

# SACRAMENTO COUNTY

## Phase II Consolidation of Medi-Cal Specialty Mental Health Services



Cultural Competence Plan  
Update  
September 30, 2003



# PART I

## **PART I – DATA, ANALYSIS, AND OBJECTIVES**

### **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 is 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. Sacramento County's population is the most racially and ethnically diverse, housing nearly 80 percent of Hispanics, Asian-Pacific Islanders and African-Americans in the region, and was recognized by Time magazine in September 2002 as the nation's "most integrated city".

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 35% to 35.9% between 1990 and 2000, but the percentage of these groups is still smaller than the statewide proportion of 41.9%. In the year 2000, more than 1/3 of Sacramento residents were Asian, Hispanic, African American and other non-Whites. Between 1990 and 2000, the Hispanic population increased from 12% to 16%, Asians and others (including Native Americans) increased from 9% to 14% and African Americans from 9 – 11%. The Caucasian population declined from 69% to 59%, exceeding projections of 69% to 64%, according to figures from the U.S. Census 2000, Population by Gender, Age and Race report.

Southeast Asian refugee migration peaked in the mid-1980s and remains higher in Sacramento than in the state as a whole. It is difficult to ascertain exact numbers, as the 2000 Census and other data collecting sources do not differentiate all the Southeast Asian groups from the Asian category. The communities, however, have traditional means of accounting for their numbers, including church data and funeral associations. Using traditional data sources, community leaders report the following numbers in Sacramento County: Vietnamese 25,000; Hmong 18,000-20,000; Mien 6,000–8,000; Lao 3,000, and; Cambodian 1,000. According to Southeast Asia Resource Action Center, per the Census 2000 data, California is the state with the highest number of Southeast Asians; however, the breakdown of groups is unavailable from them for counties.

Political upheaval in the former Soviet Union and in southeastern Europe has also caused the region to become home to many Russian, former Soviet and Bosnian refugees. Church data shows conservative numbers of 50,000 Russian/Formal Soviet and 3,000 Bosnian refugees in Sacramento County.

Four key demographic conditions will influence Sacramento's future:

- Growth
- New population distribution patterns
- Increasing racial/ethnic diversity including immigrant and refugee populations
- Increasing proportion of seniors

According to the Sacramento Chamber of Commerce's 2003 Sacramento Region Fact Sheet, "Sacramento County is the nation's 10<sup>th</sup> fastest growing

city based on numerical gains in population, according to the U.S. Census Bureau” (as reported in The Sacramento Bee, April 2002).

While the rate of growth of ethnic/racial populations in Sacramento County has slowed slightly from 1990 to 2000, the challenge to provide services for multicultural populations continues. The establishment of “one stop” neighborhood multi-service centers in low-income parts of the county have helped to meet health, welfare, and mental health needs in a more holistic fashion that is more acceptable for many groups. New Helvetia Neighborhood Service Center serves the Central region, Del Paso serves the Northwest region, Oak Park covers the South region, and Rancho Cordova handles the Northeast region.

Sacramento County is host to several urban and rural community center areas, providing arts, theatre, and shopping.

Old Sacramento, situated directly on the east side of the Sacramento River near the confluence of the American and Sacramento Rivers, is an on-going redevelopment project designed to lure both visitor and native to this historic and culturally-rich area. It has produced an historical timeline of the city in the K Street tunnel leading to Old Sacramento and the completion of the

waterfront promenade, among other improvements. Large shopping malls (besides the Downtown Mall) include Florin Mall in South Sacramento, completed/developing shopping regions in Elk Grove, 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, South Sacramento, and the Land Park/Pocket/Meadowview areas. The formerly identified urban community of Rancho Cordova became a city in July 2003.

Still highly populated, yet situated in somewhat of a “rural” setting, are the community areas of North Natomas, Rio Linda, Elverta, Antelope, Foothill Farms, Carmichael, Orangevale, Fair Oaks, Folsom, Rancho Murieta, Cosumnes, Laguna, and Laguna West. Two previously identified “rural” communities, Citrus Heights and Elk Grove, became cities in January 1997 and July 2000, respectively. Further to the south, there are a number of smaller communities including Galt, Isleton and Hood/Franklin.

### **Mental Health Plan Regional Service Delivery Areas**

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. CalWORKs/Medi-Cal recipients, community preferences, low income neighborhoods, population distribution

patterns of underserved groups, 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, as well as extending east along the Light Rail corridor to serve the communities of Rosemont and areas of Rancho Cordova accessible to public transit.
- **South Region** – A geographically expansive region includes Land Park/Pocket, Meadowview, South Sacramento, Rancho Murieta, Cosumnes, 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 and families). 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 1 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 a 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 Fair Mall shopping center and Cal Expo. To help alleviate the increasing amount of traffic congestion, Highway 99 and Interstate 80 have undergone lane additions while Watt Avenue and Sunrise Boulevard along Interstate 50 have received lane additions or re-routings.

The cost of maintaining an automobile presents problems for some low income residents. 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. Light Rail has opened a new “avenue” to downtown transportation, and continues to expand its service to outlying areas in an effort to address and improve transportation issues. Currently, Light Rail extends east to the Mather Field/Mills Station and on the north side, it travels to the Watt Avenue bridge station near McClellan AFB. Light Rail is scheduled to continue its trek further west from downtown to the Amtrak station and east from Mather Field/Mills Station to historic downtown Folsom in the future. In September

2003, Light Rail began service to the south from downtown Sacramento to Meadowview Road. Phase 2 of this southern corridor proposes the extension of the line from Meadowview station to the Calvine/Auberry intersection in Elk Grove. 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, language difficulties, cultural considerations, 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 considerable difficulty for some mental health consumers.

In siting MHP facilities, ease of access is a primary consideration. Whenever possible, regions are configured so that consumers can comfortably walk to services and bicycling is an option for others. Additionally, some providers use taxis and outreach workers to assist with transportation needs.

Other forms of transportation include the Greyhound bus line, Amtrak, and the Sacramento International Airport.

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

**2a. Primary Economic Support**

In 2000, services ranked first in employment estimates with 156,400 employed in this field. Next, government employment came in with 154,700 employees, followed by the retail field with 114,000, then financial/insurance/real estate with 40,000 and finally, manufacturing at 35,400. The 2000 Census contained three other categories, agriculture with 3,300; mining/construction with 32,300; and, transportation with 22,200. Unemployment figures continue to fluctuate in Sacramento County. According to the California Department of Employment Development's September 12, 2003 Sacramento Metropolitan Statistical Area (MSA) report, the unemployment rate was 5.4 percent in August, down from 6.0 percent in July, while California had an unemployment rate of 6.5 percent and the nation carried a 6.0 percent rate. From July 2003 to August 2003, Sacramento County lost 800 jobs from different occupational sectors.

**2b. Average Income Levels**

According to the U.S. Census Bureau 2000 Sacramento County profile report, median household income is \$39,461. Information on the highest and lowest median incomes were unavailable for 2000 and various factors including increasing housing costs and reduced job opportunities have contributed to 27% of children ages 0 – 17 living in poverty in Sacramento County (2001 California Child Care Portfolio, A Project of the California Child Care Resource & Referral Network).

**2c. Welfare Caseload**

The implementation of the CalWORKs program resulted in the overall welfare caseload decline during the late 1990s and early 2000 as some

recipients returned to work. According to the Sacramento County Department of Human Assistance Databook, June 2003 report, the County averaged 25,885 families as monthly welfare recipients for fiscal year 2002-2003. This number includes monthly averages of 11,168 one-parent or disabled-parent households; 4,939 cases in two-parent households; 4,501 foster care cases, and 3,514 Aid-to-Adopt cases. While foster care cases and Aid-to-Adopt cases are handled by one office and not delineated by regions, the CalWORKs monthly average caseloads per Region are:

- Northwest Region - 3,303 cases
- Central Region - 2,080 cases
- Northeast Region - 6,647cases
- South Region - 6,661 cases

According to an official with the Department of Human Assistance, the continuing economic downturn has not adversely affected caseload increase and the average number of cases per month in 2003 have held steady since 2002.

### **Child and Family Issues**

While Sacramento has long been considered a family-friendly community—a good place to rear children—the area is sharply contrasted by the ease in which the affluent, individuals and families, who utilize the finest goods and services available, with the plight of the indigent who depend on county services to care for the needs of their children and families. Continuing trends indicate that many area families are experiencing changes and stressors that afflict families in urban areas throughout the country.

The most significant and alarming trend is the high poverty level of Sacramento County children. 27.3% of the county's children live below the poverty level, according to Census 2000. This average is much higher than the national average of 19.9% and slightly higher than the state average of 24.6%. Sacramento County continues to rank among the top five largest counties with the highest rate of families receiving CalWORKS [formerly Aid to Families with Dependent Children (AFDC)].

The growth in single-parent families, negative health indicators related to maternal and child health, and increasing family and juvenile violence may be attributable to the county's poverty level. Sacramento reports extremely high child abuse/maltreatment cases, with an "emergency response disposition" rate per 1,000 persons of 97.9%, far above the state average of 64.6%. Child welfare services launched investigations on 6.5% of the county's child population and ended a one-year period from March 2001 to February 2002 with 6,426 substantiated allegations. During the month of February 2002, 17.6 per 1,000 children were in out of home placements, again exceeding the state average of 11. Children placed out of the home often do not return to their homes for 1-2 years, once more exceeding the state average.

Other disturbing factors amongst many Sacramento County children include increased school drop out, suicide and criminal rates. The three-year average for high school drop out rate is 3.7 while the state averages at 3.0. The suicide rate for persons under age 18 is 1.6 with the state average at 1.0. The criminal rates, i.e., school violence, domestic violence, felony crimes, crimes with a weapon, have all increased above the state rates. The reported crime rate per 1,000 persons is 60.5, making it the fifth highest per capita rate in the state.

## **2d. Employment Data**

In 2000, Sacramento's per capita income growth rate fell below that of the state between 1990 and 2000. The county per capita income consistently remains below the state's average. Local job growth has seen slight increases in the mining/construction trades and transportation occupations in the past decade. Still, 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 2000 Federal poverty guideline level of \$11,250.

Major employers in Sacramento County have always included government and the military. However, the military sector's contribution to the area's economic base has declined with the closures of Mather Air Force Base (Northeast Region), the Sacramento Army Depot (Central and South Regions), and the McClellan Air Force Base (Northwest Region). Parts of Mather have been converted to low to moderate income housing while McClellan has been converted to civilian shops and services.

It was hoped that the advent of computer-based industries to the area would add many steady job opportunities, but these industries are based largely on the economic climate in the nation. The converted Army Depot closed in 2000 as a Packard Bell manufacturing plant, the Intel operation in Folsom cut positions in 2002, the Apple Computer plant in Elk Grove experiences layoffs yearly, and the Hewlett-Packard and NEC companies across the Sacramento County line have also experienced downsizing.

The California Department of Employment Development's September 12, 2003 report notes that Sacramento County's workforce declined from 745,400 July 2003 to 744,600 actually employed in August 2003.



**2000 Census Information Broken Down in Communities within the Regions follows:**

	<b>Workforce</b>	<b>Employed</b>	<b>Unemployed</b>	<b>Percent*</b>
Arden-Arcade (Northeast)	62,250	59,510	2,740	4.4%
Carmichael (Northeast)	32,140	30,790	1,350	4.2%
Citrus Heights (Northwest)	74,560	71,240	3,320	4.4%
Elk Grove (South)	11,450	10,950	500	4.4%
Fair Oaks (Northeast)	18,710	17,940	770	4.1%
Florin (South)	13,850	13,150	700	5.1%
Folsom (Northeast)	15,580	14,990	590	3.8%
Foothill Farms (Northwest)	12,040	11,350	690	5.7%
Galt (South)	5,130	4,570	560	10.8%
Isleton	550	500	50	8.4%
Laguna (South)	7,280	6,980	300	4.1%
La Riviera (Northeast)	8,420	7,960	460	5.4%
Mather (Northeast)	1,360	1,270	90	6.6%
North Highlands (Northwest)	25,050	23,030	2,020	8.1%
Orangevale (Northeast)	17,050	16,200	850	5.0%
Parkway	15,630	13,990	1,640	10.5%
Rancho Cordova (Northeast)	32,770	31,010	1,760	5.4%
Rio Linda (Northwest)	5,590	5,150	440	7.8%
Rosemont (Northeast)	15,990	15,400	590	3.7%
Sacramento City (Central) (Includes portions of other regions that are in the city limits)	221,970	206,660	15,370	6.9%

\* Percentage of unemployed of the total workforce.

Updated 2000 Census data regarding workforce by communities within Sacramento County are cited here, but carry the following precautions from the California Employment Development Department, Labor Market Information Division in their September 9, 2003 report: 1) all unemployment rates shown are calculated on unrounded data; 2) these data are not seasonally adjusted; 3) due to the introduction of the 1990 Census population figures, the data for years prior to 1990 are not comparable with data for 1990 through 1999; 4) census ratios used to calculate sub county labor force are based on 1990 Census data. According to the California Employment Development Department, “some census data is still not out due to population control factors. Population control data generates rates. The community

rates are based on specific formulations and methodology. We do not expect this information to be issued until sometime in 2005.”

### **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. 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 are highlighted elsewhere in this document, two issues, the homeless population and the number of board and care clients are of note here. In a recent survey done locally of Board & Care resources, the number of residential care homes has shrunk from 248 down to 70 in the past ten year period. 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.

While the number of licensed residential care homes has decreased, the phenomenon of unlicensed room and board homes has developed. These facilities are unregulated, charge rent for a room and one or two meals a day and provide no oversight or supervision except for the protection of the real estate. Clients come and go at will and frequently prefer this arrangement as it affords them the maximum in flexibility and freedom.

Being the largest metropolitan area in this northern area of the Central Valley, and surrounded primarily by small, rural counties, numbers of disabled individuals from

surrounding counties are placed into the array of residential homes in Sacramento. Neighboring foothill counties may host only two or three adult residential homes and when those resources are full or exhausted, Sacramento resources are often used.

Additionally, this region serves as a major transportation crossroad and as a result, there has developed an “inheritance syndrome” wherein individuals with mental disabilities sometimes pass through this region, but by plan or happenstance, remain here and become the treatment responsibility of Sacramento County. This phenomenon sometimes results in clients being placed on LPS Conservatorship and into longterm care utilizing county resources.

The issue of homelessness has received a great deal of attention in Sacramento County. By fine tuning data collection methods, the current estimated homeless population for Sacramento County as of August 2003 is 2,900. Certain homeless advocacy groups consider this number to be a conservative estimate. Nonetheless, national statistics estimate that 30 – 35 % of homeless suffer from a mental illness and that 50 – 65% suffer from co-occurring disorders of mental illness and addiction disorders.

Over the years, Sacramento County Mental Health continued to develop services that provide assistance to the homeless. Currently, a range of mental health services is available to assist and support consumers with their recovery from homelessness and mental illness. Services are provided with the understanding that needs of homeless individuals are complex and multi-faceted, taking into account gender, race, ethnicity, and the cycle of homelessness. Attention is focused on housing, co-occurring disorders of mental illness and substance abuse and untreated medical conditions. These services were greatly enhanced in FY 2000-2001 with the awarding of 5.2

million dollars to serve homeless individuals (AB 2034.) Services are recovery focused, culturally competent and field based.

The Division of Mental Health contracts with four agencies to provide the following range of homeless mental health services: outreach, outpatient, transitional and permanent housing, as well as the AB 2034 programs that provide integrated, comprehensive, 24/7 treatment and outreach services.

Data from both outreach and the AB 2034 program indicates that 58%-60% of Sacramento County homeless clients receiving mental health services are Caucasian, 28%-29% are African-American and 7%-8% are Hispanic, with the remaining being Native American 1%, Asian 1% and other.

## **B. Demographics (by ethnicity, age and primary language spoken)**

### **B1. General Population in County**

Data from the 2000 US Census were obtained for each census tract in the County for purposes of describing the general population in Sacramento County. From those data, the following descriptions of ethnicity, age, and primary language spoken in the household are drawn. In 2000, 1,223,499 individuals were residents of Sacramento County.

**Ethnicity** – The ethnic breakdown of the general population is presented in Figure 2. In response to the changing racial and ethnic makeup of the United States, the US Census Bureau revised the racial and ethnic classifications used in the 2000 Census. In addition to establishing four racial categories (American Indian or Alaskan Native, Asian or Pacific Islander, Black, White), two ethnicity categories were established (Hispanic origin and Not of Hispanic origin). Per the US Census Bureau’s new standards, Hispanics and Latinos may be of any race. Therefore, the category “Latino” in Figure 2 represents the percent of individuals who identify as being of Hispanic origin. The race of these individuals is reflected in the other racial categories depicted in Figure 2, therefore, the percentages in Figure 2 sum to more than 100%.

The four racial categories established by the US Census are broken down further into the categories depicted in Figure 2 in order to reflect the categories the Cultural Competence Workgroup in Sacramento County included in its human resources assessment. Please note that “American Indian” includes Alaskan Native, Eskimo, and Aleut, “Other Asian” includes Asian Indian, two or more Asian categories, and

other Asian, “Native Hawaiian” includes other Pacific Islander, Guamanian, and Samoan, and “Some other race” includes Mulatto, Creole and Mestizo.

As Figure 2 indicates, the general population was quite diverse in 2000. Although approximately 74% of the population fell into one of two ethnic groups (Caucasian and African American), there were a variety of ethnic groups represented in the general population of the County. In addition, 16% of the population indicated it was of a Hispanic origin.

**Age** – Figure 3 shows that approximately 27% of the population was under 17 years old, 57% was between the ages of 18 and 60, and 14% was over the age of 60 in 2000.

**Primary Language Spoken** – The primary languages spoken by the general population five years old and older are presented in Figure 4. 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 76% of the general population was English in 2000. Spanish accounted for an additional 10% of the population. Mien was the only one of Sacramento County’s original seven threshold languages that was not categorized separately on the Census. Individuals with Mien as their primary language would have been included in the “Other” category on the 2000 Census.

## **B2. General Population in County by Region**

Data from the 2000 US Census were obtained for each census tract in the County. Some census tracts run through more than one service delivery region. In these cases, the numbers of people in the census tract were proportionally split to estimate the regional split. Below is a description of the Central, Northeast, Northwest, and Southern service delivery regions of the County. As Figure 5 illustrates, approximately 19%, 26%, 24%, and 31% of the total County population resides in each of these regions, respectively.

**Ethnicity** - The ethnic breakdown of the general population by region is illustrated in Figure 6. As the graph indicates, the regions differ somewhat with respect to ethnic diversity. More than 80% of the Northeast Region is comprised of Caucasians, with African Americans comprising less than 5% of the population, and less than 10% of the population declaring to be of Hispanic origin. In contrast, Caucasians comprise less than 50% of the population in the South Region, with almost 15% being African American, and approximately 20% of the population declaring to be of Hispanic origin. The Central and Northwest Regions fall in between with respect to the ethnic diversity of the general population.

**Age** – Figure 7 illustrates the age breakdown of the general population by region. As the graph indicates, the four regions are very similar, with a few exceptions. Specifically, the South and Northwest Regions have slightly higher percentages of youth younger than 13. In addition, the Central and Northeast Regions have a somewhat higher percentage of individuals over the age of 65.

**Primary Language Spoken** - The primary languages spoken by the general population by region are presented in Figure 8. As the graph indicates, the regions

differ somewhat in terms of the primary language spoken in the home. As with ethnic distribution, the South Region has the highest percentage on the non-English speaking population (more than 30% identify a language other than English as their primary language). It is interesting to note that although more than 80% of the Northeast Region is comprised of Caucasians, 30% of the population identifies a language other than English as their primary language. Diversity of a population in terms of language does not necessarily, therefore, equate to diversity of a population in terms of ethnicity.

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

Data from the 2002 MEDS file were supplied to the County by the State Department of Mental Health for the purpose of describing the population of Medi-Cal beneficiaries in Sacramento County. From those data, the following descriptions of ethnicity, age, and primary language spoken in the home 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” (which also includes “Unknown”). There were 254,132 Medi-Cal eligible beneficiaries in the January 2002 MEDS file.

**Ethnicity** - The ethnic breakdown of Medi-Cal eligible beneficiaries is presented in Figure 9. All categories of ethnicity from the MEDS file are depicted in the graph and overlap with the categories the Cultural Competence Workgroup in Sacramento County included in its human resources assessment.

As the graph indicates, ethnicity of the Medi-Cal eligible population is very diverse. Less than 40% of the population is Caucasian. Other ethnic groups comprising notable proportions of the population include African American (19%), Latino (17%), Vietnamese (3%), Lao (6%), and Asian or Pacific Islander (2%).



**Age** – The age breakdown of Medi-Cal Eligible beneficiaries is illustrated in Figure 10. Almost half the population (49%) is less than 18 years old, while over 10% of the population is aged 60 or more.

**Primary Language Spoken** - The primary language spoken by Medi-Cal beneficiaries is presented in Figure 11. As the graph indicates, the primary language spoken varies greatly. In addition to English (which is the primary language of more than half of the eligible population), seven languages are primary for a substantial portion of the Medi-Cal population: Spanish (9%), Hmong (4%), Russian (7%), Vietnamese (3%), Cantonese (1%), Mien (1%), and Lao (1%). These languages also represent Sacramento County’s original seven threshold languages.

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

Data from the 2002 MEDS file were supplied to the County by the State Department of Mental Health. In order to obtain the data by region, Sacramento County requested an additional MEDS file containing zip codes. The MEDS file with zip code data provided by the State contained records for only 253,843 of the 254,132 Medi-Cal eligible beneficiaries. The data depicted in the regional graphs (Figures 12-15) is based on the 253,843 individuals for whom zip code information was available. Because the County service regions are divided by Census Tracts and not zip code, the zip code data were further transformed to Census Tract data for the regional information. Specifically, zip codes were categorized within census tracts and some zip codes covered more than one census tract. The number of people in zip codes which covered more than one tract were proportionately split to estimate the tract numbers, which could then be divided among the regions.

Below is a description of the Central, Northeast, Northwest, and Southern service delivery regions of the County. As Figure 12 illustrates, approximately 19%, 14%, 27%, and 31% of the total County Medi-Cal population resides in each of these four regions, respectively. In addition to the four service delivery regions, “Out of County” and “Unknown” regions are illustrated. The former represents clients with zip codes falling outside of Sacramento County. The latter represents clients whose mailing address was a PO Box, so the zip code of their residence is unknown. These two categories will not be represented in the discussion that follows. They are presented here only for completeness. The rest of the discussion focuses on clients receiving services in one of the four service delivery regions in the County.

**Ethnicity** - The ethnic breakdown of the Medi-Cal eligible beneficiary population by region is illustrated in Figure 13. As the graph indicates, the regions differ somewhat with respect to ethnic diversity. More than 60% of the Northeast Region is comprised of Caucasians, with African Americans and Latinos comprising a little more than 10% each. In contrast, Caucasians comprise less than 20% of the population in the South Region, with a little more than 20% of the populations being both African American and Latino. The Central and Northwest Regions fall in between with respect to the ethnic diversity of the Medi-Cal eligible beneficiary population.

**Age** – Figure 14 illustrates the age breakdown of the Medi-Cal eligible beneficiary population by region. As the graph indicates, the four regions are very similar, with a few exceptions. Specifically, the South and Northwest Regions have slightly higher percentages of youth younger than 13. In addition, the Central and Northeast Regions have a somewhat higher percentage of individuals over the age of 65.

**Primary Language Spoken** - The primary languages spoken by the Medi-Cal eligible beneficiary population by region are presented in Figure 15. As the graph indicates, the regions differ somewhat in terms of the primary language spoken in the home. As with ethnic distribution, the South Region has the highest percentage on the non-English speaking population (more than 50% identify a language other than English as their primary language). It is interesting to note that in each of the four service delivery regions, more than 40% of the Medi-Cal eligible beneficiary population identifies a language other than English as their primary language.

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

The “Migrant and Seasonal Farmworker Enumeration Profiles Study” prepared for the Migrant Health Program, Bureau of Primary Health Care, Health Resources and Services Administration (Alice Larson, PhD, 2000), was used as the resource for obtaining the seasonal migrant data. The Migrant Health Program enumeration reports are some of the few sources offering migrant and seasonal farm work (MSFW) estimates at the County level. The last time such data were published was in 1990. Data for the enumeration profile are based on the Nation Farmworker Database, the National Agricultural Worker Survey, and the Migrant Health Program Statistics. Data in the report covered the years 1993 to 1997. Per the 2000 enumeration report, Sacramento County is estimated to have 6115 MSFWs with a total of 4766 non-farmworkers in the household (total of 10,881 migrants).

While there are no direct numbers indicating the use of Medi-Cal by migrants, the National Agricultural Worker Survey (1997-98) indicated that 13% used Medi-caid. Extrapolating, one might estimate approximately 1400 Medi-Cal eligible beneficiaries

among the migrant farmworkers of Sacramento County (i.e., 13% of 10,881 migrants). There is no information regarding the regions associated with the migrant workers.

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

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

Data from the 2002 MEDS file were supplied to the County by the State Department of Mental Health for the purpose of describing the Medi-Cal eligible individuals who had used Medi-Cal specialty mental health services in Sacramento County. From those data, the following descriptions of ethnicity, age, diagnosis, and primary language spoken in the home are drawn. The data are presented in terms of the use of inpatient, crisis, outpatient, and day treatment/residential services. There were 16,450 people who had used Medi-Cal specialty mental health services in the January 2002 MEDS file, with 329 using inpatient services, 1645 using crisis, 13,982 using outpatient, and 494 using day treatment/residential services. 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”. Please also note the very low number of clients using inpatient Medi-Cal specialty mental health services. The low number is due partly to the fact that Sacramento’s inpatient unit is a large PHF and is not reimbursed through Medi-Cal. Therefore, the inpatient data in the MEDS file does not reflect actual inpatient utilization, especially for the adult population.

## **C1a. Medi-Cal Beneficiaries**

Figures 16 through 20 illustrate the service utilization information for all individuals in the January 2002 MEDS file. Figure 16 shows the overall service mix for the County, with the majority of clients receiving outpatient mental health services.

Figure 17 illustrates that 83 % of clients receiving services fall into one of three ethnic categories (White [51%], Black [24%], and Hispanic [8%]). Figure 18 illustrates that over half (54%) of the Medi-Cal eligible clients served are under the age of 21. Less than 5% of the clients are 60 years or older. The distribution of client diagnoses is illustrated in Figure 19. The data show that 40% of clients have a primary diagnosis of depressive disorder or schizophrenia and other psychotic disorder. In addition, there are significant numbers of clients diagnosed with adjustment disorders (12%), anxiety disorders (10%), bipolar disorders (11%), and conduct disorders (8%). Finally, Figure 20 illustrates that the primary language of 58% clients who had received specialty mental health services was English. Although many of Sacramento's threshold languages are not represented by the clients, there is a high percentage of clients with a primary language of "Other."

## **C1b. All Services (clients)**

**C1b1. Inpatient.** Figures 21 through 24 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received inpatient mental health services. Figure 21 shows that the majority of inpatient utilization can be accounted for by three ethnic groups: White (55%), Black (19%), and Hispanic (9%).

Related to the fact that Sacramento's adult inpatient unit is a large PHF and is not reimbursed through Medi-Cal, Figure 22 shows that 84% of the Medi-Cal Eligible inpatient utilization is accounted for by youth under 21 years of age. Figure 23 illustrates that the four most frequent diagnostic categories include depressive disorders (33%), bipolar disorders (18%), schizophrenia and other psychotic disorders (16%), and anxiety disorders (12%). Finally, Figure 24 illustrates that the primary language of 67% clients who had utilized inpatient services was English. Although many of the languages included on the graph indicate very few clients spoke these languages, there is a high percentage of "Other."

**C1b2. Crisis.** Figures 25 through 28 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received crisis mental health services. Figure 25 shows that the majority of crisis utilization can be accounted for by three ethnic groups: White (54%), Black (23%), and Hispanic (6%).

Figure 26 indicates a substantial proportion of crisis services are utilized by youth under the age of 18 years (39%), while older adults utilize very few of these services (4%). Figure 27 illustrates that the three most frequent diagnostic categories include depressive disorders (22%), schizophrenia and other psychotic disorders (22%), and bipolar disorders (15%). Finally, Figure 28 illustrates that the primary language of 55% of the clients who had utilized crisis services was English and 1% was Spanish. Again, there is an extremely high rate of "Other" (42%).

**C1b3. Outpatient.** Figures 29 through 32 illustrate the ethnicity, age, diagnosis,

and primary language spoken for clients who had received outpatient mental health services. Figure 29 shows that the majority of outpatient utilization can be accounted for by three ethnic groups: White (52%), Black (23%), and Hispanic (8%).

Figure 30 indicates that the majority of outpatient services are utilized by youth under the age of 21 years (54%), while older adults utilize very few of these services (4%). The distribution of client diagnoses is illustrated in Figure 31. The data show that 40% of clients have a primary diagnosis of depressive disorder or schizophrenia and other psychotic disorder. In addition, there are significant numbers of clients diagnosed with adjustment disorders (12%), anxiety disorders (10%), bipolar disorders (11%), and conduct disorders (8%). Finally, Figure 32 illustrates that the primary language of 58% of the clients who had utilized outpatient services was English, 2% was Spanish, and 1% was Hmong. Again, there is an extremely high rate of “Other” (38%).

**C1b4. Day Treatment/Residential.** Figures 33 through 36 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received day treatment/residential mental health services. Figure 33 shows that the majority of day treatment/residential utilization can be accounted for by two ethnic groups: White (56%) and Black (26%).

Figure 34 indicates that the majority of day treatment/residential services are utilized by youth under the age of 21 years (64%), while older adults utilize very few of these services (1%). The distribution of client diagnoses is illustrated in Figure 35. A surprising finding shows that 34% of clients have a

deferred diagnosis. The most commonly held diagnoses after that are schizophrenia and other psychotic disorder (16%), anxiety disorders (12%), depressive disorders (9%), bipolar disorders (9%), and conduct disorders (8%). Finally, Figure 36 illustrates that the primary language of 63% of clients who had utilized day treatment/residential services was English and there was an extremely high rate of “Other” (36%).

**C2. Most recent available number of Medi-Cal beneficiaries using medically necessary specialty mental health services by County region (FFS and SD/MC) arrayed by one of the following service category groupings:**

Data from the 2002 MEDS file were supplied to the County by the State Department of Mental Health for the purpose of describing the Medi-Cal eligible individuals who had used Medi-Cal specialty mental health services in Sacramento County. In order to obtain the data by region, Sacramento County requested an additional MEDS file containing zip codes. Because the County service regions are divided by Census Tracts and not zip code, the zip code data were further transformed to Census Tract data for the regional information. Specifically, zip codes were categorized within census tracts and some zip codes covered more than one census tract. The number of people in zip codes which covered more than one tract were proportionately split to estimate the tract numbers, which could then be divided among the regions.

The following section, therefore, describes service utilization in terms of inpatient, crisis, outpatient, and day treatment/residential, by service delivery region and by ethnicity, age, diagnosis, and primary language spoken in the home. 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” (which includes “Unknown”).



## **C2a. Medi-Cal Beneficiaries**

Figures 37 through 41 illustrate the regional service utilization information for all individuals in the January 2002 MEDS file. Figure 37 shows the regional service mix for the County, with the majority of clients in each region receiving outpatient mental health services. There is a very slight tendency for clients in the Central Region to have somewhat elevated crisis and day treatment/residential utilization.

Figure 38 illustrates considerable variation in the client ethnic distribution in the service delivery regions. For example, the Caucasian populations vary from just over 30% in the South region to almost 70% in the Northeast region. Likewise, the African American populations vary from over 30% in the South region to just over 10% in the Northeast region. Although not as dramatic, the Latino population runs from about 5% in the Northeast region to more than 10% in the South region.

Figure 39 illustrates that the Central and Northeast regions provide services to somewhat fewer youth under the age of 18, but have a tendency to provide somewhat more service to adults aged 40-59. The distribution of client diagnoses by region is illustrated in Figure 40. The data show that although there is variation among the regions, the two most frequent diagnoses are always depressive disorders and schizophrenia and other psychotic disorders. Finally, Figure 41 illustrates that the primary language of Medi-Cal eligible clients who had received specialty mental health services by region. As the figure indicates, English was the primary language in all regions. The South region showed a somewhat higher Spanish speaking population than the other regions. In addition, there is a high percentage of "Other" across all regions.

## **C2b. All Services (clients)**

**C2b1. Inpatient.** Figures 42 through 45 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received inpatient mental health services by region. Figure 42 shows that the ethnic distribution of clients utilizing inpatient services was most diverse in the South region, followed by the Central, Northwest, and Northeast regions.

Again, related to the fact that Sacramento's adult inpatient unit is a large PHF and is not reimbursed through Medi-Cal, Figure 43 shows that most of the Medi-Cal eligible inpatient utilization is accounted for by youth under 21 years of age. However, the regions differ somewhat, with the Northeast and Northwest regions having somewhat higher percentages of latency age youth and the South and Central regions having somewhat higher percentages of transition age youth. Figure 44 illustrates that the two most frequent diagnostic categories for all regions include depressive disorders and bipolar disorders. In comparison to the other regions, the Central region has a somewhat higher frequency of anxiety disorders, while the Northwest region has a somewhat higher frequency of ADHD. Finally, Figure 45 illustrates that the primary language of clients utilizing inpatient services was most diverse in the South region, followed by the Central, Northwest, and Northeast regions. In addition, there is a high percentage of "Other" across all regions.

**C2b2. Crisis.** Figures 46 through 49 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received crisis mental health services by region. Figure 46 shows that the ethnic distribution of clients

utilizing crisis services was most diverse in the South region, followed by the Northeast, Northwest, and Central regions.

Figure 47 indicates that in the Northwest, Northeast, and South regions, the age category with the most frequent crisis utilization is 21-39 year olds. The Central region also has a substantial proportion of 40-59 years olds utilizing crisis services. Figure 48 illustrates that the three most frequent diagnostic categories for all regions include depressive disorders, bipolar disorders, and schizophrenia and other psychotic disorders. In comparison to the other regions, the Central region has a somewhat higher frequency of schizophrenia and other psychotic disorders. Finally, Figure 49 illustrates that the primary language of clients utilizing crisis services was most diverse in the South region. In addition, there is a high percentage of “Other” in all regions.

**C2b3. Outpatient.** Figures 50 through 53 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received outpatient mental health services. Figure 50 shows that the ethnic distribution of clients utilizing outpatient services was most diverse in the South region, followed by the Central, Northwest, and Northeast regions.

Figure 51 indicates that outpatient services in the Central region are provided to a slightly older group of clients. The age distributions of clients in the regions, however, are remarkably similar. Figure 52 illustrates that the two most frequent diagnostic categories for all regions include depressive disorders and schizophrenia and other psychotic disorders. Finally, Figure 53 illustrates that the primary language of clients utilizing outpatient services was most diverse in the South region. In addition, there is a high percentage of “Other” in all regions.

**C2b4. Day Treatment/Residential.** Figures 54 through 57 illustrate the ethnicity, age, diagnosis, and primary language spoken for clients who had received day treatment/residential mental health services. Figure 54 shows that ethnic distribution of clients utilizing day treatment/residential services was most diverse in the South region, followed by the Central, Northwest, and Northeast regions.

Figure 55 indicates that day treatment/residential services in the Central region are provided to a slightly older group of clients. The age distributions of clients in the regions, however, are remarkably similar. It indicates that the majority of day treatment/residential services are utilized by youth under the age of 21 years (64%), while older adults utilize very few of these services (1%). The distribution of client diagnoses is illustrated in Figure 56. As before, a surprising finding is that in each region, the majority of clients served have a deferred diagnosis. On the whole, the diagnostic profiles of the regions are very similar. Finally, Figure 57 illustrates that the primary language of most clients who had utilized day treatment/residential services was English in each of the regions, although there was an extremely high rate of “Other.”

- C2. ANALYSIS: An annual analysis of the population assessment and utilization data, and conclusions drawn by the MHP in terms of designing and planning for the provision of appropriate and effective specialty mental health services. The analysis may include:**
- **Access for specific groups by mode of service and age group;**
  - **Comparison of disparities by ethnic group along service types;**
  - **Discrepancies and utilization by mode of service.**

**Specifically identify any objectives related to the need for, and the provision of, culturally and linguistically competent services based on the**

**population assessment, the identified threshold languages and the disparities or discrepancies in access and service delivery. The objectives shall be measurable and include specified activities to meet objectives, required resources and identified timelines.**

**Ethnicity** – The general and Medi-Cal populations in Sacramento are both very ethnically diverse. Only 64% of the general population and 39% of the Medi-Cal population is Caucasian. Given that only 39% of the Medi-Cal population is Caucasian, the service use patterns are somewhat surprising. In fact, the utilization data suggest that in every respect, compared to the Medi-Cal population, we are serving higher numbers of Caucasian and African American clients and lower numbers of Latino clients than we would expect. For example, while Latinos comprise 17% of the Medi-Cal population, they comprise only 8% of clients utilizing specialty mental health services. The proportion of Latino clients in day treatment/residential services is extremely low (only 3%). It should be noted that the under-utilization of mental health services by the Latino population is not specific to Sacramento County. Rather, the State Department of Mental Health has identified a need for all California counties to prioritize outreach to this population, and further, to identify and eliminate barriers to accessing and remaining in service. To this end Sacramento County has been actively gathering information from a variety of stakeholders in a series of focus groups. We plan to aggregate the information and identify strategies to increase our penetration rate in the Latino community.

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. Specifically, 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.

**Age** –Although youth under the age of 21 comprise 31% of the general population in Sacramento, they account for more than half (54%) of the Medi-Cal population. Further, youth are utilizing services in Sacramento in proportion to the number of youth in the Medi-Cal population. Specifically, youth are receiving 54% of the services overall, as well as 54% of the outpatient services. Although it appears that youth are over-utilizing inpatient services (84%), this is an artifact of our adult inpatients not being Medi-Cal billable.

Of greater concern is the apparent lack of service being provided to older adults in our community. Individuals over the age of 60 comprise 14% of the Medi-Cal population, but only 4% of those who receive specialty mental health services.

When the data are examined on a regional basis, it is difficult to identify meaningful patterns across or between the regions. The most obvious may be that to some extent, the South region tends to serve somewhat younger clients, while the Central region tends to serve somewhat older clients.

**Primary Language** – The general population data indicates that Sacramento is comprised primarily of English and Spanish speaking people (76% and 10% respectively). The Medi-Cal population data suggests a very different picture. Only 53% of this population is English speaking. The original seven threshold languages (Spanish, Hmong, Russian, Vietnamese, Cantonese, Mien, and Lao) account for an additional 26% of the population. The service utilization data are difficult to interpret since so many clients were classified in the “Other” category (which includes Unknown). What is clear, is that only 3% of clients whose primary language was classified as one of Sacramento’s original threshold languages have been served (vs. 26% of the Medi-Cal population).

The general population regional data illustrate clear differences with respect to language diversity. The most diverse region is the South and the least diverse is the Northwest. The most diverse Medi-Cal population is also in the South region, but the least diverse becomes the Northeast region. Regional language diversity of clients differs depending on the specific service. In general, however, the Central region tends to be the most diverse and the Northwest region tends to be the least.

**Diagnosis** – There are no general population or Medi-Cal population data regarding diagnosis. The utilization data indicates that with the exception of day treatment/residential services, Sacramento primarily serves clients with depressive disorders, schizophrenia and other psychotic disorders, and bipolar disorders. Interestingly, the day treatment/residential data suggested that the majority of those clients had deferred diagnoses.

**Summary** – In sum, the general population in Sacramento County is very diverse in terms of ethnicity, age, and primary language spoken in the home. Although the Medi-Cal population mirrors this diversity (and in fact, makes it more dramatic), the service utilization patterns indicate that Sacramento is under-serving specific portions of the population. Measurable objectives for this plan will be addressed after an analysis of the human resource data.

### **C3. OBJECTIVES**

**3A. Report the progress toward your objectives, as listed in the MHPs revised CCP to design, plan, and provide culturally and linguistically appropriate and effective mental health services based on your population data analysis and conclusions. Identify barriers that impede progress in your objective. What steps have been taken to address identified barriers?**

Please refer to Section II 3 for measurable objectives.

**3B. Identify any new or changed or updated objectives developed to reflect a better way to meet the needs identified in the original or, if applicable, new population analysis.**

Please refer to Section II 3 for new or changed objectives.

**3C. Has the MHP identified any local trends that impact culturally competent services? If yes, please describe. For instance, change in Medi-Cal populations, ethnic population, threshold language, influx of immigration or migrant workers, etc.**

Since the 2002 Cultural Competence Plan Update in which Sacramento was cited as having the 2<sup>nd</sup> highest number of newly arriving refugees, Sacramento now leads in the largest number of newly arriving refugees in the state. Using California Department of Social Services Refugee Program Branch data, the following represents the new arrivals for the FFY 2002-2003 in the state:

Sacramento County	1292
Los Angeles	714
San Diego	334
Santa Clara	311
Orange	218

Sacramento County continues to experience a significant number of refugees predominantly from the former Soviet Union, the Middle East, Vietnam and Liberia. The following are the countries arrived from or ethnicities, for the FFY 2002-2003:

Afghanistan	12
Iran	28
Vietnam	17
Former Russia	1229



Other (Liberia)	6
Total	1,292

Note: This report includes October 1, 2002 through August 31, 2003.

September new arrivals were not available at this reporting time.

From Federal Fiscal year 2002 (October 1, 2001 through September 30, 2002), Sacramento County received 1,775 new arrivals. 1,325 were reported from the former Soviet Union, with the remainder from Laos, Vietnam, Iran and Bosnia.

As the county saw an increase in the number of Eastern European refugees, it experienced a decrease in the number of Lao and Mien Medi-Cal recipients in the community. These two languages no longer meet the threshold language criteria for Sacramento County. Since we continue to have numbers of consumers from these communities requesting and receiving services, we continue as if these languages meet the threshold language requirements.

The influx of refugees from Eastern European countries and others required that over the last several years we add staff that speak their languages, train existing staff about these new populations and design services that specifically meet their needs. To begin, we hosted a day-long refugee conference on May 1, 2002 that focused on the mental health needs of new refugee communities in Sacramento County. The conference was well received. We are partnered with a local refugee health program to train staff on the needs of these communities.

Growing diversity requires additional strategies to ensure that new populations receive appropriate mental health services. One strategy includes partnership with federally funded programs designed to meet the resettlement needs of refugees. In FFY 2002-2003, Sacramento County through Sacramento Employment and Training (SETA) Resettlement Set-Aside (RESS), funded a program to provide and enhance Family Well-Being within refugee families. This program identified and provided social adjustment and culturally competent orientation services to refugee families at high risk. Hmong, Laotian, Cambodian, Ethnic Chinese, Mien, Bosnian and others were provided such services as translation/interpretation, crisis intervention, individual or group counseling, assistance with health management and more. Refugee communities have been very responsive to these services which are holistic and compatible with cultural considerations. Mental health services are folded into other social services. Studies were shown that this program design is effective in treating refugee communities. At the end of the FFY, over 2,669 units of services were provided. This program has been continued into FFY 2003-2004, with identified groups to include the former Soviet Union and the Balkan states.

While Sacramento County Mental Health does not fund these programs, we collaborated with these agencies during the planning process and continue to work collaboratively with funded community based agencies to provide support to the agencies through participation at community forums; active participation in evaluation of current services and planning for future needs; providing education and training to community based staff to identify individuals suffering from chronic and persistent mental illness; arranging culturally appropriate linkage paths to county mental health services for

individuals requiring services beyond those provided by the resettlement agencies; and, participating in outreach efforts. Our strategy to partner with other community agencies to meet refugee community mental health needs has proven successful and has expanded the MHP's capacity to arrange and provide services for a growing refugee community.

Sacramento County continues to work to meet the mental health needs of refugee children. Sacramento continues to have the highest number of newly arriving refugee children in the state. While more up-to-date statistics are not available, from 1997 – 2001, Sacramento had 4040 newly arriving children. These children add to the large number who arrived during the 1990s. We continue to strive to develop and secure funding for programs that meet the unique needs of refugee children and their families.

To further address the needs of refugee and immigrant populations, University of California, Davis, Department of Psychiatry partnered with Sacramento County to establish a Cultural Consultation Service (CCS). CCS is only one of three services established in North America. CCS staff provide individual client assessment, staff training and consultation to individuals and programs funded by the Sacramento MHP throughout the County. As a result of a training needs assessment conducted by CCS staff in Summer 2002, a training series has been developed to assist staff who provide services to immigrant and refugee populations. The training series is scheduled to commence in Fall 2003.

# **PART II**

## **PART II – ORGANIZATIONAL AND SERVICE PROVIDER ASSESSMENT UPDATE**

### **1. HUMAN RESOURCES ASSESSMENT DATA**

#### **1A. Current Composition**

In 1997, the Cultural Competency Workgroup developed a Human Resources Survey that staff of each agency (contract provider and county-operated facility) and the Division of Mental Health administrative units have completed annually. The survey has been modified several times since 1997, in response to comments from the community (See Appendix A for the most recent version of the survey). The latest Human Resources survey was distributed in Spring 2003 to all the original respondents, including members of the Mental Health Board. The Survey elicited information regarding the ethnicity of staff, languages spoken by staff, and languages staff reads and writes. The survey gathered separate information for six staff functions, including: Board of Directors, Administration/Management, Direct Services, Clerical Support, Interpreters/Translators, and Other. The latter category primarily represents volunteer staff, student interns, and on-call staff members. Responses from 3412 service and administrative staff were received. Below is a description of the information.

#### **A1. Ethnicity by Function**

##### **A1a. Administration/management;**

##### **A1b. Direct services;**

##### **A1c. Support services;**

##### **A1d. Interpreters;**

##### **A1e. Staff who have voluntarily self-identified as consumers.**

Figure 58 illustrates that across all staff functions, the ethnic categories represented in the County are quite diverse. In the five years that have passed since the original cultural competence plan was submitted, Sacramento has been successful in increasing the ethnic diversity of its staff. While the percentage of staff

self-identifying as Caucasian has decreased (from 66% to 62%), the percentage of staff self-identifying as Latino, Mien, Former Soviet, Hmong, Lao, and Vietnamese have all increased. Although current percentages of staff in these ethnic categories remain relatively low, the sheer number of staff in each ethnic category continues to grow. For example, although 0.7% of staff self-identify as Vietnamese, that represents 239 Vietnamese staff in our system (compared to 105 Vietnamese staff five years ago).

Figure 59 shows that ethnic diversity, not surprisingly, depends on the function of staff. Staff categories with a high degree of ethnic diversity include Interpreters, “Other,” support services, and direct services. Although the Board of Directors and Administration/Management shows less diversity, at least 10 ethnic categories are represented in each. Please note that the ethnic distribution of consumers illustrated in Figure 59 is data that are one year old. In an effort to make our Human Resources survey more user-friendly in 2003, we asked consumers to self-identify, but did not ask them to identify their ethnicity. At the same time, we also refrained from asking the ethnicity of family members. We will re-incorporate both items in the version we distribute in 2004.

## **A2. Bilingual Staff by Function and Language**

**A2a. Administration/management;**

**A2b. Direct services;**

**A2c. Support services;**

**A2d. Interpreters;**

**A2e. Staff who have voluntarily self-identified as consumers.**

Across all staff functions, Sacramento has 480 bilingual staff (about 14.1% of all staff). Figure 60 illustrates that across all staff functions, the bilingual capabilities represented in the County are quite diverse. In the five years that have passed since the original cultural competence plan was submitted, Sacramento has also been successful in increasing the bilingual ability of its staff. Specifically, five years ago,

we reported 158 staff with bilingual capability, which at that point represented 7.5% of all staff.

Figure 61 shows that bilingual capability also depends on the function of staff. Of course, 100% of the interpreters are bilingual and they show tremendous diversity in the languages they are capable of speaking. Particularly impressive, however, is that fully 14.5% of the direct service staff are proficient in a language other than English, and are proficient in over 12 languages in total. Please note that the language proficiency of consumers is not included in Figure 61. We have never asked for this information on our Human Resources survey but will incorporate it in the version we send out in 2004.

### **A3. Staff Proficiency in Reading and/or Writing in a Language Other Than English by Function and Language**

**A3a. Administration/management;**

**A3b. Direct services;**

**A3c. Support services;**

**A3d. Interpreters.**

Across all staff functions, Sacramento has 328 staff capable of reading/writing in languages other than English (about 9.6% of all staff). Figure 62 illustrates that across all staff functions, there is diversity in the languages that staff is capable of reading/writing. Figure 63 shows that capability of reading/writing in languages other than English also depends on the function of staff. Almost 100% of the interpreters are proficient in reading/writing languages other than English. There is also tremendous diversity in the languages interpreters are capable of reading/writing. Particularly impressive, however, is that almost 10% of the direct service staff are capable of reading/writing in a language other than English, and there is proficiency in over 12 languages.

## **B. LOCATION**

As before, this description is based on the results of the latest Human Resources survey distributed in Spring 2003. The Survey elicited information regarding the ethnicity of staff, languages spoken by staff, and languages read and written by staff . The survey gathered separate information for six staff functions, including: Board of Directors, Administration/Management, Direct Services, Clerical Support, Interpreters/Translators, and Other. In addition to presenting information regarding human resources in 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 travels to the client.

*\*\*Please note that although Sacramento County is divided into four service delivery regions, only three regions and non-regional services are illustrated in this section. The organization responsible for providing services in the fourth region also provides non-regional services. Because we collected the Human Resources information by organization rather than by program, we could not differentiate the staff providing regional services. In subsequent years, we intend to modify our methodology to make this possible.*

### **B1. Ethnicity by Function**

**B1a. Administration/management;**

**B1b. Direct services;**

**B1c. Support services;**

**B1d. Interpreters;**

**B1e. Staff who have voluntarily self-identified as consumers.**

Figures 64 through 70 present the regional breakdown of ethnicity for the seven staff functions. In most cases, staff associated with agencies providing non-regionalized services represent the most diverse groups. A notable exception occurs in the case of direct services. Figure 66 illustrates the percentages of ethnically diverse staff in the South, Northeast, and Central regions. An additional item of interest is related to the limited ethnic diversity of administration. Specifically, Figure 65 shows that the



administration in the Northeast region is primarily Caucasian (78%), with the remainder being African American. Although the South and Central regions display somewhat more administrative ethnic diversity, the Non-regional services are clearly more heterogeneous.

## **B2. Bilingual Staff by Function and Language**

**B2a. Administration/management;**

**B2b. Direct services;**

**B2c. Support services;**

**B2d. Interpreters.**

Figures 71 through 76 present the regional breakdown of languages other than English spoken by bilingual staff for six staff functions. In all cases, staff associated with agencies providing non-regionalized services represent the most diverse groups. In terms of quality service for clients whose primary language is not English, however, the staff group most critical in which to have bilingual ability is the direct service staff. Figure 73 shows this breakdown. As the figure indicates, the South region has direct service staff with the ability to speak in all seven original threshold languages. The Northeast and Central regions have staff with this ability in 4 and 3 of the languages, respectively. Depending on the particular situation, the degree of difficulty associated with not having direct service staff capable of conversing in the remaining languages may be attenuated by the non-regional services having the capabilities.

