SACRAMENTO COUNTY

Phase II Consolidation of Medi-Cal
Specialty Mental Health Services

Cultural Competence Plan

July 1998

Sacramento County
Phase II
Outpatient Consolidation
Cultural Competence Plan

Sacramento County Board of Supervisor

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Robert P. Thomas

Department of Health and Human Services
Jim Hunt, Director

Mental Health Services
Tom Sullivan, LCSW, Director

Sacramento County Mental Health Cultural Competency Plan

Cultural Competence is defined as a set of congruent practice skills, behaviors, attitudes and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations. The cultural competence continuum is:

- Cultural Destructiveness
- Cultural Incapacity
- Cultural Blindness
- Pre-Competence
- Basic Competence
- Advanced Competence[1]

A culturally competent agency acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge and the adaptation of services to meet culturally unique needs.

A culturally competent mental health system values its employees, its consumers and understands the community it serves and values consumers.

The Sacramento County Mental Health Cultural Competence Plan outlines how Sacramento County will institutionalize cultural competence in the delivery of quality, cost-effective mental health services.

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Thomas J. Sullivan, Director
Sacramento County Division of Mental Health

[1] Cross et al. 1989

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Jo Ann Johnson, LCSW, Program Coordinator
Sacramento County Mental Health Minority Services Coordinator

Bernadette Lynch, MSW, Quality Assurance Director
Sacramento County Mental Health Quality Assurance

Cultural Competency Workgroup

Sylvia Aguirre-Aguilar, MPH	Executive Director El Hogar Mental Health and Community Service Center, Inc.
Tracy Herbert, Ph.D.	Sacramento County Division of Mental Health
Jan Hunt	Executive Director Southeast Asian Assistance Center
Jo Ann Johnson, LCSW	Sacramento County Division of Mental Health
Hank Lee	Sacramento County Mental Health Board Board Member of the Alliance for the Mentally Ill, Sacramento
Mary Nakamura, MSW	Program Coordinator Transitional Living & Community Support, Inc.
Jacinto Nambo, MHRS/MSC	Sacramento County Division of Mental Health
Michelle Olson, MA	River Oaks Center for Children
Nicola Simmersbach, MFCC	Sacramento County Division of Mental Health
Sayuri Sion, MHW	Asian Pacific Community Counseling
Toua R. Thao, MSW, ACSW	La Familia Counseling Center
Uma Zykofsky, LCSW	Sacramento County Division of Mental Health

Support Staff

- Sandi Nelson
- Mary Ordillas
- Kacey Vencill

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STATEMENT OF PHILOSOPHY

The Sacramento County Mental Health Plan recognizes that cultural competence is a goal toward which professionals, agencies and systems should strive. Becoming culturally competent is a developmental process and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, consideration of the dynamics that result from cultural differences that impact treatment, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

The Sacramento County Mental Health Plan shall serve people regardless of race, ethnicity, national origin, sex, age, sexual orientation, cultural beliefs and family practices, family values, degree of acculturation, disabilities, or religious beliefs. The Mental Health Plan promotes a workforce with the knowledge, skills, abilities and sensitivity to work with all county residents who need specialty mental health services.

By having a well-trained culturally competent staff, the Mental Health Plan will be better able to provide quality services to our culturally diverse client population. Similarly, the Mental Health Plan will insure persons of culturally diverse backgrounds full access to services that are culturally and linguistically appropriate and sensitive to their needs.

VISION

The Sacramento County Mental Health Plan is committed to providing all beneficiaries the necessary services and support to attain and maintain the most dignified life existence possible.

MISSION

The Sacramento County Mental Health Plan is committed to:

Providing a service system in which consideration of cultural competence is an integral part of all aspects of service planning, delivery and quality improvement through:

Providing easy access to beneficiary centered, culturally competent, and family focused mental health services;

Providing a system to meet the culturally diverse needs of our community;

Providing quality services that are cost effective, culturally competent, and that reduce use of high cost resources;

Providing services in an environment that respects the beneficiary's rights, culture, customs and confidentiality;

Providing services that will be delivered in a system monitored by continuous quality improvement principles;

Providing integrated services that coordinate physical health care with mental health care;

Providing interagency collaborative services achieved through public/private community partnerships.

PRINCIPLES

All individuals have a basic human right to be treated with dignity and respect;

Inclusion of the beneficiary, family, and community support system in the individual treatment and system planning processes is critical to quality outcomes;

Effective communication, including consideration of the linguistic needs of beneficiaries as appropriate, and respect for the relationship between individuals, families and providers are essential for successful outcomes;

Treatment should always be delivered in the most appropriate and least restrictive environment and level of care;

The treatment process is strength based;

Beneficiary choice will be honored within available resources.

Part I

PART I – POPULATION ASSESSMENT

A. COUNTY GEOGRAPHIC AND SOCIO-ECONOMIC PROFILE

A1. Geographical Location and Attributes of Sacramento County by Service Delivery Region

A1a. Main Urban and Rural Centers

Sacramento County, located in Northern California, is the most populous county in the greater Sacramento area region, accounting for 70 percent of the people living in the four-county area including Yolo, El Dorado, Placer and Sacramento counties. Sacramento County's population is also the most racially and ethnically diverse – nearly 80 percent of the region's Hispanics, Asian-Pacific Islanders and African-Americans live in Sacramento County. Sacramento's rich cultural diversity was one reason the Federal government chose Sacramento as a pilot city for the 2000 Census. Sacramento is also the capital of the state and the ethnic/racial makeup of the region is a reflection of the growing diversity of the State and the nation.

The ethnic or racial profile of Sacramento County differs from California's overall profile. Of the total population, the non-white ethnic/racial populations grew from 25% to 35% between 1980 and 1990, but the percentage of these groups is still smaller than the statewide proportion 43%. It is projected that by the year 2000, nearly 1/3 of Sacramento residents will be Asian, Hispanic, African American and other non-Whites. Between 1990 and 2000, the numbers of people of color will grow at twice the rate of the White population in the County. Between 1990 and 2000, Hispanics are projected to increase from 12 to 14% of the population, Asians and others (including Native Americans) will increase from 10 to12%, and African

Americans from 9-10%. The Caucasian population will decline from 69% to 64% of all county residents.

Southeast Asian refugee migration peaked in the mid-1980s and remains higher in Sacramento than in the state as a whole. Approximately 25,000 (some community leaders think this is an undercount) Southeast Asians emigrated from Cambodia, Vietnam, and Laos to Sacramento from 1980 to 1990 with an overall increase of 14% in this population group. Approximately 3.5% of all Californians live in Sacramento County, but more than 6% of the state's Southeast Asian refugees reside here.

Four key demographic conditions will influence Sacramento's future:

- Growth
- New population distribution patterns
- Increasing racial/ethnic diversity
- Increasing proportion of seniors

The Sacramento region was one of the fastest growing areas of the state during the 1980s. While the rate of population increase in the region's largest county has slowed somewhat, continued growth especially in the county's eastern and southern extremities, is expected during the 1990s.

The past decade brought many newcomers to the region, and racial/ethnic populations grew from 25 percent to 30 percent of the county's population. Helping these new arrivals integrate into Sacramento's community fabric and building ties between and among the community's diverse populations provides challenges for the future.

Sacramento County is host to several urban and rural community center areas, including most recently, the redeveloped downtown shopping area in the heart of the city.

The continuing redevelopment of Old Sacramento, situated directly on the east side of the Sacramento river near the confluence of the American and Sacramento rivers, has been an ever changing redevelopment area. Large shopping malls (besides the Downtown Mall) include Florin Mall in the South Area, Arden Fair Mall in the north area, Sunrise Mall in the

northeast portion of the county, and a 60-store Outlet Mall in nearby Folsom. Urban communities surrounding the city of Sacramento include South Natomas, North Highlands, Del Paso Heights, Arden-Arcade, Rancho Cordova, South Sacramento, and the Land Park/Pocket/Meadowview areas.

Still highly populated, yet situated in somewhat of a "rural" setting, are the community areas of North Natomas, Rio Linda , Elverta, Antelope, Citrus Heights, Foothill Farms, Carmichael, Orangevale, Fair Oaks, Folsom, Rancho Murieta, Cosumnes, Elk Grove, Hood/Franklin, Laguna, Galt and Isleton.

The Sacramento Mental Health Plan (MHP) is a blend of public and private contracted community-based traditional and non-traditional providers who are located at multiple service sites throughout the County. These community-based service sites were based on client needs, community

considerations and population clusters, i.e. AFDC/Medi-Cal recipients, community preferences, access to transportation, the availability of service space and the interest/willingness of residents to have mental health services located in their neighborhood.

For planning and service delivery purposes, the county is broken into four services delivery areas. These Sacramento County Mental Health Regional Services Delivery Areas (regions) are:

- **Northwest Region** – Serves North and South Natomas, Rio Linda-Elverta, Antelope, Citrus Heights and North Highlands.
- **Northeast Region** – Contains the communities of Arden-Arcade, Carmichael, Orangevale, Fair Oaks, Folsom, and Rancho Cordova.
- **South Region –** A geographically expansive region including Land Park/Pocket, Meadowview, South Sacramento, Rancho Murieta, Consumnes, Elk Grove, Franklin-Laguna, Galt and Isleton.
- **Central Region** – Situated directly in the core of the City of Sacramento and serves the downtown population.

A wide array of service providers are located in these regions (serving adults, older adults, and children). In order to provide the flexibility necessary to meet the needs of consumers and to maximize services, some sites are full service regional centers serving beneficiaries in that region.

Other sites provide specialized services that are available to all eligible consumers. Each region contains a regional program (Regional Support Team -RST) that provides a full range of mental health services to adults who live in that region as well as other services (Specialty Services) that are available to any adult in the county that requires the service and meets admission criteria.

The Children's System of Care is configured according to level of service intensity required by the individual child and family being served. The most intensive programs serve clients countywide. Community and school-based outpatient services are located in over 40 sites covering all geographic regions of the county. Figure A displays the regions and identifies Regional and Specialty Programs.

A1b. Terrain and Distances

The County is comprised of 637,220 acres, or 995.7 square miles (these numbers include both land and water areas). Sacramento is known for its rivers; the American and Sacramento Rivers converge in Sacramento. The rivers are attractive areas that contribute to the beauty and uniqueness of the area. The rivers, however, present significant challenge for design of transit routes, etc.

The terrain for most of Sacramento County is relatively flat to the Folsom area, which borders the El Dorado County foothills. Folsom begins a gently rolling terrain, which continues into the

Cosumnes/Rancho Murieta areas. Directly south of the downtown area, the topography is considerably flat. Between the Elk Grove/Laguna area and Galt the land is also primarily flat and used for farming or cattle. The countryside near the southern most town of Isleton includes acres of pear trees and grapevines, with the Sacramento River flowing through the middle of that community.

A1c. Main Transportation Routes and Availability of Public Transportation

Driving is a way of life in Sacramento. Main transportation routes are plentiful, and include Interstate 80 running east and west and serving the Central, Northeast and Northwest Regions. Interstate 5 and Highway 99, running somewhat parallel to each other in a north and south orientation, serve the Northeast, Central, and South Regions. State Route 50, beginning at the middle of the main Sacramento interchange and moving east through Sacramento County into El Dorado County, serves the Northwest and Central Regions. The Capital City Freeway is used by parts of the Central and Northwest Regions. This portion of roadway was previously known as Interstate 80 and Business Loop 80. Highway 160, running from Isleton continuously next to the Sacramento River and through the city of Sacramento, connects Downtown Sacramento with the Capital City Freeway close to the Arden Mall Shopping Center and Cal Expo.

The cost of maintaining an automobile presents problems for some consumers. Some solve the problem by carpooling. Public

transportation is available in each of the Regions in the form of a bus transit system, and to a limited extent, the Sacramento Light Rail system. While Light Rail has opened a new "avenue" to downtown transportation, it is still somewhat limited in its routes. For example, the furthest it travels to the east is to the Butterfield Station, on the outskirts of Rancho Cordova. On the north side it travels to a stop on Interstate 80 west of the Watt Avenue Bridge, near McClellan AFB. While public transportation is a viable option for some, scheduling problems, long waits at bus and light rail stations, problems coordinating connecting conveyances, financial constraints, inconvenience, and problems associated with some forms of mental illness present difficulty for some mental health consumers.

Some regions are configured so that consumers can comfortably walk to services and bicycling is an option for others. Additionally, some Children's providers use taxis and outreach workers to assist with transportation needs.

Other forms of transportation routes include the Greyhound bus line Union Pacific Railroad, and the Sacramento International Airport.

2. Socio-economic Characteristics of Sacramento County by Service Delivery Region

2a. Primary Economic Support

In 1990, *office employment* ranked first in employment estimates with 125,406 employed in this field. Following, *retail* came in with 85,288

employees, the *medical* field with 37,473, *manufacturing* at 26,536, and *education* at 22,516. The column of O*ther* actually had more employees (165,596); however, it should be noted that the 1990 Census does not define what *Othe*r represents.

2b. Average Income Levels

According to the Sacramento Community Services Planning Council's 1996 "Community Trends and Issues" publication, median household income in 1990 in Sacramento County was $32,297. Rancho Murieta, a portion of the Southeast Region, had the highest median income of $69,720, while downtown Sacramento Central Region, had the lowest, $16,336. Overall, 12.5% of the County's population was living below the poverty level when the 1990 Census was taken.

2c. Welfare Caseload

Welfare caseloads have continued to climb; however, the passage and implementation of the CalWORKs program should result in caseload decline as most recipients will be required to return to the workforce.
This will have an impact on the tax base for Sacramento County and California. According to the Sacramento County Department of Human Assistance Databook, as of March 1998, approximately 46,000 families were welfare recipients. This number includes 31,755 one-parent or disabled-parent household; 8,235 cases in two-parent households; 4,715

foster care cases, and 1,265 Aid-to-Adopt cases. The approximate total caseload per Region are:

- Northwest Region - 13,800 cases
- Central Region - 6,000 cases
- Northeast Region - 11,000 cases
- South Region - 15,200 cases

While Sacramento has long been considered a family-friendly community—a good place to rear children—recent trends indicate that area families are experiencing some of the same changes and stresses that afflict families in urban areas throughout the country. Of particular significance is the increasing poverty level of children, a phenomenon attributable to the growth in single-parent families, negative health indicators related to maternal and child health, and increasing juvenile and family violence.

More Sacramento children live in poverty today than a decade ago. According to the 1980 Census, approximately 14 percent of Sacramento's children were living in poverty, but by 1990, the child poverty rate had grown to 20 percent. Sacramento registers the highest rate of families receiving Aid to Families with Dependent Children (AFDC) among California's largest counties.

2d. Employment Data

Income continues to grow but families are having a more difficult time making ends meet. Sacramento's per capita income growth rate exceeded

that of the state between 1990 and 1993. The county per capita income still remains below the state's average. Local job growth is primarily in the service sector where many jobs are seasonal, part-time, or temporary and may not provide health and other benefits. The salary of a single woman, with one child, making minimum wage, puts the family of two below the Federal poverty level of $10,030.

Major employers in Sacramento County include government and the military; however, their contribution to the area's economic base has declined with the closure of Mather Air Force Base (Northeast Region), the Sacramento Army Depot (Central and South Regions), and the future closing of McClellan Air Force Base (Northwest Region). Promoting the area as the next "Silicon Valley II" has countered the decline in the military government economic base. The Army Depot is now the center for the manufacture of Packard Bell computers. Folsom is home to a very large Intel operation, and just across the Sacramento County line into Placer County are the Hewlett-Packard and NEC plants. Apple Computer lies south of the city in Elk Grove.

According to the 1990 Census, Sacramento County had a total of 533,600 in the work force with 509,700 actually employed. As a result, the number of unemployed was approximately 23,900, or 4.5%.

1990 Census Information Broken Down in Communities within the Regions follows:

	Workforce	***Employed***	***Unemployed***	***Percent****
North Highlands (Northwest)	20,250	18,950	1,300	6.4%
Rio Linda (Northwest)	4,520	4,240	280	6.2%
Foothill Farms (Northwest)	9,790	9,340	450	4.6%
Orangevale (Northeast)	13,880	13,330	550	4.0%
Citrus Heights (Northwest)	60,670	58,620	2,140	3.5%
Arden-Arcade (Northeast) (includes the LaRiviera area)	57,580	55,520	2,130	3.9%
Rancho Cordova (Northeast) (Includes the Rosemont area)	39,710	38,190	1,520	3.6%
Carmichael (Northeast)	26,200	25,330	870	3.3%
Fair Oaks (Northeast)	15,250	14,770	490	3.2%
Folsom (Northeast)	12,720	12,340	380	3.0%
Galt (South)	4,120	3,760	360	8.7%
South Sacramento (South) (Includes the areas of Florin, Meadowview, Parkway, South Land Park, and Pocket)	23,830	22,330	1,500	6.2%
Elk Grove (South)	9,330	9,010	230	3.5%
Laguna (South)	5,940	5,750	190	3.2%
Sacramento City (Central) (Includes portions of other regions that are in the city limits)	179,920	170,020	9,900	5.5%

*** Percentage of unemployed of the total workforce.**

3. Other relevant county or regional characteristics of interest.

As the seat of political activity for the entire state, Sacramento is arguably the most politically "savvy" community in California. Sacramento has attained diversity within local government structure with a high level of ethnic/racial representation in leadership positions from the Mayor's office to law enforcement and local boards and commissions. The State Capitol area includes the governor's office, the legislative branch of government and the judiciary. Sacramento is the home of lobbyists, CSAC and many other political entities.

In addition to the political overlay, Sacramento County has all of the challenges expected of a large metropolitan area. While some of these issues have been

highlighted elsewhere in this document, two issues, the homeless population and the number of board and care clients are of note. There are 400-500 licensed board and care facilities housing children, adults and the elderly in Sacramento County. Of that number, approximately 175 of those residences house mental health and elderly clients. Many of these clients in these homes receive services in our system. To facilitate communication and improve services, a *Residential Forum*, which involves about 100 board and care facilities for adults, meets periodically and the Division of Mental Health coordinates a listing of vacancies that are circulated throughout the system. A small number, 12 homes with 115 beds, are involved in the ACT Program (Augmented Care and Treatment). Residents in these homes receive additional services designed to assist them in remaining at this level of care. Without these services many clients would require more restricted services.

The issue of homelessness has received a great deal of attention in Sacramento County. A needs assessment completed in Spring 1996 documented that 1,313 (35%) of an estimated 5,000 Sacramento homeless are mentally ill. (This is the most recent assessment available and it is believed the numbers are still accurate.) Guest House, a non-traditional mental health outpatient facility designed to serve the homeless, was established in 1991. Located in an area frequented by homeless people, Guest House provides a non-threatening, informal, low-keyed environment for clients who are often reluctant to accept mental health treatment in more traditional settings. The budget for services at Guest House was augmented in 1997 in response to need. Moving a large number of homeless, mentally ill individuals from the streets and helping them gain stability requires the use of a systematic process involving outreach, advocacy and clinical services. Sacramento County Mental Health continues to develop services that provide assistance to the homeless.

B. DEMOGRAPHICS (by ethnicity, primary language spoken, and gender and age)

B1. General Population in County

Data from the 1990 US Census were obtained for each zip code in the County for the purposes of describing the general population in Sacramento County. From those data, the following descriptions of ethnicity, primary language spoken in the household, gender and age are drawn. In 1990, 1,051,400 individuals were residents of Sacramento County.

Ethnicity - The ethnic breakdown of the general population is presented in Figure 1. The categories of ethnicity that are depicted in the graph are those that overlap with categories the Cultural Competence Workgroup in Sacramento County included in its human resources assessment. In addition, the 1980 Census included certain ethnic classifications that are placed in the *Other* category on the graph including Eskimo, Aleut, Asian or Pacific Islanders, and Other.

As the graph indicates, the general population was quite diverse in 1990. While approximately 86% of the population fell into one of three ethnic groups (Caucasian, African American, Latino), there was a variety of ethnic groups represented in the general population of the County.

Primary Language Spoken -The primary languages spoken by the general population are presented in Figure 2. The language categories depicted in the

graph are those that overlap with categories the Cultural Competence Workgroup in Sacramento County included in its human resources assessment. In addition, the Census included certain languages that are placed in the *Other* category on the graph including German, Yiddish, Other West German, Scandinavian, Greek, Indic, Italian, French, Portuguese, Polish, Slavic, Mon-Khmer, Native American, Other Indo-Euro, Arabic, Hungarian, and Other.

As the graph indicates, the primary language of 82% of the general population was English in 1990. Spanish accounted for an additional 8.5% of the population. It is interesting to note that of Sacramento County's seven threshold languages, three were not categorized separately on the Census (i.e., Hmong, Mien, and Lao). Individuals with these as their primary language would have been included in the *Other* category on the 1990 Census.

Gender and Age - Figures 3 and 4 illustrate the gender and age breakdowns of the general population in 1990. With respect to gender, Figure 3 shows that the population had a slightly higher percentage of females than males (51% vs. 49%). With respect to age, Figure 4 shows that approximately 26% of the population was under 18-years old, 59% was between the ages of 18 and 60, and 15% was over the age of 60.

B2. General Population in County by Region

Because data from the 1990 United States (US) Census were obtained for each zip code in the County, it was a straightforward task to collate the general population numbers by service delivery region. The numbers of people in zip codes which covered more than one region were proportionately split to estimate the regional numbers (e.g., 95830 was split so 2/3 of the population was reflected in the South and

1/3 was reflected in the Northeast). Below is a description of the Northeast, Central, South, and Northwest service delivery regions in Sacramento County and approximately 32%, 14%, 31%, and 23%, respectively, of the total County population resides in each of these regions.

Ethnicity - The ethnic breakdown of the general population by region is illustrated in Figure 5 (see Appendix A for the specific percentages of ethnicity by region). Once again, ethnic classifications included in the “other” category are Eskimo, Aleut, Asian or Pacific Islanders, and Other. As the graph indicates, the four Regions differ somewhat with respect to ethnic diversity. Almost 82% of the Northeast Region is comprised of Caucasians, with African Americans and Latinos comprising an additional 11% of the population. In contrast, Caucasians comprise less than 60% of the populations in the Central and South Regions (60% and 55%, respectively). In these regions, African Americans constitute 10% and 12% of the population, while Latinos constitute another 12%. Other ethnic categories represented in relatively large numbers include Vietnamese (1%), Chinese (4%), Japanese (2%), Native American (1% in the Central Region), and Filipino (2% in the South).

In terms of ethnic diversity, the Northwest Region falls somewhere in between the Northeast and the Central/South Regions. Here, approximately 71% of the population is Caucasian, with African Americans comprising almost 9% and Latinos comprising almost 10%. The Northwest Region also has large numbers of Native Americans (1%) and Filipinos (1%).

Primary Language Spoken - The primary languages spoken by the general population by region are presented in Figure 6 (see the Appendix for the specific percentages of primary language by region). Once again, languages placed in the *Other* category include German, Yiddish, Other West German, Scandinavian, Greek, Indic, Italian, French, Portuguese, Polish, Slavic, Mon-Khmer, Native American, Other Indo-Euro, Arabic, Hungarian, and Other.

As the graph indicates, the regions differ somewhat in terms of the primary language spoken in the home. The Northeast and Northwest Regions are very similar, with almost 90% of the populations speaking English. Both of these regions also have about 6% of the population with Spanish as their primary language. Once again, the Central and Southern Regions are more diverse. Here, only 77% and 75% of the populations have English as their primary language. In addition, 12% of both regions are Spanish speaking, 1% speak Vietnamese, 4% speak Chinese (note that the 1990 US census did not differentiate Chinese languages), and 1% of the population in the South speaks Filipino.

Gender and Age - Figures 7 and 8 illustrate the gender and age breakdowns of the general population by region in 1990. With respect to gender, Figure 7 shows that each of the 4 regions are similar with the proportions of males and females represented in the general population. All regions had a slightly higher percentage of females than males (51% vs. 49%).

With respect to age, the four regions are very similar with a few exceptions. The South and Northwest Regions have slightly higher percentages of children 11-

years old and under. In addition, the Central Region has a somewhat higher percentage of individuals over the age of 65.

B3. Most Recent Available Number of Medi-Cal Beneficiaries in County

Data from the 1996 Meds file were supplied to the County by the State Department of Mental Health for the purposes of describing the population of Medi-Cal beneficiaries in Sacramento County. From those data, the following descriptions of ethnicity, primary language spoken in the household, gender and age are drawn. Please note that due to the sources of data for the Meds file, there are large numbers of people whose ethnicity and primary language are *Other* or *Unknown.* There were 243,033 Medi-Cal eligible beneficiaries included in the January 1996 Meds file.

Ethnicity - The ethnic breakdown of Medi-Cal eligible beneficiaries is presented in Figure 9. The categories of ethnicity that are depicted in the graph are those that overlap with categories the Cultural Competence Workgroup in Sacramento County included in its human resources assessment. In addition, ethnic classifications from the Meds file that are placed in the *Other* category on the graph include Asian or Pacific Islander and Other.

As the graph indicates, ethnicity of the Medi-Cal eligible population is very diverse. Less than half the population is Caucasian (43%). Other ethnic groups comprising notable proportions of the population include African American (19%), Latino (14%), Vietnamese (4%), Chinese (2%), and Lao (7%).

Primary Language Spoken - The primary languages spoken by Medi-Cal

eligible beneficiaries are presented in Figure 10. The language categories depicted in the graph are those that overlap with categories the Cultural Competence Workgroup in Sacramento County included on its human resources assessment. In addition, language categories from the Meds file that are placed in the *Other* category on the graph including Italian, French, Polish, Portuguese, Turkish, Ilacano, Farsi, Arabian, Armenian, and Other.

As the graph indicates, the primary language spoken by the Medi-Cal eligible population varies greatly. In addition to English (which is the primary language of almost 62% of Medi-Cal eligible individuals), seven languages are represented by substantial portions of the Medi-Cal eligible population: Spanish (6.5%), Hmong (5%), Russian (4.2%), Vietnamese (3.6%), Cantonese, (1.9%), Mien (1.4%), and Lao (1.4%). These seven languages also represent Sacramento county's threshold languages.

Gender and Age - Figures 11 and 12 illustrate the gender and age breakdowns of the Medi-Cal eligible population. With respect to gender, Figure 11 shows that the population has a higher percentage of females than males (56% vs. 44%). With respect to age, Figure 12 illustrates that half of the Medi-Cal eligible population is younger than 18 years of age, and almost 10% of this population is over 65 years of age.

B4. Most Recent Available Number of Medi-Cal Beneficiaries in County by Region

Data from the 1996 Meds file were supplied to the County by the State Department of Mental Health for each zip code in the County. The numbers of people in zip codes which covered more than one region were proportionately

split to estimate the regional numbers (e.g., the zip code 95830 was split so 2/3 of the population was reflected in the South and 1/3 was reflected in the Northeast). Below is a description of the Northeast, Central, South, and Northwest Regions in Sacramento County. Approximately 23%, 13%, 38%, and 25%, respectively, of the Medi-Cal eligible population reside in each of these regions.

Ethnicity - The ethnic breakdown of the general population by region is illustrated in Figure 13 (see the Appendix for the specific percentages of ethnicity by region). Once again, ethnic classifications from the Meds file that are placed in the *Other* category on the graph include Asian or Pacific Islander and *Other*. As the graph indicates, the four regions differ somewhat with respect to the ethnic diversity of Medi-Cal eligible beneficiaries, with the Northeast and Northwest Regions having less diversity than the Central and South Regions. The Northeast and Northwest Regions are primarily comprised of Caucasians (66% and 54%), with African Americans (13% and 18%), Latinos (9% and 12%), Vietnamese (1% and 1%), and Laotians (2% and 7%) also being represented in substantial numbers.

The Central and South Regions, however, have no real *majority* population. Instead, these regions are comprised of Caucasians (34% and 26%), African Americans (24% and 22%), Latinos (17% and 17%), Vietnamese (2% and 7%), Chinese (2% and 3%), Laotians (5% and 9%), and Cambodians (1% in the South).

Primary Language Spoken - The primary languages spoken by the general population by region are presented in Figure 14 (see the Appendix for the specific percentages of primary language by region). Once again, language categories

from the Meds file that are placed in the *Other* category on the graph including Italian,French, Polish, Portuguese, Turkish, Ilacano, Farsi, Arabian, Armenian, and *Other*.

As the graph indicates, the regions differ in terms of the primary language spoken in the home, with the differences between regions mirroring those identified for ethnicity. The Northeast and Northwest Regions are very similar, with 69% of the Medi-Cal eligible populations speaking English. Both of these regions also have five of the seven threshold languages represented including, Spanish (4% and 5%)), Hmong (2% and 5%), Russian (7% and 6%), Vietnamese (2% and 1%), and Lao (1% and 2%). The Central and Southern Regions again are more diverse. Here, only 56% and 55% of the Medi-Cal eligible populations have English as their primary language. In addition, all seven of the threshold languages are represented in these regions: Spanish (8% and 8%)), Hmong (4% and 8%), Russian (2% and 2%), Vietnamese (3% and 7%), Cantonese (3% and 4%), Mien (2% and 2%), and Lao (1% and 1%).

Gender and Age -Figures 15 and 16 illustrate the gender and age breakdowns of the Medi-Cal eligible population by region. With respect to gender, Figure 15 shows that four regions are similar with the proportions of males and females represented in the general population. All regions have a slightly higher percentage of female beneficiaries.

With respect to age, the four regions are very similar with a few exceptions. The South and Northwest Regions have slightly higher percentages of Medi-Cal eligible children 17 years and under. In addition, the Central Region appears to

have a somewhat higher percentage of Medi-Cal eligible individuals over the age of 60.

B5. Seasonal Migrants Available Number of who are Medi-Cal Beneficiaries in the County by Region (estimate number if available and appropriate)

In trying to determine the number of Medi-Cal eligible seasonal migrants, several agencies were contacted, including the Department of Education, Migrant Services, the Employment Development Department, State Department of Mental Health, State of California Rural Health Division and Primary Care Service, and Sacramento County Primary Health Services. Sacramento County Primary Health Services was unable to supply relevant information. While they do keep track of the number of illegal aliens and medically indigent, they do not have information regarding whether these individuals are seasonal migrants.

The State Department of Mental Health provided a referral to the Employment Development Department (EDD). The Department of Education also provided a referral to the Employment Development Department. EDD was able to supply some limited information for 1993. In particular, in 1993, Sacramento County registered 1,567 migrant farm workers, who had a total of 2,777 dependents (for a total of 4,344 migrants). There was no information, though, regarding the Medi-Cal eligibility of these individuals. However, if the assumption was made that all of the migrants were Medi-Cal Eligible, this would represent only 1.8% of the total Medi-Cal population in the County.

C. UTILIZATION OF MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES (by ethnicity, primary language spoken, and gender and age):

C1. Most recent available number of Medi-Cal beneficiaries using medically necessary mental health services in the County (FFS and SD/MC) arrayed by one of the following service category groupings:

Data from the 1996 Meds file were supplied to the County by the State Department of Mental Health for the purposes of describing the individuals who had used Medi-Cal specialty mental health services in the previous year in Sacramento County. From those data, the following descriptions of ethnicity, primary language spoken in the household, and gender and age are drawn. The data are presented in terms of the used of in-patient/residential services, out-patient/case management services, and day treatment services. There were 13,671 people who had used Medi-Cal specialty mental health services in the January 1996 Meds file, with 246 using in-patient/residential services, 13,279 using out-patient/case management services, and 174 using day treatment services. It is worth noting that there are large numbers of individuals whose ethnicity and primary language are *Other* or *Unknown* due to the sources of the data from the Meds file.

C1a. Inpatient and Residential

Figures 17 through 20 illustrate the population characteristics of those individuals who utilized in-patient/residential services. Figure 17 shows the ethnic breakdown of this population. Although the majority of the population is Caucasian, there are also substantial proportions of African Americans and Latinos. The primary language spoken is English (see Figure 18), although there

are many individuals included in the *Other* category. Figure 19 shows that there are slightly more males than females using in-patient/residential services (51% vs 49%). Finally, in terms of age, Figure 20 illustrates that fully 35% of these services are being utilized by youth under the age of 18, almost 62% of these services are being utilized by adults between the ages of 18 and 59, and 3% of services are used by adults 60 and over.

C1b. Outpatient Including Case Management or Non-Hospital

Figures 21 through 24 illustrate the population characteristics of those individuals who utilized out-patient/case management services. Figure 21 shows the ethnic breakdown of this population which is very diverse. Although the majority of the population is Caucasian, there are also substantial proportions of African Americans and Latinos. Moreover, at least eight additional ethnic categories are represented including Vietnamese, Chinese, Lao, Japanese, Korean, Native American, Cambodian, and Filipino. The primary language spoken is English (see Figure 22), although six of Sacramento's seven threshold languages are also well represented (Spanish, Hmong, Russian, Vietnamese, Cantonese, and Mien). The seventh language, Lao, is most likely included in the *Other.* Figure 23 shows that there are slightly more females than males using out-patient/case management services (53% vs 47%). Finally, in terms of age, Figure 24 illustrates that only 19% of these services are being used by youth under the age of 18, while almost 74% of these services are being used by adults between the ages of 18 and 59.

C1c. Day Treatment

Figures 25 through 28 illustrate the population characteristics of those individuals over the age of 60 who utilized day treatment services. Figure 25 shows the ethnic breakdown of this population. Although the majority of the population is Caucasian, there are also substantial proportions of African Americans and Latinos. The primary language spoken is English (see Figure 26), although there are many individuals included in the *Other* category. In contrast to the previous two service categories, Figure 27 shows that there are more males than females using day treatment services (58% vs 42%). Finally, in terms of age, Figure 28 illustrates that fully 62% of these services are being used by youth under the age of 18, while almost 27% of these services are being used by adults.

C1d. Other categories may be added later.

There is no other category at this time.

C2a. Inpatient/Residential

The data available for the preparation of this plan did not allow for the simultaneous breakdown of region and service category. Using a document from the State Department of Mental Health entitled "Medi-Cal Eligible Beneficiaries for January 1996 and Number of Medi-Cal Users of Mental Health Services: Total and by Record Type, Zip Code," staff hand counted the number of Medi-Cal eligible beneficiaries in each region according to zip code and determined the ethnic composition, primary language, and gender and age breakdown in each. This document, however, contained no information on the type of service utilized. Rather, information regarding service type was garnered from another document from the State Department of Mental Health entitled "Population Assessment Data." This document

listed the number of individuals in the county, the number of Medi-Cal eligible beneficiaries, the number of people receiving mental health services, and the number of people receiving inpatient/residential, day services, and/or outpatient and case management services. These data, however, could not be broken down by region.

Therefore, our regional analysis is limited to an analysis of all service types combined. Figures 29 through 32 illustrate the ethnic representations, primary languages, gender breakdowns, and age ranges of the service use patterns in the four regions in Sacramento County.

Figure 29 illustrates service use by ethnicity by region (see the Appendix for the Specific percentages of ethnicity by region). Of the four regions, the Northeast is the most homogenous, with 70% of services being used by Caucasians. African Americans and Latinos utilize an additional 13% of services. The Central and Northwest Regions look very similar with respect to ethnic breakdown. Just over half of individuals utilizing services are Caucasian, with significant representation by African Americans and Latinos (about 20%). The most heterogeneous region is the South, with Caucasians utilizing only 32% of services, African Americans 18%, Latinos 4%, Vietnamese 2%, and Chinese and Lao 1% each. It is somewhat disconcerting, however, that 41% of those using services in the South are in the *Other* category, which includes unknown information. If this information were available, the ethnic breakdown might be very different.

Figure 30 illustrates service utilization by primary language by region (see the Appendix for the specific percentages of primary language by region). The issue of unknown information is obvious here for all four regions. That is, there are large proportions of individuals in each region who are categorized *Other.* If they were categorized by the appropriate primary language, the distribution of languages

could change substantially. With this caveat in mind, it appears that the South Region is the most heterogeneous, with several languages being represented in considerable proportions including, English, Spanish, Hmong, Vietnamese, Cantonese, Mien, and Lao. Although these languages are all represented to some degree in the other regions, the numbers are much lower.

Figure 31 illustrates service utilization by gender by region. In the Northeast, South, and Northwest Regions, more females than males utilize services. In contrast, in the Central Region more males than females utilize services. Figure 32 illustrates service utilization by age by region. Here, the Central Region is the most homogenous, with almost 95% of services being provided to individuals over the age of 18. The Northeast and South Regions are comparable, with approximately 20% of services being provided to youth 17 years and younger, and 75 % to individuals 18 through 59. Finally, in the Northwest Region over 30% of services are provided to youth aged 17 years and younger.

D. ANALYSIS

Before analysis of the data presented thus far is completed, it is important to reiterate the sources of the data. The general population figures came from the 1990 United States Census and the Medi-Cal data were supplied from the January 1996 MEDs file. Therefore, data from different years are being compared. Further, different ethnicities and languages were coded in both sources and there is a fair amount of missing/unknown data associated with the MEDS file. In spite of these potential limitations, patterns across the data suggest a fairly representative picture of Sacramento County.

Ethnicity -The general and Medi-Cal populations in Sacramento are both very ethnically diverse. Only 68% of the general population and 43% of the Medi-Cal population is Caucasian. Given that only 43% of the Medi-Cal population is Caucasian, the service use patterns are somewhat surprising. Specifically, day treatment is being provided primarily to Caucasians (66%, with an additional 24% to African Americans), as are in-patient or residential services (64% Caucasian, with an additional 16% to African Americans) [note that African Americans comprise approximately 19% of the Medi-Cal population]. Even the out-patient service use pattern, which shows much more diversity, indicate that Caucasians are over-represented. Here, 51% of services are going to Caucasians and 16% to African Americans. The difference between the out-patient services and the in-patient and day treatment services is that nine additional ethnicities are being provided with out-patient services.

When the ethnic representation is examined in the four service delivery regions, the general population, Medi-Cal population, and service delivery data all point to a similar conclusion. That is, ethnic diversity differs across the four regions. Inspection of the data leads to the conclusion that a continuum exists with the regions falling from the least to most diverse: Northeast, Northwest, Central, and South.

Primary Language Spoken -The general population data indicates that Sacramento is comprised primarily of English and Spanish speaking people (82% and 9% respectively). The Medi-Cal population data suggests a very different picture. Only 62% of this population is English speaking. The seven threshold languages (Spanish, Hmong, Russian, Vietnamese, Cantonese, Mien, and Lao) account for an additional 25% of the population. Again, the service utilization patterns do not reflect the diversity inherent in

the Medi-Cal population. Day treatment and in-patient services are provided to English speaking people and those classified as *Other.* Out-patient services are more reflective of the language diversity with those receiving services being categorized into thirteen different primary languages.

When primary language is examined in the four service delivery regions, the general population, Medi-Cal population, and service delivery data all point to a similar conclusion. It is also one that mirrors what is found in terms of ethnic diversity. That is, frequency of primary languages differs across the four regions. Inspection of the data leads to the conclusion that a continuum exists with the regions falling from the least to most diverse: Northeast, Northwest, Central, and South.

Gender - Slightly more than half of the general population is female (51%), with a somewhat higher percentage of the Medi-Cal population being female (56%). It is, therefore, interesting that more males than females receive in-patient services (51% vs. 49%) and day treatment services (58% vs. 42%). On the other hand, more females than males receive out-patient services (53% vs. 47%).

When all service types are combined and the data are examined on a regional basis, the Northeast, South, and Northwest Regions follow the same pattern; in all three, more females than males receive services. In contrast, in the Central Region, this pattern is reversed with males receiving more services that females.

Age - Although youth under the age of 17 comprise about one quarter of the general population in Sacramento, they account for fully 50% of the Medi-Cal population. Further, youth are utilizing many of the intensive mental health services, including 63% of day treatment and 35% of in-patient and residential services. While the older adult population (over 65) accounts for only 9% of the Medi-Cal population, they are using 26% of the day

treatment services. It appears that the adult population (18-64) is depending primarily on out-patient services. This age group accounts for 41% of the population, yet utilizes 78% of the out-patient services.

When all service types are combined and the data are examined on a regional basis, it appears that the South is the most diverse region with respect to serving relatively large numbers in each age group. In addition, the Northeast and Northwest Regions are serving large numbers of youths aged 17 and younger (21% and 31% respectively).

Summary - In sum, the general population in Sacramento County is very diverse in terms of ethnicity, language representation, and age. Although the Medi-Cal population mirrors this diversity, it appears that intensive specialty mental health services are primarily being used by the English speaking, Caucasian subset of this population. Although out-patient services are being provided to a broader array of individuals, these too are not reaching the spectrum of potential clients in the County. Measurable objectives for this plan will be addressed after an analysis of the human resource data.

