American communities included as part of the stakeholder process?

Yes. About 2 years ago, as part of our original outreach for MHSA the “Native Network” group was formed. This group includes many Native American’s from multiple tribes. One objective of this group is to provide input to community and county planning. The county has also hosted and taken part in several Native American trainings/outreach activities (e.g. Pow Wow, drumming ceremonies). Native American representatives are regular attendees at county and community policy and planning meetings (including Workforce Development).

A representative from the tribal council received our questions and brought back their input. This representative attended Workforce Development input/planning sessions and provided input from the local tribal council. The council is comprised of a consortium of many local tribes.

Was the Auburn Rancheria contacted?

Yes. In creating our local stakeholder group “The Campaign for Community Wellness” many outreach activities were planned with the Native American community (see above), including the Auburn Rancheria.

Was there outreach to Russian-speakers and Spanish-speakers in their stakeholder process?

Yes, Placer developed within the last 3 years a Latino Leadership Council that is also very active in county policy, procedures, and planning. Like the Native Network, the Latino Leadership has joined the cultural competency committee, the Campaign for Community Wellness, and attended Workforce Development planning meetings. The Workforce Development Coordinator attended a Latino Leadership meeting to get input on Workforce Development needs and planning. Additionally the Workforce Development Coordinator is an active member of the Placer Cultural Competency Committee and continues to develop relationships with representatives from any diverse population that will engage.

Placer has made outreach attempts to the Russian-speakers in our community. Workforce Development Coordinator contacted a local psychiatrist who is Russian speaking to receive input. She also contacted local churches where Russian speakers may gather. These attempts have not been successful in developing a strong relationship at this time; however, Placer is continuing to seek new ways to build relationships with this community.
**Exhibit 3**
Do you have specific strategies to serve the unserved populations?

Yes, Placer has begun to organize and build relationships with faith-based organizations. We have also contracted with John Ott, who is helping us use a community approach. We also have had Bruce Anderson come and train out whole staff on being more welcoming. Our Campaign for Community Wellness group engages the community and develops innovative ways to reach our unserved populations. Also, we have just begun our cultural competency planning. We are developing a needs baseline and then plan to create a strategic plan around cultural competent and welcoming strategies.

Specifically with new workforce development monies, we plan to outreach more to the community through High School and Community College programs. We will use the, soon to be formed, Leadership Academy (comprised of diverse community members) to do outreach to unserved/underserved populations. We hope to fill intern positions, give scholarships, and provide classes to our unserved/underserved populations as well.

**Exhibit 4**

**Action 1**

With Objective 12, do you specific strategies on how you will implement it?

We have a consumer employment program within the county (Navigator program) that we will target first. This will serve as a baseline for how the training is received and the success rate of it. If successful, we will recruit consumers who have a desire to move into the mental health field from our existing clients, high school and community college student disability programs, and other community programs.

With all of these objectives, do you have tools you are going to use for ongoing assessment of these objectives?

As one form of measurement we plan to use surveys to get baseline information. Then we will use the same/or similar survey later to measure progress. We will also ask clients, staff, and supervisors about changes they see as a result of implementation. We can also count the number trained, the number to enroll in new classes, the number of new programs, the number of outreach activities, etc. that are completed from year to year.

**Action 3**

Within this action, how does the county define diversity?

Our definition of diversity arose through our stakeholder process... simply “diversity including and beyond ethnicity.” Placer will include: race, ethnicity, language, sexual orientation, mental health and physical disabilities, religious diversity, rural, and other diversity with a broader scope as defined by each individual.

Is there a plan to address the accountability and measurement part?

We plan on utilizing the diverse Workforce Development Workgroup (who reports to the Campaign for Community Wellness and the Mental Health Director) to employ oversight and accountability for implementation.
Is there a strategy of how the county will identify consumer and family member trainers?

We have worked with CIMH to identify consultants in this area. We will continue to use them and other counties to help identify effective trainers. We also plan to develop trainers internally through our Leadership Academy and with our existing Consumer Council.

Action 4

You referenced quality control in the action, but is there a plan of how you will address monitoring and gathering baseline data?

The Workforce Development Coordinator will be responsible to gather data about E-learning and report this to the management team and WET Workgroup for review. We will continually monitor the effectiveness and usefulness of these trainings through survey’s, focus groups, and asking for feedback from users of the product.

Do you have a vision of what the content of the training will include?

We hope to provide many of the mandatory CEUs for licensure as well as upload past trainings for people to review who were not present at the time of the training. We also hope to have recovery oriented trainings and other trainings that support the overall direction of the department. The values including, but not limited to: cultural competency, co-occurring competency, welcoming, recovery, community wellness, and more.

Action 5

Do you know how participants will be selected?

We hope to train all mental health staff in Placer. Ideal participants in the Certification Program will include: Consumer employees, unserved/underserved community members, people with disabilities, newly graduated (potentially High School students), Nursing/Health Care staff/students, and other students in our “hard to fill” classifications.

Do you know how trainers will be selected?

We plan to have CASRA or META train the trainers. Trainers will include, but not limited to: the Workforce Development Coordinator, the Consumer Development Supervisor, Consumer Employees, and members of the Leadership Academy.

Action 9

Is there a way in which you plan to measure outcomes?

Outcomes will be based on: the number of enrollees in targeted classes that are filled based on the scholarships provided, the number of hard to fill positions that are filled based on incentives; the number of interns increased; number of people who attend outreach/lectures offered by leadership academy members; etc. The Workforce Development Coordinator will be responsible to collect and report this data to stakeholders and the state.
Ultimately, the desired goal would be an increase in eligible and qualified candidates for the hard to fill positions. We will lay the groundwork to be able to fill these positions once hiring freezes are lifted. In the meantime, we will support our local contracted agencies in filling hard to fill positions with diverse employees. We will be able to measure how many diverse and hard to fill intern positions are filled as a result of our efforts.

Are there any target populations with this action?

Diverse staff, and diverse high school students, consumers and family members, and other hard to fill staff/potential staff.

If you have any further questions, please call or e-mail Amy Ellis at 530-886-3415 or arellis@placer.ca.gov.
APPENDIX F-3

County: Placer

Date: 03/26/2010

Instructions: Welfare and Institutions Code section 5848 specifies that DMH shall establish requirements for the content of the annual update and updates including reports on the achievement of performance outcomes for services. Provide an update on the overall progress of the County’s implementation of the MHSA including CSS, PEI and WET components during FY 2008/09.

<table>
<thead>
<tr>
<th>CSS, WET and PEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Briefly report on how the implementation of the MHSA is progressing: whether implementation activities are generally proceeding as described in the County’s approved Plan, any key differences, and any major challenges.</td>
</tr>
<tr>
<td>[ X ] Please check box if PEI component not implemented in FY 08/09.</td>
</tr>
</tbody>
</table>

Community Services and Supports

CSS Implementation activities are generally proceeding as described in the County’s approved Plan. Challenges, although not major, include staffing changes, restructuring of non-CSS programs, capacity of existing programs and community partners to sustain service levels, and county-wide economic stressors increasing the need for services. Despite these challenges Placer was able to significantly exceed annual services targets in several work plans, particularly in the area of System Development. For example, our Lake Tahoe System Development Program was able to serve 57 Latino individuals. This is more than 50% over the targeted 35.

Program highlights for 08-09 include:

• Relocation of the Welcome Center. The new space allows for increased on-line access and space for several simultaneous activities.
• The creation of a Transitional Review Team (TRT). This team is composed of partner agencies and Children’s System of Care representatives who meet monthly to create a more fluid transition for youth who are entering adulthood.
• Summer youth employment projects coordinated through the Youth Coordinator resulted in the development of a Rights Packet for youth placed in probation, mental health, or child welfare placements and three educational videos: Youth Rights, Advocacy for Affordable Youth Activities and Advocacy to Improve Educational Opportunities for Youth in Placement.
• In Spring of 2009, TAY and most Adult FSP services were transitioned to Turning Point Community Services. Adult System of Care continued to provide Older Adult FSP and PTAY services.
• The Older Adult FSP Program staff gave eight public presentations describing the Older Adult program and providing referral information to community groups and hospital staff. Thanks in part to these outreach efforts the team started with 12 partners and ended with 19 serving a total of 24 individuals during this reporting period. The team is now housed with Public Guardian staff, allowing Public Guardian Deputies to participate in discussions with regard to partners who are currently on conservatorship.
• The Lake Tahoe Community Educator facilitated a middle school boy’s group, educated Latino fathers, assisted in training Promotoras and worked closely with the schools and Family Resource Center to increase outreach and understanding while reducing stigma amongst the Latino community.
Workforce Education and Training

WET Implementation activities are generally proceeding as described in the County’s approved Plan. Highlights from the 08-09 FY include:

- Relationship building with local colleges and universities, resulting in increased opportunities for internships
- Involvement in regional collaborative meetings and efforts to increase capacity and cohesion amongst central region counties
- The WET coordinator participates in the Cultural Competency and Change Agent groups allowing for greater integration of staff and system development activities
- Consumers, staff, families, and community providers attended Recovery Model trainings including Job Retention for Clients in Employment, Wellness Recovery Action Plan and Connecting Employment with Recovery
- Development of our eLearning contract preparing for 09-10 implementation

Major challenges to implementation include working with and/or adapting county processes to allow for the distribution of stipends, keeping advisory group and community members engaged in the process, local college challenges due to budget and program reductions and the impacts of reductions on staff development activities.

Prevention and Early Intervention

Placer County’s PEI Plan was approved in February of 2009 and implementation is progressing generally as planned. No PEI services were delivered in 08-09 as the remainder of this FY was used to develop Requests for Proposals and ensure stakeholder participation in each stage of the process.

2. Provide a brief narrative description of progress in providing services to unserved and underserved populations, with emphasis on reducing racial/ethnic service disparities.

All of Placer County’s CSS, WET and PEI programs provide outreach to unserved and underserved populations, with an emphasis on reducing racial/ethnic service disparities. Each program strives to deliver culturally and linguistically competent services to both consumers and family members. Nearly all of Placer’s newly approved services under PEI benefit historically underserved members. In particular the Latino Leadership Council and Native Network are working to increase services, awareness, and opportunities to two of Placer’s primary identified underserved populations: Latinos and Native Americans.

The Latino Leadership Council (LLC) initiated the strategic planning process to become a 501c3 non-profit organization. They continue to seek funding opportunities and collaborate with organizations to secure funding that helps develop and sustain culturally competent services for Latino populations. 15 community educators, called Promotoras, were trained. These individuals will help to educate and engage Latino populations in basic health, which includes public health issues as well as mental health issues. The LLC completed research among its membership and community to finalize recommended plans for the MHSA PEI funding. Based on these recommendations PEI funding was allocated to provide Latino populations skills for dealing with their children who are at-risk for gang activities. Presentations to the Western Placer Unified School District personnel showcased the Parent Project curriculum and Promotoras programs.

The LLC worked with a consultant to identify ways that the LLC can help to develop the capacity of the community to improve their own wellness. In collaboration with Placer County Community
Health Department, LLC coordinated a health fair to provide screening services for Latino adults. On May 30, 2009, the Latino Leadership Council partnered with the Placer County Community Health Department to coordinate the first-ever Latino Health Fair in Lincoln, CA. More than 200 Latino adults received screenings and their children received free childcare so the parents could concentrate on understanding information about their health.

The Native Network continues an active role in providing input to county/community planning groups. Information is gathered from a consortium of local tribes and interviews by a Native American consultant with elders/leaders. The Native Network has utilized many assessments/means of gathering and reporting on the needs of Native American youth, families, and communities. MHSA dollars were critical to the establishment of a Native Cultural Center where Placer residents are now able to receive a host of services as outlined under the plan. Included in the recently approved PEI plan is funding for a Native Youth liaison.

3. Provide the following information on the number of individuals served:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>CSS</th>
<th>PEI</th>
<th>WET</th>
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<tbody>
<tr>
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<td></td>
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<tr>
<td><strong>Child and Youth (0-17)</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Transition Age Youth (16-25)</strong></td>
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<td>147</td>
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<tr>
<td>Training/Technical Assist.</td>
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<td></td>
<td></td>
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<tr>
<td><strong>Adult (18-59)</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Older Adult (60+)</strong></td>
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<thead>
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<th>Race/Ethnicity</th>
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<th>WET</th>
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<tr>
<td><strong>White</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>African American</strong></td>
<td>89</td>
<td></td>
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</tr>
<tr>
<td><strong>Asian</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>Pacific Islander</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Native American</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>69</td>
<td></td>
<td></td>
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<tr>
<td><strong>Multi</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
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<td></td>
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</tr>
<tr>
<td><strong>Unknown</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Other Cultural Groups</th>
<th>CSS</th>
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<th>WET</th>
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<tr>
<td><strong>LGBTQ</strong></td>
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</tr>
<tr>
<td><strong>Other</strong></td>
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<table>
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<th>Primary Language</th>
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<tbody>
<tr>
<td><strong>English</strong></td>
<td>2488</td>
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<tr>
<td><strong>Spanish</strong></td>
<td>32</td>
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<tr>
<td><strong>Vietnamese</strong></td>
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<tr>
<td><strong>Cantonese</strong></td>
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<tr>
<td><strong>Mandarin</strong></td>
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<tr>
<td><strong>Tagalog</strong></td>
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<tr>
<td><strong>Cambodian</strong></td>
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<td><strong>Hmong</strong></td>
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<td><strong>Russian</strong></td>
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<tr>
<td><strong>Farsi</strong></td>
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<tr>
<td><strong>Arabic</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>18</td>
</tr>
</tbody>
</table>
Ethnic Demographic Data is collected on all individuals served through FSP and Crisis Triage. In order to increase access and reduce stigma, some components of Placer’s System Transformation Programs, including outreach activities and our drop-in Wellness Center do not collect specific demographic data. Placer will continue to strive to collect the most accurate data possible while engaging diverse populations.
## APPENDIX F-4

**County:** Placer  
**Program Number/Name:** # 3 Lake Tahoe System Development  
**Date:** 3/26/10

<table>
<thead>
<tr>
<th>Previously Approved</th>
<th>CSS and WET</th>
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</thead>
<tbody>
<tr>
<td><strong>No.</strong></td>
<td><strong>Question</strong></td>
</tr>
<tr>
<td>1.</td>
<td>Is this an existing program with no changes?</td>
</tr>
<tr>
<td>2.</td>
<td>Is there a change in the service population to be served?</td>
</tr>
<tr>
<td>3.</td>
<td>Is there a change in services?</td>
</tr>
<tr>
<td>4.</td>
<td>Is there a change in funding amount for the existing program?</td>
</tr>
</tbody>
</table>
| a) | Is the change within ±15% of previously approved amount? | ☒ | ☐ | FY 09/10 funding FY 10/11 funding Percent Change  
If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below. |

5. **For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served.  
**For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.