## **B3. Staff Proficiency in Reading and/or Writing in a Language Other Than English by Function and Language**

**B3a. Administration/management;**

**B3b. Direct services;**

**B3c. Support services;**

**B3d. Interpreters.**

Figures 77 through 82 present the regional breakdown of languages other than English that staff can read and/or write for six staff functions. Again, in all cases, staff

associated with agencies providing non-regionalized services represent the most diverse groups. As above, however, quality service for clients whose primary language is not English requires that direct service staff have abilities in languages other than English. Figure 79 shows this breakdown. As the figure indicates, the South region has direct service staff with the ability to read/write in six of seven original threshold languages. The Central region has staff with this ability in 2 of the languages, and the Northeast region reports no staff with this ability. Depending on the particular situation, the degree of difficulty associated with not having direct service staff capable of reading/writing in the remaining languages may be attenuated by the non-regional services having the capabilities.

**ANALYSIS: An analysis of the human resources composition by location data in contrast to the population needs assessment data for each population category, and conclusions drawn by the MHP in terms of designing and planning for the provision of appropriate and effective specialty mental health services.**

- **Identify any objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population and human resources assessment.**
- **Identify disparities between the Medi-cal beneficiary population and the cultural, ethnic and linguistic diversity of the MHP's direct service providers.**
- **Compare the percentages of culturally, ethnically, and linguistically diverse direct service providers to the same characteristics of the Medi-Cal beneficiary population. Any identified disparity must be addressed in the CCP.**

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 who reflect the Medi-Cal population of the County. Almost 40% of staff identify as non-Caucasian, while about 14% of them have bilingual ability that, in total, covers over 20 languages. Moreover, in the last five years Sacramento County mental health service providers have been successful in

increasing both the ethnic diversity of the workforce and the bilingual capability of staff. (See Figure 83)

On the whole, when the data are examined on a regional basis, the impressive diversity of staff is again highlighted. Potentially troublesome areas are the lack of ability of direct service staff in the Central region to serve individuals in Cantonese, Mien, Russian, or Vietnamese, and the lack of ability of direct service staff in the Northeast region to serve individuals in Hmong, Lao, and Mien. Although the non-regional services (including the Assisted Access programs – Southeast Asian Assistance Center serving the Southeast Asian communities and Former Soviet/Eastern European communities and Asian Pacific Counseling Center serving the API communities) have the staff to provide assistance to the consumers in these regions, it is not clear that this is sufficient. Therefore one need for Sacramento is to support the hiring of staff who have abilities in threshold languages not yet represented in the regions.

Comparison of the percentage of culturally, ethnically and linguistically diverse direct service providers to the same characteristics of the MediCal beneficiary population reveals some significant differences. When comparing the primary language breakdown of the Medi-Cal population with that of our direct service staff, a great disparity is evident in 3 languages: Russian, Vietnamese, and Hmong. (See Figure 84)

When comparing the ethnic breakdown of the Medi-Cal population with that of our direct service staff, a great disparity is evident in 4 ethnic groups: Vietnamese, Laotian, Latino, and Caucasian. (See Figure 85) While Caucasians are over represented in direct service staff compared to the Medi-Cal population, the remaining

three ethnic groups are under represented. We are not able to make comparisons with respect to the Hmong, Mien, or Former Soviet groups because the Medi-Cal data are unavailable. In summary, one need for Sacramento is to support the hiring of bilingual/bicultural staff who are Vietnamese, Laotian and Latino and bilingual/bicultural staff who speak Russian, Vietnamese and Hmong.

### 3) OBJECTIVES

- A. Report the progress toward your objectives, as listed in the MHP's CCP, to design, plan, and provide culturally and linguistically appropriate and effective mental health services based on your human resources composition in contrast to the population needs assessment data and conclusions. Identify barriers that impeded progress in your objective. What steps have been taken to address identified barriers?**

#### **Objectives from 1998 Cultural Competence Plan**

**Objective 1.** Support the hire of staff that have the ability in threshold languages not yet represented by type of program (i.e. target programs focusing on children and families) and by region (i.e. Central, Northeast and Northwest Regions).

- For all original threshold languages except Russian, we have been successful in increasing the percentage of direct service staff who are able to provide services in those languages. The percentages for all except Spanish, however, remain at less than 1%.

**Barriers/Successes** – Some of the barriers that led to only partial achievement of the objective are outline in Part II, Section 3 of this document.

We will continue to work to recruit bilingual staff. This objective will be updated in Section II, 3B below.

**Objective 2.** Do an in-depth analysis of the composition of staff in terms of ethnicity and languages, as compared to the composition of consumers utilizing services.

- Language comparison – of Sacramento’s original threshold languages, our direct service staff appears to be underrepresented in only Russian and Mien. In the remaining five languages, the proportion of direct service staff available is greater than the proportion of clients. (See Figure 86)
- Ethnicity Comparison – for the data that are available and presented in Figure 87, (client ethnicity data are not available for Mien, Hmong, and Former Soviet), it appears that direct service staff is significantly underrepresented for African American clients. The proportion of Laotian staff is also slightly less than the proportion of Laotian clients. The remaining four ethnic categories for which comparative data are available suggest equal or greater proportions of staff to clients.

**Barriers/Successes** – The successes are listed above. Barriers to fully achieving this goal are related to human resource constraints outlined in Section II, 3C of this document.

This objective will be updated in Section II, 3B.

**Objective 3.** Hire 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 parent training and hiring parents as providers.

- The Family Coordinator has been hired and is an active member of the Executive Management Team; organizes parent support groups and routinely conducts training to the system regarding parent involvement issues.

**Barriers/Successes** – Sacramento County is now well known statewide for its Family Advocacy program developed by staff in the Children’s System of Care. The Family Coordinator/Advocate Supervision played an important role in the development of this highly successful program.

The objective as written has been achieved.

The next step in further insuring the provision of culturally and linguistically competent services for Sacramento County’s diverse communities is to involve multicultural parents. To this end, the new objective in this area will be found in Section 3B below.

- The number of family members has increased from 42 in 1998 to 210 in 2003 - an increase of 400% in 5 years.

The objective as written has been achieved. All components of Objective 3, while achieved, will be monitored to maintain current levels.

**Objectives developed subsequent to those contained in 1998 Cultural Competence Plan as reported in the 2002 Cultural Competence Plan Annual Submission in Summer 2002. Numerous objectives were developed between 1998 – 2001. Report on progress towards those objectives were contained in the 2002 Annual Submission. This section contains report on progress of objectives developed since 2001.**

**Objective 4.** Increase capacity of service delivery by number, type, and ethnicity.

- The following tables illustrate mental health service utilization rate (general and by ethnicity) during each fiscal year in relation to the total number of Medi-Cal recipients in Sacramento County at the beginning of each calendar year. The increase in Utilization Rate column refers to the increase in the utilization rate from the prior year, expressed as a percentage. The figures for Unduplicated Clients served were obtained from the County of Sacramento Client Activity Tracking System (CATS). The State of California Department of Health furnished the number of Medi-Cal recipients.

### MENTAL HEALTH SERVICES UTILIZATION RATES

Year	Number of Unduplicated Clients Served July 1 – June 30	Number of Medi-Cal Recipients, January 2002, January 2001, and January 1999	Utilization Rate	Increase in Utilization Rate
2001-2002	27,157	251,418	10.8%	2.9%
2000-2001	24,948	238,553	10.5%	29.6%
1999-2000	18,871	233,219	8.1%	19.1%
1998-1999	16,091	237,431	6.8%	

### UTILIZATION RATE BY ETHNICITY 2001-2002

Ethnicity	Number of Unduplicated Clients Served, July 1, 2001 to June 30, 2002	Number of Medi-Cal Recipients, January, 2002	Utilization Rate 01/02	Utilization Rate 00/01	Increase (Decrease) in Utilization Rate
Caucasian	14,039	96,955	14.5%	14.0	3.6%
African American	6,160	48,820	12.6	11.7	7.7%
Hispanic	3,096	39,252	7.9	7.5	5.3%
Other (including multi-ethnic)	3,019	19,738	5.3	8.6	(38.4%)
Other Asian/Pacific Islander	405	15,044	2.7	9.3	(70.9%)
Laotian	161	14,821	1.1	0.9	22.2%
Vietnamese	200	7,324	2.7	2.2	22.7%
Chinese	77	3,689	2.1	2.2	(4.5%)
Totals	27,157	245,643	11.1	10.5	5.7%



### UTILIZATION RATES BY ETHNICITY 2000-2001

Ethnicity	Number of Unduplicated Clients Served, July 1, 2000 to June 30, 2001	Number of Medi-Cal Recipients, January, 2001	Utilization Rate	Increase/ (Decrease) in Utilization Rate
Caucasian	13,319	94,981	14.0%	33.3%
African American	5,659	48,184	11.7%	21.9%
Hispanic	2,686	35,752	7.5%	21.0%
Other (including multi-ethnic)	2,525	29,396	8.6%	36.5%
Other Asian/ Pacific Islander	379	4,090	9.3%	97.9%
Laotian	139	15,092	0.9%	(52.6%)
Vietnamese	159	7,264	2.2%	22.2%
Chinese	82	3,794	2.2%	57.1%
Totals	24,948	238,553	10.5%	29.6%

**Barriers/Successes:** During Fiscal Year 2001-2002, the MHP was successful in increasing the number of clients served by 2,209. The overall utilization rate increased by 5.7%. While the utilization rate increased in all communities except Chinese and multi-ethnics, the utilization rate in two specially represented ethnic groups in Sacramento's demographics profile (Laotian and Vietnamese) increased at a significantly greater rate, suggesting that the MHP outreach efforts are effective.

An update of this objective is expressed as a penetration rate objective is in Section IV 3 of this document.

**Objective 5.** Ensure MHP staff participate in cultural competence training to improve skill set necessary to better serve diverse communities.

- 50% of direct service staff will attend cultural competence training annually.

**Barriers/Successes** - Cultural Competence training numbers exceeded the goal of 50% of direct service staff attending cultural competence training annually by 59%.

While this objective spanned 2 years and was intended for direct service staff, administrative/management staff was also included in training activities and their attendance was tracked also.

A new training objective will be indicated in Section 3B below.

- Service staff will participate in culturally competent dual diagnosis training twice annually.

**Barriers/Successes** – Two culturally competent dual diagnosis training were conducted annually.

- Cultural Competence will be integrated and embedded in all training/educational opportunities.

**Barriers/Successes** - The MHP was successful in integrating and embedding cultural competence in all training/education opportunities 60% of the time. While Sacramento County was reasonably successful with this objective with a 60% rate, this objective presented quite a challenge. Our greatest success was in training conducted by MHP staff, as we exercised full control over the content. The challenge was greater when outside trainers were used and, as in some cases, greater

vigilance was required to assure their skill in cultural competence as well as their specialized subject area. In some cases, co-presenters or other strategies were necessary to incorporate cultural competence into the material. As cultural competence expertise increases, it will be easier to find subject matter experts in various areas of mental health who are also culturally competent.

We will continue to embed cultural competence in all trainings.

We plan to implement use of the California Brief Multicultural Scale and training modules as soon as they are available. This will assist in the development of individualized training plans for staff. Meanwhile, cultural and ethnic specific training will continue.

**Objective 6.** Ensure MHP progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide *Cultural Competence Agency Self Assessment* survey.

**Barriers/Successes** – Over the years, the Cultural Competence Agency Self Assessment has been modified after feedback from those who have completed it. Analysis of the completed surveys has assisted MHP administrators in assessing the effectiveness of system-wide cultural competence goals and the development of new ones. The assessment also allows individual agencies the opportunity to track their own progress. The MHP requires contract and county operated programs to include a cultural competence goal in their Annual Work Plan. Many agencies use the Cultural Competence Agency Self Assessment

data to formulate these goals. As a result of the 2002 survey, for instance, efforts to train interpreters were intensified and a new objective to this end has been developed.

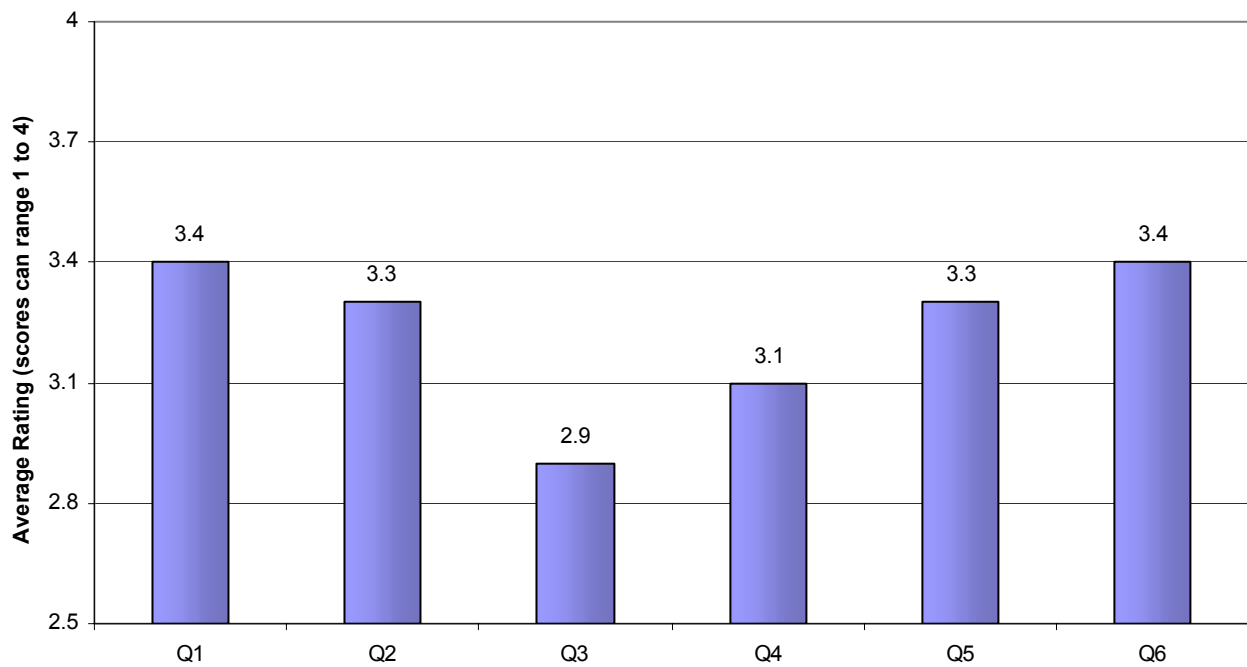
We will continue to issue the survey biennially. (See Appendix B for most recent copy of Agency Self Assessment.)

### **Cultural Competence – Agency Self-Assessments**

In 2002, 1,389 staff provided ratings on the Agency Self-Assessment of Cultural Competency. The Self-Assessment requests staff to provide information on four domains: Administration, Program and Policy Development, Consumer Related Services and Staff Training, and Service Delivery. We developed multiple items to assess each domain, and staff responded to each item on a 4-point scale (i.e., strongly agree, probably agree, probably disagree, or strongly disagree). Higher scores on each item indicate strong agreement. Two major themes are apparent across the domains. First, staff perceives the need for help in the area of working with and training of interpreters. Staff reported being less satisfied on all items referring to this topic. Second, there are a couple of areas where the Mental Health Plan can improve regarding the recruitment and retention of culturally diverse and culturally skilled staff. Below we summarize staff responses in each domain. Each summary contains the major findings in that domain, a graph of item responses, and a listing of the actual items.

## Section I: Administration

As the graph indicates, staff generally felt the administration was operating in a culturally competent manner. The average score across all 6 items was 3.2 and most of the individual items had ratings between 3 and 4 (4 being the highest possible rating). The rating of 2.9 for “The management team ensures that staff is proficient in working with interpreters” is one that stands out as worthy of further investigation.



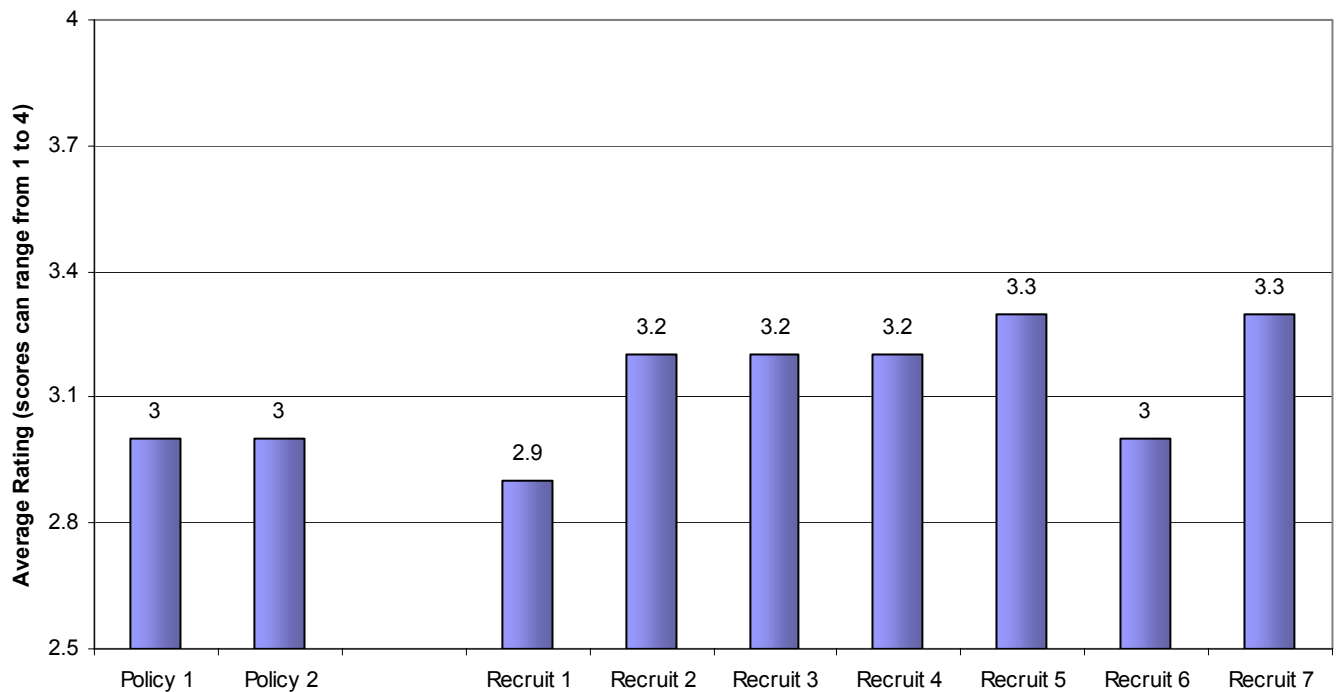
Items:

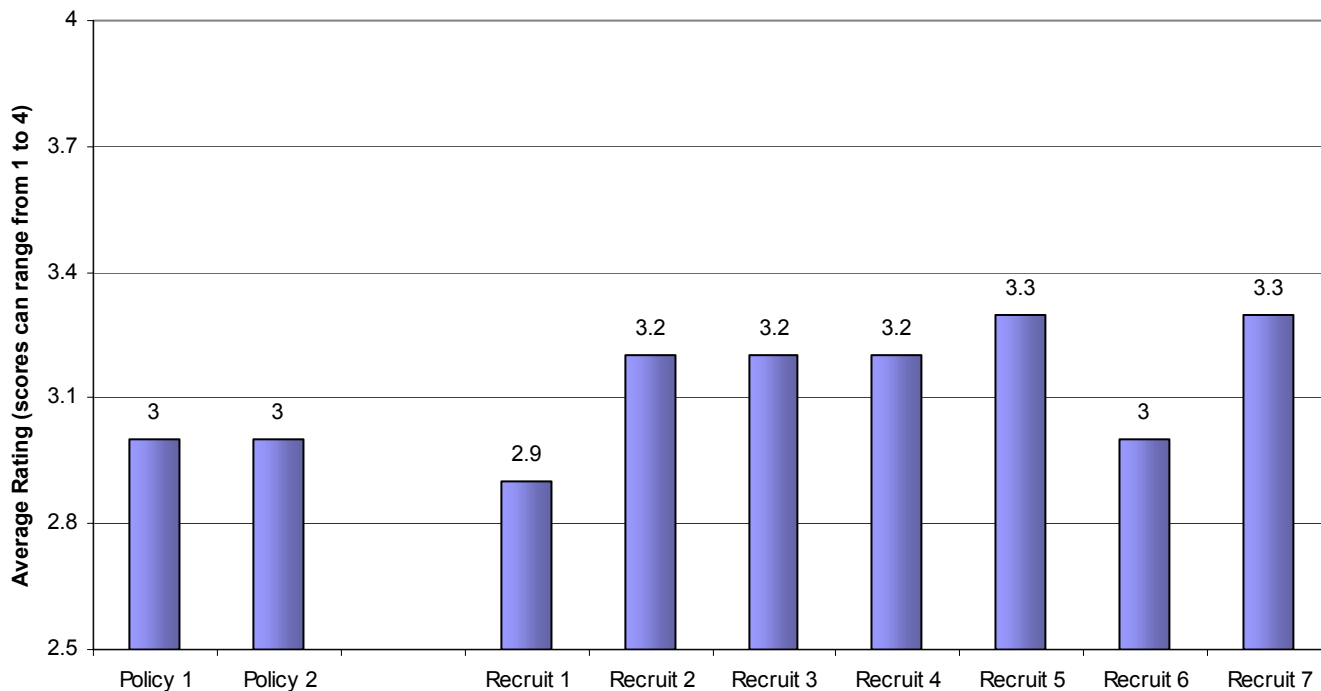
1. The management team is responsible for implementing the mission statement and goals relative to cultural diversity.
2. The management team strives to recruit culturally and linguistically competent staff from diverse groups that reflect the cultural diversity of the population served.
3. The management team ensures that staff is proficient in working with interpreters.
4. The management team ensures access to culturally competent interpreters.

5. 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.
6. The management team ensures that non-discrimination policies are clearly written and annually reviewed.

## Section II: Policy Development, Recruitment and Retention

As the graph indicates, staff generally felt that policy development, recruitment and retention was operating in a culturally competent manner. The average score across all 9 items was 3.1 and most of the individual items had ratings between 3 and 4 (4 being the highest possible rating). The responses to both policy development items and 2 of the recruitment and retention items (# 1 and # 6) provide possible future training areas for the Mental Health Plan.





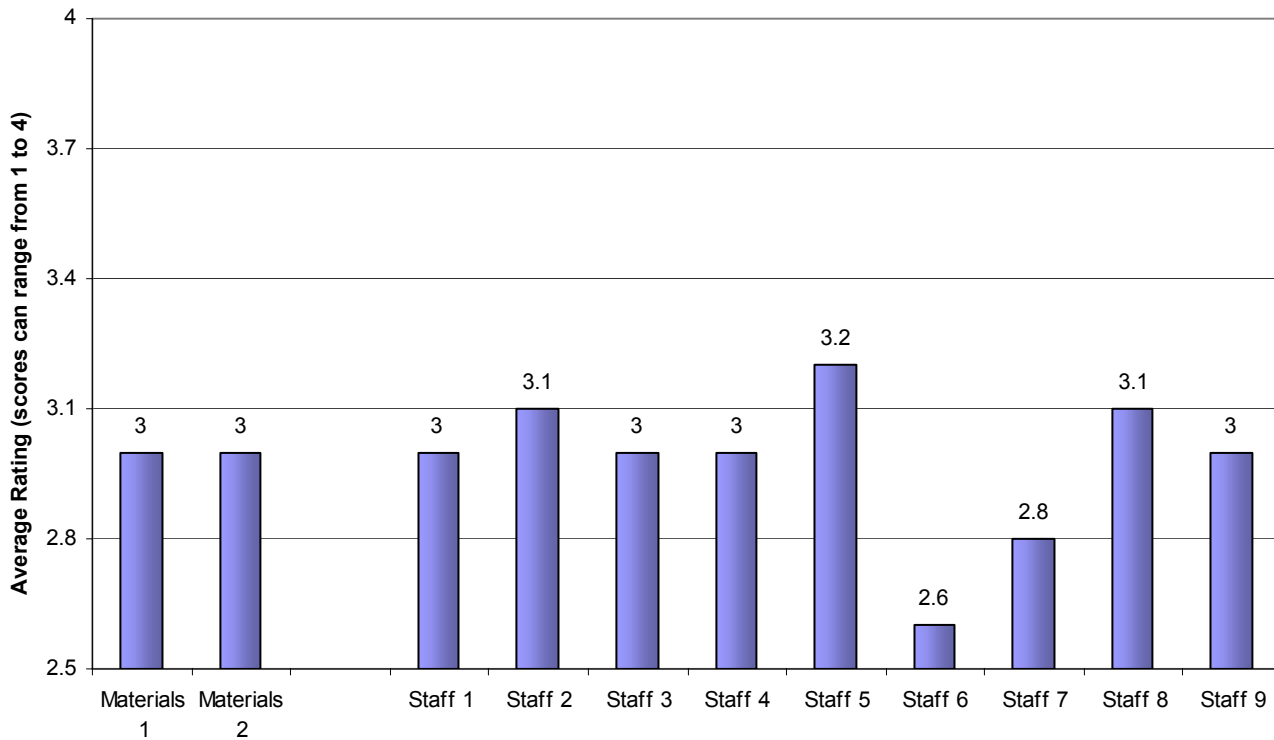
Policy Development Items:

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

Recruitment and Retention Items:

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 annual cultural competency training.
5. People of diverse ethnicity have been retained on staff.
6. Opportunities for advancement are provided for staff that demonstrates, among other skills, cultural competency.

7. There is a commitment to creating an atmosphere of support for cultural diversity throughout programs and activities.



### Section III: Consumer Related Services and Staff Training

As the graph indicates, staff generally felt that consumer related services and staff development and training was operating in a culturally competent manner, although to a somewhat lesser extent than the previous 2 domains. The average score across all 11 items was 2.9, although most of the individual items had ratings of at least 3. The responses to both items regarding interpreters (# 6 and # 7) provide a clear need for future training areas for the Mental Health Plan.



#### Material and Environment Items:

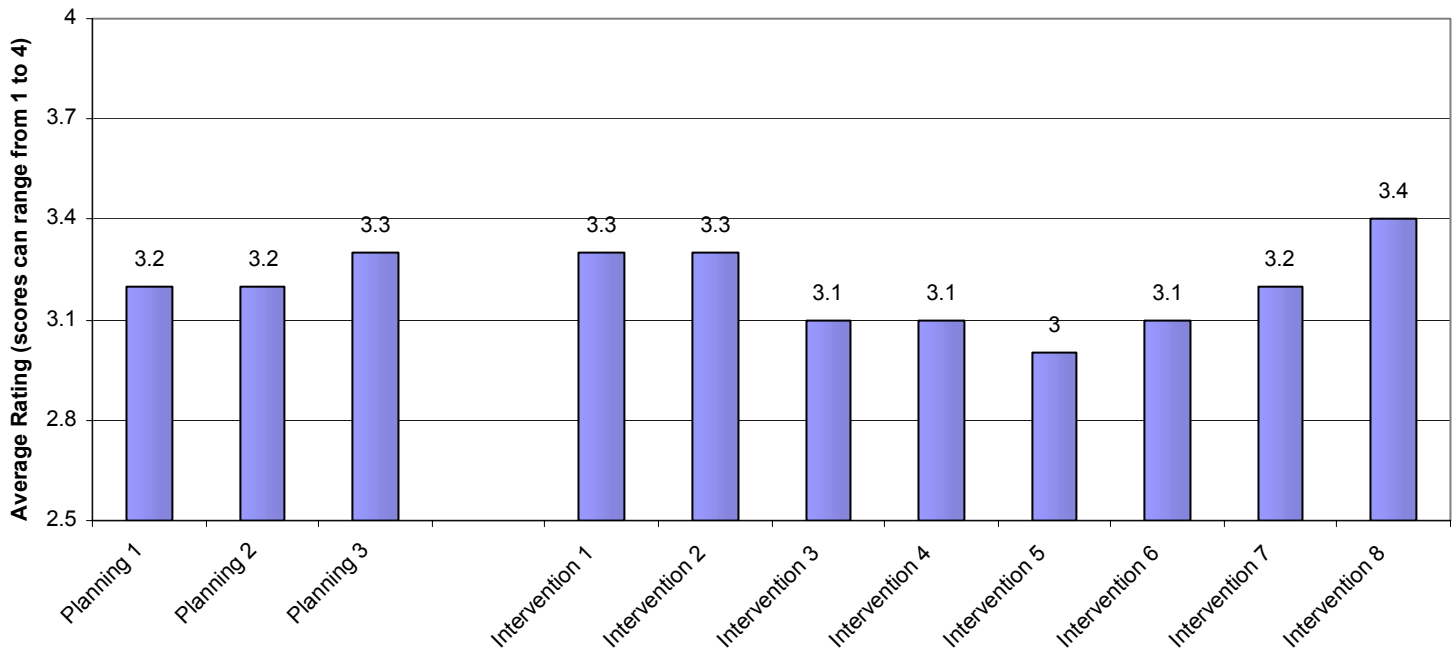
1. Resources (e.g., videotapes, program brochures, newsletters), programs, and services designed to reach culturally diverse groups are developed and collected and are also oriented to the populations the agency serves.
2. The physical environment of the agency is reflective of the different cultural populations served.

#### Staff Development and Training Items:

1. Staff is trained in regard to cross-cultural communication, culturally diverse family customs, and conflict resolution in different cultural groups.
2. Staff continually examines their own cultural beliefs and attitudes to better understand the dynamics of cultural difference and interaction.
3. Staff routinely discusses barriers to working across cultures.
4. Staff routinely discusses issues related to working with consumers or co-workers of diverse ethnicity.
5. Persons from the agency attend cross-cultural workshops when offered.
6. Staff is trained in the use of interpreters.
7. Interpreters are trained on basic skills and knowledge about mental health issues.
8. Staff is culturally sensitive and has the capability for serving consumers whose primary language is not English.
9. There is a documented policy/practice to follow when the agency is not proficient in a client's language or culture.

#### Section IV: Service Delivery

As the graph indicates, staff generally felt that service delivery was operating in a culturally competent manner. The average score across all 11 items was 3.2 and most of the individual items had ratings between 3 and 4 (4 being the highest possible rating). The responses to 4 of the intervention items (# 3 through # 6) provide possible future training areas for the Mental Health Plan.



#### Planning and Assessment Items:

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 Items:

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

**Objective 7. Increase Bilingual Staff by 5%.**

- Using data from the Human Resources Survey, we found that the number of direct service staff with the ability to speak at least one of Sacramento's original seven threshold languages increased from 215 in 2002 to 308 in 2003.

**Barriers/Successes:** This is an increase of 43% in one year. While we are pleased with the increase, the diversity in Sacramento County requires that efforts be continued to ensure that we meet language proficiency requirements. We will continue targeted recruiting as outlined in 3C.

This objective will be updated in Section II, 3B.

**B. Identify any new or changed or updated objectives developed to reflect a better way to meet the needs identified in the original or, if applicable, new population analysis.**

**2003 Cultural Competence Plan Objectives**

**Objective 1.** Increase the percentage of direct service staff by 5% annually to reflect the racial and ethnic makeup of the communities speaking threshold languages until the proportions of direct service staff equals the proportion of Medi-Cal beneficiaries.

**Objective 2.** By July 1, 2004, 90% of staff identified as interpreters will have completed at least 6.5 hours of interpreter training.

For a list of all objectives identified in this document, please see Appendix D.

**C. Has the MHP identified any local trends in human resources that impact culturally competent services? For instance, staff turnover, difficulty in finding culturally and linguistically competent service providers, availability of interpreters, etc. If yes, please describe.**

The issue of availability of culturally and linguistically competent service providers is a challenge throughout the state. Sacramento County, as with most California counties, experiences considerable difficulty finding culturally competent staff including clinicians and interpreters. The problem is complicated by the diversity of our county and local hiring considerations.

There is high turnover throughout the Sacramento County MHP as staff elect to move from one agency to another. Additionally, the Division of Mental Health has, at times, hired staff from contract provider agencies after staff are trained and meet the educational requirements for county positions. These factors, as well as others, have led to an environment in which some agencies are reluctant to be as cooperative with other programs as they would like for fear that staff would be recruited by other programs.

In the best of circumstances, personnel issues in the Sacramento County Mental Health System are complex. The MHP is a blend of county and contract provider agencies. In many ways, it is easier for contract provider agencies to hire staff than the county which is required to follow civil service procedures. Contract agencies have more flexibility in hiring. Once a need is identified, contractors can, within

budgetary and human resource availability considerations, hire staff with the necessary language proficiency. If staff do not fit existing job positions and descriptions, positions can be created that match their skills and talents.

In the county system, however, the process is very different. An example of this is an interpreter position or clinical assistant. A potential applicant may have great skill but lack the necessary educational/experience to meet minimum requirements necessary for an established job classification. In this case, county personnel regulations prohibit hire and the timely creation of appropriate positions is not possible. In most cases, applicants must meet the requirements of a pre-existing list of countywide positions.

A partial list of county positions include: Masters level staff, including Senior Mental Health Counselor and Mental Health counselor; Bachelor's level Mental Health staff and clerical positions. It takes time to create new positions, requiring significant paperwork, numerous levels of review and approval before a position can be put in place. There are no direct service provider positions for interpreters, who do not meet educational/experience requirements, or non-licensed or non-Bachelor's level people in the county system. In fact, although Sacramento County leads the state in the number of consumer and family members, we are unable to provide county jobs for most of those employees. The same holds true for interpreters and many other staff support positions. The county relies on contract provider agencies to employ these individuals. In the contract provider arena, agencies can create positions and job descriptions as needed and appropriate. As long as the applicant meets Medi-Cal and other funding source requirements for service delivery staff, there is no problem. This allows competent people to enter employment and if they are interested, creative arrangement can be made to support them in their continued educational pursuits.

The flexibly exercised arrangements in the contract provider arena are generally not possible in the county system because of civil service regulations. The county does have employees in clerical positions that act as interpreters, translators and cultural interpreters. These individuals are tested for their bi-lingual/bicultural skills and can then interpret for staff. This is only a partial solution however, since said staff are still primarily responsible for assigned clerical duties. Labor relations issues sometimes creates an environment in which clerical staff feel uncomfortable spending too much time interpreting as their colleagues complain about assuming more of the workload. Additionally, "working out of class" complaints are sometimes lodged.

We would prefer to have an adequate number of bilingual/bicultural clinical staff throughout our system to meet our needs. This certainly remains a goal. With the number, however of threshold languages, and the number of newly arriving refugees, this remains a challenge.

Sacramento County has taken a number of steps to recruit staff throughout our mental health system. Prior to 1998, Division of Mental Health staff were recruited and hired by a centralized Human Resources Unit responsible for Mental Health as well as four other divisions/bureaus within the Department of Health and Human Services. With this centralized approach, the specialized hiring needs of Mental Health were not a primary consideration. Mental Health has assumed more responsibility for aggressive recruitment for staff at county as well as contract provider agencies starting in 1999. These efforts are financed these efforts directly out of the mental health budget. Recruiters target venues where numbers of individuals in targeted hiring categories congregate (primarily people who are bilingual/bicultural and speak threshold languages or populations with significant numbers in the community). The increase in the number of bilingual/bicultural staff in the mental health system demonstrates the

success of these methods. Some newer programs, i.e. CalWORKs, have been able to structure hiring to the needs of communities served and have benefited greatly from recruitment efforts. Other programs have been limited to expanding bilingual/bicultural capacity as vacancies occur or programs expand.

Since 2001, Sacramento County has had a hiring freeze imposed by County Personnel and approved by the County Executive Office as required by the Board of Supervisors. This freeze is an attempt to address severe county budget concerns and mitigate further need for staff deduction to the extent possible. Since this time, Sacramento County Mental Health has primarily only been able to hire at our inpatient unit with only a few exceptions in key areas, including two positions at our Child & Adult Access Teams. One position has been filled with bilingual/bicultural staff and the second position is expected to be filled shortly by staff that meet language requirement needs. In the rare event that permission is given to hire into a county position, every effort is expended to fill the position with staff who meet the need for culturally and linguistically proficient staff.

Targeted recruiting will continue to be conducted as contract agencies are still hiring, and to maintain current levels of culturally, ethnically and linguistically diverse county staff as much as possible.

# PART III



**PART III: TRAINING IN CULTURAL COMPETENCE (SINCE JULY 31, 2002)**

This section requires a description of cultural competence training for staff and contract providers, including training in the use of interpreters since your last annual submission.

**a) What cultural competence training has the MHP provided since the last CCP Update, including Competency in Client Culture? List training and staff attendance by function:**

- A) Administration/management;**
  - B) Direct services: MHP’s staff**
  - C) Direct services: contractors**
  - D) Support services; and**
  - E) Interpreters**
  - F) General public**
  - G) Mental Health Board/Agency Board of Directors**
  - H) Community Event**
- \*number is an estimate of attendance**

Training Event	Presenter	Description of Training	No. of attendees	Attendees by Function	Date
Sexuality and Aging: Working with Gay/Lesbian/Bi-Sexual And Transgendered Older Adults	Herbert Bauer, MD, MPH, Kristy Finzer, MFT	Presentation on understanding aging demographics of gay/lesbian/bisexual and transgendered (GLBT) older adults from historic, current a& future perspectives, and how heterosexual privilege and fear impact mental health	140	A – D	10/23/03
Is Recovery from Schizophrenia Within Our Grasp – Client Perspective	Leo Torres, Formerly of HRC Peer Support & SacPort Advanced Implementation, Kathleen Briggs, Turning Point ISA, Robert Liberman, MD	1.5 hr discussion of SacPort modules from client perspective	100	H	10/3/03

Latino Behavioral Health presentation to MHTC Inservice Training	Favia Cruz	1 hr training for inpatient staff on health issues impacting Latinos	8	B	9/25/03
Cultural Variables in the Assessment and Treatment of Mexicano/Chicano Consumers	Arnold De La Cruz, PhD Rachel Garcia Guerrero, LCSW	1.5 hr training to service provider staff on assessment of Latinos	82	B-C	9/16/03
Latino Behavioral Health Week Training for MERT and Adult Crisis Staff	Claudia Solla	1 hr training for crisis staff on mental health issues of Latinos	10-15	A, B, D	9/16/03
Latino Behavioral Health presentation at Medical Director's meeting	Favia Cruz	1 hr training for psychiatrists on mental health issues of Latinos	10	B, C	9/9/03
Southeast Asian Mental Health	Hendry Ton, M.D.	Presentation to HRC staff	41	A, C	6/11/03
Substance Abuse in Asian Americans	Hendry Ton, M.D.	Presentation to HRC staff	37	A, C	6/11/03
Southeast Asian Mental Health: Assessment and Treatment Principles	Hendry Ton, M.D.	1.5 hr presentation to inpatient staff	6 41	A B	5/15/03
Integrated Dual Diagnosis Services	Ann S. Yabusaki, PhD	6 hr training on Dual Diagnosis services for ethnic populations	4 54 9	A B - C E	5/13/03
Working with Diverse Populations: Practical Approaches	Hendry Ton, M.D.	Presentation on service delivery to diverse populations			4/5/03
Models of Mental Health Care for Multicultural Societies	Lawrence Kirmayer, MD	1.5 hrs Grand Rounds presentation on Cultural Consultation Service in Toronto	6 3	A B - C	4/5/03

Cultural Competency with Dual Diagnosis Issues	Hendry Ton, M.D., Asian Pacific Counseling Center Staff, Sacramento Chinese Community Center Staff, Mexican American Alcoholism Program Staff	4 hr training on mental health and substance use/abuse issues for specific cultural & ethnic groups and cultural competency in mental health and alcohol/drug intervention and treatment	81	A – C	3/25/03
Cultural Consultation Service	Hendry Ton, M.D.	Overview of Cultural Consultation Service	6 18 4	A B D	3/10/03
Fundamentals of Cultural Competence	Jo Ann Johnson, LCSW	1.5 hrs cultural competence training to contract provider supervisory staff	17	A	1/31/03
Fundamentals of Cultural Competence	Jo Ann Johnson, LCSW	1.5 hrs cultural competence training to contract provider agency Board of Directors	10	G	1/23/03
Power and Politics	Rose Bohr, MFT	Equitable, fair treatment of all people (consumer focused)	4	A, B	1/03
Fundamentals of Cultural Competence	Jo Ann Johnson, LCSW	2.5 hrs cultural competence training to contract provider agency Board of Directors	12	A, C	12/12/02
Cultural Consultation	Hendry Ton, MD	Cultural consultation services in treatment of ethnic minorities.	11	A C E	11/21/02
Fundamentals of Cultural Competence	Jo Ann Johnson, LCSW	1.5 hrs cultural competence training for Dual Diagnosis providers, administrators, staff	72	A, C	10/8/02
National, State & Regional Perspectives on Mental Health Services to the Latino Community	Rachel Guerrero, LCSW Sylvia Aguirre-Aguilar, Jesus Cervantes, Anita Barnes	Training on development of outreach strategies to service needs of Latino/Hispanic community	68	B - C	9/17/02

Youth & Family Advocacy Client Culture- Youth and Family Perspective	Rebecca Hawkins, Youth Advocate	Presentation at Sac County Mental Health Treatment Center	16	A – C	8/02
Native Americans Mental Health Issues		Mental Health issues of Native Americans	25	A G	7/16/02
Religion and Spirituality: Psychiatry Takes A New Look	Francis Lu, MD	1.5 hr Grand Rounds presentation on issues of spirituality from a multi cultural viewpoint	7	A, C	6/28/02
Cultural Competence Training	Jo Ann Johnson, LCSW	2.5 hr presentation including Sacramento’s diversity, service patterns. Skills of culturally competent service delivery, etc.	4 19	A B	5/23/02
Acculturation & Body Image of African American Women	Gia Washington, PhD	1.5 Grand Rounds presentation summarizing findings from the Surgeon General’s Report	3 6 4	A B C	5/15/02
Mental Health Day – Community Education Event	Various agencies, presenters	Mental Health Board, Provider and Community partnership event that provided education about the needs of our diverse populations	150+	H	5/11/02
A Forum to Address and Understand the Mental Health Needs of Refugees	Various presenters	7.5 hour conference on the mental health needs of refugees in the Sacramento area	27 97 125 11 9 3	A B C D E G	5/1/02
Suicide & Hispanics A Cross-Cultural Perspective	Pedro Ruiz, MD	1.5 hr Grand Rounds presentation	4 6 11	A B C	4/12/02
Cultural Competence at Access Points-Adults	Uma Zykofsky, LCSW Jesus Cervantes, MA	1.5 hr training for Adult Access Team members focusing on the needs of mono-lingual or limited English speaking individuals requesting mental health service	1 10	A B	4/10/02

Consumer Empowerment & Recovery Training	Tina Wooten Dave Hosseini Ed Diksa	1.5 hr Grand Rounds presentation on Client Culture, Empowerment and Recovery	6 7 16 9 11	A B C D F	3/29/02
Language access Issues for Crisis Workers	SMHTC Administrative Staff	1.5 hr training for staff of crisis unit that answer after hours line	2 14	A B	3/19/02
Lunch & Learn: API/SEA Service & Cultures	Staff of SAAC and APCC	1.5 presentation on mental health issues of API/SEA populations			2/19/02
Diversity	Stanley Sue, PhD	1.5 Grand Rounds presentation summarizing findings from the Surgeon General's Report	3 5 8 2	A B C E	1/8/02
The Surgeons General's Report on Mental Illness	Steve Lopez, PhD	1.5 hr Grand Round presentation summarizing the Surgeon General's Report	5 11 13 1 2	A B C E G	11/30/01
Cultural Competency: Seeking Wise Solutions	Matthew Mock, PhD Yolanda Sanchez, PhD	Training to increase knowledge of cultural competence & related issues with older, diverse clients	165		10/17/01
Acupuncture for Wellness	Cindy Palay-Lyon	1.5 hr training on alternative medicine for diverse populations	7 9 2 4	B C D E	10/16/01
Latino Behavioral Health Week – Sacramento County Children's Mental Health	Sacramento County Children's Mental Health programs	1.0 hr presentation on mental health issues in Hispanic communities	60	A – E	9/28/01
Latino Behavioral Health Week – Turning Point	Turning Point staff	1.0 hr presentation on mental health issues in Hispanic communities			9/25/01
Latino Behavioral Health Week – MAAP	MAAP staff	1.0 hr presentation on mental health issues in Hispanic communities	35	A – E	9/21/01

Latino Behavioral Health Week – Eastfield/Ming Quong	EMQ staff	1.0 hr presentation on mental health issues in Hispanic communities		A – E	9/20/01
Latino Behavioral Health Week—Visions Galt	Visions staff	1.5 hr presentation on mental health issues in Hispanic communities	27	A – E	9/19/01
Lunch and Learn: Cultural Perspectives on Mental Health in Latino Communities	Sylvia Aguirre-Aguilar, MA Jesus Cervantes, MA	1.5 hr presentation for Latino Behavioral Health Week	71	?	9/18/01
Asian Pacific Counseling Issues	APCC staff	1.5 hr presentation on mental health issues in Asian Pacific Islander communities	27	A – E	8/21/01
Integrating Cultural Competence into SacPort Implementation	Alex Kopelowicz, MD	Modules for psychiatric rehabilitation	6 41 34 3	A B C E	8/18/01
SAAC Services & Overview of Cultures Served	Jan Hunt, Director	2 hour presentation on mental health issues of SEA, Russian and Former Soviet Union populations	3 15 2	A B C	7/29/01
Integrating Core Principles of Cultural Competence into Clinical Practice	Matthew Mock, PhD	6.5 hrs of basic training on cultural competence principals and practices	4 10 61	A B C	6/11/01
Mental Health Day – Community Education Event	Various agencies, presenters	Mental Health Board, Provider and Community partnership event that provided education about the needs of our diverse populations	300+	H	5/19/01
Cultural & Interpreter Training	SAAC staff and Director	2 hour training	4 24	A C	5/18/01
Customer Service Training for the Limited English Customer	Linda Taylor, Elmer Dixon	6.5 hr training for support staff with tips and interactive experiences on how to provide quality services to limited English speaking population	27	D	5/15 –17/01, 5/22 -23/01

Customer Service Training: Delivering Services for Multi-Cultural Public	Linda Taylor, Elmer Dixon	6 hr presentation on providing customer service to Eastern European and SE Asian populations	11	D	5/16/01
Operationalizing Your Cultural Competence Plan	Rachel Guerrero, LCSW Josie Romero, LCSW Carl Havener, MSW	6.5 hr training for administrators on implementation of cultural competence plans	2	A	5/14/01
Consumer Speaks	Various consumer presenters	Day long presentations by clients on client culture, empowerment	150	A – H	5/11/01
Integrating Core Principals of Cultural Competence: Into Clinical Practice	Matthew Mock, PhD	6.5 hr training on cultural competence principals	11 45 30	A B C	4/25/01
Cross Cultural Communication: Therapeutic use of Interpreters in Mental Health for Interpreters	Evelyn Lee, EdD	6.5 hr training for interpreters designed to enhance their skills	2 6 15	B C D	3/27/01
Cross Cultural Communication: Therapeutic Use of Interpreters in Mental Health for Interpreters	Evelyn Lee, EdD	6.5 hr training for clinicians on how to use interpreters	2 6 15	A B C	3/26/01
Mental Health in India	Ana Sores, MD	1.5 hr Psychiatric Grand Rounds presentation on Mental Health service in India	3 10 4	A B C	3/23/01
Cross Cultural Challenges in Assessment & Treatment of Post Traumatic Stress Disorder	J. David Kinzie, MD Anthony J. Marsella, PhD, DHC	4 hr conference on PTSD in Refugees, PTSD treatment strategies, & PTSD pharmacology	3 33 12	A B C	3/17/01
Cultural & Psychopathology: Foundations & Directions	Anthony J. Marsella, PhD, DHC	1.5 hr Psychiatric Grand Rounds	7 23 17	A B C	3/16/01

Cross Cultural Communication: Therapeutic Use of Interpreters in Mental Health	Evelyn Lee, EdD	6 hr training for interpreters	14	E	3/14/01
Cross Cultural Communication: Therapeutic use of Interpreters in Mental Health	Evelyn Lee, EdD	6.5 hr training in use of interpreters for clinicians	7 11	B C	3/13/01
Clinical Issues in Cultural Psychiatry: Native American Perspectives	Spero Manson, PhD	1.5 hr Psychiatric Grand Rounds	9 19 27	A B C	3/02/01
Introduction to Consumer Culture	Lavon Novac Alice Washington	6 hr training on client culture: including definition, empowerment & impact on system	2 9 18 3	A B C E	1/26/01
Refugee Mental Health Forum	Phyllis Iwasaki Rachel Guerrero Laura Hardcastle John Tuskan Elzbieta Gozdzia	6 hour workshop on refugee issues	3	A	1/17/01
Cultural Competence 101	Jo Ann Johnson, LCSW	6 hr training on principals of cultural competence	7 8	B C	1/08/01
Mental Health Treatment & Services for Asian American: Some Advances & Many Challenges	Nolan Zane, PhD	1.5 hr Grand Rounds Presentation	5 13 9	A B C	12/8/00
Racism, Culture & Training: The Japanese Case Study	Satsuki Ina, PhD	1.5 hr Grand Rounds Presentation on mental health issues of Japanese Americans	7 19 21 3	A B C e	11/17/00



Operationalizing Your Cultural Competence Plan	Rachel Guerrero, LCSW Josie Romero, LCSW Carl Havener, MSW	6.5 hr training for administrators- Implementation of cultural competence plans	4 6	A C	11/16/00
Cross Cultural Perspective – Issues on Mental Health	El Hogar	1.5 hr presentation including service needs, impact of culture	55	A-G	9/22/00
Latino Behavioral Health Presentation – Visions Unlimited	Visions bilingual- bicultural staff	Community/Staff presentation on Mental Health Issues for Latinos	2 17	A C	9/21/00
Cross Cultural Perspectives on Mental Health	Sylvia Aguirre- Aguilar, MA Jesus Cervantes, MA	1.5 hr presentation on Mental Health issues in the Latino community	4 4 19 6 2 35	A B C D E F	9/19/00
Integrating Core Principles of Cultural Competency into Clinical Practice	Matthew Mock, Ph.D	Cultural competence principles, implementation and practice skills	35	A - C	9/18/00
Russian Cultural Training	SAAC Russian speaking Staff	2 hour training on mental health issues of Eastern European and Former Soviet communities	5 25	A B	7/26/00
Clinical Issues in Cultural Psychiatry: Asian Pacific American Perspective	Albert Gaw, MD	1.5 hr Grand Rounds presentation on Asian Pacific Islander issues	2 6 2 1	A B C E	6/28/00
Stigma & Under-Utilization of Mental Health Service in Asian American Population	Florence Wong, PhD	1.5 hr Grand Rounds presentation on Asian American mental health issues	3 9 11 4 1	A B C E G	6/14/00