Figure A

Program Locations

0 7 14 Miles

Adult Sites

- Specialized Programs
- Managed Care
- Full Service Providers

Children Sites

- Specialized Providers
- Full Service Providers

Roads

Regions

- Central
- Northeast
- Northwest
- South

Figures 1-32

Figure 1: Ethnicity of General Population

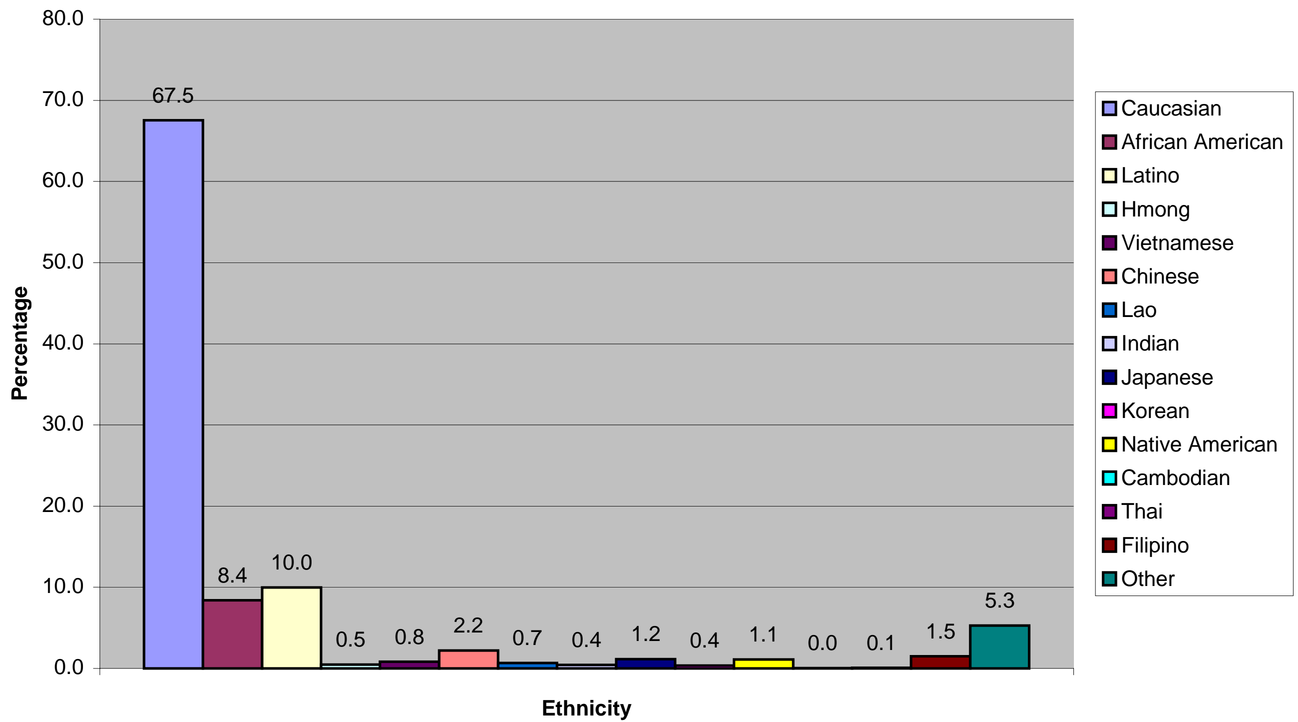


Figure 2: Languages Spoken by the General Population

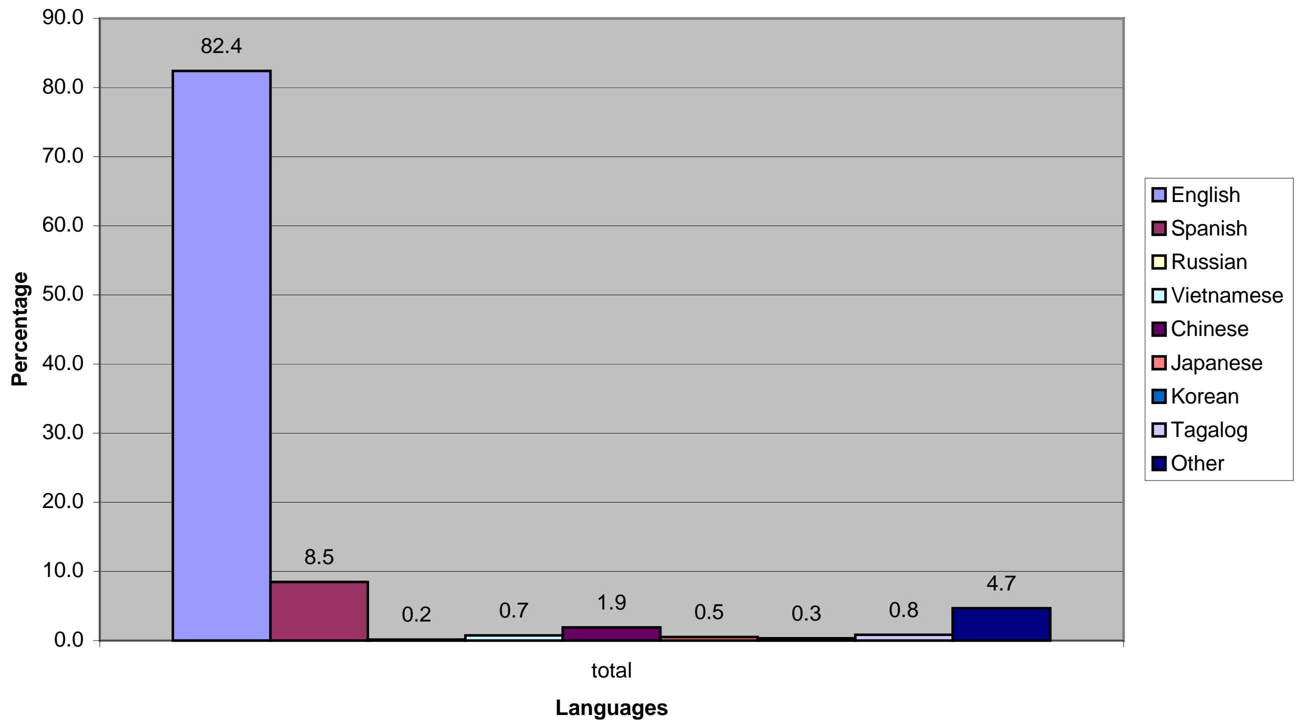


Figure 3: Gender Breakdown of General Population

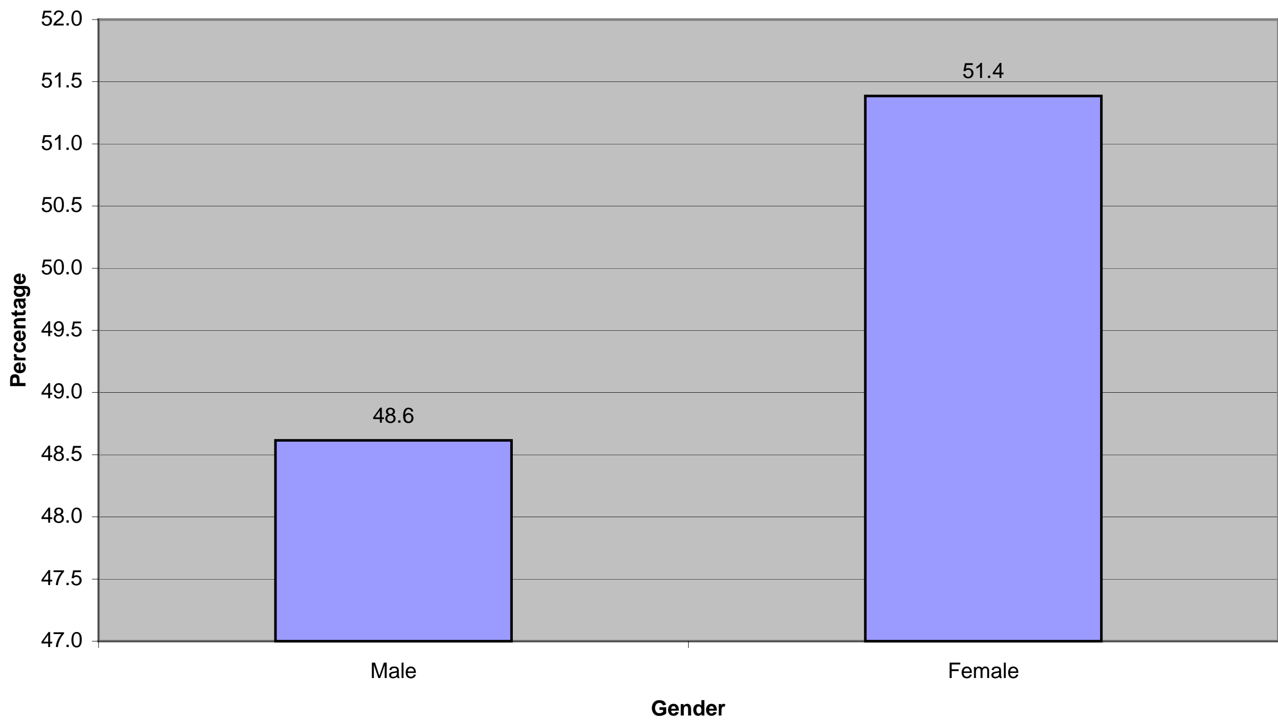


Figure 4: Age Ranges of the General Population

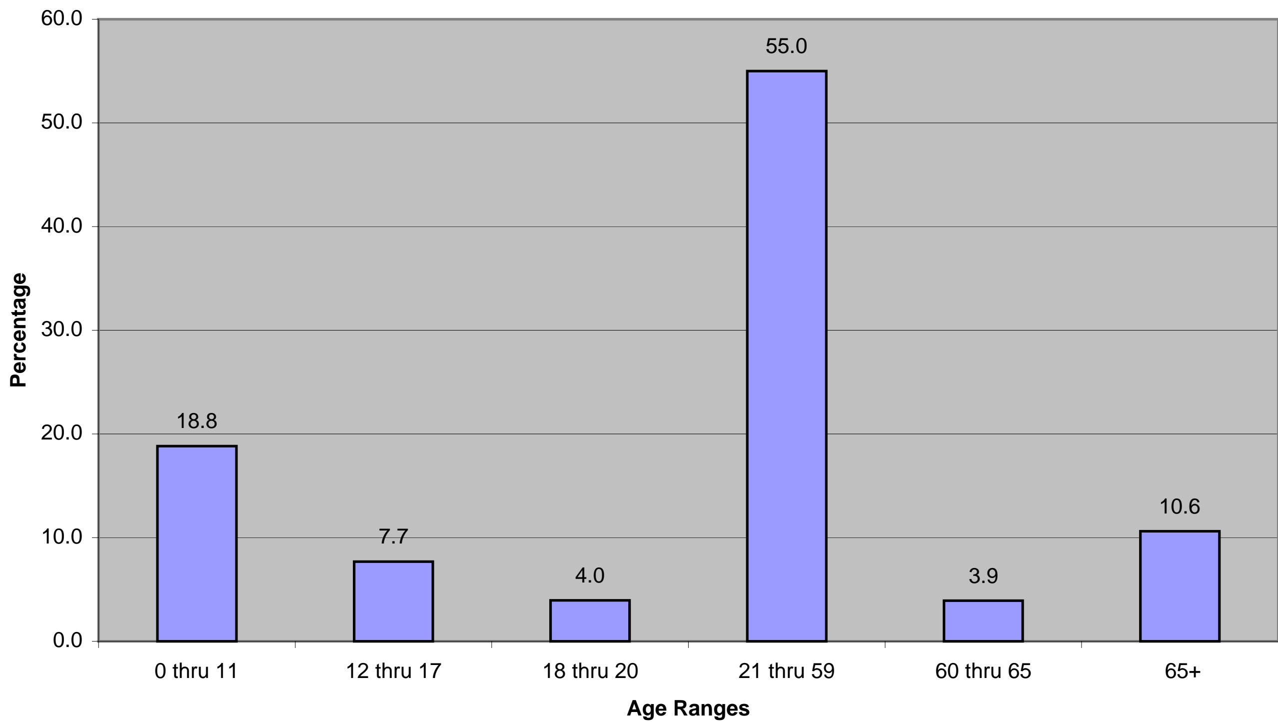


Figure 5: Ethnicity of General Population by Region

90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Percentage

Northeast
Central
South
Northwest

Region

Caucasian
African American
Latino
Hmong
Vietnamese
Chinese
Lao
Indian
Japanese
Korean
Native American
Cambodian
Thai
Filipino
Other

Figure 6: Languages Spoken by the General Population by Region

100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Percentage

Northeast
Central
South
Northwest

Region

English
Spanish
Russian
Vietnamese
Chinese
Japanese
Korean
Tagalog
Other

Figure 7: Gender Breakdown of the General Population by Region

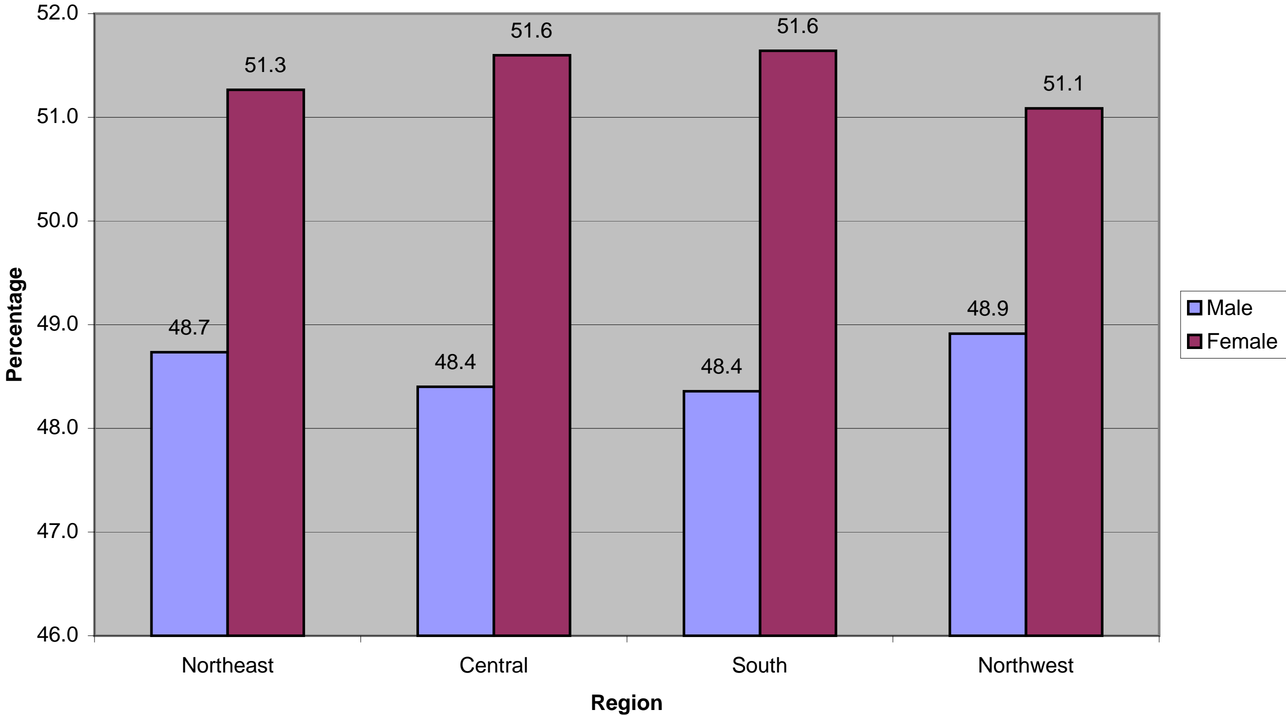


Figure 8: Age Ranges of the General Population by Region

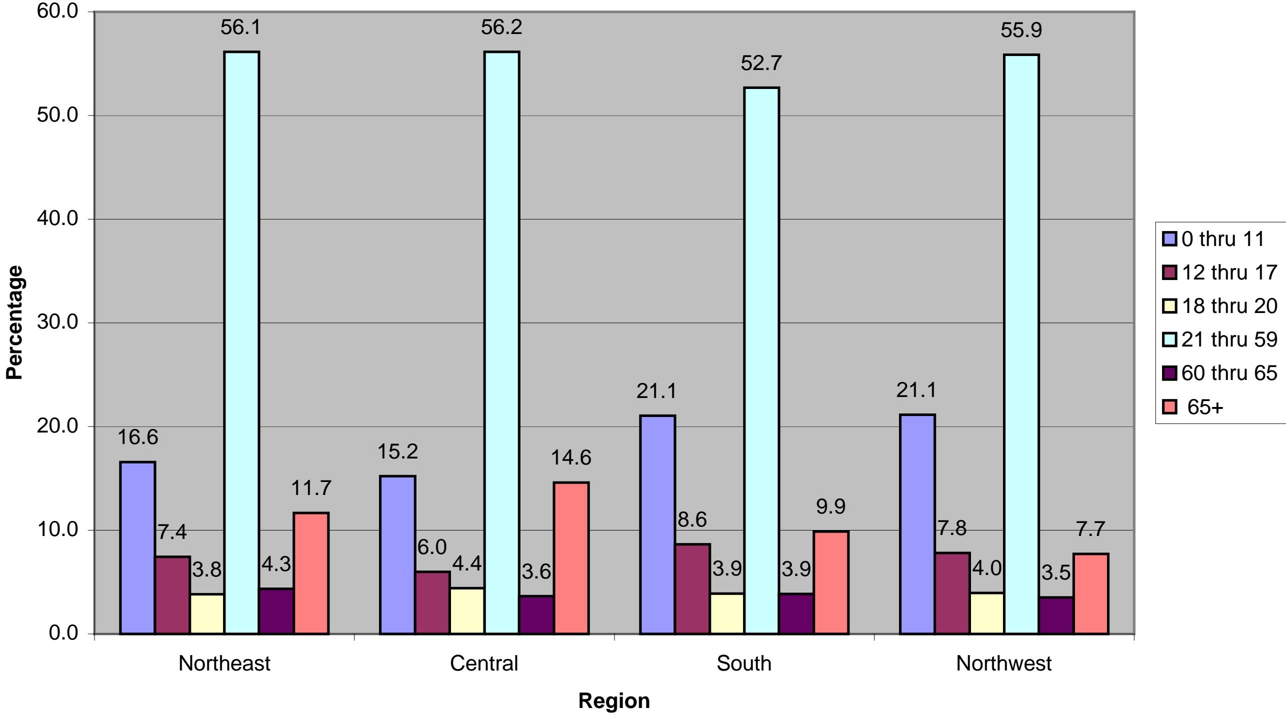


Figure 9: Ethnicity of Medi-Cal Eligible Beneficiaries

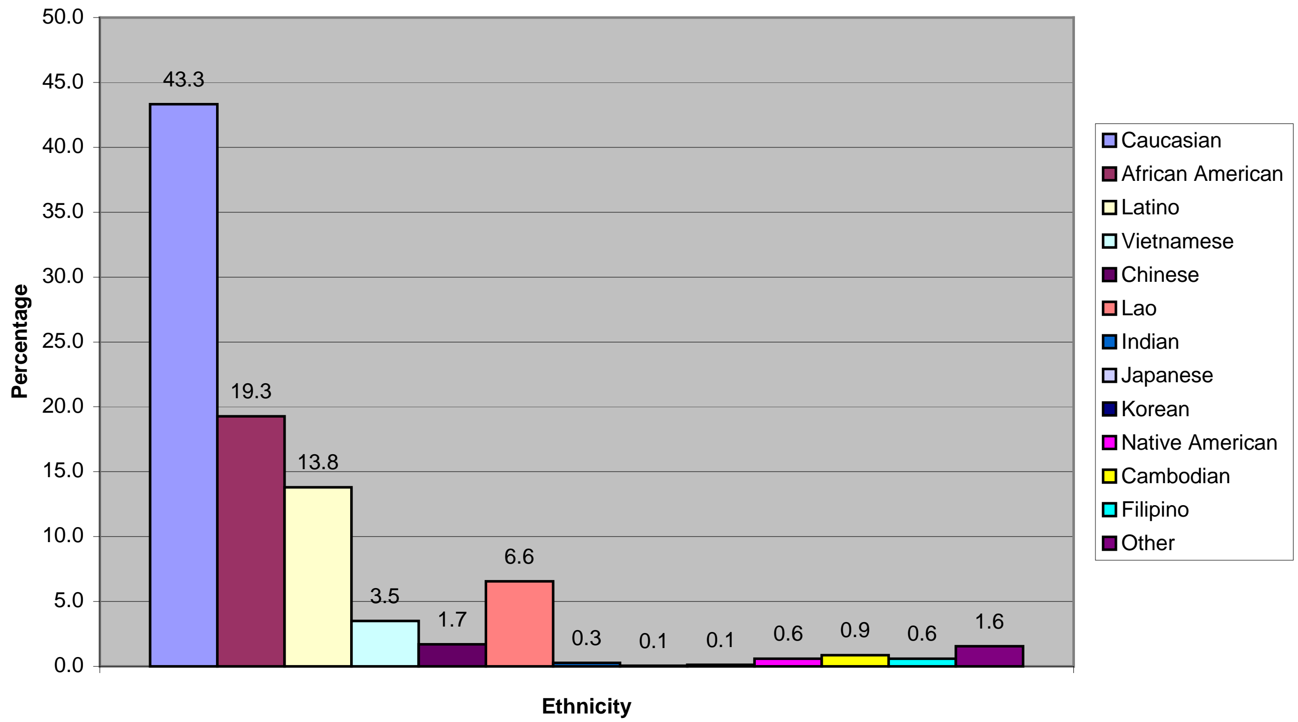


Figure 10: Languages Spoken by Medi-Cal Eligible Beneficiaries

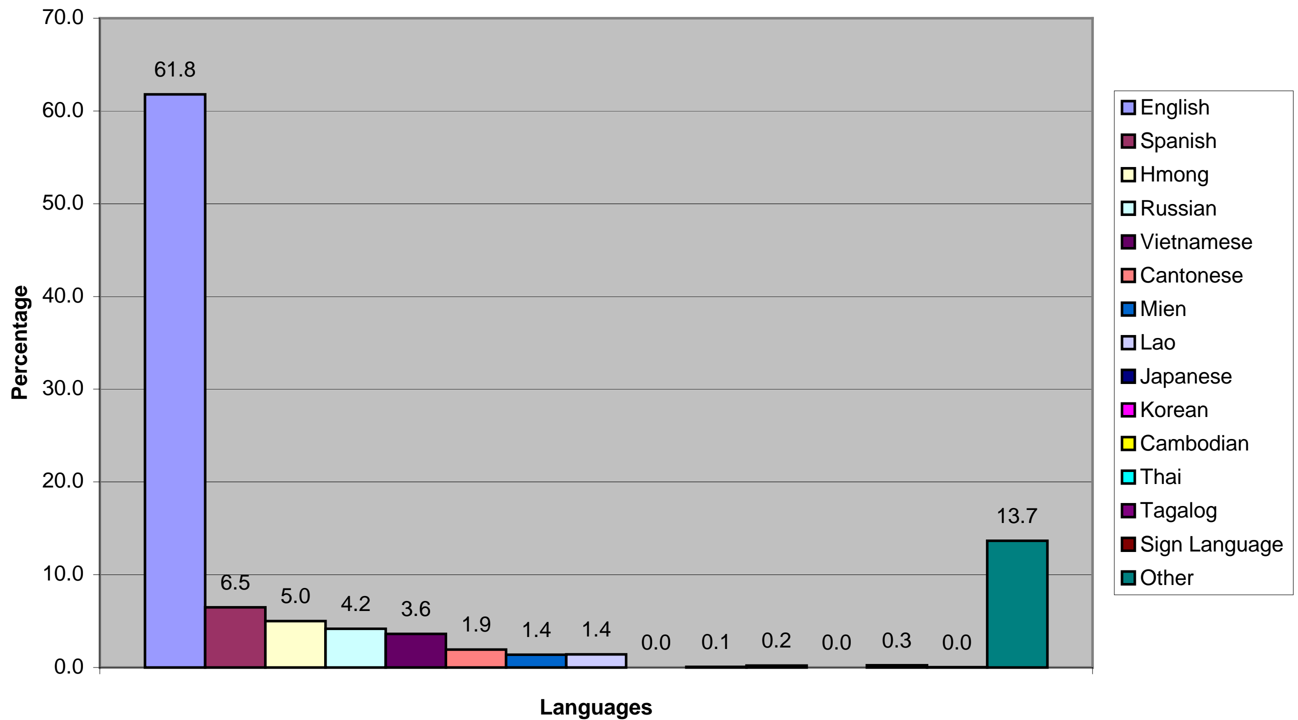


Figure 11: Gender Breakdown of Medi-Cal Eligible Beneficiaries

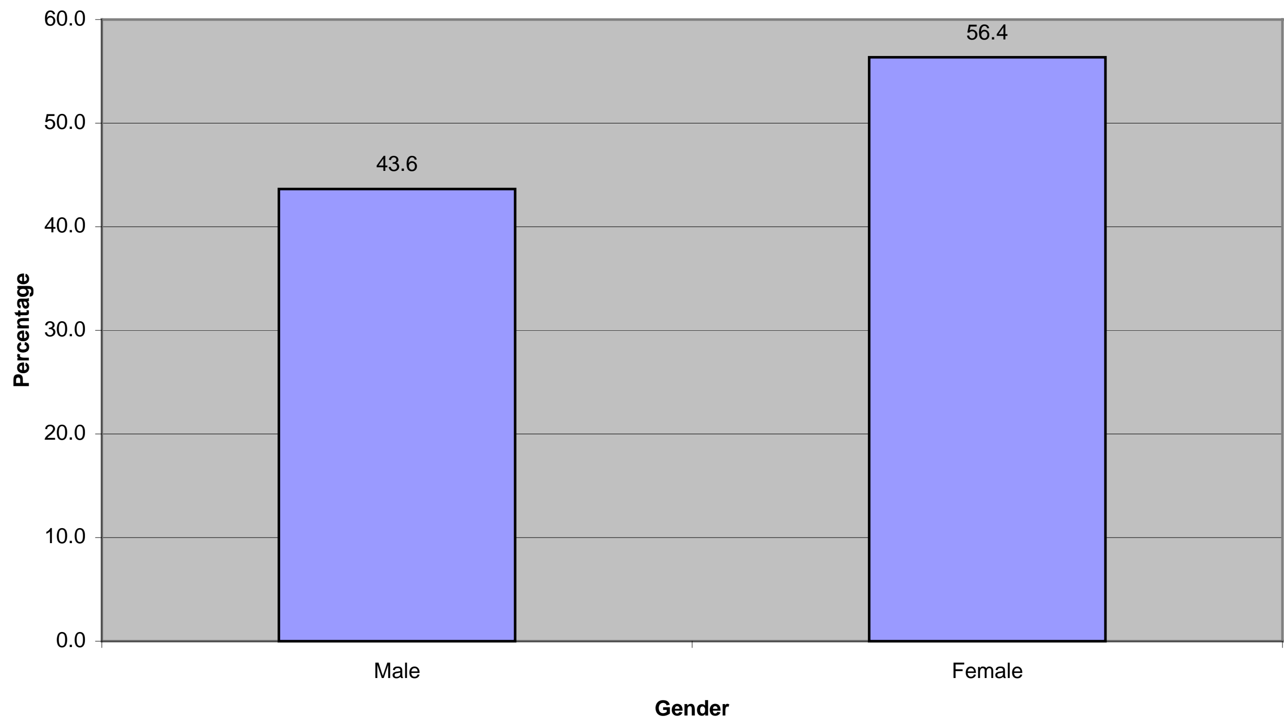


Figure 12: Age Ranges of Medi-Cal Eligible Beneficiaries

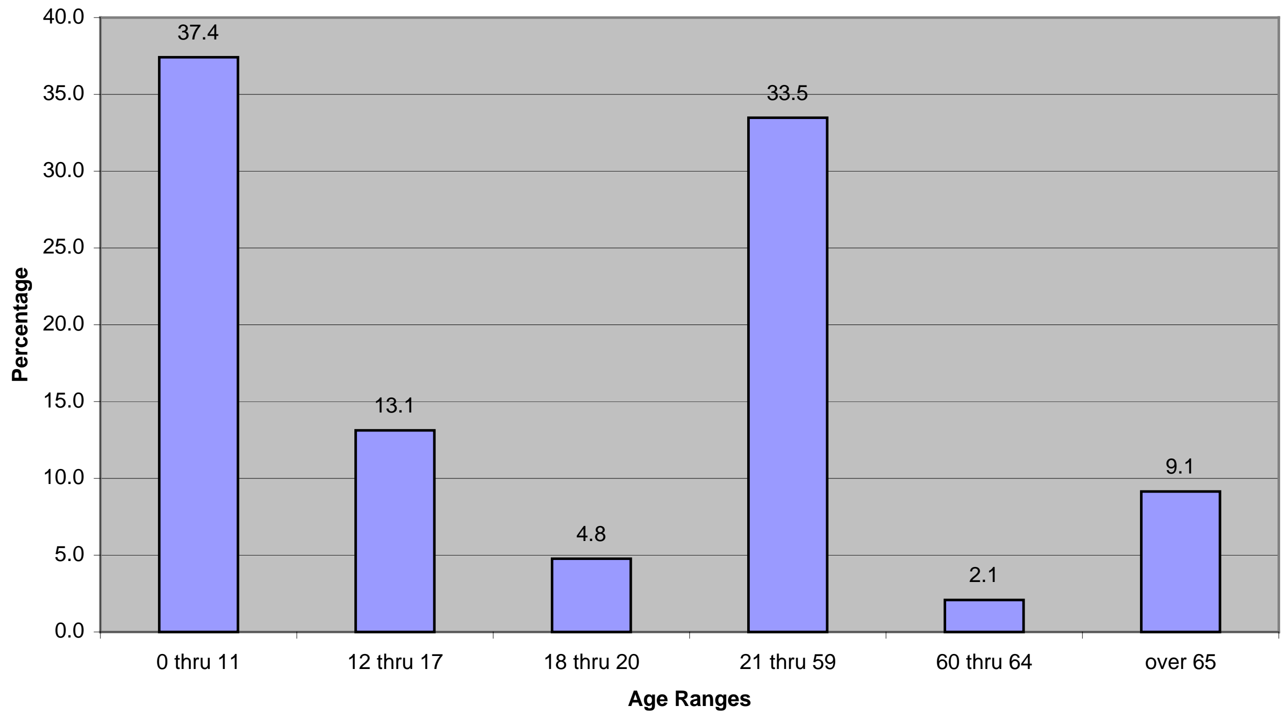


Figure 13: Ethnicity of Medi-Cal Eligible Beneficiaries by Region

Percentage
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Northeast
Central
South
Northwest
Region

Caucasian
African American
Latino
Vietnamese
Chinese
Lao
Indian
Japanese
Korean
Native American
Cambodian
Filipino
Other

Figure 14: Languages Spoken by Medi-Cal Eligible Beneficiaries by Region

Percentage
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Northeast
Central
South
Northwest
Region

English
Spanish
Hmong
Russian
Vietnamese
Cantonese
Mien
Lao
Japanese
Korean
Cambodian
Thai
Tagalog
Sign Language
Other

Figure 15: Gender Breakdown of Medi-Cal Eligible Beneficiaries by Region

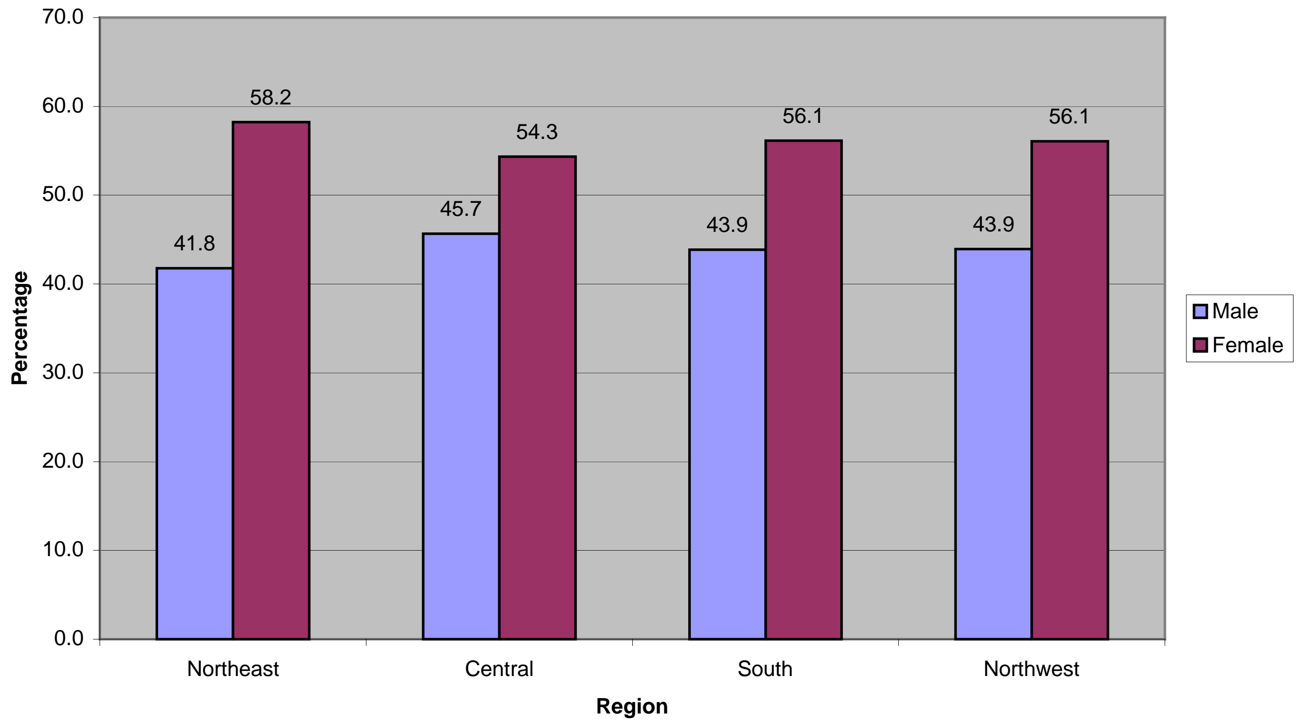


Figure 16: Age Ranges of Med-Cal Eligible Beneficiaries by Region

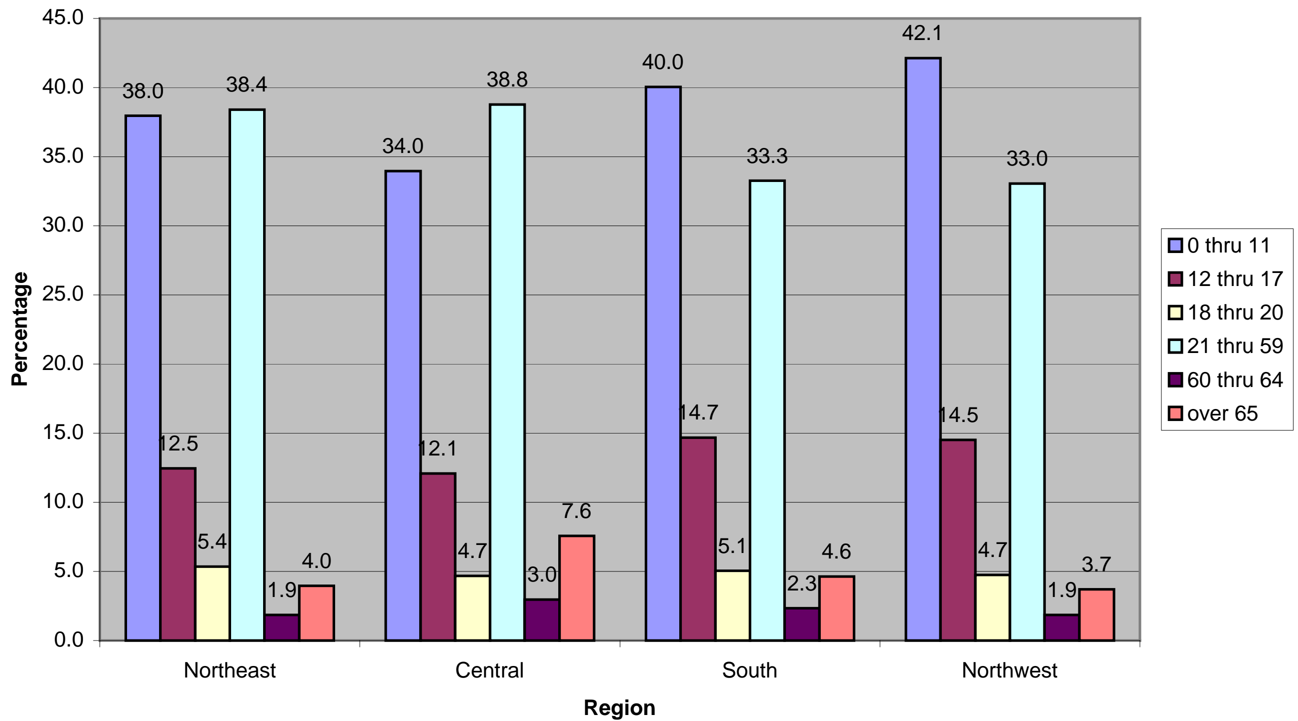


Figure 17: Utilization of In-Patient/Residential Services by Ethnicity

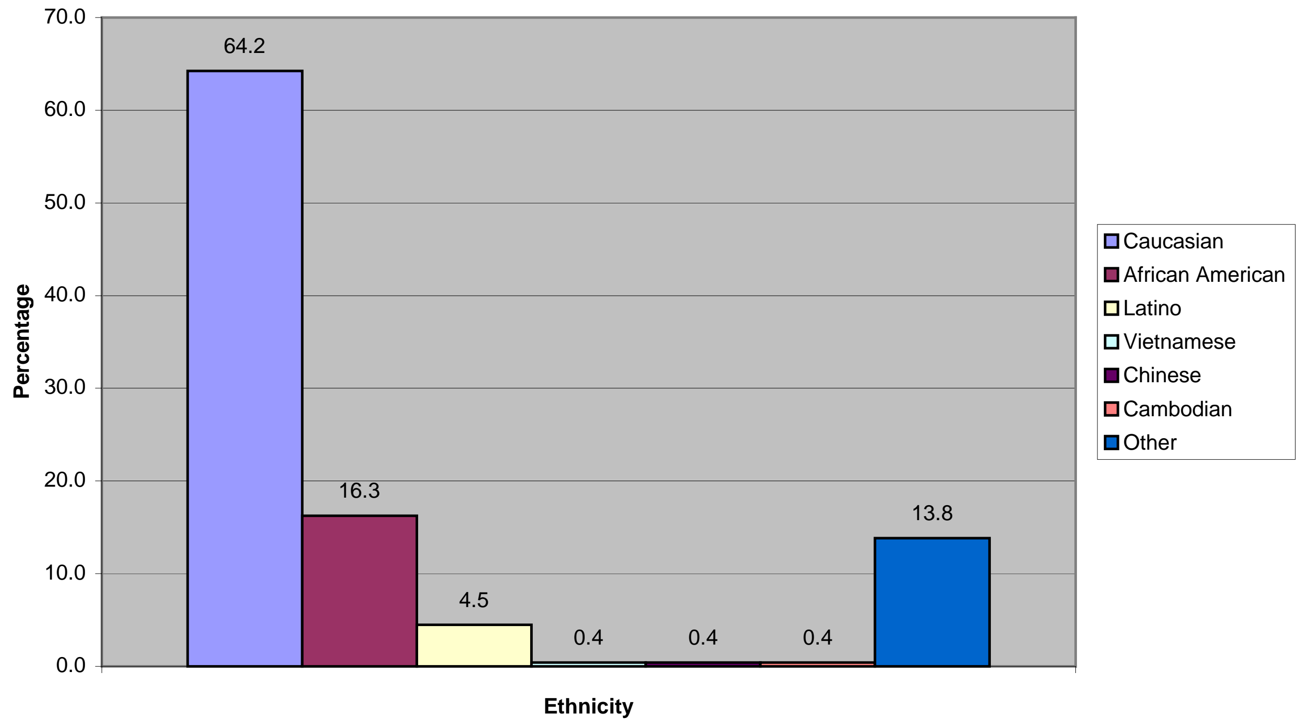


Figure 18: Utilization of In-Patient/Residential Services by Primary Language

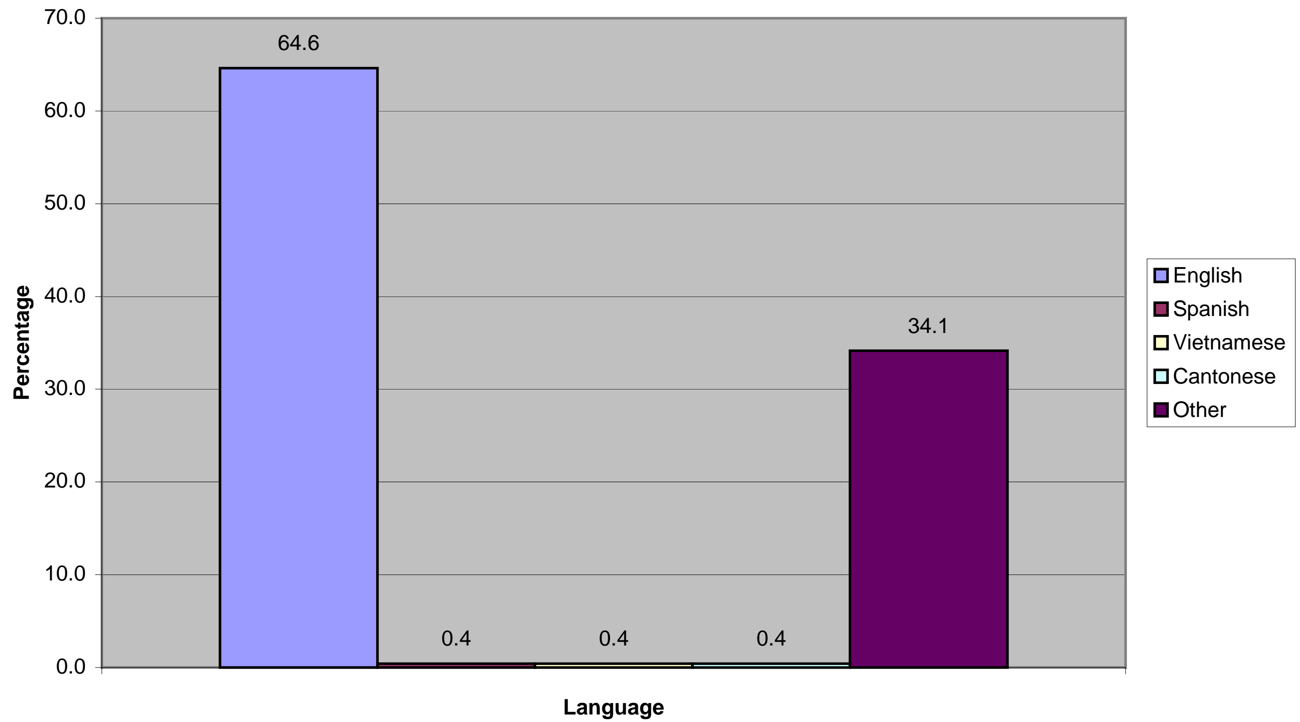


Figure 19: Utilization of In-Patient/Residential Services by Gender

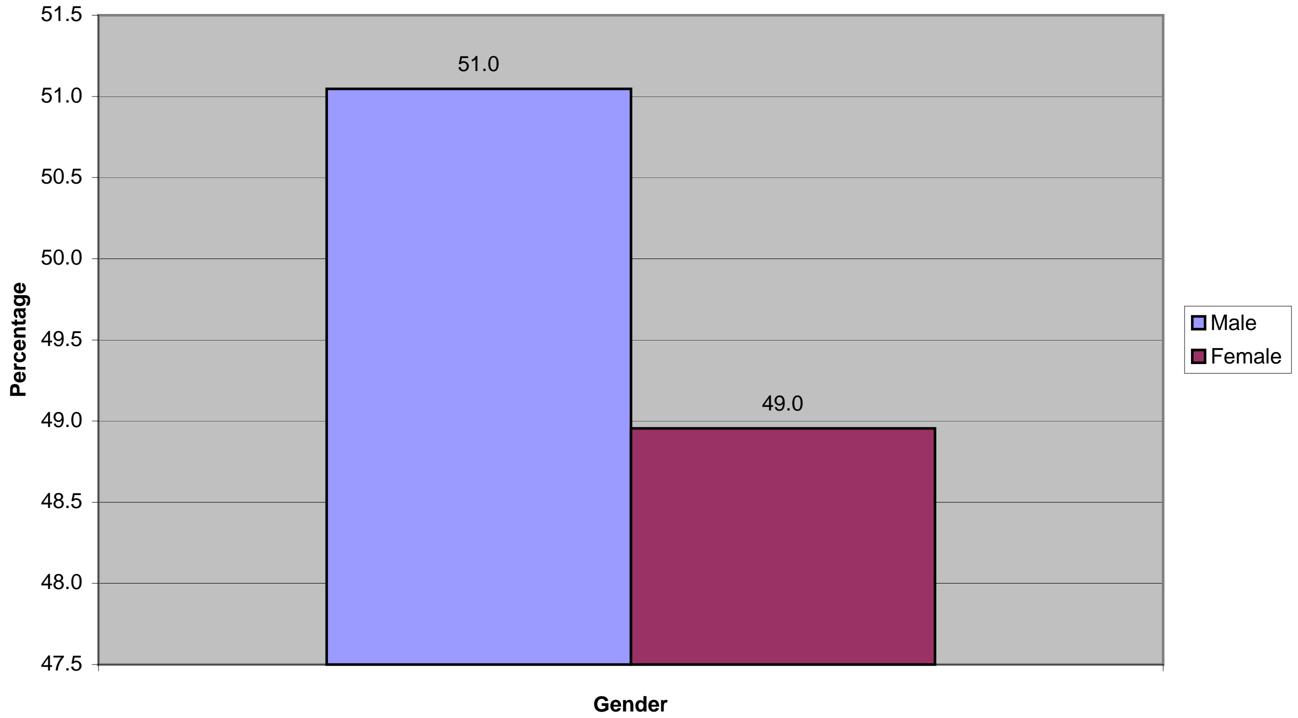


Figure 20: Utilization of In-Patient/Residential Services by Age

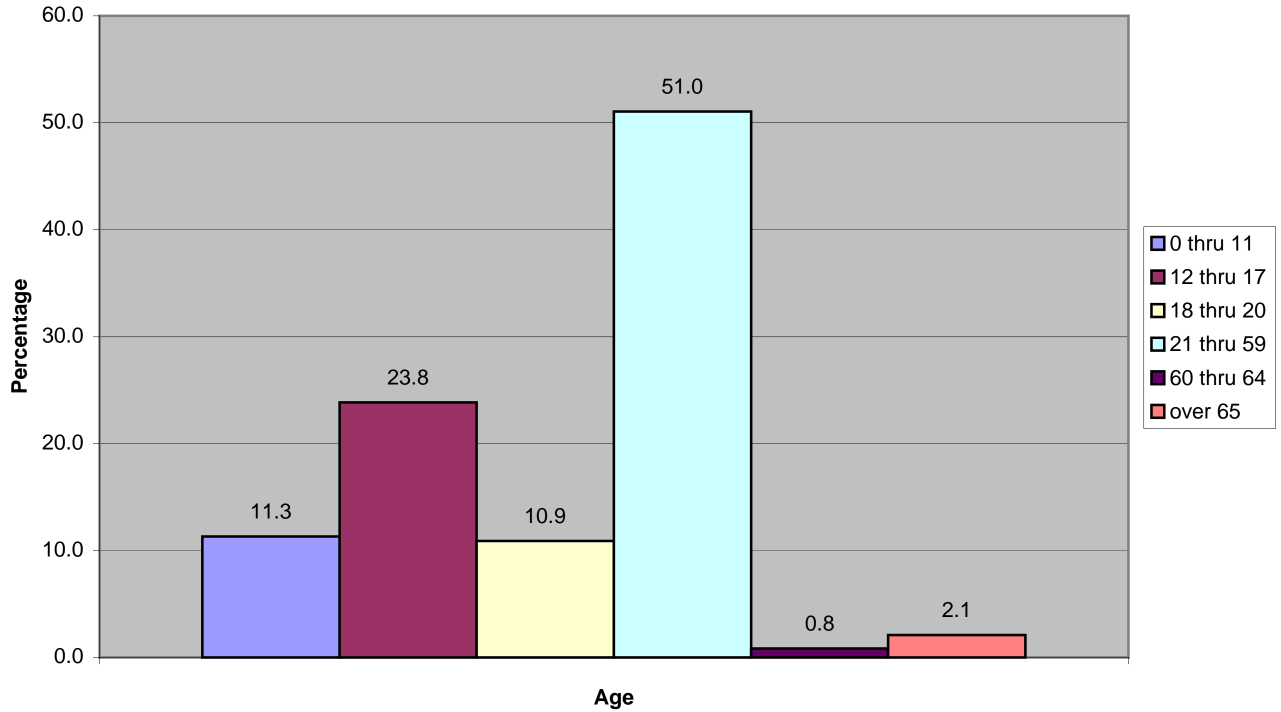


Figure 21: Utilization of Out-Patient/Case Management Services by Ethnicity

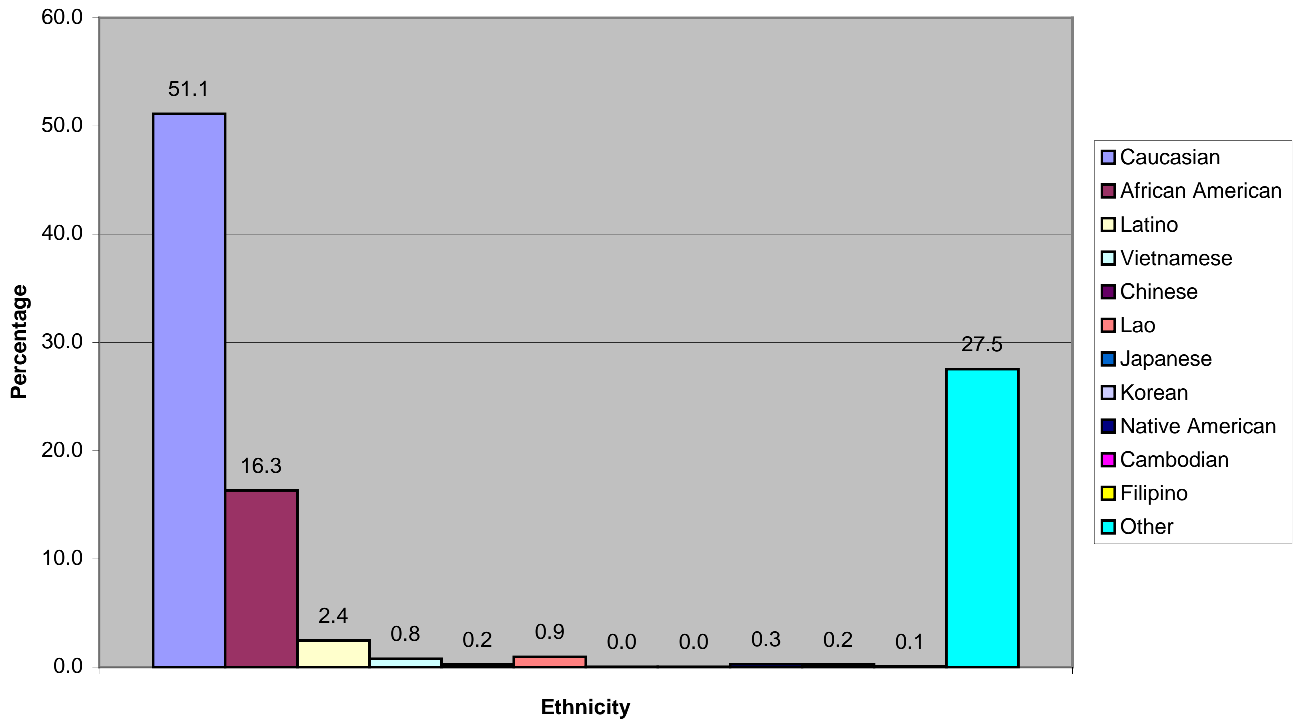


Figure 22: Utilization of Out-Patient/Case Management Services by Primary Language