The Lake Tahoe System Development program provides services that are culturally competent and focus on a welcoming system to increase access to mental health services for Latinos in Tahoe, focusing on the disparity of mental health services provided to Latinos. Additional bilingual/bicultural clinical and support staff allows staff to eliminate the waiting list for services. The plan also supports community outreach and engagement to reduce stigma and fear of mental health services through partnerships with Latino leadership and Family Resource Centers. Training and support for identification of mental illness issues in families utilizing natural community strengths and cultural models will continue to be developed and implemented.
APPENDIX F-6

County: Placer

Program Number/Name: #1 Children’s FSP- Rallying Around Families Together

Date: 3/26/10

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<tbody>
<tr>
<td>No.</td>
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<td>1.</td>
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<td>2.</td>
<td>Is there a change in the service population to be served?</td>
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<tr>
<td>3.</td>
<td>Is there a change in services?</td>
</tr>
<tr>
<td>4.</td>
<td>Is there a change in funding amount for the existing program?</td>
</tr>
<tr>
<td>a)</td>
<td>Is the change within ±15% of previously approved amount?</td>
</tr>
<tr>
<td>5.</td>
<td>For CSS programs: Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. For WET programs: Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.</td>
</tr>
</tbody>
</table>

Children’s System of Care (CSOC) will continue to expand wraparound services to include children (17 years and under) with Severe Emotional Disorders who do not meet the Government Code 26.5 criteria for Special Education Services. CSOC works closely with the schools to identify the children who qualify for this program. Special attention and outreach occurs in the Latino community to address ethnic disparity. Working in concert with leadership development activities, staff utilizes the services of Family Advocates, Youth Coordinators and Mentors.
APPENDIX F-6

County: Placer

Program Number/Name: #2 Consumer/Staff Development

Date: 3/26/10

<table>
<thead>
<tr>
<th>Previously Approved</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>1. Is this an existing program with no changes?</td>
<td>☒ ☐</td>
<td>If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2</td>
<td></td>
</tr>
<tr>
<td>2. Is there a change in the service population to be served?</td>
<td>☐ ☒</td>
<td>If yes, complete Exh. F1; If no, answer question #3</td>
<td></td>
</tr>
<tr>
<td>3. Is there a change in services?</td>
<td>☐ ☒</td>
<td>If yes, complete Exh. F1; If no, answer question #4</td>
<td></td>
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<tr>
<td>4. Is there a change in funding amount for the existing program?</td>
<td>☐ ☒</td>
<td>If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly</td>
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<td>☐ ☒</td>
<td>FY 09/10 funding FY 10/11 funding Percent Change</td>
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<tr>
<td>5. For CSS programs: Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. For WET programs: Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.</td>
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</table>

The WET advisory committee composed of county and community representatives including consumers, family members and cultural brokers will assist in identifying effective evidenced-based models for each topic area and determining trainers and the most cost effective manner to provide these trainings and meet these objectives.

Objectives:
- Provide a minimum of 12 days of training. All training will be made available to Placer County Systems of Care, consumers/family members, mental health/drug and alcohol community partners who have frequent contact with mental health consumers/staff. While not all training providers have been identified for the specific training topics, it will be the responsibility of the local WET coordinator and advisory group to identify, organize, and evaluate each training. Training will include post tests to insure that training concepts are incorporated into practice. All training providers will be knowledgeable of the fundamental principals of MHSA and will integrate them throughout the training. Placer will incorporate the client and family voice into trainings to expand beyond the clinical perspective of the trainee. Trainings will be provided
through diversified methods (e.g. interactive, classroom style, group learning, etc.)
Training topics may include: Clinical skills in best practices (e.g. motivational interviewing, welcoming), Recovery/Wellness training, co-occurring competency, suicide assessment/treatment, Listening Well, and Cultural Competence.
## ATTACHMENT F-7

**County:** Placer  
**Program Number/Name:** #7 Retention Efforts  
**Date:** 3/26/10

### CSS and WET

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<tbody>
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<td><strong>Question</strong></td>
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</tr>
<tr>
<td>1.</td>
<td>Is this an existing program with no changes?</td>
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<td>2.</td>
<td>Is there a change in the service population to be served?</td>
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### Percent Change

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<tr>
<th>FY 09/10 funding</th>
<th>FY 10/11 funding</th>
<th>Percent Change</th>
</tr>
</thead>
</table>

If yes, answer question #5 and complete Exh. E1 or E2 accordingly; If no, answer question #2

If yes, complete Exh. F1; If no, answer question #3

If yes, complete Exh. F1; If no, answer question #4

If yes, answer question #4(a); If no, complete Exh. E1 or E2 accordingly

If yes, answer question #5 and complete Exh. E1 or E2; If no, complete Exh. F1 and complete table below.

### 5. **For CSS programs:** Describe the services estratégias and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served.

### 5. **For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.

- Newsletters for county employees and make contributions to Placer’s community newsletter (Campaign for Community Wellness).
- Develop appreciation strategies to create welcoming and appreciative organizational cultures.
- Develop and implement a recovery oriented new employee orientation.
ATTACHMENT F-8

County: Placer

Program Number/Name: #8 Internship Programs

Date: 3/26/10

<table>
<thead>
<tr>
<th>Previously Approved</th>
<th>CSS and WET</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Question</td>
</tr>
<tr>
<td>1.</td>
<td>Is this an existing program with no changes?</td>
</tr>
<tr>
<td>2.</td>
<td>Is there a change in the service population to be served?</td>
</tr>
<tr>
<td>3.</td>
<td>Is there a change in services?</td>
</tr>
<tr>
<td>4.</td>
<td>Is there a change in funding amount for the existing program?</td>
</tr>
<tr>
<td>a)</td>
<td>Is the change within ±15% of previously approved amount?</td>
</tr>
<tr>
<td>5.</td>
<td>For CSS programs: Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served. For WET programs: Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.</td>
</tr>
</tbody>
</table>

Objectives:
- Four to eight interns will be offered recovery oriented supervision (particularly bi-lingual/bicultural and those with lived experience). We will look for a combination of Bachelors and Masters level students. Students will be offered a comprehensive internship that allows them to experience various aspects of Placer’s integrated system.
- At least two Medical field interns (e.g. Nursing/psychiatric technicians) will be offered supervision and psychiatric experience.
- A rotation schedule will be developed with Sierra College Nursing program to provide eight students with exposure to public mental health.
- 6 hours per week of a contracted licensed clinician to provide supervision for interns working toward licensure.
ATTACHMENT F-9

WET PLAN/OBJECTIVES

TRAINING AND TECHNICAL ASSISTANCE:

Consumer and Staff Development

- The WET subcommittee will identify effective evidenced-based models for each topic area and determine trainers and most cost effective manner to provide these trainings.
- Provide annual trainings and ongoing consultations to develop staff competencies in the areas identified by our stakeholders.
- Incorporate the client and family voice into trainings to expand beyond the clinical perspective of the trainee (e.g. Listening Well being led by Placer consumer’s who have been trained to train consumer/family members and staff).
- Provide trainings/ technical assistance with diversified methods (e.g. interactive, classroom style, group learning, etc.)

Objectives:

- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula.
- Incorporate into each of these trainings, specific cultural, gender, economic and spiritual issues which need to be addressed to better serve the diverse minority population of our County.
- Evaluate internal versus external resources for proposed trainings.
- Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc).
- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula.
- Provide training, as appropriate, to employed consumers / family members with the goal of training all within 5 years.
- Incorporate outcome measures to ensure efficacy of training programs.
- Continue offering trainings for incoming staff, contracted providers and employed consumers / family members.
- Develop a resource library available to all providers and consumers.
- Address the issues of stigma and discrimination faced by mental health consumers and by family members.
- Ensure that staff is exposed to various client and family member viewpoints and to better understand the client and family experience.
- Employees, including consumers and family members, will evaluate via evaluation forms, survey’s, and by committee, the effectiveness of their training experiences to allow them to:
  - Understand the public mental health system
  - How to navigate the system more easily
  - Develop skills to reduce stigma and discrimination

Leadership Development Activities:
- Establish a leadership academy of 10-20 mental health staff (consumer and family trainers will be identified).
- Bring in trainings and/or consultants who will train staff in recovery oriented leadership skills including: meeting facilitation, community outreach, professional presentations, technical writing, team motivation, etc.
- Develop a mental health speaker’s bureau who train/speak about MHSA core values to partner agencies, in classroom settings, or other community venues.
- Provide 5 stipends at $500 each to members who provide relevant recovery oriented trainings to partner’s agencies (as determined eligible by WET workgroup). *To be funded in Action 9.

Objectives:
- Evaluate internal versus external resources for proposed trainings
- Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
- Ensure the inclusion of diversity, wellness, recovery, resiliency in all training curricula
- Provide leadership development training, as appropriate, to employed consumers / family members with the goal of training all within 5 years
- Incorporate outcome measures to ensure efficacy of training programs
- Continue offering trainings for incoming staff, contracted providers and employed consumers / family members
- Develop a resource library available to all providers and consumers
- Address the issues of stigma and discrimination faced by mental health consumers and by family members.
- Ensure that staff and community is exposed to various client and family member viewpoints and to better understand the client and family experience.
- Develop opportunities for leadership to grow through member’s of the leadership academy being allowed to discuss wellness, recovery, and resiliency as well as introduce students/community members to the mental health field.

E-Learning Contract Objectives:
- Provide greater ease for staff, community providers, consumers and family members to access training and educational courses which meet license requirements and/or provide career path development, as well as rehabilitation and consumer employment courses.
- Explore providing a community access portal for consumers and family members and key stakeholders to meet their training and information needs.
- Increase quality and availability of diverse training offerings while reducing cost.
- Provide compliance and quality control for legal requirements by linking to the County’s existing education and licensing tracking system.
- Research existing training modules that offer established credibility
- All staff will be trained in a set of core wellness, recovery, and resiliency oriented classes within 5 years.
MENTAL HEALTH CAREER PATHWAY PROGRAMS

Psychosocial Rehabilitation Certification Program Activities:
- Research existing training modules that offer established credibility (CASRA, RICA, NAMI, SAMHSA, etc)
- Purchase a Psychosocial Rehabilitation Curriculum (e.g. CASRA, META) along with necessary call-specific resource materials to provide training.
- Train Placer County Staff to “train the trainer” to teach course curriculum to current/potential mental health staff (including consumers/family members).
- Research and outreach to local Junior colleges to explore offering the recovery oriented mental health courses as a class for credit.
- Pursue stipends/scholarships toward USPRA certification and class enrollment if outreach to Junior colleges is successful.

Objectives:
- Address the issues of stigma and discrimination faced by mental health consumers and by family members.
- Ensure that staff and community is exposed to various client and family member viewpoints and to better understand the client and family experience.
- Enhance the skill level of consumers/family members working in the mental health field
- Provide opportunities to enhance job skills and educational advancement
- Encourage consumers and family members to further pursue the mental health field.
- Increase consumer voice within mental health organizations
- Train all staff in relevant course material within 5 years

Outreach and Enhanced High School Career Tracts Activities:
- Develop a contract with at least 1 school district with the outcome of starting a Mental Health Professions Academy or similar program by September 2009.
- Conduct a minimum of 4 speaking engagements annually. Target health care professionals, youth, consumers and their families from and within diverse communities.
- Attend Job Fairs and develop new ways of recruiting for hard to fill positions (e.g. utilize Nursing employees to help with recruitment, etc.)
- Provide 2 paid internships for high school students annually
- Provide opportunities for high school age volunteers within the public mental health system.

Objectives:
- Identify early and facilitate mental health career information
- Educate early learners in wellness, recovery, and wellness principles
- Increase “hard to fill” positions by increasing opportunities and knowledge about how to enter the mental health field.

Increased Retention Efforts Activities:
- Newsletters for county employees and make contributions to Placer’s community newsletter (Campaign for Community Wellness).
Develop appreciation strategies to create welcoming and appreciative organizational cultures.
Further collaboration with community partners
Develop and implement a recovery oriented new employee orientation

Objectives:
Support cultural differences and stories to help decrease stigma
Develop new and innovative strategies to decrease stigma and increase cultural competence in the workforce
All staff develop skills to reduce stigma and discrimination
Maintain/retain quality employees in the Mental Health Workforce
Increase productivity of employees by creating a welcoming environment.

RESIDENCY, INTERNSHIP PROGRAMS
Internship Programs
Objectives:
Expand internships to consumer/family members, the medical field, as well as diverse master’s level interns who meet Placer’s identified needs.
Provide recovery oriented supervision (meeting necessary requirements for individualized intern).
Provide (if possible) needed interns to target areas specified in needs assessment (e.g. bi-lingual/bi-cultural in Tahoe and/or Lincoln).
Expand internships on the career ladder to include non-master’s level students/potential students and provide supervision and support.

FINANCIAL INCENTIVE PROGRAMS
Stipends and/or Scholarships and Grants Actions:
Provide stipends/and or scholarships each year to individuals wishing to pursue higher education / career pathway opportunities in Mental Health Service.
Establish an application process that would determine eligible individuals for a stipend or scholarship.
Establish a process with key stakeholders for reviewing applications and recommendations for stipends, scholarships or grants.
Provide accountability and support to the individuals approved to receive stipends, scholarships, or grants.
Allocate funds for Speaker’s Bureau participants.
Allocate funds for consumers and family members to attend relevant trainings, classes, or conferences each year. *beginning FY 2010-11
Allocate stipends for 5 new interns as outlined in Action 8 *beginning FY 2010-11.
Allocate stipends for 2 HS student interns *beginning FY 2010-11

Objectives:
Community (e.g., HS students) hear from a variety of local leaders about being in and entering the Mental Health Field
Decrease stigma and bias around consumer/family members and increase consumer voice.
• Decrease workforce shortages by creating incentives for hard to fill positions in difficult to recruit areas.
• Increase consumer and family member participation in trainings and classes
• Increase interns trained and receiving work experience in a mental health setting and design strategies to retain interns and/or encourage hard to fill staff to continue toward the mental health field.
## ATTACHMENT F-10

### WET - PROGRAM SPECIFIC

**County:** Placer  
**Program Number/Name:** # 4 Transforming Services through Co-Occurring, Resiliency/Recovery, Cultural Competency and Family/Client-driven System (Systems Development Strategy)  
**Date:** 3/26/10

| No | Question                                                                 | Yes | No               | 1. Is this an existing program with no changes? | If yes, answer question #5 and complete Exh.E1 or E2 accordingly; If no, answer question #2  | 2. Is there a change in the service population to be served? | If yes, complete Exh. F1; If no, answer question #3  | 3. Is there a change in services? | If yes, complete Exh. F1; If no, answer question #4  | 4. Is there a change in funding amount for the existing program? | If yes, answer question #4(a); If no, complete Exh. E1or E2 accordingly  | a) Is the change within ±15% of previously approved amount? | FY 09/10 funding  | FY 10/11 funding  | Percent Change | If yes, answer question #5 and complete Exh. E1or E2; If no, complete Exh. F1 and complete table below.  |
|----|------------------------------------------------------------------------|-----|------------------|------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|

**For CSS programs:** Describe the services/strategies and target population to be served. This should include information about targeted age, gender, race/ethnicity and language spoken of the population to be served.  
**For WET programs:** Describe objectives to be achieved such as days of training, number of scholarships awarded, major milestones to be reached.

Placer Systems of Care will continue to improve the system capacity for co-occurring competent, culturally competent, recovery/resiliency oriented and client/family driven services through the use of evidence-based models that promote recovery and increase the level of participation of clients and families. In collaboration with the WET plan Placer will continue to provide: Opportunities for training for staff, providers, consumers and families on the principles of the recovery model; Leadership development for consumers, families and the Consumer Council; Peer support programming through the Welcome Center; Latino Leadership Counsel growth; Consumer Navigators and Peer Advocate programs; the Youth Coalition; Change Agents for Co-occurring systemic transformation efforts.
APPENDIX F-11

County: Placer County
PEI Project Name: Ready for Success: Youth and Family Support Program
Date: 9/10/08

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select as many as apply to this PEI project:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. PEI Priority Population(s)

Note: All PEI projects must address underserved racial/ethnic and cultural populations.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select as many as apply to this PEI project:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Children and Youth at Risk for School Failure</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ready for Success: Youth and Family Support Program Summary [Form #3]

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

Placer County’s community and stakeholder input process to determine the PEI priority populations was the first part of the overall 9 month process which led to the recommended plan. The priority populations were determined by January 2009, five months after the process began. As described in Section 2 of this plan, Placer County worked with the Campaign Steering Committee consisting of over 30 stakeholders to select the priority populations. The Steering Committee were trained by a California Institute of Mental Health expert and incorporated relevant Placer County statistics, input from four community forums.
and PEI plans from five PEI work groups (Children/Youth, Depression & Suicide, Tahoe, Latino Leadership Council, and Native Network). Additionally, input from a consumer council as well as a consumer survey was reviewed in the planning process. Statements of need identified in the 2005 MHSA/Community Services and Supports Community Process were also revisited and made relevant to the discussion.

Specifically, the programs developed under the Strengthening Families Project were derived from the Children/Youth work group with active participation from the Tahoe, Latino and Native Network groups. Two members representing education and Placer Children System of Care chaired the Children/Youth work group.