Core Principles of Cultural Competence in Clinical Practice	Matthew Mock, PhD	Cultural competence principles, implementation and practice skills	7 34 40 4	A B C E	5/22/00
Cultural Competence: Training & System Perspectives	Francis Lu, MD	1.5 hr. Psychiatric Grand Rounds training	6 8 11	A B C	4/26/00
Cultural Competence Plan Forum: Introduction and Implementation of the Sacramento County Mental Health Plan	Jo Ann Johnson, LCSW Tracy Herbert, PhD	4 hr training on the implementation of the county plan	24 13 21 4 3 2	A B C D E G	3/20/00
Cultural Competence Plan Presentation	Sacramento County Mental Health Board	1 hr presentation to the Mental Health Board. Providing overview of the plan incorporating cultural competence principles and Board responsibilities	10	G	1/5/00
Consumers of Color Client Culture	Rachel Guerrero, LCSW Donna Nunes Alice Washington Andrew Stambi	6.5 hr Conference on Consumer Culture	2 2 12	A B C	10/27/99
Introduction to Cultural Competence	Rachel Guerrero, LCSW	Cultural Competence 101 including principles, demographic data, definitions and State requirements	27 16 51 81 11	A E B F C G D	10/4/99
Cultural Competence & Use of Interpreters	Jan Hunt, SAAC Uma Zykofsky, LCSW Ricky Thou, Sayuri Sion, Jacinto Nambo	4 hour training on how to use interpreters for system-wide access teams	4 22	A B	7/6/99

Transgender Issues	Dr. Karasic	1.5 Grand rounds presentation on clinical issues relative to treatment of transgender patients	4 3 9	A B C	4/14/99
Pharmacogenetics In Treatment Resistant Schizophrenia: Ethnopsychopharmacology and the New Anti-Psychotics	Michael Smith, MD	1.5 Hr Psychiatric Grand Rounds training on the effects of new antipsychotics on ethnic populations	3 11 4	A B C	2/3/99
Perils & Pitfalls of Working with Ethnic Minority Caregivers	Rita Haregrave, MD	1.5 hr Grand Rounds presentation focusing on issues related to providing service to diverse communities especially caregivers	2 6 3	A B C	1/20/99
The DSM IV Cultural Formulation: Clinical Implications	Russell Lim, MD	1.5 hr presentation on the cultural formulation	4 3 7	A B C	10/14/98
Overcoming Non-Adherence to Psychotropic Medications: A Cultural Perspective		1.5 Grand Rounds presentation	4 16 8	A B C	
Accessing Services at SAAC for Children's Access Team	Jan Hunt	2 hour focused training for members of Access Team	1 14	A B	

**A) List training and staff attendance of cultural competence training provided through outside agencies/resources other than the MHP's internal training process. Include trainings set up by direct services contractors.**

Training Event	Presenter	Description of Training	No. of attendees	Attendees by Function	Date
Providing Culturally & Linguistically Competent Services for Refugees & Asylees who may have Mental Health Needs	Josie T. Romero, LCSW	Interpreting training for interpreters and those utilizing interpreters	14 21	B – C B – C	10/20/03 10/21/03
Regional Co-Occurring Disorders Training Oakland, CA	Christie Cline, MD, Ben Eiland, MA, Jo Ann Johnson, LCSW, Jaime Molina, MSW, Walter Schulze, MA	Principles of integrated care for persons with co-occurring disorders	2	A	9/4/03
Providing Culturally & Linguistically Competent Services for Refugees & Asylees who may have Mental Health Needs	Josie T. Romero, LCSW	Interpreting training for interpreters and those utilizing interpreters	40 40	B – C B – C	7/21/03 7/22/03
Taking Action	Sandi Holman, MS Culture Coop., Youth Services Provider Network Staff	Organizational practices that support cultural unity and diversity appreciation	21	A – D, G	5/22/03
Global Mental Health: Implications for American Psychiatry	Arthur Kleinman, M.D.	Socio-anthropological presentation of MH needs globally	3 6	A B	5/16/03
Deeping Your Understanding	Sandi Holman, MS Culture Coop., Youth Services Provider Network Staff	Expanded discussion on youth client culture, diversity and its impact on organizations	Approximately 31	H (youth consumers & guests)	4/29/03
Providing Culturally & Linguistically Competent Services for Refugees & Asylees who may have Mental Health Needs	Evelyn Lee	Interpreting training for interpreters and those utilizing interpreters	0		4/21/03 4/22/03 CANCELLED To be rescheduled

Working with Diverse Populations	Russell Lim, MD, Rachel Guerrero, LCSW, Hendry Ton, MD, Alan Koike, MD, Arnold de la Cruz, PhD, Rita Hargrave, MD	4 hr. conference on mental health issues of 3 ethnic specific groups	66	A – C	4/5/03
Beginning the Journey	Sandi Holman, Culture Coop., Youth Services Provider Network Staff	3 hr. interactive training on youth/client culture and diversity	62	A - D	4/3/03
Emerging challenges in International Mental Health	Byron Good, PhD	Examination of the challenges in international mental health	7 5 5	A B C	3/21/03
Unequal Treatment in Health & Mental Health Care : An Overview & Policy Perspective	Mary Jo Good, PhD	1.5 hrs Presentation on cultural psychiatry	4 4 3	A B C	3/21/03
TLCS New Staff Orientation – Cultural Competence	Mary Nakamura	Overview of Cultural Competence as it applies to building rapport with clients and strengthening the working relationship	7	C	3/20/03
Cultural Awareness Training	Lisa Soto, MFT	Cultural competence in assessment & treatment of diverse cultural groups	10	C	3/17/03
Translating Research into Practice: Reducing Disparities in Mental Health Care for Mexican Americans	Sergio Aguilar-Gaxiola, PhD	1.5 hrs Grand Rounds presentation	7 2 4	A B C	3/14/03
AT&T Language Line	Meghan Stanton	Educate staff on how to use AT&T Language Line	9	B	3/14/03

Narrative Therapy	David Nylund	Narrative therapy and culture	16	B A D	3/12/03
Soul Food: From Africa to America	Marilyn Washington Amadu Turay	Diversity Training	8 18 6	A B D	3/11/03
Cultural Competence for Non-Clinical Staff	Kathryn Ecklund, Ph.D.	4 hour interactive seminar on working effectively in a diverse workplace. Open to community business members.	3 7	A D	3/4/03
Community Advisory Board Meeting	Laura Mason-Smith, FSA	Issues , barriers, needs regarding suicide in the African American, Latino and Hmong communities	12	A, F	2/27/03
Models of Mental Health Care for Multicultural Societies	Laurence Kirmayer, M.D.	Examination of cross-national variations in the theory and practice of intercultural mental health.	2	A,C	2/21/03
Impact of Grief from a Family Perspective	Janice Massie, Family Advocate, Kathy Lee, Family Advocate, Dolores Mora, Family Advocate	Family perspective on grief & the grieving process for parents & caretakers who raise children with mental health special needs	2 4	A C	2/13/03
Multi-Culturally Competent Practice of Assessment & Psychotherapy	Kathryn Ecklund, Ph.D.	7 hour interactive seminar on using Best practices when working in a diverse population. Emphasis on clinical practice.	3 24	A B	2/11/03
Recovery: Steppin' Ahead Client Culture	Daniel Fisher, MD, Laurie Aherne, Kay Tucker	Presentation on client culture & recovery from consumer perspective	100		2/11/03
Mental Health Association Banquet	Daniel Fisher, MD, Laurie Aherne, Kay Tucker	Presentation on client culture & recovery from consumer perspective	150	A - H	2/10/03

Cultural Competency Training	Michele Nunn Michelle Oweka	Overview of cultural competency summit from November 2002	25	B	2/4/03
Mary Ellen Copeland's Wellness Recovery Action Plan – Client Culture	Sharon Kuehn, Mertice "Gitane" Williams	Educating service providers and consumers on benefits on a concrete recovery system	25	A - H	2/4/03
Mary Ellen Copeland's Wellness Recovery Action Plan – Family Perspective	Sharon Kuehn, Mertice "Gitane" Williams	A concrete recovery system for individuals who experience psychiatric symptoms	25	F	2/3/03
Cultural Presentation by Positive Cultural Exchange Committee	Mary Mays, Terri Sims, Caroline Funderburg	Black History month recognition & celebration honoring history, culture & food	32	A - C	2/03
Head Start Conference	River Oak Center for Children staff	Presentation on mental health issues concerning diverse communities	40	A - E	2/03
Cultural Presentations in our Positive Cultural Exchange committee	La Familia staff	Black History month recognition and celebration honoring history, culture and food	32	A - C	2/03
Northgate Point Staff Training	Jason Daniel Chris Stringer	Ethnicity & Language	6 11 2	A B D	1/31/03
California Working Families Policy Summit 2003	California Center for Research on Women & Families	Information sharing and discussions on access the mental health and health care for low income residents	3	A	1/24/03
Latino Access Study Presentation	Lonnie Snowden, PhD Josie Romero, LCSW Rachel Guerrero, LCSW	Presentation on information and examples on how counties can design an access study	3 9	A B	1/17/03
Cultural Presentation by Positive Cultural Exchange Committee	Sandra Guzman	Video on "Nigger" - exploring changing language. Agency-wide presentation & discussion group	25	A - C	1/03

14 <sup>th</sup> Annual Conference for American Indian Women	Deborah Kawkeka	3-day conference for American Indian Women. External attendance by staff.	1	B	12/3 – 5/02
Northgate Point Staff Training	Bajazeda Lakisic, M.D.	Case Conference Presentation in working with Russian clients	6 18 3	A B D	12/3/02
Services for Diverse Populations: Multicultural & Bilingual Services for Asian Pacific Community	APCC Staff	1.5 hr training on Mental Health issues in the Asian Pacific Community	2 11 14 2 9	A B C D E	12/02
Working Effectively with Native American Women	Native American Training Institute Multiple presenters	2 day workshop addressed issues of native persons in work force & native spirituality for healing	1	B	12/02 (2 days)
HRC New Employee Orientation	Video Presentation AT&T Language Line Services	Training on the use of AT&T Language Line Services to meet the needs of non-English speaking clients	1	B	11/22/02
Multi-cultural Issues in Psychotherapy	Satsuki Ina, Ph.D., Rocio Curry, LCSW, Dee Bridges, MFT	Discussion & training regarding clinical issues in working with culturally & ethnically diverse clients—impact of racism	3	A	11/22/02
Issues Concerning Biracial Children in Foster Care	Catherine Lieb, LCSW	Case conference	5	B	11/21/02
Northgate Point Staff Training	Bonnie Sanders, LCSW Min Lo, MSW	Implementing New Documentation, including use of cultural formulation	6 16	A B	11/20/02
Demystifying the Mental Health System: Trading Secrets Conference	Pam Hawkins Ann Edwards-Buckley	1.5 hr workshop highlight Child & Family mental health services, featuring Family & Youth perspective	90		11/19/02



CASRA Conference Culver City, Ca	R.C. Arrieta, M. Jiminez Jr., A. Toledo, Sr., James Rogers, CPRP, Peter McKimmin	Implementing an effective treatment model for dually diagnosed members of the Latino community. Understanding immigration patterns & cultural identity among Latino consumers. Culture, worldview & resilience—culture centered and strength based approach to recovery	3	A	11/13-14/02
Mental Health: Culture, Race & Ethnicity: A Supplement to Mental Health, A Report of the Surgeon General	Lonnie Snowden, PhD	1.5 hrs Grand Rounds presentation on Surgeon General's Report	5 4 5	A B C	11/15/02
TLCS New Staff Orientation – Cultural Competence	Mary Nakamura	Overview of Cultural Competence as it applies to building rapport with clients and strengthening the working relationship	9	C	11/12/02
Multi-Culturally Competent Practice of Assessment & Psychotherapy	Kathryn Ecklund, Ph.D.	7 hour interactive seminar on using BEST practices when working in a diverse population. Emphasis on clinical practice.	3 24	A B	11/4/02
Northgate Point Staff Training	Neha Bahadur, M.D.	Cultural Presentation – Indian Consumer	7 14 3	A B D	11/1/02
Cultural Presentation by Positive Cultural Exchange Committee	Sid de la Torre	Native American Alcoholism & Recovery. Agency-wide presentation & discussion group	15		11/02
The September 11 <sup>th</sup> Tragedy One Year Later Psychiatric Responses to Terrorism & PTSD	Robert Hales, MD, Robert J. Ursano, MD, John M. Oldham, MD, Peter S. Jensen, MD	4 hr presentation on response of individuals from diverse populations	4 4	A B	10/25/02
Issues Concerning Biracial Children in Foster Care	Catherine Lieb, LCSW	Case conference	5	B	10/24/02

HRC New Employee Orientation	Tamara Navarro, MFT HRC Quality Improvement Coordinator	Training on agency procedures on using interpreters	1	B	10/24/02
African-American Issues	Arnold Hailasse	Working with African-American youth	12		10/23/02
White Privilege	Christine Ramsey	Training on issues of white privilege & impact on treatment	16	B A D	10/16/02
Use of Cultural Formulation in Assessment Northgate Point Training	Melissa Jacobs Lee Jonathan Neufeld	New Documentation & Procedures, including use of Cultural Formulation	4 18 4	A B D	10/16/02
Families First Cultural Competence Training	Julie Kurtz, MFT Jacqueline Villafane, MFT Intern	Self Awareness Training (6 Hours)	120	A,B,D	10/9/02, 10/11/02
HRC New Employee Orientation	Tamara Navarro, MFT HRC Quality Improvement Coordinator	Training on agency procedures on using interpreters	2	B	10/9/02
Child Rearing Practices in Ethnic Communities Synposium	Various speakers	Parenting practices & ways to work with African America, Southeast Asian & Hispanic families	5	B	10/2/02
Working Effectively with African-American Families	Nancy Boyd-Franklin, Ph.D.	6 hour seminar on effective Best practices for working clinically with African-American families. Emphasis on clinical practice.	13 85 100	A B F (profess. community)	9/26/02
Community Advisory Board Meeting	Anita Barnes, La Familia Director	Issues of suicide in the Latino Community	8	A, F	9/26/02

Media & Image for Multicultural Youth	Janine Hughes Christine Ramsey	Media Culture – multicultural teen’s identity	14	B A D	9/25/02
Success in a Multicultural Organization	Trula M. LaCalle, Ph.D.	Managing diversity in an organization	3	A	9/24/02
Cultural Awareness Training	Charles Stevens, LCSW	Cultural competence in assessment & treatment of diverse cultural groups	8	C	9/24/02
Cross Cultural Health Care Program—Bridging the Gap	Cross Cultural Health Care Program	Intensive Training for medical interpreters	3	C	9/23-27/02
Cultural Awareness Training	Dale Brody, Psy.D, MFT	Cultural competence in assessment & treatment of diverse cultural groups	11	C	9/17/02
HRC New Employee Orientation	Tamara Navarro, MFT HRC Quality Improvement Coordinator	Training on agency procedures on using interpreters	1	B	9/11/02
HRC New Employee Orientation	Tamara Navarro, MFT HRC Quality Improvement Coord.	Training on agency procedures on using interpreters	7	B	9/7/02
ASOC Partnership Conference	Pam Hawkins, Family Advocate, Rebecca Hawkins, Youth Advocate	Parent & youth perspective on models for family partnership	4 7	A B, C	9/6/02
Gang Prevention	Frank Robles	Gang prevention with ethnic populations	12	B A D	9/4/02
Geriatric Network Staff Training	Various staff members	Mental Health for African Americans & Asian and Pacific Islanders: Cross-Cultural Considerations (staff group review of treatise)	15	C,D	9/4/02

Family/Parent Perspective: Mental Health Service Providers	Pam Hawkins, Family Advocate	Parent Perspective & experiences on mental health services for families	3 2 12	A B C	9/4/02
TLCS New Staff Orientation – Cultural Competence	Mary Nakamura	Overview of Cultural Competence as it applies to building rapport with clients and strengthening the working relationship	11	C	8/21/02
Time Management and Cultural Issues	Laurie Johnson	Northgate Point cultural competence training	1 14	A B	8/21/02
Repairing Relationships After An Abrupt Foster Placement: Change for an Eleven-year Old African American Male	Edward Rudin, M.D.	Case consultation	10	B	8/13/02
Foster Care: Mental Health issues with counseling Hispanic Populations – Med Clinic training	Susan Wycoff, Ph.D., NCC	Behavioral health department training in knowledge and skills for counseling Hispanic populations	150	C, D	8/12/02
Cultural Presentations by our Positive Cultural Exchange Committee	Wendy Greene	Agency-wide presentation and discussion group	100		8/02
Cultural Competence	CAPC	How to be aware of family’s cultural background when serving them	15	B C	7/25/02
Multi-Culturally Competent Practice of Assessment & Psychotherapy	Kathryn Ecklund, Ph.D.	7 hour interactive seminar on using BEST practices when working in a diverse population. Emphasis on clinical practice. Open to community professionals. BBS & MCEP approved.	3 24	A B	7/9/02

Strengths-Based Approaches	Jinnie Matracken	Strengths-Based Approaches with multi-cultural youth	13	B A D	7/07/02
Cultural Presentations by our Positive Cultural Exchange Committee	Salaam Shabazz	Video on “Black Is/Black Ain’t” agency wide presentation and discussion group	25		7/02
IAPSRS Conference Toronto, Canada	Laurene Finley, CPRP Anita Pernel-Arnold, CPRP	Innoculation against discrimination—how discrimination is experienced, healing the wounds	1	A	6/12/02
HRC Inservice Training	James Rogers	Issues in providing culturally competent services to clients who are dually diagnosed	7 23	A B	6/12/02
Bridging the Gap: Intensive Health/ Mental Health Interpreter Training	Cross cultural Health Care Program	40 hour intensive training for interpreters	4	E	6/10-14/02
IAPSRS Conference Toronto, Canada	Laurene Finley, CPRP	Building a culturally competent PSR program—assessing an agency’s cultural competence & developing corrective plans	1	A	6/10-11/02
TLCS New Staff Orientation – Cultural Competence	Mary Nakamura	Overview of Cultural Competence as it applies to building rapport with clients and strengthening the working relationship	8	C	6/5/02
Cultural Training	Ron Alonzo	Discussed working with Latino modules	1 8 7	B A D	5/13/02
Understanding the Mental Health Needs of Mien & Hmong cultures	Staff from these cultures	Presenters talked about how mental health is seen and what conflicts might arise	5 36 15	A C, E D	5/8/02
Gaps in Mental Health Utilization in Latinos	Sergio Aguilar-Gaxiola, Ph.D.	Disparities in health care, service utilization, recommendations	1	B	5/3/02

Cultural Presentations by our Positive Cultural Exchange Committee	Sandra Guzman	Farm worker experience in California & the UFW organizing effort . Agency wide presentation & discussion group	20		4/02
Bridging the Gap: Intensive Health/ Mental Health Interpreter Training	Cross cultural Health Care Program	40 hour intensive training for interpreters	3	E	3/25-29/02
Bridging the Gap: Intensive Health/ Mental Health Interpreter Training	Cross cultural Health Care Program	40 hour intensive training for interpreters	2	E	3/19 -23/02
Bicultural adoptions: Mental health issues related to African American siblings being adopted by a white family	Maria Fearman, MFTI	Case conference/agency training	6	B	3/13/02
Acculturation and Body Image of African American Women	Gia Washington, PhD	Body image perceptions and attitudes among African Americans	3 7 2	A B G	2/15/02
Youth & Family Development Principles as Reflected in Child & Family System of Care	Pam Hawkins, Family Advocate, Lisa Bertaccini, LCSW	Presentation on Youth & Family Partnership: implementation & benefits – Child & Family perspective	16	A	2/4/02
CalWORKs Policy Summit	Various speakers	Policies summit	1	A	1/18/02
Dual Diagnoses: Substance Abuse & Psychiatric Disability as It Relates to Employment Outcomes & Services – Client Culture	Dan Raudenbush	Training for service providers to increase awareness & knowledge about dually diagnosed clients	6 19	A B	1/8/02
Cultural Presentations by our Positive Cultural Exchange Committee	Satsuki Ina	Japanese experience of Japanese interment camps	30		1/02

Demystifying the Mental Health System: Trading Secrets Conference	Pam Hawkins Ann Edwards-Buckley	1.5 hr workshop highlight Child & Family mental health services, featuring Family & Youth perspective	90		10/24/01
Medical Consequences of Illicit Drug Use: Prevention & Clinical Mgmt	Lawrence S. Brown, Jr., MD, MPH, Henry "Skip" Francis, MD	7 hr conference addressing AOD issues for diverse populations	2 5	A B	7/20/01
Latino Behavioral Health Institute "De Aqui Para Adelante"	Various presenters	8 hour conference on Latino mental health issues with 22 workshops and 1 keynote speaker	2 9	A B	6/01/01
The Family Study Center Masters Series 2001 – Race, Culture, & Psychotherapy A Contextual Perspective for Treatment	Satsuki Ina, PhD Family Study Center Staff	Clinical treatment of multicultural population	2 3 4	A B C	5/12/01
The Soul & Science of War Trauma, Ethnic Cleansing, & Genocide	Stevan Weine, MD, Colin Shapiro, MD, other speakers	6 hr Post-traumatic difficulties faced by war victims	1 3 2	A B E	5/3/01
BHC Heritage Oaks Cultural Competence Training		Cultural competence framework: clinical considerations			4/13/01
Sixth Annual Hmong National Conference	Various presenters	2 day conference devoted to issues affecting the Hmong community	1 3 2 4	A B C E	3/30/01 & 4/01/01
Multi-Cultural Violence Prevention Conference	Various presenters	2 Day conference on issues of domestic violence with a multi-cultural perspective	4 3 2	B C E	3/16-17/01
Cultural Competence in the Treatment of Child Abuse	Various presenters	Child abuse training from a multi cultural perspective	6 21 36 3	A B C G	3/09/01

Cultural Competence and Mental Health Summit VIII	Various presenters	2 day multi cultural Mental Health training	4 22 89 2 3	A B C D E	11/28 – 29/00
Refugee Training	Survivors International	Seminar designed to acquaint attendees with Survivors International's work	1	A	11/21/00
Health and Healing Practices for People of African Ancestry	Various presenters	8 hour training on the mental health needs of the African American community	1 5	A B	10/26/00
Demystifying the Mental Health System: Trading Secrets Conference	Pam Hawkins Ann Edwards-Buckley	1.5 hr workshop highlight Child & Family mental health services, featuring Family & Youth perspective			10/24/00
Latino Behavioral Health Institute Conference	Various presenters	2 day conference devoted to behavioral health issues	3 2 1	A B C	9/20-21/00
Family Strengths Conference	Various presenters	2 Day general conference with multiple workshops, some of which focused on multicultural issues	3 7 8	A B C	8/28 – 29/00
The Partnership Conference-- Complex PTSD Among Refugees	Alice Tsoi, Mary Chea, Karita Hummer	Two 1.5 workshops	3	A	4/28/00
Cultural Competence; Introduction and Relevancy to Recovery	Matthew Mock, PhD Jo Ann Johnson, LCSW	1.5 hr workshop	5	A	4/28/00
Multi-Cultural Family Violence Prevention	Various presenters	2 Day conference with workshops on a multi-cultural perspective of family violence	6 7	B C	3/ 17-18/00



Cultural Competence & Mental Health Summit VII	Various presenters	2 day conference on mental health issues for diverse populations	4 22 89 2	A B C D	11/28 – 29/99
Multicultural/Diversity Management of Conflict & Violence Incident Reduction Training Seminar	Various presenters	7 hr training of detecting violent behaviors, crisis intervention and school violence from a multicultural perspective	2	A	10/15/99
Dual Diagnosis Training	Pablo Stewart	6 hr Dual Diagnosis Training incorporating cultural issues	1 25	A B	10/99
Latino Behavioral Health Institute 5 <sup>th</sup> Conference	Various presenters	3 day conference with 48 workshops and 4 keynote presenters discussing a multitude of issues related to Latino mental Health	3 2 1	A B C	9/21-23/99
Workshop for Interpreter/Translators in the Mental Health Settings	Carl Waddle, PhD	7 hr Interpreter training for clinicians and interpreters, including techniques for interpreters and use of idioms, concerns of practitioners and rules for use of non- professional interpreters	6 20 24 22	A B C D	9/10/99
Cultural Competence & Mental Health Summit VI	Various Presenters	2 day conference devoted to the mental health needs of diverse populations	4 26 32 2	A B C D	11/3-4/98

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# **PART IV**

## **PART IV- CCP SELECTED REQUIREMENTS**

1. **MHP's have assessed factors and developed plans and evidence of implementation of these plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:**
  - **Location, transportation, hours of operation or other relevant areas;**
  - **Adapting physical facilities to be comfortable and inviting to persons of diverse cultural backgrounds; i.e., posters, magazines, décor, signs; and,**
  - **Locating facilities in settings that are non-threatening, including co-location of services and/or partnerships with community groups.**

In response to changing need in Sacramento County, a community-wide needs assessment was conducted in the late 1990s to determine current and future need for social service facilities. Multiple factors were considered including changing demographics (increase in diverse communities, income levels, shifting population centers, etc), population projections, current and projected utilization rates, and transportation considerations. The needs assessment documented the service needs of Sacramento County's diverse communities and provided a number of recommendations to better serve all residents of Sacramento County. The recommendations included the following:

1. Promote the decentralization of County services where feasible as a means to improve accessibility and service delivery;
2. Promote co-location of services for the convenience, ease of case access, effectiveness and efficiency of services for consumers;
3. Promote exploration of innovative ways to increase accessibility to services.

The needs assessment resulted in a countywide plan for siting human service facilities including social services, health, and mental health. The plan included a framework that guided the location of county or county contracted direct service facilities and led to the establishment of multi-service agencies strategically located in high need areas

throughout the county; collocation of existing services and numerous innovative community/home based programs. These programs have been very successful in increasing access for culturally and linguistically diverse populations.

While the services were well received by consumers, members of the larger community expressed concerns about siting programs throughout the community. Representatives from various neighborhoods, business groups, providers, consumers, consumer representatives, family members, and Sacramento City and County representatives came together in a community-wide process that ultimately led to recommendations of policies and guidelines for siting service facilities. The recommended policies and guidelines were adopted in 2001.

The Sacramento County Mental Health community was actively involved in the human services siting project from analysis of the needs assessment and implementation of the siting plan, to the adoption of the Good Neighbor Policy. The needs assessment analysis supported the regional distribution of mental health service sites. There currently are approximately 90 mental health programs strategically located throughout the county including schools, apartment complexes, multi-service centers, co-located programs, churches and full service and specialized mental health facilities. These programs/agencies employ culturally and linguistically competent staff that provides services for diverse communities. Additionally, numerous mental health programs are home based including an innovative partnership that provides comprehensive health services, mental health services, parent education and support for expectant and new families throughout the county.

In addition to location, MHP administrators consider hours of operation and transportation issues when making contract and/or siting decisions. In each of the four service regions, a significant number of Sacramento County MHP programs for children

and adults operate beyond an 8AM-5PM day. These programs operate into the evening to accommodate working adults and families.

Access to public transportation lines is also a program requirement. Additionally, some programs are required to hire staff that can provide transportation to and from appointments if transportation is a barrier. Childcare is also provided in some programs.

As required by the Good Neighborhood Policy, MHP facilities must meet standards for cleanliness, attractiveness, litter control, removal of graffiti, parking and maintenance of landscape. The MHP requires facilities to be comfortable and inviting to consumers from diverse cultures and requires culturally and linguistically appropriate posters, magazines, décor, and signage.

To ensure that all requirements are met to facilitate the ease with which culturally and linguistically diverse populations obtain services, the (Re) Certification Assessment Survey includes criteria that addresses some of the issues outlined above. Trained Sacramento County Mental Health Quality Management staff completes the Survey biennially. Facilities are approved, approved provisionally and disapproved. Any action other than approval requires a Plan of Correction within 30 days and a follow-up visit. (See Appendix C for materials related to this section.)

## **2. PENETRATION/RETENTION RATES**

- A) Track penetration and retention rates by ethnic groups**
- B) Compare these rates across ethnic groups**
- C) Compare these rates of ethnic groups in the Medi-Cal beneficiary population**
- D) Analyze these rates for each group by factors including age, diagnosis, gender, and primary language of the Medi-Cal mental health clients to identify potential problem areas**
- E) Establish a “percent improvement” for penetration and retention rates of ethnic groups with low penetration/retention rates**

**F) Take specific actions to meet the “percent improvement” improvement in “E” above.**

**Penetration** - Sacramento County tracks and presents penetration rate data for our annual workplan. We typically compare and analyze these data by particular characteristics of the Medi-Cal population, including ethnicity, primary language, age, and gender. For the current purposes, we used data from the 2002 MEDS file supplied to the County by the State Department of Mental Health. From those data, we obtained frequency distributions for beneficiary ethnicity, age, and primary language spoken in the home (please note that gender was not included in the data supplied by the State). There were 254,132 Medi-Cal eligible beneficiaries in the January 2002 MEDS file.

Data from the 2002 MEDS file were also used to describe the Medi-Cal eligible individuals who had received Medi-Cal specialty mental health services in Sacramento County. From those data, we obtained frequency distributions of client ethnicity, age, diagnosis, and primary language spoken in the home. There were 16,450 people who had used Medi-Cal specialty mental health services in the January 2002 MEDS file. This represents an overall penetration rate of 6.47%.

Figures 88 to 90 illustrate Sacramento’s penetration rate by ethnicity, age, and primary language spoken in the home as they compare to the countywide and statewide averages. Penetration rate for different diagnoses cannot be calculated because there is no base-rate for diagnoses for the whole Medi-Cal eligible population.

**Ethnicity** – Figure 88 illustrates that, while the penetration rate for the majority of ethnic groups falls below the County and State average, we are doing well with certain populations (i.e., Alaskan or American Native, Black, Guamanian and White). Ethnic populations with particularly low penetration rates (i.e., < 2%) include: Asian Indian,

Asian/Pacific Islander, Chinese, Korean, Laotian, Samoan, and Vietnamese. Although our Latino population penetration rate is relatively low (3.1%), it is not as low as the penetration rates for Asian and Southeast Asian populations living in the County.

We would like to note two things regarding Figure 88. First, Sacramento has two agencies who do not bill Medi-Cal, but who primarily serve the Asian and Southeast Asian populations. Therefore, although these penetration rates are very low, we believe we are reaching greater proportions of these populations than the data demonstrate. In the coming years, we would like to explore possible methods of capturing this information. Second, Sacramento has a significant number of individuals who classify their ethnicity as “Former Soviet.” This group is captured under Caucasian or “Other” in the MEDS file, so the data do not tell us what the penetration rate is for this group.

**Age** – Figure 89 illustrates that our penetration rates for each group are, for the most part, in line with what might be expected. Two notable exceptions include the penetration rate for transition age youth (3.5%), and the rate for adults over the age of 65 (1.3%).

**Language** – Figure 90 illustrates that our penetration rates for each primary language are very poor with the exception of English, Japanese, and Sign Language.

**Ethnicity by Age** – The table below illustrates that penetration rates for the different ethnic categories vary somewhat depending upon the age group one focuses upon. Although the general age pattern is evident across all ethnic groups (i.e., lower penetration rates for transition age youth and for adults over the age of 65), the trend is more dramatic in some ethnic categories (i.e., Caucasian versus Latino).

<b>PENETRATION RATES: ETHNICITY BY AGE</b>							
	0-12	13-17	18-20	21-39	20-59	60-64	65+
Alaskan Native or American Indian	10.6	11.4	3.3	5.0	8.3	0	0
Amerasian	0	0	0	0	50.0	0	0
Asian Indian	1.4	3.1	1.0	1.4	1.0	10.5	0
Asian or Pacific Islander	2.0	2.0	2.0	2.0	2.4	2.4	.4
African American	7.8	12.1	4.2	5.3	11.8	4.6	1.6
Cambodian	4.6	8.2	1.7	3.7	3.1	11.1	0
Chinese	.5	1.6	.2	0	1.0	0	.4
Filipino	3.4	7.5	2.1	1.4	2.0	0	.3
Guamanian	12.3	7.7	0	0	0	0	0
Hawaiian	5.1	14.3	0	0	0	0	0
Latino	3.4	7.4	1.8	.9	2.2	.6	.5
Japanese	7.5	14.3	0	7.1	0	0	0
Korean	2.0	0	0	0	4.6	0	0
Laotian	.6	1.4	.3	1.3	1.6	0	0
Other/Unknown	10.1	16.2	10.9	20.5	15.0	6.4	1.0
Samoan	1.8	3.2	0	0	2.1	0	0
Vietnamese	.7	.7	.7	.9	.4	0	0
Caucasian	8.0	12.9	5.2	7.3	13.2	8.6	1.8

**Retention** - Sacramento County began to track and present retention rate data for our annual workplan this year. We compare and analyze these data by particular characteristics including ethnicity, primary language, gender, and diagnosis. The data we present below are extracted from our local information system, and include all clients served during FY 01-02 (i.e., non-Medi-Cal clients are also included). The data are presented separately for the Adult and Child populations because our definition of retention differs.

**Adult Retention** - Figures 91 through 94 present retention rates for our adult population. Clients were considered “retained” if they had their first non-crisis outpatient



visit during the fiscal year, and had at least two more outpatient visits in the following six month period. Figure 91 shows that Caucasian, Hispanic, and African Americans have the lowest rates of retention. Likewise, Figure 92 shows that English and Spanish speaking clients have the lowest rates of retention. Therefore, while the penetration rate we show for Asian and Southeast Asian clients is relatively low, these data show that once they are in the system, we seem to do a better job of keeping them here.

Figure 93 shows that females have a slightly higher retention rate than males. Figure 94 illustrates that retention rates for conduct disorders, ADHD, and adjustment disorders are very low in the adult population. This is most likely an artifact of the target population, which for the most part, does not include these diagnoses. Therefore, if an adult client was to be diagnosed with one of these disorders, they would most likely be referred for follow-up outside of our adult system of care.

**Child and Youth Retention** - Figures 95 through 98 present retention rates for our child and youth population. Clients were considered “retained” if they had their first non-crisis outpatient visit during the fiscal year, and had at least two more outpatient visits in the following four week period. The shortened follow-up period for children and youth reflects the level of intensity of service most receive in our system. Figures 95 and 96 illustrate the retention rates by ethnicity and primary language. It is evident that all rates are very high when compared to the rates obtained in the adult system.

Nonetheless, there appears to be somewhat lower retention of youth whose ethnicity and/or language is Hmong or Vietnamese. In addition, Spanish speaking youth are retained at a lower rate than others.

Figure 97 shows that gender does not appear to impact the retention rates of youth. Likewise, Figure 98 shows that all diagnostic categories are retained at approximately equal rates.

### 3. GOALS/OBJECTIVES

#### Penetration Rates

Our penetration rate data guide us in refining a goal we have had in the past. Specifically, we previously set the goal of increasing our penetration rate in underserved populations by 1.5%. Based on the penetration rate data, we are now re-stating that goal in terms of ethnicity, primary language, and age.

**(1) Ethnicity.** The table below represents the FY 00-01 and FY 01-02 penetration rates for Sacramento’s original threshold populations that are distinguishable from the MEDS file (the Hmong, Mien, and Former Soviet populations can not be identified). As is evident, we have been successful in increasing our penetration rates in most of the populations, although the absolute penetration rates remain very low. We need to continue to expend effort in helping these populations to access services.

<b>Ethnicity</b>	<b>Penetration Rate 00-01</b>	<b>Penetration Rate 01-02</b>	<b>% Increase</b>
Chinese	.4	.7	75%
Hispanic	2.8	3.1	11%
Laotian	.9	.9	--
Vietnamese	.6	.7	17%
Caucasian	8.4	8.6	2%

**(2) Language.** In examining the penetration rate data for Sacramento's original threshold languages, it is evident that we have not yet been successful in bringing large percentages of these populations into our system. Other than English, only Mien and Lao show penetration rates over 1.5% (1.9 and 2.2 respectively). Therefore, we would like to focus on increasing our penetration rates in Spanish, Hmong, Russian, Vietnamese, and Cantonese to 1.5%.

**(3) Age.** Although Sacramento shows relatively consistent penetration rates over age categories, we would like to focus on increasing the penetration rates for transition age youth (currently 3.5%), and the rate for adults over the age of 65 (currently 1.3%).

We also have an issue we would like to explore further, but not yet prioritize as a goal. We pointed out earlier that penetration rates for the different ethnic categories vary somewhat depending upon the age group one focuses upon. Although the general age pattern is evident across all ethnic groups (i.e., lower penetration rates for transition age youth and for adults over the age of 65), the trend is more dramatic in some ethnic categories (i.e., Caucasian versus Latino). This is an issue we would like to evaluate more closely, and will probably address in a later plan update.

## **Client Outcomes**

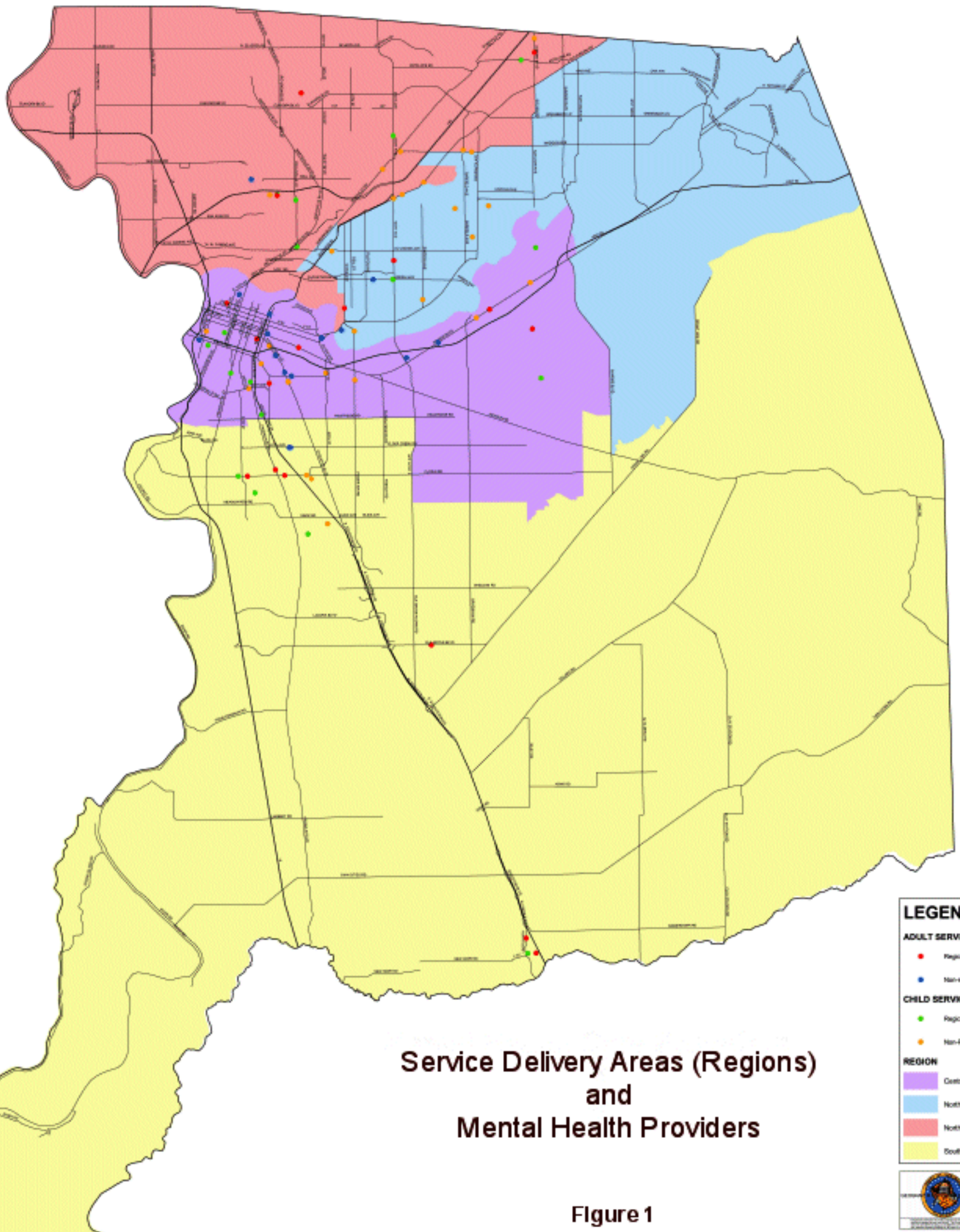
**(1)** One indirect measure of whether clients are receiving culturally competent and linguistically proficient services is indicated by their outcomes over time. If proficient services are rendered, outcomes of clients from underserved populations will be equivalent to other service recipients. Therefore, another

goal for the coming year will be to determine whether client outcomes are equivalent regardless of ethnic group or primary language.

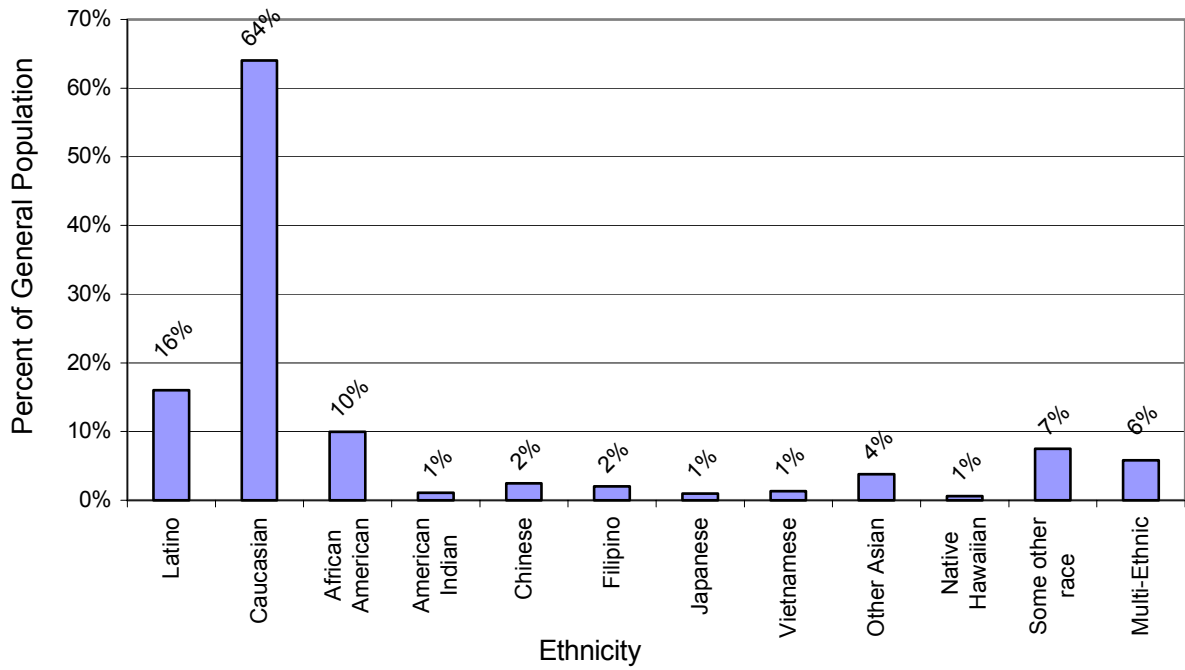


# **FIGURES 1 - 98**

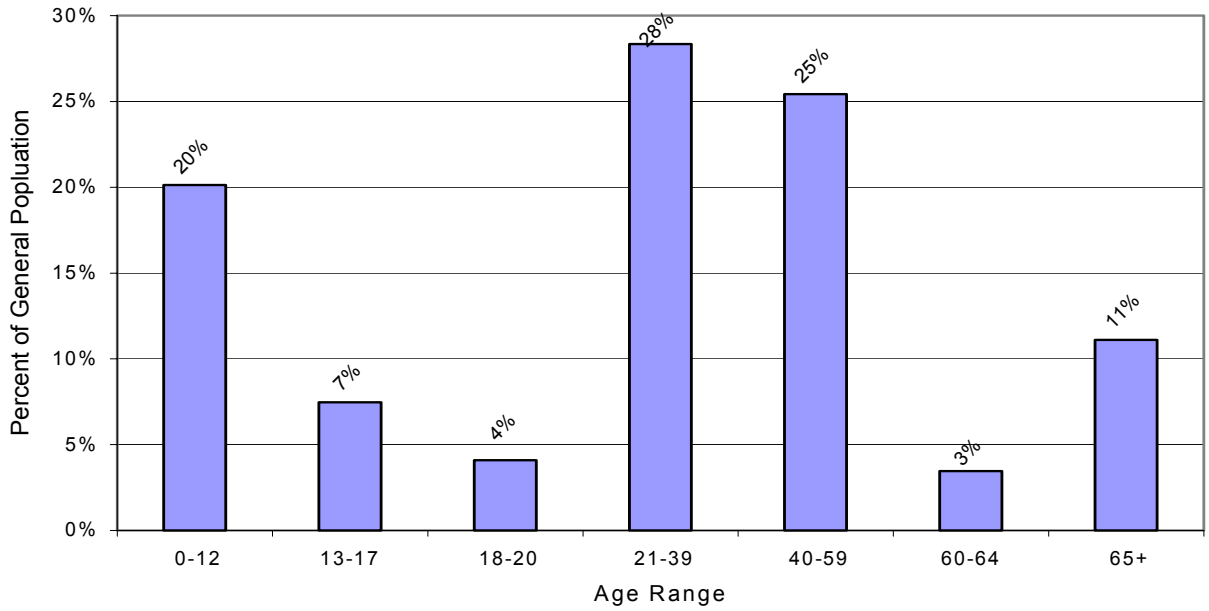
# COUNTY OF SACRAMENTO



**Figure 2: Ethnicity of General Population**

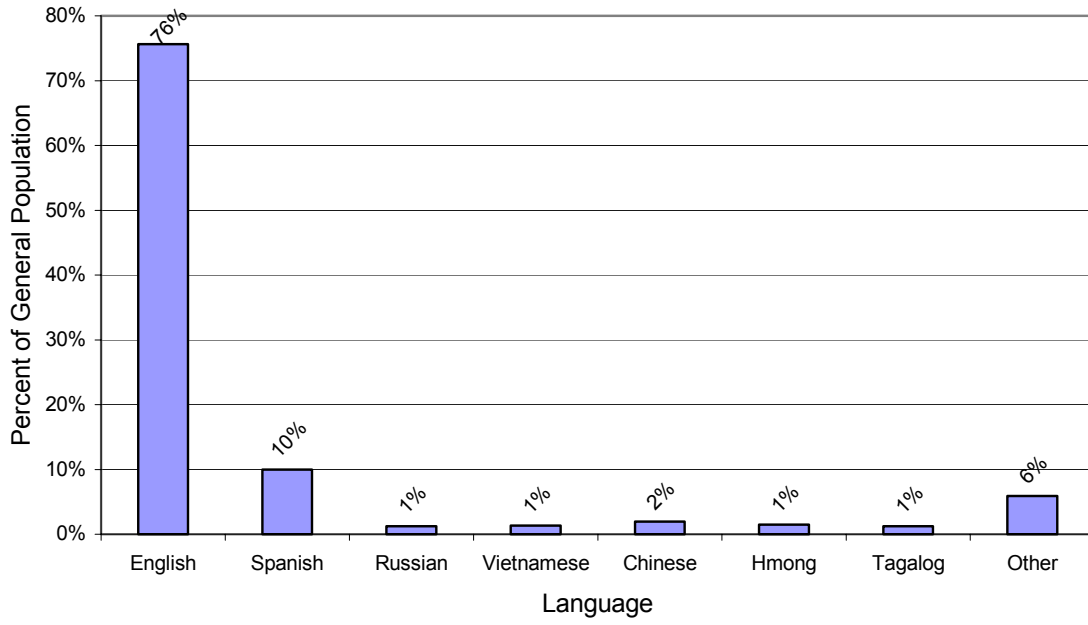


**Figure 3: Age Ranges of the General Population**

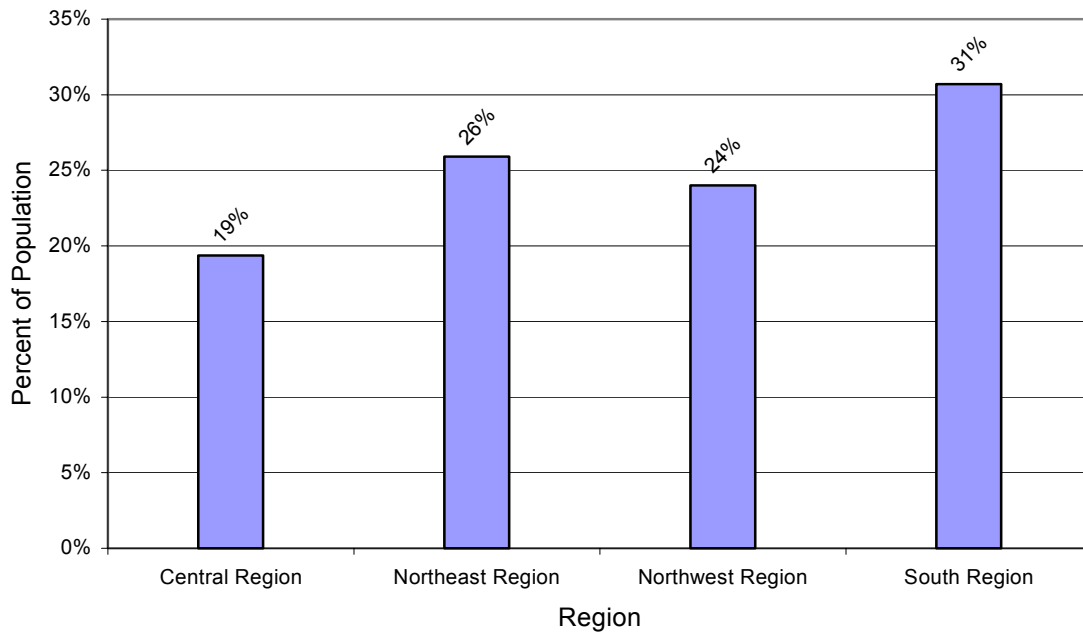




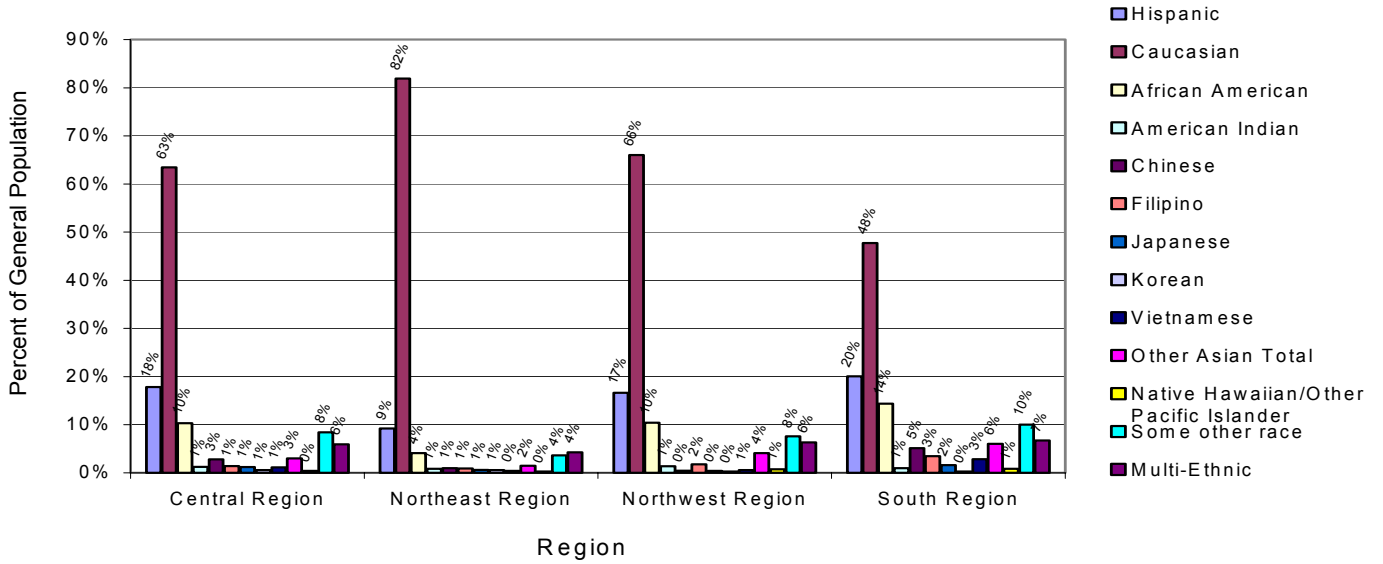
**Figure 4: Languages Spoken by the General Population**