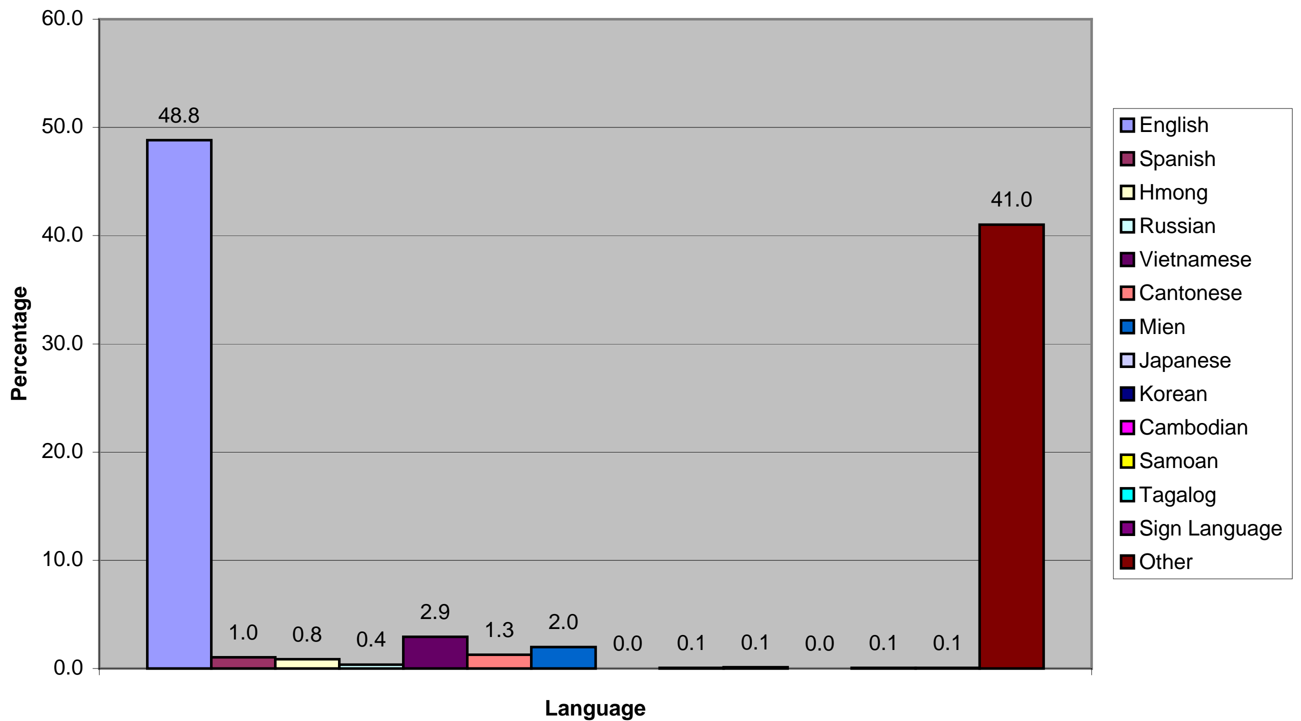


Figure 23: Utilization of Out-Patient/Case Management Services by Gender

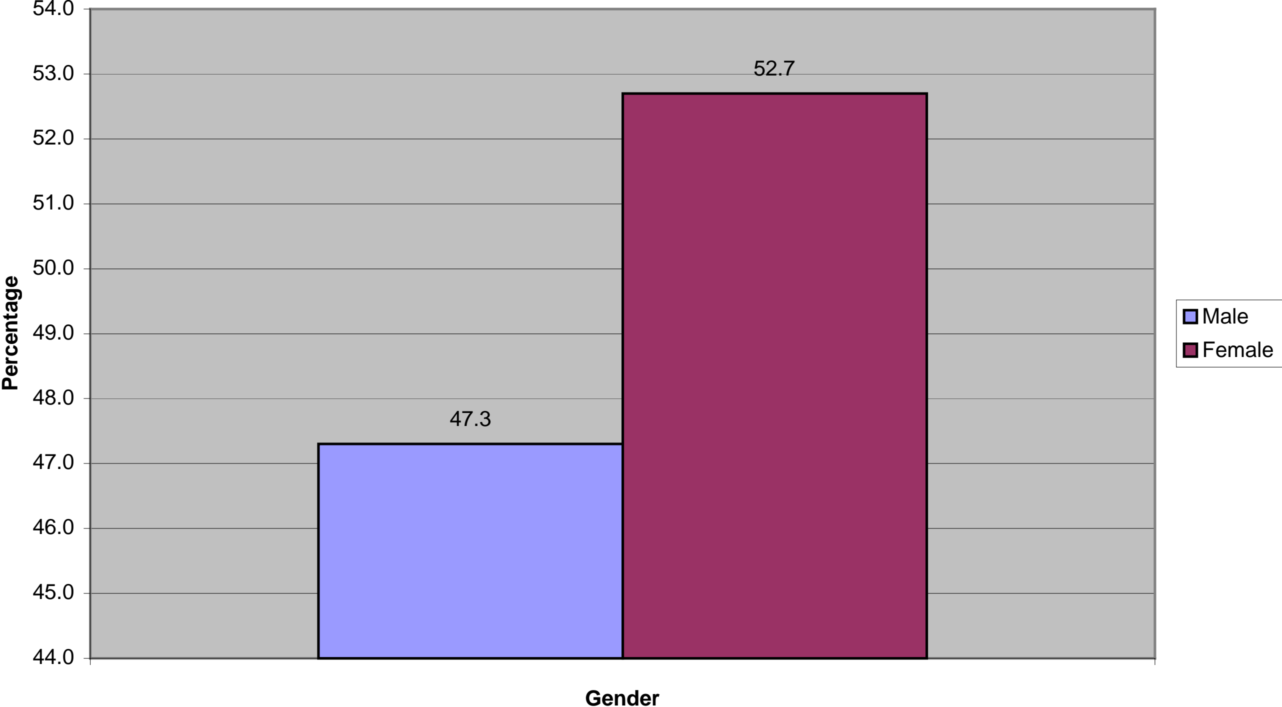


Figure 24: Utilization of Out-Patient/Case Management Services by Age

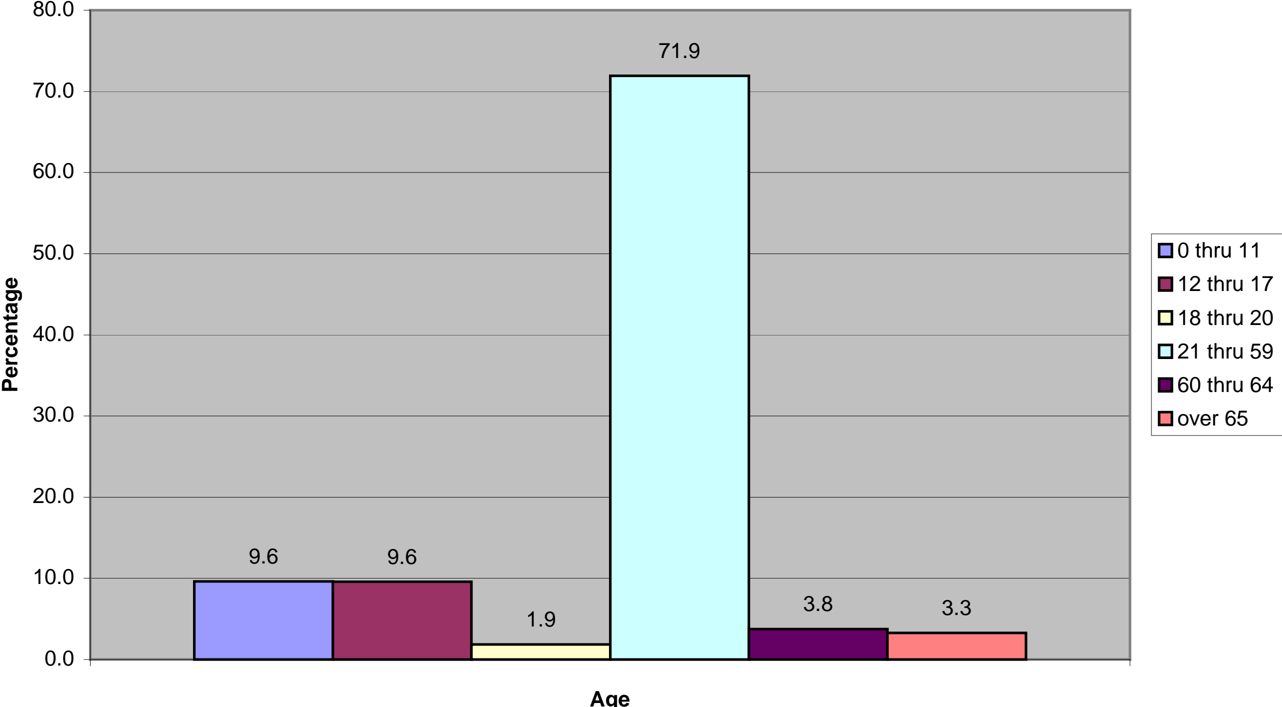


Figure 25: Utilization of Day Treatment Services by Ethnicity

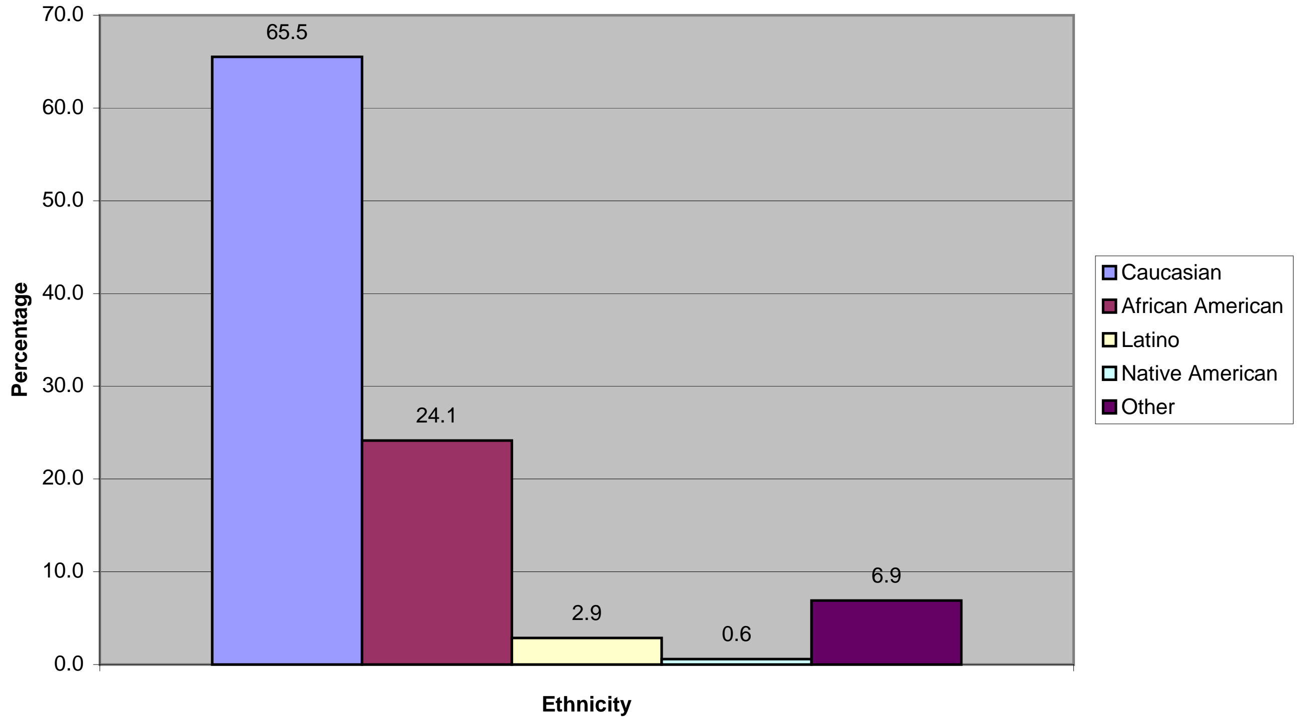


Figure 26: Utilization of Day Treatment Services by Primary Language

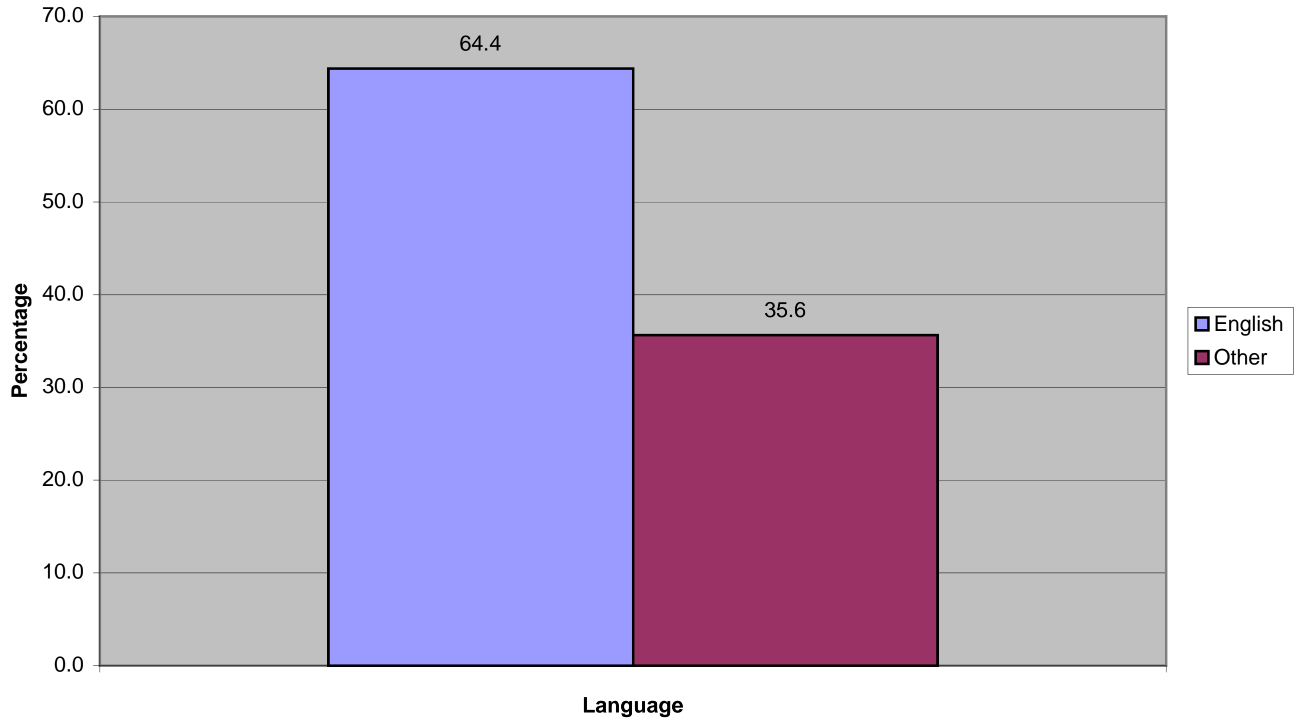


Figure 27: Utilization of Day Treatment Services by Gender

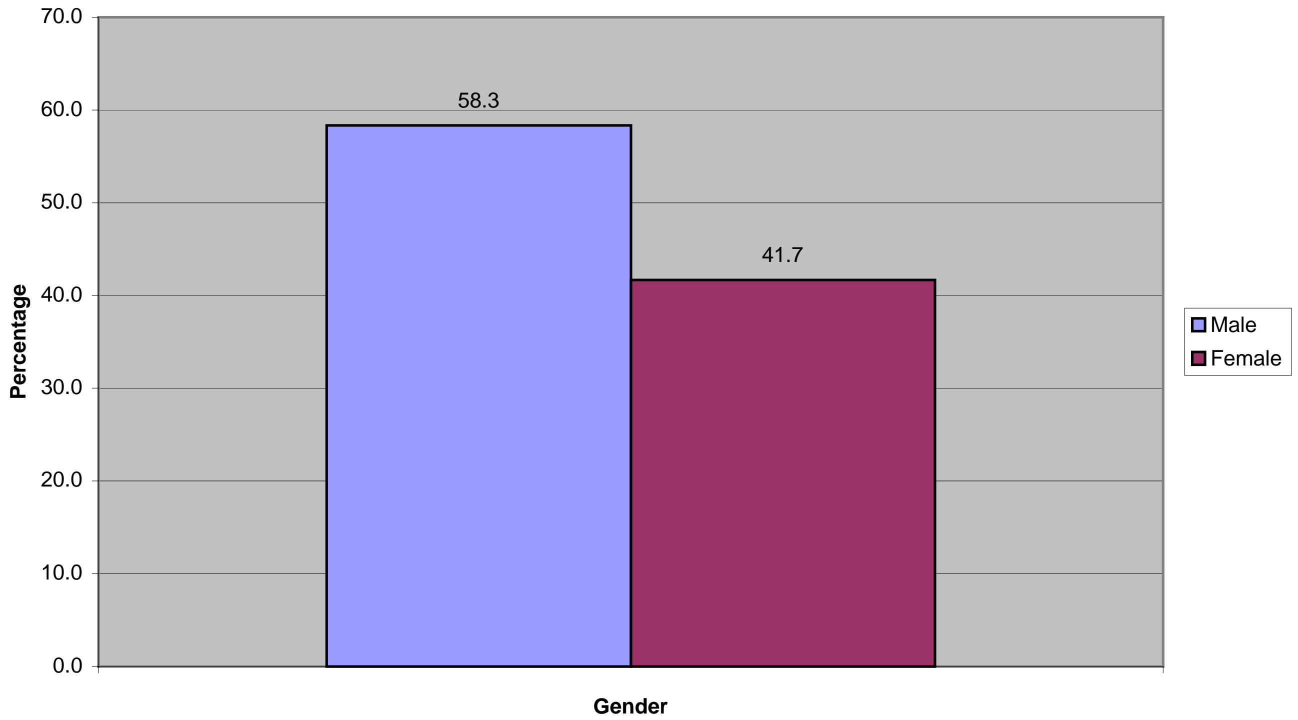


Figure 28: Utilization of Day Treatment Services by Age

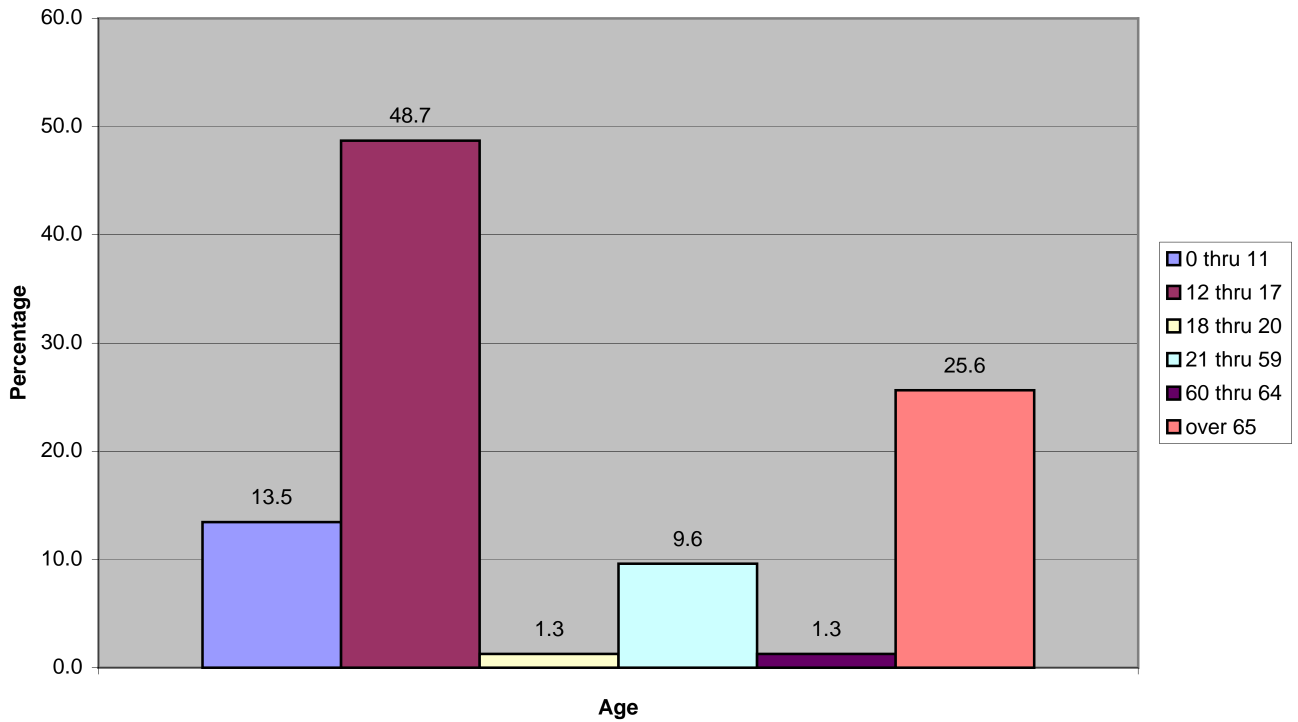


Figure 29: Utilization of All Services by Ethnicity by Region

Percentage

80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Northeast
Central
South
Northwest

Region

Caucasian
African American
Latino
Vietnamese
Chinese
Lao
Japanese
Korean
Native American
Cambodian
Filipino
Other

Figure 30: Utilization of All Services by Primary Language by Region

Percentage

70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Northeast
Central
South
Northwest

Region

English
Spanish
Hmong
Russian
Vietnamese
Cantonese
Mien
Lao
Japanese
Korean
Cambodian
Tagalog
Sign Language
Other

Figure 31: Utilization of All Services by Gender by Region

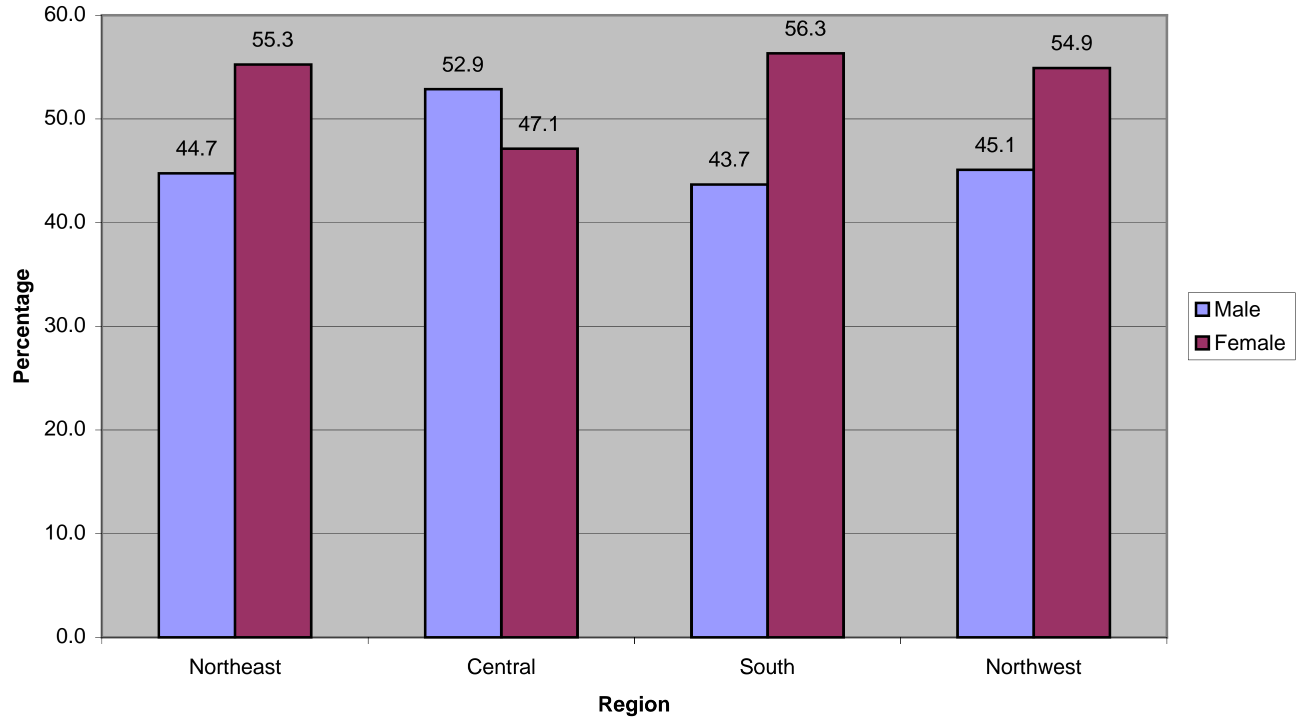
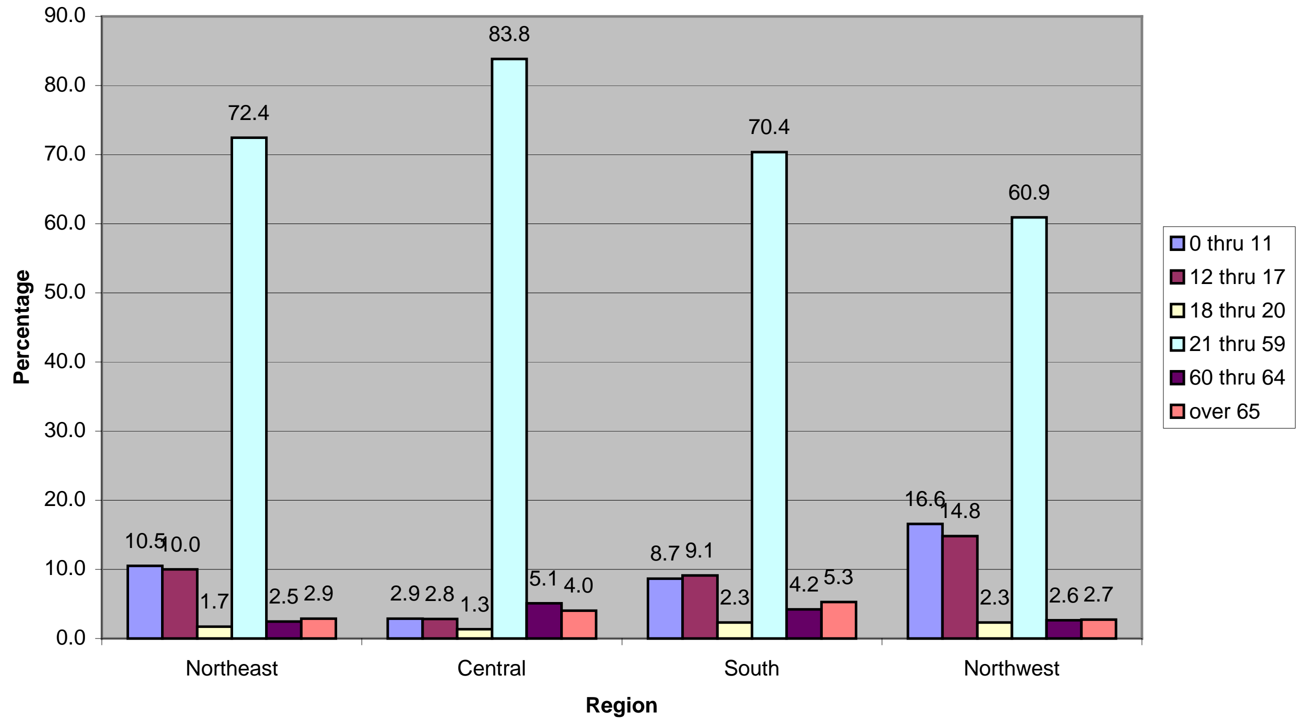


Figure 32: Utilization of All Services by Age Range by Region



Part II

PART II - ORGANIZATIONAL AND SERVICE PROVIDER ASSESSMENT

A. Overall MHP Policy and Administrative Direction

A1. Policies and procedures that reflect (or any plans to reflect) steps taken to institutionalize the recognition and value of cultural diversity within the MHP. For example, the importance of providing culturally competent specialty mental health services shall be reflected in:

A1a. mission statement;
A1b. statements of philosophy;
A1c. strategic plans;
A1d. policy and procedure manuals;
A1e. human resource training and recruitment policies;
A1f. specialty mental health contract requirements; or
A1g. other key documents.

The MHP acknowledges the importance of institutionalizing recognition of the value of cultural diversity and the impact diversity has on service delivery. Sacramento County has taken steps, as reflected in the **STATEMENT OF PHILOSOPHY, VISION, MISSION, and PRINCIPLES** sections of this document to demonstrate its commitment to these issues. The MHP believes these issues of diversity must be recognized in all county and contract provider program design. Written principles, policies, and procedures assists staff in implementing program design and underscores the value and commitment placed on cultural diversity and competence by administration at the highest levels.

All county and contract providers shall have policies and procedures in place that reflect steps taken to institutionalize the recognition and value

of cultural diversity and the impact diversity has on service delivery. Providers must demonstrate that they recognize that beneficiaries from diverse ethnic and linguistic backgrounds often have different, unique mental health service issues.

By January 1, 1999, the MHP will have a fully developed plan for annual review of all county and contract documents which reflect the importance of providing culturally competent mental health services.

The following documents will be reviewed:

- mission statements;
- statement of philosophy;
- strategic plans;
- policy and procedure manuals;
- human resource and training and recruitment policies;
- specialty mental health contract requirements; and
- other key documents as appropriate.

All documents will be reviewed to determine that County and contract providers recognize and are incorporating the important principles outlined in:

Cultural Competence Standards in Managed Mental Health Services Care for Four Underserved/Underrepresented Racial/Ethnic Groups
Final Report from Working Groups on Cultural Competence in Managed Mental Health Care
October 1997
Pre-Publication Copy

Funded by
The Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

Sponsored by
The Western Interstate Commission for Higher Education (WICHE)
Mental Health Program

- Principle of Cultural Competence

  A culturally competent system includes the recognition that recovery and rehabilitation are more likely to occur where services and providers have, and use, knowledge and skills that are culturally competent and compatible with the backgrounds, families and communities of the population they serve. Cultural competence includes the attainment of knowledge, skills and attitudes that enable administrators and practitioners with the MHP to provide effective care of diverse populations, i.e., to work within the consumer's values and conditions in which they live. The incorporation of variance in defining normative acceptable behavior when determining mental wellness/illness and the utilization of the knowledge of those variables in treatment planning are crucial to obtainment of positive outcomes.

- Principle of Consumer-Driven System of Care

  A consumer-driven system of care promotes the consumer and family as the most important participants in service-provision process. Whenever possible and appropriate, provider services take into consideration the significant role family plays in the lives of many consumers from diverse ethnic populations.

- Principle of Community-Based System of Care

  The MHP promotes a system of care that values and recognizes, as much as possible, the strengths of providing a full continuum of services. The system would focus on providing services in a natural community setting, delivering

services that include familiar and valued community resources, and providing treatment in the least restrictive environment possible.

- Principle of Quality Care

  The MHP recognizes that the costs of the MHP delivery system are best maintained through effective, quality services that emphasize outcomes and positive results. It also acknowledges the important value of ethnic/cultural considerations, particularly as it relates to assessment and treatment planning.

- Principle of Natural Support

  Natural community support and culturally competent practices are viewed as integral parts of a system of care and contribute to desired outcomes. Spiritual and religious leaders, traditional healing practices (and practitioners) and the school system should be incorporated into service delivery when relevant or possible.

  The MHP accepts that a comprehensive understanding of the WICHE principles and achievement of cultural competence is a dynamic process based on a continuum of learning.

  As we begin the journey to full understanding and implementation of cultural competence, document reviews will assist assuring a full understanding and implementation of the Cultural Competence Plan.

In the January 1999 review, the following documents should be available:

- Statement of Philosophy incorporating cultural competence considerations
- Mission statement incorporating cultural competence issues
- Detailed strategic plans outlining how the providers plan to institutionalize and implement cultural competence at all levels in their agencies
- Policy and procedure manuals that reflect significant movement to embrace and incorporate cultural competency processes

All County and contract providers are expected to comply with human resource, training, and recruitment policies and special mental health contract requirements outlined in Part II, Section C, Numbers 4, 5, 6 (pages 53-60 of this Plan).

Additionally, an Agency Self Assessment (Part II, Section C, Number 3, page 52 and Appendix C of this plan) is due annually beginning in January 1999.

A2. Practices that reflect (or any plans to reflect) recognition and value of *cultural diversity within the MHP in terms of the solicitation of diverse* input to mental health planning and services, such as:

A2a. Relationship with and involvement of diverse ethnic Medi-Cal beneficiaries, family members, advisory committees, local boards and commissions and community organizations in MHP planning for services.

Sacramento County Division of Mental Health continues to be committed to the meaningful participation of beneficiaries/consumers, family members and providers in the planning and design of the mental health delivery system as outlined in

Sacramento County Phase II Consolidation of Medi-Cal Specialty Mental Health Services. The Phase II Implementation Task Force met twice weekly from April 6, 1997 through June 12, 1997. At the culmination of this community planning process, the Plan was submitted to the Mental Health Board for their approval and to the Human Services Coordinating Council for their review. After securing the necessary approvals, the Plan was sent to the State of California Department of Mental Health.

The Phase II Implementation Task Force reconvened in August 1997. Seven workgroups, including a Cultural Competence Workgroup, were formed to draft the details of the implementation plan. The Phase II Implementation Task Force reviews the progress of the workgroups at its monthly meeting. The Phase II Implementation Task force is represented by:

- AFDC Representative
- Services Representative, California Society for Clinical Social Work
- Co-Chair and Board Member, Sacramento County Mental Health Board
- Co-Chair/Psychiatrist, Sacramento County Mental Health Board
- Consumer Advocate and Liaison, Division of Mental Health
- Director of Program Compliance, OMNI Healthcare
- Executive Director, El Hogar Health and Community Service Center, Inc.
- Executive Director, Asian Pacific Community Counseling
- Executive Director, Sacramento Mental Health Treatment Center
- Executive Director, Southeast Asian Assistance Center
- Family Member Representative of Sacramento Alliance for the Mentally Ill
- Family Advocate and Liaison, Division of Mental Health
- Health Program Manager, Adult System of Care, Division of Mental Health
- Health Program Manager, Child Welfare Services
- Health Program Manager, Children's System of Care, Division of Mental Health
- Health Program Manager, Quality Improvement Director, Department of Mental Health

- Health Program Manager, Sacramento Mental Health Treatment Center
- Medi-Cal/CMISP Assistant Program Specialist, Department of Human Assistance
- Mental Health Director, Sacramento County
- Mental Health Service Line Chief, Kaiser Permanente
- Representative, National Association of Social Workers
- Psychologist and Director of River Oak Center for Children
- Representatives of Families with Minor Children
- State Contracts Specialist, Kaiser Permanente
- Treatment Coordinator, Drug and Alcohol Bureau, DHHA

The Cultural Competence Workgroup was responsible for the development of the Sacramento County Cultural Competency Plan. Jo Ann Johnson, LCSW, Sacramento County Minority Services Coordinator, issued an invitation to interested individuals to participate in the development of the Plan. The Cultural Competence Workgroup met weekly from August 1997 to June 30, 1998.

The Cultural Competence Workgroup solicited input from a wide range of representatives including:

- Consumer Representative
- County Mental Health Children's Services Line Staff Representative
- County Mental Health Adult Services Representative
- Executive Director, El Hogar Mental Health and Community Service Center, Inc.
- Board Member, Sacramento County Mental Health Board
- Board Member of the Sacramento Alliance for the Mentally Ill
- Family Member Representative
- Executive Director, Southeast Asian Assistance Center
- Executive Director, Asian Pacific Counseling Center
- Contract Provider, Children's Services Representative
- Contract Provider, Adult Services Representative
- Program Coordinator, Sacramento County Division of Mental Health, Children's Services
- Program Coordinator, Sacramento County Division of Mental Health, Adult Services
- Quality Improvement Representative

The Cultural Competence Workgroup has worked cooperatively with the Quality Assurance Workgroup on issues of mutual interest.

Members of the Quality Assurance Workgroup have attended Cultural Competence Workgroup meetings and members of the Cultural Competence Workgroup have acted as advisors to Quality Assurance as they develop culturally competent beneficiary literature. The Cultural Competence Workgroup also collaborated about issues of accessibility and linguistic requirements with the Workgroup that developed the automated attendant system used by the Central Access Team.

The Cultural Competence Workgroup will continue to meet to complete the Cultural Competence Plan requirements due January 1999. The Workgroup will become a committee of Quality Assurance and will take an active role in the continued development and monitoring of cultural competence in Sacramento County.

A2b. Working on skills development and strengthening of community organizations involved in providing essential services.

The Cultural Competence Workgroup will be actively involved in skills development and strengthening of community agencies through active outreach to the agencies and the Cultural Competence Committee. In addition, the Agency Self-Assessment will assist community agencies to identify the areas needing improvement.

3. The process used or planned in the development of the CCP for consolidation of specialty mental health services.

3a&b. Expected involvement at various organizational levels and plans for review of the CCP at all level within the organization.

Cultural Competence Workgroup members have been involved in numerous discussions concerning the development of the Cultural Competence Plan. Discussions occurred at the Cultural Competence Task Force meetings, at their respective agencies and/or interest groups, at meetings, other gatherings and in informal conversations. Feedback from these discussions has been reviewed at the weekly Cultural Competence Workgroup meetings and has provided a wide range of valuable input from various organizations. Various members of the Sacramento County Division of Mental Health Management Team have either attended Cultural Competence Workgroup meetings or have discussed related issues with the Cultural Competence Committee Chair or members. The Sacramento County Division of Mental Health Management Team reviewed the Cultural Competence Plan for overall appropriateness, consistency in service delivery, fiscal accountability and applicability to managed care. They provided input to a draft of the Cultural Competence Plan prior to submission to the State of California, Department of Mental Health.

Every attempt has been made to provide the fullest range of input from various organizations and interested parties from all levels. While the Cultural Competence Plan is under review by the State of California, Department of Mental Health, the Plan will be circulated to key members of the community, including consumers and family members, the Mental Health Board, providers and other interested parties. After the Plan is approved by the State, the Cultural Competence Plan will be presented to the Mental Heath Board and the Sacramento County Board of Supervisors for their approval.

A forum will be held to discuss the approved Cultural Competence Plan and distribute the Plan to all providers, consumer groups, family members, community organizations and other interested parties and/or groups. This will be one step in a series of discussions planned to involve the community in the implementation of cultural competence in Sacramento County. Meetings will also be held with Administrators of county-operated and contract agencies to discuss the specific philosophical underpinnings of the Plan and to outline specific implementation strategies. Information gleaned from these meetings will be used to develop a training module necessary to assist providers implementing the outlined requirements. With this extended discussion and distribution plan, the MHP looks forward to community support and "buy in" for the Sacramento County Cultural MHP Competence Plan.

B. HUMAN RESOURCES

Current Composition

The Cultural Competency Workgroup developed a Cultural Competency Survey (See Appendix B) that each existing agency (contract provider and county-operated facility), and Division of Mental Health administrative unit completed regarding among other issues, the ethnicity of staff, languages spoken by staff, languages staff reads and writes, and gender. The workgroup was of the opinion that all staff functions, from the top down, should be surveyed as different staff functions have varying impact on policy formations. The reference, the survey was gathered separate information for seven staff functions: Board of Directors, administration/management, direct services, clerical, interpreters, translators, and *Other*. The latter category primarily represents volunteer staff, student interns, and on-call staff members. For the purposes of the survey, "interpreters" related to people who convey language orally, while "translators" were those who use written

language. The survey was completed in January and February 1998, and will be (re-issued) annually. A total of 2095.33 FTE's comprise the staff involved in specialty mental health services in the county. A copy of the Cultural Competency survey can be found in Appendix B. (Appendix A contains specific percentages for a graphs in Figures 33-74.)

The Cultural Competency Workgroup plans to review the survey and make modifications before the next annual update. It should be noted that the Workgroup recognized the Mental Health Board was inadvertently omitted in the January and February 1998 release. They will be included in the January 1999 survey.

B1. Ethnicity by Function:

B1a. Administration/management;
B1b. Direct services;
B1c. Support services; and
B1d. Interpreters.

Figure 33 illustrates that across all staff functions, the ethnic categories represented in the County are quite diverse. Figure 34 shows that ethnic representation and/or diversity, not surprisingly, depends on the function of staff region. Administration/management is the most ethnically homogenous, with almost 81% being comprised of Caucasians. Together African Americans and Latinos account for an additional 12%. Boards of Directors are somewhat more diverse, with almost 73% being Caucasian, 8% Chinese, 8% African American, 2 % Japanese, 2% Filipino, and 4% Latino. One of the most positive aspects of these data is the diversity shown by staff providing direct services. Over 20 different ethnic groups are represented including those listed on the graph as well as those included in the *multi-ethnic* and *other* categories (European, Middle Eastern, North African, Jewish, Puerto Rican, Egyptian, Asian/Pacific Islander, and Northern European).

B2. Bilingual Staff by Function and Language:

B2a. Administration/management;
B2b. Direct services;
B2c. Support services; and
B2d. Interpreters.

Across all staff functions, Sacramento has bilingual staff in approximately 158 FTEs (about 7.5% of all staff positions). Figure 35 illustrates that across all staff functions, the bilingual capabilities represented in the County are quite diverse. Languages in the “other” category include Ukranian, Indian, French, Ilongo, Visayan, Fijian, Hindi, German, Bicol, Malaysian, Ukraine, Turkish, Punjabi, Telugu, Arabic, Italian, Portugese, Polish, Hebrew, Yoruba, Czech, Serbo Croatian, Urdu, Parsian, Pashto, Polish, and Danish. Figure 36 shows that bilingual capability also depends on the function of staff region. Of course, interpreters and translators show tremendous diversity in the languages they are capable of speaking. Most impressive, however, is the diversity represented by bilingual board members, administration/management, and direct services. For example, with respect to direct services staff, almost 9.5% are bilingual, and are proficient in over 20 different languages.

B3. Staff Proficiency in Reading and/or Writing in Language Other than English by Function and Language:
B3a. Administration/management;
B3b. Direct services;
B3c. Support services; and
B3d. Interpreters.

Across all staff functions, Sacramento has staff capable of reading/writing in languages other than English in approximately 140 FTE’s (about 6.7% of all staff). Figure 37 illustrates that across all staff functions, there is diversity in the languages that staff is capable of reading/writing. Languages in the “other” category include Ukranian, Indian, French, Ilongo, Visayan, Fijian, Hindi, German, Bicol,

Malaysian, Turkish, Punjabi, Telugu, Arabic, Italian, Portugese, Polish, Hebrew, Yoruba, Czech, Serbo Croatian, Urdu, Parsian, Pashto, Polish, Latin, and Danish. Figure 38 shows that bilingual capability also depends on the function of staff by region. Of course, interpreters and translators show tremendous diversity in the languages they are capable of reading/writing. The diversity represented by board members, administration/management, and direct service staff who are capable of reading/writing languages other than English are impressive. For example, again with respect to direct services staff, almost 8.2% have the ability to read/write in a second language, and as a group are capable in over 20 different languages.

B4. Staff Gender by Function, Unduplicated FTEs with Data Displayed: (Sacramento County Cultural Competency Workgroup Added this Section)

B4a. Administration/management;
B4b. Direct services;
B4c. Support services; and
B4d. Interpreters.