The Children/Youth work group roster included representation from:

- Child Abuse Prevention Council
- Children's System of Care (3)
- Adult consumer
- Placer First 5 Commission
- Latino Leadership Council
- Native Network
- North Roseville Recreation Center
- PEACE for Families
- Placer County Office of Education K-12 (3)
- Placer Union High School District
- Rocklin Unified School District (2)
- Roseville Police Department
- Sierra Council on Alcoholism and Drug Dependence
- Sutter Health
- Tahoe Truckee Unified School District
- Tahoe Women's Services
- Family member/United Advocates for Children and Families of California
- Whole Person Learning

Data used to determine priority populations and needs included: surveys taken at Placer Juvenile Justice Center, statistics for children and youth from the National Center for Children in Poverty, local data from Placer County Children System of Care, Department of Education as well as input from the Native, Youth, and Latino focus groups to name a few.

The Children and Youth work group used community input, relevant local, state, cultural, geographic and national research on to find programs with the best outcomes for children and youth at risk of school failure, in stressed families and at risk for involvement in the juvenile justice system. The group recommended a selective strategy for strengthening families through parenting education programs and youth development.
Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

### 1. PEI Key Community Mental Health Needs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select as many as apply to this PEI project:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population(s)

**Note:** All PEI projects must address underserved racial/ethnic and cultural populations.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
<th>Older Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Select as many as apply to this PEI project:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
</tbody>
</table>

**Bye-Bye Blues Project: Reducing Depression & Suicide Prevention**

**B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).**

Multi-stakeholder Input Process to Determine Priority Populations: Placer County’s community and stakeholder input process to determine PEI priority populations was conducted as part of an overall PEI planning process that spanned a 9-month period beginning in September 2007 and ending June 2008. As described in Section 2 of this plan, Placer County engaged the existing Campaign for Community Wellness Steering
Committee consisting of over 50 stakeholders to select the priority populations most in need of prevention and early intervention services. The Steering Committee was guided by research presented by a California Institute of Mental Health expert, relevant Placer County, state and national statistics. Additionally, input from four regional community forums and plans from five work groups (Children/Youth, Depression & Suicide, Tahoe, Latino Leadership Council, and Native Network) informed the decision making process. Likewise, a consumer council and local survey were employed in the planning process. Statements of need identified in the 2005 MHSA/CSS Community Process were also revisited and integrated to the planning.

Key Data Points for Priority Populations (source: DMH, OAC): Mothers: Parents with depression is the most consistent and well-replicated risk factor for children; those with a depressed parent have a 2-3 times increased risk of having a major depressive disorder and are 4-6 times overall more likely to receive a psychiatric diagnosis. Typically, a third of children with depressed mothers have a current psychiatric disorder. An estimated 1 in 4 mothers suffer from depression at some point during their lifetime. Sixty-eight percent of women who experience a mental disorder are parents.

- Older adults: Older adults have the highest rate of suicide in Placer County. Of older adults who committed suicide, 75% saw their primary care doctors the week prior to their death.
- Native American: Nationally, suicide is the number one cause of death in males aged 15-24.
Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

### 1. PEI Key Community Mental Health Needs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
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</thead>
<tbody>
<tr>
<td>Select as many as apply to this PEI project:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Disparities in Access to Mental Health Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Psycho-Social Impact of Trauma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. At-Risk Children, Youth and Young Adult Populations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Stigma and Discrimination</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. Suicide Risk</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### 2. PEI Priority Population(s)

**Note:** All PEI projects must address underserved racial/ethnic and cultural populations.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Children and Youth</th>
<th>Transition-Age Youth</th>
<th>Adult</th>
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</tr>
</thead>
<tbody>
<tr>
<td>C. Select as many as apply to this PEI project:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Trauma Exposed Individuals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Individuals Experiencing Onset of Serious Psychiatric Illness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Children and Youth in Stressed Families</td>
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<tr>
<td>5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bridges to Wellness Project: Awareness, Stigma Reduction, Linking to Resources Project Summary**

### B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).**

Placer County conducted a community and stakeholder input process to determine the PEI priority populations over a 9-month period beginning in September 2007 and ending in June 2008. As described in Section 2 of this plan, Placer County worked with the
Campaign Steering Committee consisting of over 40 stakeholders to select the priority populations. The Steering Committee was guided by research presented by a California Institute of Mental Health expert, relevant Placer County statistics, input from four community forums, and PEI plans from five PEI work groups (Children/Youth, Depression & Suicide, Tahoe, Latino Leadership Council, and Native Network). Statements of needs identified in the 2005 MHSA CSS Community Process were also revisited and made relevant to the discussion.

The anti-stigma and discrimination efforts developed under the *Bridges to Wellness Project: Awareness, Stigma Reduction and Linking to Resources* came out of recommendations of several of the work groups as well as the Steering Committee who wanted to support efforts to increase awareness, decrease stigma and link people to useful services for various age groups and underserved/unserved populations.

The Campaign for Community Wellness has a social marketing team that supports the goals of decreasing stigma and discrimination across age groups and ethnicities. Research shows better outcomes when interventions are targeted to specific groups (Corrigan, 1995). Per this research, the Campaign social marketing team has developed a plan that will adapt messages to underserved ethnic, racial and cultural populations. The key message of the Campaign for Community Wellness social marketing effort is that mental health is a community responsibility.

The Bridges to Wellness Project will work in concert with the Campaign for Community Wellness social marketing efforts to change public perceptions.
# APPENDIX G

**LANGUAGE ACCESS**

<table>
<thead>
<tr>
<th>APPENDIX G-1</th>
<th>SOC Policy on Accessing Interpreter Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX G-2</td>
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</tr>
</tbody>
</table>
Policy

Placer County Mental Health Plan (MHP) is committed to ensuring that clients are provided informational material to help obtain knowledge and assist them to access needed services. In addition, the MHP is also committed to ensuring that all clients receive assistance with a language barrier in order to access such information materials and needed services in accordance with state and/or federal law.

Purpose

To ensure that Medi-Cal beneficiaries and non-Medi-Cal clients are fully informed regarding access to mental health services in an easy to understand and culturally competent manner, including and through the use of interpreter services to ensure compliance with all state and federal regulations, including regulations regarding informing materials, Advance Health Care Directives, and Privacy Practices (HIPAA).

Procedure

Assistance with a Language Barrier

Placer County used the AT&T Language Line Translation Service. It is an over-the-phone interpretation service, which allows a provider to access over 140 different languages from any county extension. This service is available 24 hours a day, seven days a week.

To receive a call or to reach an interpreter or a relay operator:

1. Tell caller to please hold for operator assistance. (In Spanish, “Por favor espere en la línea para asistencia con una operadora.”)
2. Press the “Transfer button” this will place the caller on conference hold.
3. Dial Ext. 3333. This will access the Language Translation Line Service.
4. Give language request ie…Spanish, German, etc.
5. Give your client ID # 501053 and organization name “Placer County.”
6. Give your personal code - your extension number.
7. Once you hear the interpreter is on the line with you, press the “Conference” button.

- For additional information on procedure or code of conduct, see your guide “Language Line Translation Services” in your office or call the County Office of Communications at ext. #7737.

**Assistance with Deaf/Speech Impaired**

California Relay Service (CRS) is a free telephone assistance service available 24 hours a day, seven days a week. This service provides human voicers for people who have difficulty being understood by the public. CRS enables those who are deaf, hard of hearing, or speech impaired/disabled to use Text Telephones (TDDs) or Personal Computers (PCs) to use voice telephone through a professionally trained relay operator.

“Speech-To- Speech” is a part of the California Relay Service (CRS) and is provided through the Deaf and Disabled Telephone Program. This service was developed for consumers with speech disabilities.

When you use CRS, you dial into the relay center and ask the Relay Operator to dial the number you want to call. The Relay Operator then stays on the line to “convey” the conversation between you and the called party. Simply request Voice Carry Over (VCO) or Hearing Carry Over (HCO). The relay operator conveys TDD-typed messages verbally and spoken messages via TDD. Your conversion is completely confidential.

To use CRS, dial one of the numbers below to meet your specific need. When using your P.C., select two-line VCO. This requires that you have a modem (or TDD) and a two-line telephone. One of the telephone lines must have 3-way conferencing from a local telephone company.

**TDD:** For the hearing impaired dial 1-800-735-2929
**Voice:** For those with speech disabilities dial 1-800-735-2922
**Spanish:** For the deaf/speech impaired who need translation service dial 1-800-855-3000
**Computer:** For those who want to use their own PCs to type messages and receive messages.
POLICY

The Placer County Adult and Children's System of Care (SOC) and Sierra County Health and Human Services will provide free interpreters and/or linguistically proficient staff for all hours, including regular operating hours, for each service, for each Key Points of Contact site, for each threshold and non-threshold language.

PURPOSE

This policy and procedure provides guidelines for the provision of interpreters and linguistically proficient staff at Key Points of Contact.

DEFINITION

Key Points of Contact are defined as: “Common points of entry into the mental health system, including 24-hour toll free line, beneficiary problem resolution system, inpatient hospital or other central access or contact locations where there are face-to-face encounters with consumers as designated by the MHP.” (DMH Information Notice No. 02-03.) “Mandated Key Points of Contact” are defined as: (Key Points of Contact) that are located in regions or areas that meet threshold language population concentrations.” (DMH Information Notice No. 02-03.)

Reference: DMH Information Notice No. 02-03.

PROCEDURE

B. The Placer County SOC identifies the following sites as Key Points of Contact:
   - Adult Intake Services (888-886-5401 and 916-787-8860)
   - Family and Children's Services (866-293-1940 and 916-872-6549)
   - Psychiatric Health Facility, Cirby Hills, Roseville
   - Turning Point Community Programs
   - Placer County Children's Shelter, Auburn
In addition, the SOC identifies the following sites as Mandated Key Points of Contact with threshold languages identified:

- The Lighthouse, Lincoln (Spanish)
- Sierra Family Services, Kings Beach (Spanish)

Sierra County HHS identified the following sites as Key Points of Contact:

- Mental Health Crisis Services (887-435-7137)
- Mental Health Services (530-993-6746)

C. Placer/Sierra Counties will provide linguistically proficient staff and/or interpreters for threshold and non-threshold populations.
   A. To the extent possible, the Placer/Sierra MHP will hire bicultural-bilingual and /or linguistically proficient staff in Mandated Key Points of Contact.
   B. When linguistically proficient staff are unavailable, the Placer/Sierra Mental Health Plan (MHP) will hire interpreters.
   C. Staff will be trained on the use of the ATT Language Line Translation Services. See Attachments A and B.
   D. Staff will be trained on how to arrange in-person translation services via county contract.
   E. Clients may bring their own interpreters and have the right to approve interpreters arranged by the Placer/Sierra MHP.

D. The Placer/Sierra MHP will provide interpretive services in Key Points of Contact.
   A. Interpretative services are available through the 24 hour ATT Language Line Translation Services. See Attachments A.
      - Staff are to be trained on the use of this service.
   A. When possible, bicultural-bilingual staff will be hired in Key Points of Contact.
   C. Staff will be trained on how to arrange in-person translation services via county contract.
   D. Clients may bring their own interpreters and have the right to approve interpreters arranged by the MHP.
   E. Staff may use on-site bilingual resources. Alternately, staff may request the ASOC Director's Executive Secretary obtain a current list of Placer MHP bicultural-bicultural staff and their phone numbers from the HHS Personnel Analyst.
Procedure for Accessing Interpreter Services
(Translation of Languages/Deaf/Disabled Speech)

Assistance with a Language Barrier

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1. Tell caller to please hold for operator assistance. (In Spanish, “Por favor espere en la línea para asistencia con una operadora.”)
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3. Dial Ext. 3333. This will access the Language Translation Line Service.
4. Give language request i.e….Spanish, German, etc.
5. Give your client ID # 501053 and organization name “Placer County.”
6. Give your personal code - your extension number.
7. Once you hear the interpreter is on the line with you, press the “Conference” button.

• For additional information on procedure or code of conduct, see your guide “Language Line Translation Services” in your office or call the County Office of Communications at ext. #7737.

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“Speech-To-Speech” is a part of the California Relay Service (CRS) and is provided through the Deaf and Disabled Telephone Program. This service was developed for consumers with speech disabilities.

When you use CRS, you dial into the relay center and ask the Relay Operator to dial the number you want to call. The Relay Operator then stays on the line to “convey” the conversation between you and the called party. Simply request Voice Carry Over (VCO) or Hearing Carry Over (HCO). The relay operator conveys TTY-typed messages verbally and spoken messages via TTY. Your conversation is completely confidential.

To use CRS, dial one of the numbers below to meet your specific need. When using your P.C., select two-line VCO. This requires that you have a modem (or TTY) and a two-line telephone. One of the telephone lines must have 3-way conferencing from a local telephone company.

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Voice: For those with speech disabilities dial 1-800-735-2922
Spanish: For the deaf/speech impaired who need translation service dial 1-800-855-3000
Computer: For those who want to use their own PCs to type messages and receive messages.
Please say the following phrase to Spanish speaking callers:

"Por favor espera en la línea mientras obtengo a un intérprete para usted."

It will let them know that you are getting an interpreter for them.
Family Members as Interpreters

**POLICY**

Placer County Mental Health Plan (MHP) is committed to ensuring that clients are able to obtain knowledge and access appropriate services. To this end, the MHP is also committed to ensuring access to linguistically proficient staff and interpreters to assist with this process in accordance with state and/or federal law.

**PURPOSE**

To ensure that Medi-Cal beneficiaries and non-Medi-Cal clients have access to linguistically proficient staff and interpreters in order to be fully informed regarding access to mental health services in an easy to understand and culturally competent manner.

**PROCEDURE**

**Person Responsible: System of Care Staff**

8. Provide Interpreter services to Medi-Cal beneficiaries following the Placer/Sierra County Systems of Care Policy and Procedure on the Use of Linguistically Proficient Staff and Interpreters.

9. Provide Interpreter services without the expectation that family members will provide interpreter services, due to clinical dynamics, and creation of a dual role for family members. Use of family members is to be avoided in all instances possible. Exceptions include when the beneficiary requests a family member due to comfort level or cultural factors.
Questions and Comments

1. Did you find county employees to be courteous and respectful?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Comments:

2. Did staff return your phone calls by the end of the next day after you left a message?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Comments:
- Sometimes but would not give any information
- Sometimes phone number not working when he was called
- By next day

3. Were you offered a Spanish-speaking provider or interpreter?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Comments:
- Not need interpreter speaks english
- Does not need was born in Santa Rosa
- Speak English born here in Mexico but has live since was 5 yrs old
- She spoke english
4. Were you given written information about our services that you could understand?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Comments:

5. If you had a case manager, did you work together to plan your treatment?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Comments:
- Been a while since contacted
- Did not want to answer she was told not to talk to anyone

6. Were you able to get all the services from us that you thought you needed?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Comments:

7. Did the services that were provided help you with your problems?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Comments:
- Help a lot

8. Overall, did you like the services you got from us?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Comments:

9. Is there anything else you would like to tell us about your experience?

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Comments:
- Workers are very helpful – Groups services are very good and help to talk about problems – Liked the group sessions very much – Does not have any drug or problems
- Was told not to give info out, would not answer questions because was not told of this survey

Extra Comments not specific to any one question:
- Did not want to give any information until I assured her that I was not going to ask about her personal problems
- This client could not answer question because of his illness – His mother died and is taking real hard – His sister is trying to find some kind of job for him because he is very tired of doing nothing and will do volunteer work

Client Information

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Child</th>
<th>Adult</th>
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<tbody>
<tr>
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<td>2</td>
</tr>
</tbody>
</table>

![Bar chart showing data distribution](chart.png)

<table>
<thead>
<tr>
<th>Total Respondents</th>
<th>Male</th>
<th>Female</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>Auburn</td>
<td>Roseville</td>
<td>Lincoln</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
IDENTIFICAR LA INFORMACIÓN

Estudiante:
 Padres:
 Fecha de nacimiento:

Razón para la referencia: es referido por Ann Valentino, psicólogo de la escuela para el distrito unificado de Tahoe Truckee para la evaluación conforme al código administrativo 26.5 de California. Esta evaluación es para determinar si el funcionamiento educativo de este niño está interferido por la salud mental. Los personales de la escuela están preocupados por los arrebatos emocionales, denegación para conformarse con instrucciones, colocando lo y otros en situaciones peligrosas, agresión contra otros estudiantes y comportamiento sexual inapropiado. Estas dificultades han resultado en tiempo perdido de la instrucción de sala de clase y han hecho necesario su colocación en una sala de clase individual y portable con dos terapeutas del comportamiento.