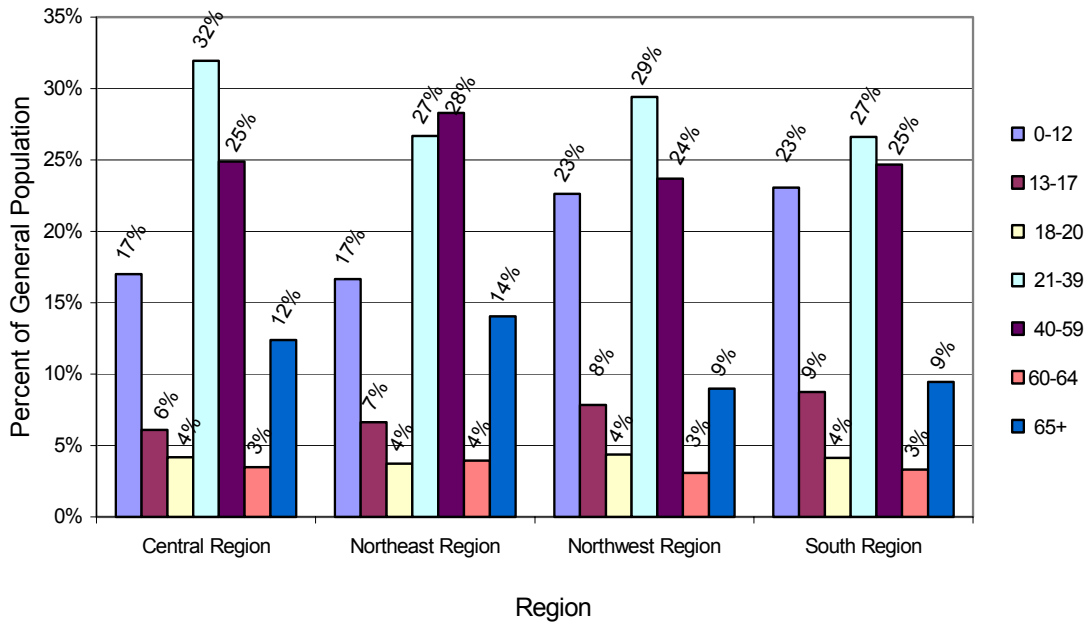
**Figure 5: Population of Sacramento County by Region**



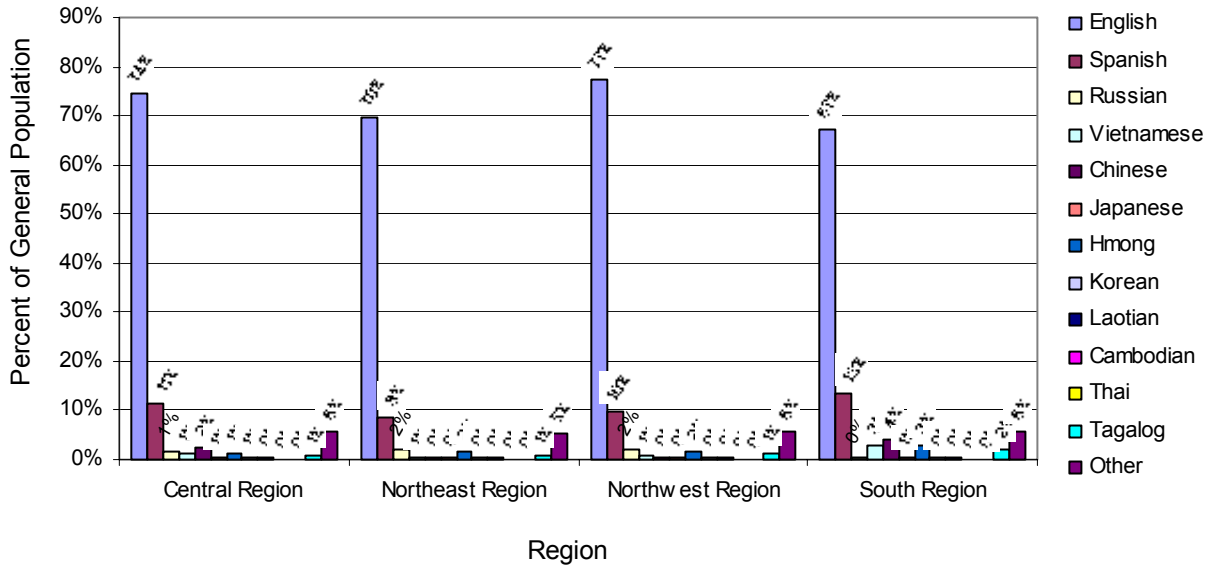
**Figure 6: Ethnicity of General Population By Region**



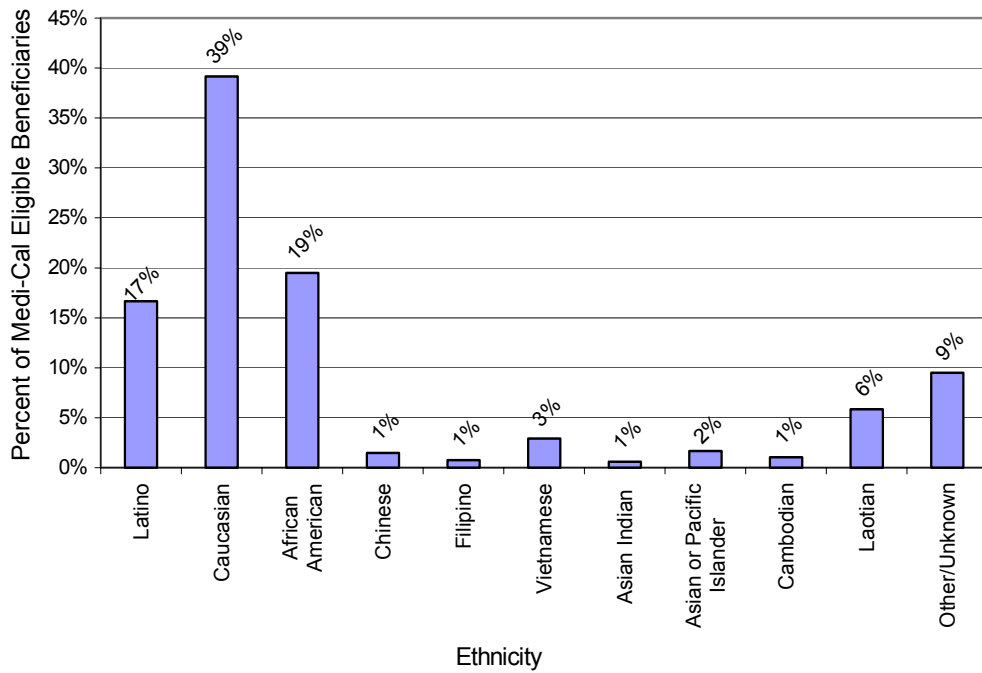
**Figure 7: Age Ranges of the General Population by Region**



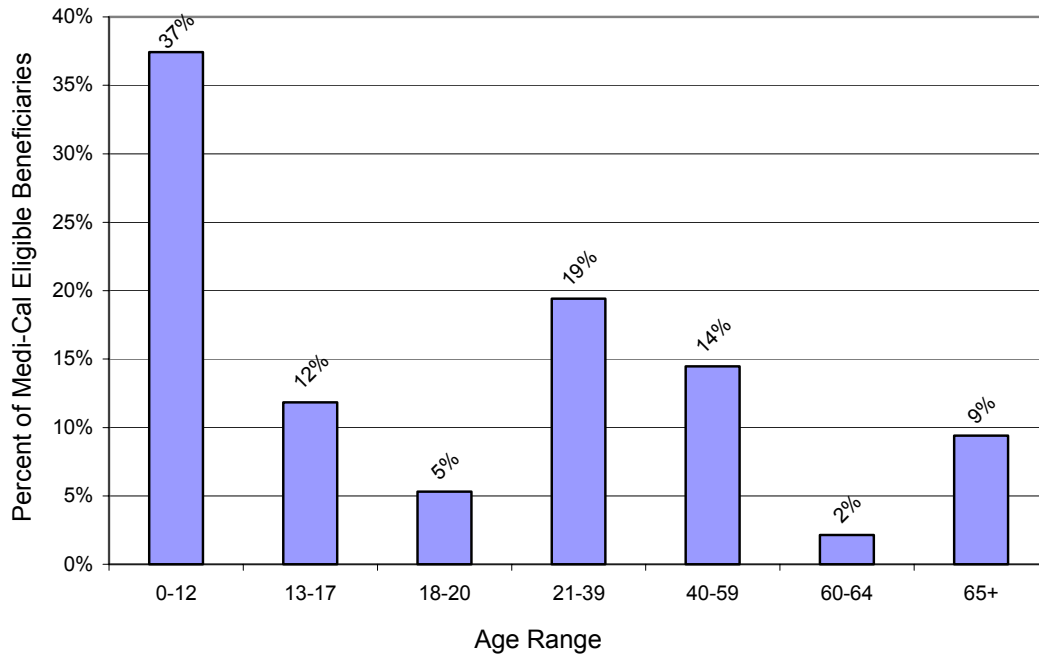
**Figure 8: Languages Spoken by the General Population by Region**



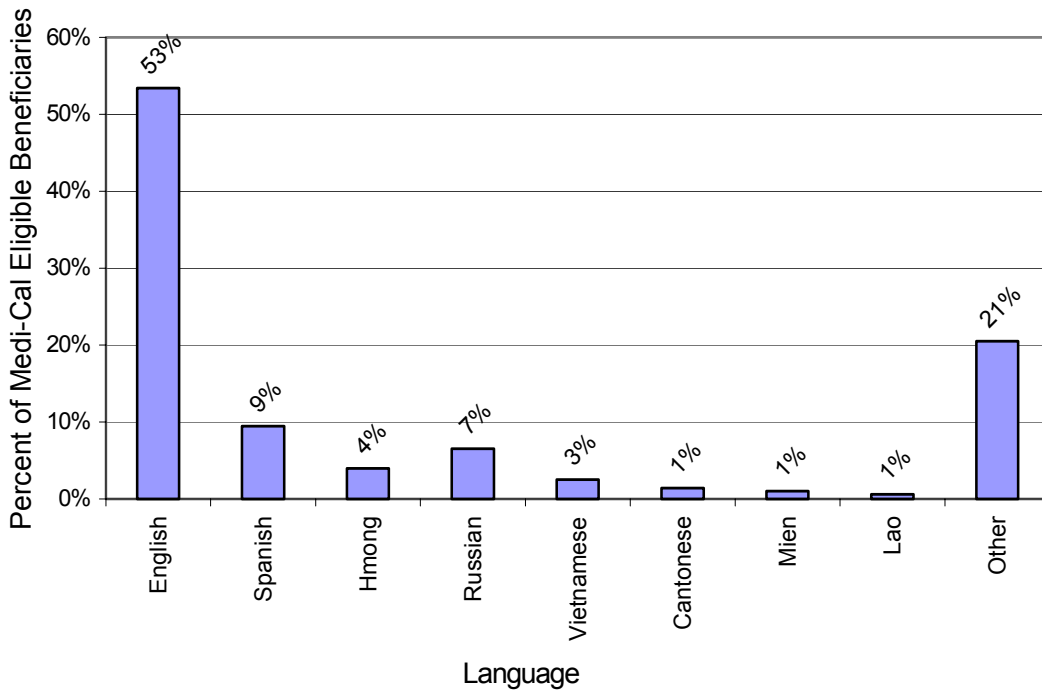
**Figure 9: Ethnicity of Medi-Cal Eligible Beneficiaries**



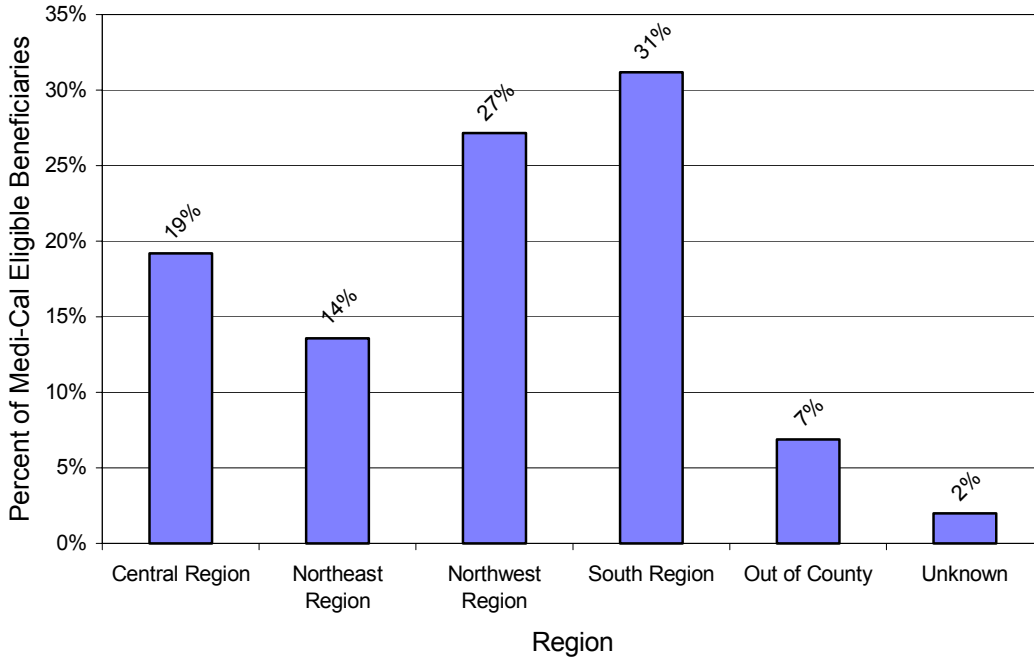
**Figure 10: Age Ranges of Medi-Cal Eligible Beneficiaries**



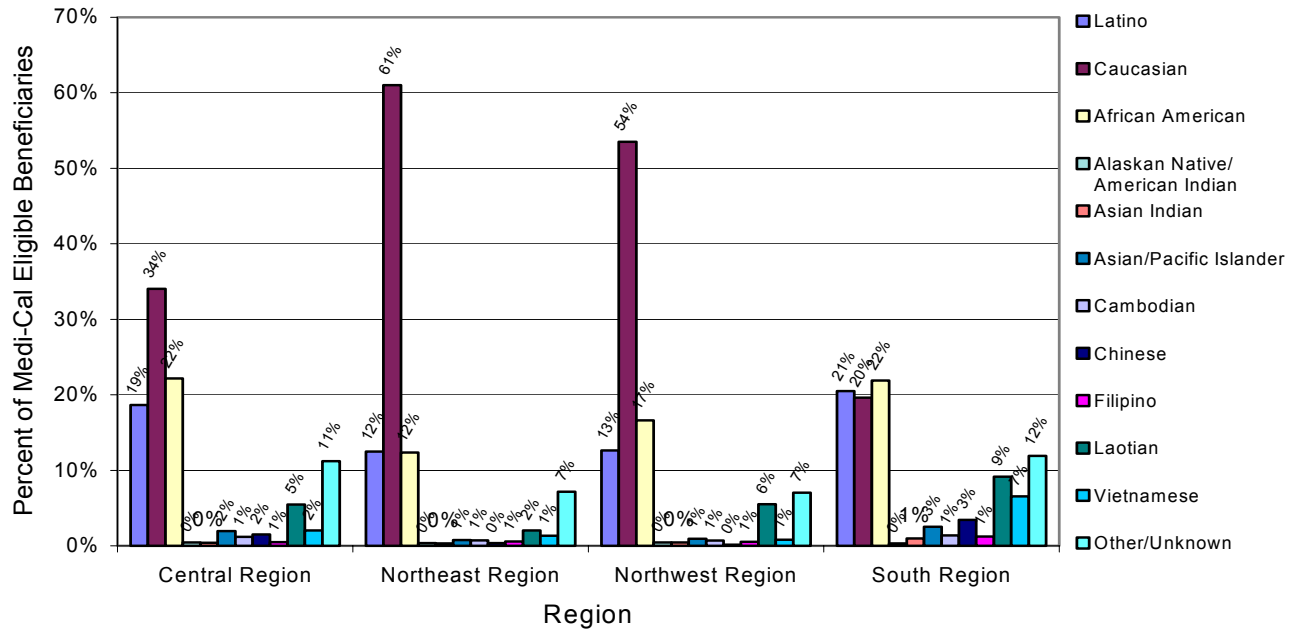
**Figure 11: Language Spoken by Medi-Cal Eligible Beneficiaries**



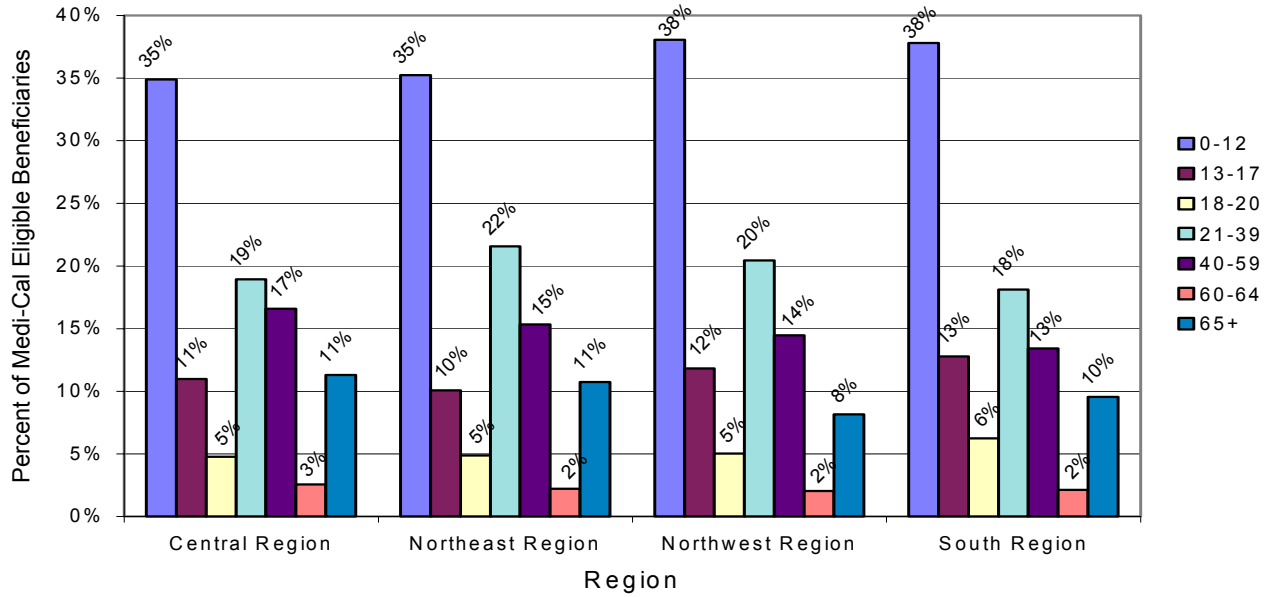
**Figure 12: Medi-Cal Eligible Beneficiaries by Region**



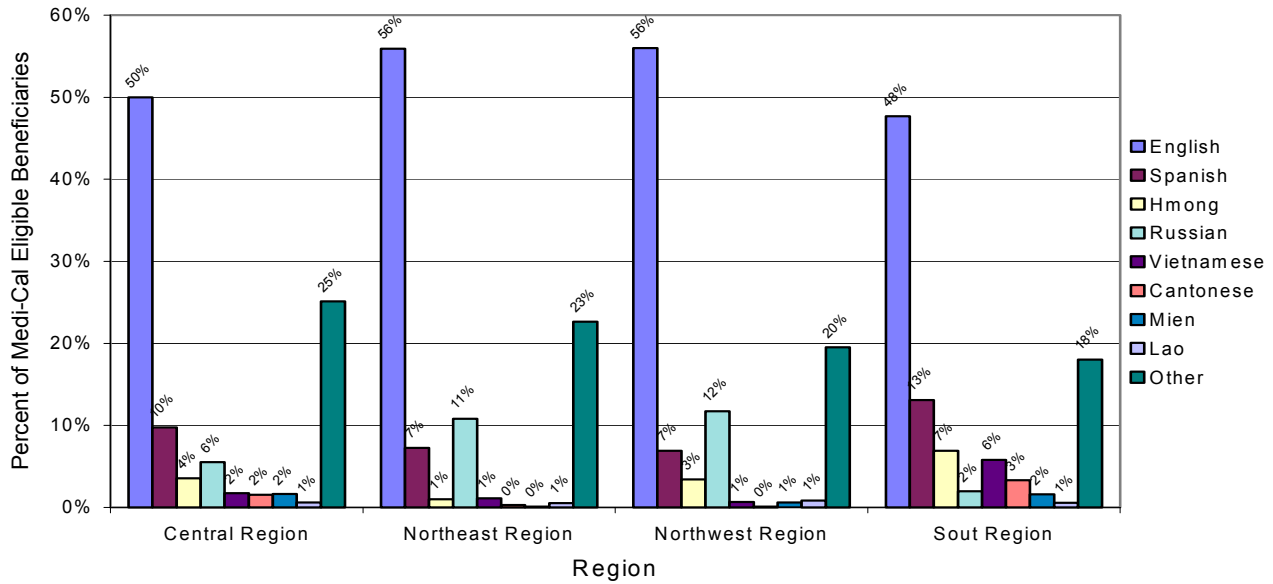
**Figure 13: Ethnicity of Medi-Cal Eligible Beneficiaries by Region**



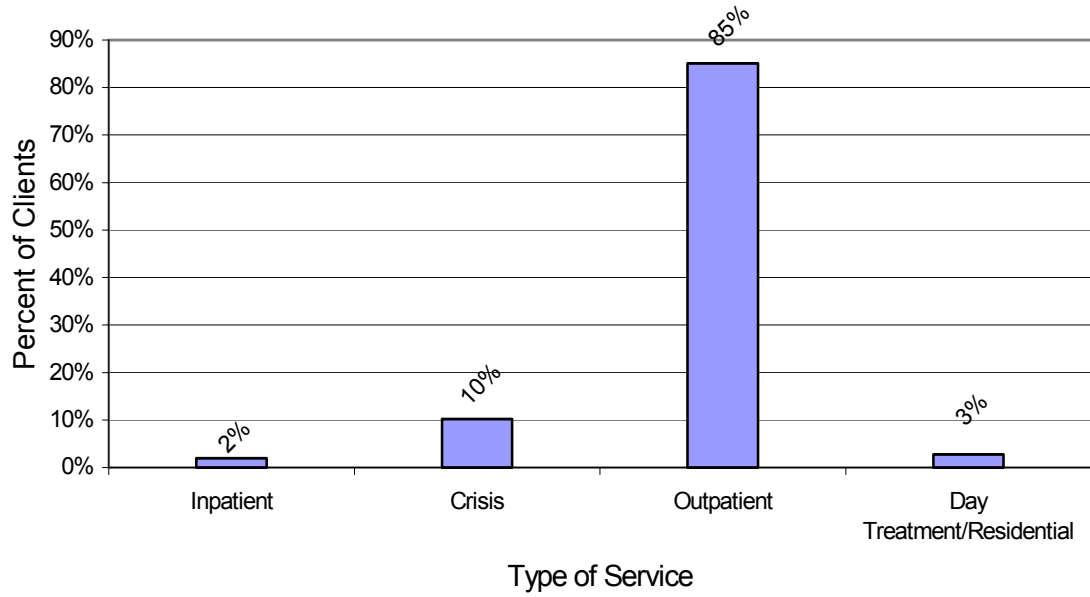
**Figure 14: Age of Medi-Cal Eligible Beneficiaries by Region**



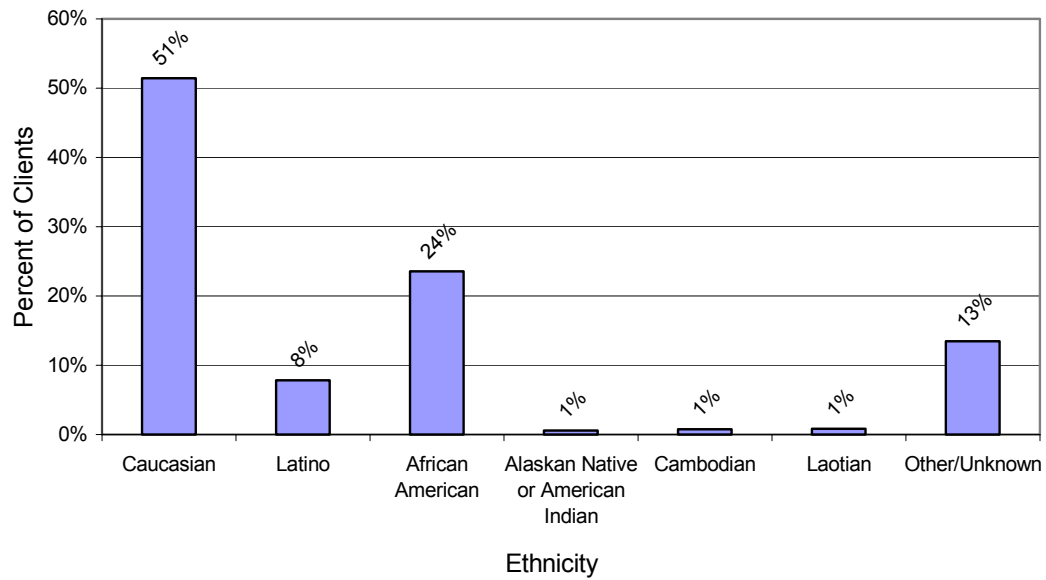
**Figure 15: Languages Spoken by Medi-Cal Eligible Beneficiaries by Region**



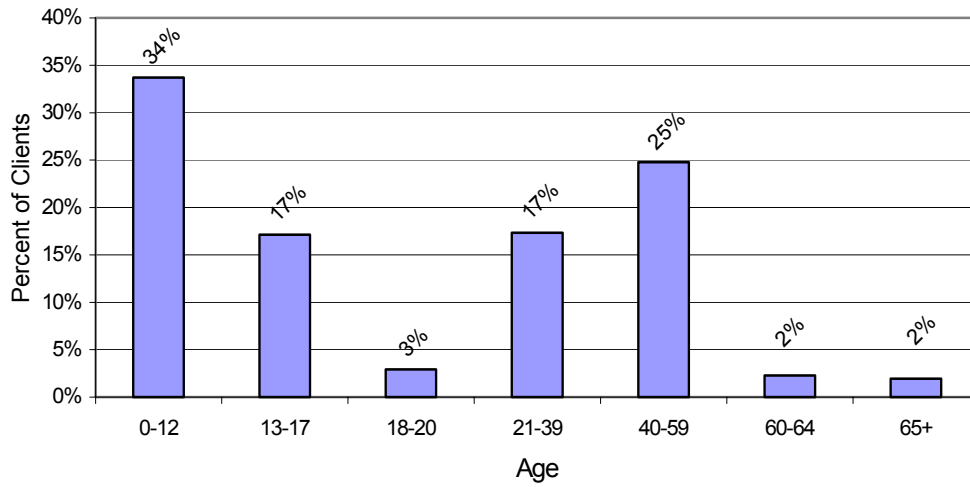
**Figure 16: Types of Mental Health Services Received by Medi-Cal Beneficiaries**



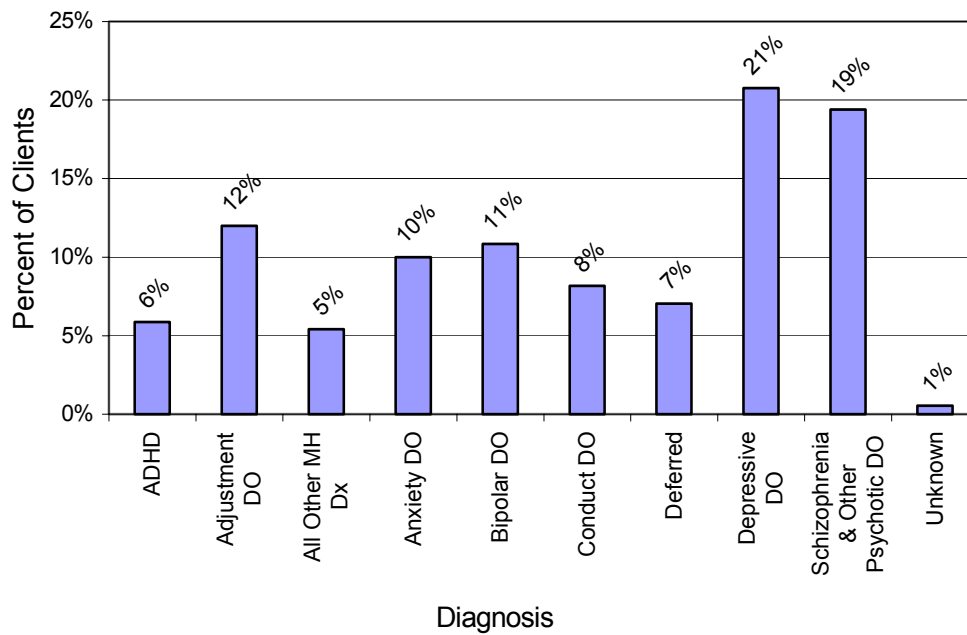
**Figure 17: Ethnicity of Medi-Cal Beneficiaries Receiving Speciality Mental Health Services**



**Figure 18: Age of Medi-Cal Beneficiaries Receiving Speciality Mental Health Services**

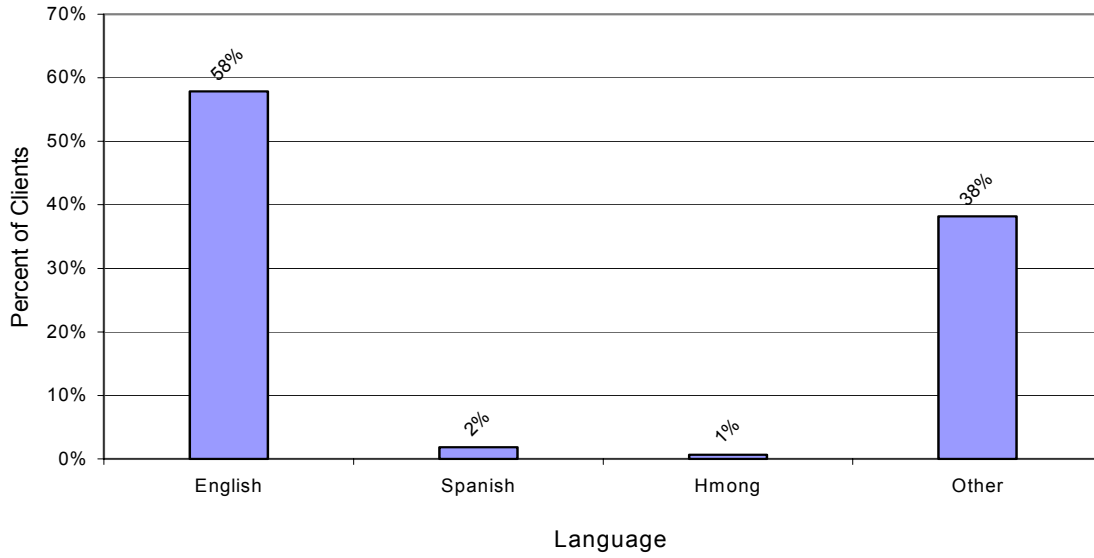


**Figure 19: Diagnosis of Medi-Cal Beneficiaries Receiving Specialty Mental Health Services**

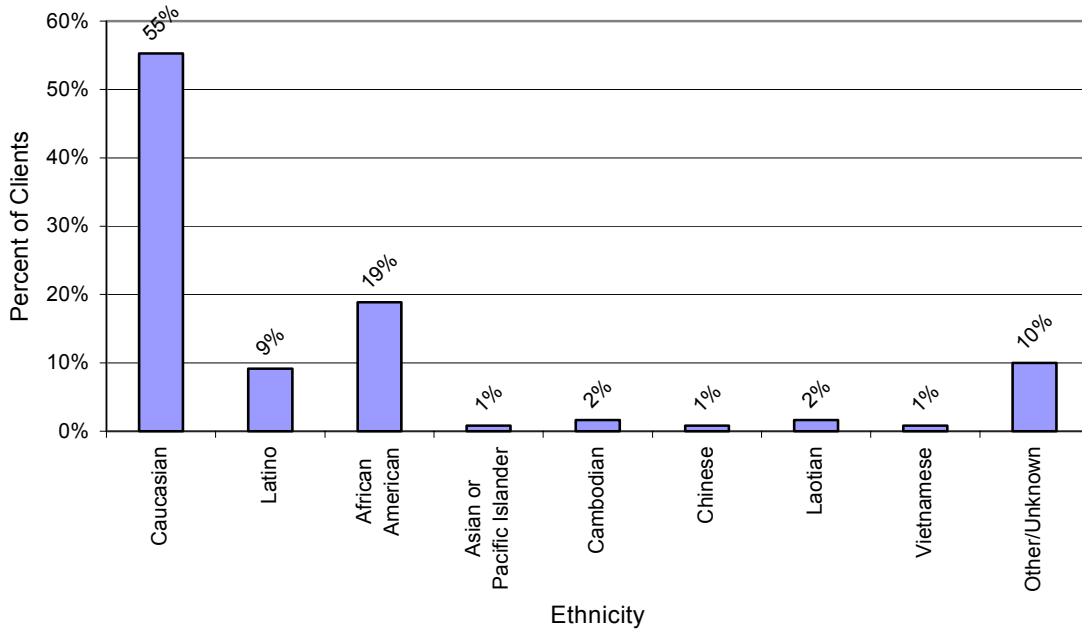




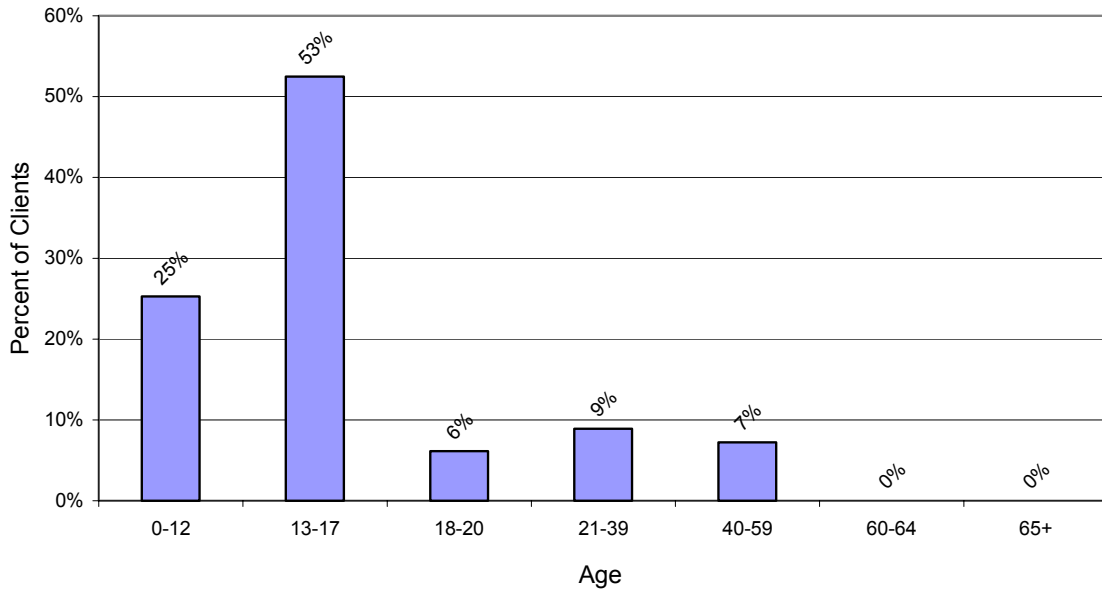
**Figure 20: Primary Language of Medi-Cal Beneficiaries Receiving Speciality Mental Health Services**



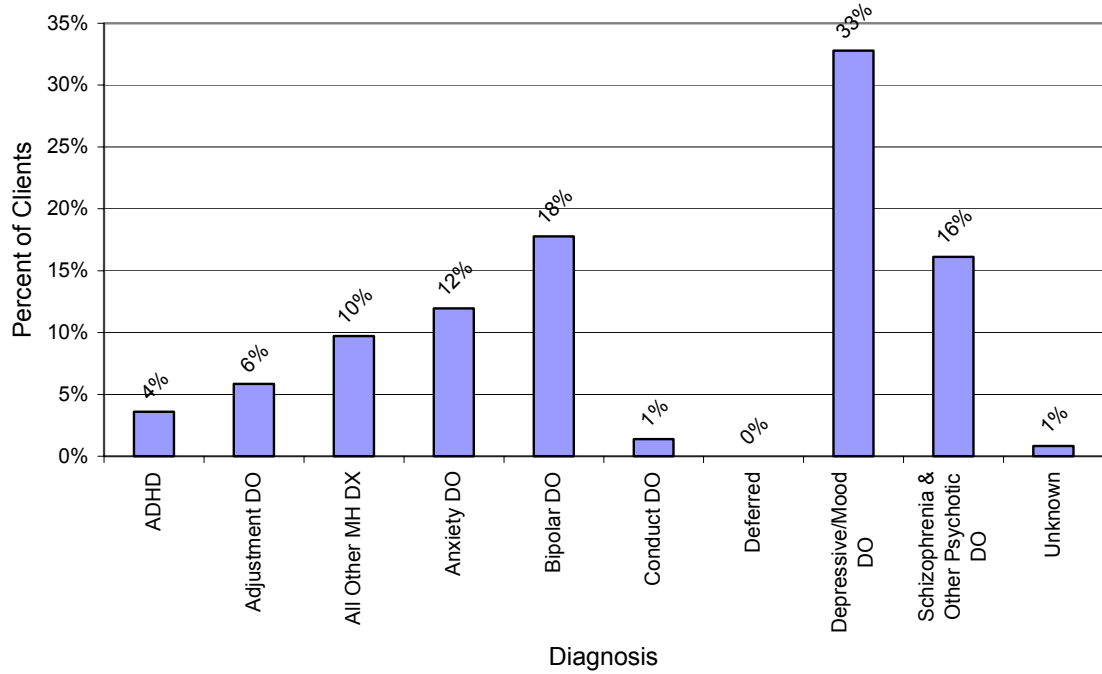
**Figure 21: Utilization of Inpatient Services by Ethnicity**



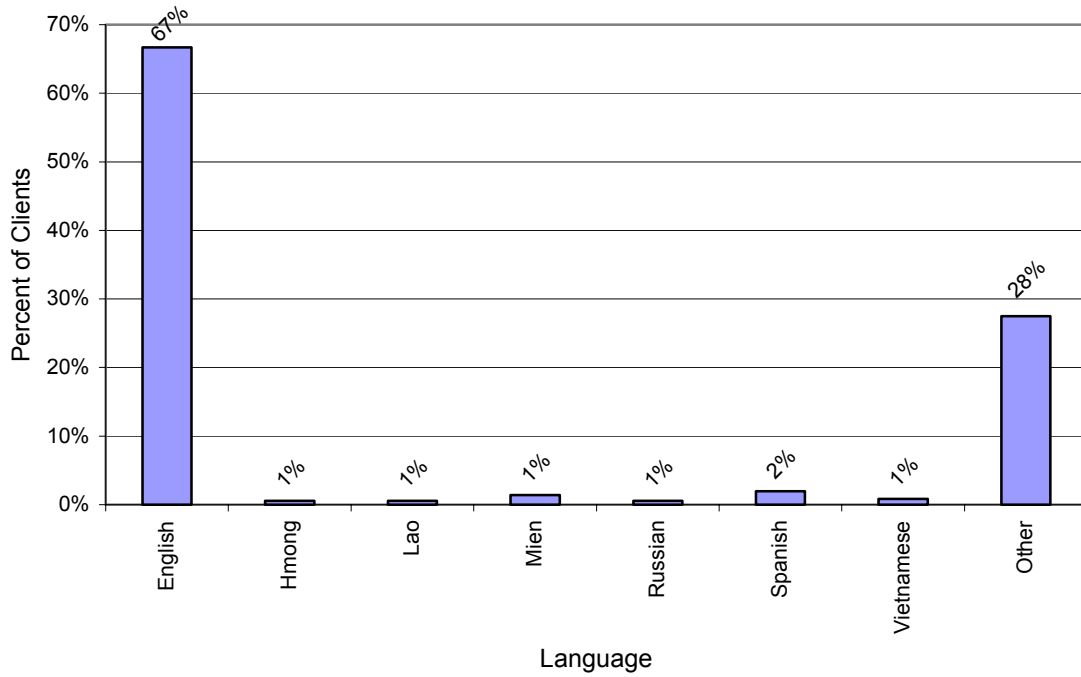
**Figure 22: Utilization of In-Patient Services by Age**



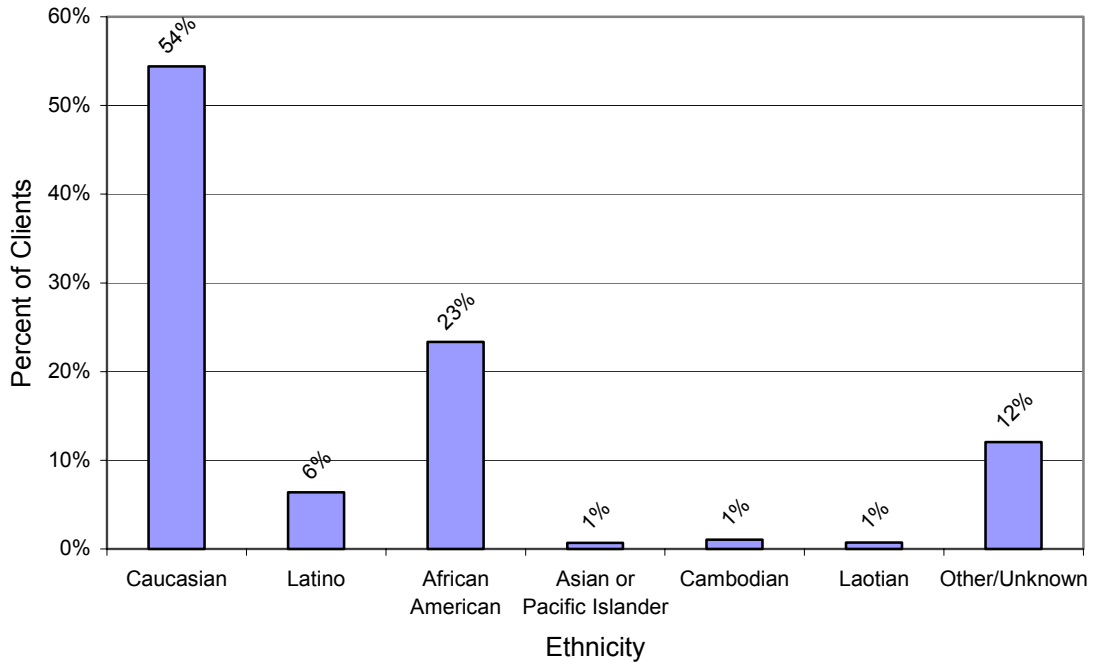
**Figure 23: Utilization of In-Patient Services by Diagnosis**



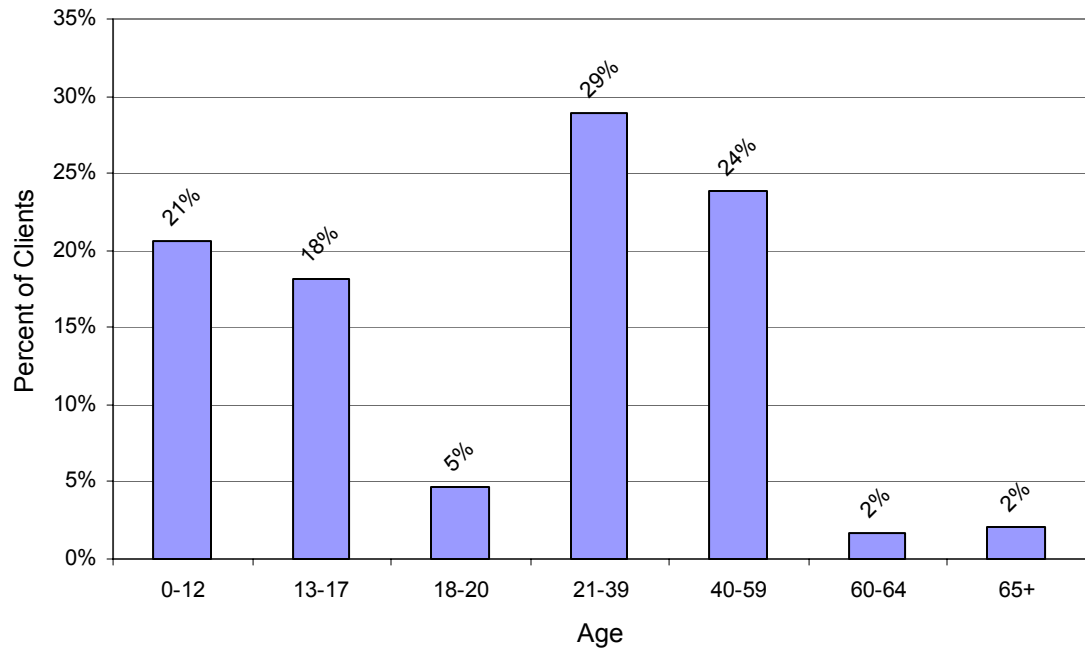
**Figure 24: Utilization of In-Patient Services by Primary Language**



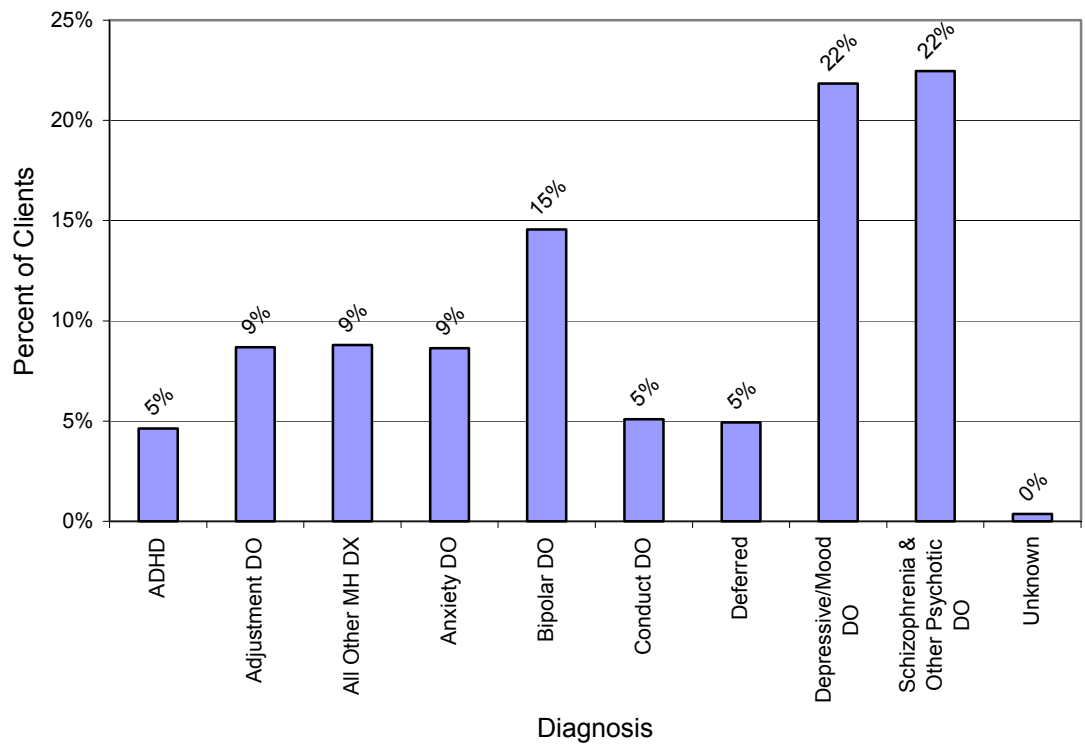
**Figure 25: Utilization of Crisis Services by Ethnicity**



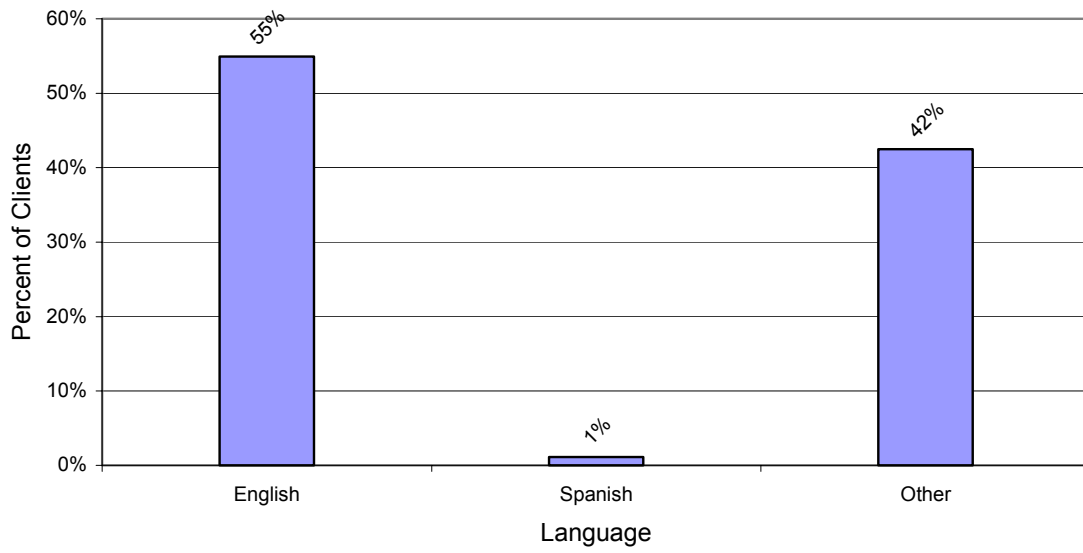
**Figure 26: Utilization of Crisis Services by Age**