Figure 39 illustrates that across all staff functions, there are more female than male staff (64% vs. 36%). Figure 40 shows that gender breakdown, not surprisingly, depends on the function of staff. In only one case, however, are males the predominant gender (i.e., Board of Directors). The discrepancy between the percentage of males and females is relatively large for clerical staff, interpreters, translators, and *other.*

Location

As before, this description is based on the results of a survey that each existing agency completed the ethnicity of staff, languages spoken by staff, languages staff reads and writes, and gender. The survey gathered separate information for seven staff

functions: Boards of Directors, administration/management, direct services, clerical, interpreters, translators, and *other.* In addition to presenting information regarding human resources in each of the four service delivery regions, *non-regional* human resources characteristics are presented. Many of these services are specialized with respect to type of service (e.g., intensive, culturally specific, probation-related mental health services, etc.). For these non-regional services, service location tends not to be an issue because in many cases, the service goes to the client.

B1. Ethnicity by Function:

B1a. Administration/management;
B1b. Direct services;
B1c. Support services; and
B1d. Interpreters.

Figures 41 through 47 present the regional breakdown of ethnicity for the seven staff functions. In all cases, staff associated with agencies providing non-regionalized services represent the most diverse groups. There are two items of particular interest when these data are examined. First, the administration/management in the South Region is the most homogenous, with over 70% being Caucasian and the remainder being African American (see Figure 42). Second, the administration/management and direct service staff in the Northeast Region appear relatively diverse (see Figure 42 and 43). These two issues will be addressed in the analysis to follow.

B2. Bilingual Staff by Function and Language:

B2a. Administration/management;
B2b. Direct services;
B2c. Support services; and
B2d. Interpreters.

Figures 48 through 54 present the regional breakdown of languages other than English spoken by bilingual staff for the seven staff functions. In all cases, staff associated

with agencies providing non-regionalized services represent the most diverse groups. A noteworthy issue that was raised in the previous section resurfaces. The administration/management in the South Region has no bilingual capability – they are not even included in Figure 49. Potentially more problematic, however, is the number of threshold languages direct service staff are capable of speaking in each of the regions (see Figure 50). Although the Northeast Region is the most diverse with five of seven threshold languages represented within direct service staff (Hmong, Lao, Mien, Spanish, and Vietnamese), only two languages are represented in the South and Northwest Regions (Cantonese, Spanish), and one in the Central Region (Spanish). The South and Northwest Regions, however, have both developed strategies to serve consumers in their primary languages. The Northwest Region contracts with another agency for interpreters to be on-site. The languages these interpreters are proficient in include Russian, Hmong, Lao, and Mien, meaning that six of the seven threshold languages are represented in the Northwest (Vietnamese is the only language not covered). The South Region has interpreters on staff that are capable in Hmong, Lao, Mien, Vietnamese, and Russian, with the result that all seven threshold languages are represented in the South. Therefore, the Central Region is the only region that does not appear to have the ability to serve consumers in languages other than English and Spanish. Depending on the particular situation, the degree of difficulty associated with not having direct service staff capable of conversing in the threshold languages may be attenuated by the non-regional services having the capabilities.

As above, however, the Northwest and South Regions have interpreters either on staff or contracted to expand their language capabilities. For the Central Region, the degree of difficulty associated with not having direct service staff capable of

reading/writing in the threshold languages may be attenuated by the non-regional services having the capabilities.

B3. Staff Proficiency in Reading and/or Writing in Language Other than English by Function and Language:

B3a. Administration/management;
B3b. Direct services;
B3c. Support services; and
B3d. Interpreters.

Figures 55 through 61 present the regional breakdown of languages other than English that staff can read and/or write for the seven staff functions. In all cases, staff associated with agencies providing non-regionalized services represent the most diverse groups. The discussion above in terms of spoken languages is relevant here also. That is, there are no staff in administration/management in the South region that can read or write anything other than English (see Figure 56). Moreover, the number of threshold languages direct service staff are capable of reading/writing is minimal (see Figure 57). Specifically, only two languages are represented in the South and Northwest Regions (Cantonese, Spanish), and one in the Central Region (Spanish). The Northeast Region is the most diverse, with four of seven threshold languages (Hmong, Lao, Spanish, and Vietnamese). As above, however, depending on the particular situation, the degree of difficulty associated with not having direct service staff capable of reading/writing in the threshold languages may be attenuated by the non-regional services having the capabilities.

B4. Staff Gender by Function, Unduplicated FTEs with Data Displayed:

B4a. Administration/management;
B4b. Direct services;
B4c. Support services; and
B4d. Interpreters.

Figures 62 through 68 present the gender breakdown of staff for the seven staff functions. There are several noteworthy points. First, the Central and South Regions have equal representation of males and females on their boards (see Figure 62). This is in contrast to the County as a whole, as well as the Northeast, Northwest, and non-regional agencies, where more men comprise the boards of directors. Second, as Figure 63 illustrates, the regions differ with respect to the proportion of men and women in administration/management. The Northeast and Central Regions are the most balanced (57% women, 43% men), and the South Region is the least balanced (86% women, 14% men). Figure 64 shows that this pattern holds with the proportions of females and males comprising direct service staff. One new thing here, however, is that in the Northwest region, there are more men than women providing direct services.

Analysis

Sacramento County uses a public planning process to prioritize mental health needs in our system. In Spring 1998, both the Children's and Adult System Ad Hoc Committees identified cultural competence goals in their list of priorities. Across the county, there is tremendous diversity in terms of ethnicity and language capability of staff associated with the provision of mental health services. It is impressive that agencies providing mental health services have been so successful in recruiting and retaining staff that reflects the Medi-Cal population of the County. Almost 35% of staff identify as non-Caucasian while about 8% of them have bilingual ability that, in total, covers over 20 languages.

On the whole, when the data are examined on a regional basis the impressive diversity of staff is again highlighted. One troublesome finding is the lack of ability in the Central Region to serve individuals in languages other than English or Spanish. Although the non-regional

services have the staff to provide assistance to the consumers in the Central Region, it is not clear whether this is sufficient. In particular, the services that are likely to be provided on a regional basis are out-patient services. Recall from the utilization data, that the majority of ethnic and language diversity arises in out-patient services. It therefore seems that one urgent need for Sacramento is to support the hiring of staff who have abilities in threshold languages not yet represented in the regions. This would include Hmong, Lao, Mien, Vietnamese, and Russian in the Central Region, Russian and Cantonese in the Northeast, and Vietnamese in the Northwest.

The data were also examined from the perspective of whether the focus of the program was adult consumers or children and families. The striking difference between these programs arise, again, in the ability to serve consumers in their primary language. Over 10% of staff serving adult consumers are bilingual, while only 6% serving children and families are bilingual. Moreover, the diversity of language capability is also less, with four of the seven threshold languages represented in the children's programs (Cantonese, Hmong, Lao, Spanish), versus all seven in the adult programs. This discussion suggests that one goal Sacramento County should have is to support the hiring of staff who have ability in the threshold languages not yet represented. The focus should be twofold: by type of program (i.e., target programs focusing on children and families), and by region (i.e., Central, Northeast, and Northwest Regions).

A second goal for the 1999-2000 is to do an in-depth analysis of the composition of staff in terms of ethnicity and languages, as it compares to the composition of consumers utilizing services. The data available for this plan were not conducive to this goal. Data from the MEDs file included too many *Other* ethnicities and languages to be useful. In the future, it is our hope that CSI will be able to provide more helpful data. In the meantime, several sub-goals have been identified that will aid in the collection of useful

data for such an analysis:

- Training of staff to heighten awareness of the need for accurate data regarding client ethnicity and primary language.

- Modifying the demographic information sheet associated with Performance Outcomes to collect information on primary languages of clients and their families to use in comparing to staff capabilities. Information on ethnicity is already collected. We can say, for example, that in programs focusing on children and their families the ethnic breakdown of the youth is 57% Caucasian, 11% Latino, and 23% African American. The ethnic breakdown of direct service staff is 70% Caucasian, 7% Latino, and 16% African American, suggesting that Caucasians are over-represented in staff, while Latinos and African Americans are underrepresented.

- Modifying the Cultural Competence Human Resources Survey to collect information on staff who is a family member of a consumer (i.e., we already collect information on self-identified consumers, but Sacramento is committed to serving families as well).

One way to reach these goals in the Children's System of Care comes from a $1.4 million Children's System of Care Grant (AB1667). The three-year work plan for that grant focuses on two areas of cultural competence: ethnicity and including family members of children with serious emotional disturbance.

The System of Care grant allocated $15,000 to cover the cost of cultural competence training focused on client ethnicity.

The cultural competence goal related to family members in the System of Care grant is to "improve family participation in all aspects of policy development, planning, case assessment, case planning, and treatment." The identified measurable objectives/strategiesto reach this goal is the hiring of a Family Coordinator to coordinate parent activities; attend Division of Mental Health Executive Management Team; develop parent support information groups; facilitate staff training regarding philosophy of parent involvement issues and techniques; and assist in parent trainings and hiring parents as providers.

Thus far, a Family Coordinator has been hired; parent support and informational groups have been developed; and some training has occurred.

C. Quality of Care: Competency

C1. Consumer Culture: How the MHP incorporates within its staff and contractor competency evaluation and training plans, the culture of being a mental health consumer and experiencing the mental health system.

Sacramento County has a history of involving consumers in all phases of mental health service planning, delivery and evaluation. There are 160 self-identified declared consumers working or volunteering our system. These consumers are valuable resources to educate our system to the values, beliefs and lifestyles of consumers. In addition to the information that they contribute, consumer culture and the experience of being a mental health consumer will be included in the MHP core curriculum.

C2. Consumer of Mental Health Services. The percentage of staff who have voluntarily self-identified as consumers of specialty mental health services, by ethnicity, by function, and region.

Information regarding the percentage of staff who self-identify as consumers of mental health services was gathered at the time that each agency was surveyed for the ethnicity of staff, languages spoken by staff, languages staff reads and writes, and gender. The survey gathered consumer ethnicity information for seven staff functions: Board of Directors, administration/management, direct services, clerical, interpreters, translators, and *Other*. The latter category primarily represents volunteer staff, student interns, and on-call staff members. No interpreters or translators self-identified as consumers. A total of 160 staff across the remaining five functions did identify themselves as consumers. This represents just over 7.5% of all staff involved in the delivery of mental health services in the County.

Figure 69 illustrates that the ethnicity of consumer staff is fairly diverse. Although the majority of consumer staff is Caucasian there is also substantial representation by African Americans, Latinos, Chinese, Asians, Native Americans, and Filipinos. With the exception of administration/management, Figure 70 further illustrates that the diversity is maintained across the different staff functions.

Figures 71 through 74 illustrate the ethnicity of consumer staff by region for board members, administration/management, direct services, and clerical support. The most important element on each of these graphs is what is missing. For example, the Northwest and South Regions have no consumer representation on their boards (see Figure 71). Further, the Northwest region has no consumer representation in administration/management (see Figure 72). Finally, Figure 73 shows that staff providing direct services in the South Region has no consumer representation.

C3. Competency Evaluation: The current or planned process for evaluating staff and contractor knowledge and ability to provide culturally competent specialty mental health services.

The Cultural Competence Committee in Sacramento County has developed an Agency Self-Assessment of Cultural Competence that will be completed annually (See Appendix C for a copy of the assessment). The purpose of the survey is to help providers of mental health services identify strengths and weaknesses in its response to culturally diverse staff and consumer population. Moreover, the information the assessment requests should enable the agency to develop action steps for specific management and/or service delivery changes to progress toward the goal of cultural competence. There are six sections to the self-assessment. Different groups of staff (i.e., Board of Directors, management team, clerical support, service delivery, and supervisory staff) respond to each section.

The sections cover several topics, including Valuing Diversity, Governance, Administration, Program and Policy Development, Consumer-Related Services and Staff Training, and Service Delivery. The Division of Mental Health will be responsible for collecting, collating, and dispensing self-assessment results simultaneously to the agency director, and the County out-patient and minority services coordinators. The County coordinators will discuss results with agency representatives and identify goals for the agency.

The Cultural Competence Committee plans to develop individual staff assessments in the future. Staff is important to assess on an individual level because ultimately, it is staff who interacts with Beneficiaries of mental health services. The committee first developed the agency self-assessment, however, for two reasons. First, staff will have difficulty achieving higher levels of cultural competence if the philosophy is not supported at the agency level. Second, it was deemed less threatening by Committee members to begin the examination of cultural competence at the agency rather than individual level.

C4. Selection of contract providers. How a contractor's ability to provide culturally competent specialty mental health services is taken into account in the selection of contract providers.

The ability to provide quality mental health services is a requirement of all contract providers. The ability to provide culturally competent services is a primary component of quality services. In past requests for proposals (RFPs), applicants were required to address issues of cultural diversity. In future RFPs, applicants will be required to address issues of cultural diversity and their ability to deliver culturally competent services. They will be informed of the Cultural Competence Plan and must demonstrate that they will comply with all requirements.

C4a. Identification of any cultural competence conditions in contracts with mental health providers.

The contractor's ability to provide culturally competent specialty mental health services will be considered in the contractor's selection process. To ensure that contractors provide culturally competent specialty mental health services, the Sacramento County contract will include a new language clause which will be added to all new and existing contracts.

The new clause will read: *The contractor must comply with all requirements of the Sacramento County Cultural Competence Plan.*.

C5. Recruitment and Retention. The current or planned efforts to Recruit and retain culturally competent staff and contract providers reflective of the population receiving services.

Recruitment, successful hiring and retention of culturally competent county and contract provider staff are of utmost importance. The MHP is committed to securing a wide range of applicants who, to the extent possible, reflect the cultural/ethnic/linguistic background of the client population.

The completion of the Cultural Competency Survey in January and February 1998 (see Section Part II, B1) has allowed the MHP to better assess recruitment and retention needs. It focused attention on the areas of greatest need. Annual completion of the survey will create the capability for timely reevaluation of need and adjustment of service delivery systems as necessary. Comparison of annual data also allows for evaluation of the effectiveness of methods used. Results of the annual survey can also be used to formulate goals and objectives for individual providers.

The following is intended as a menu of strategies that can be used by county and contract providers to enhance recruitment and hiring efforts. The menu is offered to allow programs the retention and flexibility to tailor their efforts to meet the individual needs of their agencies.

Recruitment and Hiring Strategies

- The development and implementation of innovative and assertive outreach to colleges and universities that train mental health and allied professionals;
- The exploration of the possibility of acquiring funds to provide financial support (stipends) for human service students with the agreement that they work in a MHP funded agency for at least one year following graduation;
- The encouragement of staff that are currently employed in the system to return to work and support them in their academic efforts i.e., flex time, use of any available educational reimbursement funds, etc;
- Advertise in professional journals and attend "job fairs" and other forums where prospective applicants seek employment opportunities;
- The maintenance of a mailing list composed of community and ethnic organizations that are informed of openings and are requested to post job announcements;
- County and contract staff shall be encouraged as much as possible to reach out to the community in which it serves and advise community members of hiring needs;
- Ongoing outreach to high schools, community colleges, community groups and other organizations in order to encourage interested youth and young adults to explore the possibility of a career in human services; and
- Contract and county providers shall ensure that hiring panels are racially/ethnically representative and that methods to ascertain the applicant's cultural competence are employed.

Retention

- Once culturally competent staff are hired, efforts to retain them are crucial. Retainment efforts will be concentrated in the areas of education/training, evaluation, compensation, and promotion.

Education and Training Strategies

- Provide orientation, education and on-going training to staff to enable them to enhance their cultural sensitivity and competence.
- Develop multicultural and cross-cultural training;
- Develop sensitivity skill building training;
- Encourage and provide avenues for communication among staff to broaden knowledge of cultural differences and cultural competence;
- Discuss issues that impede recruitment, hiring and retention of culturally diverse, culturally competent staff;
- Solicit the support and involvement of supervisors and managers in staff training; and
- Develop a mentor program for new staff that promotes cultural diversity and cultural competence.

Evaluation Strategy

- Both county and contract providers should include assessment of cultural competency skills in employee performance reviews.

Compensation Strategies

- County and contract providers shall explore the possibility of establishing a Bilingual/Bicultural Differential Pay Policy for staff who are required to use bilingual skills in performing direct services to persons receiving specialty mental health services. Criteria shall be established that delineate a basis for the pay differential, e.g., employees who are required to use bilingual/bicultural skills on a continuing basis should pass a proficiency exam.
- If financial rewards are not feasible, the providers may consider development of a recognition system to reward cultural competence excellence.

C6. Training in Cultural Competence. The past (within the last three years), current or planned cultural competency training for mental health services.

Over the past three years, staff have attended the following trainings:

- Cultural Competence Mental Health Summit III

- Cultural Competence Mental Health Summit IV
- Cultural Competence Mental Health Summit V
- Diversity and Sexual Harassment Training
- Sacramento Civil Rights Division Training
- Effective Home-Based Strategies for Support—Considerations in Working with Latino Families
- Cross Cultural Services East Indian Culture
- Pharmacogenetics
- Children's System of Care, July 1998 – Promoting Cultural Competence in Children's System of Care
- Human Sexuality Cultural Diversity Implications
- Monthly Adult Case Conferences Sponsored by Sacramento County Division of Mental Health
- Sacramento County Quarterly Dual-Diagnosis Training

In Fall 1998, the MHP will survey the providers for training needs. At the conclusion of this survey the MHP will establish training goals and timelines for the system. Providers can use this data to develop individual agency training goals. It is anticipated that staff will attend at least two training sessions annually. It is anticipated that training topics will include the following:

- Accessing Cultural Proficient Services and Language Skills
- Use of Interpreters
- Ethnicity, Culture and Mental Illness
- Treatment of Adults, Children and Families of Color
- Suicide and Special Populations
- Historical Trauma and Mental Health
- Socio-Economic Issues

- Traditional and Non Traditional Healing Practices
- Mental Health and People of Color.
- Cultural Competence 101
- Consumer Culture and the Experience of Being a Consumer

Training shall be provided at the beginning, intermediate and advanced levels. There shall be a variety of trainers including system staff and guest speakers. They will use a variety of training techniques to enhance adult learning patterns.

Training is currently available from the following sources:

- Sacramento County Quarterly Dual-Diagnosis Training
- Sacramento County Monthly Case Conference organized by University of California, Davis
- School of Medicine Faculty
- Sutter Center for Psychiatry Grand Rounds
- UCD Medical Center Grand Rounds
- Cultural Competence Summit
- Statewide Mental Health/Department of Rehabilitation BEST Training
- Mental Health/Department of Rehabilitation GEO Training
- Various Guest Lecturers and Trainers

The MHP will assume an active role in encouraging all current providers of training to incorporate cultural competence issues in their training components.

Quality Assurance will maintain a library of articles and publications pertaining to cultural competence. County and contract provider staff are encouraged to

submit copies of articles and bibliographies which will be disseminated to staff periodically.

Sacramento County's Minority Services Coordinator is an active member of the Central Region Minority Services Coordinator's Group. The group is discussing the feasibility of organizing regional trainings in cultural competence. As this is developed, Sacramento County will participate.

C7. Certification or Credentialing Processes. The process(es) used or planned to certify, credential or otherwise ensure staff proficiency in issues of cultural competence, including the provision of culture-specific services to Medi-Cal beneficiaries.

Sacramento County is aware of and has been involved in the debate covering the pros and cons of certification versus credentialing. We look to the State Department of Mental Health, CIMH and CMHDA to continue to spur the debate and provide leadership and direction as we consider what is most useful at the county level. With the information at hand, it appears that certification might be a better option since cultural competence is a field subject to refinement and change as we increase our understanding of the subject matter. While the debate continues, the following will be adopted: individuals will receive a certificate of completion for successful completion of coursework/training. A document to evaluate the effectiveness of coursework/training and to evaluate attendees' comprehension of the subject will be developed. This document will be distributed at the end of all coursework/training and is the basis for issuing a certificate. When all the issues concerning certification versus credentialing are clarified, Sacramento County will adopt final processes to assure staff proficiency.

D. Quality Assurance

D1. Outcomes Measures. Identification of any consumer outcome measures used by the MHP that are culture specific.

The county currently has several instruments in place to assess the quality of care for consumers, (Let's talk several culture specific.) First, the county has developed a satisfaction survey to assess consumer satisfaction in their contact with the Access Team (see the Appendix). This is a first point of contact with the Mental Health system for many consumers, and a positive experience is important. This survey is available in English, as well as in all seven threshold languages.

For the children's system of care, the county has been administering a battery of 7 instruments for one and a half years. These instruments predominately assess child functioning and client satisfaction, and have been very useful in determining the outcome of care for children in the county. The child functioning instruments are available in English as well as Vietnamese, Russian, Spanish, and Cambodian. The County will implement a similar process for adults in Fall 1998 to assess service outcome. The instruments to be implemented are available in Spanish and English.

D2. Staff Satisfaction. A description of methods, if any, used to measure staff experiences or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services.

Recall that the Cultural Competence Workgroup developed an Agency Self-Assessment of Cultural Competence to be completed annually. There are six sections to the self-assessment and different groups of staff (i.e., Board of Directors, management team, clerical support, service delivery, and supervisory staff) respond to each section. The sections cover topics, including Valuing Diversity, Governance, Administration, Program and Policy Development, Consumer-Related Services, Staff Training and Service Delivery. Because all staff will complete this survey, the information collected will provide staff opinion regarding their agency's ability to value cultural diversity. In the future, the County may add a section to this survey to assess staff satisfaction with the MHP's ability to value cultural diversity in its workforce and culturally and linguistically competent services.

D3. Grievances and complaints. A description of how Medi-Cal beneficiary grievance and complaint data is analyzed and any comparisons rates between the general beneficiary population and ethnic beneficiaries.

The beneficiary grievance and complaint data will be analyzed quarterly and compared to the general beneficiary population composition by ethnicity.

Figures 33-74

Figure 33: Ethnicity of All Staff

Percentage

70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

65.9 15.3 7.6 0.6 0.3 0.5 2.0 0.1 0.1 1.1 1.5 0.3 1.0 0.3 2.1 0.3 1.2

Ethnicity

Caucasian
African American
Latino
Hmong
Russian
Vietnamese
Chinese
Mien
Lao
Indian
Japanese
Korean
Native American
Cambodian
Filipino
Multi-Ethnic
Other

Figure 34: Ethnicity of Staff by Function

Percentage

90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Board of Directors
Administration/Management
Direct Services
Clerical
Interpreters
Translators
Other

Function

Caucasian
African American
Latino
Hmong
Russian
Vietnamese
Chinese
Mien
Lao
Indian
Japanese
Korean
Native American
Cambodian
Filipino
Multi-Ethnic
Other

Figure 35: Languages Spoken by Bilingual Staff

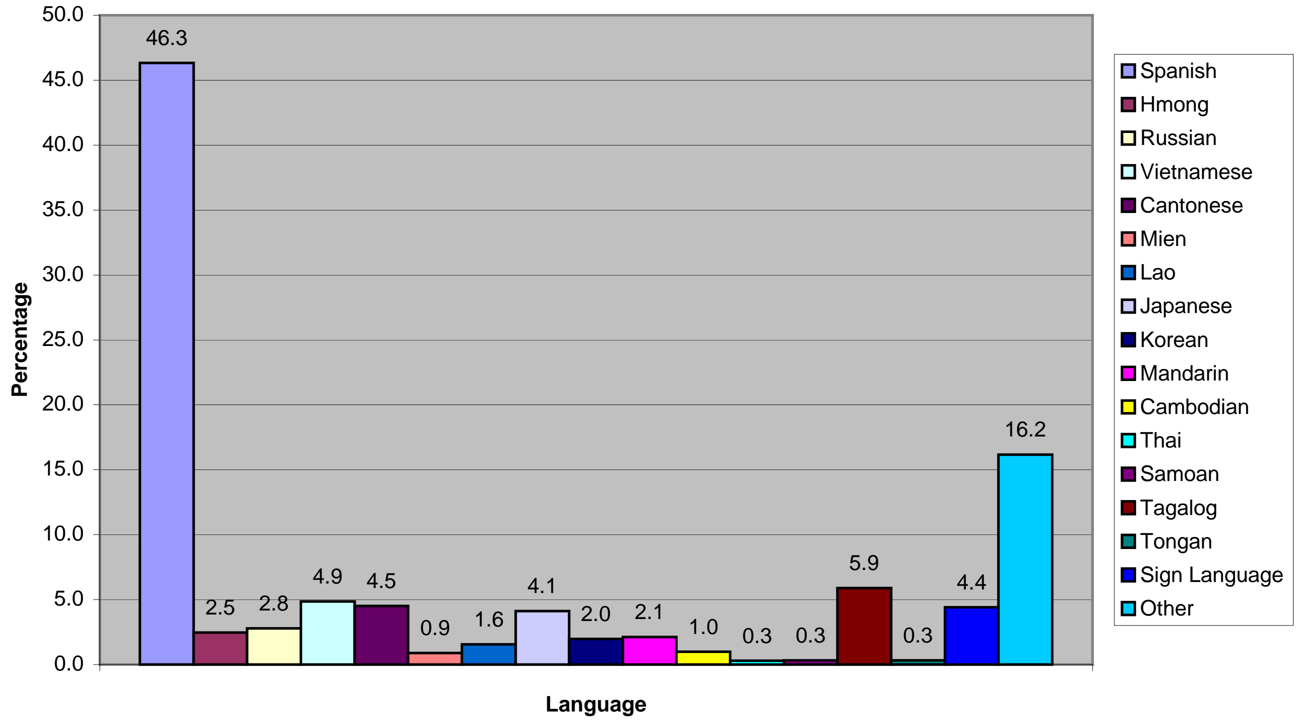


Figure 36: Languages Spoken by Bilingual Staff by Function

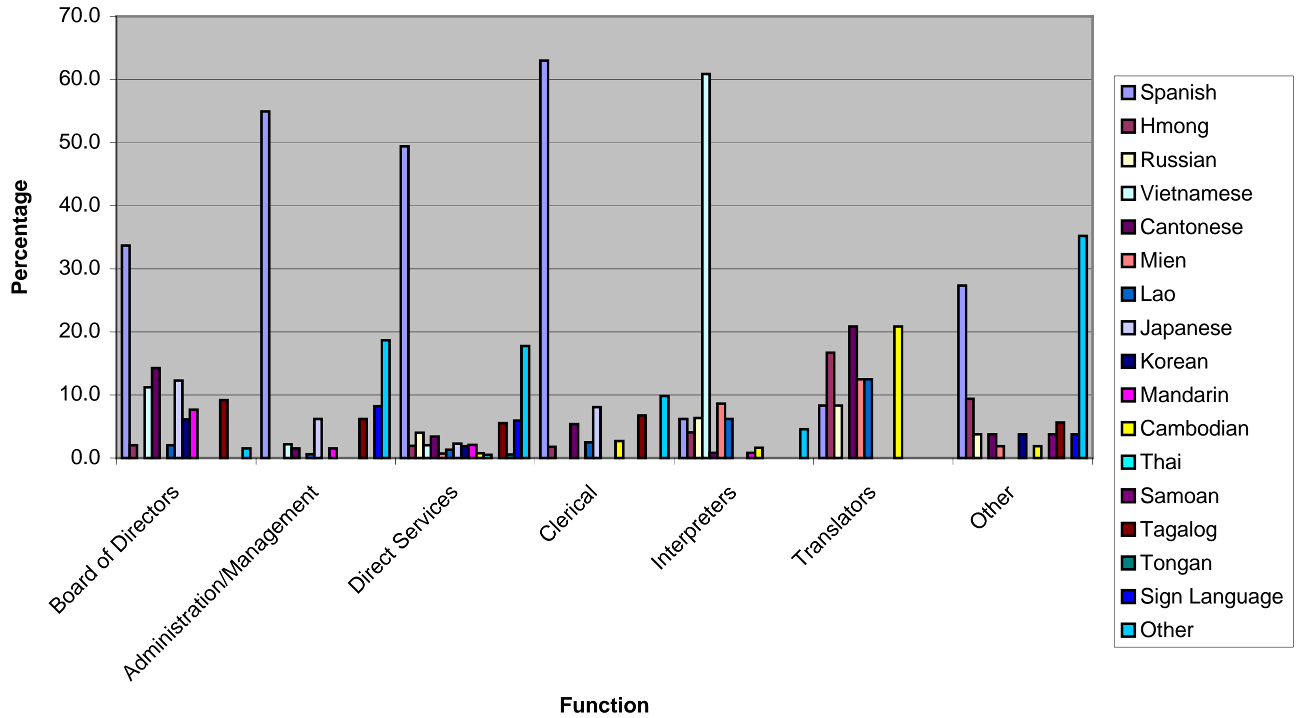


Figure 37: Languages Staff Reads/Writes

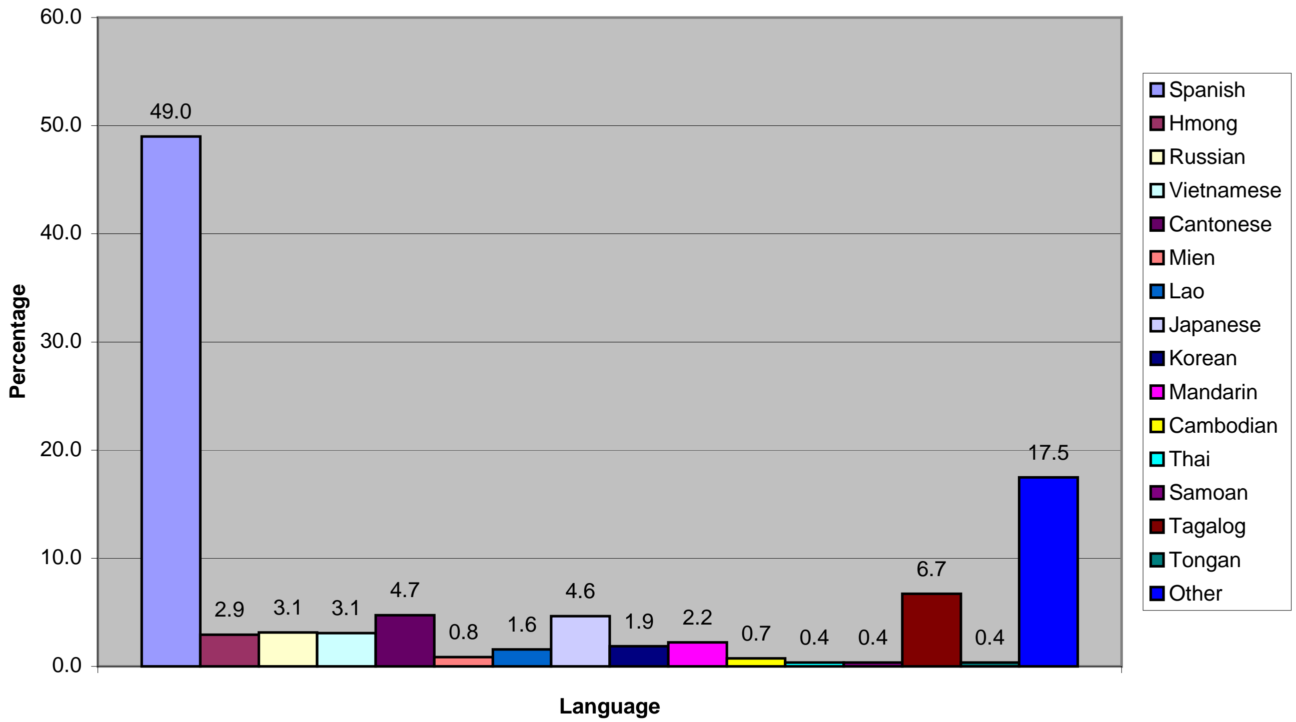


Figure 38: Languages Staff Reads/Writes by Function

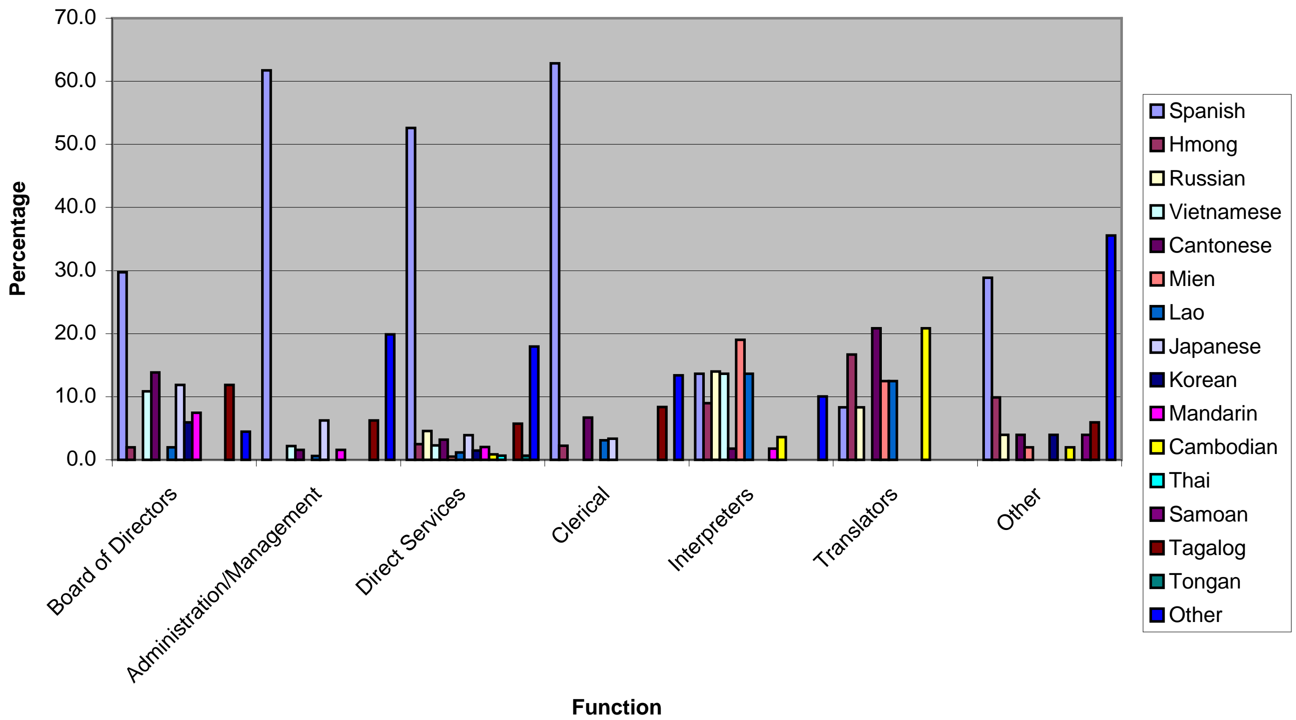


Figure 39: Gender of Staff

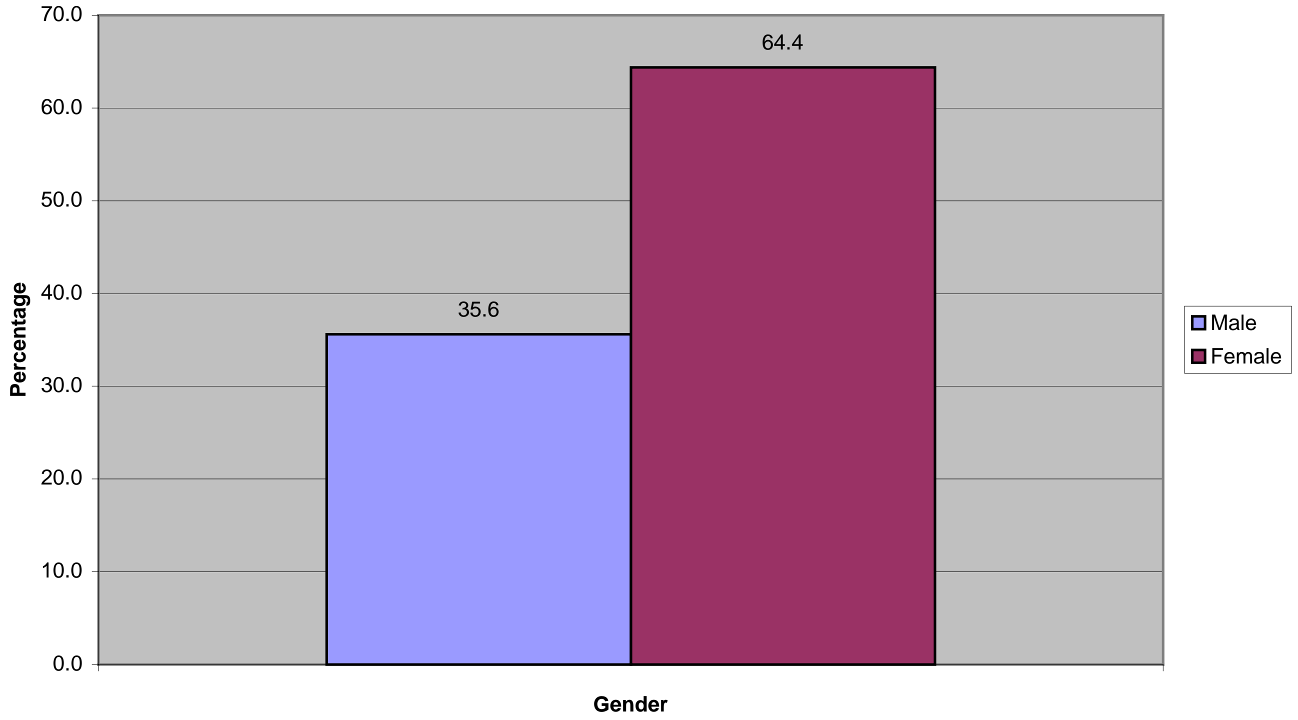


Figure 40: Gender of Staff by Function

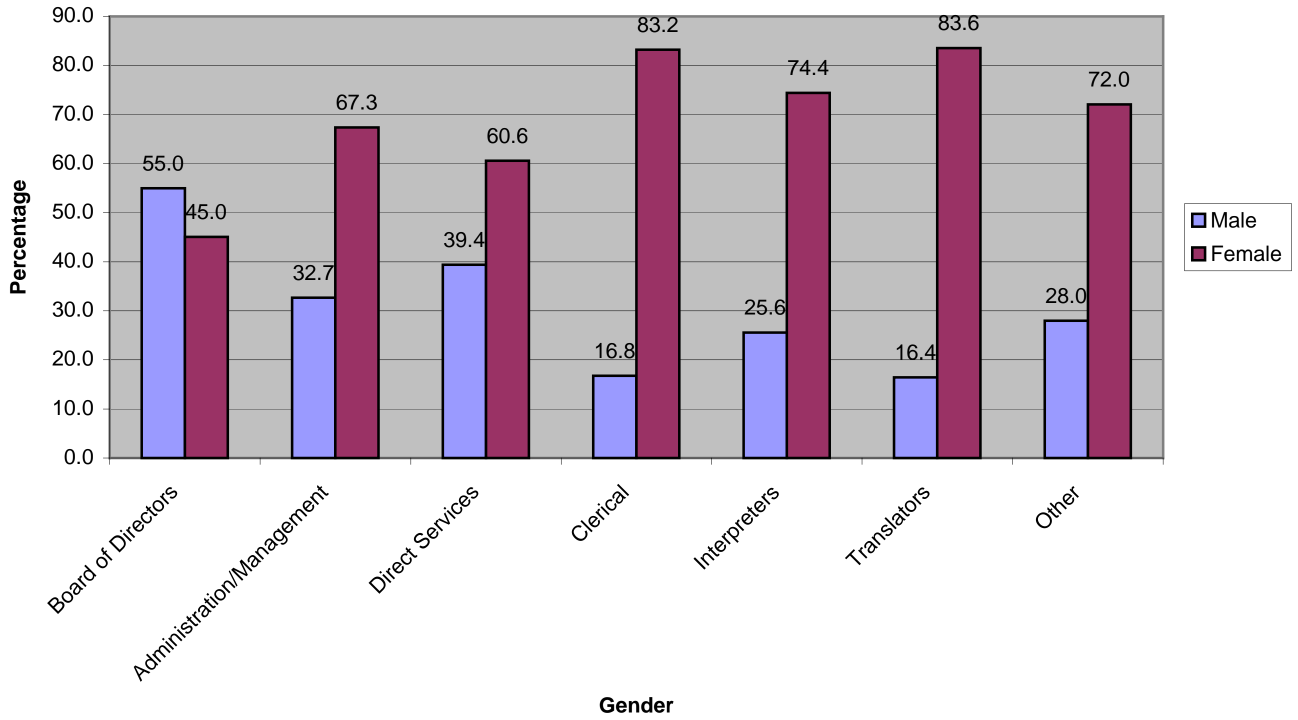


Figure 41: Ethnicity of Board Members by Region

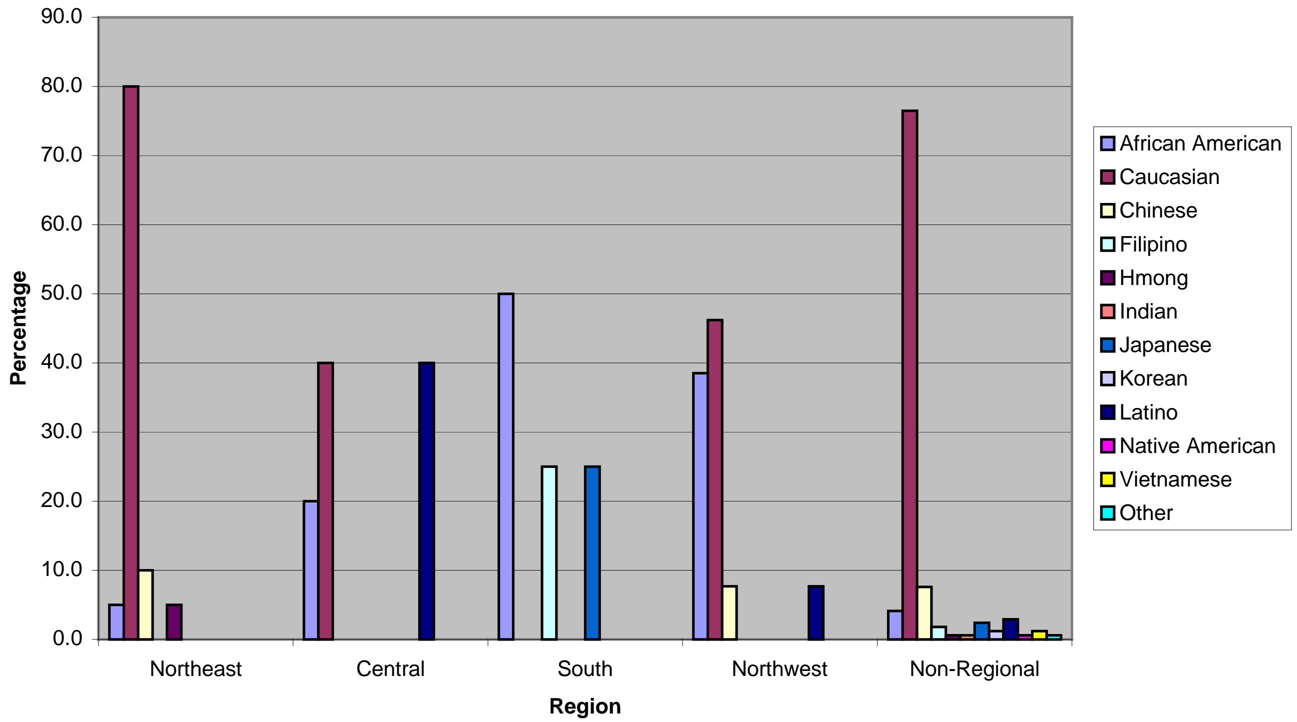


Figure 42: Ethnicity of Administration/Management by Region

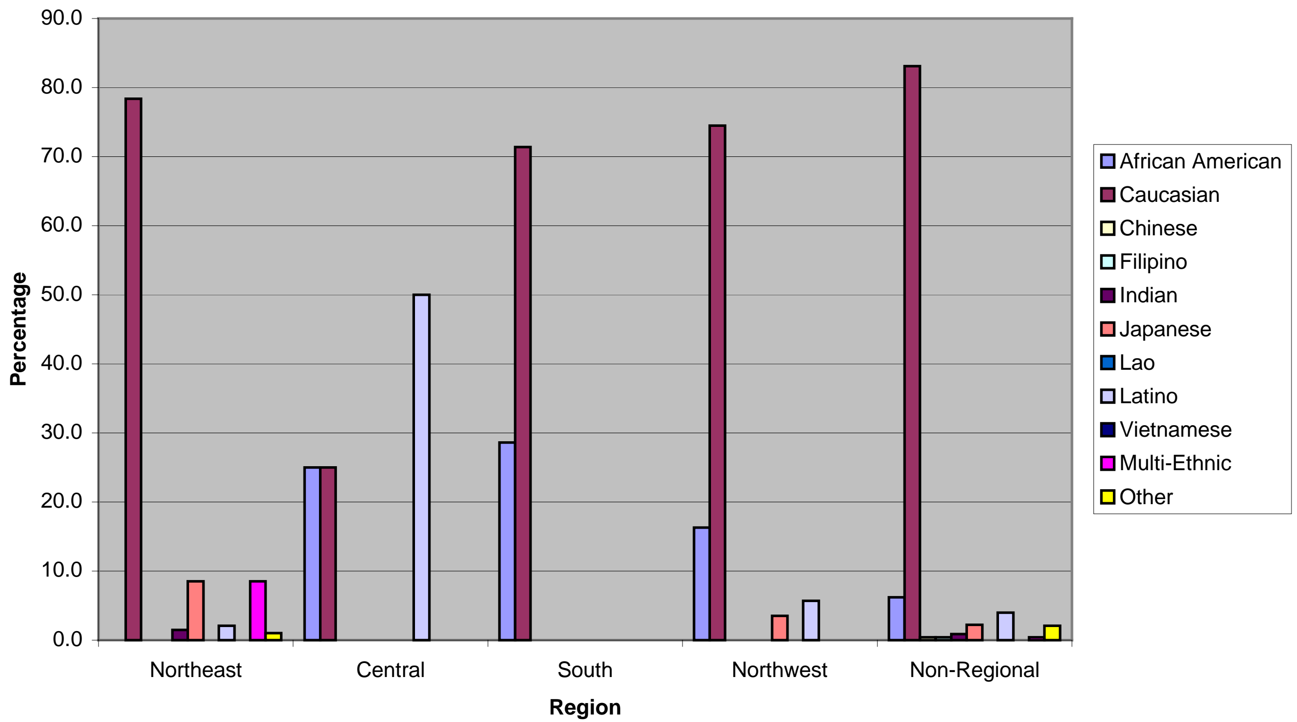


Figure 43: Ethnicity of Direct Service Staff by Region

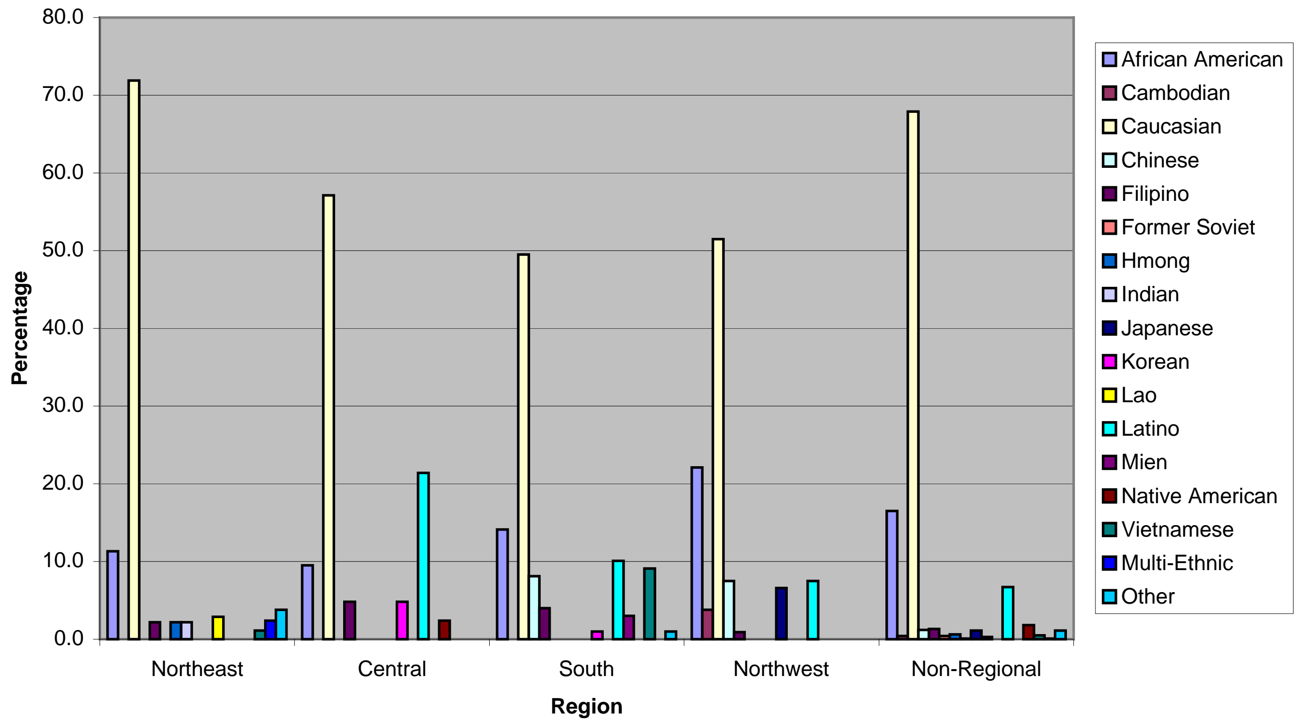
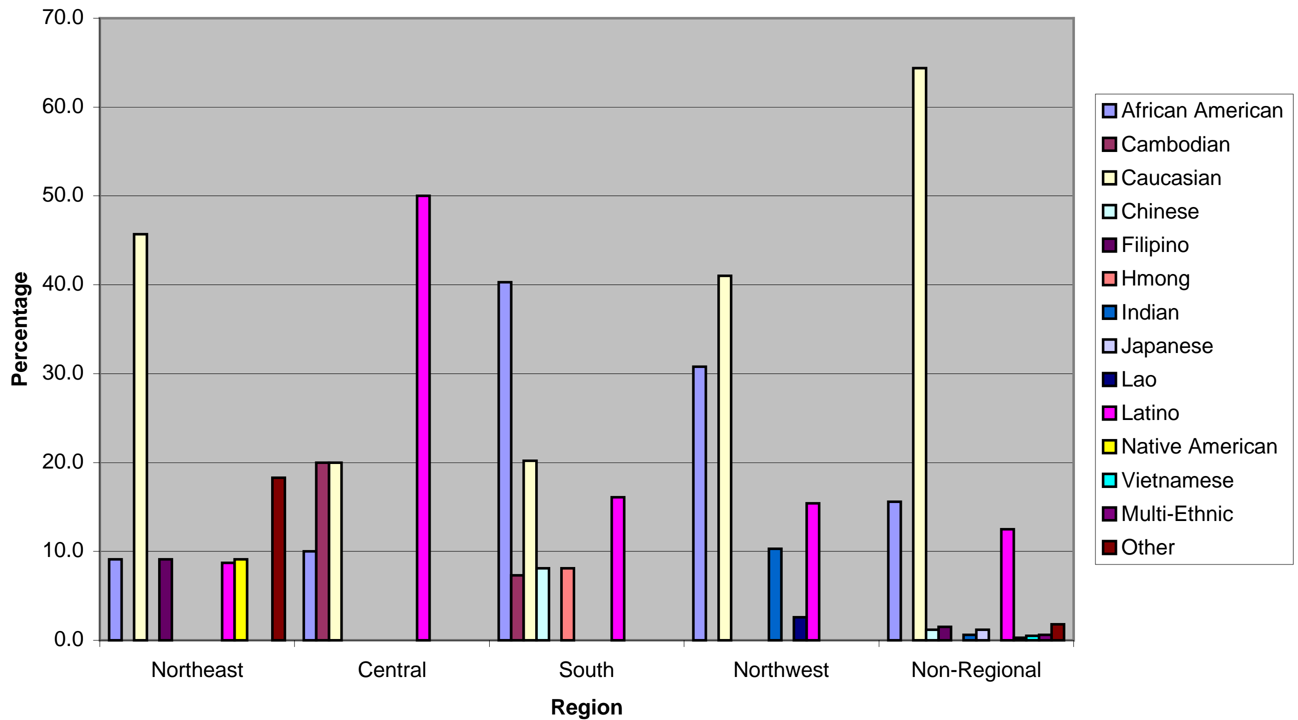