Los padres de están abrumados por su comportamiento y Otras realidades de sus vidas y parece que los padres de están haciendo lo mejor que puedan para asistir con la educación de su niño.

Contactos: asiste terapia en el Sierra Family Services aproximadamente una vez cada dos meses. También visita La psiquiatra que se contrata a la clínica de salud del condado del Placer trimestralmente o según lo necesite. Las terapias que hablan no han demostrado para ser eficaces en ayudar a este niño a ajustar a las necesidades de la asistencia de escuela y está tratado a través de la medicación. Lo están tratando actualmente con Strattera 40 por día y Risperdal 0.25 por día para tratar una diagnosis del síndrome de Hyperkinetic con el retraso mental.

GRAVAMEN CLÍNICO

Última Historia Significativa: es el segundo más joven de 5 niños de y de tiene una hermana menor que tiene 7 años. Dos hermanos mayores recibieron la instrucción de la educación especial bajo criterios
calificativos del retraso mental. Asumen que un hermano mayor y una hermana menor están aprendiendo normalmente. Los padres parecen carismáticos y aparece que están cuidando para sus niños y ha hecho esfuerzos de identificar y de tener acceso a servicios y a los recursos para ellos. Es evidente que tiene una
inhibibilidad de aprender y no puede manejar o regular sus emociones. El no puede entender y respetar las sensaciones y las emociones de otras ni es capaz de definir los límites del comportamiento aceptables basados en conocimiento social cognoscitivo.

MÉDICO A excepción de la cirugía corregir una hernia en 2000 no es ninguna evidencia de que está con nada más que salud física excelente.

EXAMINACIÓN MENTAL DEL ESTADO ha aparecido ser alerta, despierto y conciente de sus alrededores. Le divulgán para aparecer feliz, sintiendo pero no contesta a preguntas en ninguna manera elaborada. El tiene respuestas de una palabra a las preguntas. El no aparece ser ansioso ni depresivo. Su intuición y el juicio son muy inmaduros. El no está con intención de suicidarse ni esta homicida. El goza jugar de juegos y ha indicado que le gusta ir a la escuela. En septiembre de 2006 fue sacado accidentalmente de Strattera y Risperdal por su madre y desarrolló comportamiento hiper sexual y alucinaciones a fondo. Cuando era otra vez medicación obediente, las alucinaciones acudieron y el comportamiento hiper sexual cesaron. Los desórdenes mentales transitorios pudieron haber sido un aspecto de los síntomas del retraso de la medicación prescripta. El comportamiento de puede ser no-obediente durante un periodo. El es obediente la mayoría del tiempo pero el extremo de su incumplimiento con reglas o instrucciones detras seriamente de sus comportamientos positivos. puede ser agresivo y hostil. El es extremadamente hiperactivo y tiene dificultad extrema en centrarse en una idea o una actividad específica que a él no le gusta. es diagnosticado por su psiquiatra que trata con el síndrome hiperkinético asociado al retraso mental. No hay otra diagnóstico de la salud mental hecha en este tiempo. El funcionamiento adaptante es deficiente; sin embargo, hay una certa indicación que este niño tiene cierto nivel de la Inventiva funcionales. La Inventiva se pueden considerar como solamente el gimnasio o molestando a su madre o profesor para algo que él desea pero este comportamiento es la indicación del proceso del pensamiento que puede ser, y está probablemente, utilizado para ayudarle a desarrollar habilidades de la vida.

Los disparadores del comportamiento son desconocidos. Allí no se parece pensar patrones de rechazo o miedo del daño. Sus comportamientos son probablemente comportamientos aprendidos para obtener lo que él desea.

FORMULACIÓN

es un varón hispanico de 13 años. Él está en la custodia legal y física común de sus padres. Noe ha entrado adolescencia y los cambios sociales,
sexuales y emocionales están ocurriendo a él. Él no ha aprendido que las habilidades para manejar o para regular sus emociones o comportamientos y él pueden pasar las estructuras que eran provechosas en sus años más jóvenes. No hay evidencia para sospechar un pensamiento formal o un desorden perceptivo a excepción de los síntomas transitorios que ocurrieron cuando lo sacaron de sus medicaciones psicofármacos de la prescripción. No aparece que ha habido una repetición de estos síntomas transitorios. Está aprendiendo algunas habilidades de la vida pero su hiperactividad y su inabilidad de manejar o de regular sus emociones y comportamientos están interfiriendo con su educación en una manera progresivamente más desafiadora mientras que él consigue más viejo. Pues las presiones sociales aumentan, sus capacidades que hacen frente serán probadas y él puede experimentar comportamientos impulsivos crecientes.

RECOMENDACIONES

Esta evaluación indica que está experimentando un efecto nocivo sobre su capacidad de beneficiar de la instrucción de sala de clase debido a conflicto emocional en curso y de su inabilidad de regular esas emociones, que alternadamente provocan comportamientos impulsivos. El conflicto y la inhabilidad emocionales de regular emociones también está contribuyendo a su desarrollo de los comportamientos que lo enajenan más lejos del ambiente académico y social que él necesita en esta fase de desarrollo de su vida. Los servicios médicos mentales conforme a un IEP se autorizan. Se recomienda que reciba servicios médicos mentales conforme al capítulo 26.5. El tratamiento puede tratar los criterios siguientes del tratamiento:

Caja fuerte: El estado emocional y el comportamiento de pueden ser imprevisibles. Mientras que él consigue más viejo, él puede ser visto como amenaza por otras y cualquiera sea lastimado por las personas o por accidente.

Servicios Propuestos:
1. 26.5 sierra servicios de los servicios
2. de la familia para coordinar cuidado psiquiátrico.
3. El ajuste de la estructura de la escuela como madura físicamente.

Resultados:
1. tendrá un marco de tiempo extendido a aprender manejar y regular la emoción.
2. recibirá el tratamiento médico para asistir con sus emociones y comportamiento.

Sanz: Los comportamientos impulsivos y de riesgo elevado pueden ser la amenaza más grande a físico y a los servicios médicos emocionales propuestos:
1. 26.5 sierra servicios de los servicios
2. de la familia para coordinar cuidado psiquiátrico.

Resultados:
1. tendrá suficiente estructura para contener su impulsivity.
2. aprenderá determinar el grado del riesgo asociado a su comportamiento.

EN EL PAÍS: La comunicación entre la escuela, los padres, el sierra servicios de la familia y el siqua el médico clínica del condado del placer seguirá siendo sucinta.

Servicios Propuestos:
1. 26.5 sierra servicios de los servicios
2. de la familia para proporcionar la coordinación para el cuidado psiquiátrico.
3. El sierra servicios de la familia se comunicará directamente con los padres en un mínimo de quarterly o según lo necesite:

Resultados:
1. La comunicación será consolidada con la coordinación mejorada del equipo.
2. No habrá errores en instrucciones y recomendaciones médicas.

EN ESCUELA: tiene dificultad en mantener el foco constante en la escuela debido a los síntomas debilitantes del hyperkinesis y del retraso mental.

Servicios Propuestos:
1. 26.5 servicios para tratar habilidades de regla emocionales.
2. El sierra servicios de la familia coordinará cuidado psiquiátrico.
3. Un IEP que refleja una meta de contener dentro de la característica de la escuela.

Resultados:
1. mantendrá un nivel óptimo del foco y de la calma física a través de la medicación.
2. La estructura para crecerá con sus necesidades de la estructura.

FUERA DE APURÓ:
aprenderá expresar sus necesidades con la comunicación verbal más bien que con la agresión y el impulsivity.

Servicios Propuestos:
1. 26.5 servicios para tratar habilidades de regla emocionales.
2. Estructura en la escuela y en el país hasta tal hora que tiene la capacidad de regular sus emociones y comportamientos.

Resultados:
1. Habrá un requisito reducido para mantener extraescolar o para proporcionar la experiencia alternativa de la sala de clase debido a su agresión hacia otras o a su de inhabilitación de seguir las peticiones de los profesores y del otro personal de la escuela.

CONCLUSIÓN
es un niño que está experimentando dificultad en la obtención de una educación debido a dificultades emocionales. La cooperación entre los padres, el distrito de la escuela, el sierra servicios de la familia, la clínica de la salud del condado del placer y otras agencias de la comunidad es desarrollando un plan educativo individualizado mejorará grandemente la probabilidad que generará
una educación máxima y desarrollará las habilidades interpersonales y emocionales que conducirán a la mejor vida posible del adulto. En este tiempo, no aparece que la sicoterapia será provechosa a la familia que aconseja, especialmente consulta a los padres puede ser absolutamente provechosa.

Efrain Estrada, MSW

Tracey Barrett, MA
APPENDIX G-6

CLIENT SERVICES INFORMATION SHEET (CSI)

1. Your (Client) Legal Name: (Last) ____________________________ (First) ____________________________ (Middle) ____________________________
2. Birth Name: (Last) ____________________________ (First) ____________________________ (Middle) ____________________________
3. AKA (other names used): (Last) ____________________________ (First) ____________________________ (Middle) ____________________________
4. Social Security #: ____________________________ Date of Birth: ____________________________ Age: ______ Mother's First Name: ____________________________
5. Place of Birth: (City) ____________________________ (County) ____________________________ (State) ____________________________ (Country) ____________________________
6. Sex: ☐ Male ☐ Female ☐ Other Identification: ☐ Valid Driver's License ☐ I.D. State Number ____________________________
7. Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Coupled ☐ Separated ☐ Unknown/Not Disclosed
8. Address: (Mailing Address) ____________________________ ____________________________ (City) ____________________________ (State) ____________________________ (Zip) ____________________________
9. Address: (Physical Address) ____________________________ ____________________________ (City) ____________________________ (State) ____________________________ (Zip) ____________________________
10. Phone 1: ____________________________ Phone 2: ____________________________ Email: ____________________________
11. Ethnicity: Are you Spanish, Hispanic, or Latino? ☐ Yes ☐ No
   For example: Mexican, Central American, South American, Cuban, or mother Hispanic group?
12. Race: Please check or list the race(s) that describe your identity the best. (You can check or list up to 5.)
   ☐ White/Caucasian ☐ Black/African American ☐ American Indian or Alaska Native
   ☐ Other ____________________________
13. Primary Language: Please check or list one.
   ☐ English ☐ Spanish ☐ Russian ☐ American Sign Language ☐ Other ____________________________
14. Preferred Language: I prefer to receive services in the following language:
   ☐ English ☐ Spanish ☐ Russian ☐ American Sign Language ☐ Other ____________________________
15. Would you like any culturally specific services? ☐ Yes ☐ No ☐ Not sure If you, identify the type and describe.
   ☐ I would like to receive services in my preferred language.
   ☐ I would like to receive services from a provider who is competent in my culture. (Culture can mean race,
   religion, sexual orientation, or any other group identity that you may have.) What is the culture or group identity:
16. Do you need wheelchair access or other accommodation for a disability? ☐ No ☐ Yes ____________________________
17. Please list your next of kin and other members of your family/household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Client</th>
<th>Date of Birth</th>
<th>Social Security No. (if available)</th>
<th>Address</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sister</td>
<td></td>
<td>Same as above</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>S. AN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. Insurance Coverage: Do you have any of the following insurance plans or benefits? Check all that apply.
   ☐ Medi-Cal ☐ Medi-Care Part A ☐ Part B ☐ Healthy Families: ____________________________ (plan)
   ☐ No Health Insurance ☐ VA Benefits ☐ Other Health Insurance: ____________________________ (plan)
19. May we identify our agency if we call? You home? ☐ Yes ☐ No Your work? ☐ Yes ☐ No

Signature of Person Completing: ____________________________ Date: 04/13/07

CARE/014 Rev. 05/01/06 Yellow Copy: Clinical - for VA/VAIR Support/Client
**PLACER COUNTY SYSTEMS OF CARE**

**Authorization #:** A - 50814  
**Client:** 188599

**Date of Authorization:** 10/17/2007  
**Episode:** 4 - MH FFS Catworks MFT, MFCC O/P  
**Type of Authorization:** Mental Health O/P  
**Level of Care:** Standard  
**Account Type:** Adult - MH Services

**Provider Authorized:** 9832  
RAHDAH-AHMADZAI, SONIA, MFT  
1633 POPPY CIRCLE  
ROCKLIN CA 95765

---

**Services provided outside of the dates of authorization will not be reimbursed. Additionally, in order to receive payment, only the services/goods authorized may be provided.**

**Period of Authorization is:** From: 10/17/2007 To: 10/24/2007

### Services/Goods Authorized

<table>
<thead>
<tr>
<th>Code/Description</th>
<th>Quantity</th>
<th>Cost Per Unit</th>
<th>Amount Authorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>90806 Individual Therapy - 45 to 74 min</td>
<td>120</td>
<td>0.83</td>
<td>99.60</td>
</tr>
<tr>
<td>90887 Collateral Services</td>
<td>120</td>
<td>0.83</td>
<td>99.60</td>
</tr>
</tbody>
</table>

---

**Total Amount Authorized**  
199.20

All required clinical documentation and written Requests for Reauthorization should be mailed to:  
SOC Managed Care Unit  
11716 Enterprise Dr.  
Auburn, CA 95603  
Phone: (530) 886-5400

Requests for Reauthorization should be submitted at least 10 days prior to end of authorization.

Mail invoices to: **Please attach a copy of this service authorization form to each invoice.**

HHS CAPP Unit (MSO)  
379 Nevada St.  
Auburn, CA 95603  
Phone: (530) 886-1872

For authorization questions, please contact case manager below.

**Case Manager:** Sandy Gather, Client Svcs. Pract. II  
**Office:** HS STONEHOUSE  
**Phone #:** 916-784-6087

**Immediate Supervisor:** Cara Lucero, Client Svcs. Prog. Supervisor  
**Phone #:** 530-889-7617

**Authorized by:** Cara Lucero, LCSW, Client Svcs. Prog. Supervisor  
**Phone #:** 530-889-7617

---

**228**
Profile:

Last Name: Rahel-Ahmadzai  First Name: Sonia

Tax ID:  Social Security #: 051-70-5592

DEA # (for MDs): LMT  Date Issued: 12/31  Expiration: 4/30/06

Cultural Identity (optional): Afghanistan

Clinic / Group / Corporation Name:

Supervisor (for interns only):

Primary Office Address:

Street: 4731 Five Star Blvd # E  Suite: E
City: Rocklin  County: Placer  Zip: 95767
Phone: 630-0300  Fax:

Secondary Office Address:  Not Applicable

Street:
City:  County:  ZIP:
Phone:  Fax:

Billing Information:  Payee and office same as above

Payable to: Sonia Rahel-Ahmadzai
Street: 1633 Poppy Circle  Suite:
City: Rocklin  State: Ca  ZIP: 95765
Phone: 630-0300  Fax:

Availability / Accessibility:

Handicap accessible?  Yes  No  Parking on site?  Yes  No  Public Transportation nearby?  Yes  No
Currently Available?  Yes  No  Available Weekends?  Yes  No
Hours Available:  Days Available:

Professional / Medical Education:

Medical / Professional School: National University

Address: Lawrence Ave
City: San Jose  State: Ca  ZIP:

Degree Received: Masters  Date Obtained: Counseling Psychology
CONFIDENTIAL

LANGUAGES:

Please identify languages in which you can provide services, other than English:

☐ None
☐ American Sign Language
☐ Spanish
☐ Russian
☐ Other: Farsi/Dari and Hindi

Please include proficiencies as follows: ☐ Bilingual ❏ Reading ☐ Writing

CULTURE:

Please identify any culture/faith in which you may provide cultural competency:

☐ None
☐ American Indian
☐ African American
☐ Hispanic
☐ Russian
☐ Other: Afghan

SERVICE SITE:

If the site from which you will be delivering services differs from the "billing office" information provided in the Managed Care Provider Application, please explain and provide location information:

ADDITIONAL COMMENTS:

Eleven years I experience working with emotionally disturbed kids of families, with diversity of emotional and environmental challenges. I have been part of community-based pediatrics (i.e. group homes, foster care, kinship, etc.) utilizing a strengths-based family centered model that focuses on cognitive behavioral and clinical orientation. I understand that, depending upon the information received, a supplemental application may be required. I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application or termination of my participation agreement.