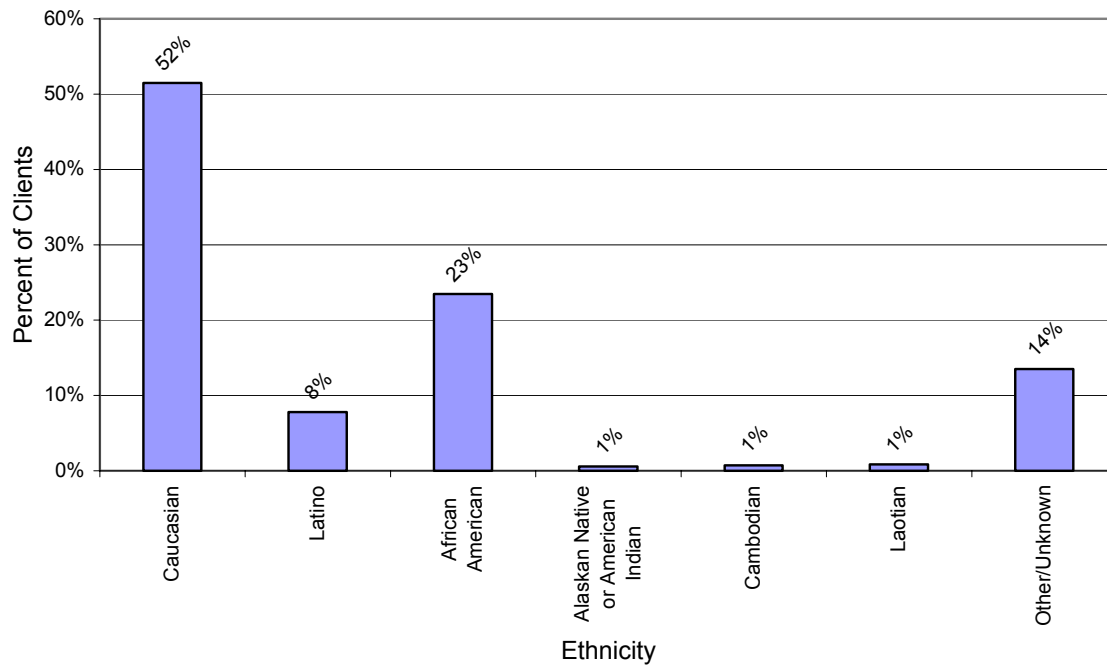
**Figure 27: Utilization of Crisis Services by Diagnosis**



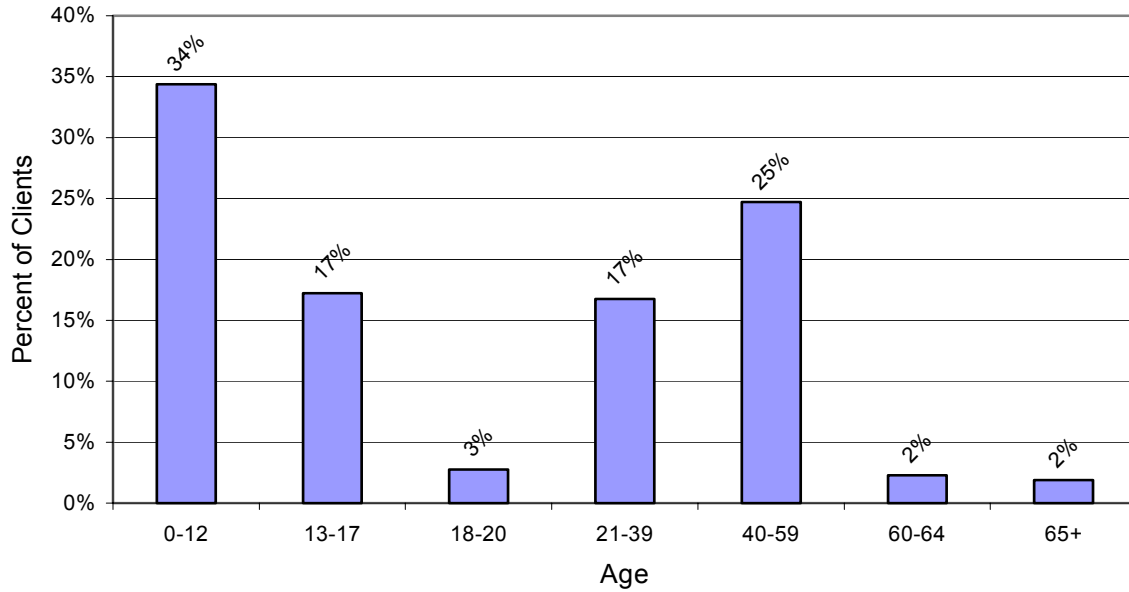
**Figure 28: Utilization of Crisis Services by Primary Language**



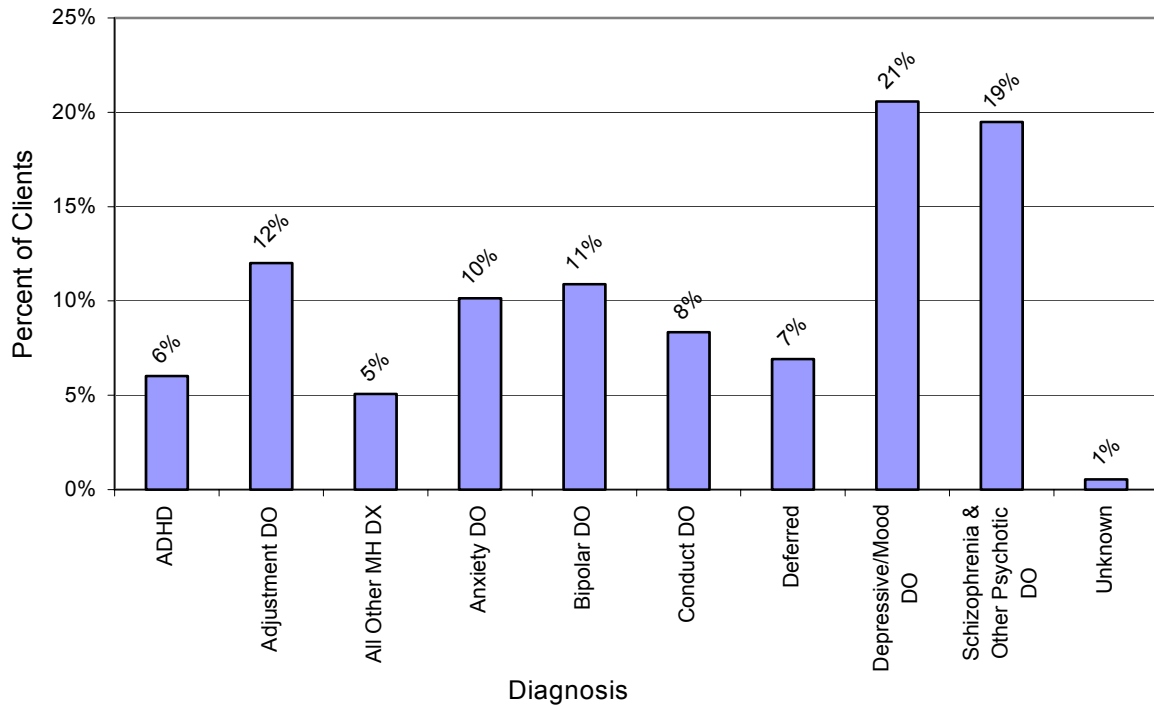
**Figure 29: Clients Receiving Outpatient Services by Ethnicity**



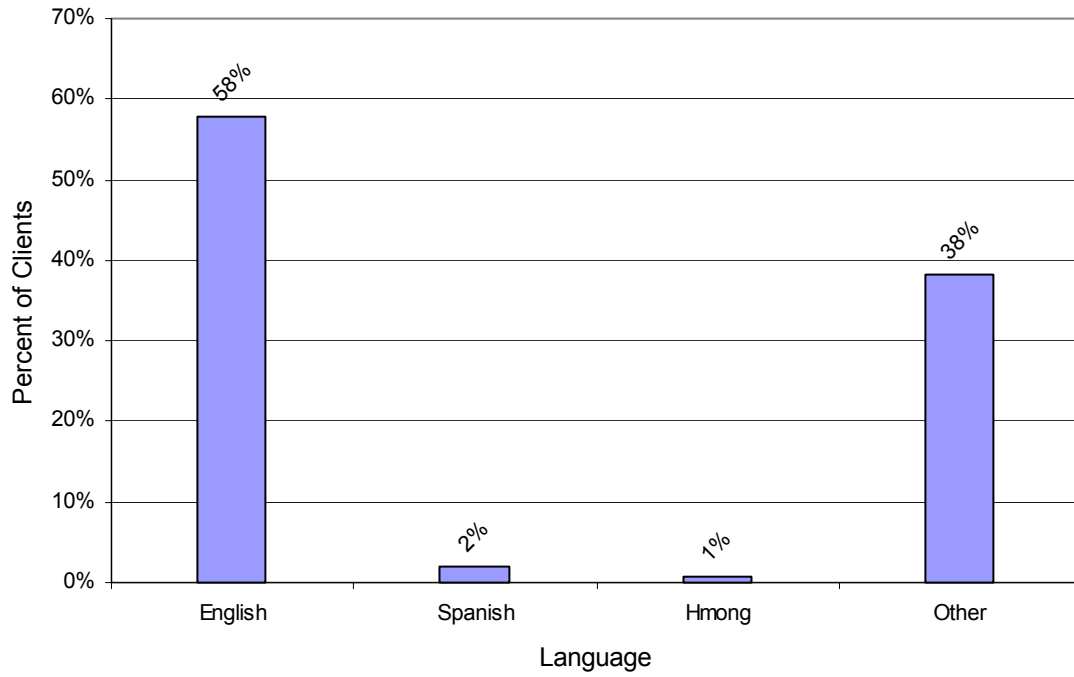
**Figure 30: Utilization of Outpatient Services by Age**



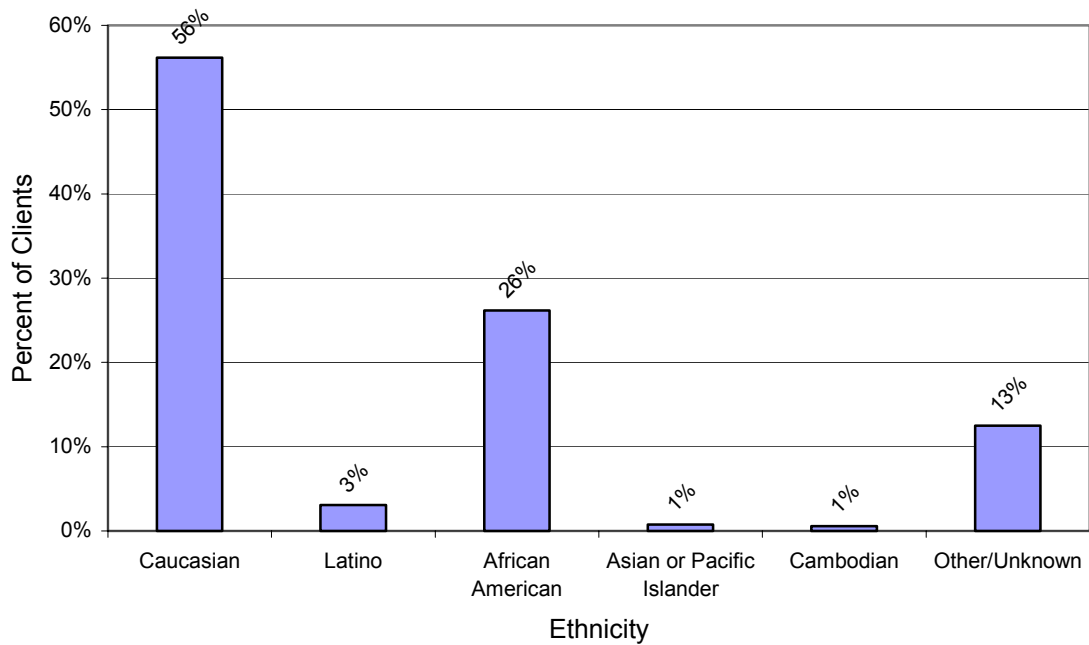
**Figure 31: Utilization of Outpatient Services by Diagnosis**



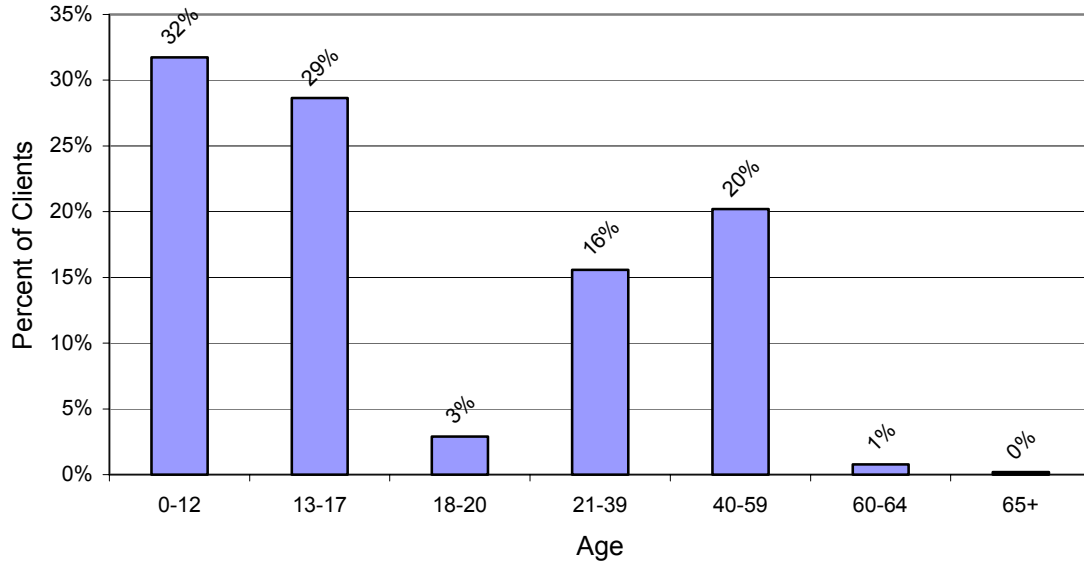
**Figure 32: Utilization Of Outpatient Services by Primary Language**



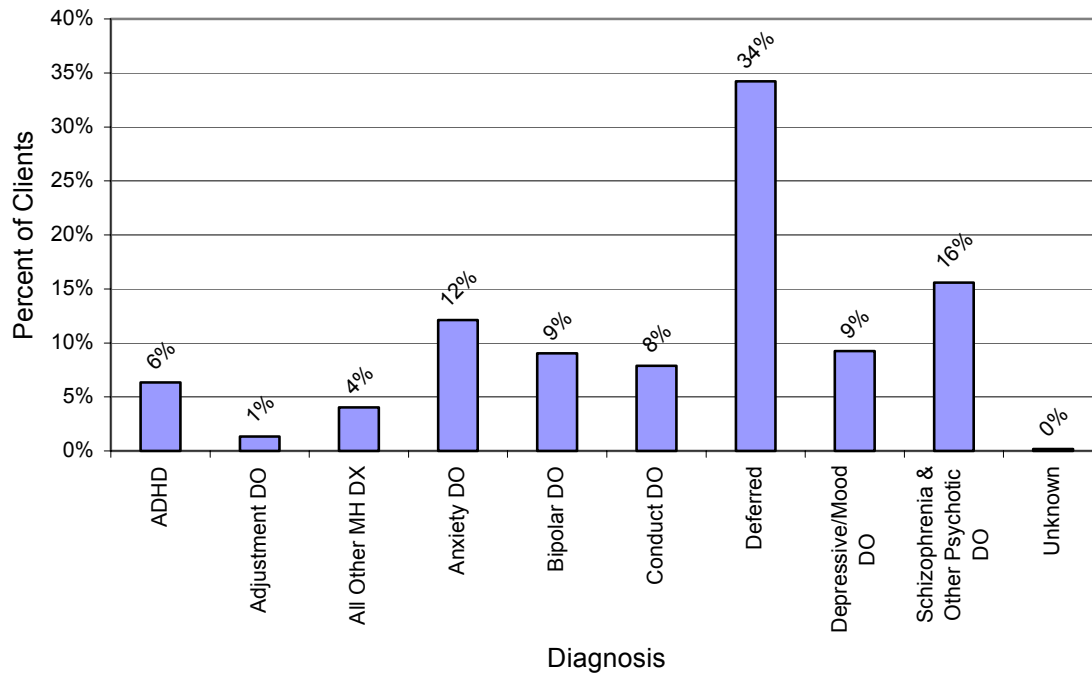
**Figure 33: Utilization of Day Treatment/Residential Services by Ethnicity**



**Figure 34: Utilization of Day Treatment Services by Age**

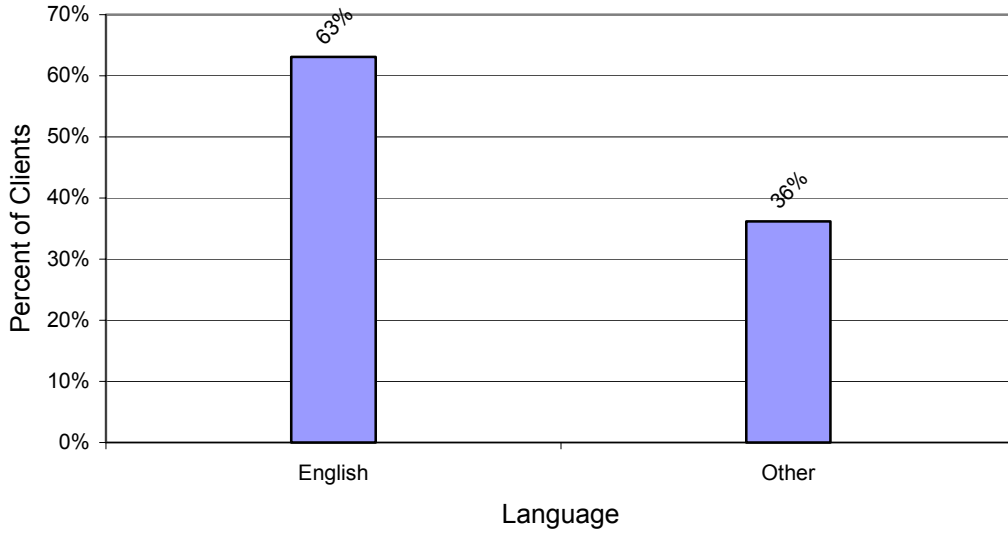


**Figure 35: Utilization of Day Treatment Services by Diagnosis**

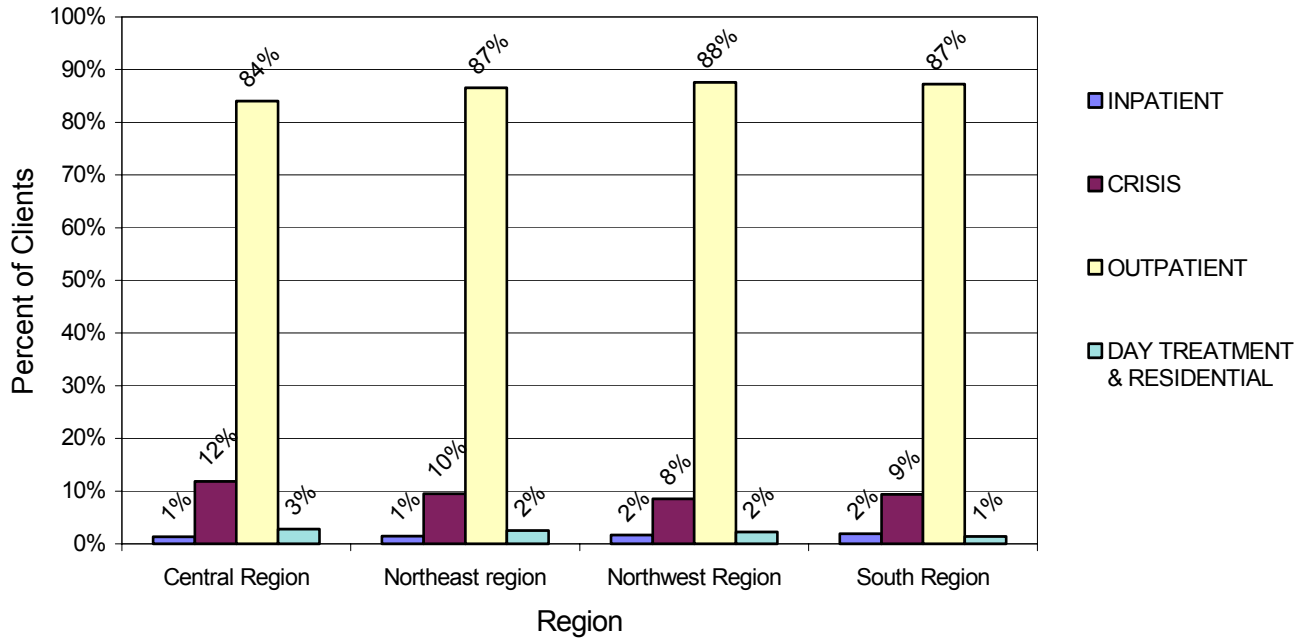




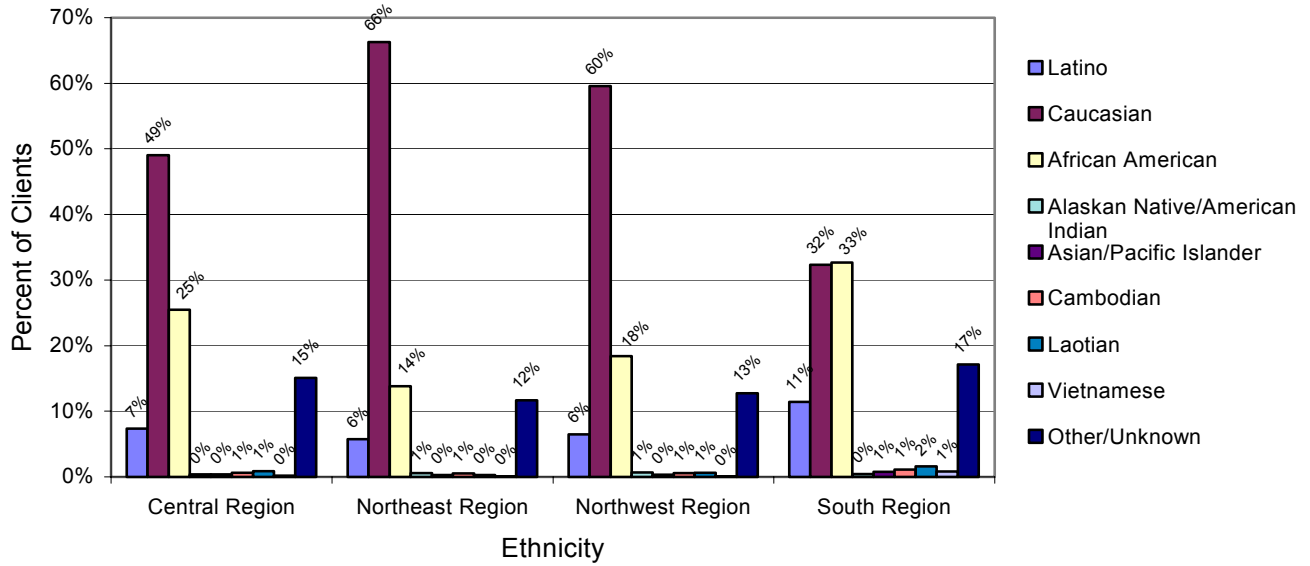
**Figure 36: Utilization of Day Treatment Services by Primary Language**



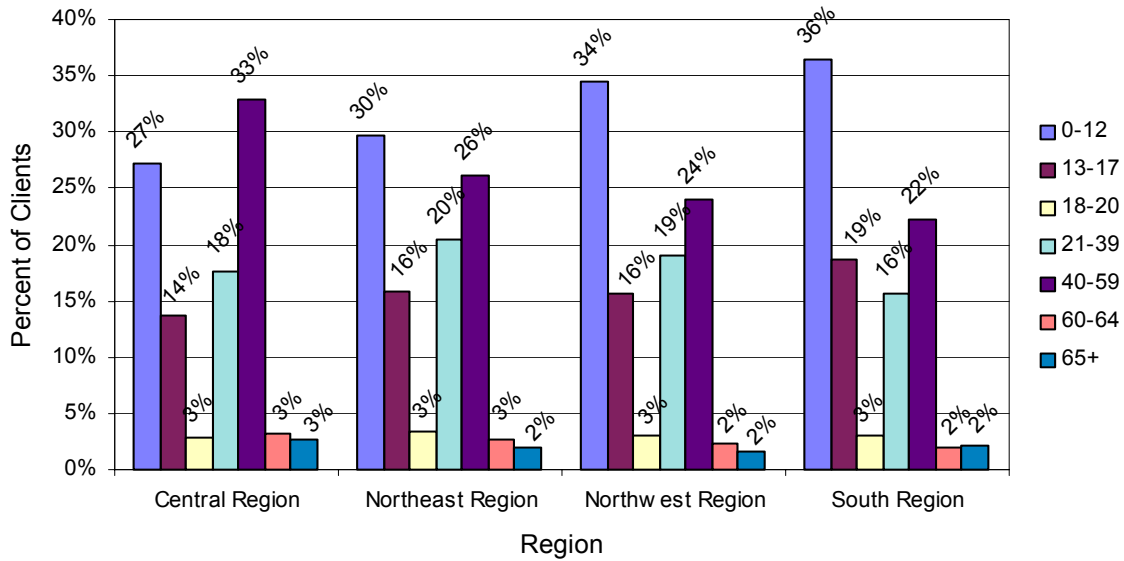
**Figure 37: Type of Services Received by Medi-Cal Beneficiaries Receiving Mental Health Services By Region**



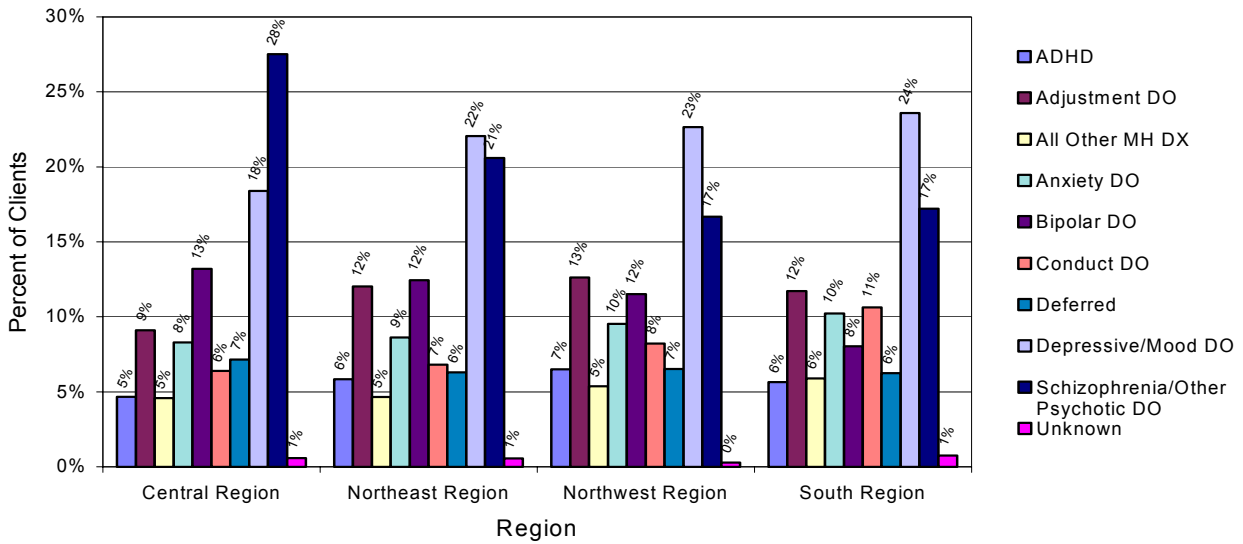
**Figure 38: Ethnicity of Medi-Cal Beneficiaries Receiving Mental Health Services by Region**



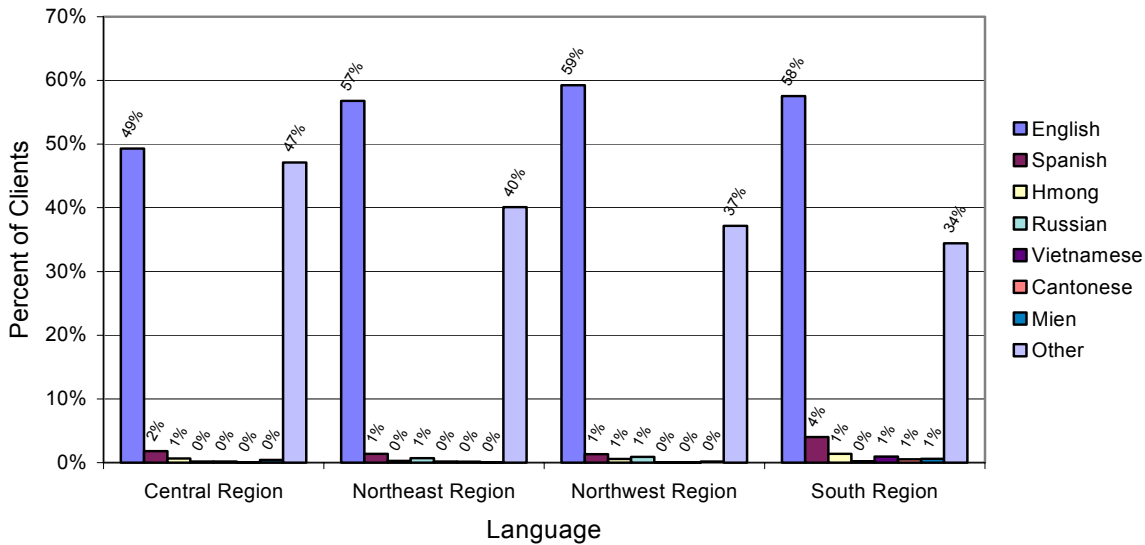
**Figure 39: Age of Medi-Cal Beneficiaries Receiving Mental Health Services by Region**



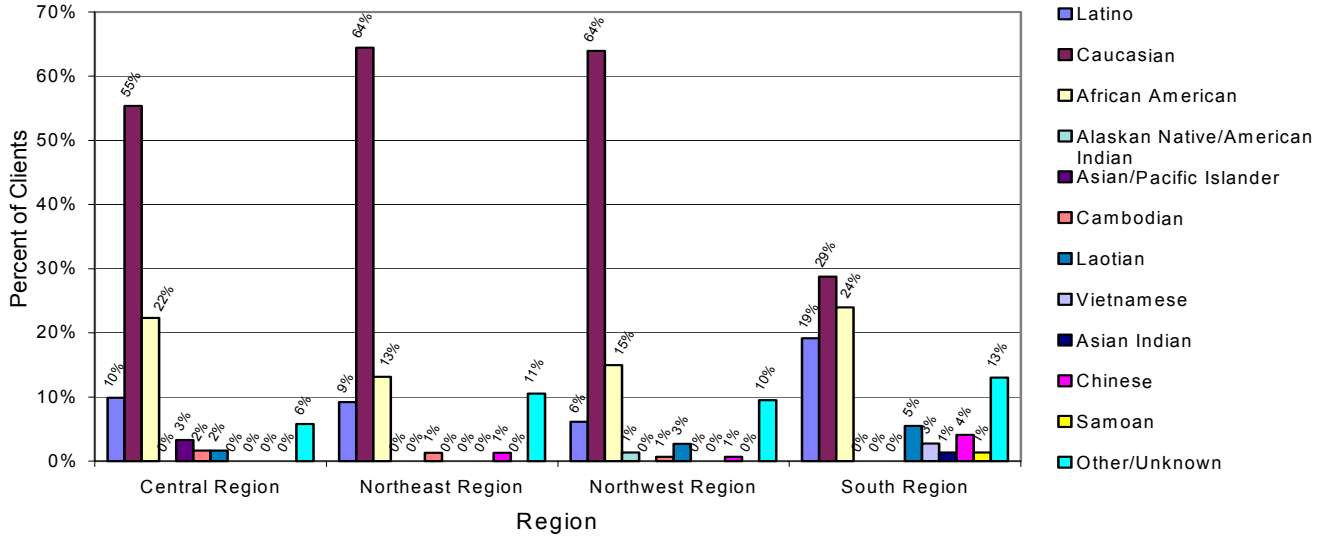
**Figure 40: Diagnosis of Medi-Cal Beneficiaries Receiving Mental Health Services by Region**



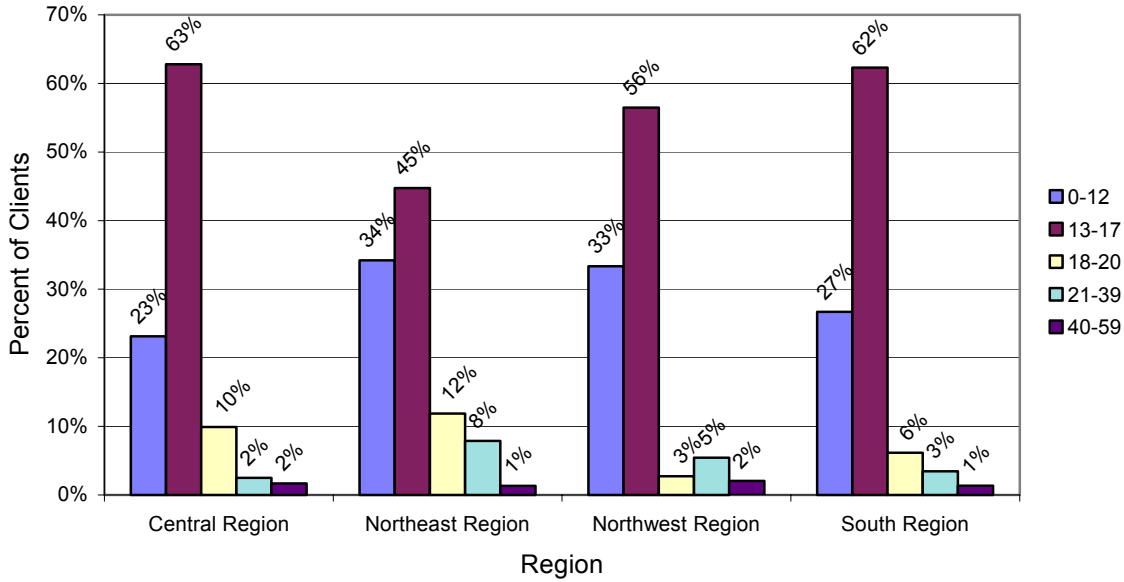
**Figure 41: Primary Language Spoken by Medi-Cal Beneficiaries Receiving Mental Health Services by Region**



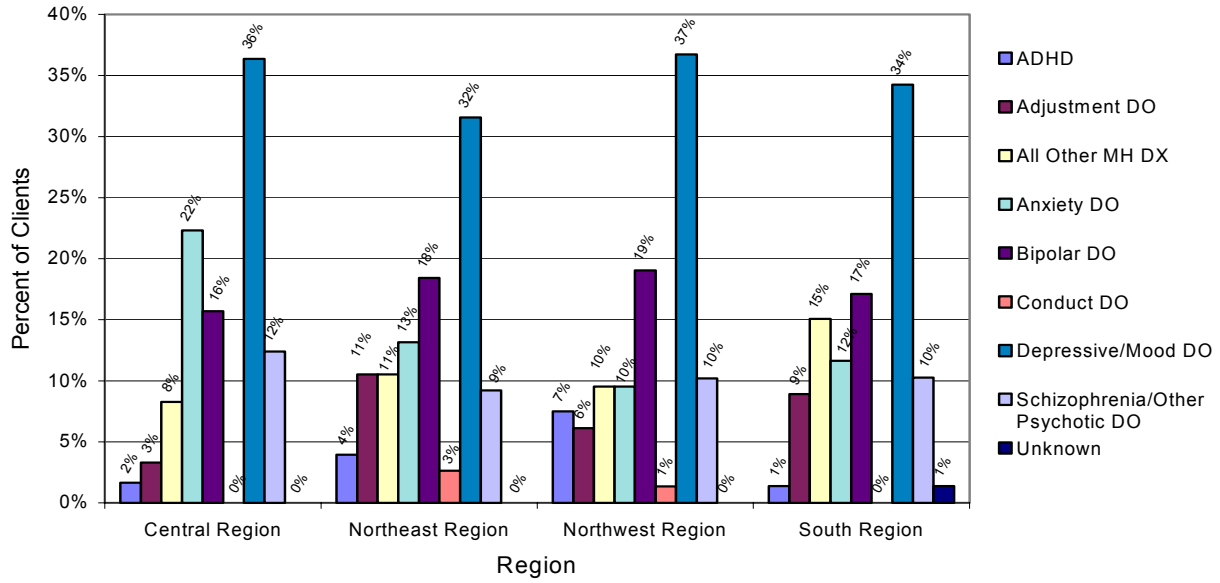
**Figure 42: Ethnicity by Region for Medi-Cal Beneficiaries Receiving Inpatient Mental Health Services**



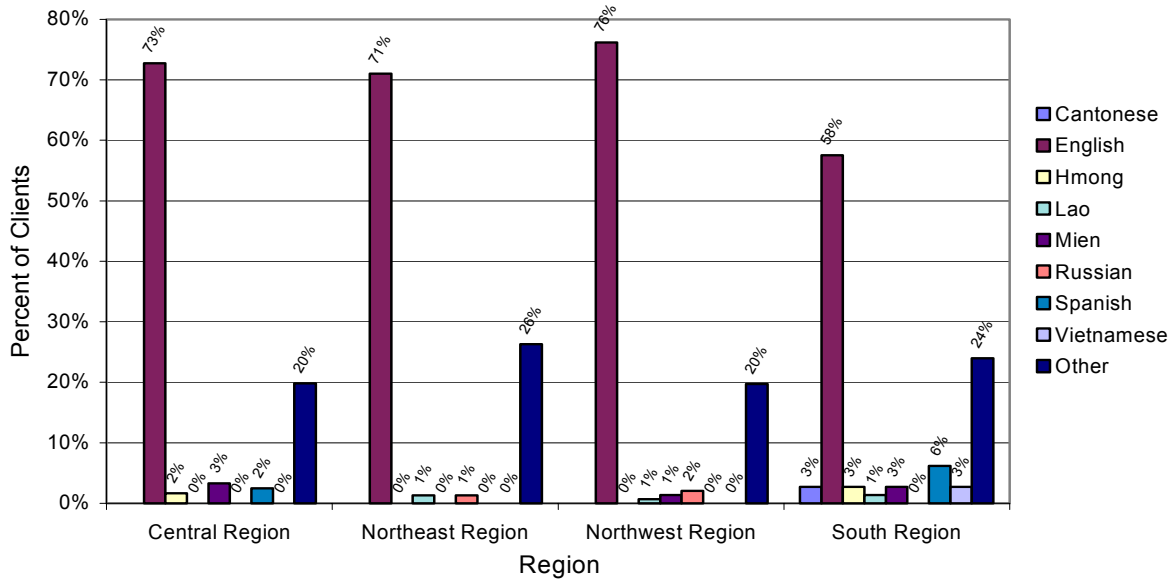
**Figure 43: Age by Region for Medi-Cal Beneficiaries Receiving Inpatient Mental Health Services**



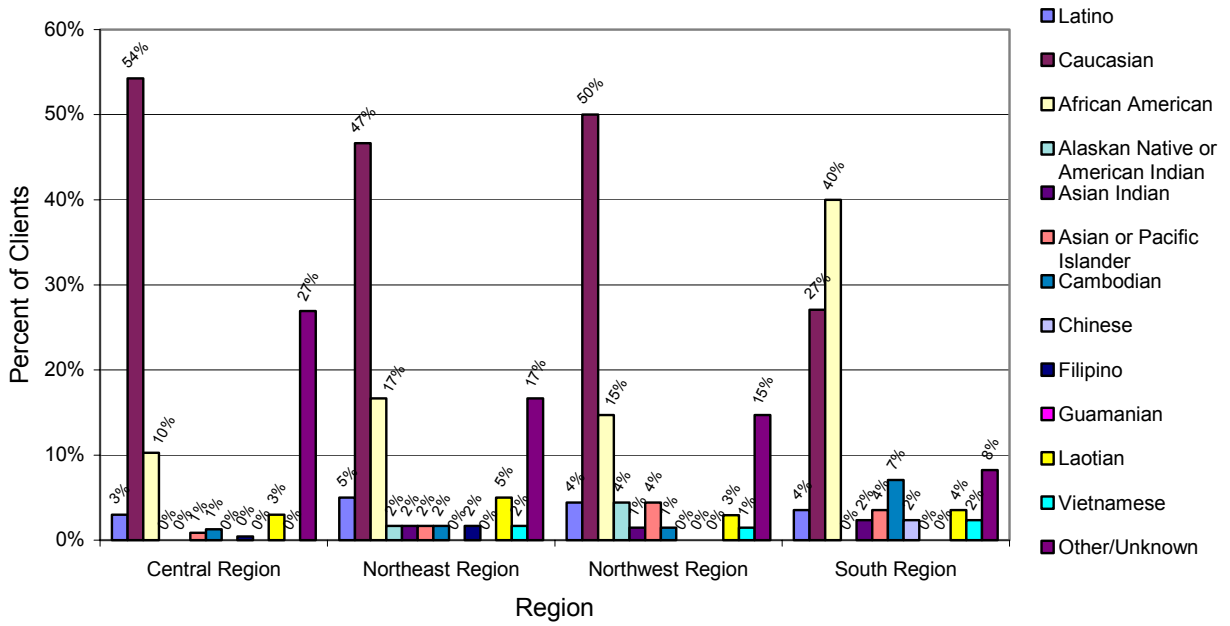
**Figure 44: Diagnosis by Region for Medi-Cal Beneficiaries Receiving Inpatient Mental Health Services**



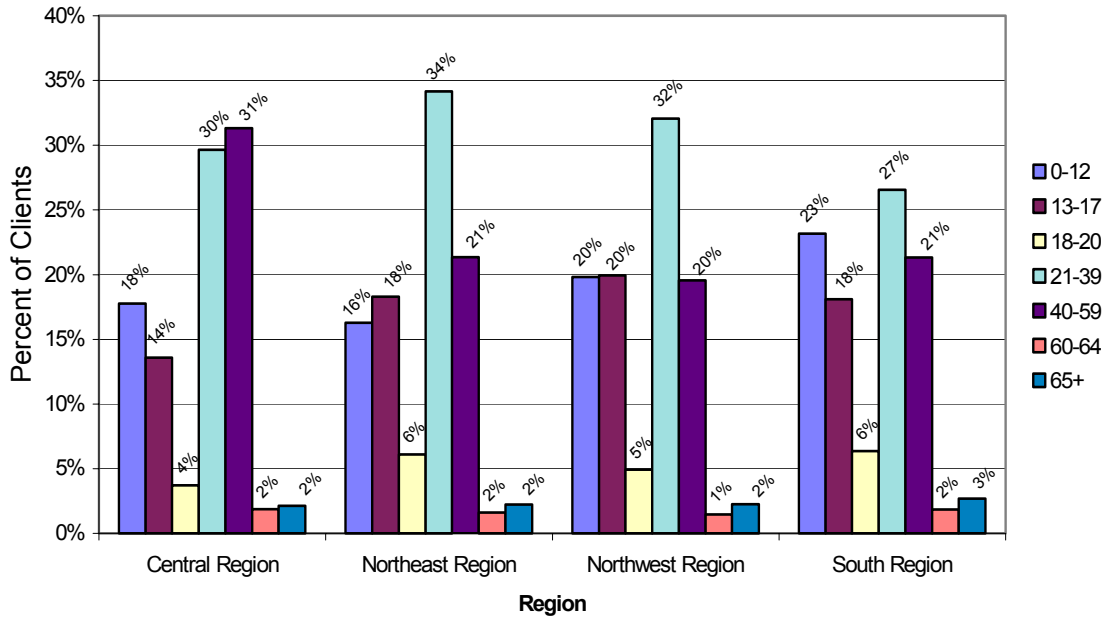
**Figure 45: Language by Region for Medi-Cal Beneficiaries Receiving Inpatient Mental Health Services**



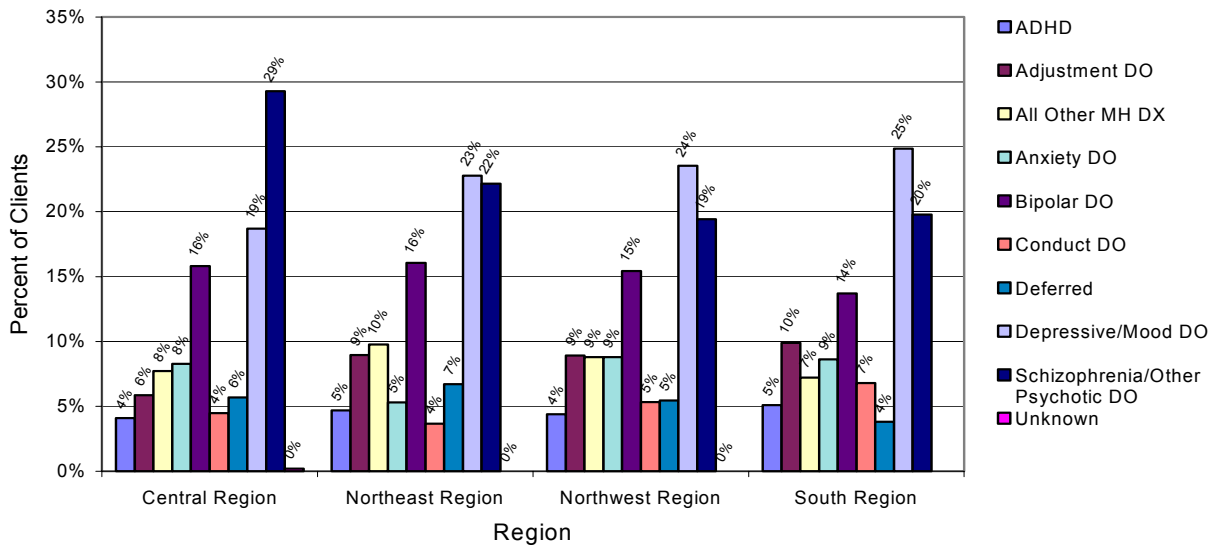
**Figure 46: Ethnicity by Region for Medi-Cal Beneficiaries Receiving Crisis Mental Health Services**



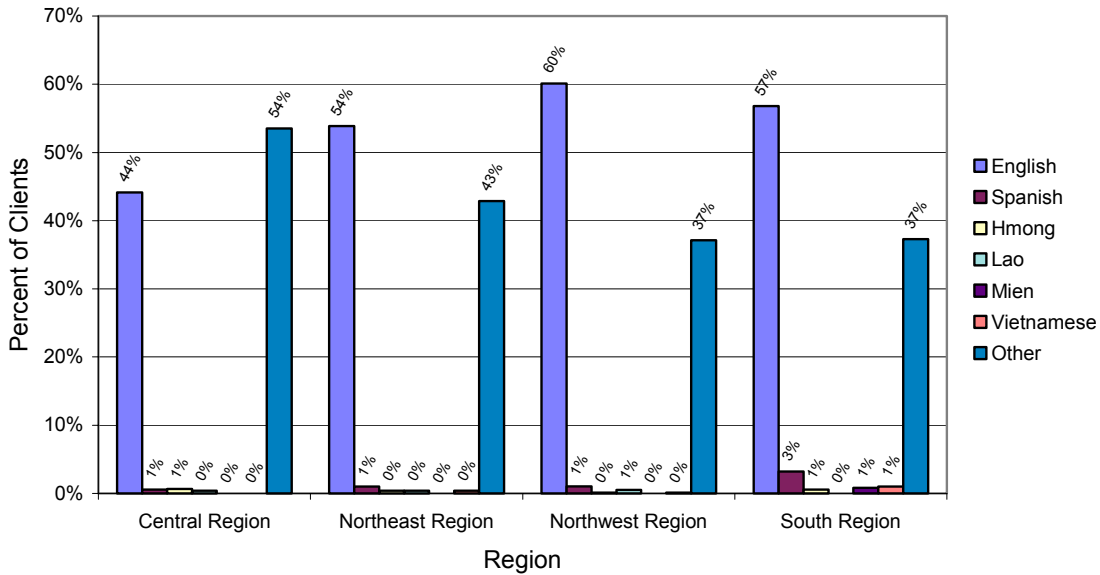
**Figure 47: Age By Region for Medi-Cal Beneficiaries Receiving Crisis Mental Health Services**



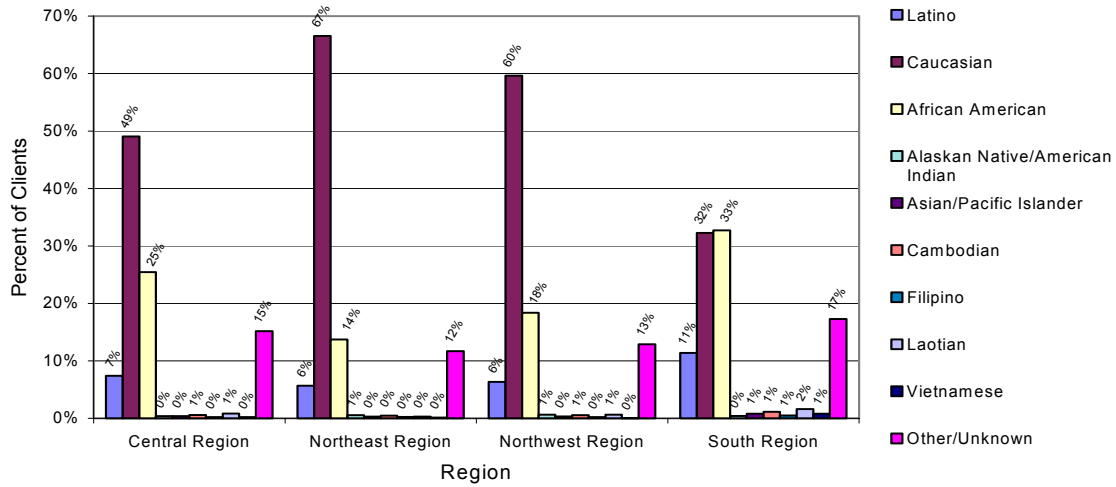
**Figure 48: Diagnosis By Region for Medi-Cal Beneficiaries Receiving Crisis Mental Health Services**