Figure 44: Ethnicity of Clerical Support by Region



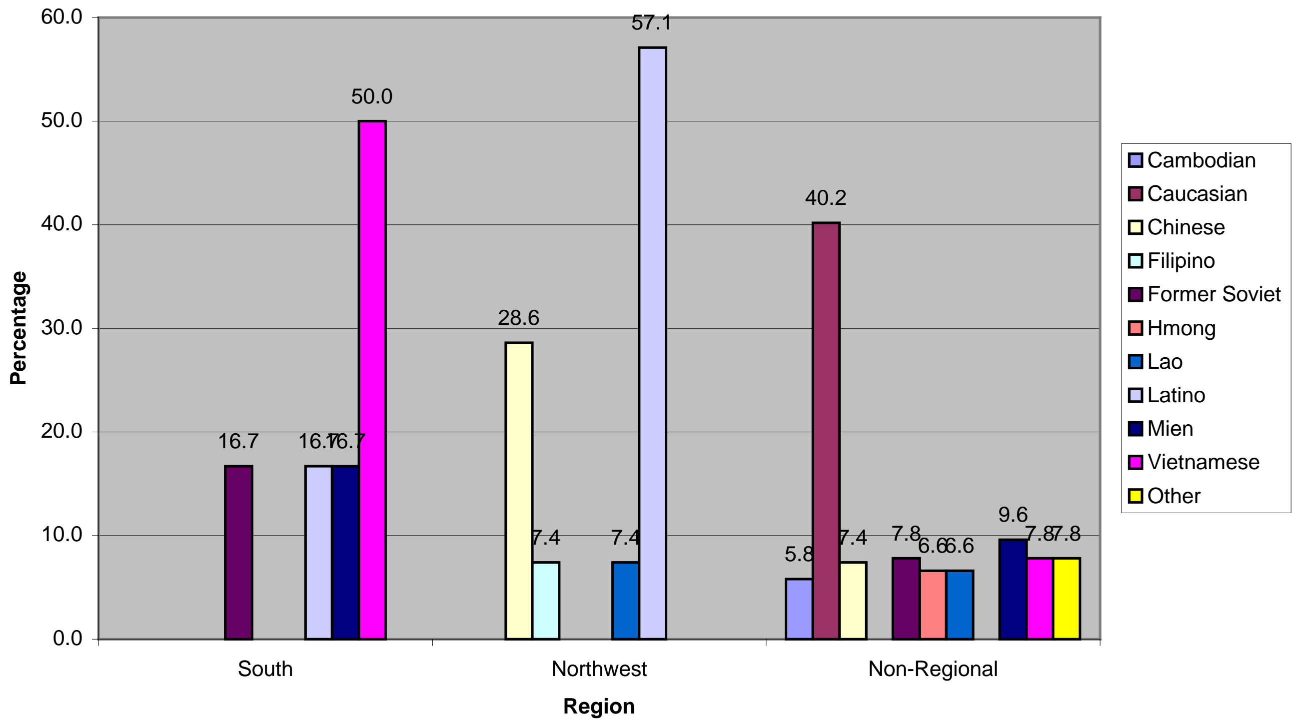


Figure 45: Ethnicity of Interpreters by Region
Percentage
Region
South
Northwest
Non-Regional
60.0
50.0
40.0
30.0
20.0
10.0
0.0
16.7
16.7
16.7
50.0
28.6
7.4
7.4
57.1
5.8
40.2
7.4
7.8
6.6
6.6
9.6
7.8
7.8
Cambodian
Caucasian
Chinese
Filipino
Former Soviet
Hmong
Lao
Latino
Mien
Vietnamese
Other

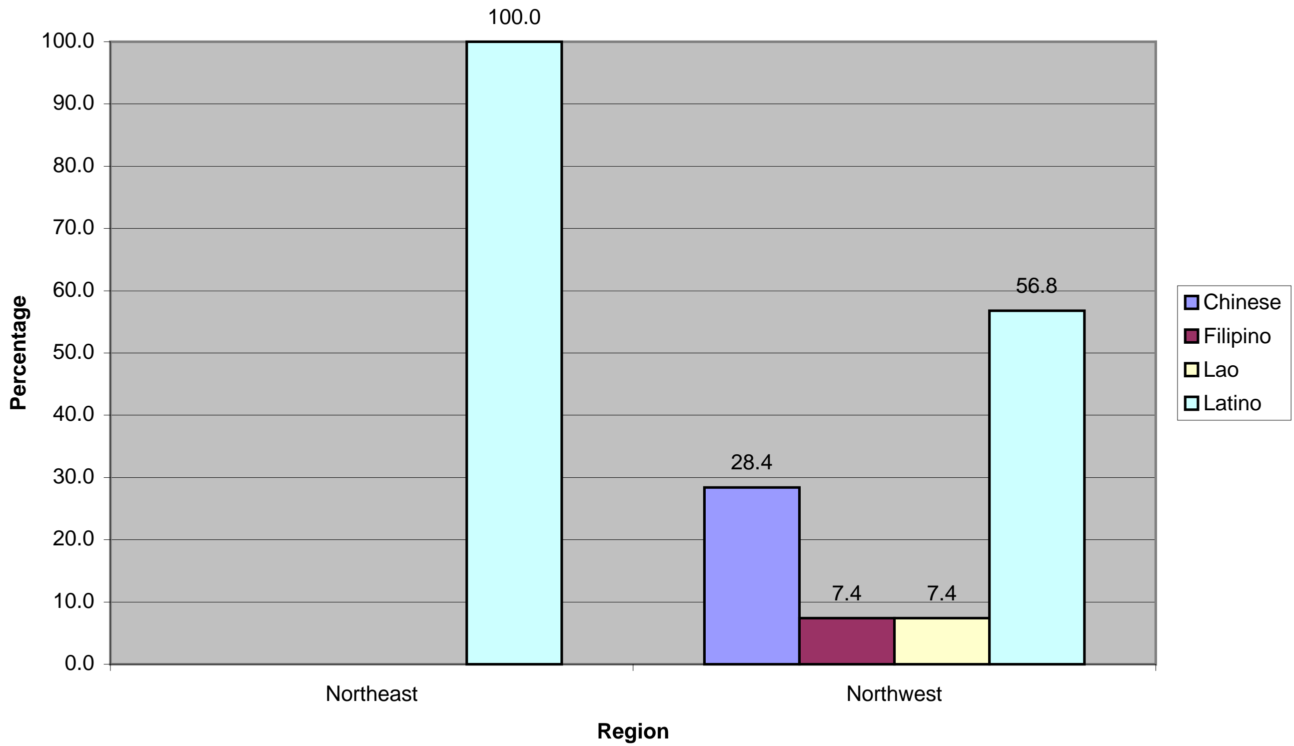


Figure 46: Ethnicity of Translators by Region
Percentage
Region
Northeast
Northwest
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
100.0
28.4
7.4
7.4
56.8
Chinese
Filipino
Lao
Latino