I understand that, as a panel member of the Placer County Mental Health Managed Care Plan, I must comply with the responsibilities and procedures as outlined in the Placer County Systems of Care Network Providers Manual, and I agree to accept the rates as established by the Placer County Mental Health Managed Care Plan.

Signature of Provider:

Sonia Rahel-Ahmadzai

Date: 11/6/04

Print Name
CLIENT SERVICES INFORMATION SHEET (CSI)

Instructions: May be completed by client, client's representative, clerical support, or practitioner. "Client" is the individual receiving services.

1. Your (Client) Legal Name: (Last) [Redacted] (First) [Redacted] (Middle) [Redacted]
2. Birth Name: (Last) [Redacted] (First) [Redacted] (Middle) [Redacted]
3. AKA (other names used): (Last) [Redacted] (First) [Redacted] (Middle) [Redacted]
4. Social Security #: [Redacted] Date of Birth: / / Age: _ Mother's First Name: ___
5. Place of Birth: (City) [Redacted] (State) [Redacted] (Country) [Redacted]
6. Sex: ☐ Male ☐ Female ☐ Other Identification: ☐ Valid Driver's License ☐ I.D. ☐ State Number
7. Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown/Not Disclosed
8. Address: (Mailing Address) [Redacted] (City) [Redacted] (State) [Redacted] (Zip) [Redacted]
9. Address: (Physical Address) [Redacted] (City) [Redacted] (State) [Redacted] (Zip) [Redacted]
10. Phone 1: [Redacted] Phone 2: [Redacted] E-mail: [Redacted]
11. Ethnicity: Please check or list one.
   ☐ Mexican/Mexican American ☐ Cuban ☐ Puerto Rican ☐ Other Hispanic/Latino
   ☐ Not Hispanic ☐ Other:
12. Race: Please check or list the race(s) that describe your identity the best. (You can check or list up to 3).
   ☐ White/Caucasian ☐ Black/African American ☐ American Indian or Alaska Native
   ☐ Other:
13. Primary Language: Please check or list one.
    ☐ English ☐ Spanish ☐ Russian ☐ American Sign Language ☐ Other:
14. Preferred Language: I prefer to receive services in the following language:
    ☐ English ☐ Spanish ☐ Russian ☐ American Sign Language ☐ Other:
15. Would you like any culturally specific services? ☐ Yes ☐ No ☐ Not sure
    If yes, identify the type and describe.
    ☐ I would like to receive services in my preferred language.
    ☐ I would like to receive services from a provider who is competent in my culture. (Culture can mean race, religion, sexual orientation, or any other group identity that you may have.) What is the culture or group identity:
16. Do you need wheelchair access or other accommodation for a disability? ☐ No ☐ Yes
17. Please list your next of kin and other members of your family/household:

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</table>

18. Insurance Coverage: Do you have any of the following insurance plans or benefits? Check all that apply.
   ☐ Medi-Cal ☐ MediCare Part A ☐ Part B ☐ Healthy Families: ________ (plan)
   ☐ No Health Insurance ☐ VA Benefits ☐ Other Health Insurance: ________ (plan)

19. May we identify our agency if we call your home? ☐ Yes ☐ No Your work? ☐ Yes ☐ No

Signature of Person Completing: __________________________
Date: 7/30/09

Print copy: Client Copy
Yellow Copy: Clinical - for AVATAR input/Printed
placed County Systems of Care

Managed Care Unit
Case Management Checklist
Opening/Closing Mental Health Chart

Client's Name: [Redacted]   AVATAR #: [Redacted]
SSN #: [Redacted]   DOB: [Redacted]
Case Worker: Wally Keller

Date Given to Caseworker: 6/17/2009

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
</table>
| 6/26/09 | 1st CW Phone Contact (CW)  
Client informed to select Provider and confirm with CW  
☐ Left msg.  
☐ Phone disconnected—letter sent |
| 6/1/09 | 2nd CW Phone Contact (CW)  
Client informed to select Provider and confirm with CW  
☐ Left msg.  
☐ Phone disconnected—letter sent |
| 6/14/09 | Initial Close-Out Letter sent to client due to no client response (CW) |
| 6/26/09 | Initial auth for Assessment completed (CW) |
| 6/26/09 | Provider informed initial auth has been approved (CW) |
| 8/21/09 | Authorization signed by Supervisor (Sup) |
| [Redacted] | Auth—AVATAR Data Entry (C) |
| 7/30/09 | Assessment received and staffed: ☑ by CM  ☐ at CM consult |
| ☑ Case accepted by MCU  
☐ Referral to ASOC  
☐ Referral to CSOC  
☐ Counseling not recommended by therapist  
☐ Client does not meet Medical Necessity criteria. NOA sent: |
| 8/21/09 | If Child, EDIF completed—Family contacted to obtain consent to participate (CW) |
| 8/21/09 | USP and ICD-9 completed (CW) |
| [Redacted] | 4th Re-Auth received in MCU - Avatar Data Entry (C) |
| [Redacted] | 4th Re-auth request reviewed and re-auth worksheet completed (CW) |
| [Redacted] | Authorization signed by Supervisor (Sup) |
| [Redacted] | Auth—AVATAR Data Entry (C)  
☐ Returned to CM for corrections |
| [Redacted] | 2nd Re-Auth received in MCU - Avatar Data Entry (C) |
| [Redacted] | 2nd Re-auth request reviewed and re-auth worksheet completed (CW) |
| [Redacted] | Authorization signed by Supervisor (Sup) |
| [Redacted] | Auth—AVATAR Data Entry (C)  
☐ Returned to CM for corrections |
| [Redacted] | Date case closed in MCU episode in AVATAR |
| ☑ MCU Checklists and Approval for Transfer or Discharge  
☐ CARE 553a ICD-9 Diagnosis Form  
☐ CARE 624 Periodic (if being discharged from all County services) |

NMCU CM Checklist Rev. 7/1/09

232
PLACER COUNTY SYSTEMS OF CARE

Authorization #: A - 59461

Date of Authorization: 8/1/2009
Episode: 2 - MH SFS Roseville O/P (25)
Type of Authorization: Mental Health O/P
Level of Care: Standard
Account Type: Child - MH Services

Provider Authorized: 9226

SIERRA FAMILY SERVICES ROSEVILLE, OR
333 SUNRISE AVE STE 701
ROSEVILLE CA 95661

Special Instructions to Provider:
LINCOLN LIGHOUSE, ELEANOR HERNANDEZ

Services provided outside of the dates of authorization will not be reimbursed.
Additionally, in order to receive payment, only the services/goods authorized may be provided.

Period of Authorization is: From: 8/1/2009 To: 10/31/2009

<table>
<thead>
<tr>
<th>Code/Description</th>
<th>Quantity</th>
<th>Cost Per Unit</th>
<th>Amount Authorized</th>
</tr>
</thead>
<tbody>
<tr>
<td>90806 Individual Therapy - 45 to 74 min</td>
<td>720</td>
<td>2.04</td>
<td>1,468.80</td>
</tr>
<tr>
<td>10847 Family Therapy (with client present)</td>
<td>180</td>
<td>2.04</td>
<td>367.20</td>
</tr>
</tbody>
</table>

Total Amount Authorized 1,836.00

All required clinical documentation and written Requests for Reauthorization should be mailed to:
SOC Managed Care Unit
11716 Enterprise Dr.
Auburn, CA 95603
Phone: (530) 896-5400

Requests for Reauthorization should be submitted at least 10 days prior to end of authorization.

Mail invoices to: Please attach a copy of this service authorization form to each invoice.
HHS CAPP Unit (MSO)
379 Nevada St.
Auburn, CA 95603
Phone: (530) 886-1872

or authorization questions, please contact case manager below.
Case Manager: Wally Keller, Client Svcs. Prac. II
Office: MGD CARE ENT Phone #: 530-886-5410
Immediate Supervisor: Michelle Johnson, Client Svcs. Prog. Supervisor Phone #: 530-886-5463
Authorized by: Twylla Abrahamson, PHD, Client Svcs. Prog. Manager Phone #: 533-886-5440
Systems of Care Progress Note

Billing Formula: Minutes of Service: 15 + Documentation Time: 10 + Travel Time:* = Total Billable Minutes: 25

*Travel Time may only be included in billable minutes if it was necessary to travel to an offsite location to provide the service. The Travel time is roundtrip to the place of service and back to your organization. Travel time cannot be calculated when you travel from one Placer County site to another Placer County site.

Service Provided: Targeted Case Management

Location of Service: Phone

Unified Service Plan objective client is working on: New Referral

Narrative:

Client's Current Functioning/Progress: This child requires a biopsychosocial assessment to better determine the extent of the presenting mental health concerns. This child is being referred to a Network Provider for the assessment.

Current Intervention: This worker called and spoke briefly with this client's parent to discuss the request for mental health services. This worker briefly introduced the Managed Care Unit, explained the forthcoming informing packet by mail. This worker asked the parent about using Network Provider Eleanor Hernandez (Sierra Family Services, Roseville, stationed at Lincoln Lighthouse) as she is the only bi-lingual, Spanish speaking therapist in Lincoln at this time. The parent indicated that this arrangement would be satisfactory. This worker then agreed to authorize services, and prepared the worksheet and submitted it for approval.

Client's Response: This child's parent appeared to be motivated to assist her child in obtaining the needed mental health services, and agreed to encourage active involvement in treatment.

Follow-up and/or Referrals Made: This worker will monitor the client's progress in treatment, and will reauthorize services as long as they are medically necessary.

Signature (Include licensure or job title): Wally A. Keller, Client Services Practitioner

Date Completed: 6/26/2009

Print Name

Client Name: [Redacted] AVATAR Number: [Redacted]

CARE 041 Revised: 07/25/2006 SOC Official Template ©
PLACER COUNTY SYSTEMS OF CARE

Authorization #: A - 58957
Client: [Redacted]
Provider Authorized: 9226

Date of Authorization: 8/26/2009
Episode: 2 - MH SFS Roseville O/P (25)
Type of Authorization: Mental Health O/P
Level of Care: Standard
Account Type: Child - MH Services

Special Instructions to Provider:
ELEANOR HERNANDEZ, LINCOLN LIGHTHOUSE CASE /REFERRAL

SIERRA FAMILY SERVICES ROSEVILLE, OR
333 SUNRISE AVE STE 701
ROSEVILLE CA 95661

Services provided outside of the dates of authorization will not be reimbursed. Additionally, in order to receive payment, only the services/goods authorized may be provided.


<table>
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<tr>
<th>Code/Description</th>
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<th>Cost Per Unit</th>
<th>Amount Authorized</th>
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</thead>
<tbody>
<tr>
<td>90801 Assessment</td>
<td>120</td>
<td>2.04</td>
<td>244.80</td>
</tr>
</tbody>
</table>

All required clinical documentation and written Requests for Reauthorization should be mailed to:
SOC Managed Care Unit
11716 Enterprise Dr
Auburn, CA 95603
Phone: (530) 886-5400

Requests for Reauthorization should be submitted at least 10 days prior to end of authorization.

Mail invoices to: Please attach a copy of this service authorization form to each invoice.
HHS CAPP Unit (MSO)
379 Nevada St.
Auburn, CA 95603
Phone: (530) 886-1872

For authorization questions, please contact case manager below.
Case Manager: Wally Keller, Client Svcs. Pract. II
Office: MGD CARE ENT
Phone #: 530-886-5410

Immediate Supervisor: Michelle Johnson, Client Svcs. Prog. Supervisor
Phone #: 530-886-5463

Authorized by: Twylla Abrahamson, PhD, Client Svcs. Prog. Manager
Phone #: 530-886-5440

Total Amount Authorized: 244.80
PLACER COUNTY SYSTEMS OF CARE

Authorization #: A - 59461

Client: [Redacted]

Date of Authorization: 8/1/2009
Episode: 2 - MH SFS Roseville O/P (25)
Type of Authorization: Mental Health O/P
Level of Care: Standard
Account Type: Child - MH Services

Provider Authorized: 9226

SIERRA FAMILY SERVICES ROSEVILLE, OR
333 SUNRISE AVE STE 701
ROSEVILLE CA 95661

Special Instructions to Provider:
LINCOLN LIGHTHOUSE, ELEANOR HERNANDEZ

Services provided outside of the dates of authorization will not be reimbursed. Additionally, in order to receive payment, only the services/goods authorized may be provided.

Period of Authorization is: From: 8/1/2009 To: 10/31/2009

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Office: MGD CARE ENT
Phone #: 530-886-5410

Immediate Supervisor: Michelle Johnson, Client Svcs. Prog. Supervisor
Phone #: 530-886-5463

Authorized by: Twyla Abrahamson, PHD, Client Svcs. Prog. Manager
Phone #: 530-886-5440
APPENDIX G-7

LANGUAGE LINE TRANSLATION SERVICE
EST 1984

TABLE OF CONTENTS

WHAT IS IT? ................................. 1
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HOW DOES IT WORK? ................... 3
WHAT IS INTERPRETATION? .......... 2
RESPONSIBILITIES OF THE CALLER .... 2
HOW TO HANDLE A TYPICAL CALL .... 4
HOW TO MAKE A CONFERENCE CALL ... 4
HOW TO USE VIDEOCONFERENCING .... 6
WORKING WITH AN INTERPRETER ..... 8
LINGUISTIC QUALITY PROBLEMS ... 9
SECURITY .............................. 16

WHAT IS IT?

Language Line is an over-the-phone interpretation service provided by Albright which allows you access to translators for over 160 different languages 24 hours a day, seven days a week.

WHAT IS INTERPRETATION?

Interpretation is the oral transmission of a message from the original language, known as the source language, into another language, referred to as the target language.

The Interpreters' Code of Conduct requires that they:

1. Be accurate and to the point.
2. Make no additions or omissions in your message.
3. Maintain confidentiality in the context of all interpretations.
4. Refuse assignments when they may have a conflict of interest.
5. Depend on you, the client, to direct the conversation.
6. Maintain a professional demeanor and be courteous to all people involved in the interpretation.

Interpreters are trained to adapt the phonology that most accurately conveys the true meaning of your message instead of doing a word-for-word translation.

Interpreters are assigned 4-digit ID numbers. This 4-digit ID number can be used to reference back to a specific translation to companies, subjects, etc.
**Responsibility of the Caller:**

1. Be specific in the information you provide.
2. Summarize the nature of your call and provide any special instructions to the interpreter.
3. Don't assume that the interpreter or non-English speaker knows more than what you've just told them.
4. Take the lead — interpreters repeat what you say.

Remember, interpreted messages are only as good as the original message.

To ensure that you control the conversation, always:

1. Brief the interpreter.
2. Have the interpreter brief the non-English speaker.

Do not use jargon or technical jargon.

Use easily understood sentences.

Conversations can be recorded.

**How a Call is Made:**

**Answer Point:** Language, phone.

You: Name of language, (If you can not identify it, tell the Answer Point. There are language identification procedures.)

Answer Point: You must ID please.

You: 501053.

Answer Point: What organization are you calling from?

You: County of Pierce.

Answer Point: Your personal code, please.

You: Your 4-digit county extension number.

Answer Point: Hold, please, while I connect you with an interpreter. (You will hear a hold message, repeated several times.)

General phone, interpreter number ________ is on the line.

The Answer Point records this information and then tells an interpreter to the conversation.

Brief the interpreter and begin kommunicating with the non-English speaking caller.

**How to Make a Conference Call:**

1. With call in progress, ask party to remain on line.
2. Press Transfer/CONF button, receive interrupted dial tone.
3. Dial extension 2522.
4. After call is answered, press CONF/CNF button, CONF/CNF LED lights.
5. Three-way conference is established.

Give information:

- Language needed
- Client ID number: 501053
- Organization name: County of Pierce
- Personal Code: This is your extension number

If one party hangs up, other two remain connected. CONF/CNF LED goes on.