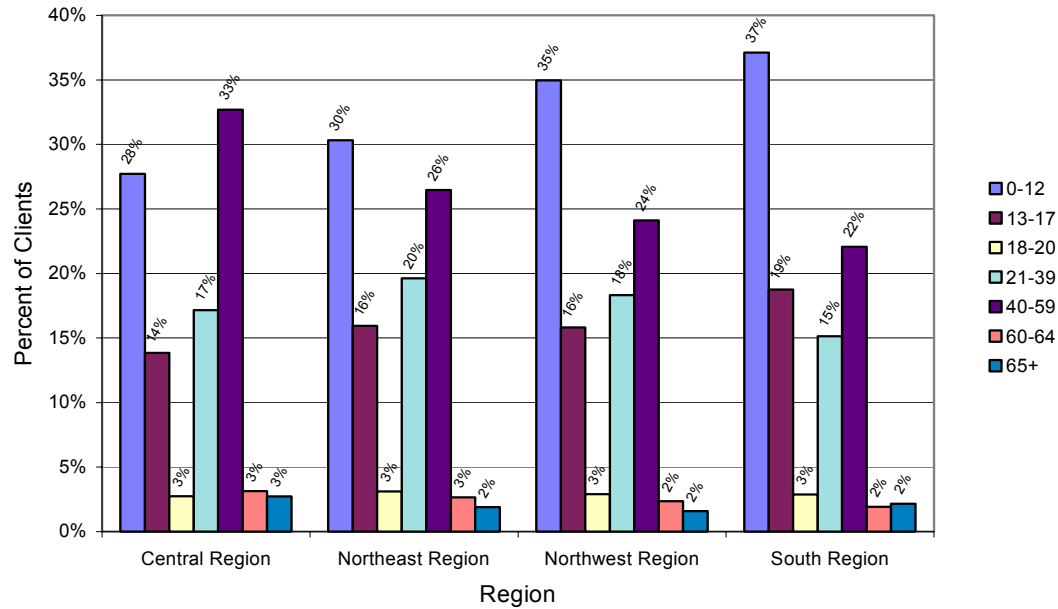
**Figure 49: Language Spoken By Region for Medi-Cal Beneficiaries Receiving Crisis Mental Health Services**



**Figure 50: Ethnicity by Region of Medi-Cal Beneficiaries Receiving Outpatient Services**

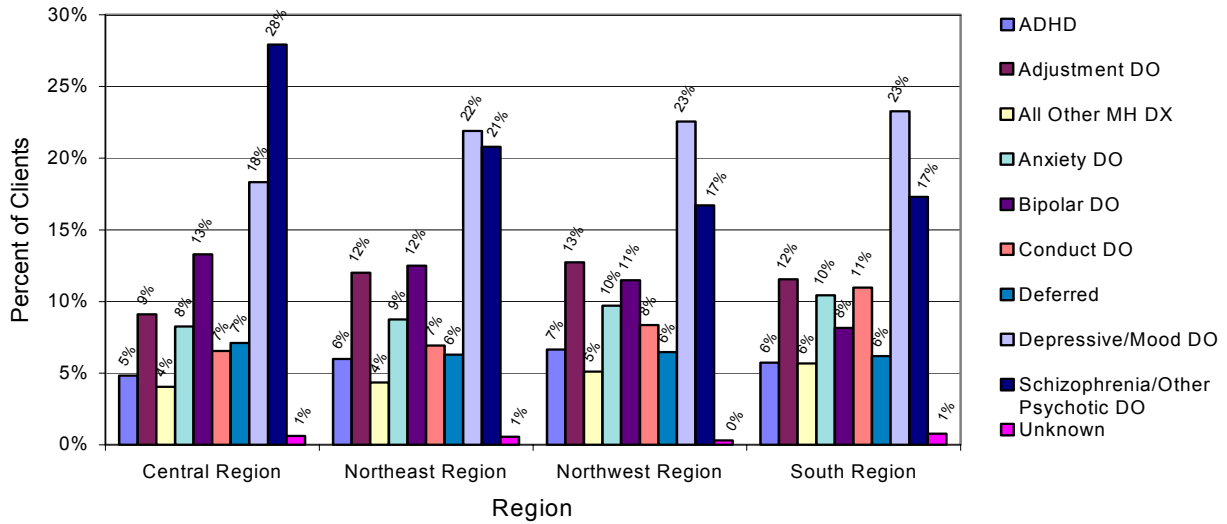


**Figure 51: Age by Region for Medi-Cal Beneficiaries Receiving Outpatient Mental Health Services**

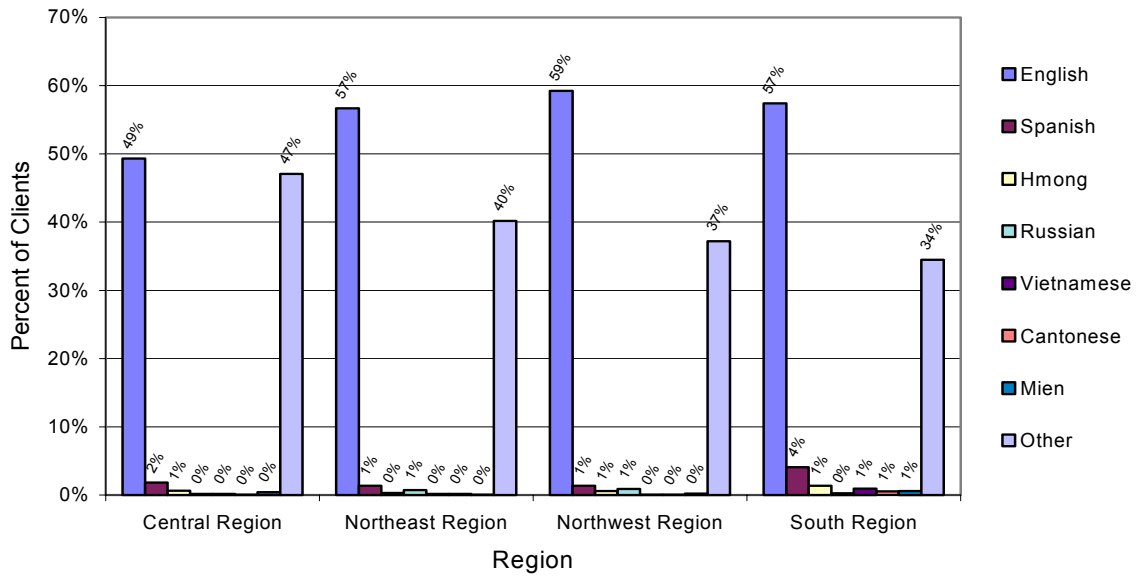




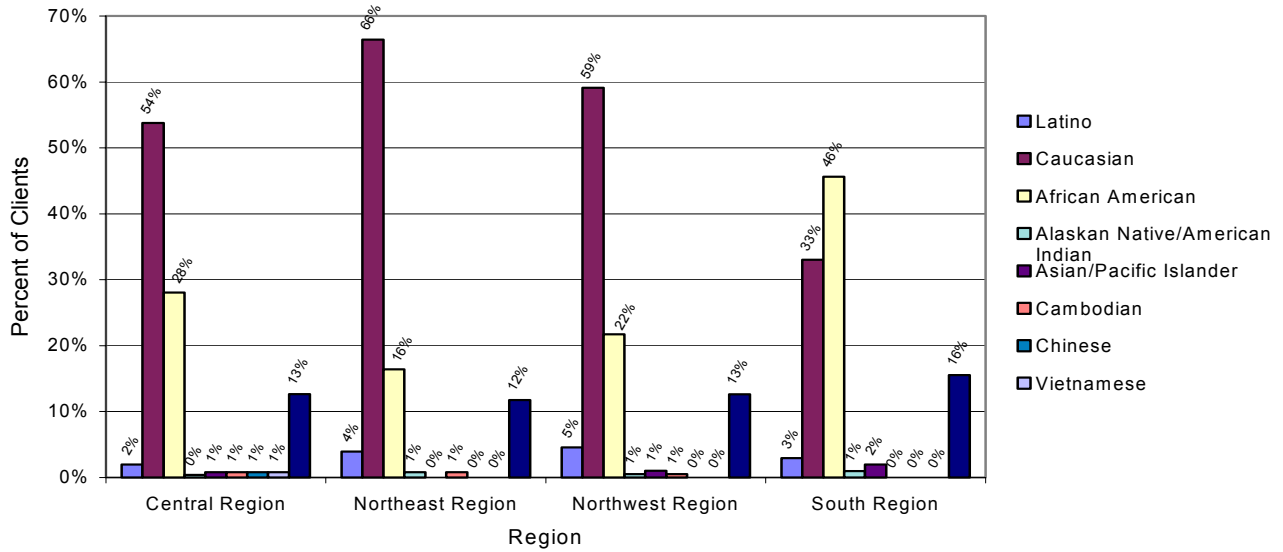
**Figure 52: Diagnosis by Region of Medi-Cal Beneficiaries Receiving Outpatient Mental Health Services**



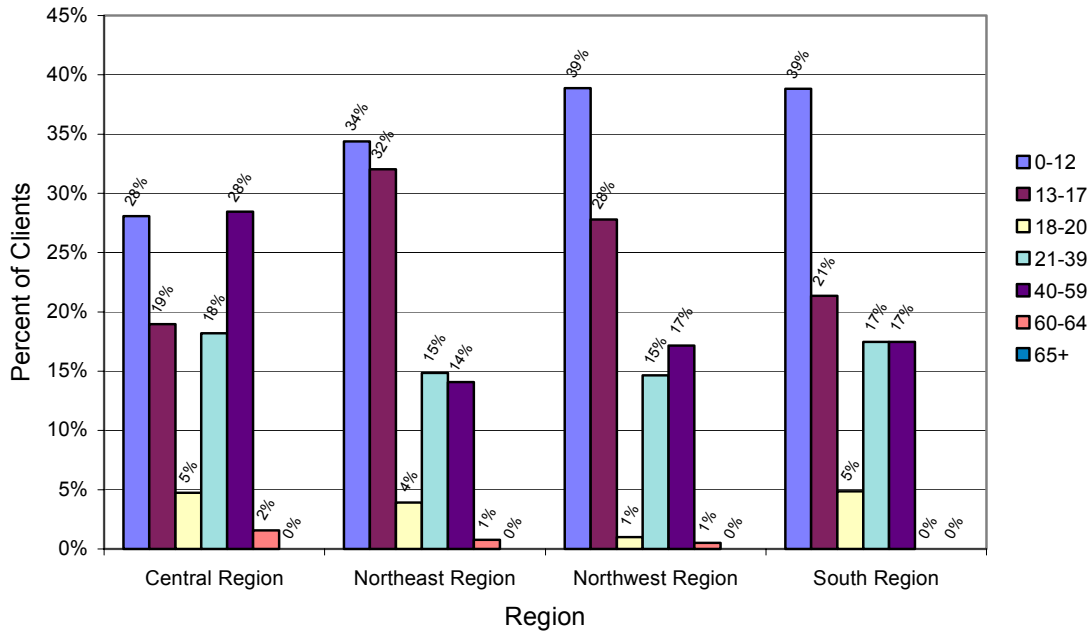
**Figure 53: Primary Language Spoken by Region of Medi-Cal Beneficiaries Receiving Outpatient Mental Health Services**



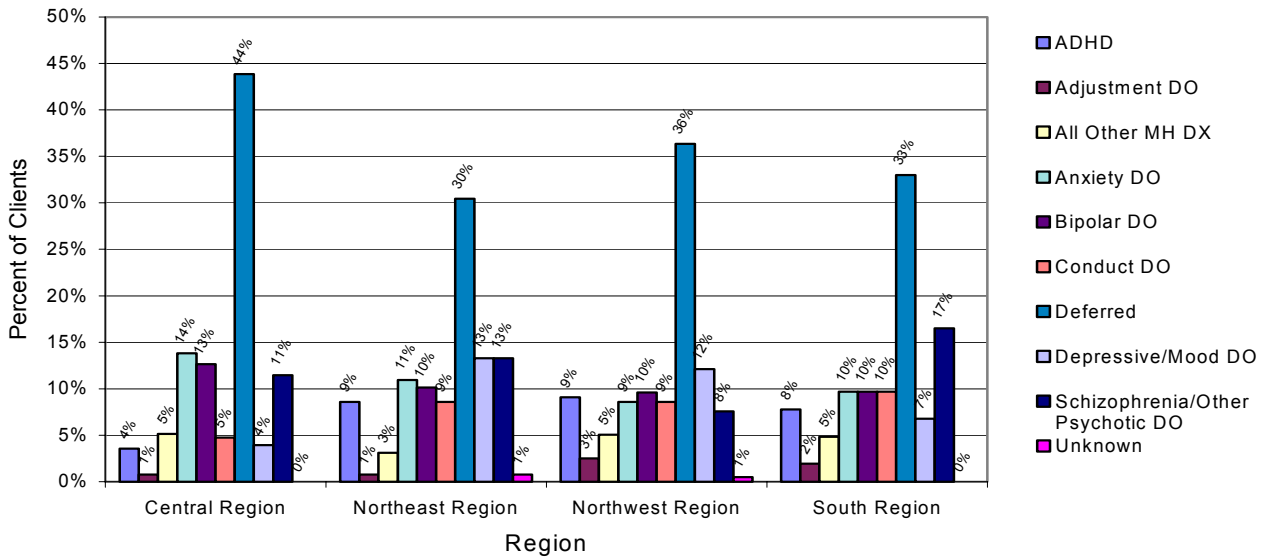
**Figure 54: Ethnicity by Region for Medi-Cal Beneficiaries Receiving Day Treatment/Residential Mental Health Services**



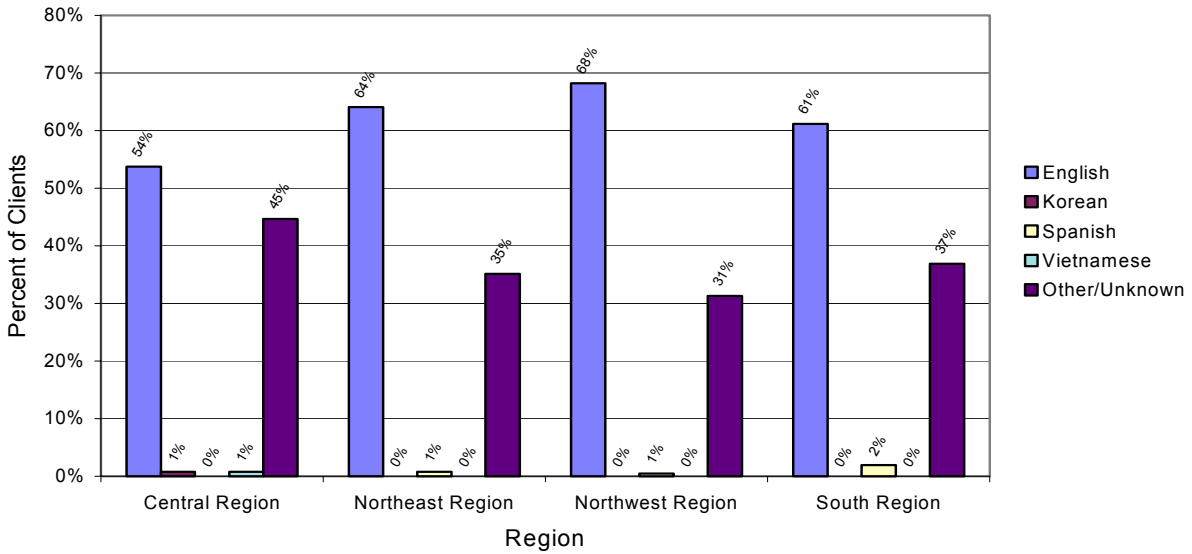
**Figure 55: Age by Region for Medi-Cal Beneficiaries Receiving Day Treatment/Residential Mental Health Services**



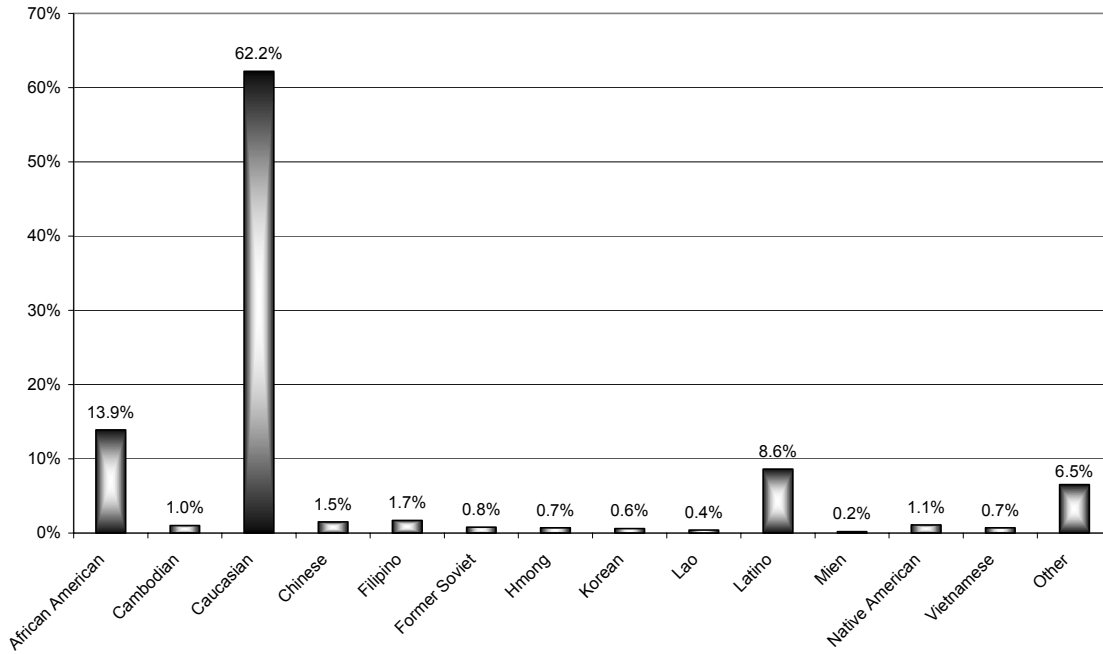
**Figure 56: Diagnosis by Region for Medi-Cal Beneficiaries Receiving Day Treatment/Residential Mental Health Services**



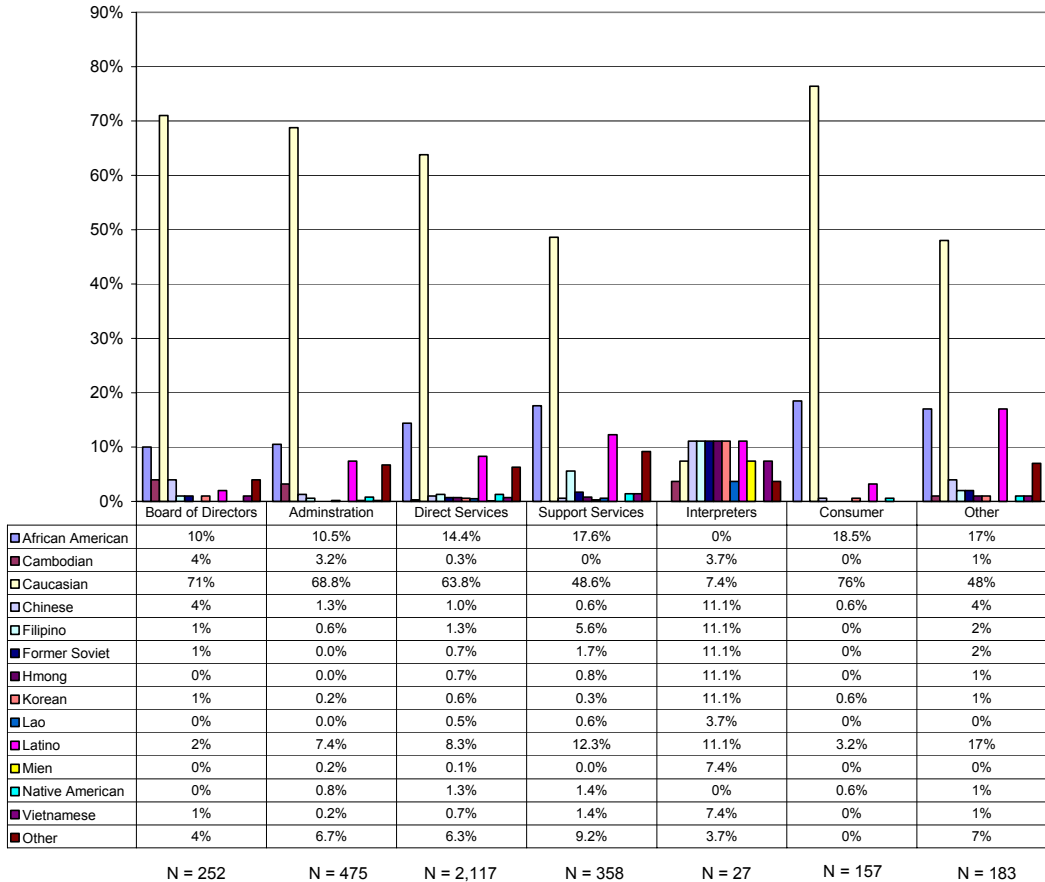
**Figure 57: Language Spoken by Region for Medi-Cal Beneficiaries Receiving Day Treatment/Residential Mental Health Services**



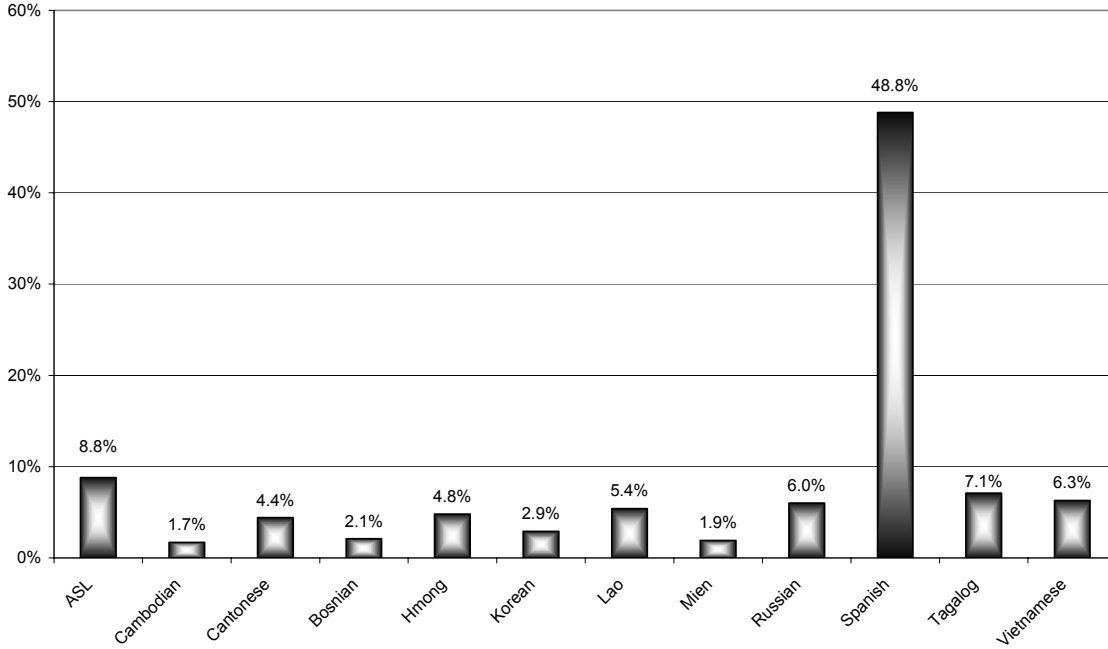
**Figure 58: Ethnicity of all staff**  
N = 3,412



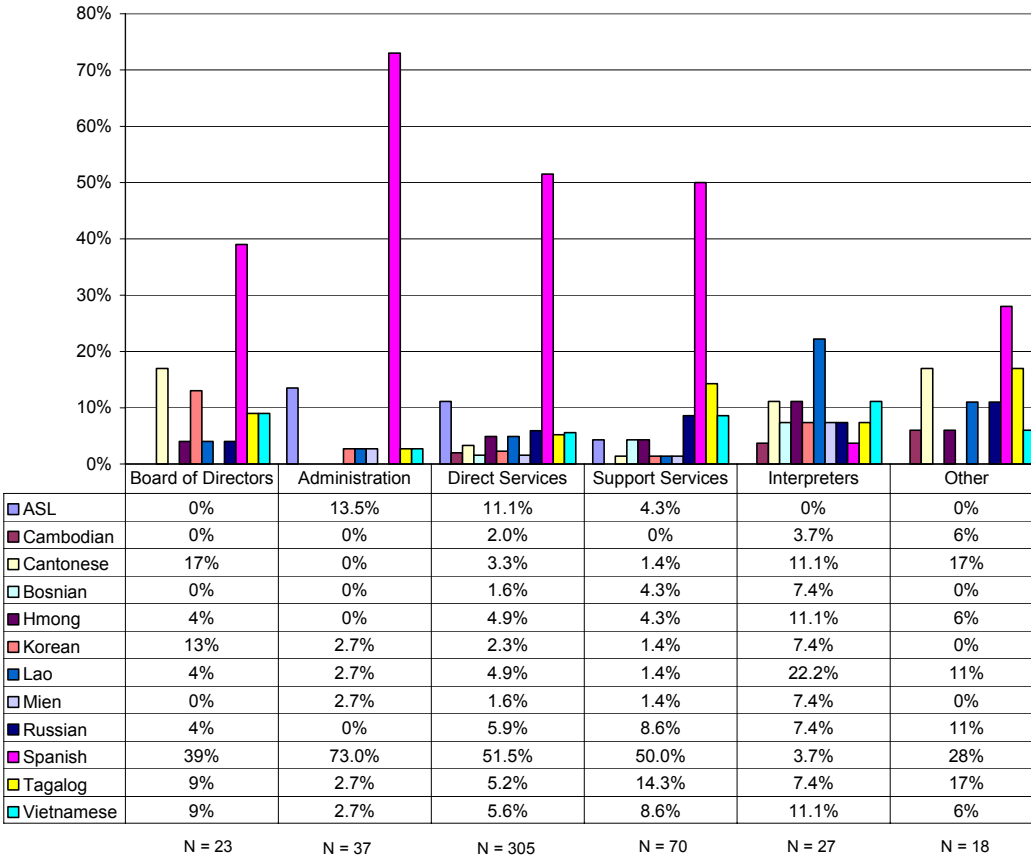
**Figure 59: Ethnicity By Function**



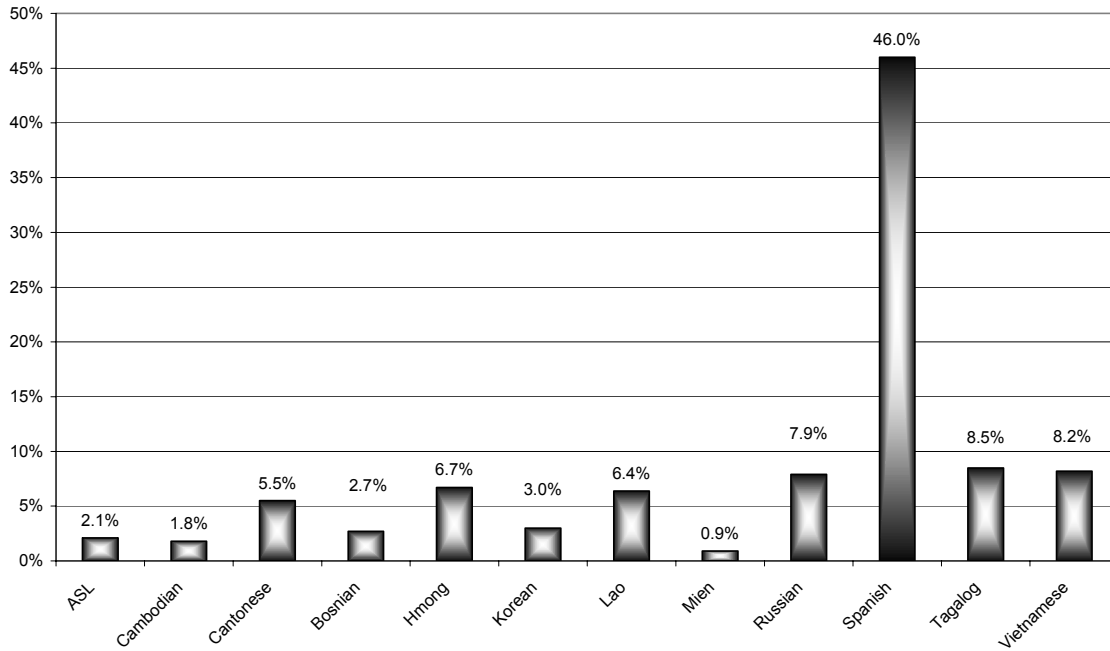
**Figure 60: Bilingual Capabilities All Staff**  
N = 480



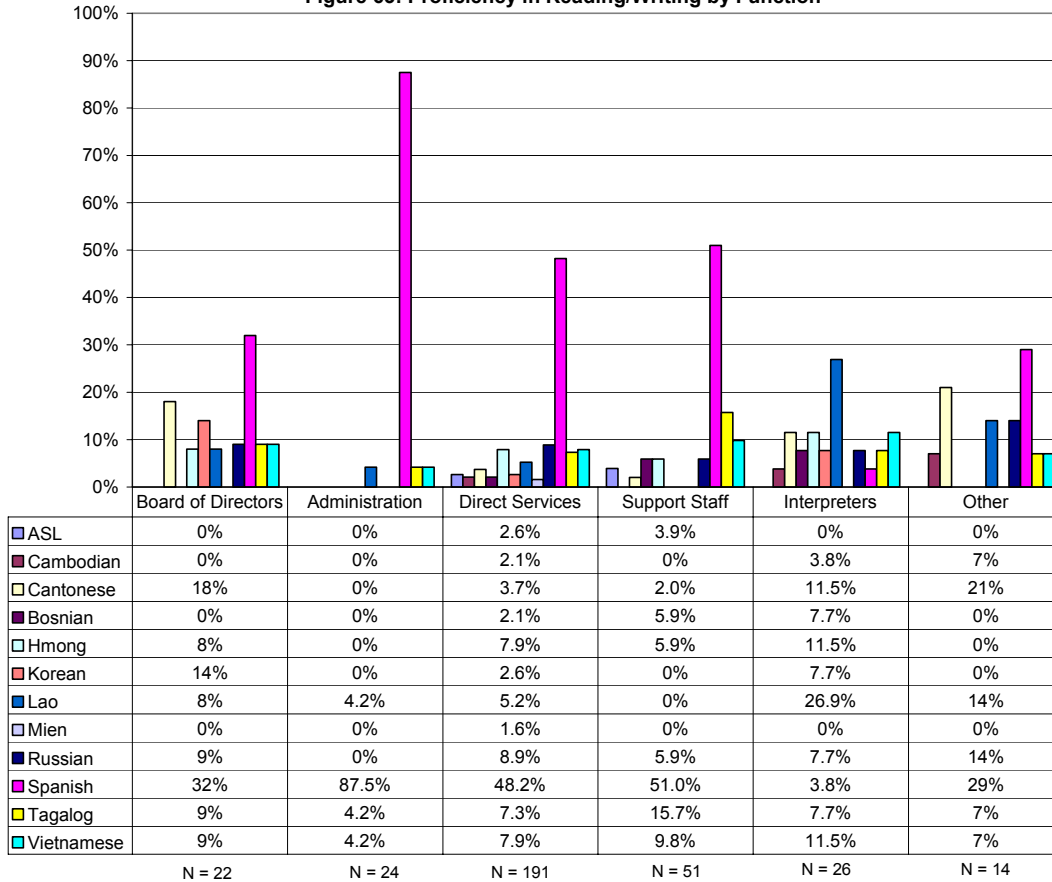
**Figure 61: Bilingual Staff by Function**



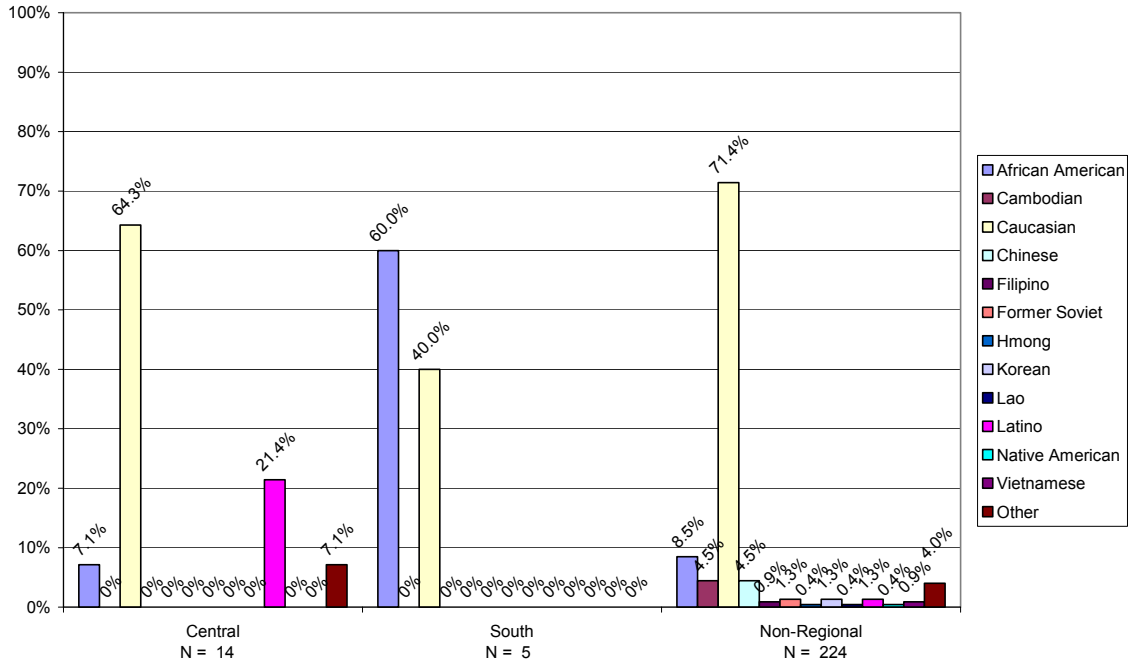
**Figure 62: Proficiency in Reading/Writing All Staff**  
N = 328



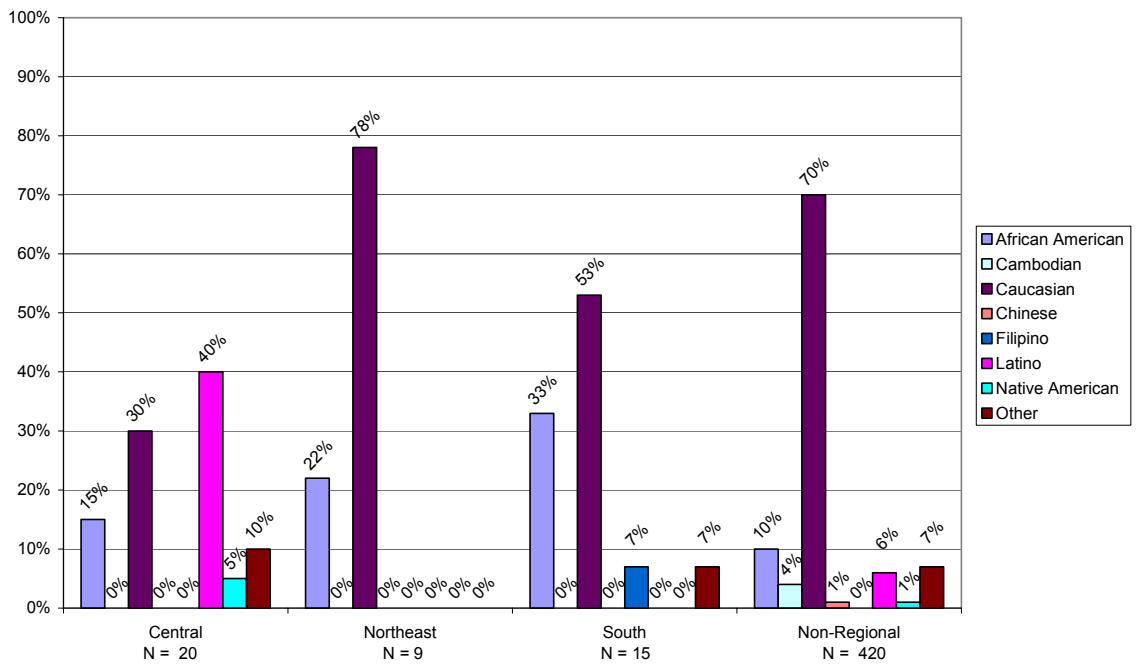
**Figure 63: Proficiency in Reading/Writing by Function**



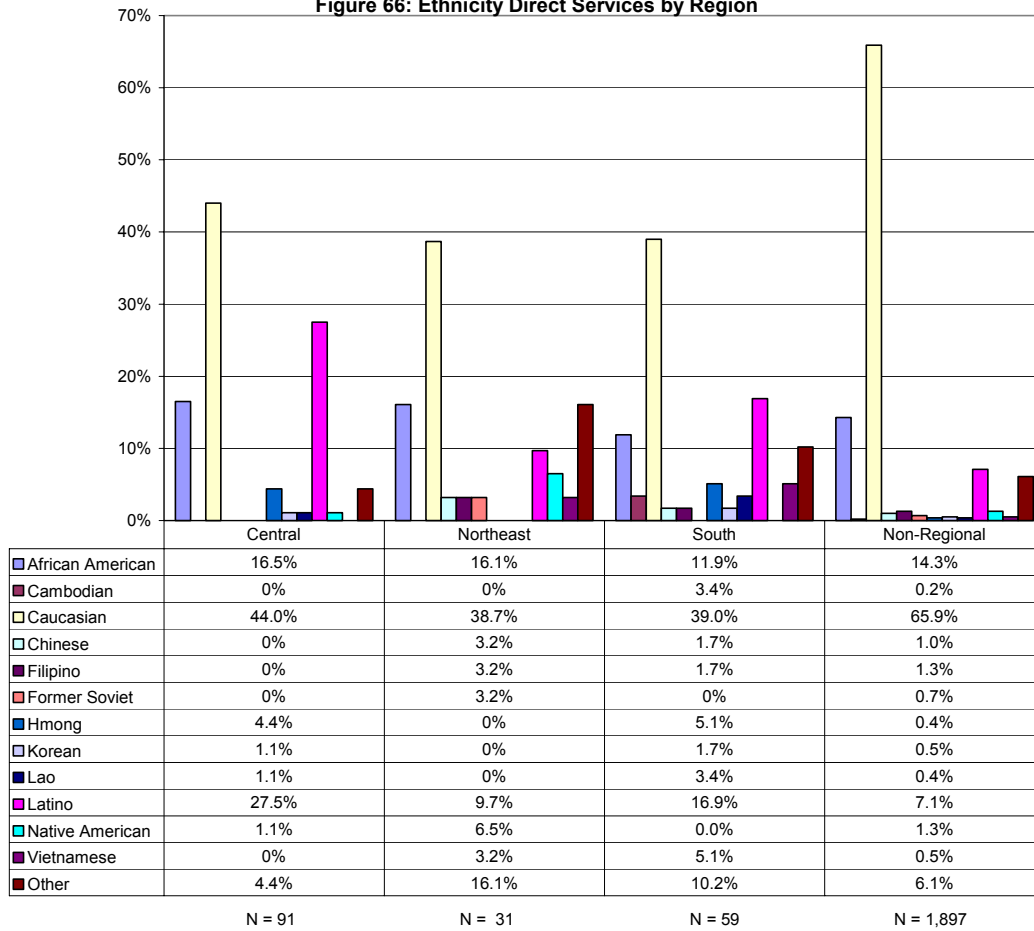
**Figure 64: Ethnicity Board Members by Region**



**Figure 65: Ethnicity Administration by Region**



**Figure 66: Ethnicity Direct Services by Region**



**Figure 67: Ethnicity Support Services by Region**

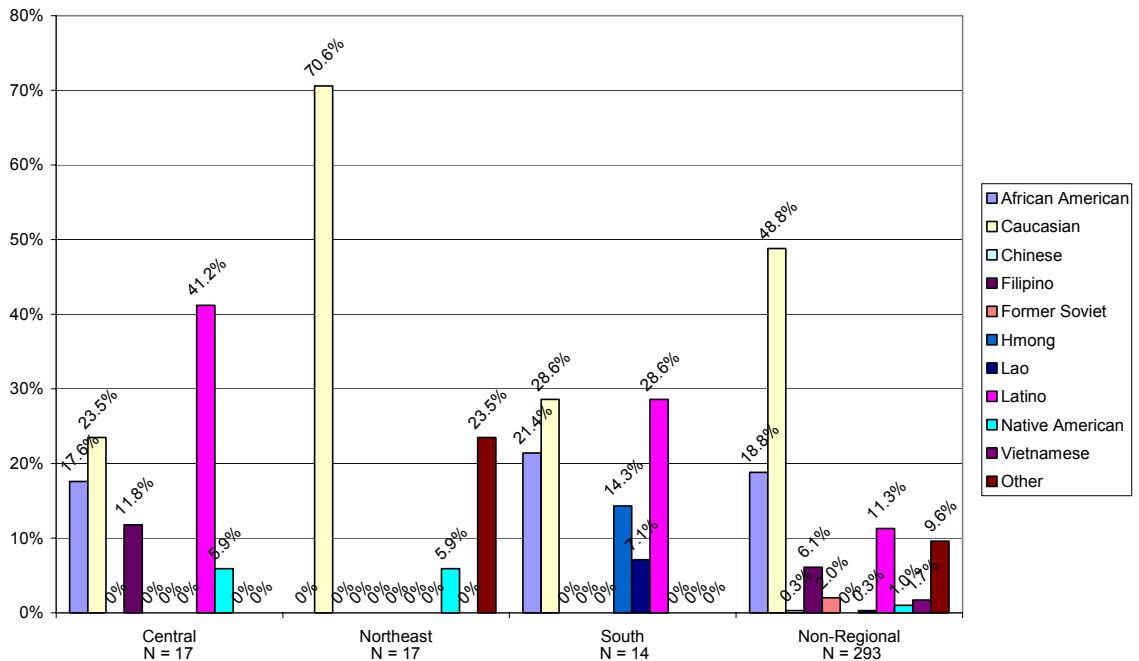




Figure 68: Ethnicity of Interpreters by Region

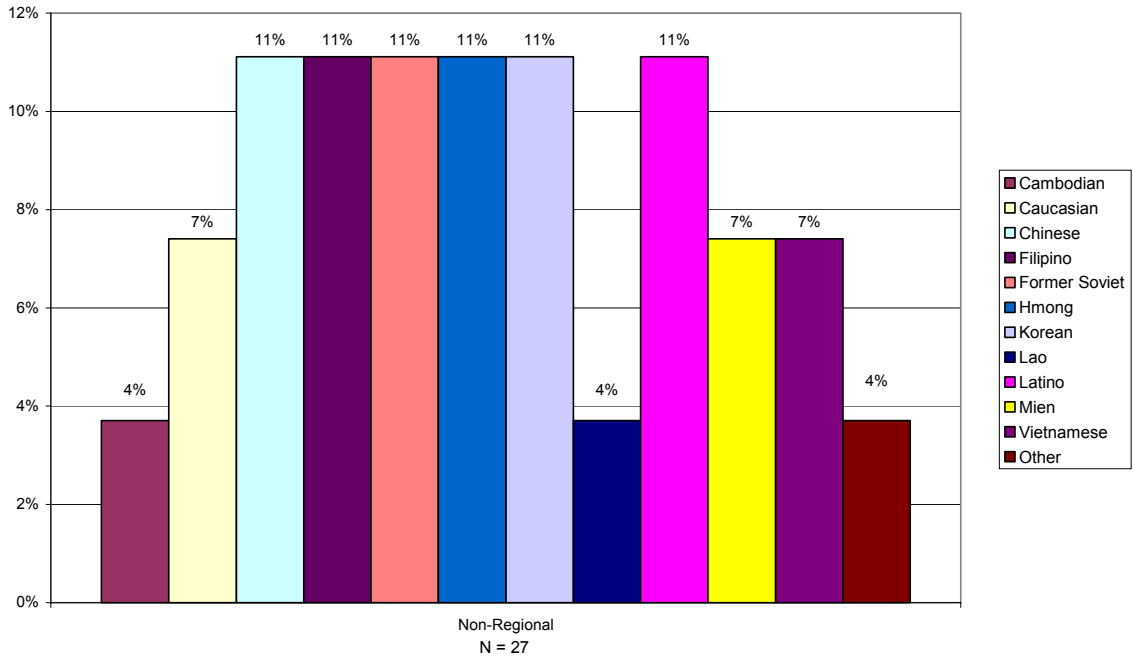
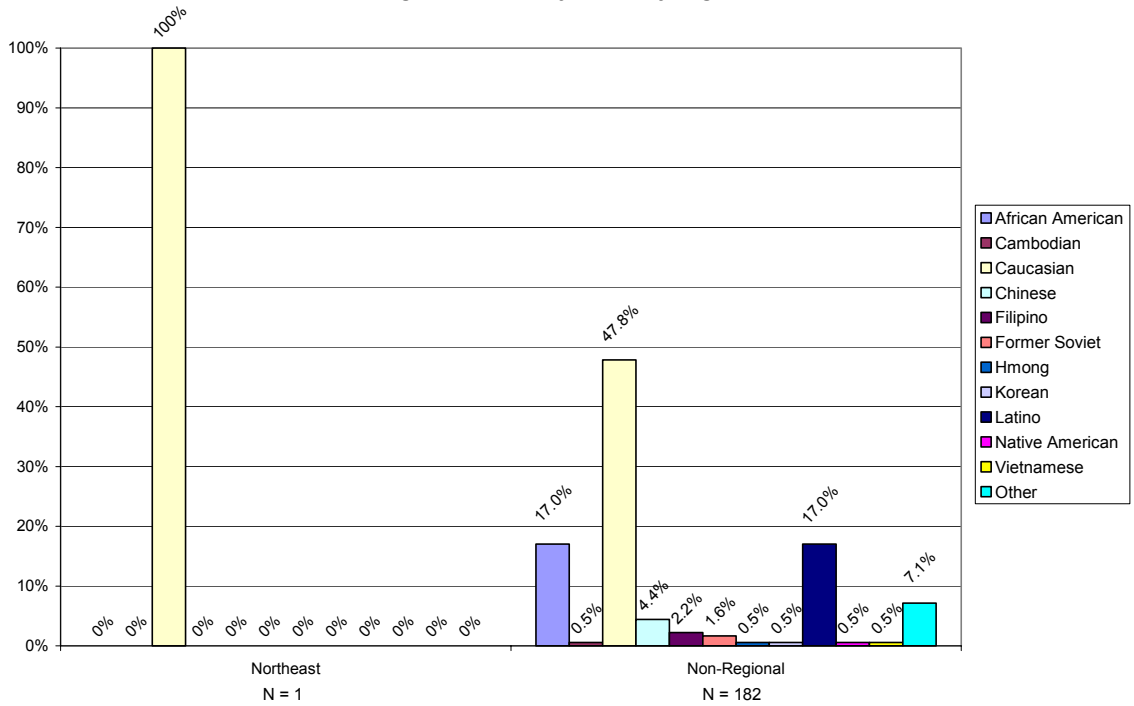
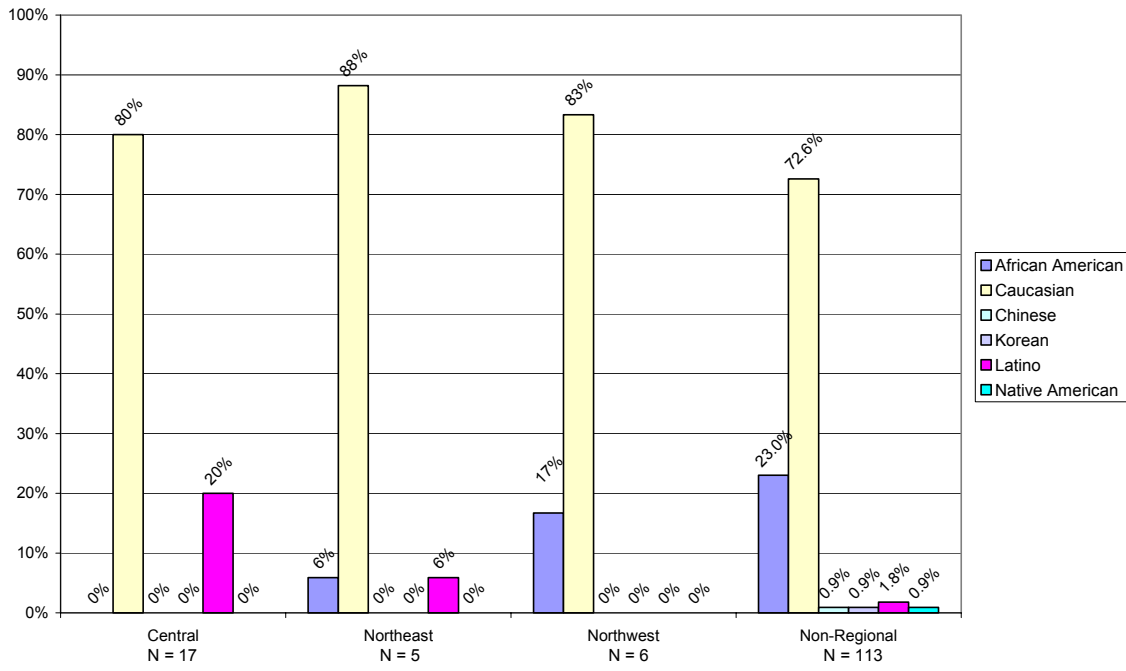