Figure 47: Ethnicity of "Other" Staff by Region

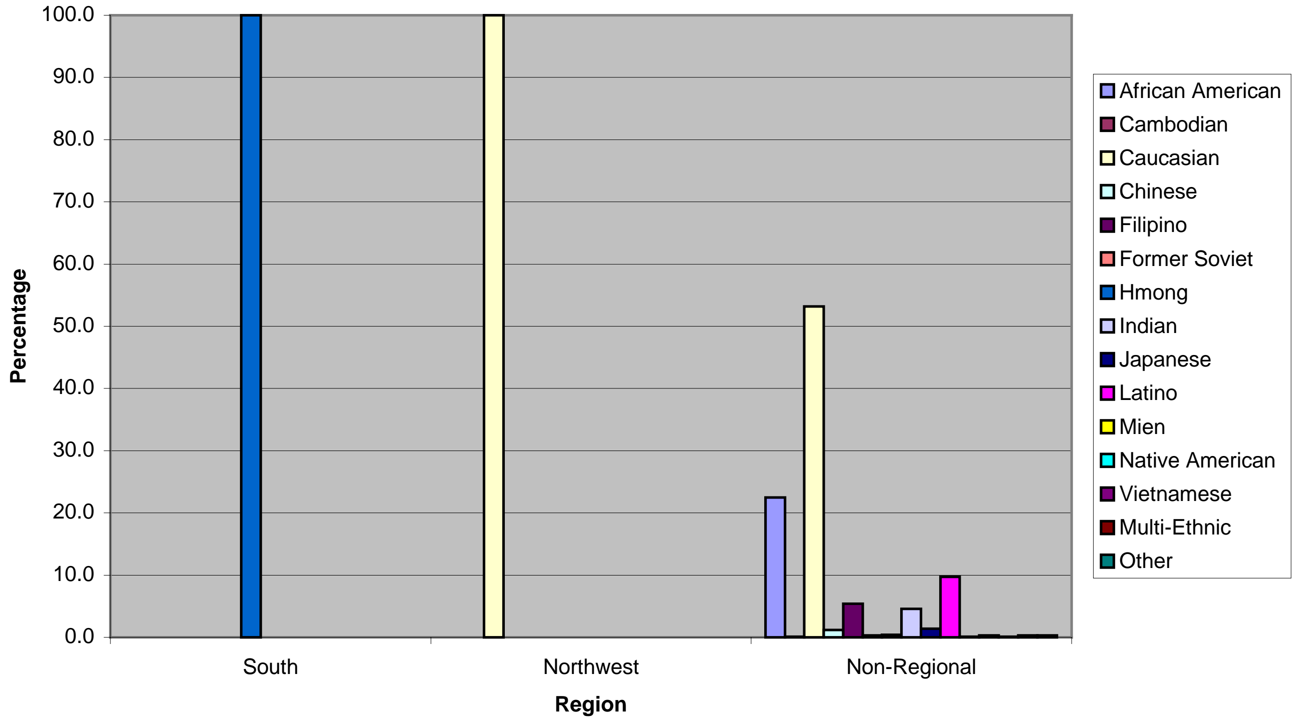


Figure 48: Bilingual Language Capability of Board Members by Region

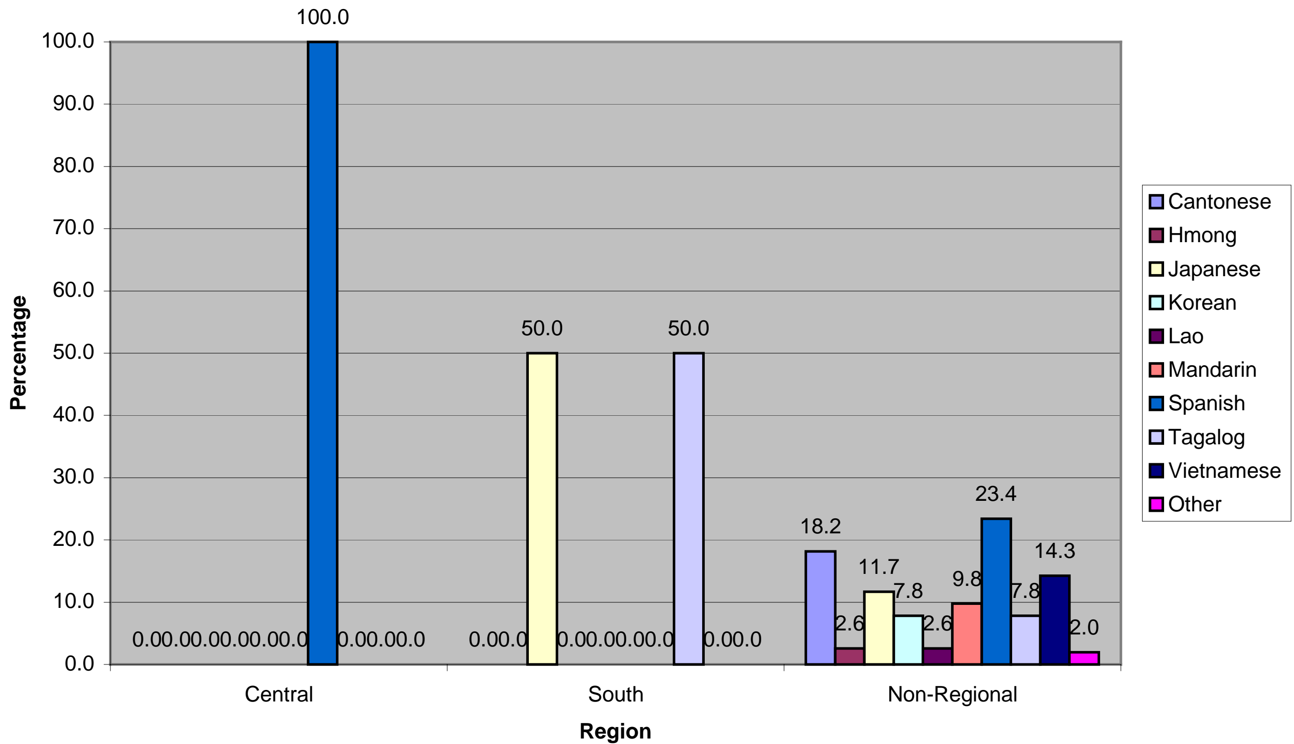


Figure 49: Bilingual Language Capability of Administration/Management by Region

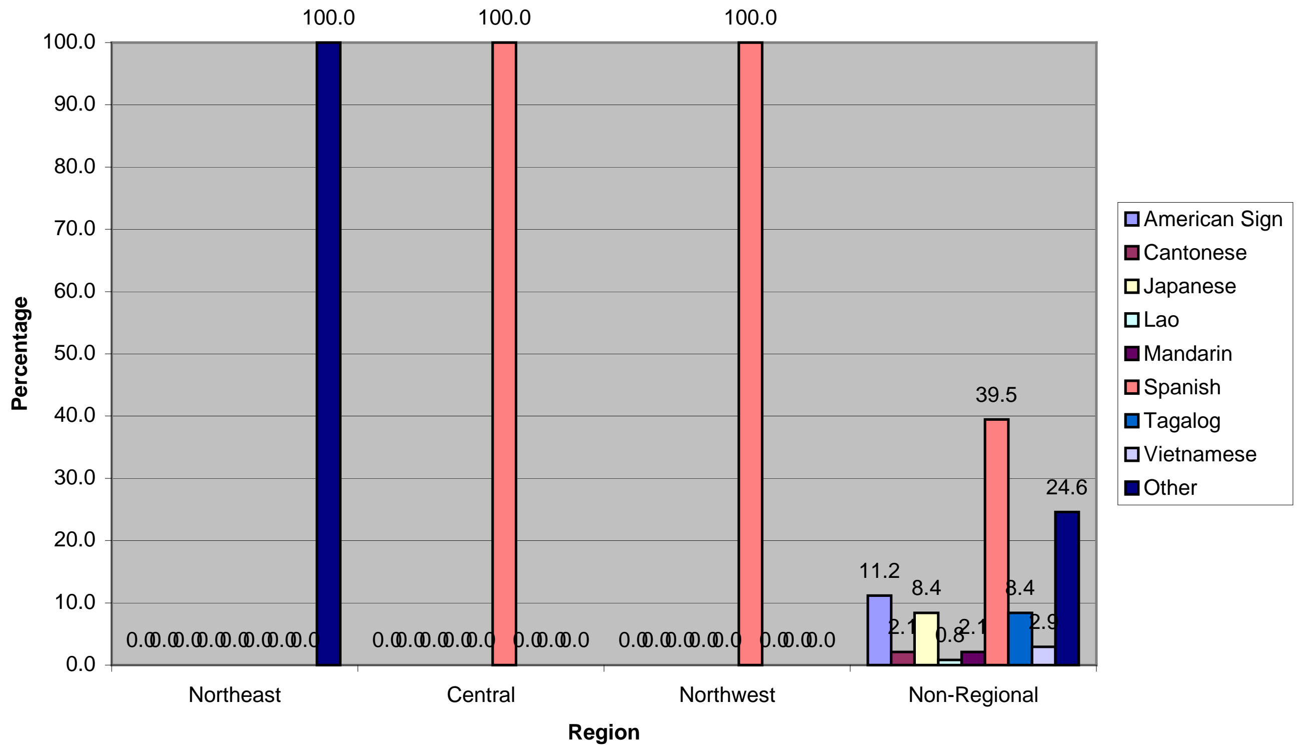


Figure 50: Bilingual Language Capability of Direct Services Staff by Region

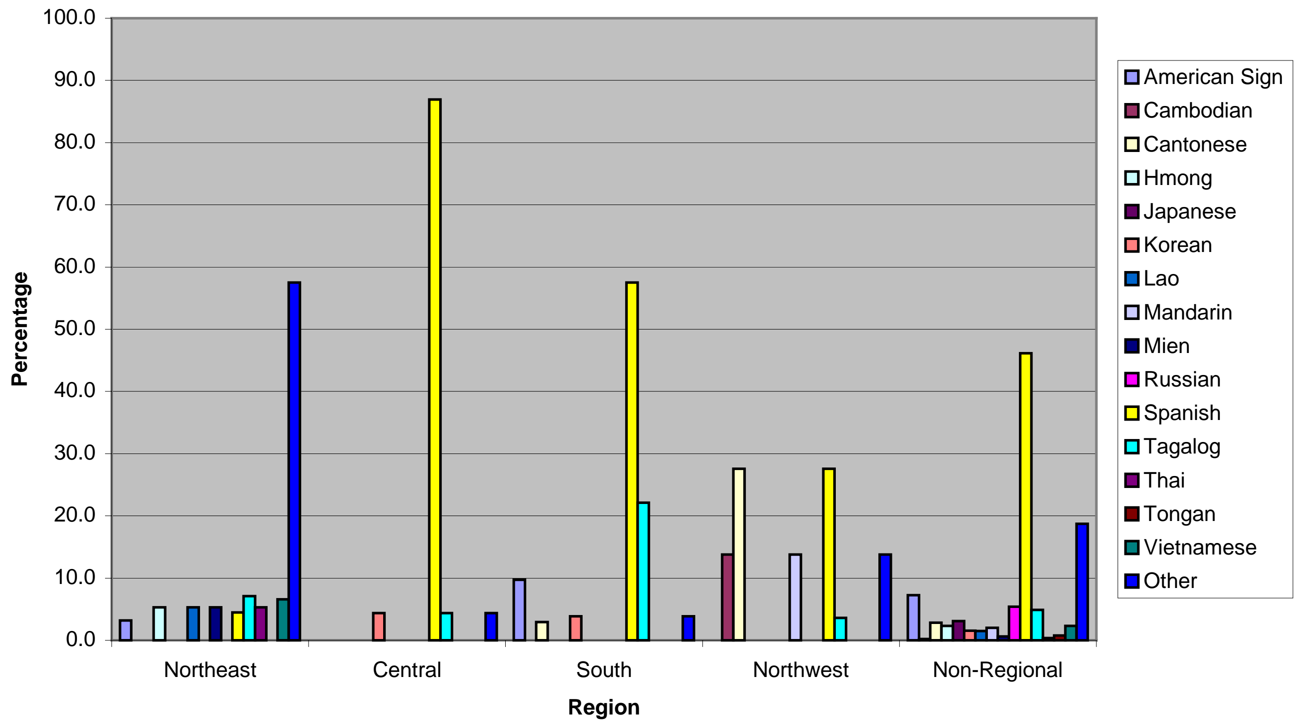


Figure 51: Bilingual Language Capability of Clerical Support by Region

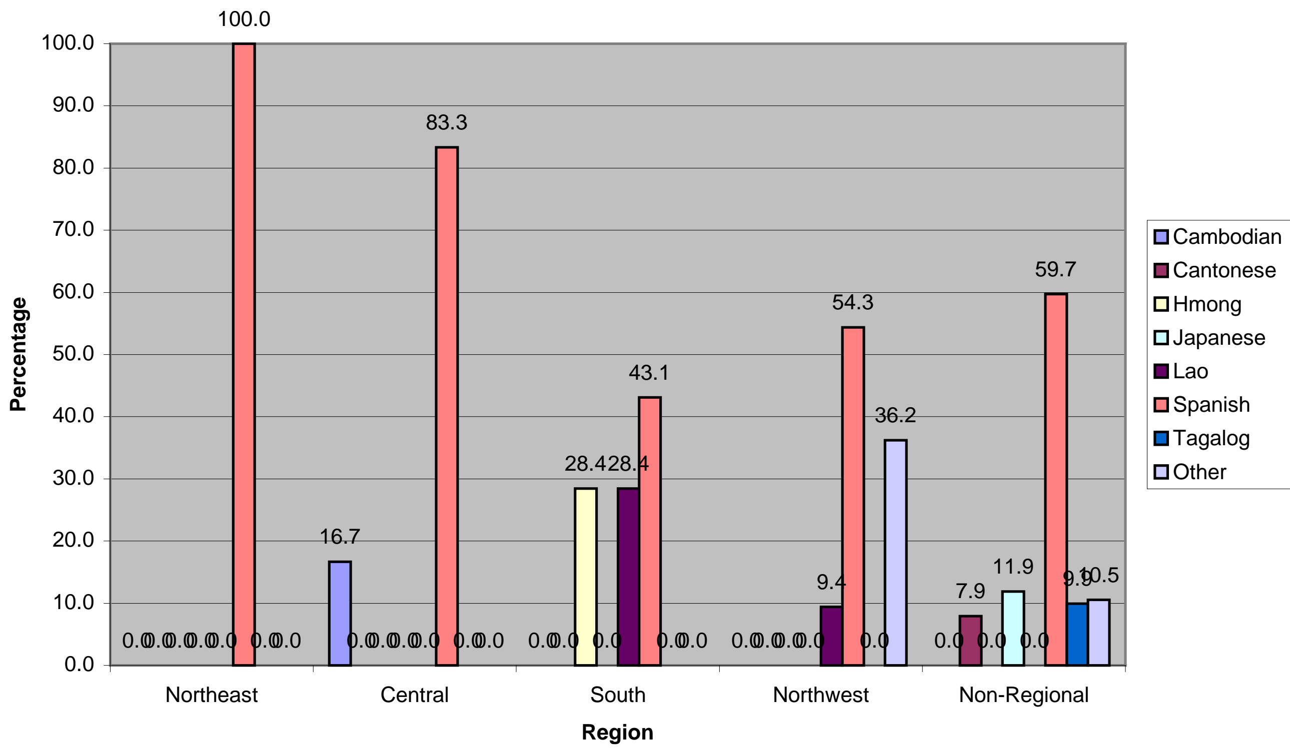


Figure 52: Bilingual Language Capability of Interpreters by Region

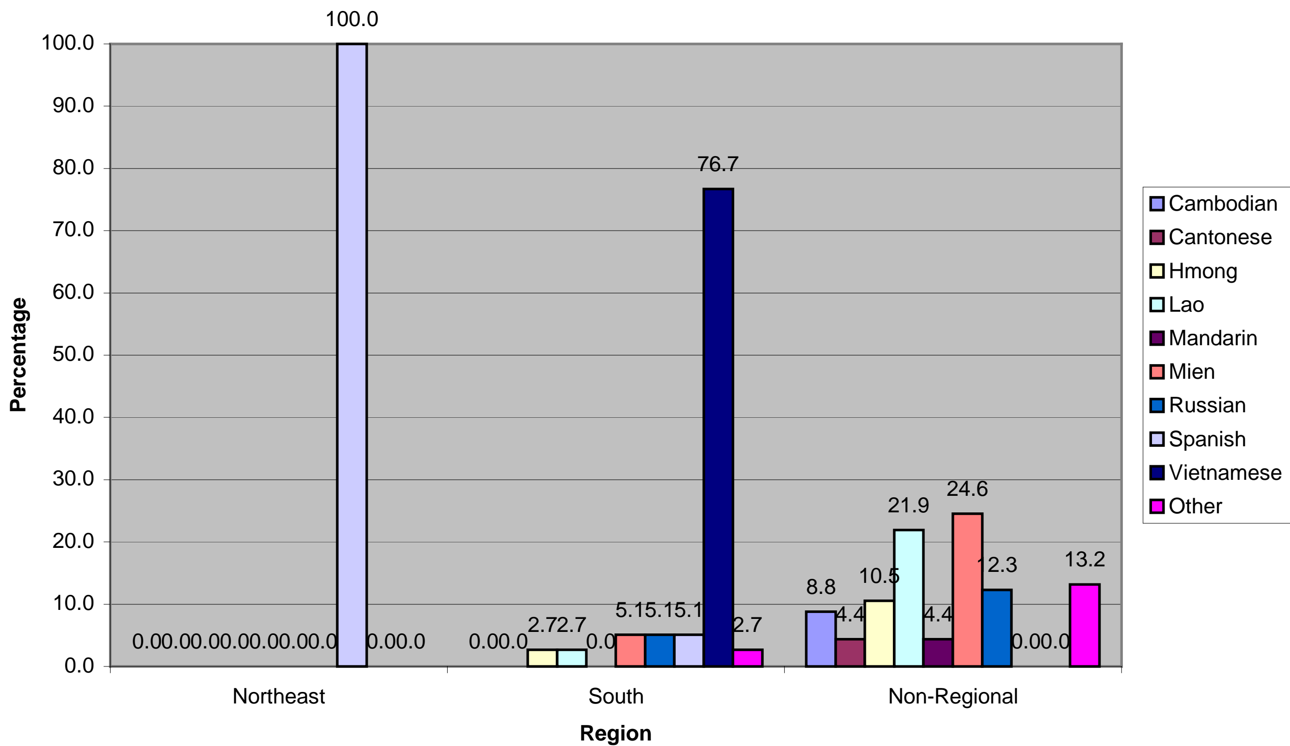


Figure 53: Bilingual Language Capability of Translators by Region

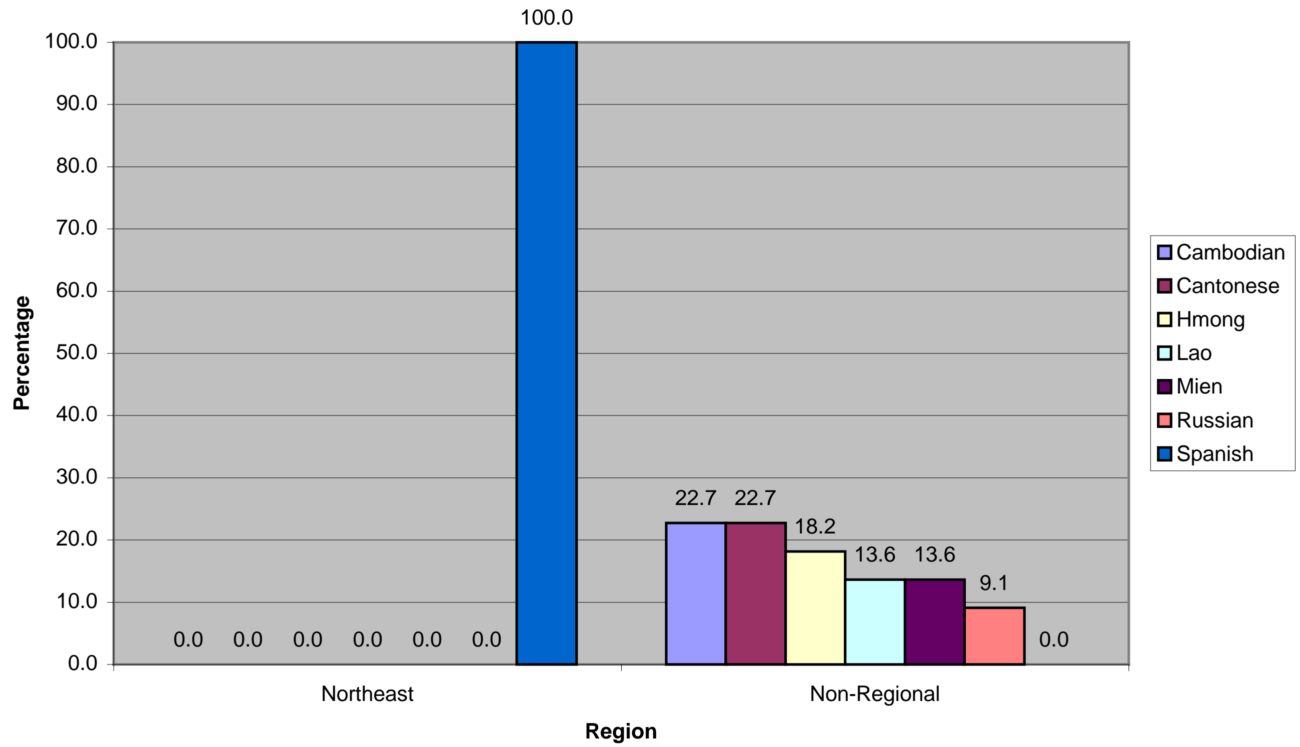


Figure 54: Bilingual Language Capability of "Other" Staff by Region

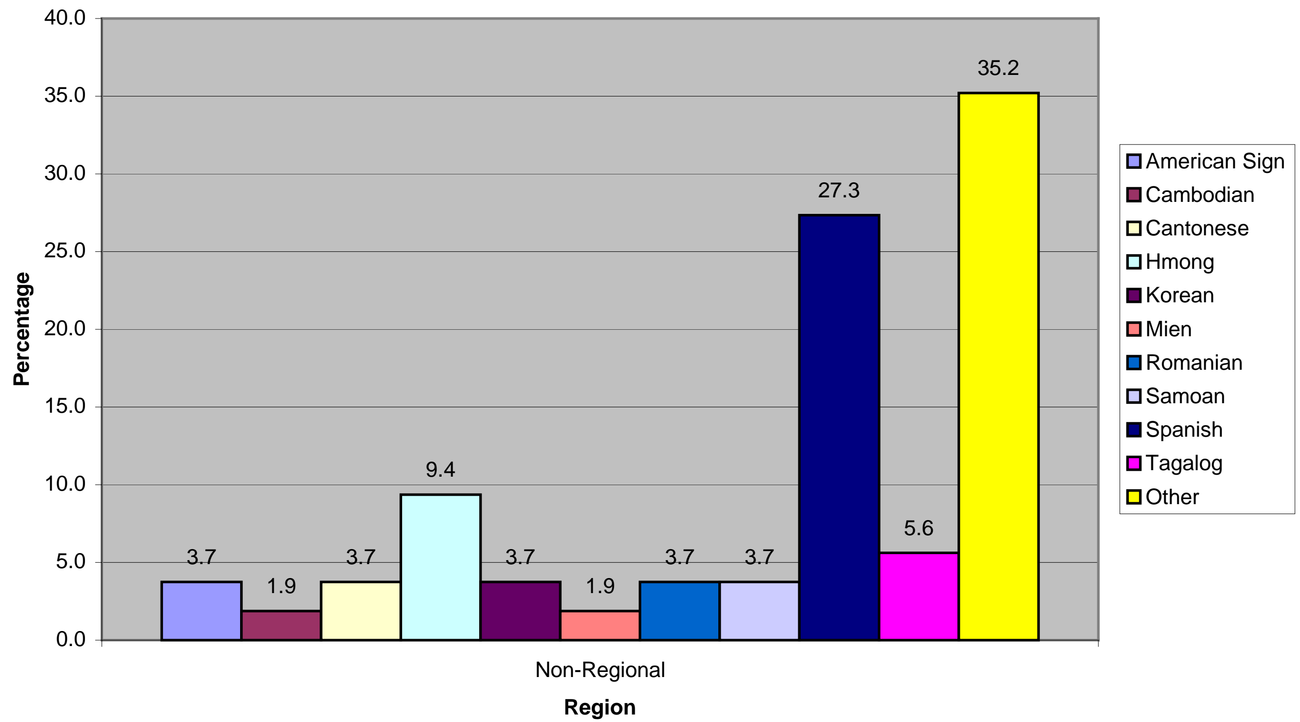


Figure 55: Languages Board Members Read/Write by Region

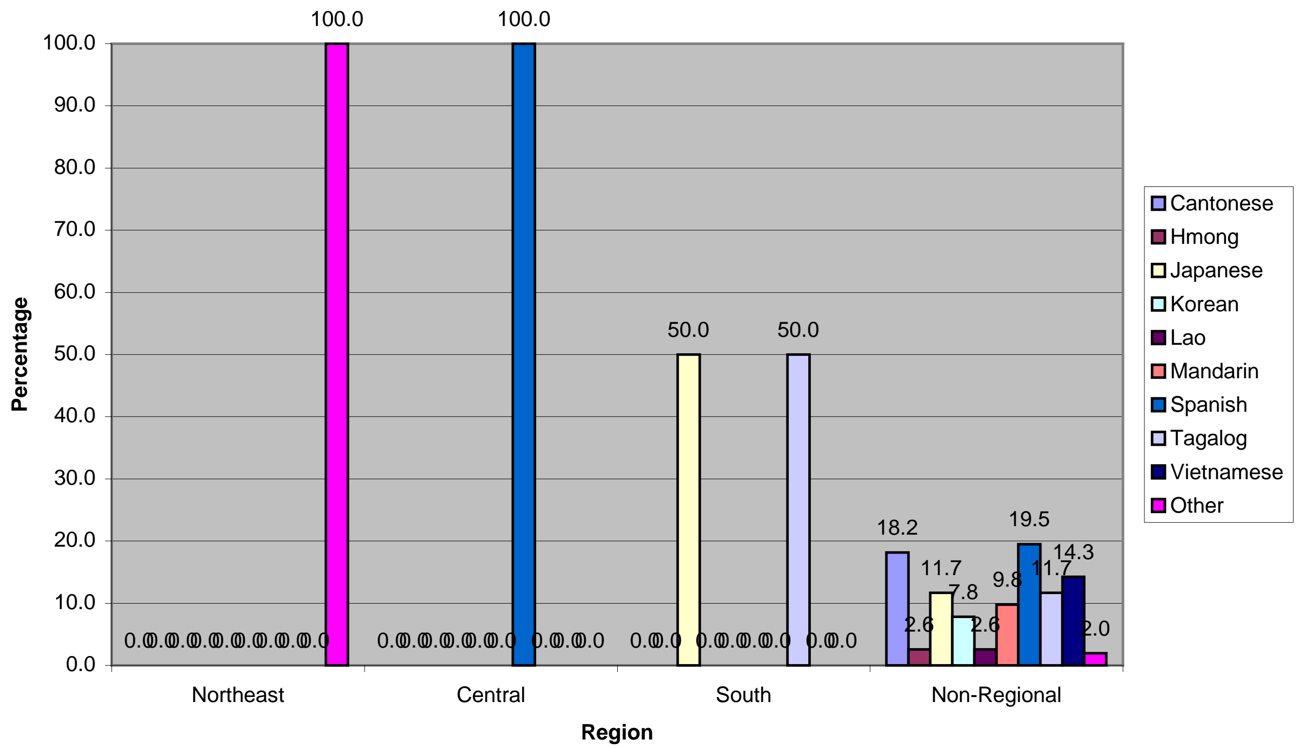


Figure 56: Languages Administration/Management Read/Write by Region

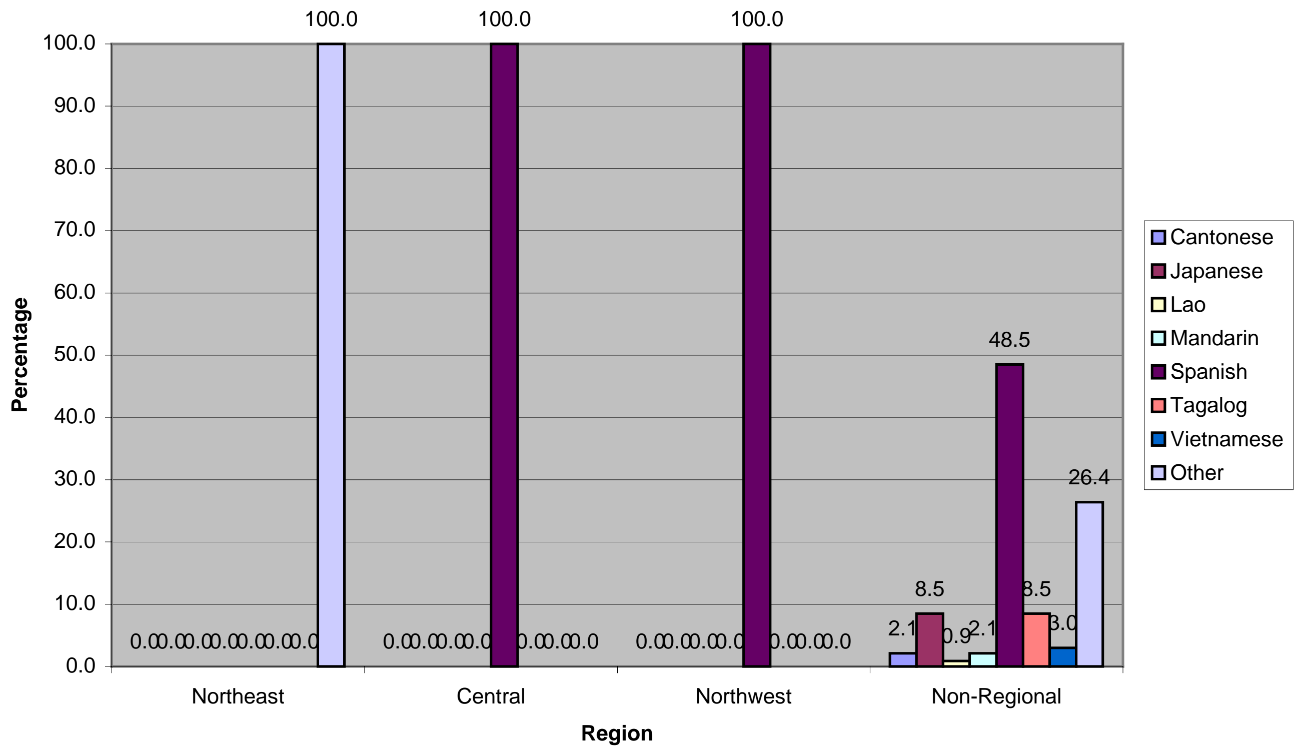


Figure 57: Languages Direct Service Staff Reads/Writes by Region

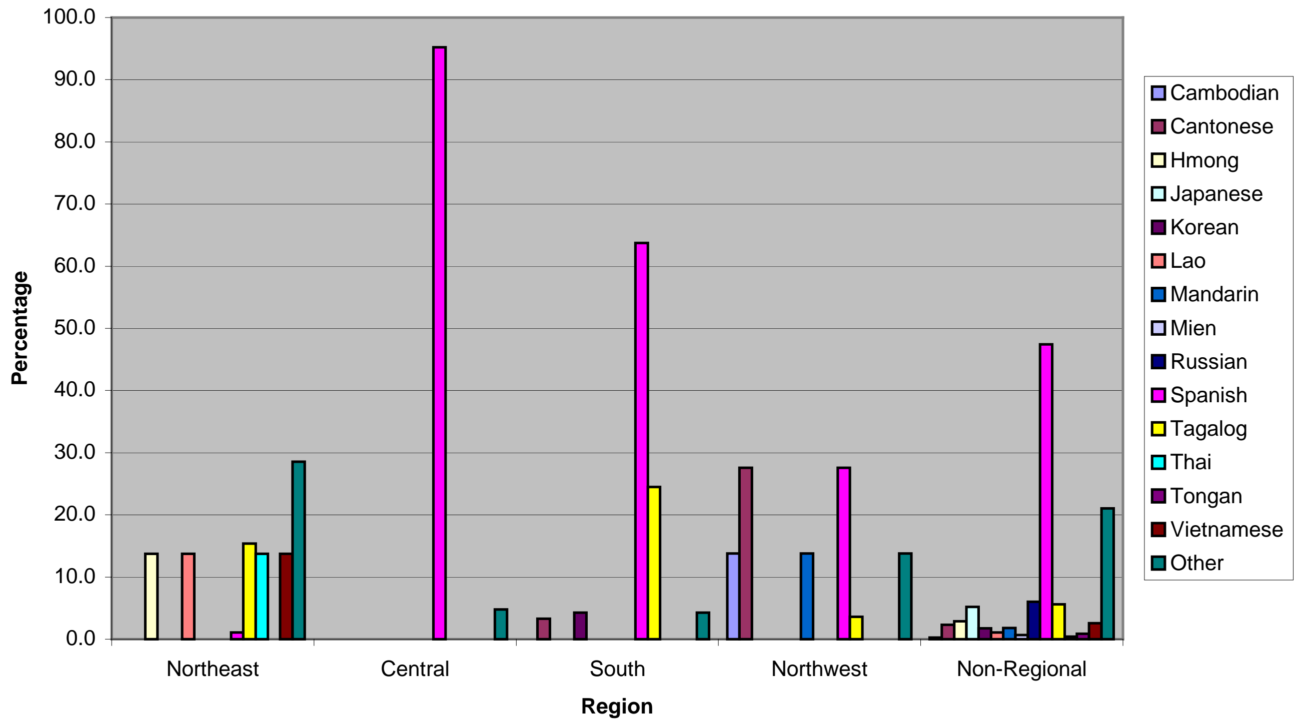


Figure 58: Languages Clerical Support Staff Reads/Writes by Region

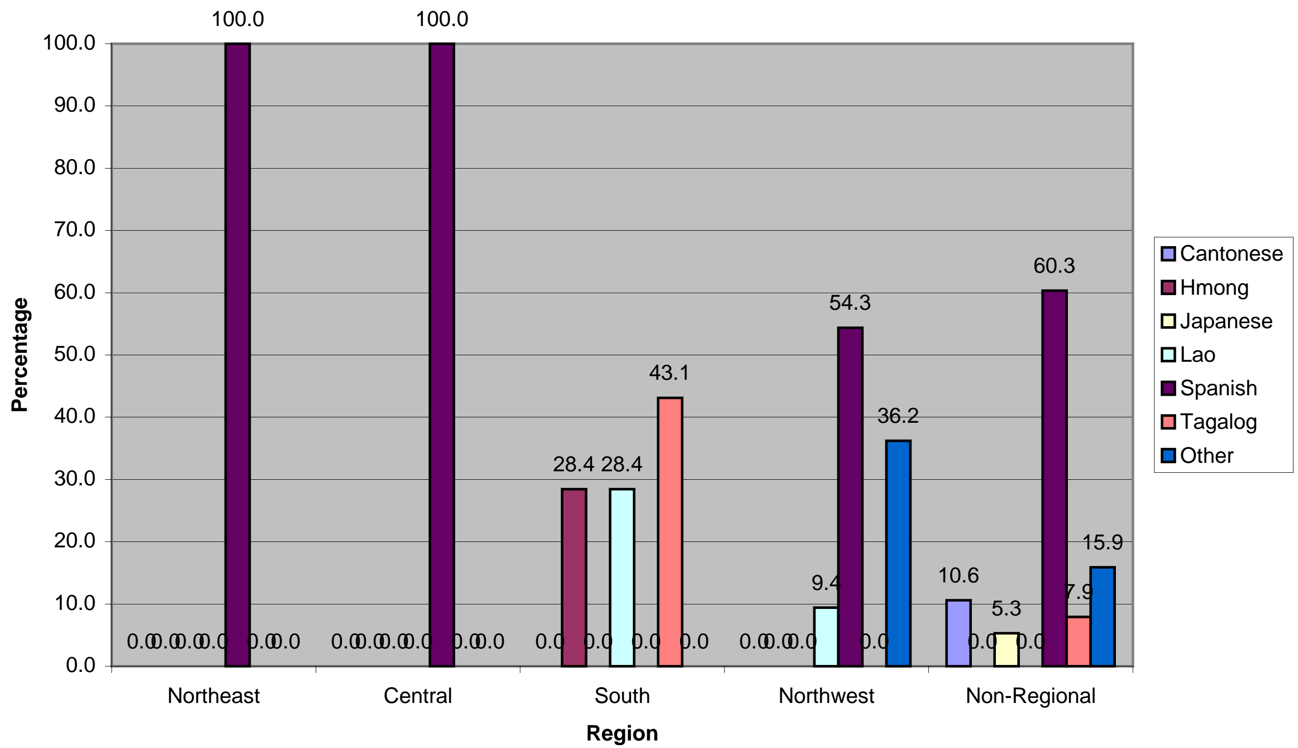


Figure 59: Languages Interpreters Read/Write by Region

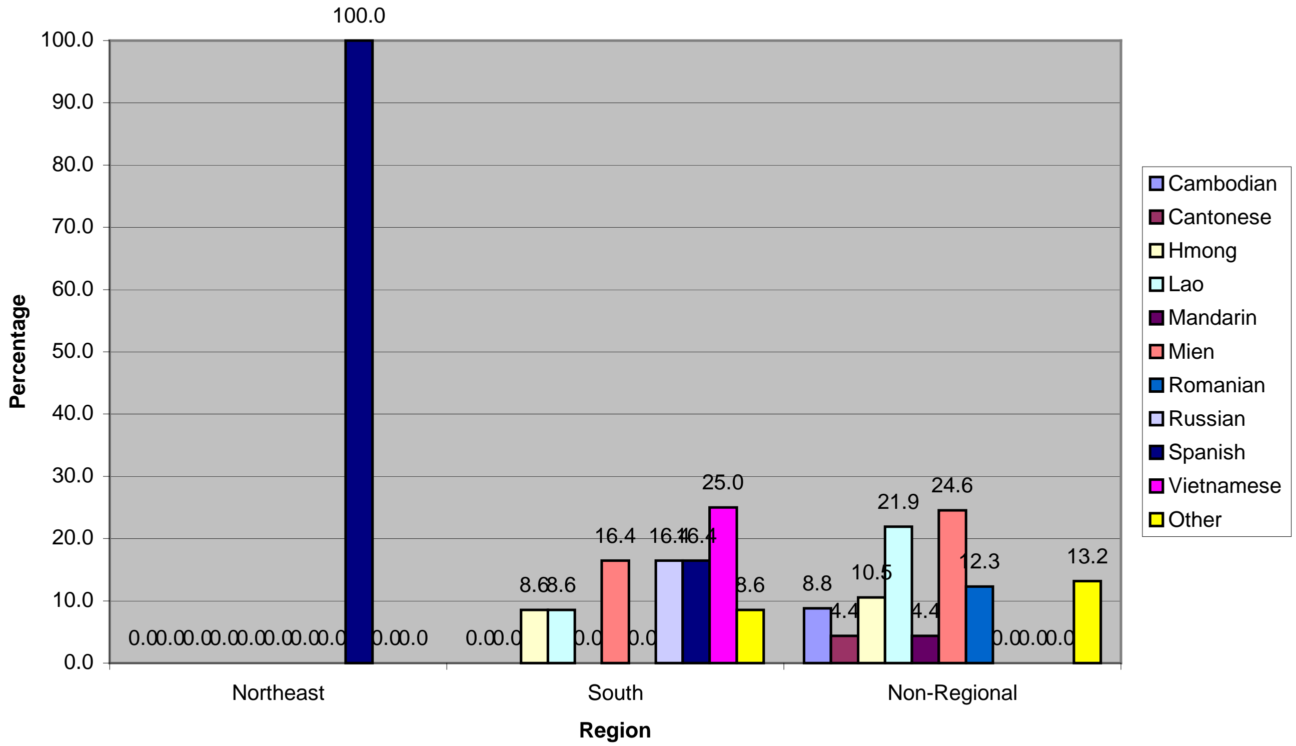


Figure 60: Languages Translators Read/Write by Region

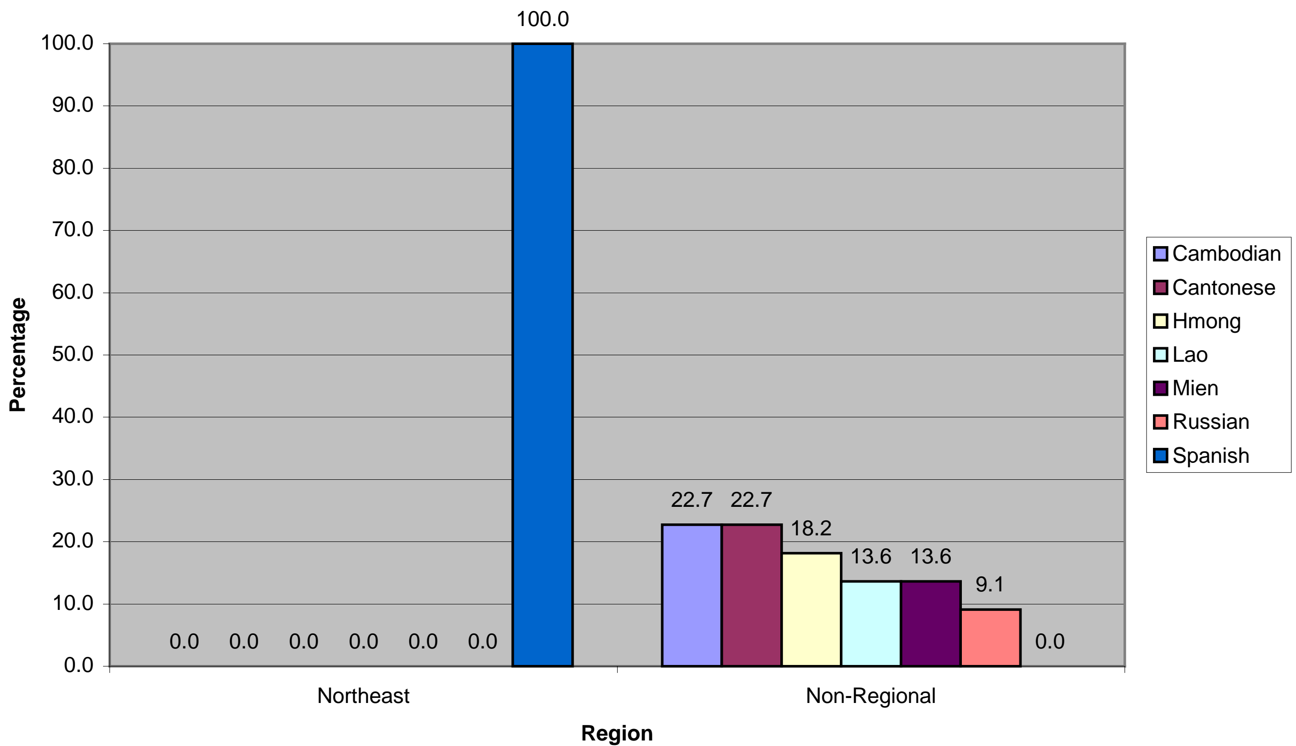


Figure 61: Languages "Other" Staff Reads/Writes by Region

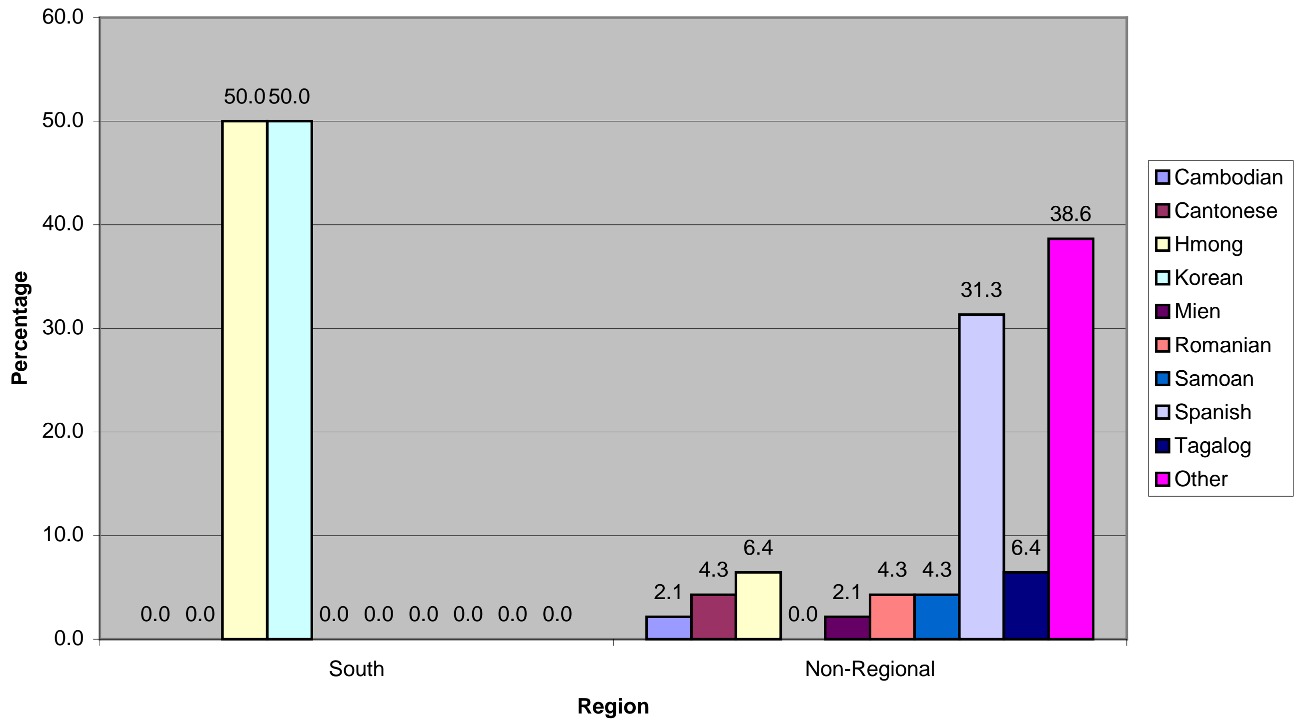


Figure 62: Gender Breakdown of Board Members by Region

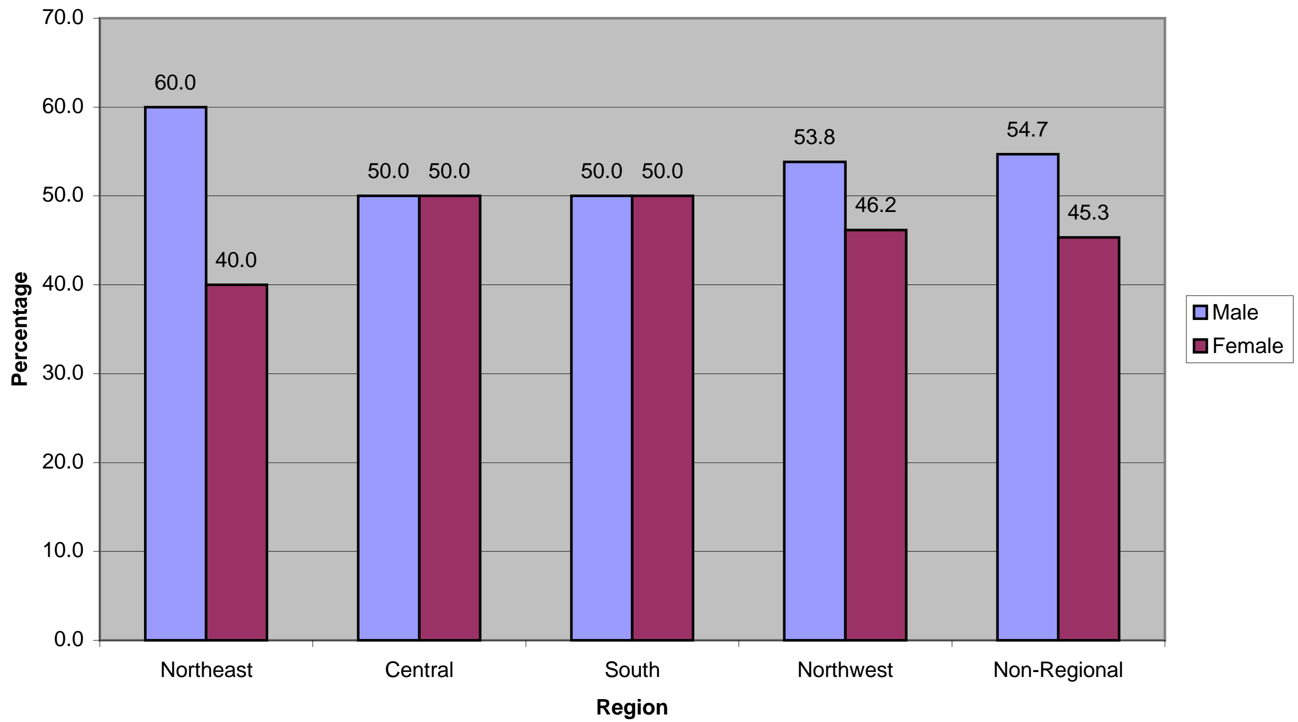


Figure 63: Gender Breakdown of Administration/Management by Region

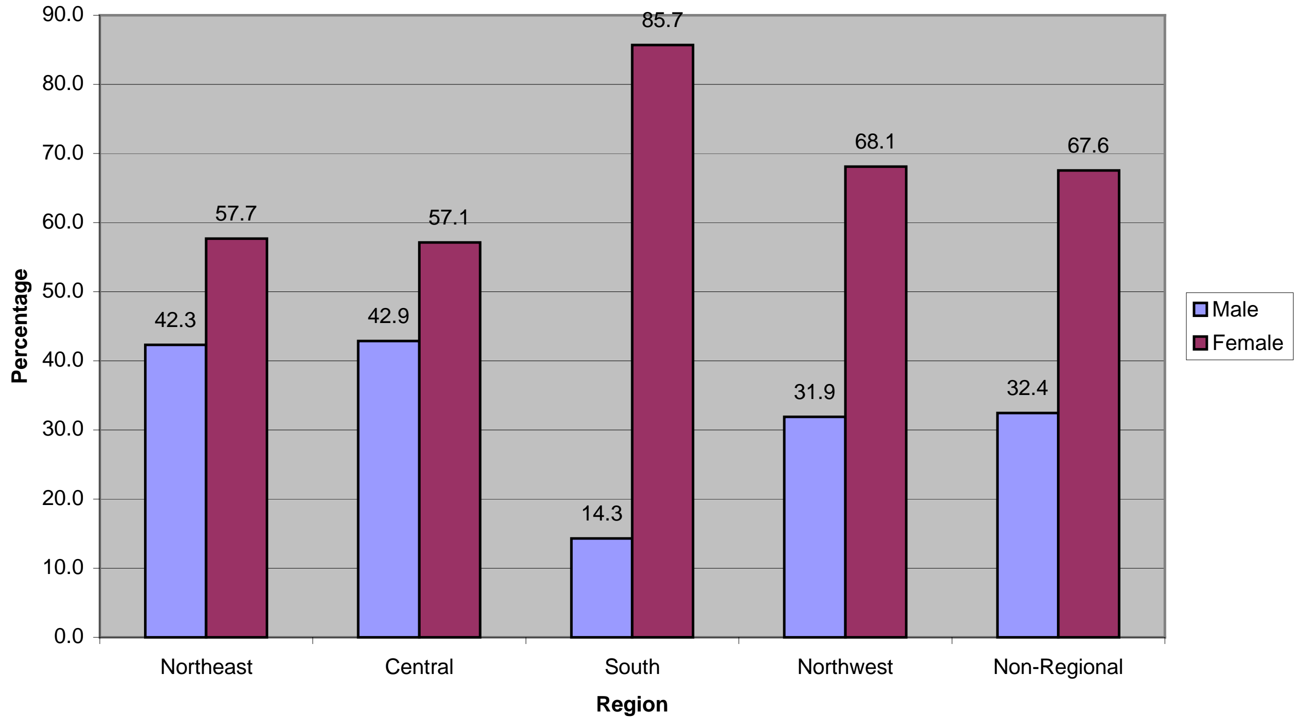


Figure 64: Gender Breakdown of Direct Service Staff by Region

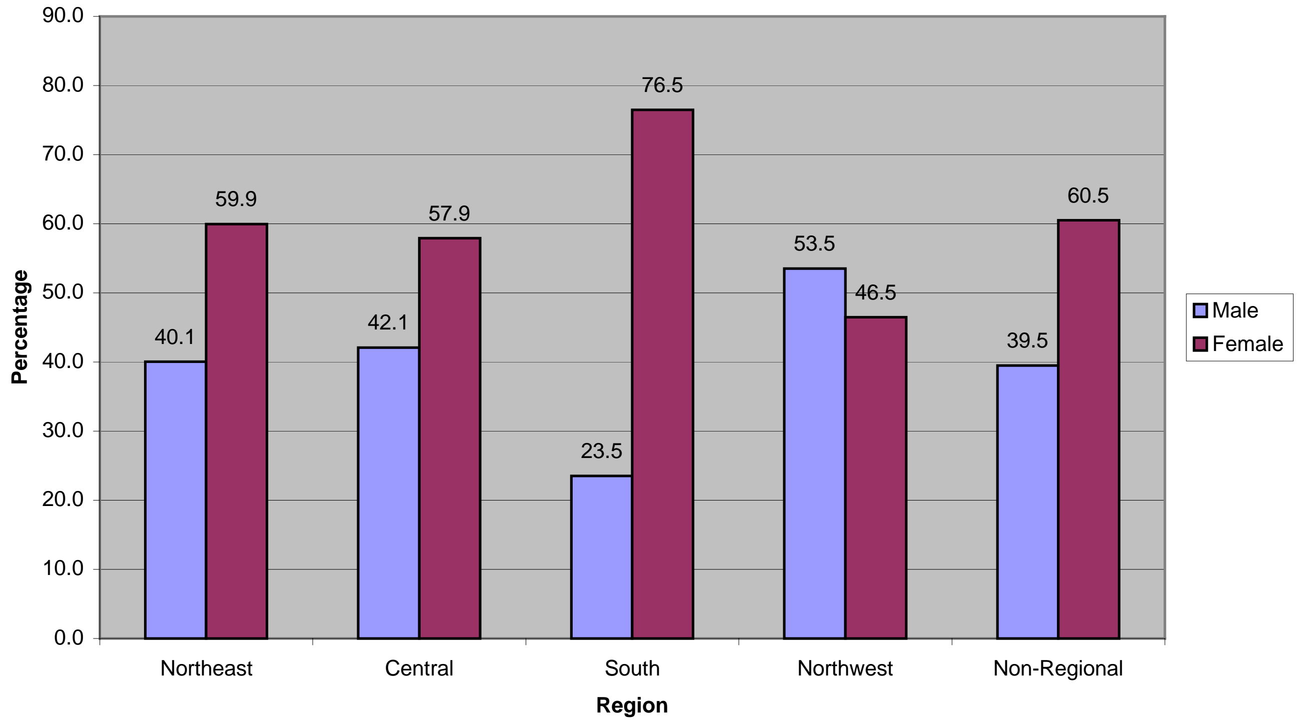


Figure 65: Gender Breakdown of Clerical Support by Region

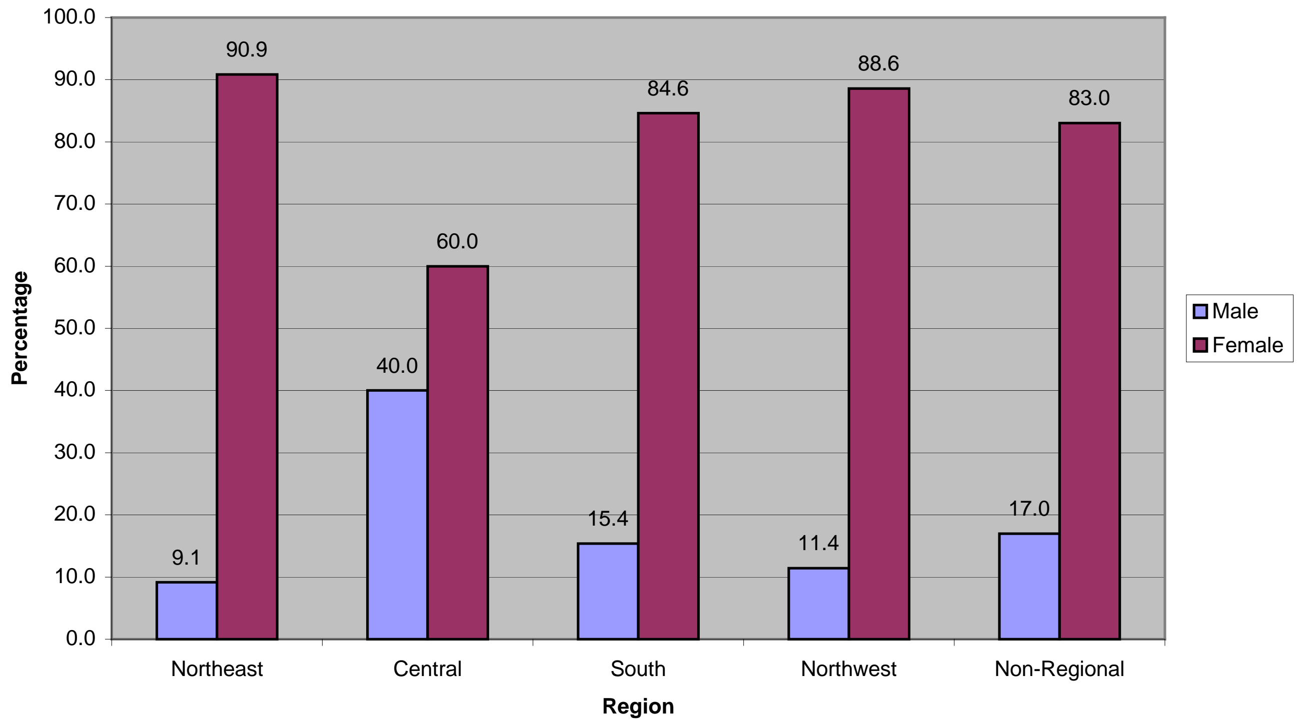


Figure 66: Gender Breakdown of Interpreters by Region

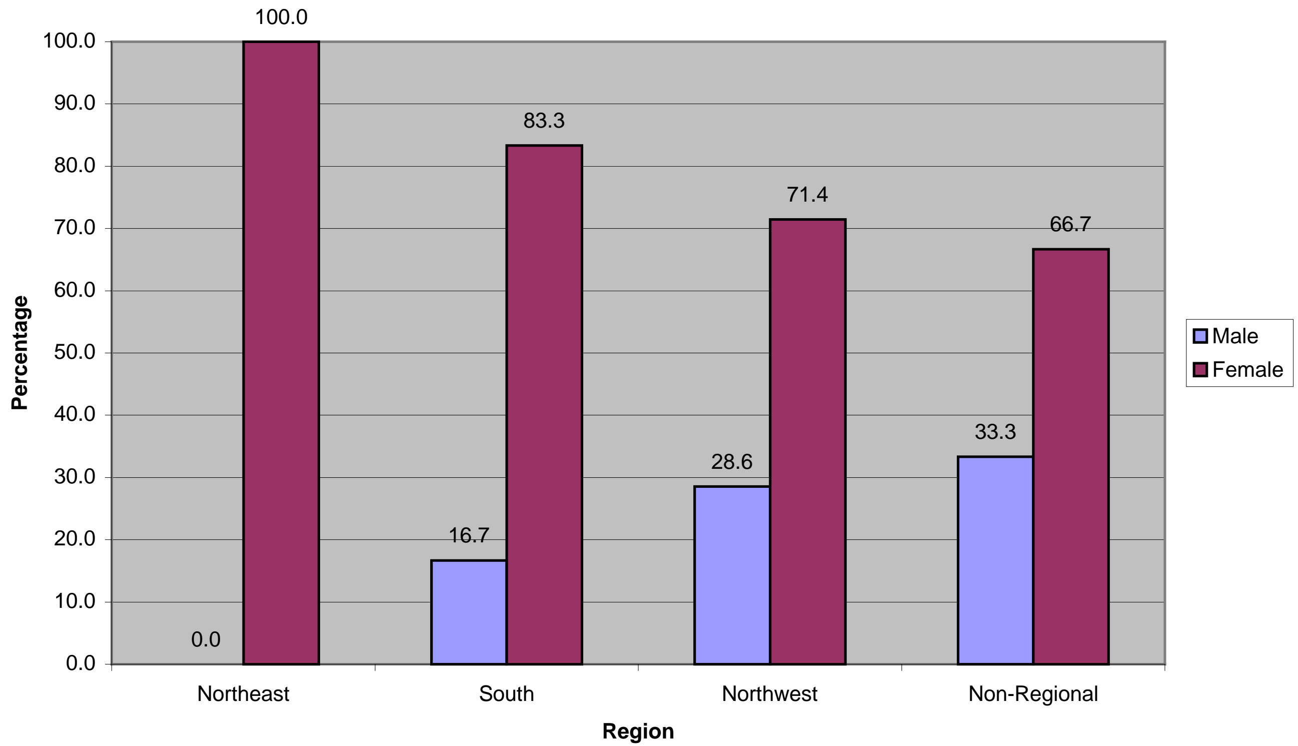


Figure 67: Gender Breakdown of Translators by Region

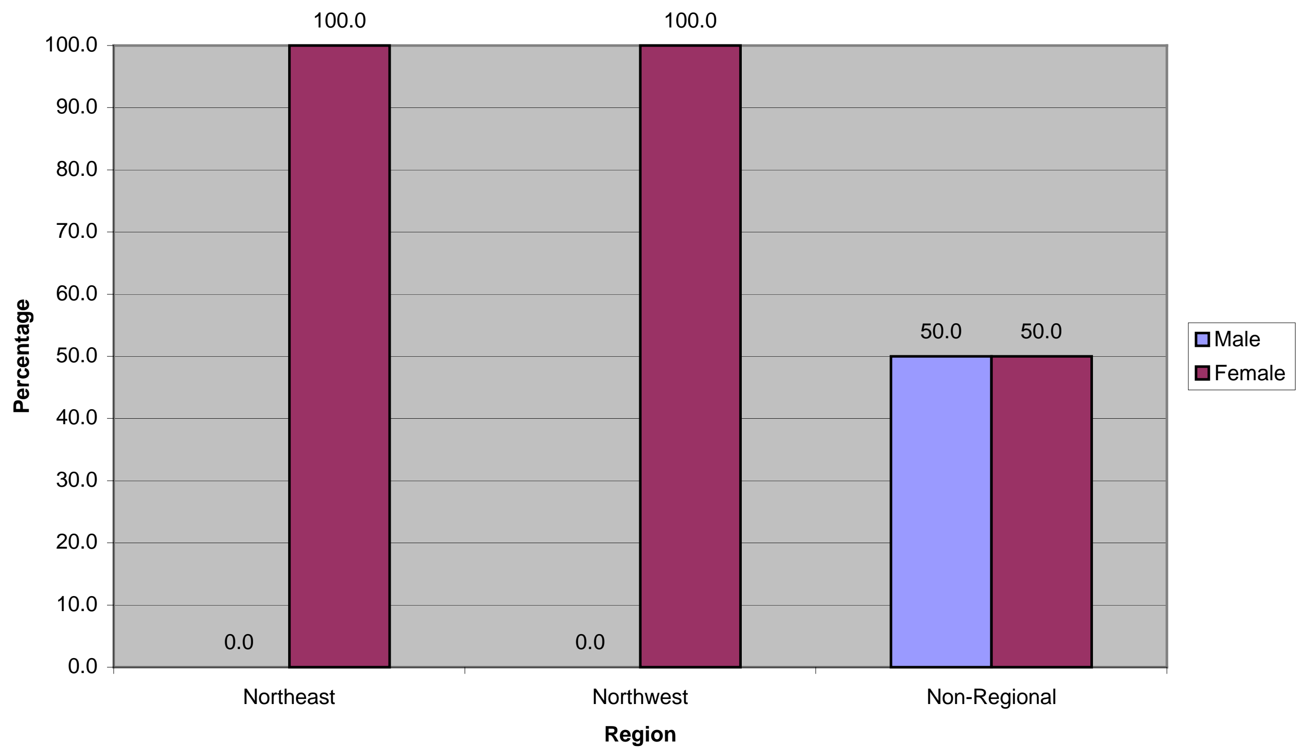


Figure 68: Gender Breakdown of "Other" Staff by Region

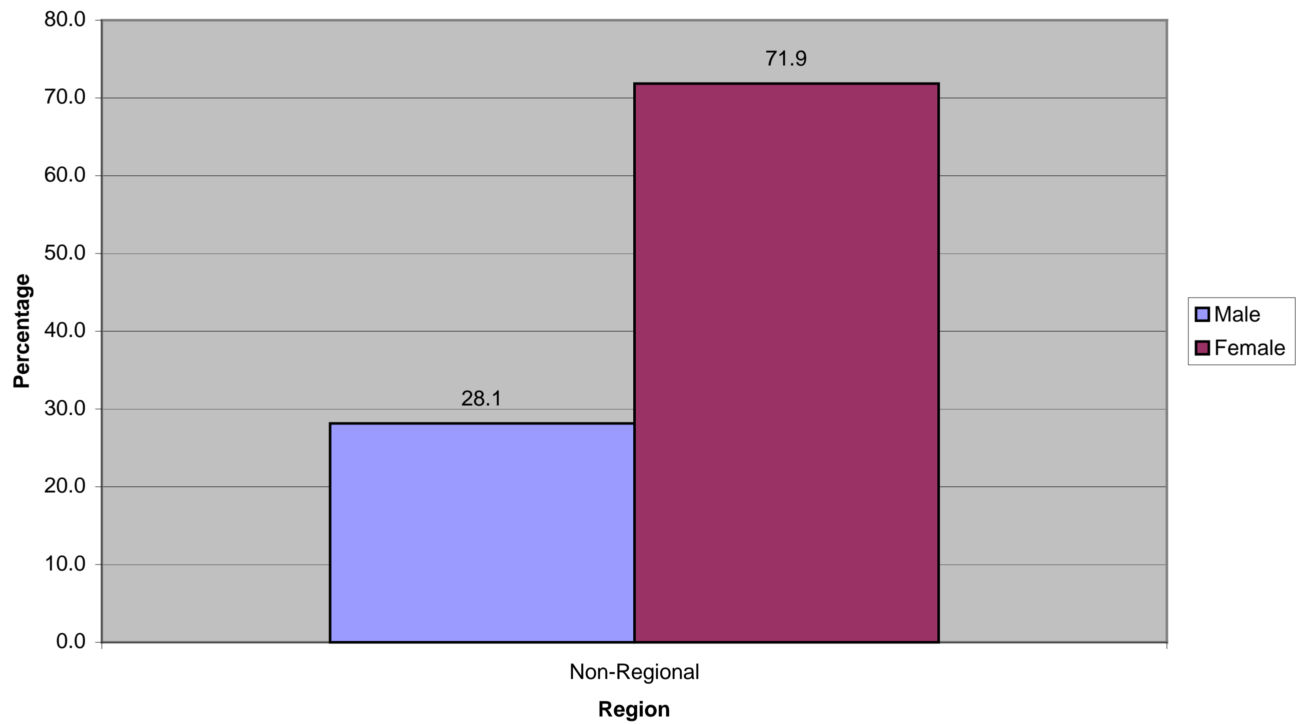


Figure 69: Ethnicity of Consumer Staff

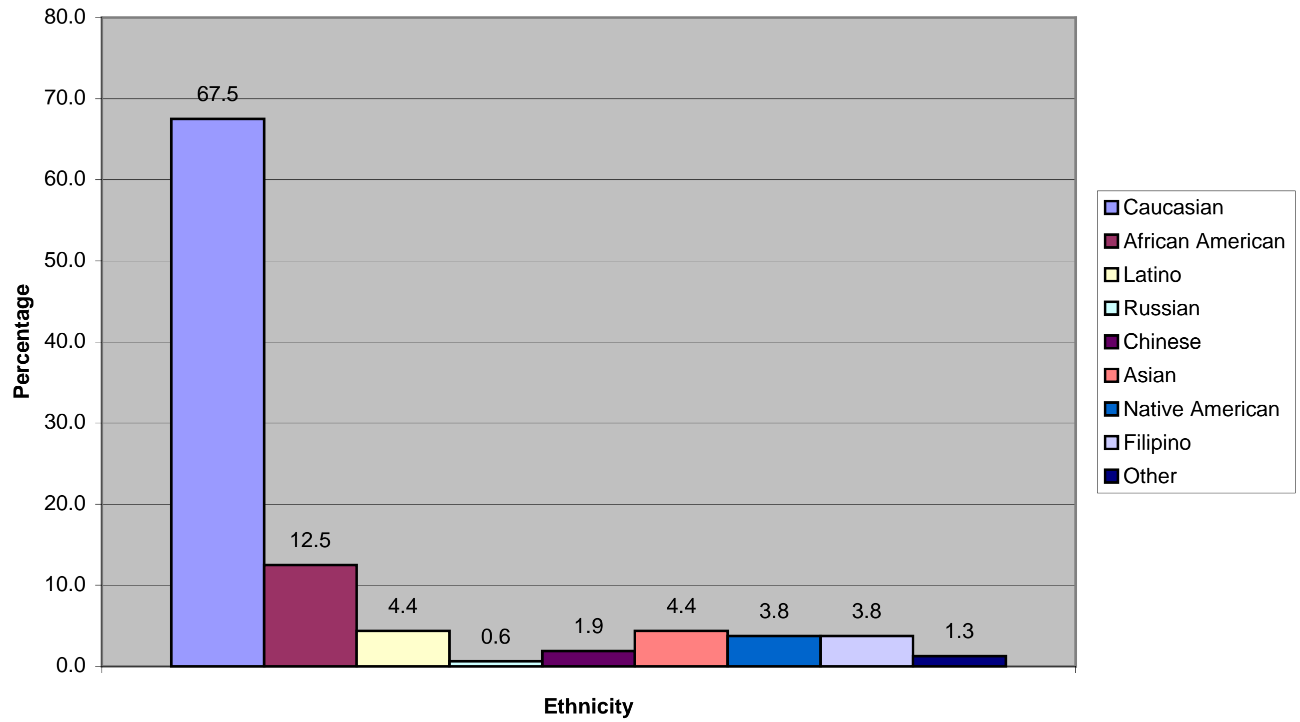
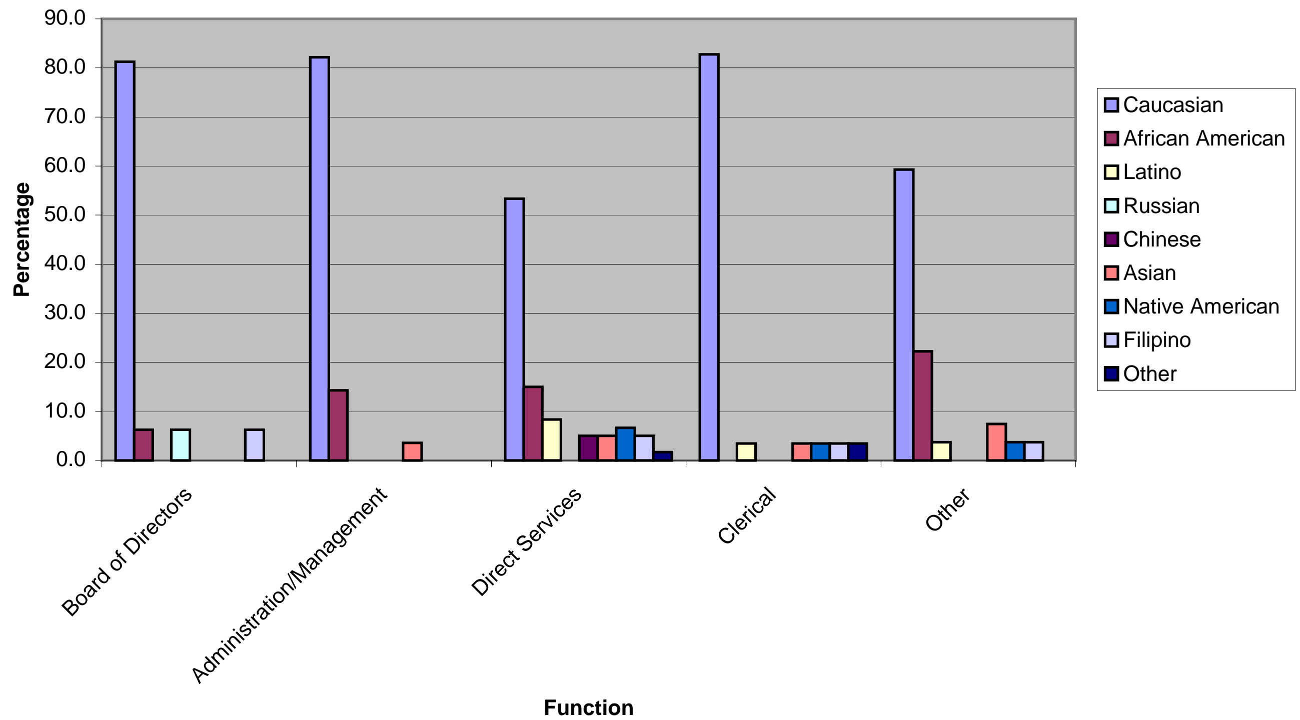


Figure 70: Ethnicity of Consumer Staff by Function



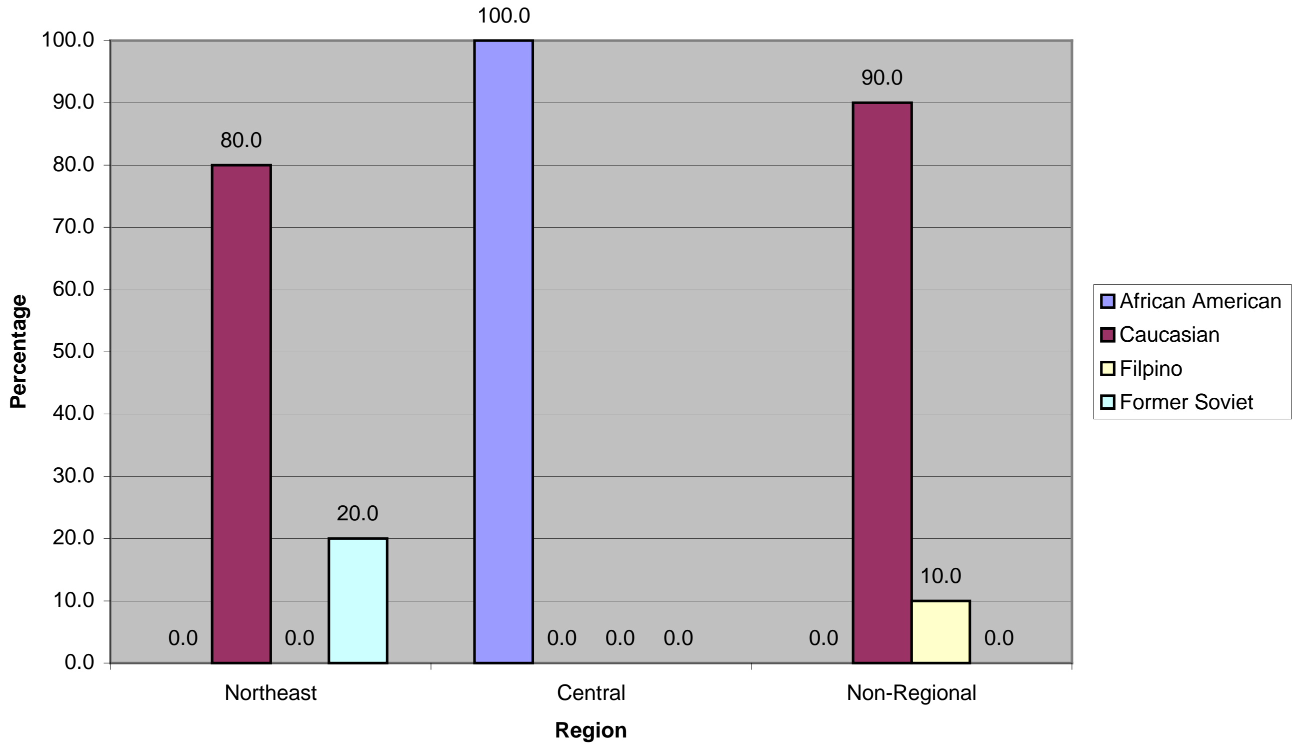


Figure 71: Ethnicity of Consumer Board Members by Region
Percentage
Region
Northeast
Central
Non-Regional
African American
Caucasian
Filpino
Former Soviet
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