**You wish to call a non-English speaker:**

1. Call language line Services, ext 2522. Give your language request, client ID number 501053, organization name and personal code (your 4-digit phone extension) to the Answer Point operator.
2. The Answer Point records this information and adds an interpreter to the conversation.
3. Brief the interpreter on the nature of the call and provide any special instructions. You may also wish to tell the interpreter what you want to accomplish during the call.
4. Conference call the non-English speaker while the interpreter is on the line.
You are face-to-face with a non-English speaker.

If necessary, use the Language ID Card to identify the individual's language.

Call Language Line Services. Ext 7333. Give your language request, client ID number 880863, organization name and phone number to the Answer Point operator.

The Answer Point operator provides your information and then informs the interpreter in the conversation.

Brief the interpreter and state how you are going to proceed with the call.

For example:

You are going to provide the telephone numbers of both you and the non-English speaker so you can have the interpreter telephone both parties.

Some suggestions for identifying the person's language in a face-to-face situation are:

- Note the person's physical characteristics.
- Consider the language that are common in the area.
- Use the Language Service Identification Card.

Message written in each language:

Points to your language

An interpreter will be called.

If necessary, write, flip, etc.

---

In the event of aulla problems:

If on occasion, you experience poor transmission quality on a call, if the interpreter cannot hear the non-English speaker, he or she will inform you and ask if the non-English speaker has a call-back number. Be sure to note the interpreter's identification number.

Ask the interpreter to tell the non-English speaker that you will call back, and have everyone hang up. Call Language Line Services, explain the situation to the Answer Point operator and ask for the interpreter by number. Tell the Answer Point operator that you need an overnight call phone to the non-English speaker and ask the Answer Point operator to note on the line to check for sound quality. When all parties are reconnected, resume the call.

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Language Line Services provides assistance to customers from virtually every conceivable environment. The very nature of their work requires that they often participate in confidential conversations. Their personal work under a strict code of conduct requires that all information passing to the work they do for us remains strictly confidential. They will neither release nor divulge information on our account without our consent. Any inquiries from an outside source about our relationship with them will be referred to us or contacted as one desires directions.

Here's how you can help maintain the overall integrity of their operation as they relate directly to you:

1. Guard your client ID number. Do not release it to persons not authorized to use Language Line Services. The unauthorized release of our ID number could result in unwanted calls being billed to our account.

2. Ensure that all conversations include statements prohibited by law as relating to personal illegal activity.

For additional information call Ext 7735.
APPENDIX G-9

Placer County
Health and Human Services

ПРЕДПОЧТЕНИЕ ЯЗЫКА И ИДЕНТИФИКАЦИЯ ВСПОМОГАТЕЛЬНОЙ ПОМОЩИ

Имя Дела: ___________________________ Номер Дела: ___________________________

Права обслуживания на родном языке

Вы имеете право на бесплатные услуги переводчика, для общения с представителями
Округа о вашем заявлении, пособии, доступных услугах или других потребностях.
Пожалуйста скажите нам на каком языке вы предпочитаете говорить.

____ Я говорю ________________________ и нуждаюсь в бесплатной Услуге Переводчика.

____ Я предпочитаю говорить на английском языке:

______________

Подпись Просителя/Получателя Дата

Письменные нужды на родном языке

Вы имеете право получить бланки и уведомления на вашем родном языке, если они были
переведены Калифорнийским Отделом Социального Обеспечения (CDSS). Иначе, Округ
переведет бланки/уведомления (скажут вам что там написано). Пожалуйста скажите нам на
каком языке вы предпочитаете бланки и уведомления.

Я предпочитаю получать бланки, уведомления, и другие доступные
документы переведенные на: __________________________

Я предпочитаю получать бланки и уведомления в Английском и не нуждаться в переведенных
бланках или уведомлениях.

______________

Подпись Просителя/Получателя Дата

Вспомогательная Помощь
Вы имеете право просить, и Округ имеет обязательство обеспечить вспомогательной помощью (TDD – услуги для глухонемых, бланки/уведомления с крупным шрифтом перевод для слепых, и т.д) чтоб помочь общению между вами и вашим работником.

Я нуждаюсь в следующем чтобы помочь мне общаться с Округом:

____________________________

____________________________
Подпись Просителя/Получателя Дата

____________________________

County Use Only: Check box to explain Interpreter/Translation/Auxiliary Aid Services Provided
En conclusión

Si cualquiera solicitaba publicarse la información que se incluye en el documento, debe presentarse una solicitud por escrito a la Dirección de Documentación de la Oficina de Programas y Desarrollo del OSHA/OSDP. Se debe adjuntar una copia del documento con la solicitud. La Oficina de Programas y Desarrollo revisará la solicitud y determinará si el documento debe ser publicado.

Si es necesario, el programa de desarrollo debe ser revisado y actualizado a medida que se recibe nueva información o se producen cambios en la regulación. El programa debe ser revisado por lo menos anualmente, o más a menudo si se encuentra una necesidad.

La Dirección de Documentación debe mantener un registro de los documentos que se han publicado en el programa de desarrollo. El registro debe incluir la fecha en que el documento fue publicado, la descripción del documento y cualquier otro dato relevante.

En el caso de que se encuentre una necesidad de revisar y actualizar el documento, la Dirección de Documentación debe notificar a todos los empleadores y trabajadores que tengan acceso a los documentos.

Si es necesario, el programa de desarrollo debe ser revisto y actualizado a medida que se reciba nueva información o se produzcan cambios en la regulación. El programa debe ser revisado por lo menos anualmente, o más a menudo si se encuentra una necesidad.

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Sus derechos

Como persona que solicita o recibe asistencia pública en California, usted tiene derecho a:

1. recibir una explicación por escrito de la deuda sobre su cuenta;
2. recibir una copia por escrito cuando se haga cualquier cambio en su deuda, beneficio o plan de servicios;
3. recibir cualquier decisión sobre su deuda, beneficio o plan de servicios.

Si cree que la información que usted ha recibido sobre su caso no es correcta, puede buscar el servicio de asistencia que se le aconseje.

Cuando usted solicite o reciba asistencia pública, sus derechos corren con un propósito para proteger sus derechos y beneficios que incluyan, entre otros:

1. recibir una explicación por escrito de la deuda sobre su cuenta;
2. recibir una copia por escrito de los cambios en su deuda, beneficio o plan de servicios.

En el Departamento de Servicios Sociales de California (DSS), hay una disposición sobre la identidad de las personas individuales (DUI). Si tiene una con la que pueda comunicarse con nosotros por medio del DSS formando gratuitamente al 1-800-544-2320.

Lo que usted puede hacer

Si cree que ha sido tratado de forma injusta en cuanto a su deuda, beneficiario o plan de servicios, puede hacer una queja escrita al Departamento de Servicios Sociales de California.

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Дискриминация

При получении денежных средств, услуг или законодательных актов, которые влияют на право человека на здоровье, услуги и меры социальной защиты, лица, имеющие право на заключение диспансеризации, не могут быть дискриминированы на основании их пола, возраста, религии, национальности, этнической принадлежности, состояния здоровья, имущественного положения, резидентства, обучения, профессионального статуса, политических взглядов, членства в профсоюзах или других общественных организациях и иных признаков. Отказ в предоставлении услуг, услуги или мер социальной защиты, принятие которых предусмотрено федеральным законом, не может быть связан с дискриминацией.

В соответствии с законом, лица, имеющие право на заключение диспансеризации, не могут быть дискриминированы на основании их пола, возраста, религии, национальности, этнической принадлежности, состояния здоровья, имущественного положения, резидентства, обучения, профессионального статуса, политических взглядов, членства в профсоюзах или других общественных организациях и иных признаков.

В случае, если у Вас есть вопросы по получению услуг, Ваши права могут быть нарушены, обратитесь к органам социальной защиты, которые обеспечат Вам право на получение услуг. Ваши права могут быть нарушены, если Вы не получите необходимую услугу, в соответствии с законом.
247
Multi-Lingual Services
If you or someone you know have problems understanding the text on the service pages, you can call the customer service at (1-800-123-456) for assistance.

Your Rights
As a person applying for or receiving public assistance in California, you have the right:

1. To receive a written explanation of the decision on your application.
2. To receive a written explanation of any change in your benefit, hardship, or service plan.
3. To appeal any decision on your eligibility, benefit, or service plan.
4. To be given any information related to your eligibility which you need to the county office.

When applying for or receiving public assistance, your rights must be explained by all persons and organizations, including county welfare departments, housing offices, and employers. If you have any questions, you may write or call the county welfare department at the address listed.

State Appropriations
A Telecommunication Device for the Deaf (TDD) is available at the California Department of Social Services (CDSS). If you have a complaint about public assistance services, you can contact CDSS at (800)-123-4567.

What You Can Do
If you have a complaint against a county or an office, public assistance benefits or service plans, you can do the following:

1. File a written complaint against the county or the county office.
2. File a written complaint against the county or the county office.

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APPENDIX H

ADAPTATION OF SERVICES

APPENDIX H-1  Copy of W&I Code 5600.3
APPENDIX H-2  SOC Appeal and Grievance Policy
APPENDIX H-3  Proposed Placer County Contractor Quarterly Report CC Guidelines
APPENDIX H-4  Proposed Placer County Contractor Annual Report CC Guidelines
APPENDIX H-1
Welfare and Institutions Code Section 5600.3
As Amended by AB 3083
Effective January 1, 2009

CALIFORNIA CODES
WELFARE AND INSTITUTIONS CODE
SECTION 5600-5623.5

5600. (a) This part shall be known and may be cited as the Bronzan-McCorquodale Act. This part is intended to organize and finance community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. It is furthermore intended to better utilize existing resources at both the state and local levels in order to improve the effectiveness of necessary mental health services; to integrate state-operated and community mental health programs into a unified mental health system; to ensure that all mental health professions be appropriately represented and utilized in the mental health programs; to provide a means for participation by local governments in the determination of the need for and the allocation of mental health resources under the jurisdiction of the state; and to provide a means of allocating mental health funds deposited in the Local Revenue Fund equitably among counties according to community needs.

(a) With the exception of those referring to Short-Doyle Medi-Cal services, any other provisions of law referring to the Short-Doyle Act shall be construed as referring to the Bronzan-McCorquodale Act.

5600.1. The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

5600.2. To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable, and which include the following factors:

(a) Client-Centered Approach. All services and programs designed for persons with mental disabilities should be client centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities. Persons with mental disabilities:

(1) Retain all the rights, privileges, opportunities, and responsibilities of other citizens unless specifically limited by federal or state law or regulations.

(2) Are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support.
(3) Shall be viewed as total persons and members of families and communities. Mental health services should assist clients in returning to the most constructive and satisfying lifestyles of their own definition and choice.

(4) Should receive treatment and rehabilitation in the most appropriate and least restrictive environment, preferably in their own communities.

(5) Should have an identifiable person or team responsible for their support and treatment.

(6) Shall have available a mental health advocate to ensure their rights as mental health consumers pursuant to Section 5521.

(a) Priority Target Populations. Persons with serious mental illnesses have severe, disabling conditions that require treatment, giving them a high priority for receiving available services.

(b) Systems of Care. The mental health system should develop coordinated, integrated, and effective services organized in systems of care to meet the unique needs of children and youth with serious emotional disturbances, and adults, older adults, and special populations with serious mental illnesses. These systems of care should operate in conjunction with an interagency network of other services necessary for individual clients.

(c) Outreach. Mental health services should be accessible to all consumers on a 24-hour basis in times of crisis. Assertive outreach should make mental health services available to homeless and hard-to-reach individuals with mental disabilities.

(d) Multiple Disabilities. Mental health services should address the special needs of children and youth, adults, and older adults with dual and multiple disabilities.

(e) Quality of Service. Qualified individuals trained in the client-centered approach should provide effective services based on measurable outcomes and deliver those services in environments conducive to clients' well-being.

(f) Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should:

1. Acknowledge and incorporate the importance of culture, the assessment of crosscultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.

2. Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups.

3. Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.
(g) Community Support. Systems of care should incorporate the concept of community support for individuals with mental disabilities and reduce the need for more intensive treatment services through measurable client outcomes.

(h) Self-Help. The mental health system should promote the development and use of self-help groups by individuals with serious mental illnesses so that these groups will be available in all areas of the state.

(i) Outcome Measures. State and local mental health systems of care should be developed based on client-centered goals and evaluated by measurable client outcomes.

(j) Administration. Both state and local departments of mental health should manage programs in an efficient, timely, and cost-effective manner.

(k) Research. The mental health system should encourage basic research into the nature and causes of mental illnesses and cooperate with research centers in efforts leading to improved treatment methods, service delivery, and quality of life for mental health clients.

(l) Education on Mental Illness. Consumer and family advocates for mental health should be encouraged and assisted in informing the public about the nature of mental illness from their viewpoint and about the needs of consumers and families. Mental health professional organizations should be encouraged to disseminate the most recent research findings in the treatment and prevention of mental illness.

5600.3. To the extent resources are available, the primary goal of use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

(b) (1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.
(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services who are not eligible for care by the United States Department of Veterans Affairs or other federal health care provider and who meet the existing eligibility requirements of this section, shall be provided services to the extent resources are available. Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(a) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(b) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

5600.35. (a) Services should be encouraged in every geographic area to the extent resources are available for clients in the target population categories described in Section 5600.3.
(b) Services to the target populations should be planned and delivered so as to ensure statewide access by members of the target populations, including all ethnic groups in the state.

5600.4. Continuum of Care. Community mental health services should be organized to provide an array of treatment options in the following areas, to the extent resources are available:

(a) Precrisis and Crisis Services. Immediate response to individuals in precrisis and crisis and to members of the individual's support system, on a 24-hour, seven-day-a-week basis. Crisis services may be provided offsite through mobile services. The focus of precrisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. The focus of crisis services is stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs.

(b) Comprehensive Evaluation and Assessment. Includes, but is not limited to, evaluation and assessment of physical and mental health, income support, housing, vocational training and employment, and social support services needs. Evaluation and assessment may be provided offsite through mobile services.

(c) Individual Service Plan. Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services. The development of the plan should include the participation of the client, family members, friends, and providers of services to the client, as appropriate.

(d) Medication Education and Management. Includes, but is not limited to, evaluation of the
need for administration of, and education about, the risks and benefits associated with medication. Clients should be provided this information prior to the administration of medications pursuant to state law. To the extent practicable, families and caregivers should also be informed about medications.

(e) Case Management. Client-specific services that assist clients in gaining access to needed medical, social, educational, and other services. Case management may be provided offsite through mobile services.

(f) Twenty-four Hour Treatment Services. Treatment provided in any of the following: an acute psychiatric hospital, an acute psychiatric unit of a general hospital, a psychiatric health facility, an institute for mental disease, a community treatment facility, or community residential treatment programs, including crisis, transitional and long-term programs.

(g) Rehabilitation and Support Services. Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs. These services may be provided offsite through mobile services.

(h) Vocational Rehabilitation. Services which provide a range of vocational services to assist individuals to prepare for, obtain, and maintain employment.

(i) Residential Services. Room and board and 24-hour care and supervision.

(j) Services for Homeless Persons. Services designed to assist mentally ill persons who are homeless, or at risk of being homeless, to secure housing and financial resources.

(k) Group Services. Services to two or more clients at the same time.

5600.5. The minimum array of services for children and youth meeting the target population criteria established in subdivision (a) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:

(a) Precrisis and crisis services; (b) Assessment; (c) Medication education and management; (d) Case management; (e) Twenty-four-hour treatment services; (f) Rehabilitation and support services designed to alleviate symptoms and foster development of age appropriate cognitive, emotional, and behavioral skills necessary for maturation.

5600.6. The minimum array of services for adults meeting the target population criteria established in subdivision (b) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:

(a) Precrisis and crisis services; (b) Assessment; (c) Medication education and management; (d) Case management; (e) Twenty-four-hour treatment services. (f) Rehabilitation and support services; (g) Vocational services; (h) Residential services.
POLICY

It is the policy of Placer County System of Care (and Sierra County Mental Health Plan) to ensure that a client’s Grievance is addressed in a sensitive, timely, appropriate, and culturally competent manner. In addition, Medi-Cal Beneficiaries who are subject to an Action may register and pursue an Appeal.