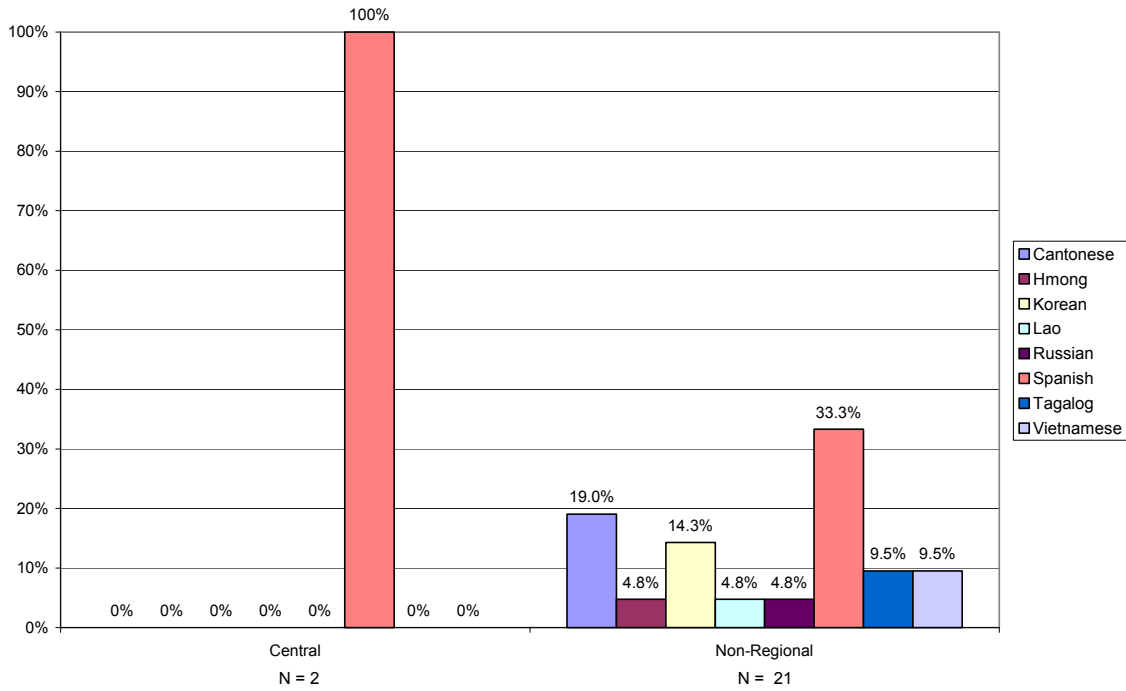
Figure 69: Ethnicity Others by Region



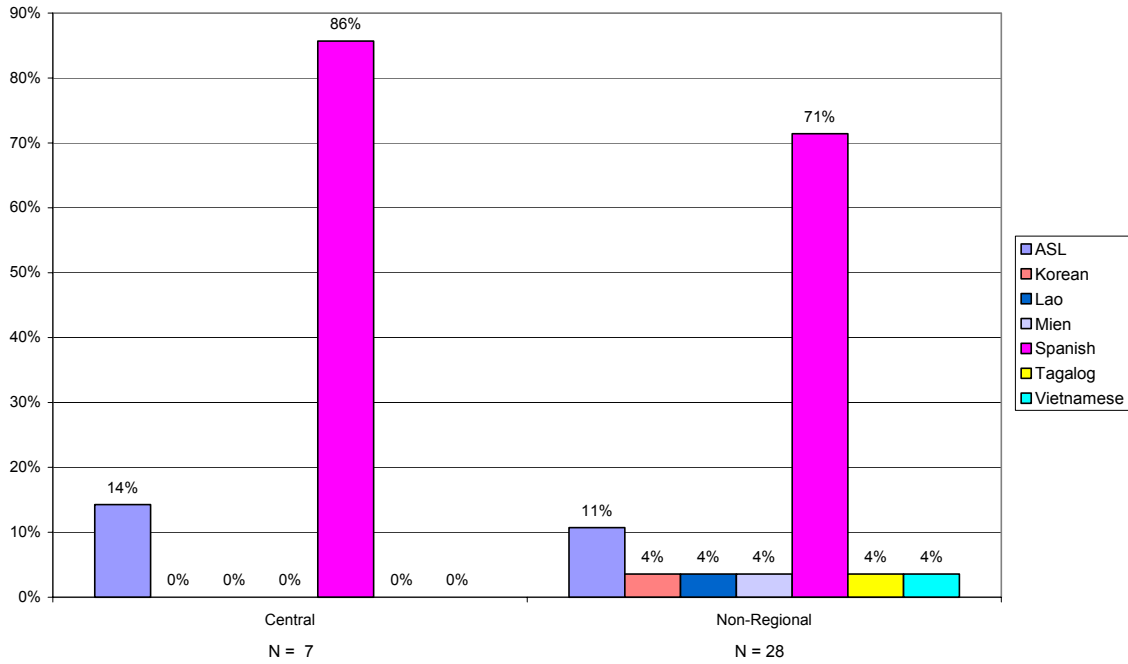
**Figure 70: Ethnicity of Consumers by Region**



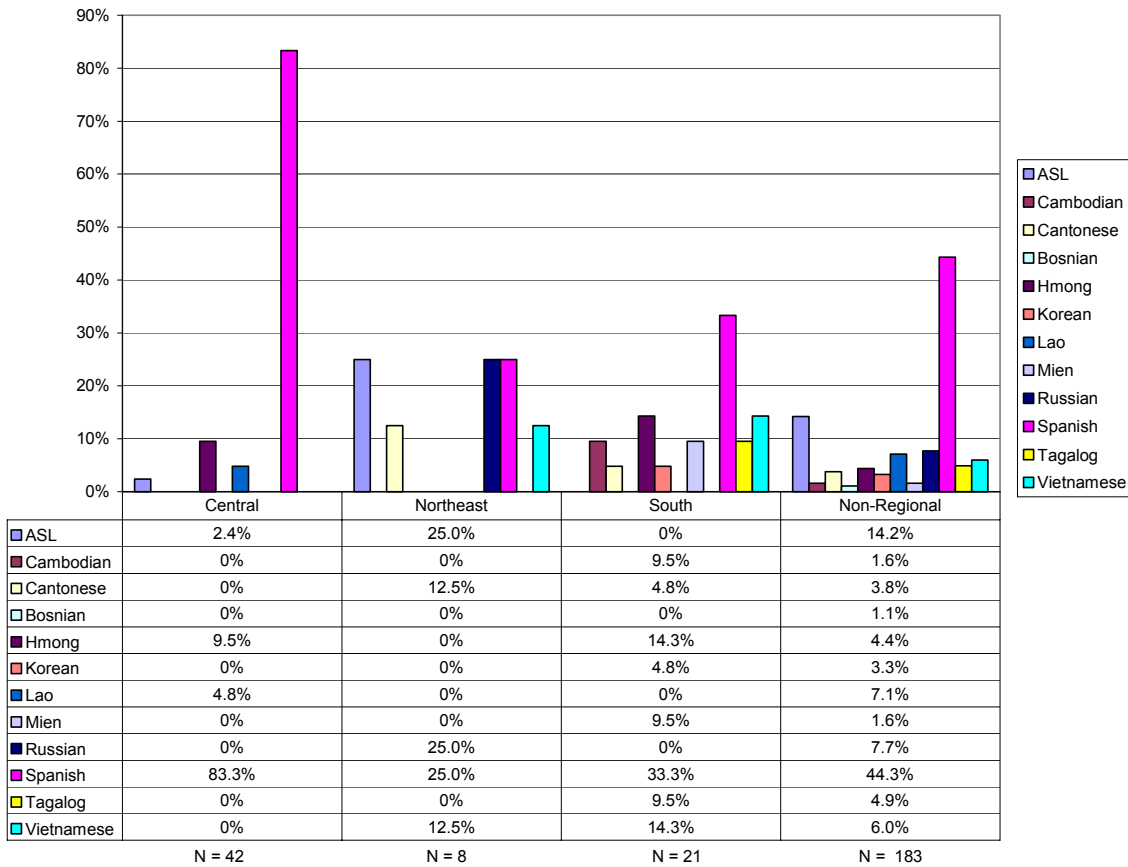
**Figure 71: Bilingual Capability of Board of Directors by Region**



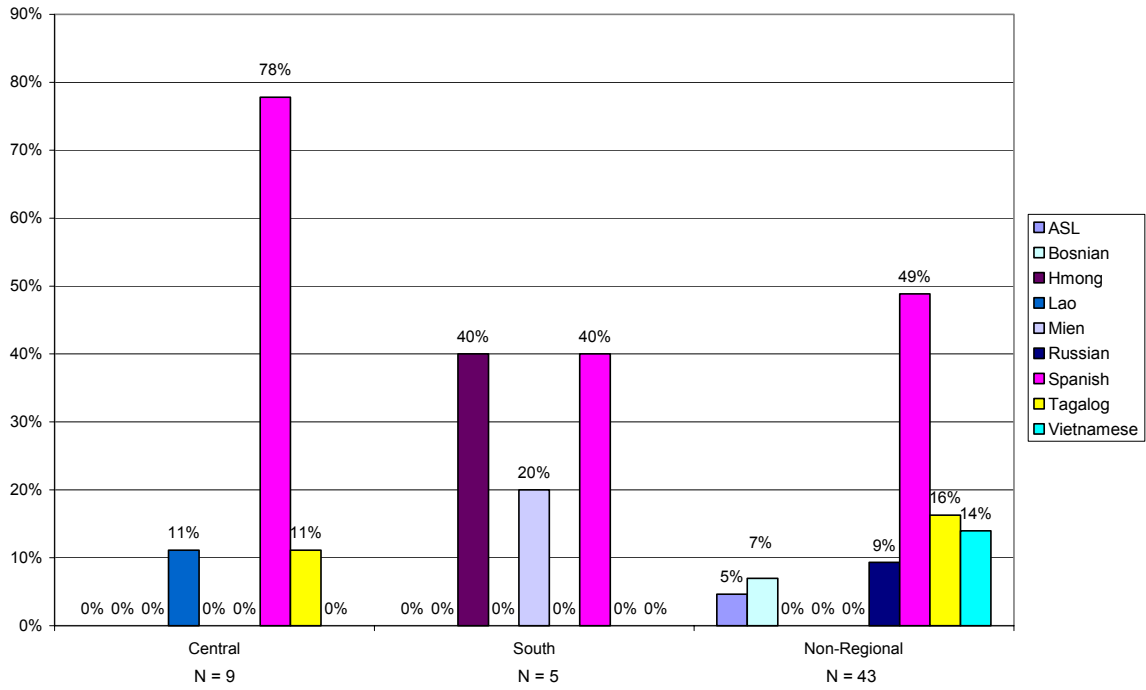
**Figure 72: Bilingual Capability of Administration/Management by Region**



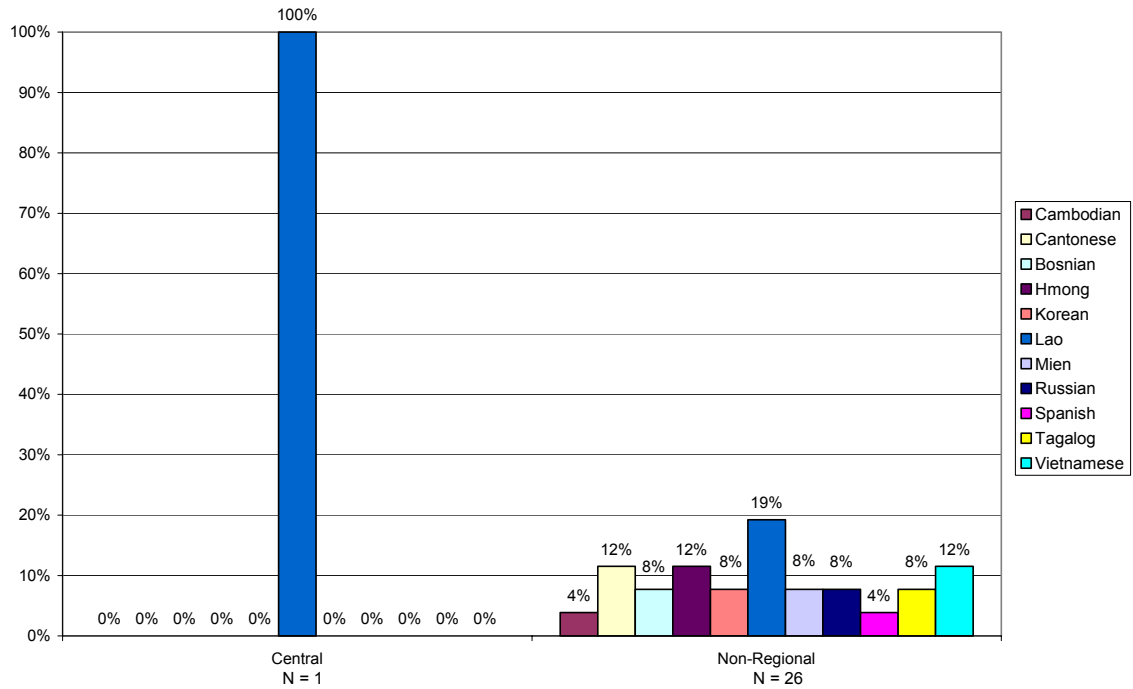
**Figure 73: Bilingual Capability Direct Services by Region**



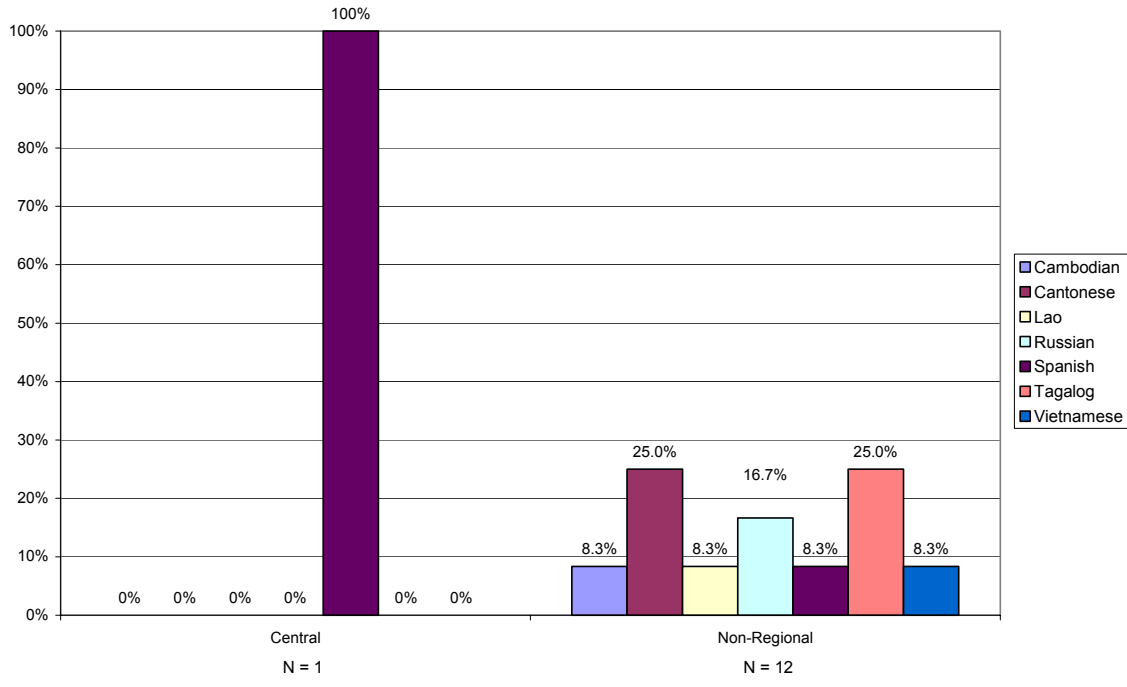
**Figure 74: Bilingual Capability of Support Services by Region**



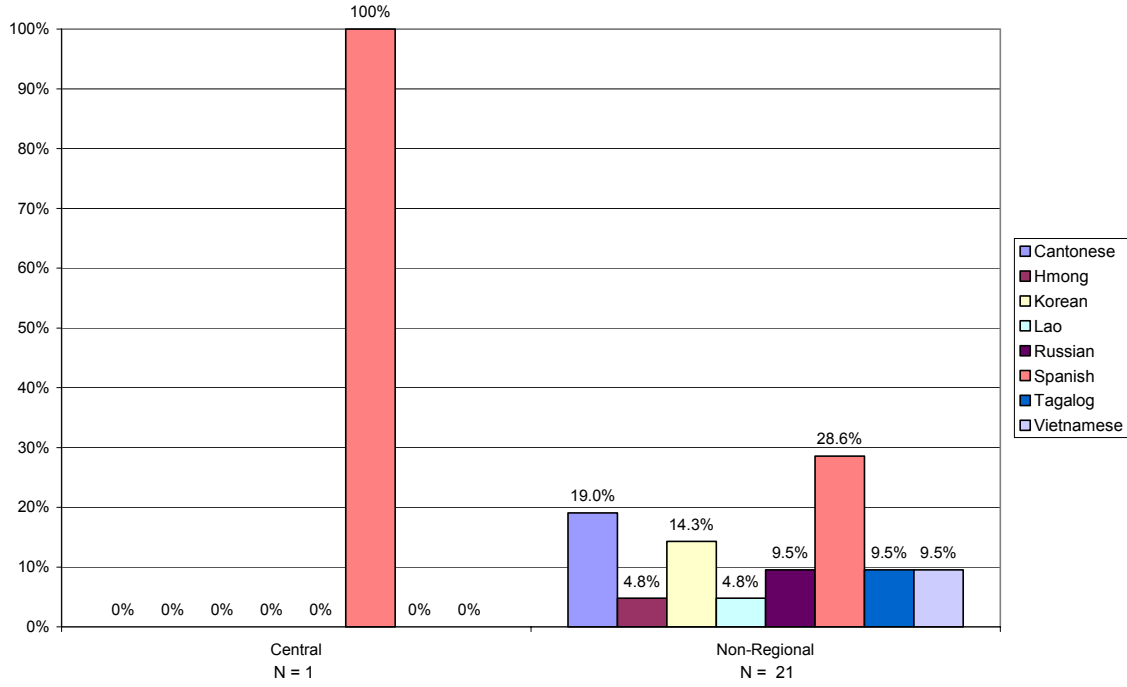
**Figure 75: Bilingual Capability of Interpreters by Region**



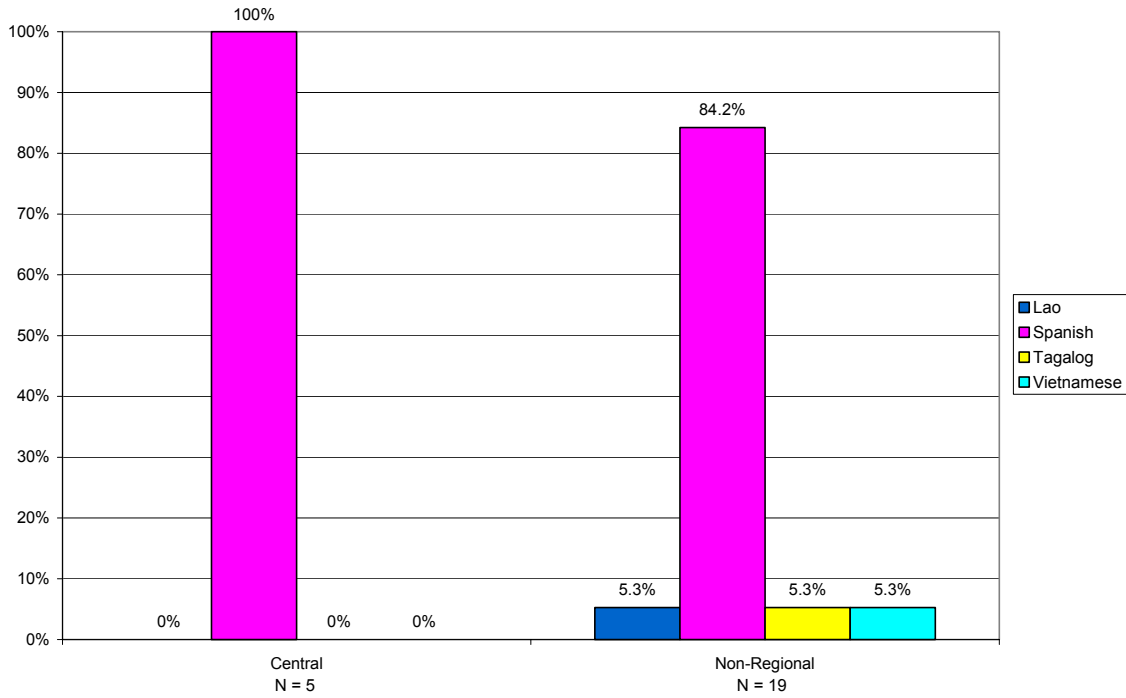
**Figure76: Bilingual Capability Other by Region**



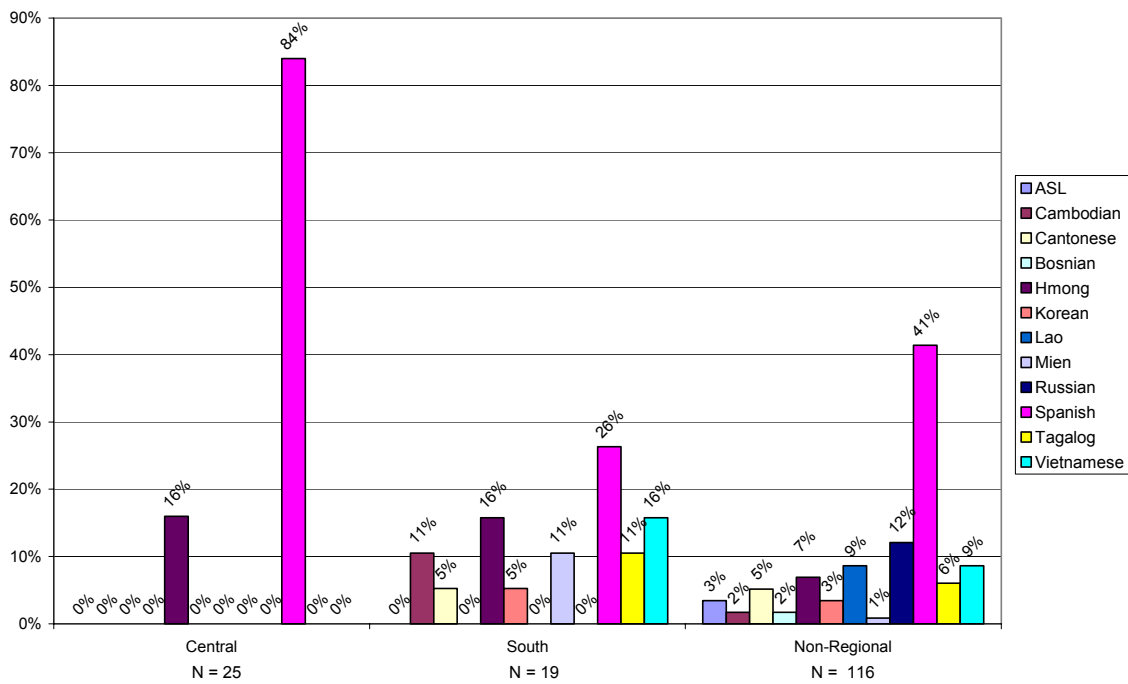
**Figure 77: Languages Board of Directors Reads/Writes by Region**



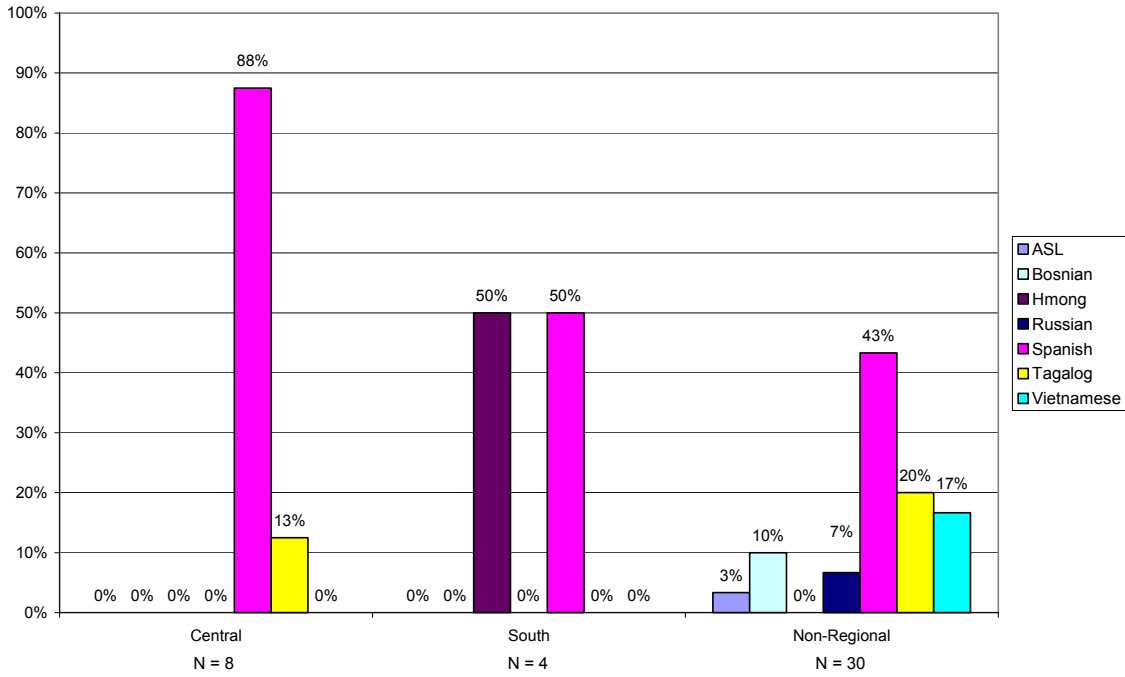
**Figure 78: Languages Administration /Mangement Staff Reads/Writes by Region**



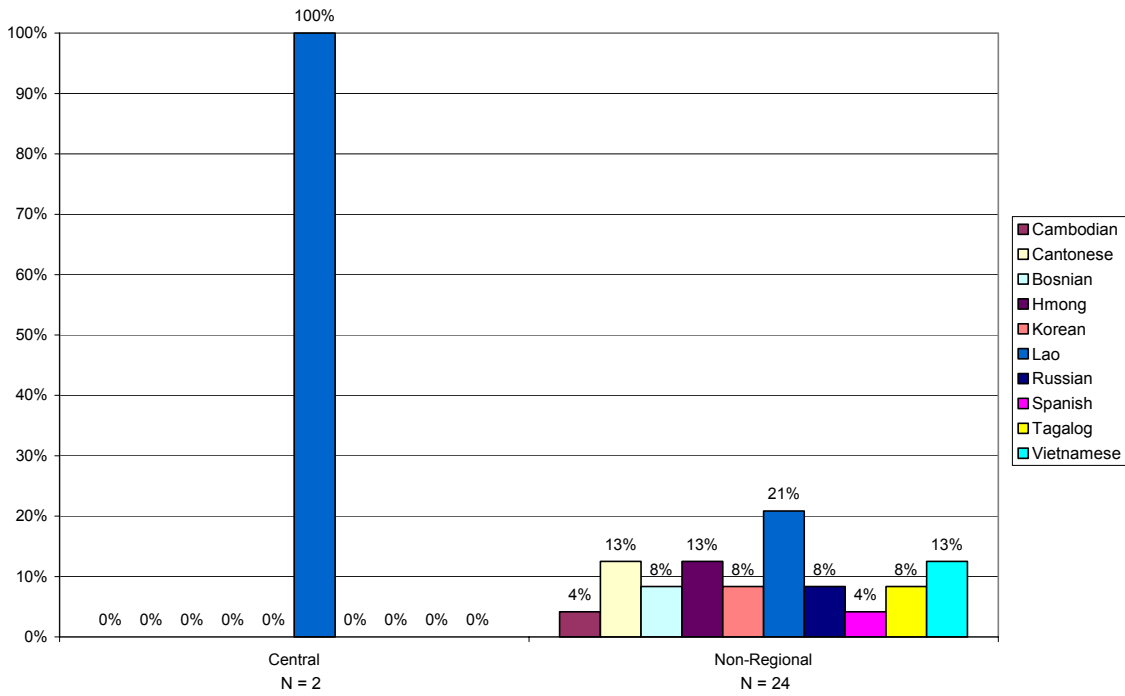
**Figure 79: Languages Direct Services Staff Reads/Writes by Region**



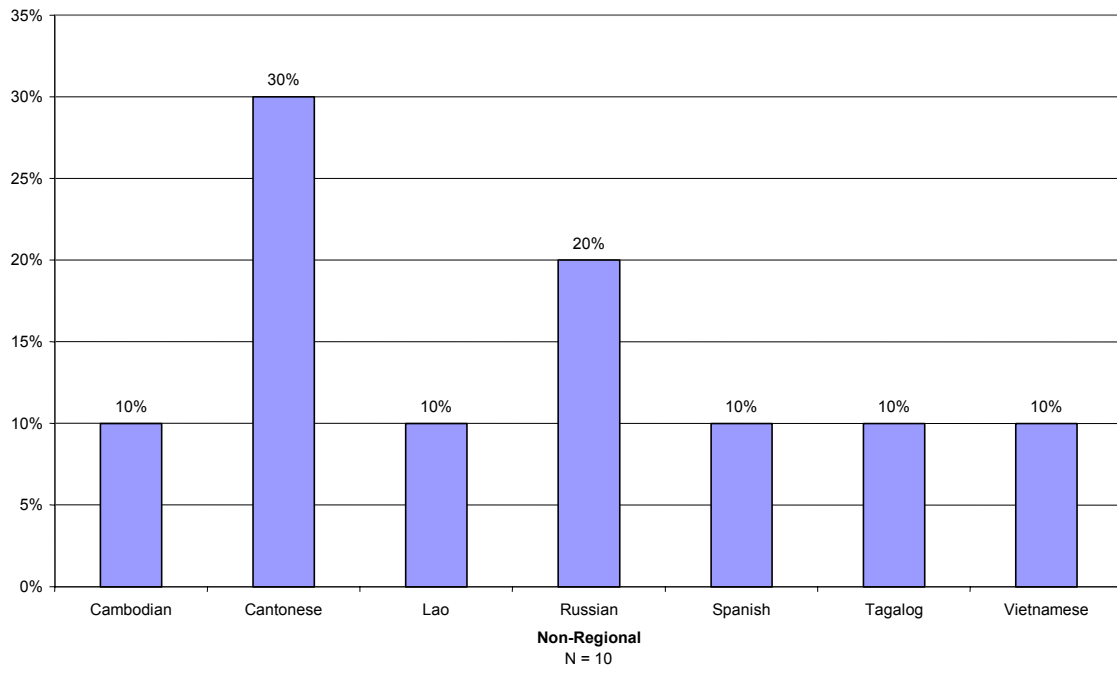
**Figure 80: Languages Support Services Staff Reads/Writes by Region**



**Figure 81: Languages Interpreters Read/Write by Region**

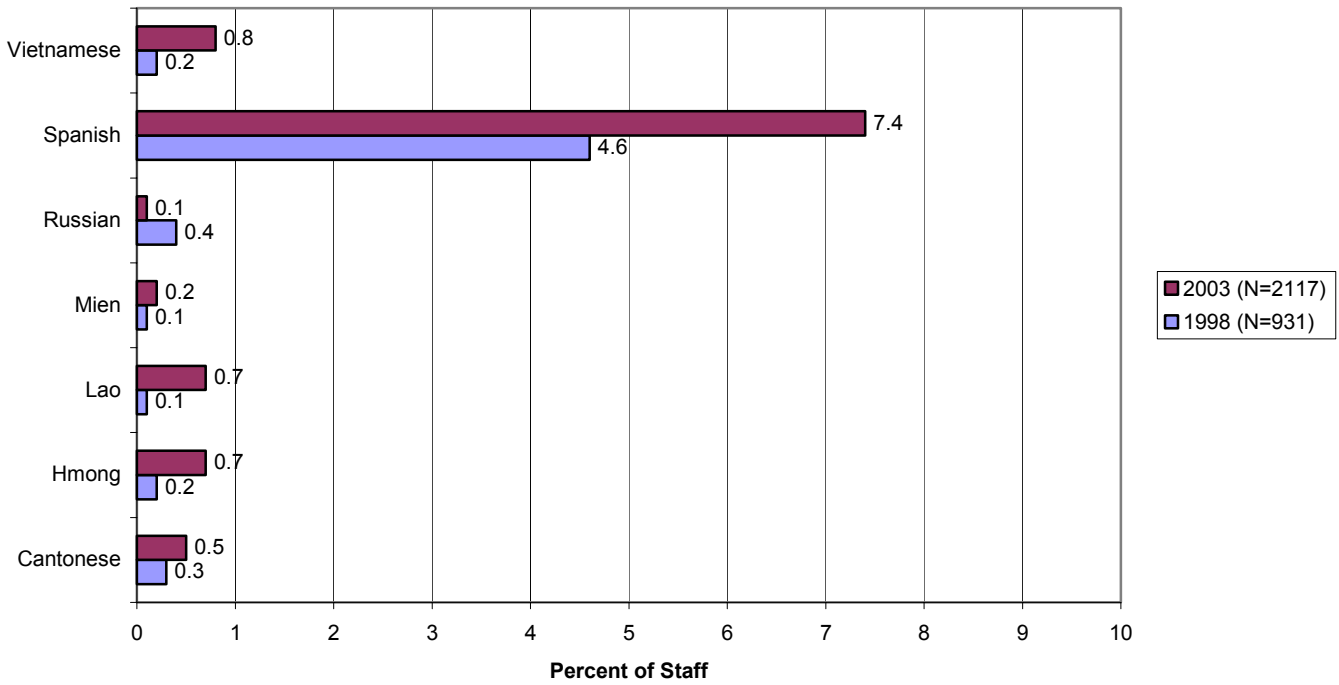


**Figure 82: Languages Other Read/Write by Region**





**Figure 83: Percent of Direct Service Staff With Oral Language Ability in Threshold Languages**



**Figure 84: Primary Language Comparison: Human Resources versus Medi-Cal Beneficiaries**

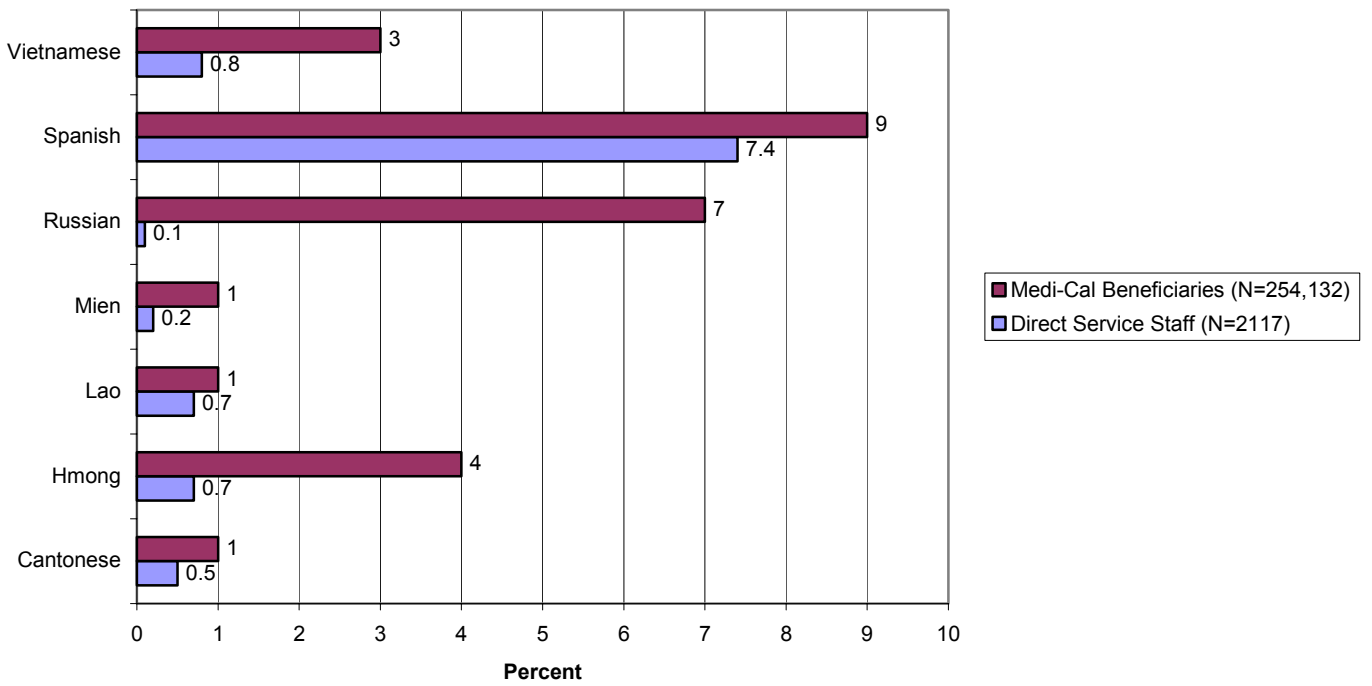
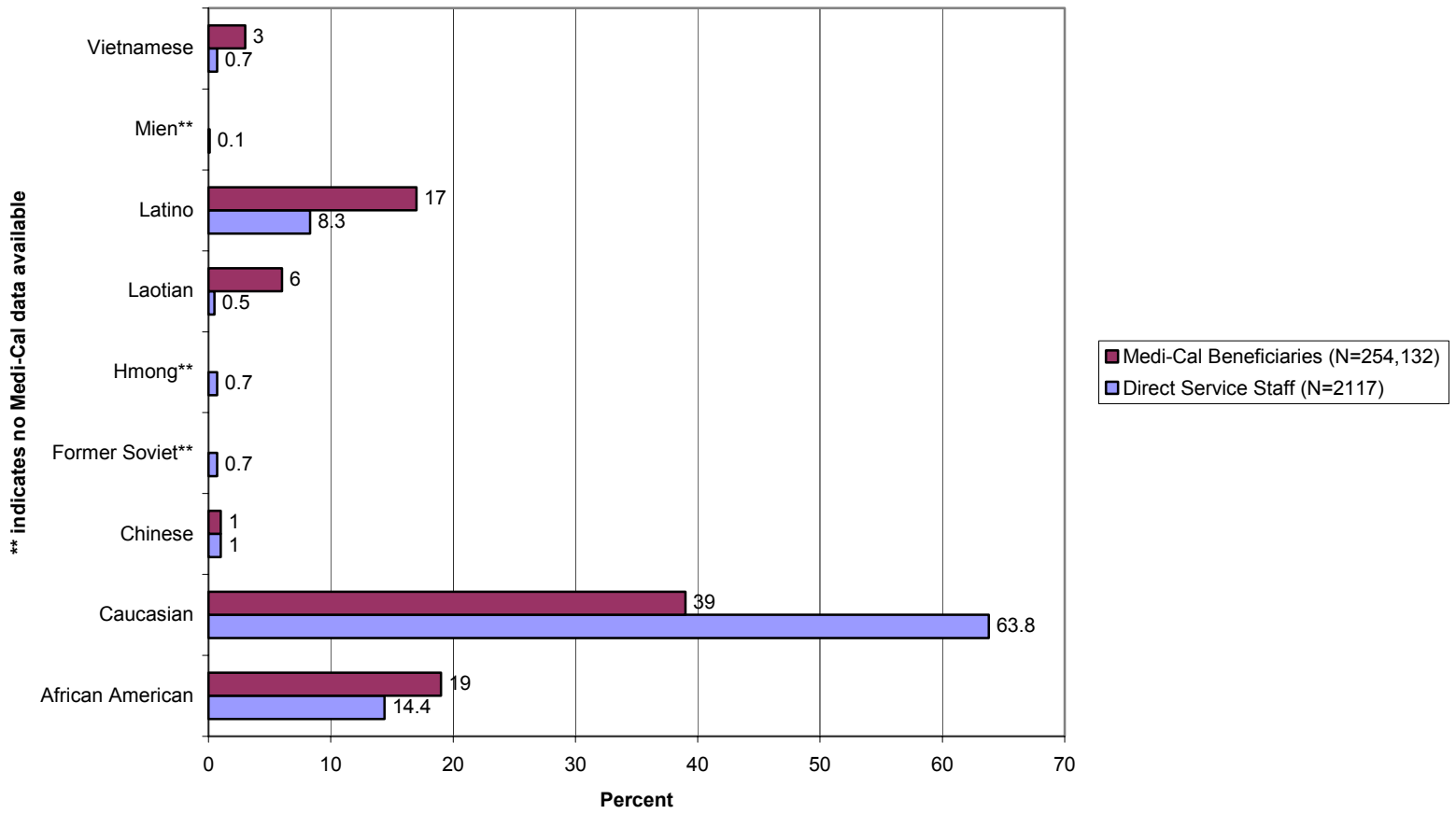
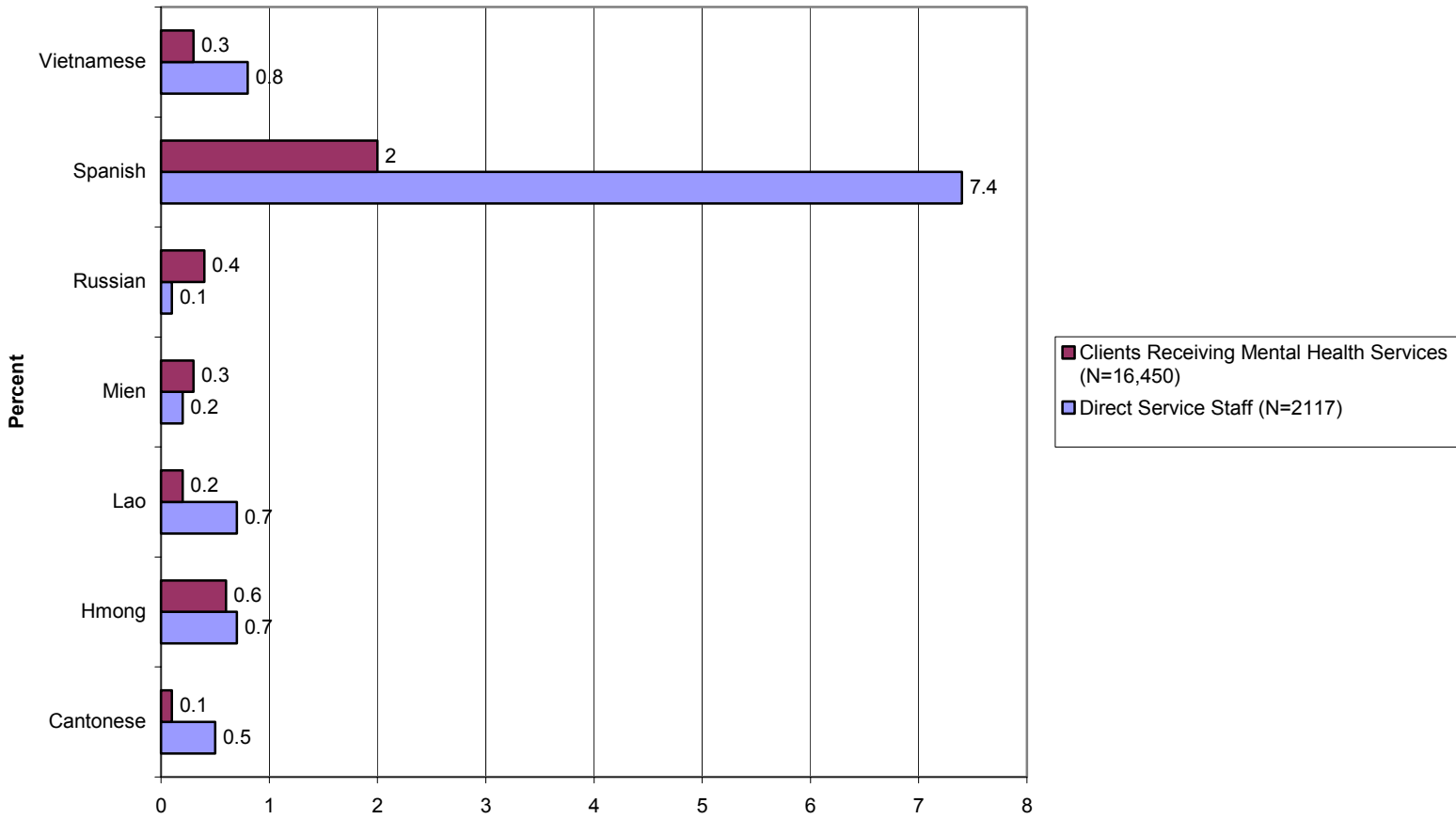


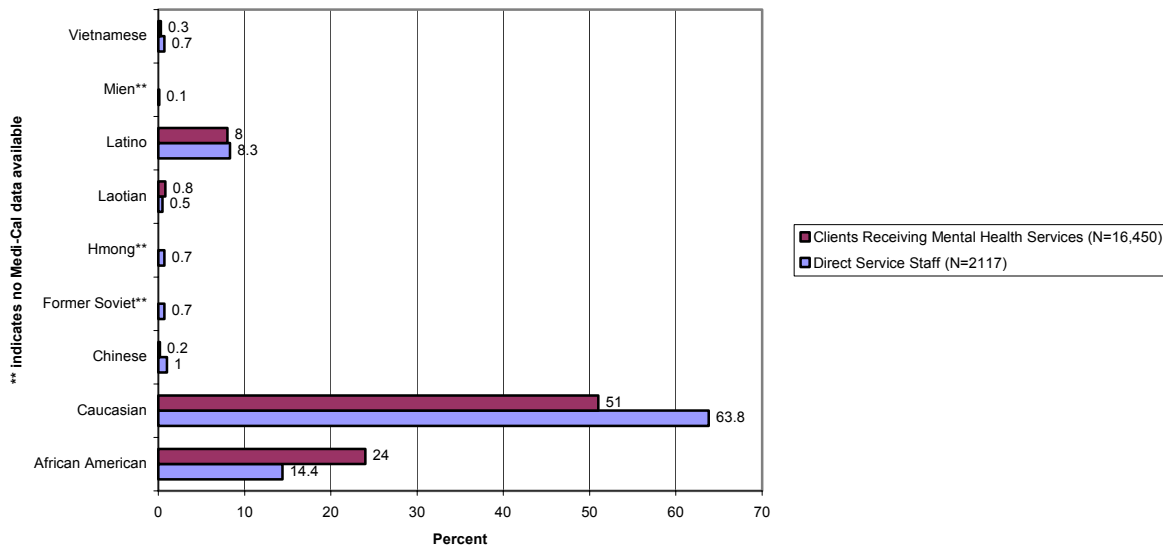
Figure 85: Ethnicity Comparison: Human Resources vs Medi-Cal Beneficiaries



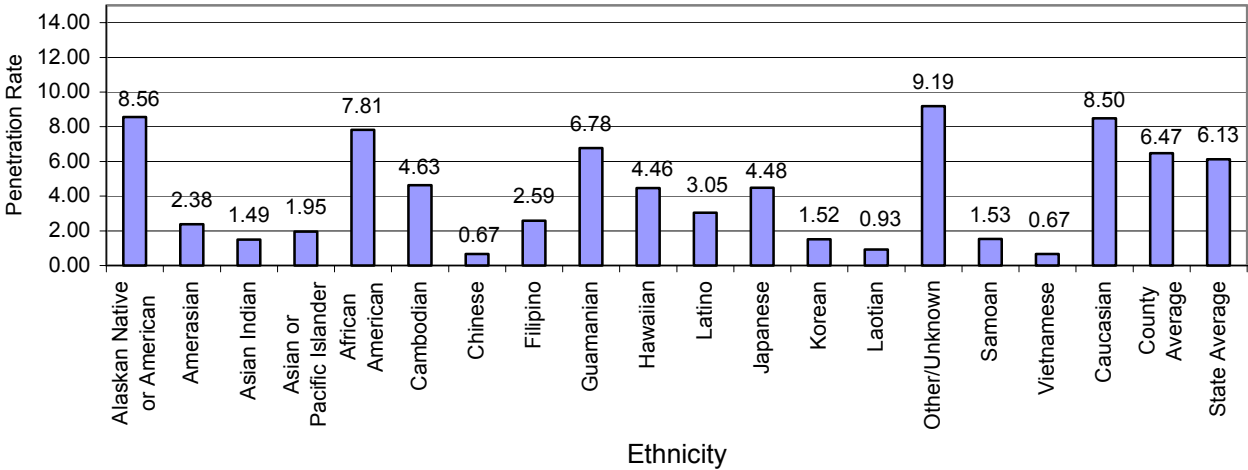
**Figure 86: Language Comparison: Human Resources vs Clients**



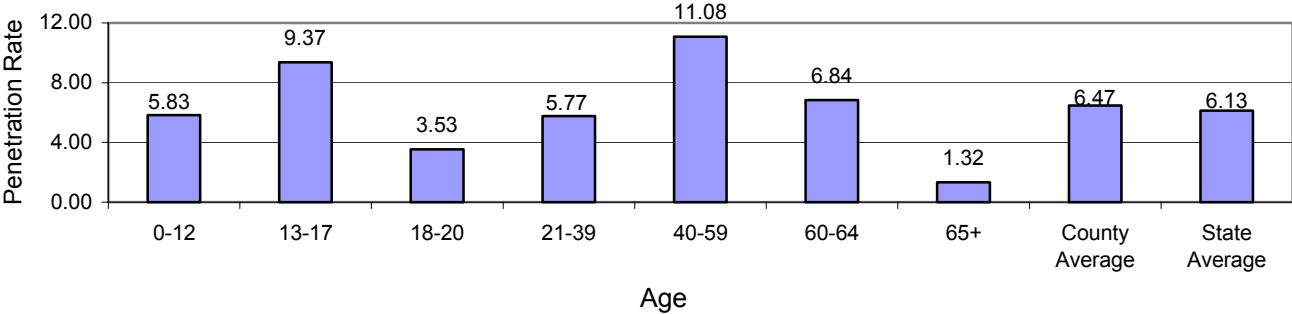
**Figure 87: Ethnicity Comparison: Human Resources vs Clients**