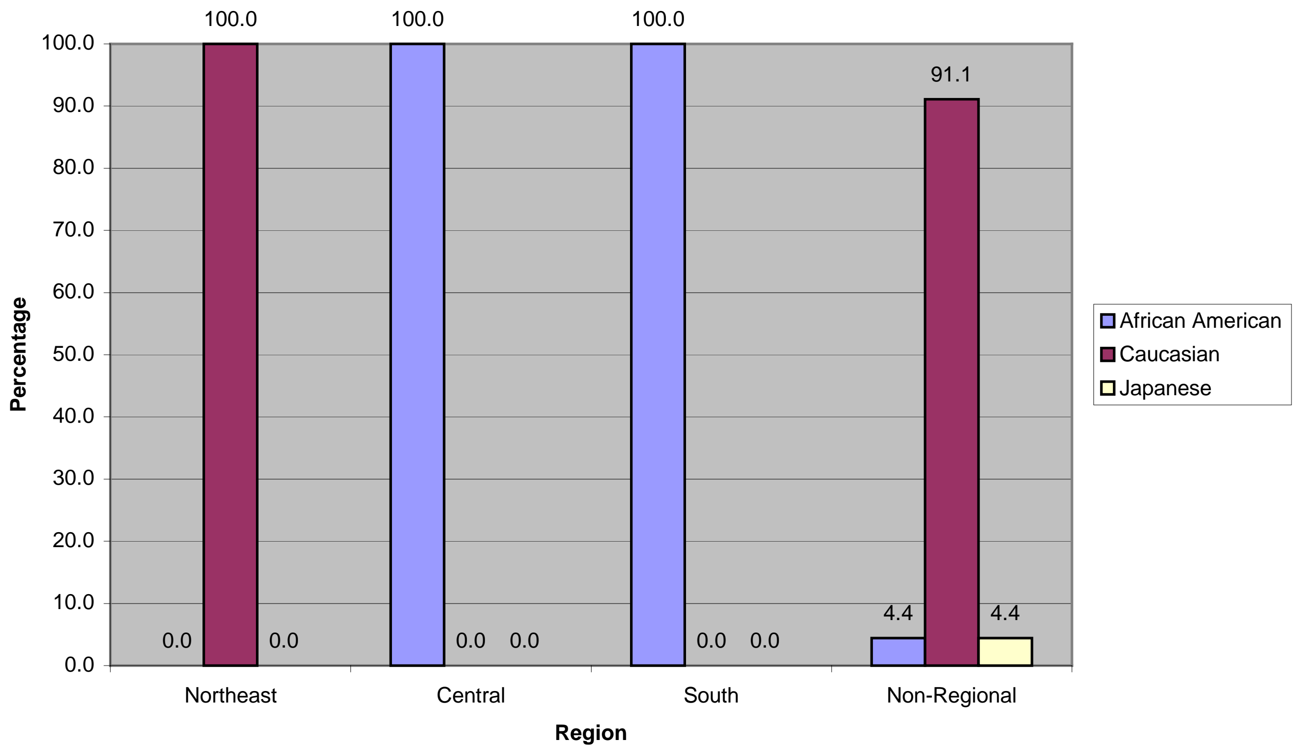


Figure 72: Ethnicity of Consumer Administration/Management Staff by Region
Percentage
Region
Northeast
Central
South
Non-Regional
African American
Caucasian
Japanese
91.1
4.4

Figure 73: Ethnicity of Consumer Staff Providing Direct Services by Region

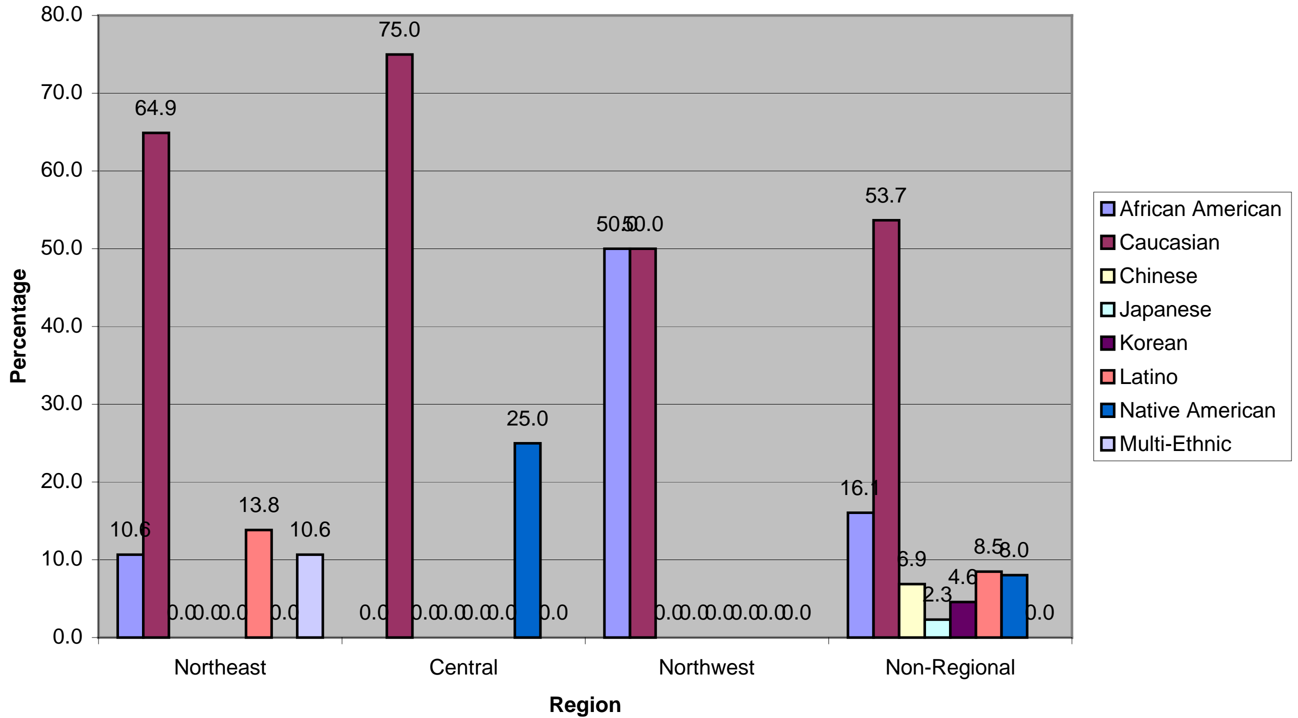
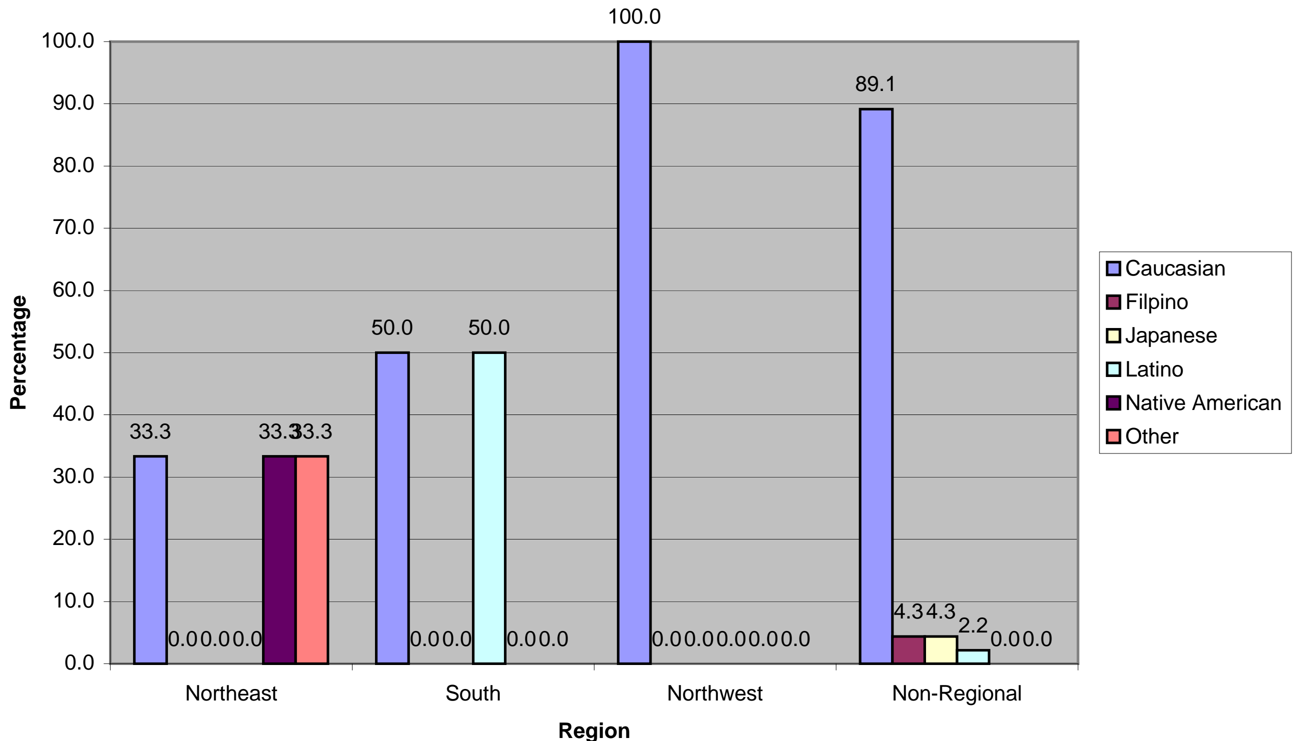


Figure 74: Ethnicity of Consumer Clerical Staff by Region



Standards

STANDARDS

I. ACCESS

Standard:

MHPs shall demonstrate evidence of medically necessary culturally and linguistically accessible services under the consolidation of Medi-Cal specialty mental health services.

A. Language Accessibility

1. MHPs have a 24-hour phone line with statewide toll-free access that has linguistic capability for all Medi-Cal beneficiaries beginning on the plan implementation date.
Measure:

1a. Evidence of operation of a 24-hour phone line with statewide toll-free access that has language capabilities for all Medi-Cal beneficiaries.

Sacramento County MHP has a 24-hour statewide toll-free access line with linguistic capability for all Medi-Cal beneficiaries when Phase II Consolidation was implemented on June 1, 1998. The toll-free telephone number is (888)881-4881.

2. MHPs have identified populations meeting the threshold language requirement of 3,000 beneficiaries, or five (5) percent, of the Medi-Cal beneficiary population, whichever is lower whose primary language is other than English, prior to the plan implementation date. (Note: DMH has provided to MHPs data on primary language obtained from 1990 Decennial Census.)

The identified threshold languages for the MHP's service area are as follows:

- Cantonese
- Hmong
- Lao
- Mien
- Russian
- Spanish
- Vietnamese

3. MHP's policies and procedures for meeting consumer language needs beginning on the implementation date.

3a. Documented evidence of policies and procedures for meeting consumers language needs.

All county and contract provider agencies should use available bilingual staff for interpretation as needed. The MHP provides a streamlined access process for all individuals. The Adult and Child Access Teams (mandated key points of contact) provide a single point of authorization for entry into the MHP service system. Appendix D contains the documented evidence of policies and procedures for meeting consumer language needs at mandated key points of service on the implementation date, June 1, 1998.

For both mandated and non-mandated key points of contact, every effort is made to comply with the *WICHE* standards as outlined in the October 1997 draft. This includes, but is not limited to, the prohibition against using family members, especially children, as interpreters except in the rare instance in which an emergency necessitates such usage or in instances in which very few people speak the language; and the caution against use of tertiary telephonic interpreters unless other sources for interpreters are unavailable.

The policy and procedure for the use of interpreters in non-mandated points of service is in Appendix D. These policies were in place on the MHP implementation date of June 1, 1998.

Two Assisted Access Programs are available to assist the consumer with language and other culturally specific needs when beneficiaries contact county and contract providers at mandated and non-mandated points of service. Southeast Asian Assistance Center (SAAC)and Asian Pacific Counseling Center (APCC) employ bilingual/bicultural staff available in the following languages: Japanese, Korean, Tagalog, Visayan, Ilocano, Capampangan, Mandarin, Cantonese, Tongan, Samoan and Fiji, Vietnamese, Hmong, Lao, Mien, Cambodian, Mandarin and Cantonese, Russian and Ukranian. The Assisted Access Programs are specialized programs and are not regionally based. They are available to provide services in any county or contract mental health provider agency in Sacramento County.

The policies and procedures for meeting the consumer language needs for all specially mental health services except the access teams is contained in Appendix D. The policies were implemented on June 1, 1998.

Two regional community programs, El Hogar and Northgate Point, have culturally specific treatment components within the agency. These treatment components have experience providing culturally competent specialty mental health services to Medi-Cal beneficiaries with specific cultural and linguistic needs. They are available for beneficiaries who need their services regardless of the region in which the beneficiary lives.

El Hogar has a long history of providing bilingual/bicultural culturally competent mental health services. They can provide services for adults and children as needed.

Northgate Point sub-contracts with SAAC and APCC to provide bilingual/bicultural, culturally competent services. They provide services for adult beneficiaries.

3b. Documented evidence of training on the use of bilingual staff or interpreters, including the core curriculum and training programs and how bilingual staff and interpreters will be utilized.

Training on the use of bilingual staff and interpreters is integral to the successful delivery of culturally competent services. Training will be provided in a series designed to focus on the specific training needs of the MHP's providers and services. All training will be based on the aforementioned *WICHE* document, *Communication Styles and Cross-cultural Communication Support Standards, Chapter.*

The MHP's goal is that all interpreters working with consumers shall be trained in formal interpreter techniques and all clinical staff shall be trained in the use of interpreters. The book edited by Evelyn Lee, *Working with Asian Americans*, Chapter 32, *Cross-Cultural Communication: Therapeutic Use of Interpreters* has been invaluable in planning training.

The first training in the series will occur in July 1997. The training will be for staff of the Access Teams and will include the following:

- Overview of Interpreting Formats
- Strategies for Overcoming the Technical Difficulties in Interpretation –

Use short, simple statements; speak clearly and slowly; avoid using a raised voice; be alert to translation error; use words or examples the patient and interpreter are familiar with; try to regulate the flow of the conversation; and encourage the interpreter to tell them when he /she is having difficulty

- Recognition of the lack of translatable words or concepts; lack of familiarity with professional terminology; and inability to interpret the cultural meaning of some symptoms and behaviors

- How to Overcome the Language Barriers: Effective Communication with Non-English Speaking Patients

- Emergency Measures: Use of Emergency Phrase Sheets for English Speakers (Tips on how to get a name and telephone number in an emergency situations)

- Language Identification - How to identify what language a caller is speaking

- Effective Use of AT&T Operators

The trainers for this session will consist of representative from APCC, SAAC, EI Hogar and county bilingual staff.

Several training sessions will be held for interpreters and the staff requiring their assistance. In addition to the curriculum outlined above, additional training topics will include:

- Issues Related To Interpreting
- Film on Translating
- Overview of Interpretation Models

- Language Assessment and Interpreter Assignment
- Content of the Pre-interview Meeting with the Interpreter
- Role Expectations
- Common Problems in Interpretation
- Role Conflicts
- Issue and Problems in Clinical Assessment

Guest trainers and county and contract provider staff will conduct this training.

See Appendix E for general policies and procedures.

4. MHPs have at least interpreters available for the threshold languages at mandated key points of contact beginning on the plan implementation date.

4a. Evidence of at least interpreters for the threshold languages at mandated key points of contact.

On the MHP implementation date of June 1, 1998, interpreters were available for the threshold languages at mandated key points of contact as outlined in Section 3 above.

4b. Documented evidence of ethnic consumer access to staff or interpreters who are linguistically proficient in threshold languages at mandated key points of contact.

Currently, at mandated key points of contact, MHP providers utilize individualized testing procedures to determine the linguistic proficiency of bilingual staff interpreters. All contacts are documented in the consumer's charts.

The MHP Cultural Competence Committee will develop a standard proficiency exam to be used across the system of care. Providers that choose not to use the standard exam can submit an alternate exam to the Committee for approval.

4c. Evidence of, or plans for, providing contract or agency staff who are linguistically proficient in threshold languages during regular day operating hours at mandated key points of contact.

The standardized proficiency exam will be available for distribution by April 1999. Contract or agency staff that are linguistically proficient in threshold languages are available during regular day operation (8 AM – 5 PM) at the mandated key points of contact.

4d. Document what services are available for ethnic Medi-Cal beneficiaries in their primary language, and record the response to the offer of interpreter.

Every attempt will be made for all specialty mental health services to be available in both threshold or non-threshold languages as much as possible. This includes services at non-mandated key points of contact and ongoing service points.

Two Assisted Access Programs are available to assist, link and provide interpreter services for all beneficiaries, child, adults and families, regardless of whether they meet the threshold language criteria. These two programs have staff who speak the following languages: Japanese, Korean, Tagalog, Visayan, Ilocano, Capampangan, Mandarin, Cantonese, Tongan, Samoan, Fijian, Vietnamese, Hmong, Lao, Mien, Cambodian, Russian and Ukranian.

Two regional support programs, El Hogar and Northgate Point have culturally specific treatment components (Latino and Asian/Southeast Asian respectively). They are available for beneficiaries with specific cultural and linguistic needs regardless of the region in which they live.

Both county and contract child and adult agencies submit the names of bilingual/

bicultural staff by language. A master list is kept of staff, language and work site. When beneficiaries who speak languages other than those spoken at the Assisted Access Programs, El Hogar or Northgate Point, every attempt is made to match the beneficiary with staff on the master list.

When necessary, if no other interpreter is available as outlined above, AT&T can be utilized.

Staff will document in the beneficiary's chart what service are available for ethnic Medi-Cal beneficiaries and shall record their response to the offer of an interpreter. Staff will conduct follow up to their offer and document the results in the chart. A log shall also be kept to record the utilization rate of consumer access to linguistically proficient staff.

5. MHPs have policies and procedures and the capability to refer and otherwise link Medi-Cal beneficiaries who do not met the threshold language criteria who encounter the mental health system at a <u>mandated</u> key point of contact, with appropriate services.

5a. Documented evidence that Medi-Cal beneficiaries who do not meet the threshold language criteria are assisted to secure or linked to appropriate services.

The system for referral and linkage of Medi-Cal beneficiaries who do not meet the threshold language criteria at a mandated key point of contact were implemented June 1, 1998. The process for linking beneficiaries in this category are the same as the process for linking beneficiaries who do not meet threshold language criteria. The linking process is described in Appendix F and Section 3 above.

Two Assisted Access Programs are available to assist and link beneficiaries who do not meet threshold language criteria with services in their primary language at mandated points of service. Southeast Asian Assistance Center (SAAC) and Asian

Pacific Counseling Center (APCC) employ bilingual/bicultural staff available in the following languages: Japanese, Korean, Tagalog, Visayan, Ilocano, Capampangan, Mandarin, Cantonese, Tongan, Samoan, Fijian, Vietnamese, Hmong, Lao, Mien, Cambodian, Russian and Ukranian. The Assisted Access Programs are specialized programs and are not regionally based. They are available to provide services in any county or contract mental health provider agency in Sacramento County.

Two regional support programs, El Hogar and Northgate Point, have culturally specific treatment components within the agency and are available to link beneficiaries to services. These treatment components have experience providing culturally competent specialty mental health services to Medi-Cal beneficiaries with specific cultural and linguistic needs. They are available for beneficiaries who need their services regardless of the region in which the beneficiary lives.

El Hogar has a long history of providing bilingual/bicultural culturally competent mental health services. They can provide services for adults and children as needed.

Northgate Point sub-contracts with SAAC and APCC to provide bilingual/bicultural culturally competent services. They provide services for adult beneficiaries.

The progressive steps used with the beneficiaries' permission to link them are as follows:

1. Use on-site bilingual staff to link beneficiaries;
2. Use appropriate bilingual staff from the Assisted Access Programs as described above or from the two regional programs as above;
3. Use staff available on master list of county and contract staff proficient in the appropriate language;
4. Use AT&T language line for non-threshold languages;

5. Contact other outside sources with appropriate bilingual staff.

5b. Document the progressive steps to assist ethnic Medi-Cal beneficiaries to obtain services in their primary language, i.e., if linguistically proficient staff or interpreters are unavailable.

All progressive steps to assist ethnic Medi-Cal beneficiaries when interpreters are unavailable will be documented. Beneficiaries will be offered the flexibility of using their own interpreters. Staff will also advise consumers that they can assist the consumer in accessing outside interpreters if that is their preference. A list of outside interpreters, agencies and/or programs that provide interpreters is available at all county and contract service sites. Their response will be recorded in the chart.

6. MHPs have policies and procedures and the capability to link Medi-Cal beneficiaries who encounter the mental health system at a non-mandated key point of contact, with appropriate services, beginning on the plan implementation date.

The MHP has the policies and procedures and the capacity to link Medi-Cal beneficiaries at a non-mandated key point of contact with appropriate services on June 1, 1998. The process is outlined in Appendix G.

The policy and procedure for linking beneficiaries with services in their primary language at non-mandated points of contact is the same as outlined in 5a for mandated points of contact. That includes use of the two Assisted Access Programs and other region programs that have linguistically proficient staff.

The progressive steps to be used to assist ethnic beneficiaries to obtain services in their language if linguistically proficient staff or interpreters are not available include:

1. Use appropriate bilingual staff from the Assisted Access Programs or the regional programs as described below;

2. Use staff available on master list of county and contract staff proficient in the appropriate language;

3. Use of AT&T Language Line;

4. Use of other outside sources that have linguistically proficient staff;

The use of children or family members is discouraged and should be considered only if the other alternatives are exhausted.

6a. Documented evidence that Medi-Cal beneficiaries (both who meet or do not meet the threshold language criteria) are assisted to secure or linked to appropriate services.

A list of Assisted Access Programs and/or providers with language capacity is maintained for beneficiaries who meet or do not meet threshold language criteria to assist them in securing appropriate services.

6b. Document the progressive steps to assist ethnic Medi-Cal beneficiaries to obtain services in their primary language, i.e., if linguistically proficient staff or interpreters are unavailable.

All progressive steps to assist ethnic Medi-Cal beneficiaries when interpreters are unavailable will be documented. Beneficiaries will be offered the flexibility of using their own interpreters. Staff will also advise consumers that they can assist the consumer in accessing outside interpreters if that is their preference. A list of outside interpreters, agencies and/or programs that provide interpreters is available at all county contract services. Their response will be recorded in the chart.

B. Written Materials Should be Available and Understandable Indicators

B1. MHPs have available culturally and linguistically appropriate written information for identified threshold languages that assist Medi-Cal beneficiaries in accessing medically necessary specialty mental health services beginning on the plan implementation date.

Measure:

B1a. Demonstrate the availability in threshold languages of general program literature used by the MHP to assist Medi-Cal beneficiaries access medically necessary specialty mental health services. The literature shall be at the appropriate literally level to reflect the population to be served. General program literature includes member service handbook or brochure, general correspondence, beneficiary problem resolution and fair hearing materials, beneficiary satisfaction surveys, orientation and community and health education materials.

Culturally and linguistically appropriate general program literature used by the MHP including member service handbook, general correspondence, beneficiary problem resolution and fair hearing materials, beneficiary satisfaction surveys, orientation and community and health education material is available at the appropriate literally level in the threshold languages.

B3. MHPs have policies and procedure for the utilization and distribution of Translated materials that assure availability to Medi-Cal beneficiaries beginning on the plan implementation date.

Measure:

B3a. Evidence of policies of and procedures to appropriately distribute and utilize translated materials.

The diversity of Sacramento County's population dictates that culturally and linguistically appropriate information is available for beneficiaries. Seven threshold languages have been identified in the County. Written materials are currently available in English, Spanish, Vietnamese, and Russian. Materials in Hmong, (it is anticipated that audio tapes will be made in Hmong to provide the information now available in writing) Chinese Mien, and Lao are in various stages of the translation process.

Written materials include: The guide, and ACCESS' satisfaction survey. The State Department of Mental Health will provide the *Notice of Action* I in all languages.

The Sacramento County Quality Management staff is responsible for the distribution and utilization of translated documents. The state MEDS file data are used to determine by region what ethnic groups constitute the 5% threshold for mandated distribution of materials. Quality management distributes culturally and linguistically appropriate materials to all providers in regions who meet the threshold requirements. Additionally, providers with less than the 5% threshold level will receive culturally and linguistically appropriate material upon request.

Quality Management staff will review MEDS data annually to determine changes in population. They maintain logs containing the annual data and the number of items distributed to each site on an on-going basis. The Policy and Procedures regarding forms and brochure distribution as well as a copy of the distribution log are located in Appendix H.

C. Responsiveness of Specialty Mental Health Services

C3. MHPs have policies, procedures and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services beginning on the plan implementation date.

The MHP had policies, procedures and practices in place on June 1, 1998 to inform all Med-Cal beneficiaries of available services. Written materials are available for consumers concerning available services at all sites.

Measures:

C3a. Evidence of a community information and education plans that enable Medi-Cal beneficiaries to access specialty mental health services.

C3b. Evidence of informing ethnic consumers regarding the availability of cultural and linguistic services and programs e.g., number of community presentations and/or forms used to disseminate information about specialty mental health services, etc.

The MHP has policies, procedures and practices to inform all Medi-Cal beneficiaries of available services. See Appendix I.

II. QUALITY OF CARE

A. Consumer and Family Role in Service Development

Indicator:

1. MHPs have policies, procedures and practices that ensure that all consumers participate in the development of their medically necessary specialty mental health treatment services, beginning on the plan implementation date. Parents, family members and other advocates can be included in this process as selected by the adult consumer.

Measures:

1a. Evidence of policies, procedures and practices that assure the involvement of consumers and families in mental health treatment services.

1b. Clinical records will indicate consumers and/or family involvement by ethnicity and primary language.

The MHP has policies, procedures and practices that assure the involvement of consumers and families in mental health treatment services. The clinical records will indicate the consumer and/or family involvement by ethnicity and primary language.

Consumers are encouraged to take active roles in the development of treatment plans. Inclusion of culturally appropriate non-traditional methods will include in treatment planning as requested and other consumers and consumer groups are encouraged to participate in treatment.

Culturally appropriate community based support systems will be used or discharged planning as appropriate. See Appendix J.

Appendix A

Ethnicity of General Population by Region: Percentages for Figure 5

	Caucasian	African American	Latino	Hmong	Vietnamese	Chinese	Lao	Indian	Japanese	Korean	Native American	Cambodian	Thai	Filipino	Other
Northeast	81.7	4.2	6.8	0.1	0.3	0.9	0.1	0.3	0.7	0.5	0.9	0.0	0.1	0.8	2.4
Central	59.5	9.9	12.4	0.5	1.0	3.7	1.2	0.4	1.5	0.5	1.3	0.0	0.0	1.0	7.0
South	54.7	11.7	12.2	0.8	1.6	4.1	0.9	0.6	1.9	0.2	1.0	0.1	0.0	2.5	7.6
Northwest	70.7	8.6	9.6	0.5	0.4	0.6	0.7	0.4	0.5	0.2	1.3	0.0	0.1	1.3	4.9

Languages Spoken by the General Population by Region: Precentages for Figure 6

	English	Spanish	Russian	Vietnamese	Chinese	Japanese	Korean	Tagalog	Other
Northeast	88.5	5.6	0.1	0.2	0.5	0.3	0.4	0.4	3.9
Central	76.7	11.5	0.2	0.9	3.6	0.7	0.4	0.5	5.4
South	74.9	11.8	0.2	1.5	3.7	0.7	0.2	1.4	5.5
Northwest	87.0	6.4	0.1	0.4	0.4	0.3	0.2	0.8	4.4

Ethnicity of Medi-Cal Eligible Beneficiaries by Region: Percentages for Figure 13

	Caucasian	African American	Latino	Vietnamese	Chinese	Lao	Indian	Japanese	Korean	Native American	Cambodian	Filipino	Other
Northeast	66.1	13.2	8.9	1.4	0.3	1.8	0.2	0.0	0.2	0.6	0.5	0.6	0.6
Central	33.5	24.2	17.2	2.4	2.4	5.5	0.2	0.1	0.1	0.7	0.7	0.7	1.6
South	26.1	22.2	17.1	6.8	3.4	9.4	0.4	0.1	0.1	0.5	1.2	0.5	2.3
Northwest	53.7	17.8	11.4	1.1	0.1	7.1	0.2	0.0	0.0	0.7	0.6	0.7	1.2

Languages Spoken by Medi-Cal Eligible Beneficiaries by Region: Percentages for Figure 14

	English	Spanish	Hmong	Russian	Vietnamese	Cantonese	Mien	Lao	Japanese	Korean	Cambodian	Thai	Tagalog	Sign	Other
Northeast	68.7	4.4	1.6	7.0	1.5	0.3	0.1	1.0	0.0	0.1	0.1	0.0	0.2	0.0	14.9
Central	55.7	7.7	3.8	1.8	2.7	2.8	2.3	1.3	0.0	0.1	0.1	0.0	0.1	0.0	21.5
South	55.0	8.4	7.5	2.0	6.8	3.8	2.3	1.4	0.0	0.1	0.4	0.0	0.4	0.0	12.0
Northwest	68.8	4.9	5.0	6.1	1.2	0.1	0.6	1.9	0.0	0.0	0.0	0.0	0.2	0.0	11.1

Utilization of All Services by Ethnicity by Region: Percentages for Figure 29

	Caucasian	African American	Latino	Vietnamese	Chinese	Lao	Japanese	Korean	Native American	Cambodian	Filipino	Other	Total
Northeast	70.2	10.7	1.8	0.4	0.0	0.2	0.0	0.0	0.2	0.2	0.0	16.3	22.3
Central	54.2	17.5	1.1	0.3	0.1	0.5	0.1	0.0	0.1	0.2	0.0	25.7	29.5
South	31.8	18.2	3.5	2.4	0.8	1.4	0.0	0.0	0.1	0.4	0.1	41.3	28.8
Northwest	55.2	18.1	2.5	0.2	0.0	1.9	0.0	0.0	0.3	0.4	0.0	21.3	19.5

Utilization of All Services by Primary Language by Region: Percentages for Figure 30

	English	Spanish	Hmong	Russian	Vietnamese	Cantonese	Mien	Lao	Japanese	Korean	Cambodian	Tagalog	Sign	Other
Northeast	56.0	0.6	0.2	0.9	1.1	0.2	0.0	0.7	0.0	0.0	0.0	0.1	0.1	40.0
Central	41.5	0.8	0.4	0.1	1.2	0.6	2.2	0.7	0.0	0.1	0.1	0.0	0.0	52.4
South	41.6	2.5	1.8	0.2	8.8	4.3	4.5	2.2	0.0	0.1	0.3	0.1	0.0	33.6
Northwest	63.1	1.0	1.4	0.7	1.2	0.0	1.3	3.1	0.0	0.0	0.0	0.0	0.1	27.9

Ethnicity of Staff by Function: Percentages for Figure 34

	Caucasian	African American	Latino	Hmong	Russian	Viet	Chinese	Mien	Lao	Indian	Japanese	Korean	Native American	Cambodian	Filipino	Multi-Ethnic	Other
Board	72.6	7.5	3.8	0.5	0.5	0.9	7.5	0.0	0.0	0.5	2.4	0.9	0.5	0.0	1.9	0.0	0.5
Admin	80.6	7.4	5.3	0.0	0.0	0.0	0.4	0.0	0.0	0.8	2.4	0.0	0.0	0.0	0.4	0.8	1.9
Direct Service	67.0	16.2	7.0	0.6	0.3	0.7	1.5	0.1	0.0	0.1	1.2	0.4	1.6	0.4	1.4	0.2	1.1
Clerical	58.5	17.3	13.6	0.5	0.0	0.3	1.5	0.0	0.1	1.0	1.0	0.0	0.7	0.9	1.7	0.5	2.4
Interpreters	23.9	0.0	16.5	3.9	7.7	13.6	10.4	8.7	5.5	0.0	0.0	0.0	0.0	3.5	1.6	0.0	4.7
Translators	0.0	0.0	57.3	0.0	0.0	0.0	28.1	0.0	7.3	0.0	0.0	0.0	0.0	0.0	7.3	0.0	0.0
Other	53.2	22.4	9.6	0.7	0.3	0.1	1.2	0.1	0.0	4.5	1.4	0.0	0.3	0.1	5.4	0.3	0.3

Languages Spoken by Bilingual Staff by Function: Percentages for Figure 36

	Spanish	Hmong	Russian	Vietnamese	Cantonese	Mien	Lao	Japanese	Korean	Mandarin	Cambodian	Thai	Samoan	Tagalog	Tongan	Sign	Other
Board	33.7	2.0	0.0	11.2	14.3	0.0	2.0	12.3	6.1	7.7	0.0	0.0	0.0	9.2	0.0	0.0	1.5
Admin	54.9	0.0	0.0	2.2	1.5	0.0	0.6	6.2	0.0	1.5	0.0	0.0	0.0	6.2	0.0	8.2	18.6
Direct Service	49.4	2.0	4.0	2.0	3.4	0.7	1.3	2.3	1.9	2.1	0.7	0.5	0.0	5.5	0.6	5.9	17.7
Clerical	63.0	1.8	0.0	0.0	5.4	0.0	2.5	8.1	0.0	0.0	2.7	0.0	0.0	6.7	0.0	0.0	9.8
Interpreters	6.2	4.1	6.3	60.9	0.8	8.6	6.2	0.0	0.0	0.8	1.6	0.0	0.0	0.0	0.0	0.0	4.5
Translators	8.3	16.7	8.3	0.0	20.8	12.5	12.5	0.0	0.0	0.0	20.8	0.0	0.0	0.0	0.0	0.0	0.0
Other	27.3	9.4	3.7	0.0	3.7	1.9	0.0	0.0	3.7	0.0	1.9	0.0	3.7	5.6	0.0	3.7	35.2

Language Staff Reads/Writes by Function: Percentages for Figure 38

	Spanish	Hmong	Russian	Vietnamese	Cantonese	Mien	Lao	Japanese	Korean	Mandarin	Cambodian	Thai	Samoan	Tagalog	Tongan	Other
Board	29.7	2.0	0.0	10.9	13.9	0.0	2.0	11.9	5.9	7.4	0.0	0.0	0.0	11.9	0.0	4.5
Admin	61.7	0.0	0.0	2.2	1.6	0.0	0.6	6.2	0.0	1.6	0.0	0.0	0.0	6.2	0.0	19.9
Direct Services	52.6	2.5	4.5	2.3	3.2	0.5	1.1	3.9	1.5	2.0	0.8	0.7	0.0	5.7	0.7	18.0
Clerical	62.9	2.2	0.0	0.0	6.7	0.0	3.1	3.4	0.0	0.0	0.0	0.0	0.0	8.4	0.0	13.4
Interpreters	13.6	9.0	14.0	13.6	1.8	19.0	13.6	0.0	0.0	1.8	3.6	0.0	0.0	0.0	0.0	10.0
Translators	8.3	16.7	8.3	0.0	20.8	12.5	12.5	0.0	0.0	0.0	20.8	0.0	0.0	0.0	0.0	0.0
Other	28.9	9.9	4.0	0.0	4.0	2.0	0.0	0.0	4.0	0.0	2.0	0.0	4.0	5.9	0.0	35.6

Ethnicity of Board Members by Region: Percentages for Figure 41

	Northeast	Central	South	Northwest	Non-Regional
African American	5.0	20.0	50.0	38.5	4.1
Caucasian	80.0	40.0		46.2	76.5
Chinese	10.0			7.7	7.6
Filipino			25.0		1.8
Hmong	5.0				0.6
Indian					0.6
Japanese			25.0		2.4
Korean					1.2
Latino		40.0		7.7	2.9
Native American					0.6
Vietnamese					1.2
Other					0.6

Ethnicity of Administration/Management by Region:

	Northeast	Central	South	Northwest	Non-Regional
African American		25	28.6	16.3	6.2
Caucasian	78.4	25	71.4	74.5	83.1
Chinese					0.4
Filipino					0.4
Indian	1.5				0.9
Japanese	8.5			3.5	2.2
Lao					<.1
Latino	2.1	50		5.7	4
Vietnamese					<.1
Multi-Ethnic	8.5				0.4
Other	1				2.1

Ethnicity of Direct Service Staff by Region: Percentages for Figure 43

	Northeast	Central	South	Northwest	Non-Regional
African American	11.3	9.5	14.1	22.1	16.5
Cambodian				3.8	0.4
Caucasian	71.9	57.1	49.5	51.5	67.9
Chinese			8.1	7.5	1.2
Filipino	2.2	4.8	4	0.9	1.3
Former Soviet					0.4
Hmong	2.2				0.6
Indian	2.2				0.1
Japanese				6.6	1.1
Korean		4.8	1		0.3
Lao	2.9				<.1
Latino		21.4	10.1	7.5	6.7
Mien			3		<.1
Native American		2.4			1.8
Vietnamese	1.1		9.1		0.5
Multi-Ethnic	2.4				0.1
Other	3.8		1		1.1

Ethnicity of Clerical Support by Region: Percentages for Figure 44

	Northeast	Central	South	Northwest	Non-Regional
African American	9.1	10	40.3	30.8	15.6
Cambodian		20	7.3		
Caucasian	45.7	20	20.2	41	64.4
Chinese			8.1		1.2
Filipino	9.1				1.5
Hmong			8.1		
Indian				10.3	0.6
Japanese					1.2
Lao				2.6	
Latino	8.7	50	16.1	15.4	12.5
Native American	9.1				0.3
Vietnamese					0.5
Multi-Ethnic					0.6
Other	18.3				1.8

Ethnicity of “Other” Staff by Region: Percentages for Figure 47

	South	Northwest	Non-Regional
African American			22.5
Cambodian			0.1
Caucasian		100	53.2
Chinese			1.2
Filipino			5.4
Former Soviet			0.3
Hmong	100		0.4
Indian			4.6
Japanese			1.4
Latino			9.7
Mien			0.1
Native American			0.3
Vietnamese			0.1
Multi-Ethnic			0.3
Other			0.3

Billingual Language Capability of Direct Services Staff by Region: Percentages for Figure 50

	Northeast	Central	South	Northwest	Non-Regional
American Sign	3.2	0.0	9.7	0.0	7.3
Cambodian	0.0	0.0	0.0	13.8	0.2
Cantonese	0.0	0.0	2.9	27.5	2.9
Hmong	5.3	0.0	0.0	0.0	2.3
Japanese	0.0	0.0	0.0	0.0	3.1
Korean	0.0	4.3	3.8	0.0	1.5
Lao	5.3	0.0	0.0	0.0	1.5
Mandarin	0.0	0.0	0.0	13.8	2.0
Mien	5.3	0.0	0.0	0.0	0.6
Russian	0.0	0.0	0.0	0.0	5.4
Spanish	4.5	87.0	57.5	27.5	46.1
Tagalog	7.1	4.3	22.1	3.6	4.9
Thai	5.3	0.0	0.0	0.0	0.4
Tongan	0.0	0.0	0.0	0.0	0.8
Vietnamese	6.6	0.0	0.0	0.0	2.3
Other	57.5	4.3	3.8	13.8	18.7

Languages Direct Service Staff Reads/Writes by Region: Percentages for Figure 57

Cambodian	0.0	0.0	0.0	13.8	0.3
Cantonese	0.0	0.0	3.3	27.5	2.3
Hmong	13.7	0.0	0.0	0.0	2.9
Japanese	0.0	0.0	0.0	0.0	5.2
Korean	0.0	0.0	4.2	0.0	1.7
Lao	13.7	0.0	0.0	0.0	1.1
Mandarin	0.0	0.0	0.0	13.8	1.8
Mien	0.0	0.0	0.0	0.0	0.7
Russian	0.0	0.0	0.0	0.0	6.0
Spanish	1.1	95.2	63.7	27.5	47.4
Tagalog	15.4	0.0	24.5	3.6	5.6
Thai	13.7	0.0	0.0	0.0	0.4
Tongan	0.0	0.0	0.0	0.0	0.9
Vietnamese	13.7	0.0	0.0	0.0	2.6
Other	28.6	4.8	4.2	13.8	21.0

Ethnicity of Consumer Staff by Function: Percentages for Figure 70

	Caucasian	African American	Latino	Russian	Chinese	Asian	Native American	Filipino	Other
Board of Directors	81.3	6.3	0.0	6.3	0.0	0.0	0.0	6.3	0.0
Administration/Management	82.1	14.3	0.0	0.0	0.0	3.6	0.0	0.0	0.0
Direct Services	53.3	15.0	8.3	0.0	5.0	5.0	6.7	5.0	1.7
Clerical	82.8	0.0	3.4	0.0	0.0	3.4	3.4	3.4	3.4
Other	59.3	22.2	3.7	0.0	0.0	7.4	3.7	3.7	0.0

Appendix B

SACRAMENTO COUNTY
Mental Health Plan

INSTRUCTIONS FOR COMPLETION OF SACRAMENTO COUNTY CULTURAL COMPETENCY SURVEY

As a required component of the Implementation Plan for Phase II Consolidation, the County is responsible for submitting a plan for culturally competent specialty mental health services. In order to complete this task, we need information from you regarding your staff, including contracted employees. The survey should be completed with current information according to the instructions below and sent to: Tracy Herbert, Division of Mental Health, DHHS, 7220 24th St., Sacramento, CA 95822. Questions should be directed to Jo Ann Johnson at (916) 875-3861 or Tracy Herbert at (916) 875-0831.

PAGE ONE

1. *First, indicate the total number of unduplicated full-time equivalent (FTE) staff falling into each category (e.g., administration/management, direct services etc.). Place this value in the column labeled "Total."*

   The first instruction asks you to indicate the number of unduplicated full-time staff equivalents in each category for each ethnicity. Please include contracted employees. For example, if there is an African American who is a full-time administrator, a 1.0 would be entered beside "Total" under African American Administration/Management. If a person fills more than one type of position, please "split" the FTEs to indicate their multiple functions. For example, if one full-time staff member spends half their time in direct services and half their time interpreting for clients, split the FTE into .5 for "direct services" and .5 for "interpreters." Likewise, if a half-time staff member spent their time the same way, you would split the FTE into .25 for "direct services" and .25 for "interpreters." An <u>EXACT</u> split is not necessary as long as a person's multiple functions are represented. So if some weeks the split is 60/40 and others it is 70/30, pick an "average."

   * For the "board member" and "other" category, treat each individual as 1.0 FTE.
   ** For purposes of this document, "interpreter" relates to a person who conveys language orally, while "translators" are those who use written language.
   *** For purposes of this document, "other" includes volunteers, student interns, and on-call staff members.

2. *Second, please indicate the number of FTE staff who have voluntarily self-identified as consumers of specialty mental health services. Place this value in the column labeled "Self-ID."*

Split FTEs in the same way as in Item 1. For example if there is a Korean who provides direct services on a full-time basis, and is also a self-identified consumer, a 1.0 would be entered beside "Total" AND "Self-ID" under Korean Direct Services. **BE ADVISED THAT RESPONSES ARE PURELY VOLUNTARY. THEREFORE, PLEASE ONLY INCLUDE THOSE STAFF WHO HAVE PUBLICLY DECLARED THEMSELVES CONSUMERS.**

Page Two

3. *Indicate the number of unduplicated FTE staff in each category who are proficient in speaking (Sp), reading (Rd), or writing (Wr) these languages.*

To complete this question, consider the language capability of each staff and split the FTE accordingly. For example if there is a person who provides direct services on a full-time basis, and is able to speak English, Hmong, and Mien, split the FTE three ways (i.e., .33 under each language) under direct service. You should do this three times -- once for languages spoken, once for languages read, and once for written language. Therefore, if the person who can speak English, Hmong, and Mien can also read and write in these languages, .33 would be placed on each of the three lines (speak, read and write) for each of the three languages.

4. *Please specify the method used to determine proficiency. For example, if a formal test/process is used, describe it in detail and attach a copy if available.*

The method used to determine proficiency may be formal or informal. We are trying to gather information about what agencies do at this point and whether the current process is meeting their needs. Therefore, whatever is done, please describe it (e.g., have a multi-lingual person on an interview panel to determine proficiency).

PAGE THREE

5. *Please list the names of staff who are proficient in languages other than English. Also indicate the languages they are proficient in.*

6. *Indicate the number of unduplicated FTE staff in each category who are men and women.*

Using the same approach as taken in Item 1, enter the total number of unduplicated FTEs in each category of staff (e.g., administration, clerical, etc.) that are filled by men and by women.

7. *Indicate the number of unduplicated FTE staff in each category who self-identify as gay or lesbian.*

Split FTEs in the same way as in Item 6. **BE ADVISED THAT RESPONSES ARE PURELY VOLUNTARY. THEREFORE, PLEASE ONLY INCLUDE THOSE STAFF WHO HAVE PUBLICLY DECLARED THEMSELVES GAY/LESBIAN.**

8. *Indicate the number of unduplicated FTE staff in each category who self-identify as disabled.*

Split FTEs in the same way as in Item 6. **BE ADVISED THAT RESPONSES ARE PURELY VOLUNTARY. THEREFORE, PLEASE ONLY INCLUDE THOSE STAFF WHO HAVE PUBLICLY DECLARED THEMSELVES DISABLED.**

Date: January 8, 1998

To: Directors of Agencies Providing Mental Health Services

From: Jo Ann Johnson, Minority Services Coordinator

Re: The Sacramento County Cultural Competency Survey

As a required component of the Implementation Plan for Phase II consolidation, the County is responsible for submitting a plan for culturally competent specialty mental health services. In order to complete this task, we need information from all agencies regarding the cultural competence of their staff, including contracted employees. To collect the needed information, we have developed the enclosed survey. We have a relatively short time line to develop the plan, so are asking that the completed survey be returned by January 30, 1998.

We will be requesting this information from you on a regular basis. Therefore, if you do not currently have a mechanism for tracking ethnicity, language proficiency, etc. of your staff, now is a good time to implement one. Agencies who pilot tested the survey told us that had they previously been following this information, the survey would have taken much less time.