Individuals will not be subject to discrimination or any other penalty for filing a Appeal/Grievance. Staff members are required to inform clients of their right to file an Appeal/Grievance, and will not be penalized for carrying out these duties. All beneficiary Grievance and Appeal information will be handled in a manner to ensure confidentiality.

An individual may authorize another person, a provider or legal representative to act on his/her behalf in the Appeal/Grievance process. The Patients’ Rights Advocate (PRA) will be available to help individuals register Appeals/Grievances, prepare written Appeals/Grievances and/or file for a State Fair Hearing.

Notices of Appeal/Grievances and expedited Appeal procedures, as well as, Grievance and Appeal forms with self addressed envelope and/or mailer will be visibly posted in accessible locations in client areas. See Attachment A for English and Spanish Appeal/Grievance Forms.

The staff person who decides any issue related to a Grievance or Appeal will not be the same individual who has made or will make a decision concerning the Grievance or Appeal at any other level of the Grievance or Appeal process, whether in a formal or informal manner.

Authority
- Code of Federal Regulations, Title 42, Chapter IV, Part 438, Section 438.400ff
- California Code of Regulations, Title IX, Chapter 11, Section 1850.205ff
- Code of Federal Regulations Part 160-164; Section 164.508 “Use and Disclosure for Which an Authorization is Required”
Also see Systems of Care Policy "Notice of Action" (ASOC 1200.620).

Definitions

“Grievance” A Grievance is defined by the State Department of Mental Health as, “An expression of dissatisfaction about any matter other than an Action.

“Action” An Action occurs (for Medi-Cal Beneficiaries only) when the MHP:

- Denies or limits authorization of a requested service; or reduces, suspends, or terminates a previously authorized service (NOA-B)
- Denies, in whole or in part, payment for a service (NOA-C)
- Fails to act within the timeframes for disposition of standard Grievances, the resolution of standard Appeals or the resolution of expedited Appeals. (NOA-D)
- Fails to provide services in a timely manner (NOA-E)

NOA-A is not covered under an Action.

“Notice of Action” (NOA) is defined as a written notice that advises a Medi-Cal Beneficiary of their rights and informs them when an Action has been taken (Specialty Mental Health Services are denied, reduced, modified, or terminated.) Also see Systems of Care Policy "Notice of Action" adopted 11/01/2007.

“Appeal” An Appeal is defined as a request by the Medi-Cal Beneficiary, or his/her representative, for review of an Action as defined above. See Attachment A "Appeal/Grievance Form."

“State Fair Hearing” (SFH) is defined as an independent review conducted by the State Department of Social Services and is the final arbiter of Appeals for Action taken by Placer/Sierra County Mental Health Plan (MHP) when services have been denied, terminated, suspended, or reduced for a Medi-Cal Beneficiary. See Attachment E.

“Expedited Appeal” An Expedited Appeal is defined as an oral or written request by the beneficiary to review an Action when the standard resolution process could jeopardize the beneficiary’s life, health or ability to attain, maintain, or regain maximum function.

"Specialty Mental Health Services” are defined as:

- Rehabilitative services, including mental health services, medication support services, day treatment, crisis intervention, adult residential treatment services and psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatrist services.

"Aid Paid Pending” allows the Medi-Cal Beneficiary to continue obtaining Specialty Mental Health Services while pursuing a State Fair Hearing.

**Procedure**

I. Appeal/Grievance Procedure

A. When an individual receiving services desires to register a Grievance or a Medi-Cal Beneficiary registers a Grievance or Appeal (challenge an Action by the MHP), they will, verbally or in writing, contact the Quality Improvement (QI) Program Manager/designee or Patient’s Rights Advocate and request a resolution.

1. If the individual makes an oral request, he/she must follow up by providing a written statement outlining his/her concerns on the Appeal/Grievance Form CARE 020 or 20a Spanish (Attachment A.) The individual may request assistance in completing the form.
2. The staff person who decides any issue related to a Appeal/Grievance or will not be the same person who has made or will make a decision concerning the Appeal/Grievance at any other level of the Grievance or Appeal process, whether in a formal or informal manner.

B. When an individual lodges an Appeal/Grievance, whether orally or in writing, the QI Program Manager’s representative will record the Grievance or Appeal on the Appeal/Grievance Log within one day of it being lodged.

C. Completion of the Appeal/Grievance Form will constitute client/personal representative authorization for use and disclosure of any necessary Protected Health Information (PHI) in accordance with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Regulations. (See Placer County Health Privacy Policies, #001 Uses & Disclosure of Protected Health Information, T-drive/HHS/HHS Share/HIPAA.)

D. All communication involving use or disclosure of PHI during the Appeal/Grievance process will be in accordance with the HIPAA Privacy Regulations, applicable State law, and DMH’s HIPAA Privacy Policies and Procedures Authorization.

E. The QI Program Manager’s designee will write an acknowledgement to the beneficiary of the receipt of an Appeal/Grievance.

F. If the Beneficiary’s Appeal is related to a Notice of Action, the Beneficiary may request Aid Paid Pending while waiting the State Fair Hearing.

G. The QI Program Manager will assess the nature of the Appeal/Grievance and assign the Appeal/Grievance to the appropriate staff person to investigate and resolve the concern.

1. During the investigation, the staff responsible for handling the Appeal/Grievance will attempt to mediate and resolve the issues raised by the beneficiary.
H. Decisions will be sent in writing to the beneficiary within 60 days for Grievances, 45 days for Appeals, and 3 days for expedited Appeals.

1. If the decision concerns an Appeal, the written response will clearly indicate that a Medi-Cal Beneficiary may request a State Fair Hearing if dissatisfied with the outcome.

I. Staff who have the appropriate clinical expertise in treating the individual’s condition or disease will make decisions in the following situations:

- Appeals based on lack of medical necessity
- Grievances regarding denial or expedited resolution of any Appeal
- Grievances/Appeals that involve clinical issues.

J. A beneficiary and/or his/her representative will have the right before and during the Appeals process to examine the beneficiary’s case file, including medical records, and any other documents and records considered during the Appeals process. Appropriate release of confidential information forms will need to be signed.

K. Upon request, the QI Program Manager or designee will provide information regarding the status of an Individual’s Appeal/Grievance to the appropriate party.

L. The QI Program Manager will be responsible to ensure issues identified as a result of the Appeal/Grievance processes are reviewed by the MHP’s Quality Improvement Committee (QIC) and/or the MHP’s administration for analysis (including aggregate data), for implementation of needed system changes can be implemented.

II. State Fair Hearing Level of Appeal

A. If the Medi-Cal Beneficiary is not satisfied with the decision made by the MHP or is not satisfied with the attempted resolution of the problem, the beneficiary may request a State Fair Hearing. Clients who are not Medi-Cal recipients may not request a State Fair Hearing.

B. When the Appeal is finalized by the State Fair Hearing, the decision will be recorded on the Appeal/Grievance Log.

C. A beneficiary has the right to submit additional information (evidence, and allegations of fact or law) to support a claim either in writing or in person.

III. Expedited Resolution of Appeals

A. An Expedited Resolution process may be requested by the beneficiary when the length of time needed for a standard resolution could jeopardize the beneficiary’s life, health or ability to attain, maintain or regain maximum function.

B. If MHP denies a request for an Expedited Resolution of an Appeal, the QI Program Manager/designee will give the beneficiary prompt oral notice of the
denial and will follow-up within two calendar days with a written notice.
C. When granted, the Expedited Resolution of Appeals must be resolved within three working days.
D. The QI Program Manager/designee will record the beneficiary’s request for an Expedited Resolution and the outcome of the request in the Appeal/Grievances Log.

III. Notification of Provider

A. When providers are included in the Grievance, Appeal, Expedited Appeal or State Fair Hearing, the provider will be notified of the final disposition.

IV. Timeframes for All Appeals/Grievances

A. All Grievances presented to the MHP must be resolved within 60 days of the date on which the Grievance was entered in the Appeal/Grievances Log.
B. All standard Appeals which request a State Fair Hearing must be resolved within an additional 45 days of the date on which the Appeal was entered in the Appeal/Grievances Log.
C. These timeframes may be extended by 14 days when the beneficiary requests the extension or the MHP shows there is a need for additional information and the delay is in the beneficiary’s interest.
D. For an expedited request for continued services after services have been denied, reduced or terminated by the MHP (Action), the MHP must resolve the issue within three working days. Oral requests for expedited Appeals do not have to be followed with a written request.
E. The Beneficiary must file an Appeal (Standard or Expedited) within 90 days of the Notice of Action.
Attachment A

Appeal/Grievance Form

Placer County Systems of Care
Appeal/Grievance Form

Note: Filing an Appeal/Grievance will not adversely affect the services you receive from Placer County Systems of Care. The client will be contacted by the Managed Care Unit within required timeframes. Please mail or fax this form to the address on the bottom of this form.

I am filing a (check one):  □ Appeal  □ Grievance

(Check “Appeal” if you have had a service denied or reduced, and you disagree with this decision. Check “Grievance” for any other complaint.)

Name of client filing Appeal/Grievance: ____________________________

I am (check one):  □ A Client  □ Acting on Client’s behalf  □ Other ____________________________

Mailing Address: ________________________________________________

Telephone Number: (____) _______________________

Please summarize the problem(s) you have had using specific details. Attach additional sheets as necessary:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please describe what you have done to try and resolve the problem:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please make any suggestions for resolution:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If you would like information about this Appeal/Grievance to be given to anyone, please list their name(s) here:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Client Signature: ____________________________ Date: ____________________________

Signature of person acting on client’s behalf: ____________________________ Date: ____________________________

Resolution: ____________________________  For County Use Only

Signature of County Staff: ____________________________ Date: ____________________________

Date written response sent to client: ____________________________

Mail or fax this form to: Placer County Systems of Care Managed Care Unit
11716 Enterprise Drive  Auburn, CA  95603
Phone: (530) 886-5400  Fax: (530) 886-5499

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Attachment A, Continued
Appeal/Grievance Form Spanish

(T Drive/HHS/SOC/Forms&Flyers/CAREForms)

Los Sistemas del Condado del Placer
Súplica/Agravio

Nota: Archivar un agravio/súplica no afectará al contrario los servicios que usted recibe de Sistemas del Condado del Placer. El Managed Care Unit dentro de timeframes requeridos entrará en contacto con el cliente. Por favor el correo o envía por telefax esta forma a la dirección en el fondo de esta forma.

Estoy archivando a (cheque uno): ☐ Súplica ☐ Agravio

(Cheque "súplica" si usted ha hecho un servicio negar o ser reducido, y usted discrepa con esta decisión. Compruebe el "agriavo" para saber si hay cualquier otra queja.)

Nombre de la súplica/ del agravio de la limadura del cliente:

Soy (cheque uno): ☐ Un cliente ☐ El actuar en el favor del cliente ☐ Otro __________

Dirección que envía: ________________________________________________

Número de teléfono: ________________________________

Resuma por favor los problemas que usted ha tenido usando los detalles específicos. Una las hojas adicionales cuanto sea necesario:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Descríba por favor lo que usted ha hecho para intentar y para resolver el problema:

____________________________________________________________________

____________________________________________________________________

Haga por favor cualquier sugerencia para la resolución:

____________________________________________________________________

____________________________________________________________________

Si usted quisiera la información sobre esta súplica/agravio que se darán a cualquier persona, enumere por favor sus nombres aquí:

____________________________________________________________________

____________________________________________________________________

Firma del cliente: _______________________________ Fecha: __________

Firma de la persona que actúa en el favor del cliente: ____________________ Fecha: __________

La Resolución:

Firma del personal del condado: ____________________ Fecha: __________

Reuesta escrita fecha enviada al cliente: ________________________________

El correo o envía por telefax esta forma a: Placer County Systems of Care Managed Care Unit
11716 Enterprise Drive Auburn, CA 95603
Phone: (530) 885-5400 Fax: (530) 886-6499

CARE 003ap Rev. 9/25/08

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Example #1:
A MHP Network Private Provider sends in a Reauthorization Request requesting 26 individual sessions over a six-month period. This is the equivalent of weekly therapy. The staff member wants to see how the client will progress over a three-month period and authorizes 13 sessions. Does a Notice of Action need to be sent?

➢ Response: No. A Notice of Action is not needed because the provider will have opportunity to request additional services (Title 9, CCR, 1850.210(c)).

Example #2:
A MHP Network Private Provider sends in a Reauthorization Request 26 individual sessions over a six-month period. The staff member makes the determination that this client would not benefit from individual therapy, but would likely do well in group therapy and authorizes 13 sessions of group therapy. Does a Notice of Action need to be sent?

➢ Response: Yes. A Notice of Action (NOA-B) must be sent because the staff member is modifying the type of service authorized (Title 9, CCR, Section 1850.210(c)).

Example #3:
A MHP Network Private Provider sends in a Reauthorization Request requesting weekly individual sessions over a three-month period. The staff member believes that therapy twice a month is sufficient for this client. Does a Notice of Action need to be sent?

➢ Response: Yes. A Notice of Action (NOA-B) is needed because the frequency of services requested by the provider is being modified (Title 9, CCR, 1850.210(c)).

Example #4:
A MHP Network Private Provider sends in a Reauthorization Request requesting weekly individual sessions over a three-month period. The staff member believes that this client has had enough therapy and denies any further service. Does a Notice of Action need to be sent?

➢ Response: Yes. A Notice of Action (NOA-B) is needed any time an authorization request from a provider is denied (Title 9, CCR, 1850.210(a)).

Example #5:
A beneficiary requests medication and medication support. No other services are requested. The beneficiary is assessed and a need is established for medication. On review by the psychiatrist or entry team, it is decided that the beneficiary will be referred back to his primary care physician who can prescribe the medication needed. Does a Notice of Action need to be sent?

➢ Response: Yes. A Notice of Action (NOA-A) is needed because there is a denial of specialty mental health services (Title 9, CCR, 1850.210(a)).

Example #6:
A beneficiary requests medication to treat a mental health impairment. The beneficiary is assessed and a mental health diagnosis is given and medication is recommended. However, the assessment also establishes that the beneficiary is currently abusing alcohol. Entry team decides that the client should have substance abuse treatment before medication can be prescribed. Is a Notice of Action needed?
Response: Yes. A Notice of Action (NOA-A) is needed because there is a denial of specialty mental health services (Title 9, CCR, 1850.210(a)).
Attachment C
Valid Reasons for Action
Denying or Modifying Medi-Cal Specialty Mental Health Services

1. Mental health diagnosis is not covered by the mental health plan (Title 9, CCR, 1830.205(b)(1)).

   Covered diagnoses:
   - Pervasive Developmental Disorders, except Autistic Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy and Early Childhood
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood or Adolescence
   - Schizophrenia and other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
   - Factitious Disorders
   - Paraphilias
   - Gender Identity Disorder
   - Eating Disorder
   - Impulse Control Disorders Not Elsewhere Classified
   - Adjustment Disorders
   - Personality Disorders, excluding Antisocial Personality Disorder
   - Medication-Induced Movement Disorders related to other included diagnoses

2. As the result of the mental disorder, there is no significant impairment in any area of life functioning nor is there a probability of significant deterioration in an important area of life functioning. (For a child (under 21) - The child will progress developmentally as individually appropriate.

3. The focus of the proposed intervention is not to address the covered mental health diagnosis (Title 9, CCR, 1830.205(b)(3)).

4. The proposed intervention will not significantly diminish the impairment nor will it prevent significant deterioration in an important area of life functioning (Title 9, CCR, 1830.205(b)(2)).

5. The condition would be responsive to physical health care based treatment.

6. The requested service is not covered by the mental health plan (Title 9, CCR, 1810.345).

7. Provider has failed to provide additional information requested necessary to authorize the proposed service.
Attachment D
Notice of Action (N.O.A.)
Frequently Asked Questions (FAQs)

1. **What is the MHP?**
   MHP is an acronym for Mental Health Plan. Placer County has entered into an agreement with the State Department of Mental Health to arrange for and/or provide specialty mental health services to Placer County Medi-Cal beneficiaries. This arrangement has made our county the Mental Health Plan for these individuals in much the same way as an HMO or other managed care plan. When a staff member authorizes, denies or modifies a request for specialty mental health services for a Medi-Cal beneficiary, he/she is representing the Mental Health Plan.