**Figure 88: Penetration by Ethnicity**



**Figure 89: Penetration by Age**



**Figure 90: Penetration by Primary Language**

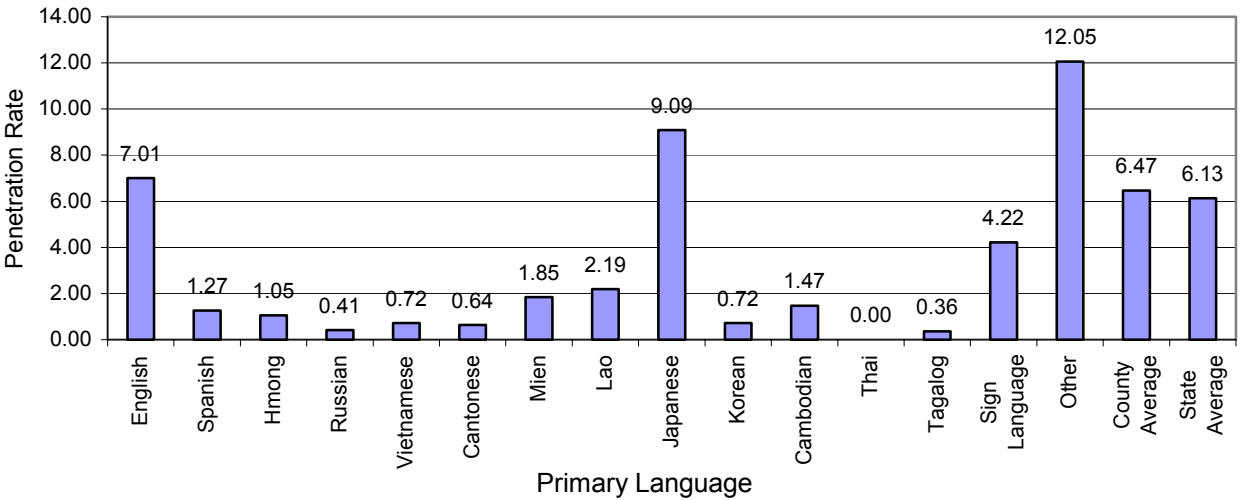


Figure 91: Adult Retention Rate by Ethnicity

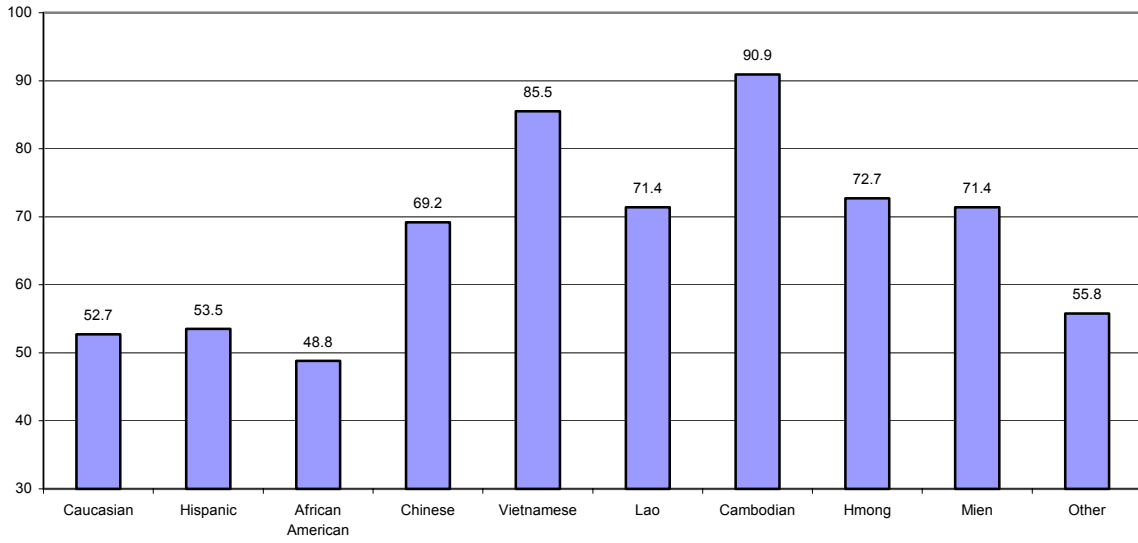


Figure 92: Adult Retention Rate by Primary Language

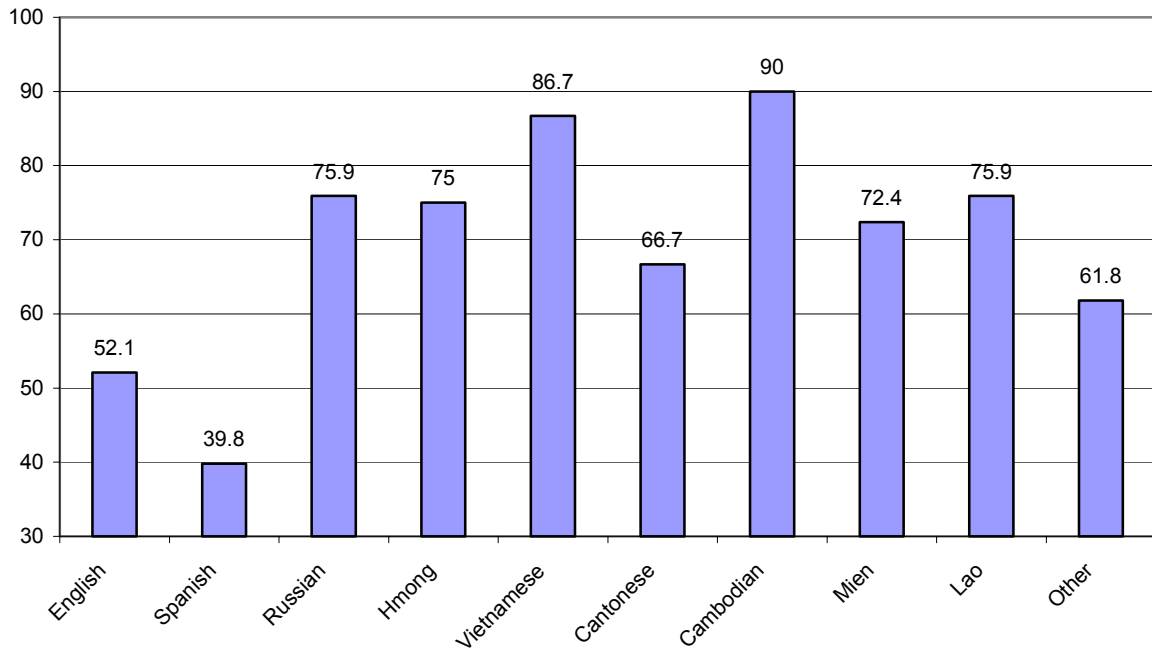


Figure 93: Adult Retention Rate by Gender

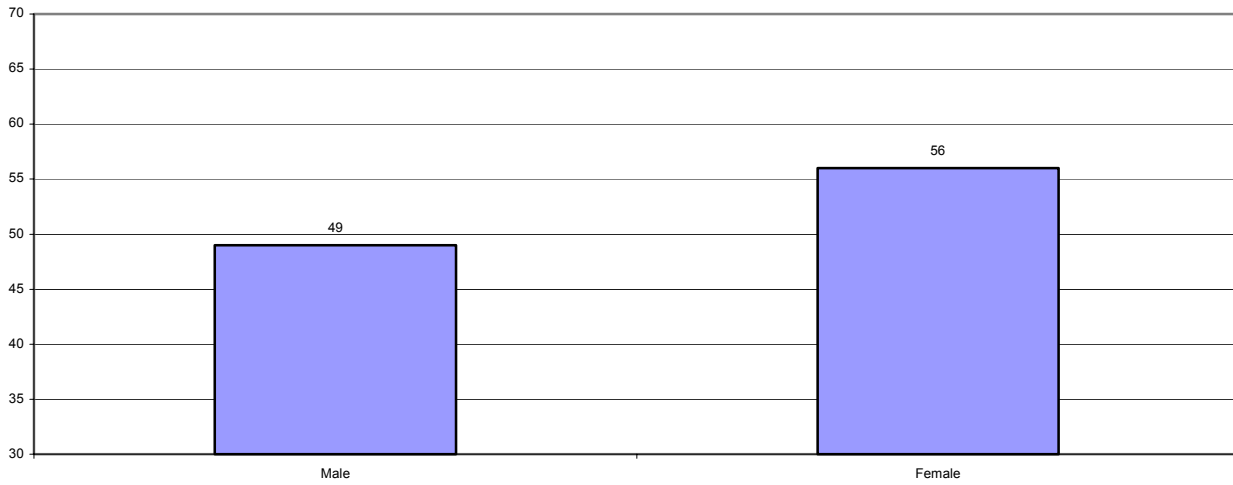


Figure 94: Adult Retention by Diagnosis

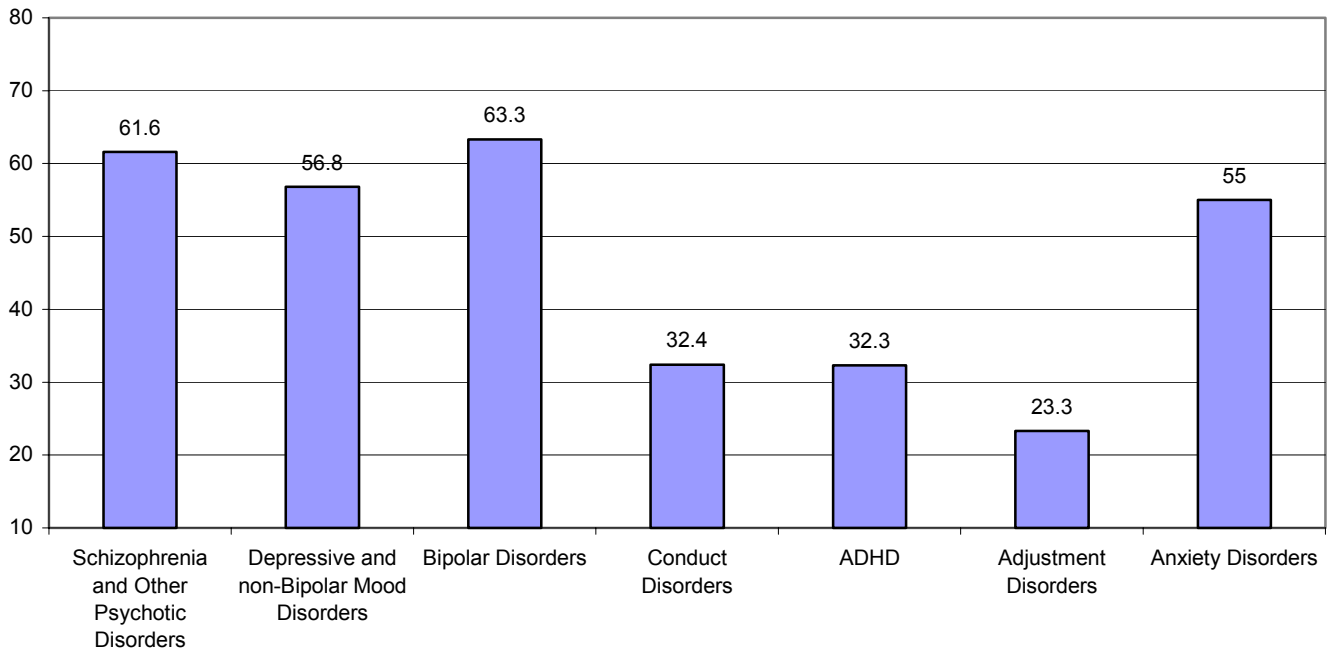


Figure 95: Child Retention Rate by Ethnicity

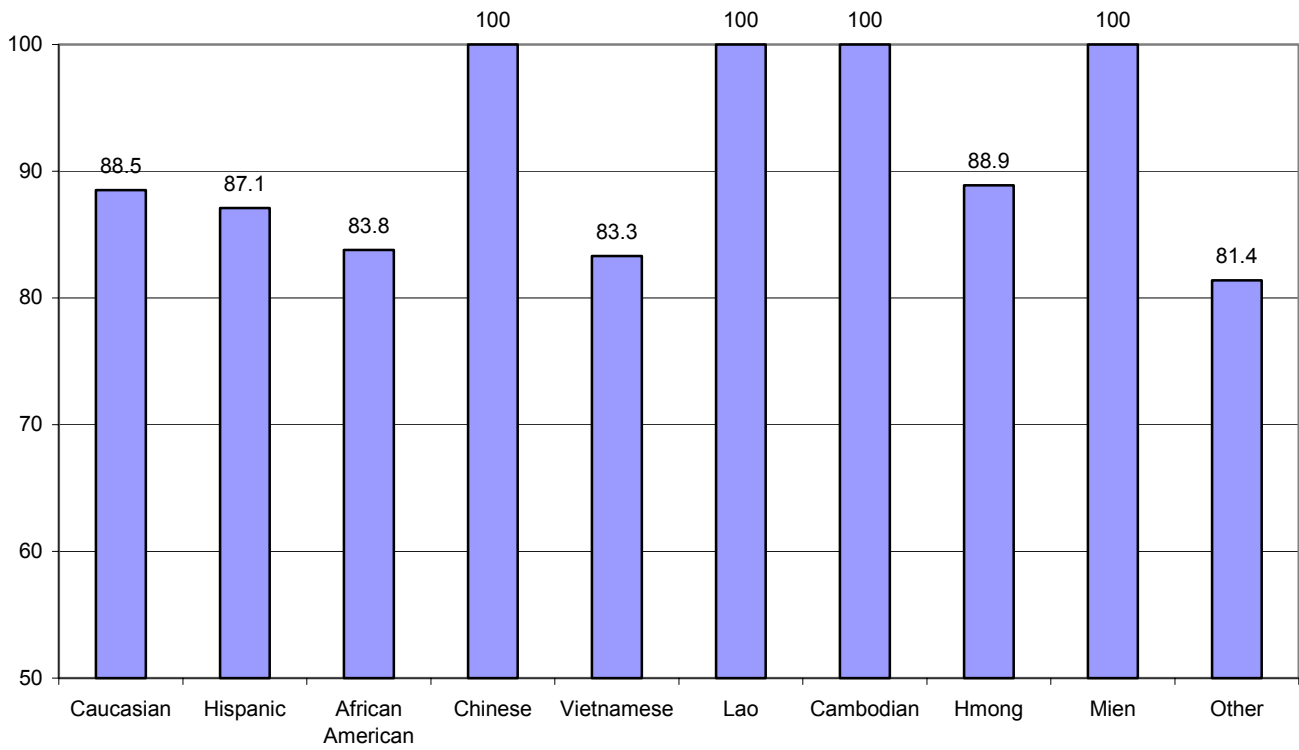
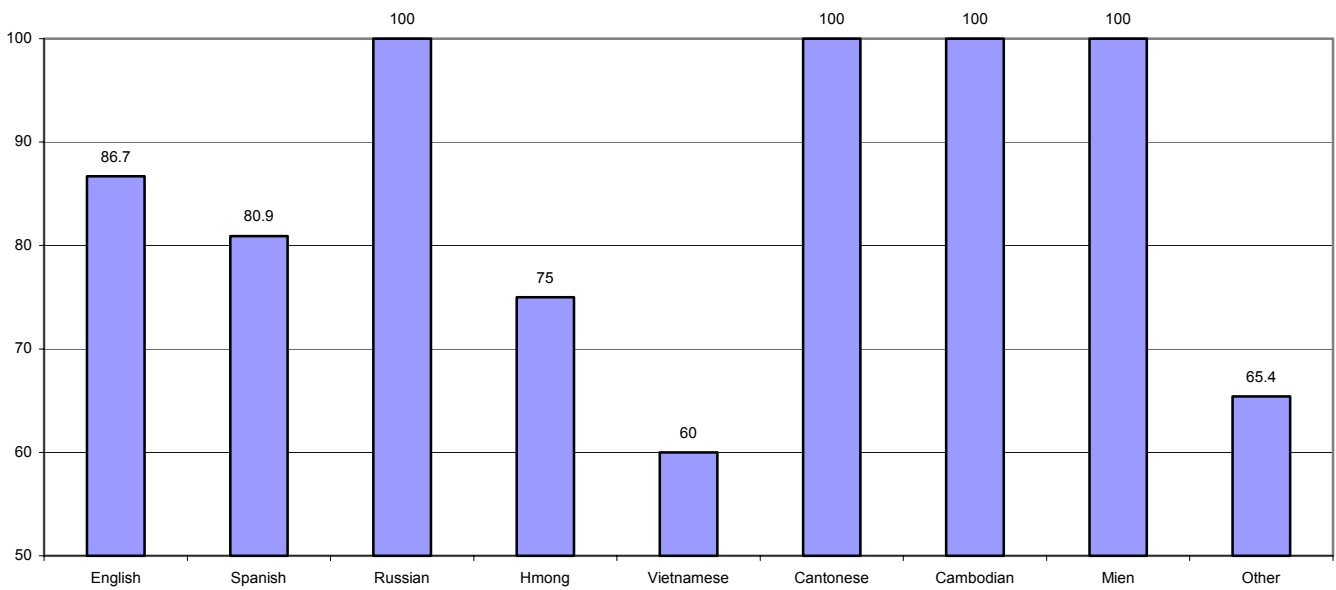
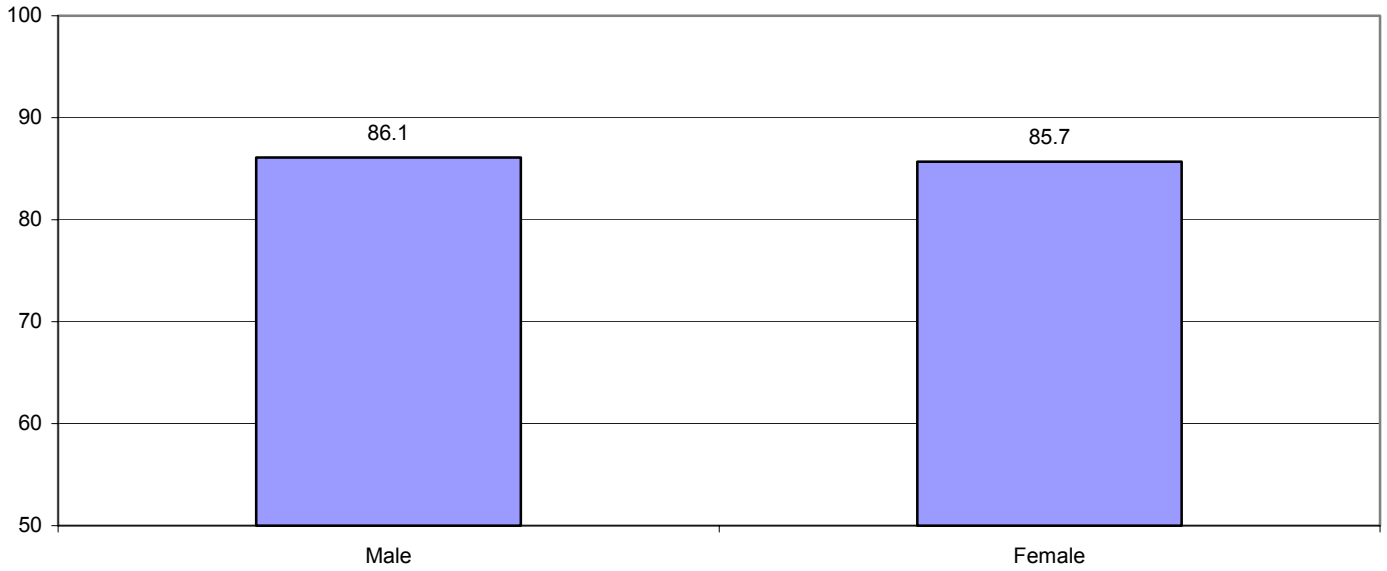


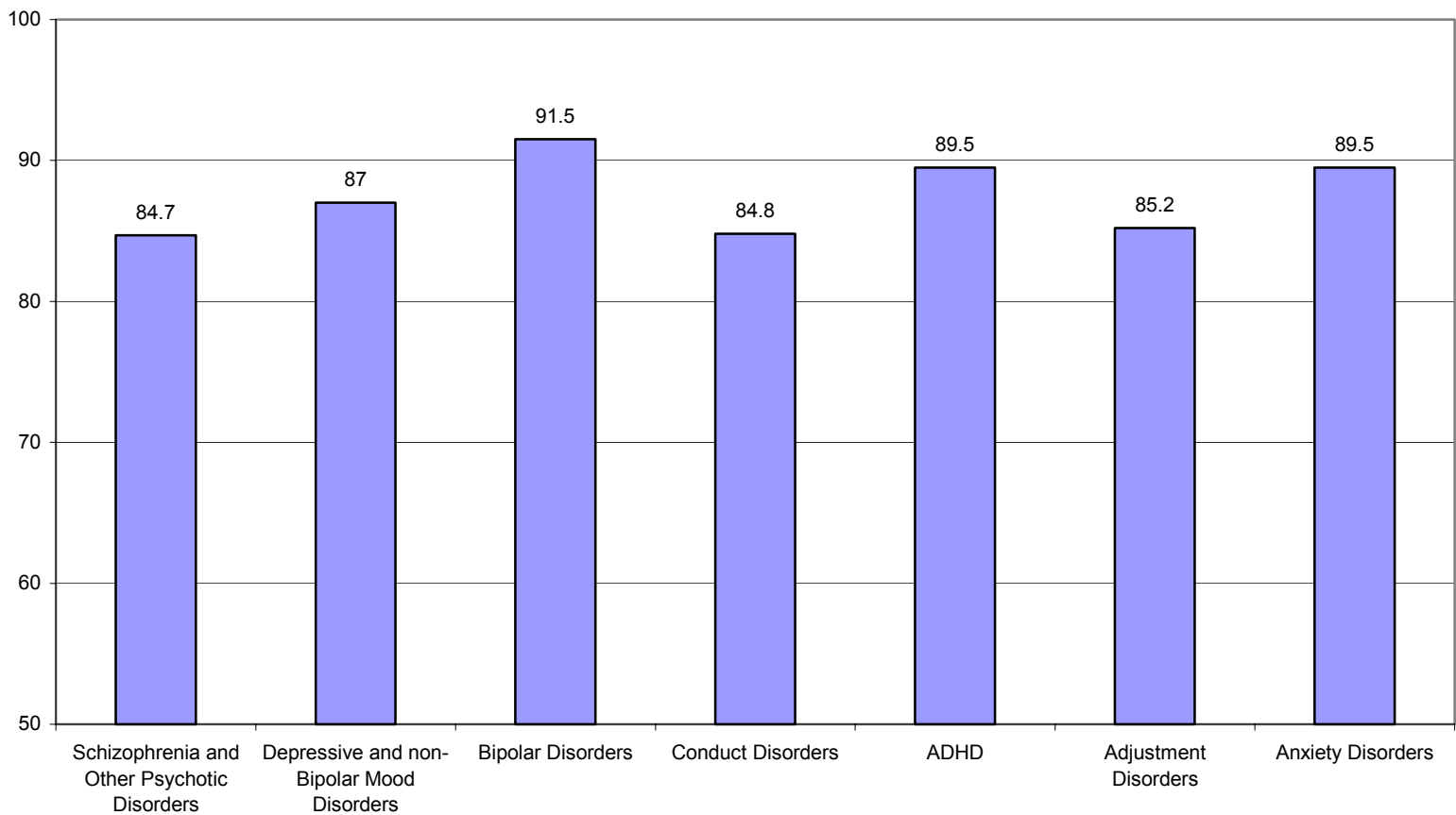
Figure 96: Child Retention Rate by Primary Language



**Figure 97: Child Retention Rate by Gender**



**Figure 98: Child Retention Rate by Diagnosis**







# **APPENDIX A**

Agency Name:

Contact Person:

Phone:

Email:

Date:



SACRAMENTO COUNTY  
Mental Health Plan

## SACRAMENTO COUNTY HUMAN RESOURCES SURVEY

---

This survey provides the Division with important information on the ethnic diversity, language capabilities and other characteristics of staff involved in the provision of Mental Health services. Please complete and return the survey by **Monday, May 5 2003**. Include only agency staff that provides mental health services for Sacramento County. Your entries should reflect actual staff numbers (not FTEs) of both part-time and full-time staff.

The last page of this survey was developed to facilitate data collection at your site. If you wish, you can distribute page 7 to staff, and then collate the information to complete and submit pages 3 to 6.

The survey can be completed on the computer as a Word document or hard copy. If completed as hard copy please type or print clearly. Completed surveys can be returned to Victor Contreras by:

- Mail: Division of Mental Health, 7001 East Parkway Suite 300, Sacramento CA 95823
- Email: [contrerasv@saccounty.net](mailto:contrerasv@saccounty.net)
- Fax: 876-5254

Questions can be directed to Victor Contreras at (916) 875-4946 or [contrerasv@saccounty.net](mailto:contrerasv@saccounty.net).

**Please complete the information box on the top of this page.**

### ***Ethnic Background (Required)***

- Page 3. Fill in the **total** number of staff, including contracted employees, falling into each staff category (e.g., Administration/Management, Direct Services etc.).

### ***Language Proficiency (Required)***

- Page 4. For each staff category fill in the **total** number of staff, including contracted employees, who are **proficient** in speaking (Speak) and reading/writing (Read/Write) these languages. By “proficient” we are referring to those who are able to provide services to clients in another language or to interpret for other staff.

### ***Language List (Required)***

- Page 5. List the names of staff who are **proficient** in languages other than English and indicate the languages they are **proficient** in. For each staff/language entered, please also indicate whether they were tested for proficiency. **Please type or print clearly.**

### ***Self-Identification (Voluntary)***

**Be advised that responses to these items are purely voluntary. Please only include staff who have publicly declared themselves consumers, family members, gay/lesbian/bi-sexual, or disabled.**

- Indicate the number of staff who have voluntarily self-identified as consumers of mental health services.
- Indicate the number of staff who have voluntarily self-identified as family members of consumers of mental health services.
- Indicate the number male and female staff within each staff category.
- Indicate the number of persons within each staff category who self-identify as gay, lesbian, or bisexual.
- Indicate the number of staff in each category who self-identify as disabled.

### ***Differential***

- Indicate whether your agency pays a differential to staff who provides services in languages other than English.
- Indicate the method your agency uses to determine language proficiency.



Agency Name:

**Ethnic Background**

Fill in the total number of staff, including contracted employees, falling into each staff category (e.g. Administration/Management, Direct Services, etc.).

	<b>Board of Directors</b>	<b>Administration/ Management</b>	<b>Direct Services</b>	<b>Clerical Support</b>	<b>Interpreters/ Translators</b>	<b>Other</b>
African American						
Cambodian						
Caucasian						
Chinese						
Filipino						
Former Soviet						
Hmong						
Korean						
Lao						
Latino						
Mien						
Native American						
Vietnamese						
Other						



Sacramento County Mental Health Plan  
Human Resources Survey 2003

Agency Name:

**Language Proficiency**

Fill in the total number of staff, including contracted employees, who are **proficient** in speaking and reading/writing in the languages listed. By “proficient” we are referring to those who feel comfortable in providing services to clients in another language. By “proficient” we are referring to those who are able to provide services to clients in another language or to interpret for other staff.

Board of Directors												
	ASL	Cambodian	Cantonese	Bosnian	Hmong	Korean	Lao	Mien	Russian	Spanish	Tagalog	Vietnamese
Speak												
Read/Write												

Administration/Management												
Speak												
Read/Write												

Direct Services												
Speak												
Read/Write												

Clerical Support												
Speak												
Read/Write												

Interpreters/Translators												
Speak												
Read/Write												

Other												
Speak												
Read/Write												

Sacramento County Mental Health Plan  
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Agency Name:

**Language Proficiency/Staff Names**

List names of staff who are **proficient** in languages other than English and indicate the languages they are **proficient** in. By “proficient” we are referring to those who are able to provide services to clients in another language or to interpret for other staff. For each language listed, please mark the box (☒) to indicate whether the staff member was tested for proficiency.

**Please type or print clearly.**

Name	Language	☒	Language	☒	Language	☒
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Please copy if more sheets are needed

Sacramento County Mental Health Plan  
Human Resources Survey 2003



Agency Name:

**Self Identification**

**Responses are purely voluntary. Please only include staff who has publicly declared themselves in the categories below.**

1) Indicate the number male and female staff within each staff category; 2) Indicate the number of staff who have voluntarily self-identified as consumers of mental health services; 3) Indicate the number of staff who have voluntarily self-identified as family members of consumers of mental health services; 4) Indicate the number of persons within each staff category who voluntarily self-identify as gay, lesbian, or bisexual.

	Men	Women	Consumer	Family Member	Self ID Gay, Lesbian or Bisexual	Self ID Disabled
<b>Board of Directors</b>						
<b>Administration/ Management</b>						
<b>Direct Services</b>						
<b>Clerical Support</b>						
<b>Interpreters/ Translators</b>						
<b>Other</b>						

**Differential:**

1) Indicate whether your agency pays a differential to staff who provide services in languages other than English; 2) Indicate the method your agency uses to determine language proficiency.

Does your agency pay a differential for staff who provide services in languages other than English?

Yes    No

Method used to determine proficiency:

Formal Testing  
 Written Exam  
 Oral Exam





Staff Name:

# SACRAMENTO COUNTY MENTAL HEALTH PLAN HUMAN RESOURCES SURVEY 2003

**THIS INFORMATION IS REQUIRED**

**1. Staff Category:**

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

**2. Ethnicity:**

- African American       Cambodian       Caucasian       Chinese       Filipino
- Former Soviet       Hmong       Korean       Lao       Latino
- Mien       Native American       Vietnamese       Other

**3. Languages other than English I speak PROFICIENTLY (able to provide services to clients or to interpret for other staff):**

- ASL       Cambodian       Cantonese       Bosnian       Hmong
- Korean       Lao       Mien       Russian       Spanish
- Tagalog       Vietnamese       Other please specify: \_\_\_\_\_

I have been tested for proficiency in the following Languages: 1) \_\_\_\_\_

2) \_\_\_\_\_

**4. Languages other than English I read/write PROFICIENTLY:**

- ASL       Cambodian       Cantonese       Bosnian       Hmong
- Korean       Lao       Mien       Russian       Spanish
- Tagalog       Vietnamese       Other please specify: \_\_\_\_\_

**THIS INFORMATION IS VOLUNTARY**

**5. Gender:**       Male       Female

**6. I am a consumer of Mental Health Services:**       Yes       No

**7. I have a family member who is a consumer of Mental Health Services:**       Yes       No

**8. I self-identify as gay, lesbian, or bisexual:**       Yes       No

**9. I self-identify as disabled:**       Yes       No



# **APPENDIX B**

*Sacramento County  
Division of Mental Health*



**Agency Self-Assessment of Cultural Competence  
March 2002**

**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 read each item carefully and use the rating scale provided to indicate the extent to which you agree or disagree with each item. Write the corresponding number beside each statement. In doing so, please remember that there is no magic score that identifies an agency as “culturally competent” or “incompetent.”

Please provide the following information:

Agency Name:

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_

The survey should be returned by Monday, April 22 and can be sent to Victor Contreras, Sacramento County Division of Mental Health, 7001 East Parkway Suite 300, Sacramento CA 95823.

## Section I: Administration

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**  
1

**Probably  
Agree**  
2

**Probably  
Disagree**  
3

**Strongly  
Disagree**  
4

### Management Responsibilities

- \_\_\_\_\_ 1. The management team is responsible for implementing the mission statement and goals relative to cultural diversity.
- \_\_\_\_\_ 2. The management team is responsible for implementing the mission statement and goals relative to cultural diversity.
- \_\_\_\_\_ 3. The management team ensures that staff is proficient in working with interpreters.
- \_\_\_\_\_ 4. The management team ensures access to culturally competent interpreters.
- \_\_\_\_\_ 5. 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.
- \_\_\_\_\_ 6. The management team ensures that non-discrimination policies are clearly written and annually reviewed.

## Section II: Program and Policy Development

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**  
1

**Probably  
Agree**  
2

**Probably  
Disagree**  
3

**Strongly  
Disagree**  
4

### Policy Development

- \_\_\_\_\_ 1. 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.
- \_\_\_\_\_ 2. Mechanisms are established to include all levels of staff, including paraprofessionals, in the decision making process, to the maximum extent possible.

### 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 annual 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 commitment to creating an atmosphere of support for cultural diversity throughout programs and activities.

### Section III: Consumer-Related Services and Staff Training

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**  
1

**Probably  
Agree**  
2

**Probably  
Disagree**  
3

**Strongly  
Disagree**  
4

#### Materials and Environment

- \_\_\_\_\_ 1. Resources (e.g., videotapes, program brochures, newsletters), programs, and services designed to reach culturally diverse groups are developed and collected and are also oriented to the populations the agency serves.
- \_\_\_\_\_ 2. The physical environment of the agency is reflective of the different cultural populations served.

#### Staff Development and Training

- \_\_\_\_\_ 1. Staff is trained in regard to cross-cultural communication, culturally diverse family customs, and conflict resolution in different cultural groups.
- \_\_\_\_\_ 2. Staff continually examines their own cultural beliefs and attitudes to better understand the dynamics of cultural difference and interaction.
- \_\_\_\_\_ 3. Staff routinely discusses barriers to working across cultures.
- \_\_\_\_\_ 4. Staff routinely discusses issues related to working with consumers or co-workers of diverse ethnicity.
- \_\_\_\_\_ 5. Persons from the agency attend cross-cultural workshops when offered.
- \_\_\_\_\_ 6. Staff is trained in the use of interpreters.
- \_\_\_\_\_ 7. Interpreters are trained on basic skills and knowledge about mental health issues.
- \_\_\_\_\_ 8. Staff is culturally sensitive and has the capability for serving consumers whose primary language is not English.
- \_\_\_\_\_ 9. There is a documented policy/practice to follow when the agency is not proficient in a client's language or culture.

## Section IV: Service Delivery

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**  
1

**Probably  
Agree**  
2

**Probably  
Disagree**  
3

**Strongly  
Disagree**  
4

### 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.
- \_\_\_\_\_ 8. It is recognized that all aspects of service delivery must be culturally competent.



## **Governance**

*(Mental Health 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**  
1

**Probably  
Agree**  
2

**Probably  
Disagree**  
3

**Strongly  
Disagree**  
4

### **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**

- \_\_\_\_\_ 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.

## **Governance (continued)**

*(Mental Health Board members)*

- \_\_\_\_\_ 4. 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.
  
- \_\_\_\_\_ 5. 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 system.

# **APPENDIX C**

**Sacramento County – Good Neighbor Policy**

**COUNTY OF SACRAMENTO  
GOOD NEIGHBOR POLICY**

Contact: Penelope Clarke  
Public Protection & Human Assistance Agency  
916 874-5886

**Introduction:**

This memorandum is intended to recommend County policy regarding good neighbor practices in the location, design, maintenance, and management of County owned and leased facilities including those occupied by organizations under contract with the County.

**Background**

In the past several years the issues over location and concentration of high impact services in neighborhoods and the lack of overarching policy guidance have been a cause of increasing concern and frustration for residents and businesses, for service providers, for people who need services and for decision makers.

A focus group comprised of representatives from neighborhood and business groups, social service providers, client and representatives of clients and representatives from the City of Sacramento and the County was formed and developed recommendations regarding policies and guidelines for siting social service facilities.

The work of this group involved recommendations for land use policy changes as well as development of good neighbor policies and practices, which would mitigate impacts on neighborhoods. Because of complex legal issues, the recommended zoning ordinance changes governing siting of facilities was not implemented by the City or the County.

The County has implemented good neighbor policies in many of its facilities and with many of its service providers, based on a case-by-case analysis of the impact of a program or facility on a neighborhood or community.

This past year, a work group of the City and County reviewed the various reports and recommendations to determine what can be implemented without significant legal barriers.

This policy paper is being developed to provide for a recommended overarching County policy on good neighbor practices.

## **Sacramento County – Good Neighbor Policy**

### **Preamble**

The County is a political subdivision, which is mandated by State and Federal law to provide certain services to all residents of the County, and which also provides desired or necessary services to enhance the well being and quality of life for its residents. Such services are provided within the territorial boundaries of all cities and the unincorporated areas of the County.

County facilities are generally located in close proximity to the constituent population served, in central areas of the County and areas that are easily accessible to public transportation. The location of facilities is ultimately a County responsibility. The County will take into consideration a whole range of factors, including location of clients served, proximity of other related services needed by clientele, and any neighborhood revitalization plans and adoption siting policies of cities. The County will solicit the affected city's input and recommendation as to location, but retains the ultimate decision as to the parameters of the search area and determination of the most appropriate sites.

As a general rule, the County does not do site searches for programs, services or facilities operated by non-county entities that may receive County funding. The county contracts for services, but does not dictate the location of the facility. All businesses within the incorporated and unincorporated areas of the county must be in good standing with whatever city or County zoning laws apply in order to receive funding.

The County of Sacramento is committed to being an integral part of the neighborhoods and communities in which it is located and will implement measures in order to minimize the impact of such facilities on those neighborhoods and communities. Through its placement and management of facilities and provision of appropriate services, the County endeavors to enhance revitalizing and strengthening neighborhoods and communities

This policy is focused on those County-owned and County-leased facilities and those service providers under contract with the County where programs provide direct service to County constituents that have a potential impact on neighborhoods through increased traffic, noise, trash, parking, and people congregating.

Generalized good neighbor policies which prohibit loitering, require litter control services, mandate removal of graffiti, provide for adequate parking and restroom amenities, require landscape and facility maintenance consistent with the neighborhood and require identification of a contact person for complaint resolution have general application to all facilities and programs.

Good neighbor policies will also address specific and individualized impacts of proposed facilities and services based on actual circumstances which must be determined through a case by case analysis.

## Sacramento County – Good Neighbor Policy

### Good Neighbor Policies

This policy applies only to County-owned and leased facilities and those service providers under contract with the County if the facility programs and projects provide direct services to County constituents which have a potential impact on neighborhoods and communities through increased traffic, noise, trash, parking, and people congregating.

The County assumes, with regard to the actual location of a particular facility or service, that all applicable zoning laws have been complied with. The focus of this good neighbor policy does not include the propriety of the location of a facility or program in a properly zoned neighborhood or community.

While location is a consideration and input from cities, neighborhoods and communities will be sought, the ultimate decision as to location rests with the County.

Once a facility is sited and in compliance with zoning laws, the intent of this policy is to identify physical impacts and measures to mitigate those impacts so as to be an integral part of the neighborhood and community the County serves.

- Policy A: Establish a cooperative relationship with all cities, neighborhoods and communities for planning and siting facilities and contracting for services where the service or project has a high impact on the neighborhood and mitigation of those physical impacts is necessary.
- Policy B: Promote decentralization of County services where feasible as a means to improve accessibility and service delivery and reduce physical impact on the environment, neighborhoods and communities.
- Policy C: Promote collocation of services, where feasible, as a way to enhance efficiency and reduce costs in the delivery of services.
- Policy D: Promote exploration of innovative ways to increase accessibility to services that could also reduce physical impacts on the environment, neighborhoods and communities.
- Policy E: Establish early communication with affected cities, neighborhoods and communities as a way to identify potential physical impacts on neighborhoods and to establish mitigation as necessary as well as appropriate property management practices so as not to be a nuisance.
- Policy F: Maintain ongoing communication with cities, neighborhoods and communities as a way to promote integration of facilities into the community, to determine the effectiveness of established good neighbor practices, and to identify and resolve issues and problems expediently.

## **Sacramento County – Good Neighbor Policy**

- Policy G: Establish generalized good neighbor practices for high impact facilities, services and projects that include:
- Provision of adequate parking
  - Provision of adequate waiting and visiting areas
  - Provision of adequate restroom facilities
  - Provision for litter control services
  - Provision for removal of graffiti
  - Provision for control of loitering and management of crowds
  - Provision for appropriate landscape and facility maintenance in keeping with neighborhood standards
  - Provision for identification of a contact person for complaint resolution
  - Provision in contracts for the County to fix a deficiency and deduct it from the money owed to the program if the program fails to fix them.
  - Provision to participate in area crime prevention and nuisance abatement efforts.
- Policy H: Establish specific good neighbor practices for high impact facilities, services and projects based on a factual analysis of circumstances that would require more oversight and extraordinary measures to ensure the resolution of problems as they occur.
- Policy I: Establish requirements that all facilities, services and projects be in compliance with various nuisance abatement ordinances and any other provision of law that applies.
- Policy J: Establish a central point of contact, within the County, for resolving non-compliance with this Good Neighbor Policy when all other administrative remedies have been exhausted.

## Sacramento County – Good Neighbor Policy

### **I. GOOD NEIGHBOR POLICY**

- A. CONTRACTOR shall comply with the Good Neighbor Policy with respect to its facility operations during the term of this Agreement. CONTRACTOR shall:
1. Be responsive to complaints and concerns of the community;
  2. Hold a “Good Neighbor” open house at least once annually to insure ongoing communications with CONTRACTOR’s neighbors;
  3. Establish an ongoing relationship with the surrounding businesses, law enforcement and neighborhood groups and assume responsibility for being an active member of the neighborhood by having continuous contacts with these groups;
  4. Comply with the public nuisance ordinances and post signs prohibiting loitering, drinking and public nuisance and any others as specified by COUNTY.
  5. Participate in area crime prevention and nuisance abatement efforts;
  6. Establish and post hours of service;
  7. Maintain the facility grounds with appropriate landscaping and litter removal;
  8. When determined appropriate by COUNTY, provide adequate security which includes patrolling the parking lot and the perimeter of the facility;
  9. Remove graffiti within twenty-four, but not to exceed seventy-two hours.
  10. Post the name and telephone number of an emergency contact person on the outside of the facility for twenty-four-hour response to problems;
  11. Be required to take corrective action as deemed necessary by COUNTY;
  12. Notify surrounding businesses and neighborhood groups, within thirty days of any operational changes, that could impact the neighborhood adversely and request recommendations from the community in an effort to mitigate any potential impacts.
- B. If, based on continuous review of CONTRACTOR’s performance, COUNTY finds CONTRACTOR has failed to perform, COUNTY shall notify CONTRACTOR in writing that corrective action must be taken by CONTRACTOR within an agreed upon time frame. If CONTRACTOR fails to comply, COUNTY will take the required corrective action and deduct the actual cost to correct the problem from CONTRACTOR’s claim, when appropriate, to ensure the integrity of this program.
- C. Exceptions may be made to the Good Neighbor Policy to exempt CONTRACTOR from one or more of the Policy provisions when necessary and appropriate, provided the spirit and purpose of the Policy is maintained. A letter from the CONTRACTOR requesting the exemption and setting forth the justification will be attached to the agreement and must be approved by DIRECTOR to make any exemption to the Good Neighbor Policy.



**Sacramento County – Good Neighbor Policy  
Sacramento County Mental Health Plan**

**(RE) CERTIFICATION ASSESSMENT**

Provider Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Provider Number: \_\_\_\_\_ Hours of Operation: \_\_\_\_\_ No. of Clients Served: \_\_\_\_\_

**SERVICES PROVIDED**

Indicate the services to be provided by placing a check mark to the right of the service category. For Day Treatment services, indicate the number of programs.

<input type="checkbox"/>	Mental Health Service	<input type="checkbox"/>	Case Management	<input type="checkbox"/>	Psy. Health Facility
<input type="checkbox"/>		<input type="checkbox"/>	Crisis Intervention	<input type="checkbox"/>	Day Tx Intensive (full day)
<input type="checkbox"/>	Medication Support	<input type="checkbox"/>	Adult Crisis Res.	<input type="checkbox"/>	Day Tx Intensive (half day)
<input type="checkbox"/>	Psychiatrist visit only	<input type="checkbox"/>	Adult Residential	<input type="checkbox"/>	Day Rehab. (full day)
<input type="checkbox"/>	Dispensing Medications	<input type="checkbox"/>	Crisis Stab. EM/UC	<input type="checkbox"/>	Day Rehab. (half day)

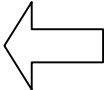
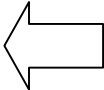
Consider the listed evaluation criteria and place a check mark in the columns labeled YES or NO as appropriate. Please attach supporting documentation as needed or when requested.

Reference: Title 9, Chapter 11, §1810.435, §1810.436. et al.

<b>EVALUATION CRITERIA</b>	<b>YES</b>	<b>NO</b>
<p><b>LICENSE TO OPERATE</b></p> <p>Does the organizational provider have the necessary licenses to operate posted? Or, if a non-profit agency, do they have a 501 (c) (3) letter from the State?</p>		

**Sacramento County Good Neighbor Policy**

EVALUATION CRITERIA	YES	NO
<b>Category 1: FIRE CLEARANCE</b>		
Does the space, which is owned, leased, or operated by the provider and used for services or staff, meet local fire codes? Please attach a copy of the fire clearance (Completed within the past 36 months).		
Comments:		

EVALUATION CRITERIA	YES	NO
<b>Category 2: PHYSICAL PLANT</b>		
1. Have there been significant changes in the physical plant of the provider site? (Some physical changes could require a new fire clearance). If yes, include the date the changes were completed and describe the changes.		
Comments:		
2. Are maintenance policies established and implemented to provide for physical safety of clients, visitors and personnel?		
3. Is the physical plant clean, sanitary and in good repair?		
4. Is the temperature of refrigerated food for clients' use between 36-46 degrees F (2-8 degrees C)?		
5. Is the physical plant is comfortable and inviting to culturally diverse populations?		
Comments:		

**Sacramento County Good Neighbor Policy**

<b>EVALUATION CRITERIA</b>	<b>YES</b>	<b>NO</b>
<b>Category 3: POLICIES AND PROCEDURES</b>		
1. Are client records and confidentiality of client records maintained in a manner that meets the requirements of applicable state and federal standards?		
2. Are there general policy and procedures on site?		
3. Are there <b>service delivery</b> policies on site?		
4. Are there procedures for reporting unusual occurrences relating to health and safety issues on site?		
5. Does the <b>program description</b> reference availability of alternate means of transportation (bus) and/or proximity to culturally diverse populations?	←	←
6. Does the <b>program description</b> , if applicable, reference the facility's co location and/or partnership with community groups?	←	←
7. Review <b>Adverse Incident Log</b> . Have there been complaints, unusual events, accidents, or injuries requiring medical treatment for clients, staff, or members of the community in the past 24 months? If yes, specify and describe.		
8. Are posters and brochures on Problem Resolution and Grievances prominently displayed?		
<b>Complaint / Suggestion Box?</b>		
<b>Type of forms available:</b> <input type="checkbox"/> Complaint <input type="checkbox"/> Grievance <input type="checkbox"/> Problem Resolution <input type="checkbox"/> Change of Provider <input type="checkbox"/> Member Handbook		
<b>Literature available in the following languages:</b> <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Hmong <input type="checkbox"/> Lao <input type="checkbox"/> Mien <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese	←	←
<b>Posters displayed in the following languages:</b> <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Hmong <input type="checkbox"/> Lao <input type="checkbox"/> Mien <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese	←	←

**Sacramento County Good Neighbor Policy**

<b>EVALUATION CRITERIA</b>	<b>YES</b>	<b>NO</b>
<p><b>Category 4: PHYSICIAN AVAILABILITY</b></p> <p>Is there a written procedure for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available? Include a description of onsite and backup M.D. coverage.</p>		
<b>EVALUATION CRITERIA</b>	<b>YES</b>	<b>NO</b>
<p><b>Category 5: STAFFING</b></p>		
<p>1. Does the Head of Service meet CCR, Title 9, Section 622-630 requirements?</p>		
<p>Name:</p>		
<p>Copy of the current license provided?</p>		
<p>Expiration Date:</p>		
<p>2. Have there been any major staffing changes?</p>		
<p>Current staffing roster provided?</p>		
<p>3. Are personnel policies on site?</p>		
<p>Comments:</p>		
<p>4. Are personnel records on site?</p>		
<p>If not, list location where personnel records are stored:</p>		
<p>5. Have all staff been appropriately credentialed in accordance with County policy?</p>		
<p>6. Is staff able to meet the threshold language and cultural needs of the clients?</p>	←	←
<p>7. On-site staff available for interpreter services in the following languages:  <input type="checkbox"/> Chinese <input type="checkbox"/> Hmong <input type="checkbox"/> Lao <input type="checkbox"/> Mien <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese</p>	←	←
<p>Comments:</p>		
<p><b>Threshold languages for this site:</b>  <input type="checkbox"/> Chinese <input type="checkbox"/> Hmong <input type="checkbox"/> Lao <input type="checkbox"/> Mien <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese</p>	←	←

**Sacramento County – Good Neighbor Policy**

EVALUATION CRITERIA	YES	NO
<b>Category 6: DAY PROGRAMS STAFFING RATIOS</b>		
Is there a day program?		
If yes, review a copy of the license, waiver/registration, or MHRS documentation for each qualified staff used to meet the staffing ratios. For each program provide the Daily Program Schedule/ Attendance Sheet for a random six week period. In addition, include corresponding Day Program Staff Rosters and Day Program Activity Schedules.		
1. Is there a Mental Health <b>Crisis Response</b> policy addressing availability and training of qualified staff (Crisis Response Worker), procedures for crisis situations and referring client for crisis intervention or stabilization within or outside the current program.		
2. Does the Day <b>Treatment</b> Intensive Program have an average ratio of (1) qualified staff to (8) clients or (2) qualified staff to (12) clients in attendance during the period the program is open? (Ch. 11 § 1840.350)		
A) Does the specified program hours meet the criteria for <input type="checkbox"/> full day (4+ hrs) or <input type="checkbox"/> half day (3 hrs)? (Ch. 11 § 1840.318)		
B) Are hours continuous?		
C) Does the program include a psychotherapy group?		
D) Is there a qualified staff (LPHA) facilitating the psychotherapy group?		
E) Does the program include a Community Meeting?		
3. Does the Day <b>Rehabilitative</b> Program have an average ratio of (1) qualified staff to (10) clients or (2) qualified staff to (12) clients in attendance during the period the program is open? (Ch. 11 § 1840.352)		
A) Does the specified program hours meet the criteria for <input type="checkbox"/> full day (4+ hrs) or <input type="checkbox"/> half day (3 hrs)? (Ch. 11 § 1840.318)		
B) Are hours continuous?		
C) Does the program include a Community Meeting?		

**Sacramento County – Good Neighbor Policy**

EVALUATION CRITERIA	YES	NO
<b>Category 7: PHARMACEUTICAL SERVICES</b> <b>Complete this section if medications are provided or stored. Storage and dispensing of medications must be in compliance with all pertinent state and federal standards.</b>		
1. Are policies and procedures in place for dispensing, administering and storing of medications?		
2. Are all drugs obtained by prescription labeled in compliance with federal and state laws?		
3. Are all drugs obtained by prescription labeled in compliance with federal and state laws?		
4. Are prescription labels altered only by persons legally authorized to do so? (Pharmacist who filled Rx)		
5. Are drugs intended for external use only stored separately from drugs for internal use?		
6. Are all drugs stored at proper temperatures?		
a. Room temperature drugs at 59-86 degrees F (15-30 degrees C). Thermometer present in medication room?		
b. Refrigerated drugs at 36-46 degrees F (2-8 degrees C). Thermometer present in refrigerator?		
7. Are drugs stored in a manner separate from foodstuff and clearly labeled?		
8. Are drugs stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication?		
9. Are drugs not retained after the expiration date?		
IM multi-dose vials are dated and initialed when opened?		
10. Is a drug log maintained to ensure the provider disposed of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws?		
a. Is there a monthly log to document that expired meds were checked?		
b. Does an authorized hazardous waste firm dispose of expired medications?		
11. Are stock prescription pads kept in a locked storage area?		
Are the physician prescription pads locked in a secure area when unattended?		
County Medical Reviewer Signature: _____ Date: _____		



**Sacramento County – Good Neighbor Policy**

**PLAN OF CORRECTION CONTINUED:**


County QI Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Representative/Position: \_\_\_\_\_ Date: \_\_\_\_\_

Initial Review:         Biennial Review:         Follow-up Review:

***RECOMMENDATION:***

Approve ( )        Disapprove ( )        Reasons:  
Provisionally Approve ( )        Plan of Correction needed within 30 days



# **APPENDIX D**

## **2003 CULTURAL COMPETENCE PLAN OBJECTIVES**

**Objective I.** Increase the percentage of direct service staff by 5% annually to reflect the racial and ethnic makeup of the communities speaking threshold languages until the proportion of direct service staff equals the proportion of Medi-Cal beneficiaries.

**Objective II.** By July 1, 2004, 90% of staff identified as interpreters will have completed at least 6.5 hours of interpreter training.

**Objective III.** Increase the penetration rate in underserved populations by 1.5% as measured for

- ethnicity
- language
- age

**Objective IV.** Increase the retention rate in underserved populations:

- 1) Retention rates in all ethnic groups will be at least 53% over a two year period.
- 2) Retention rates by primary language for adult consumers will be retained by at least 50% over a two year period.
- 3) Retention rates by primary language for all children and youth will be retained by at least 77% over a two year period.

**Objective V.** Determine whether client outcomes are equivalent regardless of ethnic group or primary language.

**Objective VI.** Ensure MHP progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide Cultural Competence Agency Self Assessment.