The survey should be completed with current information according to the instructions enclosed and sent to: Tracy Herbert, Division of Mental Health, DHHS, 3701 Branch Center Road, Sacramento, CA 95827. Questions should be directed to Jo Ann Johnson at (916) 875-3861 or Tracy Herbert at (916)875-0831.

Thanks so much for your help.

SACRAMENTO COUNTY
Mental Health Plan

AGENCY NAME:

AGENCY ZIP CODE: DATE:

CULTURAL COMPETENCY SURVEY

1. First, indicate the total number of unduplicated full-time equivalent (FTE) staff falling into each category (e.g., board of directors, administration/management, etc.) Place this value in the column labeled "TOTAL."
2. Second, please indicate the number of FTE staff who have voluntarily self-identified as consumers of specialty mental health services. Place this value in the column labeled "SELF-ID."

	African American	Cambodian	Caucasian	Chinese	Filipino	Former Soviet	Hmong	Indian	Japanese	Korean	Lao	Latino/ Hispanic	Mien	Native American	Thai	Vietnamese	Multi Ethnic (Please specify)	Other (Please specify)
BOARD OF DIRECTORS																		
Total																		
Self-ID																		
ADMINISTRATION/MANAGEMENT																		
Total																		
Self-ID																		
DIRECT SERVICES																		
Total																		
Self-ID																		
CLERICAL SUPPORT																		
Total																		
Self-ID																		
INTERPRETERS																		
Total																		
Self-ID																		
TRANSLATORS																		
Total																		
Self-ID																		
OTHER																		
Total																		
Self-ID																		

3. Indicate the number of unduplicated FTE staff in each category who are proficient in speaking (Sp), reading (Rd), or writing (Wr) these languages.

	American Sign Language	Cambodian	Cantonese	English	Hmong	Japanese	Korean	Lao	Mandarin	Mien	Romanian	Russian	Samoan	Spanish	Tagalog	Thai	Tongan	Vietnamese	Other (please specify)
BOARD OF DIRECTORS																			
Sp																			
Rd																			
Wr																			
ADMINISTRATION/MANAGEMENT																			
Sp																			
Rd																			
Wr																			
DIRECT SERVICES																			
Sp																			
Rd																			
Wr																			
CLERICAL SUPPORT																			
Sp																			
Rd																			
Wr																			
INTERPRETERS																			
Sp																			
Rd																			
Wr																			
TRANSLATORS																			
Sp																			
Rd																			
Wr																			
OTHER																			
Sp																			
Rd																			
Wr																			

4. Please specify the method used to determine proficiency. For example, if a formal test/process is used, describe it in detail and attach a copy if available.

5. Please list the names of staff who are proficient in languages other than English. Also indicate the languages they are proficient in.

6. Indicate the number of unduplicated FTE staff in each category who are men and women.
7. Indicate the number of unduplicated FTE staff in each category who voluntarily self identify as gay or lesbian.
8. Indicate the number of unduplicated FTE staff in each category who voluntarily self identify as disabled.

BOARD OF DIRECTORS	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
ADMINISTRATION/MANAGEMENT	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
DIRECT SERVICES	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
CLERICAL SUPPORT	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
INTERPRETERS	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
TRANSLATORS	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	
OTHER	
Men	
Women	
Self-ID Gay or Lesbian	
Self-ID Disabled	

APPENDIX C

Sacramento County
Division of Mental Health

Agency Self-Assessment of Cultural Competence

January 1999

Agency Self-Assessment of Cultural Competence

Instructions

This self-assessment instrument provides the opportunity for an educational, information collecting, and planning experience. It will assist your agency in identifying strengths and weaknesses in its response to a culturally diverse staff and consumer population. It will also enable the agency to develop goals for specific management and/or service delivery changes to progress toward the objective of cultural competence.

Please have staff read each item carefully, and circle the response that best describes your agency. In doing so, remember that there is no magic score that identifies an agency as "culturally competent" or "incompetent."

There are 6 sections to the self-assessment. Different groups of staff respond to each section. The table below indicates who is responsible for completing each section. It is the agency's responsibility to ensure the completion of each section by the appropriate group.

	Section I	Section II	Section III	Section IV	Section V	Section VI
Board	***X***	X				
Management Team	X		X	X		
Clerical	X				X	
Service Delivery	X				X	X
Supervisory	X				X	X

In addition to the six sections, please complete the documents checklist below by placing a check mark next to each true statement.

_____ 1. The mission statement specifically indicates that services are available to culturally diverse clients.

_____ 2. The policy and procedures specifically indicates that services are available to culturally diverse clients.

_____ 3. The personnel manual/employee handbook specifically indicates that services are available to culturally diverse clients.

_____ 4. The brochures specifically indicate that services are available to culturally diverse clients.

IV. Section I: Valuing Diversity

V. (all personnel and board)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Agree	Probably Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

_____ 1. The agency acknowledges and protects the right of individuals to their own culture and to the customs, beliefs, and practices that comprise that culture.

_____ 2. The agency affirms that an individual's culture is an integral part of the physical, emotional, intellectual, and overall development and well-being of that individual.

_____ 3. The agency is responsive to issues of cultural diversity, and designs programs and services that reflect the populations it serves.

_____ 4. Cultural factors such as language, race, ethnicity, customs, family structure, sexual orientation, and community dynamics are considered when management and service delivery strategies are developed.

_____ 5. The diversity and rights of the individuals served are respected.

_____ 6. The diversity and rights of those providing services are respected.

VI. Section II: Governance

VII. (board members)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Agree	Probably Disagree	Agree	Strongly Disagree
1	2	3	4	5	6

Mission and Goals

_____ 1. The mission statement and goals recognize the cultural and ethnic diversity of the client populations served and reflect a commitment to serve those groups sensitively and competently.

_____ 2. The board of directors reviews the mission and/or goals to assure that they reflect a commitment to the culturally diverse populations served.

_____ 3. The board of directors requests input from individuals of different cultures and/or ethnic groups in developing the mission statement and goals.

_____ 4. The board of directors delegates the responsibility for developing strategies to best implement and strengthen the goal of cultural competence.

_____ 5. The board of directors or their designee periodically reviews and evaluates the process for achieving cultural competence.

Board of Directors

New Board Members

_____ 1. In selecting new members, the board of directors considers representatives from the cultural and/or ethnic constituencies to reflect the clientele.

_____ 2. The board of directors consults organizations that represent culturally diverse groups in the board recruitment process.

_____ 3. New members of the board of directors receive an orientation to the mission statement and goals, as well as materials that provide a review of statistical data, policy statements, and client service information relative to cultural diversity and the agency.

Ongoing Board Training

_____ 1. All members of the board of directors have the opportunity to participate in special activities that focus on issues of cultural diversity, to learn about issues of cultural diversity and how those issues affect the agency's functioning.

_____2. The board of directors receives regular reports on progress made in the area of cultural competence and on the impact of cultural issues on the agency.

VIII. Section III: Administration

IX. (management team)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Disagree	Probably Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

Management Responsibilities

_____ 1. The management team is responsible for implementing the mission statement and goals relative to cultural diversity.

______ 2. The management team strives to recruit staff from culturally diverse groups to reflect the culturally diverse clientele served.

______ 3. The management team ensures that staff possesses experience and competence in working in culturally diverse communities.

______ 4. The management team strives to hire staff that is proficient in speaking the languages used in the community served.

______ 5. The management team provides opportunities for leadership development and/or advancement for all staff.

______ 6. The management team ensures that staff is proficient in working with interpreters.

______ 7. The management team ensures access to culturally competent interpreters.

X. Section IV: Program and Policy Development

XI. (management team)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Agree	Probably Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

Program Development

_____ 1. The agency is knowledgeable about federal, state, and county statutes and regulations that relate to cultural competency.

_____ 2. Organizations or individuals that represent cultural and ethnic groups in the community are consulted when programs and policies that may have a cultural impact are considered.

_____ 3. Open house-type events are held to which providers, consumers, and others concerned with service delivery are invited.

Agency Policies and Procedures

_____ 1. Mechanisms are established to include all levels of staff, including paraprofessionals, in the decision-making process, to the maximum extent possible.

_____ 2. Policies and procedures reflect respect for the cultural diversity of clients.

_____ 3. As appropriate, staff uses culturally competent consultants who can help them work more effectively within a cultural context.

Staff Recruitment and Retention

_____ 1. Position vacancies are advertised in culturally diverse print and broadcast media as well as through community information networks and organizations representing culturally diverse groups.

_____ 2. Job descriptions indicate that candidates must have an understanding of and sensitivity to serving culturally diverse populations.

_____ 3. There is a policy/plan for hiring qualified consumers/family members.

_____ 4. All staff is provided with cultural competency training.

_____ 5. People of diverse ethnicity have been retained on staff.

_____ 6. Opportunities for advancement are provided for staff who demonstrates, among other skills, cultural competency.

_____ 7. There is a clearly written nondiscrimination policy.

_____ 8. Agency performance in regard to nondiscrimination is regularly reviewed.

XII. Section V: Consumer-Related Services and Staff Training

XIII. (clerical, service delivery, supervisory)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Agree	Probably Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

Materials and Environment

_____ 1. Program brochures, annual reports, newsletters, and other publications reflect the diversity of, and are culturally and linguistically oriented to, the population the agency serves.

_____ 2. Resources (e.g., videotapes), programs, and services specifically designed to reach culturally diverse groups are developed and collected.

_____ 3. The expertise of community leaders, natural healers, elders, consumers, and other resource persons are utilized as appropriate in planning and delivering services.

_____ 4. The physical environment of the agency is reflective of the different cultural populations served.

Consumer Related Services

_____ 1. All supervisors and service delivery staff are provided with annual training in issues relating to cultural diversity and competency.

_____ 2. Staff is trained in regard to cross-cultural communication, culturally diverse family customs, and conflict resolution in different cultural groups.

_____ 3. Staff continually examines their own cultural beliefs and attitudes to better understand the dynamics of cultural difference and interaction.

_____ 4. Staff routinely discusses barriers to working across cultures.

_____ 5. Staff routinely discusses issues related to working with consumers or co-workers of diverse ethnicity.

_____ 6. Persons from the agency attend cross-cultural workshops when offered.

_____ 7. Staff is trained in the use of interpreters.

_____ 8. Interpreters are trained on basic skills and knowledge about mental health issues.

_____ 9. Staff learns as much as possible about the cultures of their clients and the cross-cultural patterns that affect the way individuals communicate, cope with problems, and use survival strategies.

_____ 10. Reception staff is culturally sensitive and has the capability for serving consumers whose primary language is not English.

XIV. Section VI: Service Delivery

XV. (service delivery and supervisors)

For the following statements, please use the rating scale below to indicate the extent to which you agree or disagree with each. Write the corresponding number beside each statement.

Strongly Agree	Agree	Probably Agree	Probably Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6

Planning and Assessment

_____ 1. Staff conducts client assessments and develops service plans in a manner that is culturally competent.

_____ 2. Staff involves clients in the development of their service plans and sets culturally relevant goals.

_____ 3. Staff considers the availability of community resources, including cultural organizations, in the service planning process.

Intervention

_____ 1. Staff empowers clients by using the client's cultural strengths and informal support networks in service delivery.

_____ 2. Staff assists clients in developing and/or maintaining cultural supports in their families and communities.

_____ 3. Outreach activities and preventive services are designed to meet the needs of culturally diverse populations.

_____ 4. Interventions use culturally diverse support networks in the service delivery process.

_____ 5. In all interventions, the impact and levels of acculturation, assimilation, and historical perspectives on the cultural or ethnic group are considered.

_____ 6. Outreach services are provided in culturally diverse communities and neighborhoods, or at other locations familiar to its clients.

_____ 7. Culturally competent, bilingual/bicultural, services are available when appropriate.

_____ 8. It is recognized that all aspects of service delivery must be culturally competent.

APPENDIX D

SACRAMENTO County Mental Health Treatment Center	POLICY AND PROCEDURE MANUAL		
	Functional Area: PATIENT CARE - GENERAL		A-1
	Subject: Language Accessibility		
	Contact Person:_____________________ __ Kathy Aposhian, RN	Approved by:_________________________ __ Charles Loker, LCSW	

Purpose: The purpose of this section is to provide policies and procedures governing the provision of interpreters' services for non-English speaking and hearing impaired patients accessing Specialty Mental Health Services. Dialing the toll free at (888)-881-4881 or local number at (916) 875-1055 may access Mental Health Services.

I. POLICY

A. All non-English speaking patients and hearing impaired patients who require interpreter's services will be provided the services of an interpreter for assessing their need for mental health services. Interpreters will be provided whenever necessary for adequate evaluation and treatment planning.

II. PROCEDURES

A. A TDY print phone is located in Interview Room 532 adjacent to the Crisis Unit for the hearing impaired.

B. The NOR-CAL Center on deafness provides interpreters for the hearing-impaired Monday through Friday, 0800-1600, by calling 349-7525.

1. The 24-hour emergency number is 962-6055.
2. California Relay Operator (800) 735-2929.

C. The agencies providing interpreters for non-English speaking clients are:

1. Sacramento County Interpreter's Office, 874-8455, Monday through Friday, 0800 - 1700. (Provides a wide variety of languages.)

2. Asian Pacific Community Counseling, 383-6783, Monday through Friday, 0800 - 1700. (Japanese, Korean, Tagalog, Visayan, Ilocano, Compampangan, Mandarin, Cantonese, Tongan, Samoan and Fijian.)

3. Southeast Asian Assistance Center, 421-1036. (Vietnamese, Hmong, Lao, Mien, Cambodian, Mandarin and Cantonese, Russian and Ukrainian.)

4. El Hogar Mental Health and Community Service Center, Inc., 441- 2933 (Spanish) are available for consultation.

5. The Mental Health Treatment Center strives for cultural diversity among its treatment staff and has a large number of employees that speak languages

other than English. A call to the Administrator on Duty will help you to identify a list of current staff that may be available to assist with interpretive needs.

D. AT&T Language Line

This service is to be used only when no other interpreters' service is available from the local community resources.

1. Clinicians use the line with patients.

2. Chart the AT&T Language Line call in the progress notes or treatment plan.

3. If the patient is unable to identify their language, try a significant other, if available. Language Cards are available in the AT&T manual in the Crisis Unit.

4. Dial AT&T Language Line: 1-800-874-9426.

5. Tell the operator who answers:

   a. Which language you are requesting.

   b. State the control number for the unit.

   c. State the unit's I.D. number.

6. The operator will connect to the appropriate interpreter. Tell the interpreter what you need. During the conference calls, the interpreter can be asked to clarify or explore with the patient any matters that may come up.

7. When the patient returns the phone, and all questions have been answered, the interpreter is told, "End of call." The interpreter is bound by confidentiality, and does not know the patient's name.
   An example of a call is:

   a. Dial 1-800-874-9426 and say, "I need Russian." (as an example.)

   b. "My name is MH000000001." (example of a patient number.)

   c. "My I.D. number is __________________."

   d. The operator connects with the appropriate translator.

   e. All the information needed is obtained. Call is ended by saying to the interpreter, "End of call."

E. In order to preserve confidentiality and objectivity of the mental status exam, relatives or friends of the patient are to be used only after all of the above resources have failed.

1. A Release of Information form is to be obtained from the patient prior to talking to relatives or friends. The relative or friend can interpret to the patient the need to sign a Release of Information form before proceeding with the interview.

SACRAMENTO COUNTY DIVISION OF MENTAL HEALTH
CHILD AND FAMILY ACCESS TEAM
POLICY AND PROCEDURE
CHILD ACCESS – MANDATED

FUNCTIONAL AREA: Client Services

POLICY: All non-English speaking clients and hearing impaired clients who require interpreter services will be provided the services of an interpreter for assessing their need for mental health services. Interpreters will be provided whenever necessary for adequate evaluation and treatment planning.

PURPOSE: The purpose is to ensure that all non-English speaking clients and hearing impaired clients have access to appropriate interpreter services in order to access their need for mental health services.

PROCEDURES:

1. The agencies providing interpreters for non-English speaking clients are:

   A. Sacramento County Court Interpreters Office (874-8455), Monday through Friday 8-5 (provides a wide variety of languages);
   B. Asian Pacific Community Counseling (383-6783), Monday through Friday 8-5 (Japanese, Korean, Chinese, Tagalog, Visayan, Ilocano, Compampangan, Mandarin,
   Cantonese, Tongan, Samoan and Fijian);
   C. Southeast Asian Assistance Center (421-1036) (Vietnamese, Hmong, Lao, Mien, Cambodian, Mandarin, Cantonese, Russian and Ukrainian);
   D. El Hogar Mental Health and Community Service Center, Inc. (441-2933) are available for consultation;
   E. The Sacramento County Division of Mental Health strives for cultural diversity among its treatment staff and has a large number of employees that speak languages other than English. A call to the Administrator on Duty at the Mental Health Treatment Center will help you to identify a list of current staff that may be available to assist with interpretive needs.

2. AT&T Language Line

   This service is to be used with no other interpreters' service is available from the local community resources.

   A. Attempt to identify the language spoken by client. If unable to do so try a significant other if available.
   B. Dial the AT&T Language Line 1-800-874-9426 and identify the language you are requesting, state the control number for the unit, the client's ID number, and the unit's I.D. number.

C. The Operator will connect to the appropriate interpreter. Tell the interpreter what you need. During the conference calls, the interpreter can be asked to clarify or explore with the patient any matters that may come up.

D. When all questions have been answered the interpreter is told “end of call”. The interpreter is bound by confidentiality.

3. The NOR-CAL Center on deafness provides interpreters for hearing impaired clients. They can be reached Monday through Friday 8-5 by calling 349-7525. The 24-hour emergency number is 916/962-6055.

POLICY AND PROCEDURE	
FUNCTIONAL AREA: PATIENT CARE - GENERAL	A-1
SUBJECT: CONSUMER LANGUAGE NEEDS (All programs except Access)	

All Sacramento County Mental Health Providers and contract providers strive for cultural diversity amongst its treatment staff.

Purpose: The purpose of this document is to provide policies and procedures for meeting consumer language needs for non-English speaking beneficiaries when on-site staff is not available.

XVI. POLICY

Every effort shall be made to provide non-English speaking patients the services of an interpreter.

II. PROCEDURES

A. Determine the primary language of the non-English speaking consumer.

B. Use on-site interpreters if available.

C. If no on-site interpreters are available, the following agencies can be used to access interpreters for non-English speaking clients:

1. Asian Pacific Community Counseling, 383-6783, Monday through Friday, 0800 – 1700.

2. South East Asian Assistance Center, 421-1036.

D. The utilization rate of linguistically proficient staff is required. Whenever bilingual staff or interpreter are utilized, it should be noted in the consumer's chart. The chart note should include services where offered and what follow up was provided.

E. In order to preserve confidentiality and objectivity, relatives or friends of the patient are to be used only at the request of the beneficiary and after all of the above resources have failed.

1. A Release of Information form is to be obtained from the patient prior to talking to relatives or friends. The relative or friend can interpret to the patient the need to sign a Release of Information form before proceeding with the interview.

Appendix E

POLICY AND PROCEDURE

Functional Area: PATIENT CARE – GENERAL	A-1
Subject: Cultural Competency Training Staff	
Contact Person:	Approved by:

Purpose: To provide Cultural Competency Training to Staff and providers to assist in the acquisitions of skills necessary to serve culturally diverse clients with services appropriate to their background.

I. POLICY

.

II. PROCEDURES

A. Trainings will occur a minimum of two times a year.

B. All trainings shall include the Core Curriculum:

Interpreters procedure

1. Training will occur a minimum of once yearly

2. Curriculum
   - Interpreting formats
   - Strategies for overcoming technical difficulties
   - Language barriers
   - Emergency measures
   - Language Identification
   - Effective use of AT & T
   - Role expectations
   - Role conflict
   - Interpreting models
   - Content of pre and post meetings

C. Additional topics may be added as appropriate.

D. Trainings will consist of presentations by staff, guest speakers, consumers, films, handouts, and informational materials.

E. Training shall contain at least one evaluation question regarding employee opinion of the value of training.

Appendix F

POLICY AND PROCEDURE

FUNCTIONAL AREA: PATIENT CARE – GENERAL	A-1
Subject: Cultural Competency: Linkage or Mandated Linkage for Non-Threshold Language Groups at Mandated Points	
Contact Person:	**Approved by:**

Purpose: Maintain a list of interpreters and providers that are culturally and linguistically proficient to provide services to the MHP beneficiaries.

I. POLICY

All non-threshold language groups will be assisted to secure appropriate services.

II. PROCEDURES

A. Determine primary language of non-English speaking consumer.

B. Determine if in-agency interpreter is available. Refer to list of Assisted Access Programs and providers with other outside providers cultural and linguistic capabilities and contact for services as appropriate.

C. Staff is discouraged from using children or family members as interpreters.

Appendix G

POLICY AND PROCEDURE	
Functional Area: PATIENT CARE – GENERAL	
Subject: Cultural Competency: Access/Non-Threshold Language	
Contact Person:	**Approved by:**

Purpose: Maintain a list of interpreters and providers that are culturally and linguistically proficient to provide services to the MHP beneficiaries.

I. POLICY

All non-threshold language group will be assisted to secure appropriate services.

II. PROCEDURES

A. Determine primary language of non-English speaking consumer.

B. Determine if in-agency interpreter is available. Refer to list of Access programs and providers with cultural and linguistic capabilities and contact for services as appropriate.

C. Staff are discouraged from using children or family members as interpreters.

Appendix G

POLICY AND PROCEDURE

Functional Area: PATIENT CARE – GENERAL	
Subject: Cultural Competency: Linkage – Non-mandated Points of Contact	
Contact Person:	Approved by:

Purpose: Maintain a list of interpreters and providers that are culturally and linguistically proficient to provide services to the MHP beneficiaries.

I. POLICY

All Medi-Cal beneficiaries (both who meet or do not meet the threshold language criteria) are assisted to secure or are linked to appropriate services.

II. PROCEDURES

A. Determine primary language of non-English speaking consumer.

B. Determine if in-agency interpreter is available. Refer to Access programs and/or providers with cultural and linguistic capabilities and contact for services as appropriate.

C. Staff are discouraged from using children or family members as interpreters.

D. Follow up should be conducted to determine if beneficiary accessed services.

Appendix H

County of Sacramento
Department of Health and Human Services
Quality Improvement Manual

POLICY/PROCEDURE REGARDING:	**Forms and Brochure Distribution**
Date: May 25, 1998 Reference: Title 9, Div 1. CCR. Chapter 11-1810.410	Manual Number: 15.00

I. INTRODUCTION

Recognizing the County of Sacramento is an ethnically rich, culturally diverse community, Quality Management will distribute culturally appropriate materials to inform MHP members of service availability, member's rights and responsibilities, and how to access services.

II. PURPOSE

This procedure outlines the steps taken to distribute culturally and linguistically appropriate materials.

III. PROCEDURE:

A. Quality Management staff will analyze State MEDS file data regarding ethnicity by census track.

B. Quality Management staff will determine by region what ethnic groups constitute the 5% threshold level for mandated distribution of materials.

C. Quality Management will identify all Providers in a given region.

D. Quality Management will distribute culturally and linguistically appropriate materials to all Providers in a region in all languages meeting the threshold requirement.

E. Providers shall post the Problem Resolution guide and make available all other culturally and linguistically appropriate materials distributed to them by Quality Management.

F. Culturally and linguistically appropriate materials in languages that do not meet the 5% threshold will be available to Providers upon request.

G. Quality Management will review MEDS file data annually to determine changes in the regions populations.

H. Providers are to request additional materials by faxing the Brochure and Pamphlet order form to Quality Management at 916/875-0877. (Attachment)

Issued by: ______________________________ Bernadette Lynch Program Coordinator Quality Management	**Contact Person:** Lisa Miller-Scott Program Coordinator 916/875-0832

BROCHURE AND PAMPHLET DISTRIBUTION LOG

Month/Year: June 1998

AGENCY	Spanish				Hmong				Russian				Vietnamese				Chinese				Mien				Lao				English			
	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance
El Hogar		1																											200	1	200	78
ACCESS Adult		1																											50	1	50	50
ACCESS Child		1																											50	1	50	50
Catholic Social Services																																
CCMS		1																											75	1	75	75
Conservators Office																																
Child & Family Institute																																
Family Service Agency																																
Guest House																																
Integrated Serv. Agency (County ISA)		1		1																									25	1	25	10
Med Clinic, MAC																																
New Helvetia, NSC		1																											25	1	25	10
Oak Park, NSC																																
Sacramento Children's Home (TLS)																																
Sacramento County Mental Health Treatment Center (MERT)		1		1																									25	1	25	10
School Based Outpatient		1																											75	1	75	75
Sutter Center for Psychiatry																																

BROCHURE AND PAMPHLET DISTRIBUTION LOG (cont'd)

Month/Year: June 1998

AGENCY	Spanish				Hmong				Russian				Vietnamese				Chinese				Mien				Lao				English			
	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance	Handbook	Poster	Pt's Rights	Grievance
Northgate Point, RST		1	50	50		1					50	50																	200	1	200	250
Consumer Self-Help,North																																
Del Paso Heights, NSC																													25	1	25	10
River Oak, Auburn																													100	1	100	100
River Oak, Laurel Hills																													50	1	50	50
Terkensha Associates																													150	1	150	50
Visions South, RST		1	50	25		1				1	25	25		1				1											125	1	125	50
Community Intervention Program (CIP)		1		1		1				1			5	1	10	10													25	1	25	10
Youth Intervention Services		1		1		1				1			5	1	10	10													25	1	25	10
BHC Sierra Vista		1		5																									25	1	25	10
Consumer Self-Help, South																																
La Familia	12	1	25	15		1								1				1											50	1	50	25
Milhous		1		5																									50	1	50	20
Patient's Rights																																
Regional Youth Services		1		2																									25	1	25	10
Turning Point, Crisis Residential																																
Turning Point, ISA																																

BROCHURE AND PAMPHLET DISTRIBUTION LOG (cont'd)

Month/Year: June 1998

	Spanish				Hmong				Russian				Vietnamese				Chinese				Mien				Lao				English			
AGENCY	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**	**Handbook**	**Poster**	**Pt's Rights**	**Grievance**
Visions, Galt		1		25		1								1				1											75	1	75	56
Human Resources Consultants (HRC)		1	50	20						1	50	50																	200	1	200	100
AFTER		1		10						1																			75	1	75	25
BHC Heritage Oaks		1		5																									25	1	25	10
East Field Ming Quong																																
Eskaton American River Manor		1		5																									25	1	25	10
Families First		1		10																												
Geriatric Network		1		5																									25	1	25	10
Jewish Family Services		1		10						1																			30	1	30	30
Med Clinic, Carmichael		1		3																									25	1	25	10
Med Clinic, Rancho Cordova		1		3																									25	1	25	10
River Oak, Eastern																																
Slocan House		1		5																									25	1	25	10
Sutter Counseling Center		1		5																									25	1	25	10
White House Counseling Center		1		10																									25	1	25	10

APPENDIX I

POLICY AND PROCEDURE

Functional Area: PATIENT CARE – GENERAL	
Subject: Cultural Competency: Community & Education Plan	
Contact Person:	Approved by:

Purpose: To disseminate information and educate the ethnic community in accessing the Latino population.

I. POLICY

The Cultural Competence Committee will provide community outreach to the Latino population.

II. PROCEDURES

The Cultural Competence Committee will participate in the following:

A. Ethnic Health Fair
B. Citizenship Day
C. Cultural Fairs
D. College and School District functions that promote mental health issues.
E. Other community activities as directed by the mental health director

Appendix J

POLICY AND PROCEDURE		
Functional Area: PATIENT CARE – GENERAL		
Subject: Cultural Competency: Client Plans		
Contact Person:	**Approved by:**	

Purpose: To ensure consumer input and participation in the development of culturally and linguistically competent mental health treatment plans.

I. POLICY

Consumers shall have full opportunity to participate in the development of their treatment services.

II. PROCEDURES

A. The Cultural/linguistic concerns, issues and preferences will be documented in the treatment plan.

B. Request for cultural input from family, friends and community support persons will be documented in the assessment and the treatment plan.

C. The treatment plan will reflect the inclusion of the input from family, friends, and community support persons.

D. Progress notes shall reflect the inclusion of cultural issues.

E. Progress notes shall reflect the inclusion of the consumer and/or family involvement, by ethnicity and primary language.

Appendix K

B HUMAN RESOURCES: NEW CONTRACT PROVIDERS

Using the survey previously developed by the Cultural Competency Committee, each new contract provider submitted information regarding among other issues, the ethnicity of staff, languages spoken by staff, languages staff reads and writes, and gender. Information for seven staff functions was gathered: boards of directors, administration/management, direct services, clerical, interpreters, translators, and "other". The latter category primarily represents volunteer staff, student interns, and on-call staff members. The survey was completed in November 1998 by the following groups: (1) County Access team for Adult Services; (2) County Access team for Children's Services; (3) the CalWORKs clinical team; (4) Jewish Family Service of Sacramento; (5) MedClinic Behavioral Health; (6) BHC Sierra Vista Hospital; and (7) BHC Heritage Oaks Hospital. These service providers reported a total of 76.3 FTE staff associated with new contracts for the provision of specialty mental health services in the county. Four of the seven staff functions were represented (boards of directors, administration/management, direct services, and clerical).

B.1 Description should include, ethnicity by function, unduplicated FTEs with data displayed by a) administration/management; b) direct services; c) support services; and d) interpreters.

Figure 1 illustrates that across all staff functions, the ethnic categories represented by new contract providers are relatively diverse. Figure 2 shows that ethnic representation and/or diversity, not surprisingly, depends on the function of staff (there are no new interpretive staff). The new boards of directors are the most ethnically homogenous, with over 90% being comprised of Caucasians. Administration/management is somewhat more diverse, with only 50% being Caucasian, 32% African American, and 17% Latino. One positive aspect of these data is the diversity shown by new staff providing direct and clerical services. Several different ethnic groups are represented including Caucasian, African American, Latino, Former Soviet, Chinese, Native American and Filipino.

B.2 Description should include, bilingual staff by function and language, unduplicated FTEs with data displayed for a) administration/management; b) direct services; c) support services; and d) interpreters.

Across all staff functions, Sacramento has new bilingual staff in approximately 17 FTE's (about 22% of all new staff). Figure 3 illustrates that across all staff functions, the bilingual capabilities represented in new staff include Spanish, Russian, Romanian, Tagalog, and "Other" (Czech, German, Serbo Croatian, French, Rarsi, Toisin, Ukranian, and Hebrew). Figure 4 shows that bilingual capability also depends on the function of staff (there were no new interpretive staff). New administration/management had no bilingual capability, while those providing direct services show tremendous diversity (almost 33% are bilingual).

B3 Description should include, staff proficiency in reading and writing in a language other than English by function and language, unduplicated FTEs with data displayed for a) administration/management; b) direct services; c) support services; and d) interpreters.

In this survey of new staff, all bilingual staff reported also being able to read/write in the languages they were proficient in speaking. Therefore, the data are identical to that displayed above.

B4 Description should include, staff gender by function, unduplicated FTEs with data displayed for a) administration/management; b) direct services; c) support services; and d) interpreters.

Figure 5 illustrates that across all staff functions, new staff are predominantly female (61% vs. 39%). Figure 5 also shows that gender breakdown depends on the function of staff (there were no new interpretive staff). In only one case, however, are males the predominant

gender (i.e., board of directors). The discrepancy between the percentage of males and females is relatively large for direct services and clerical staff.

HR Human Resources: Location

Of the new providers of mental health services, none are providing services in a regional manner. That is, all of the services are considered non-regional in that they are specialized with respect to type of service (e.g., referrals, CalWORKs clinicians, etc.). For these non-regional services, service location tends not to be an issue because in many cases, the service is provided over the phone or the service goes to the client.

HR Human Resources: Analysis

In our original submission, we noted that across the County, there was tremendous diversity in terms of ethnicity and language capability of staff associated with the provision of mental health services. Almost 35% of staff identified as non-Caucasian, and about 8% of them had bilingual ability that covered more than 20 languages. This diversity meant that agencies providing mental health services had been relatively successful in recruiting and retaining staff that reflected the Medi-Cal population of the County.

New staff have also proven to be relatively diverse. Approximately 31% identify as non-Caucasian and 22% have language capabilities beyond English. One concern raised in our original submission holds true here. Specifically, the agencies appear limited in their ability to provide services in the primary language of clients, most pointedly in the threshold languages we are responsible for. Of Sacramento's seven languages, new staff represents two (Spanish and Russian).

One of the goals we had previously noted was to support agencies in hiring staff with diverse language abilities. We are currently in the process of re-surveying our whole system to gather information on ways the ethnic and language abilities may have changed over the previous year.

Figure 1. Ethnicity of All New Staff
November 1998

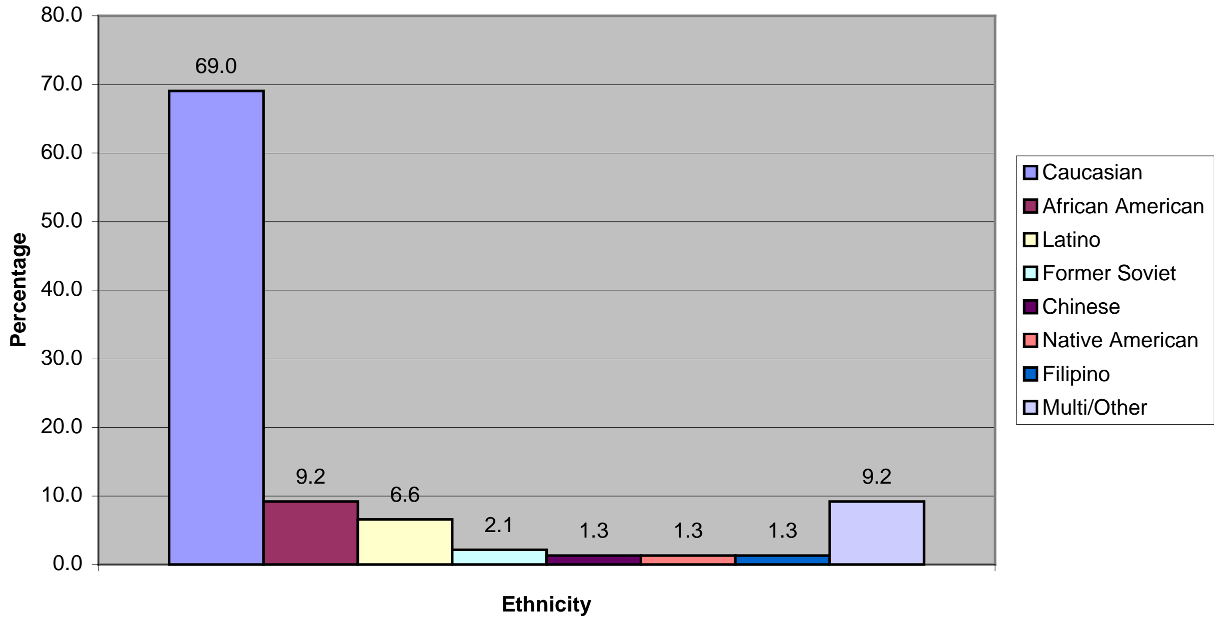


Figure 2. Ethnicity of New Staff by Function
November 1998

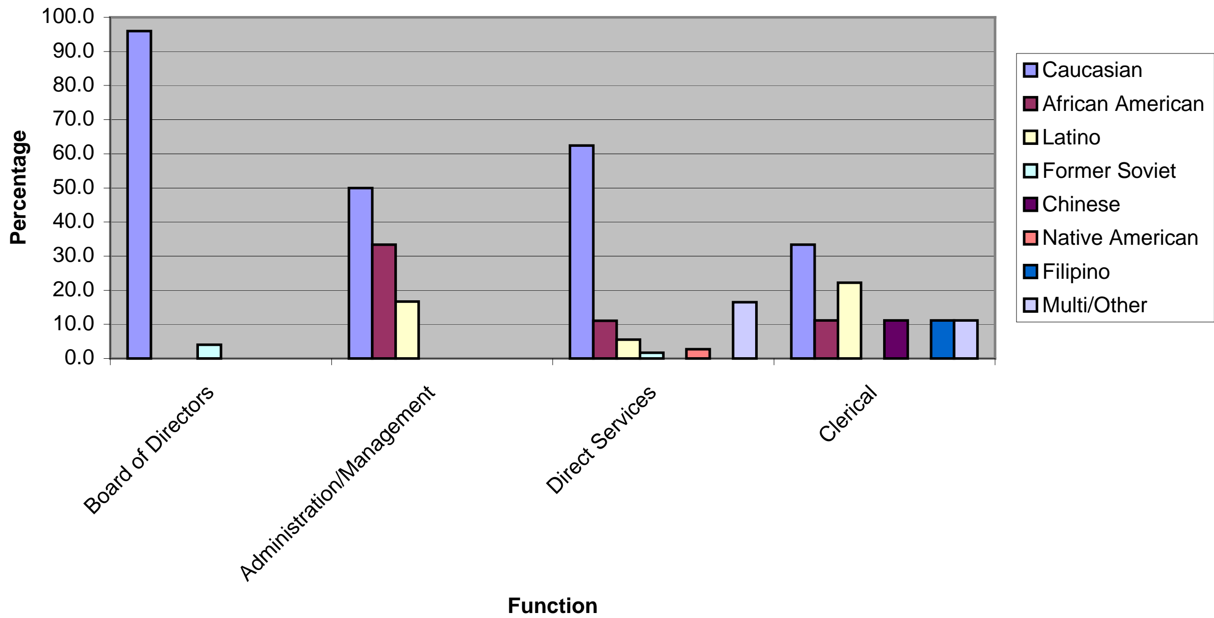


Figure 3. Languages Spoken by New Bilingual Staff
November 1988

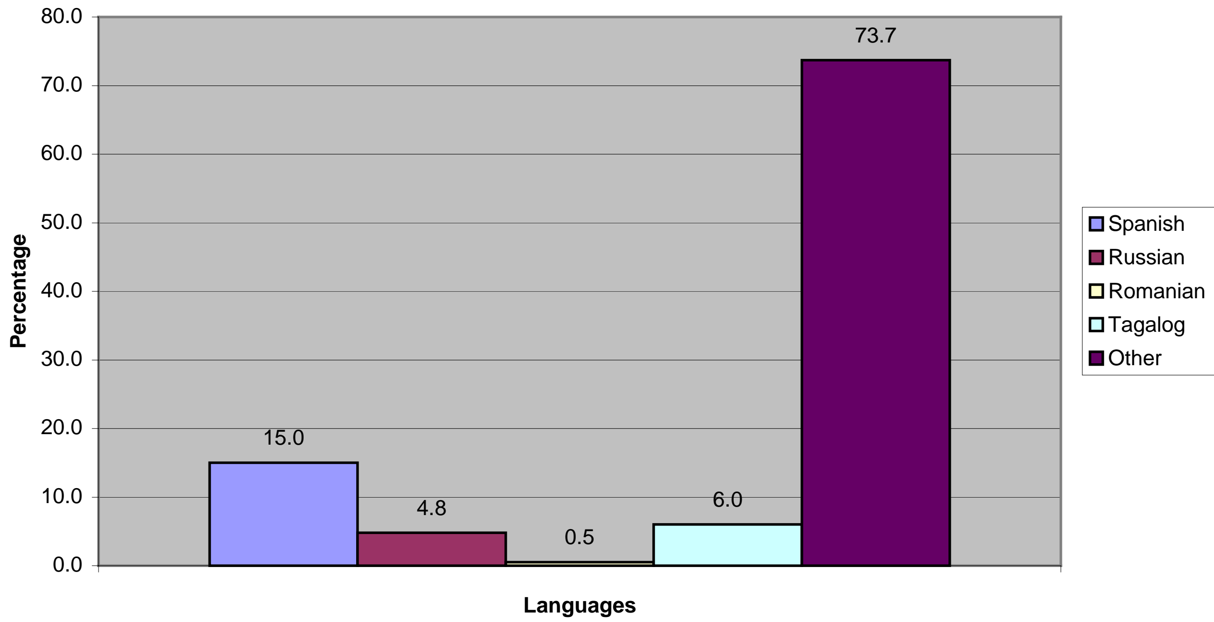
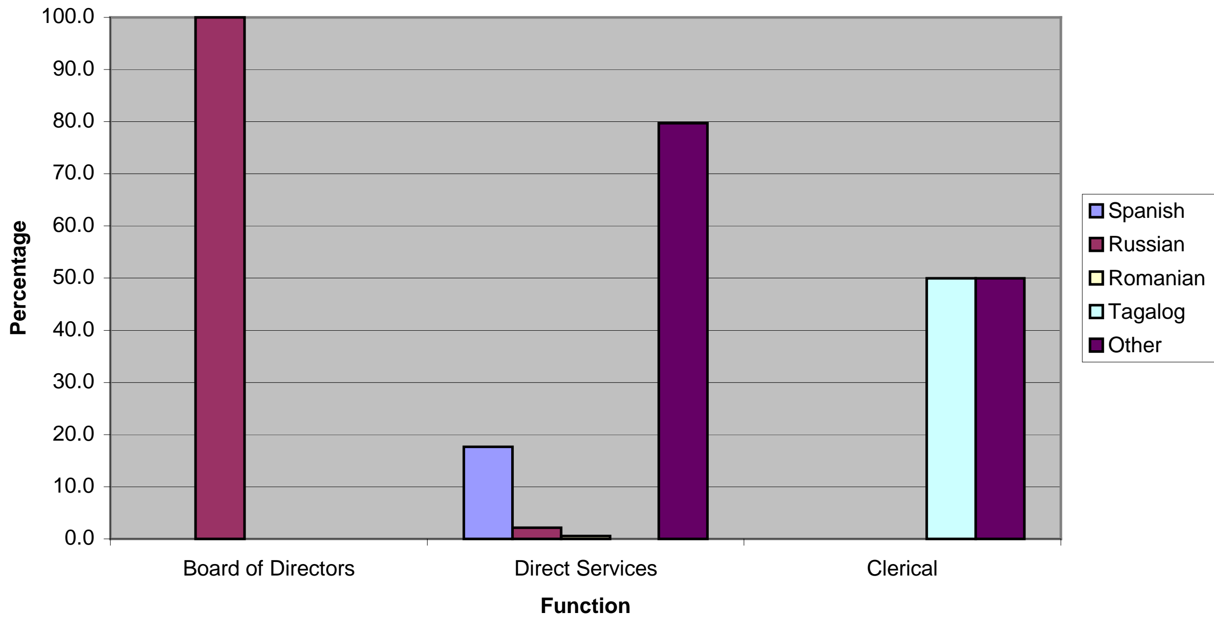


Figure 4. Languages Spoken by New Bilingual Staff by Function
November 1998



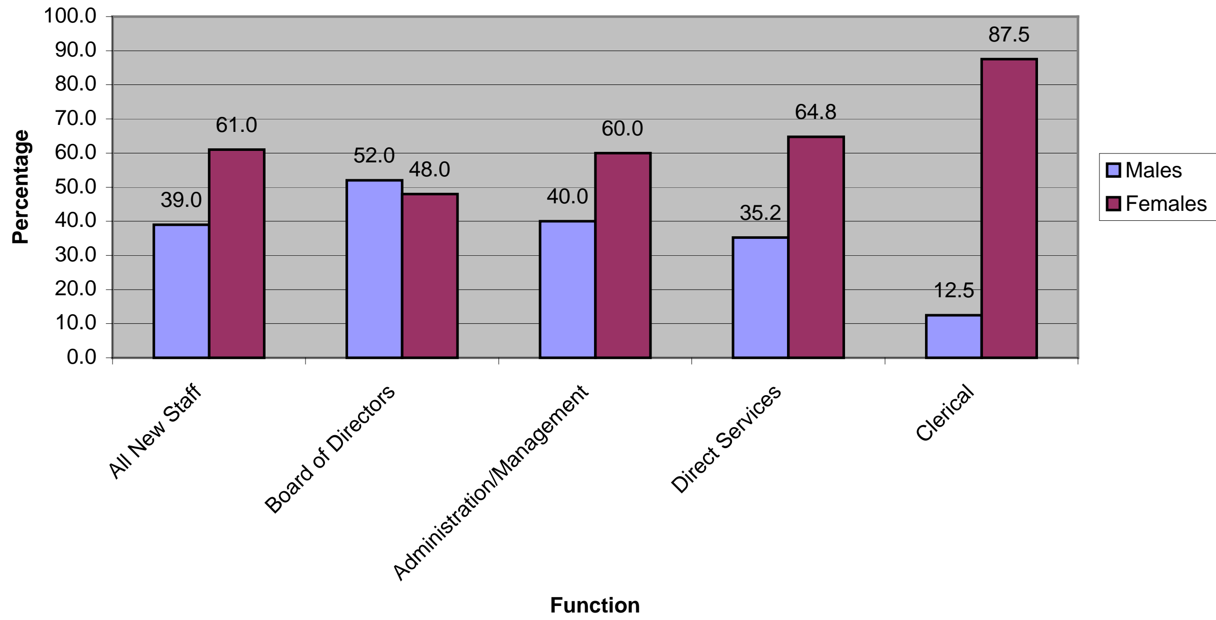


Figure 5. Gender of New Staff by Function
November 1998
Percentage
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
39.0
61.0
52.0
48.0
40.0
60.0
35.2
64.8
12.5
87.5
Males
Females
All New Staff
Board of Directors
Administration/Management
Direct Services
Clerical
Function