2. **What are “Specialty Mental Health Services?”**
   - Mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services.
   - Psychiatric Inpatient Hospital Services or Psychiatric Nursing Facility Services
   - Psychiatrist or Psychologist Services
   - Targeted Case Management
   - EPSDT Supplemental Specialty Mental Health Service (Title 9, CCR, 1810.247)

3. **What is included in the term “Mental Health Services?”**
   
   "...those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Services activities include but are not limited to assessment plan development, therapy, rehabilitation and collateral (Title 9, CCR, 1810.227)."

4. **What is the definition of collateral in terms of “Specialty Mental Health Services?”**
   
   "'Collateral' means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity (Title 9, CCR, 1810.206)."

5. **Does a NOA need to be sent for Medi-Medi clients?**
   No. Medicare clients do not fall under the Medi-Cal Mental Health Plan (Title 9, CCR, 1810.355(a)(4)). Medicare or Medi-Medi clients do not need authorization to go to an outside mental health service provider. They must go to a provider who is signed up with Medicare. Call the Managed Care Unit liaison if you need a list of providers who accept Medicare or Medi-Medi

6. **Does a NOA need to be sent if the Provider delivers services without prior authorization and then requests payment or payment authorization?**
   No. All services under the Placer County Mental Health Plan must be pre-authorized. The Provider Manual states that providers will not be reimbursed for services provided without prior authorization. A Notice of Action is not necessary (Title 9, CCR, 1850.210(a)(1)).

7. **Does the MHP have to issue a NOA every time a beneficiary requests services that the MHP has decided are not medically necessary?**
   No. The MHP only has to issue a NOA-A to a beneficiary after an assessment has been completed and it is determined that no specialty mental health services are medically necessary. However, the beneficiary has the right to request a second opinion and a new assessment may be completed (Title
9, CCR, 1810.405). **Note:** This question only applies to the beneficiary, not to provider requests.

8. **Would a NOA be required if the provider requests individual therapy and the MHP determines that group therapy would be more appropriate for the beneficiary and approves group therapy?**
   Yes. The MHP has modified the provider request and a NOA-B is required (Title 9, CCR, 1850.210 (c)).

9. **If a provider from the MHP network does an assessment and determines the beneficiary does not meet medical necessity, is a NOA-A required?**
   Yes. The beneficiary must be notified of the decision and their rights to Appeal if they do not agree with the decision including the right to a second opinion via the NOA-A regardless of whether the assessment is completed by a staff provider or a private network provider (Title 9, CCR, 1850.210(a)).

10. **If a beneficiary requests an assessment, can the MHP deny that request, and if so, is a NOA required?**
    The MHP has an obligation to determine if medical necessity criteria are met by beneficiaries requesting service.

11. **If a beneficiary calls for information about MHP services, is a NOA required?**
    Not if the MHP provides general information about services provided by the MHP. A NOA-A is required when the MHP determines that the beneficiary requesting services does not meet medical necessity for services. This determination should not be made without an assessment.

12. **When a provider determines that a reduction or termination of services is needed is a Notice of Action required?**
    No. The NOA-B is only needed if the MHP denies or modifies a provider’s request.

13. **Is a Notice of Action needed when a provider requests a specified time period for providing services and the MHP approves a shorter time frame and requires another request for the balance of services?**
    No, because the provider may request the additional time prior to the end of the time approved by the MHP. If the additional services are subsequently requested and not approved at that time, the beneficiary would then get the NOA-B.

14. **What if the MHP is unsure if a NOA should be issued?**
    MHPs should use their best judgment regarding the requirements for issuing NOAs, but should resolve doubts in favor of sending NOAs.

15. **If a provider requests authorization/reauthorization of services and does not include enough information on which to base the decision, can the request be returned to the provider? Does a NOA need to be sent?**
    The request can be returned to the provider asking for additional information. The Notice of Action can be delayed for up to 30 calendar days to allow the provider time to submit the additional information requested by the MHP. If after 30 calendar days from the original receipt of the authorization request, if the provider has not complied with the request, the MHP will send the beneficiary a Notice of Action to deny the service. If the provider does comply, the MHP will take action on the authorization request. If the action is to deny, modify or defer the request for an additional period of time, a Notice of Action must be sent to the beneficiary (Title 9, CCR, 1950.210(b)).

16. **If a Medi-Cal beneficiary is involved in a CWS case and specialty mental health services are provided as part of the case, would the Notice of Action requirements apply?**
    Yes. Although the case may be a Child Welfare Service case, the services are authorized through the MHP and will receive Medi-Cal reimbursement.
Attachment E
FAIR HEARINGS AND AID PAID PENDING
Frequently Asked Questions

What is a Fair Hearing?
A fair hearing is a State hearing provided to Medi-Cal beneficiaries pursuant to Title 22, Sections 50951 and 50953 of the California Code of Regulations (CCR). It is a part of the problem resolution processes available to beneficiaries who have concerns about Medi-Cal specialty mental health services. (Fair hearings are also used for many other state programs.) In addition to the fair hearing, Mental Health Plans (MHPs) must have complaint and Grievance processes. The complaint and Grievance processes are independent from the state fair hearing process. A beneficiary does not have to access these problem resolution processes sequentially.

Who Administers the Fair Hearing?
The Department of Health Services (DHS) contracts with the Department of Social Services (DSS) to administer the fair hearing process for the Medi-Cal program. This contract includes responsibility for MHP services.

When Can a Beneficiary Request a Fair Hearing?
The beneficiary has 90 days from the post mark day of the NOA-A or NOA-B to request a fair hearing. When aid paid pending is involved, the time frame is shorter.

Whether or not a notice of action is issued, a beneficiary has a right to request a fair hearing. If no notice of action is involved, a beneficiary may request a fair hearing at any time.

How is the Beneficiary Notified of Their Rights to a Fair Hearing?
Those rights are explained in the MHP beneficiary brochures and in the notices of action (NOAs) that the beneficiary may receive. In addition, the beneficiary is notified at the time they apply for the Medi-Cal program and on a quarterly basis by the California Department of Health Services.

How Will the MHP Be Notified That a Fair Hearing Has Been Scheduled?
When a beneficiary requests a state fair hearing, DSS will determine if the beneficiary complaint qualifies for that process. If so, DSS will notify DMH who will in turn notify the county.

What is the Mental Health Plan’s Role in the Fair Hearing?
The MHP is responsible for representing itself when a fair hearing affects them. The Department of Mental (DMH) will notify the county of the fair hearing. DSS has agreed to provide training on the fair hearing process to MHPs. DMH will coordinate this training with CIMH.

What Will Be the Role of DMH in Fair Hearings?
The Mental Health Plan’s Contract Manager will be available for technical assistance during the process. Also, during the initial policy development and implementation periods, DMH will have an opportunity to review proposed fair hearing decisions and alternate the decision if not consistent with policy.

What is Aid Paid Pending?
Under some circumstances, services being contested in a fair hearing must continue to be provided at the cost of the Mental Health Plan (MHP). Aid paid pending permits a beneficiary to continue to receive services for the MHP pending the disposition of a fair hearing.

Who Can Request Aid Paid Pending?
A beneficiary or his/her authorized representative may request aid paid pending when the MHP intends to discontinue or reduce services that had been previously approved by the MHP. The
specific circumstances of when aid paid pending applies will be included in future training on fair hearings.

**Attachment E**

**Notice of Action**

**What is a “Notice of Action?”** A notice of action is a written notification to a Medi-Cal recipient that a negative decision has been made regarding their Medi-Cal specialty mental health services. Standardized state-generated forms are used for this notification. They are referred to as NOA-A and NOA-B. The use of these forms and the notification is mandated by regulation (Title 9, CCR, 1850.210). The Notice of Action includes

- The action taken by the staff member/supervisor making the decision for the Mental Health Plan.
- The reason the action was taken, including a citation of the specific regulations or MHP authorization procedures supporting the action.
- The beneficiary's right to a fair hearing, including the method by which a hearing may be obtained and time limits for requesting a hearing.
- An explanation of circumstances under which services may be continued pending the fair hearing decision.

<table>
<thead>
<tr>
<th>Who Requests Authorization or Reauthorization</th>
<th>Action Taken by MHP</th>
<th>Who Receives Notice of Action?</th>
<th>Time Limits for sending NOA</th>
<th>Exceptions – No NOA Needed</th>
<th>Type of NOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal Beneficiary</td>
<td>Deny or Modify the initial request for service</td>
<td>Medi-Cal Beneficiary</td>
<td>Mail w/n 3 working days of the action or hand-deliver on day of action.</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Beneficiary</td>
<td>Denial of services based on an assessment.</td>
<td>Medi-Cal Beneficiary Private Provider</td>
<td>Mail w/n 3 working days of the action or hand-deliver on day of action.</td>
<td>1) The denial of the request for authorization is for services already provided. A verbal non-binding conversation with the provider of what services may be approved does not need a NOA.</td>
<td>A</td>
</tr>
</tbody>
</table>

1) The denial of the request for authorization is for services already provided. A verbal non-binding conversation with the provider of what services may be approved does not need a NOA.
| Provider | Deny the Request for Reauth. | Medi-Cal Beneficiary Provider | Mail w/n 3 working days of the action or hand-deliver on day of action. | 1) The denial of the request for authorization is for services already provided.  
2) A verbal non-binding conversation with the provider of what services may be approved does not need a NOA. | B |
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<tbody>
<tr>
<td>Provider</td>
<td>Defer action on the Request. Need more information in order to authorize.</td>
<td>None. Further action needed within 30 days.</td>
<td>Delay NOA for 30 days to give provider time to submit the additional requested information.</td>
<td>If provider complies within 30 days, take action by authorizing, denying, modifying, or again deferring the authorization for service. If the provider does not comply within 30 days, deny authorization and send NOA.</td>
<td>B</td>
</tr>
<tr>
<td>Provider</td>
<td>Modify (change) services requested by a provider.</td>
<td>Medi-Cal Beneficiary Provider</td>
<td>Mail w/n 3 working days of the action or hand-deliver on day of action.</td>
<td>If the period of time (duration) of the service is modified, no NOA is needed as long as the provider is given the opportunity to request reauthorization of services during the period authorized.</td>
<td>B</td>
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</tr>
<tr>
<td>Change or discontinue a current authorization</td>
<td>Medi-Cal Beneficiary Provider</td>
<td>Mail 10 days in advance of the action</td>
<td>B</td>
<td></td>
<td></td>
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</tbody>
</table>
### Timelines
Reports are due to your designated Program Manager/contact on the last day of the month following the quarter’s end.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quarter (July through September)</td>
<td>October 31</td>
</tr>
<tr>
<td>Second Quarter (October through December)</td>
<td>January 31</td>
</tr>
<tr>
<td>Third Quarter (January through March)</td>
<td>April 30</td>
</tr>
<tr>
<td>Fourth Quarter (April through June)</td>
<td>July 31</td>
</tr>
</tbody>
</table>

### Site Issues
For sites that are certified by Placer County, all tenant improvements **must be pre-approved** by your Program Manager or their designee and re-certified by Quality Management/Managed Care Unit. Failure to obtain certification prior to delivery of service may result in delay or denial of reimbursement.

Tenant improvements include, but are not limited to:
- Space expansion
- Plans to build
- Remodeling
- Change of Address

### Complaints
Explain how complaints are managed in your agency. Is a complaint log maintained? What elements does it contain? Please attach a blank copy of your log if you have one.

### Memoranda of Understanding (MOUs) and Subcontracts
**First Quarter:**
- Attach a copy of all MOUs and Sub-contracts related to the execution of your contract with Placer County System of Care.

**Second - Fourth Quarters:**
- Include only new or revised agreements

### Board of Directors
- Provide the name, title, and contact information for each member of your Board of Directors.
- Changes should be reported in subsequent quarterly reports.

### Cultural Competence and Language Capabilities
- Include with your Staffing Detail a list of language skills for interpretation that you have available within your agency. (See Attachment A.) If you have administrative staff with these skills, please note this under “Administrative Staff” beneath the staff names on the Staffing Detail.
- List interpreter resources that you have utilized during this past quarter, e.g. Asian Pacific Counseling Center (APCC), Southeast Asian Assistance Center (SAAC), Language World, AT&T, Norcal Center for the Deaf.
| **Productivity** | ▪ Explain how productivity is calculated for Medi-Cal billable time, and explain how it is calculated for non-Medi-Cal billable time.  
▪ Identify the expected level of productivity, by program, for each staff classification. |
| **Training** | ▪ Submit titles of trainings, training dates, and the number of staff in attendance unless otherwise specified in your contract.  
▪ Include a brief description of the training if the title is unclear.  
**Fourth Quarter:**  
▪ Submit your agency’s Training Plan for the upcoming fiscal year with the 4th Quarter report. |
| **Program Specific Outcomes** | ▪ Address each outcome as delineated in your contract. If no outcomes are listed, please suggest three to five outcomes that can be tracked and measured as evidence of contract and/or program requirements adherence. |
| **Successes and Challenges** | ▪ Describe the successes and challenges you have experienced this quarter.  
▪ Include both clinical and administrative successes and challenges.  
▪ Include system barriers and issues for further discussion with your Program Manager/Contact. |

**Technical Assistance Contact:**  
Designated Program Manager/Contact
## APPENDIX H-4

### PLACER COUNTY SYSTEM OF CARE

#### ANNUAL REPORT GUIDELINES

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timelines</strong></td>
<td>The Annual Report is due to your designated Program Manager/contact on the last day of the month following the fiscal year end.</td>
</tr>
<tr>
<td></td>
<td><strong>Annual Report (July 1 through June 30)</strong> Due: July 31st</td>
</tr>
<tr>
<td><strong>Site Issues</strong></td>
<td>For sites that are certified by Placer County, all tenant improvements must be pre-approved by your Program Manager or their designee and re-certified by Quality Management/Managed Care Unit. Failure to obtain certification prior to delivery of service may result in delay or denial of reimbursement.</td>
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<tr>
<td></td>
<td>Tenant improvements include, but are not limited to:</td>
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<td></td>
<td>• Space expansion</td>
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<td></td>
<td>• Plans to build</td>
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<td></td>
<td>• Remodeling</td>
</tr>
<tr>
<td></td>
<td>• Change of Address</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td>Explain how complaints are managed in your agency. Is a complaint log maintained? What elements does it contain? Please attach a blank copy of your log if you have one.</td>
</tr>
<tr>
<td><strong>Memoranda of Understanding (MOUs) and Subcontracts</strong></td>
<td>Annual Report: Attach a copy of all MOUs and Sub-contracts related to the execution of your contract with Placer County System of Care.</td>
</tr>
<tr>
<td></td>
<td><strong>Between Annual Report Cycles:</strong></td>
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<tr>
<td></td>
<td>• Notify your Placer County Manager or contact of any new or revised agreements</td>
</tr>
</tbody>
</table>

<p>| Board of Directors | Provide the name, title, and contact information for each member of your Board of Directors. |
| Cultural Competence and Language Capabilities | Include with your Staffing Detail a list of language skills for interpretation that you have available within your agency. (See Attachment A.) If you have administrative staff with these skills, please note this under “Administrative Staff” beneath the staff names on the Staffing Detail. |
| | Please include with your Staffing Detail anyone who can be considered bilingual/bicultural separate from bilingual only. |
| | List interpreter resources that you have utilized during this past year, e.g. Asian Pacific Counseling Center (APCC), Southeast Asian Assistance Center (SAAC), Language World, AT&amp;T, Norcal Center for the Deaf and the frequency of their usage. |</p>
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</tr>
<tr>
<td><strong>Training</strong></td>
<td>Submit titles of trainings, training dates, and the number of staff in attendance for the prior year unless otherwise specified in your contract.</td>
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<tr>
<td></td>
<td>Include a brief description of the training if the title is unclear.</td>
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<td>Submit your agency’s Training Plan for the upcoming fiscal year with the Annual Report.</td>
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<td><strong>Program Specific Outcomes</strong></td>
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**Technical Assistance Contact:**
Designated Program Manager/Contact