CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

January 25, 2010

DMH INFORMATION NOTICE NO.: 10-02

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS

REFERENCE DMH INFORMATION NOTICE NO. 02-03

The Department of Mental Health (DMH) is issuing the enclosed revised 2010 Cultural Competence Plan Requirements (CCPR). The 2010 CCPR is DMH's mechanism to expand and integrate cultural competence from Specialty Mental Health Services to the entire mental health system. This CCPR supersedes previous Information Notice 02-03 and goes into effect immediately.

"Small Counties", as defined by Title 9, California Code of Regulations, Section 3200.640, shall complete and submit a 2010 CCPR Modification, pursuant to the DMH Information Notice that will follow this notice; however, small counties can opt to complete this full 2010 CCPR.

Counties will have six months from the release of this Information Notice to complete their 2010 CCPR. During those six months, DMH will offer regional Technical Assistance Training to counties. The 2010 CCPR will be due to DMH on July 28, 2010. County CCPR submissions will be reviewed and scored by DMH. Please submit one original, three copies, and one compact disc of the document saved in PDF (preferred) or Microsoft Word (1997-2003) format to:

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, Ca. 95814

If you have any further questions regarding the 2010 CCPR, please contact the Office of Multicultural Services at (916) 651-9524, or Kimberly Knifong at (916) 653-0767, by email Kimberly.Knifong@dmh.ca.gov .

Sincerely,

Original Signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures: 2010 CCPR

cc:
Mental Health Services Oversight and Accountability Commission
Oversight and Accountability Commission Chair of Cultural and Linguistic Competency
California Mental Health Planning Council
County Mental Health Directors Association
Cultural Competency/Ethnic Services Managers

# COVER SHEET

**An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due July 28, 2010 to:**

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, California 95814

Name of County: _____

Name of County Mental Health Director: _____

Name of Contact: _____

Contact's Title: _____

Contact's Unit/Division: _____

Contact's Telephone: _____

Contact's Email: _____

## CHECKLIST OF THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

☐ **CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE**

☐ **CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS**

☐ **CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES**

☐ **CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM**

☐ **CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES**

☐ **CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF**

☐ **CRITERION 7: LANGUAGE CAPACITY**

☐ **CRITERION 8: ADAPTATION OF SERVICES**

## Purpose

The Cultural Competence Plan Requirements (CCPR) establish new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). "CCPR" in this document shall mean the county's completed cultural competence plan submission inclusive of all requirements. The original CCPR (2002), Department of Mental Health (DMH) Information Notice 02-03, addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) is designed to address all mental health services and programs throughout the County Mental Health System. This CCPR seeks to support full system planning and integration. This revised CCPR (2010) includes the most current resources and standards available in the field of cultural and linguistic competence, and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The revised CCPR (2010) works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California's diverse racial, ethnic, and cultural communities in the mental health system of care.

## Background

The CCPR (2002) revised addendum indicated that "future CCP requirements will evolve as more experience through plan development and implementation progresses. While efforts are being made on an ongoing basis to achieve cultural competence, as our competence improves, our standards will need to improve." This revised CCPR (2010) serves as an outcome of these advances in the field of cultural competence. DMH seeks to keep the County Mental Health System updated with the latest studies and applications in the field of cultural and linguistic competence, so that the mental health system functions as a highly efficient organization with the ability to provide effective and integrated services to its ethnic/racial and cultural communities. The revised CCPR (2010) serves to operationalize cultural competence at both the organizational and contractor level.

The basis for the revised CCPR (2010) criteria is the U.S. Department of Health and Human Services, Office of Minority Health (2001) *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (CLAS) (See Federal Standards, page 33 of this CCPR). The revised CCPR (2010) criteria were developed from a compilation of the CCPR (2002), CLAS, and other current cultural competence organizational assessment tools (see attached references). Combined, these documents incorporate eight domains that cover a system in its entirety:

Domain 1. Organizational Values;
Domain 2. Policies/Procedures/Governance;
Domain 3. Planning/Monitoring/Evaluation;
Domain 4. Communication;
Domain 5. Human Resource Development;
Domain 6. Community and Consumer Participation;
Domain 7. Facilitation of a Broad Service Array; and
Domain 8. Organizational Resources.

(Source: University of South Florida, 2006. *Organizational Cultural Competence: A Review of Assessment Protocols)*

Research on the above eight domains included review and analysis of 17 organizational level cultural competence assessment tools being used in the field today. The research yielded a compilation of the eight significant assessment domains as focus areas for assessing and integrating cultural competence into mental health programs. The domains work to create an organizational model for operationalizing cultural competence into systems. The inclusion of these eight domains is necessary for a County Mental Health System to effect change and progress towards a culturally competent mental health system of care in California.

From the above eight *domains*, eight *criteria* were developed to encompass the revised CCPR (2010) and assist counties in identifying and addressing disparities across the entire mental health system. Those eight criteria are as follows:

Criterion I: Commitment to Cultural Competence
Criterion II: Updated Assessment of Service Needs
Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
Criterion IV: Client/Family Member/Community Committee: Integration of the Committee Within The County Mental Health System
Criterion V: Culturally Competent Training Activities
Criterion VI: County's Commitment To Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
Criterion VII: Language Capacity
Criterion VIII: Adaptation of Services

These eight criteria are a mechanism to examine where counties lie on the scale of cultural competence. Having used the criteria to form a logic model, the CCPR's development and inclusion of the eight criteria allow counties to implement cultural and linguistic competence in a variety of settings and move toward operationalizing the concept of cultural competence. The assessment portion of the CCPR will identify areas the county may need resources, supports, and leverage to support its efforts in operationalizing cultural competence.

The County Mental Health System in California has changed greatly with the passage of the MHSA. MHSA has opened many doors for unserved/underserved individuals and works toward increasing the county workforce. As MHSA expands and increases services, DMH recognizes that county reporting requirements have also increased. The revised CCPR (2010) takes this into consideration and has focused on omitting reporting redundancies by developing one, single plan that will be applied to all programs throughout the system. Where applicable, the revised CCPR (2010) requires copies or updates of areas already addressed in other reports or plans. Some areas will apply to Medi-Cal only, while other areas will apply to the entire system; these are delineated throughout the revised CCPR (2010).

**Current State and Federal statutory, regulatory, and authority provisions related to cultural and linguistic competence and other policies, statutes, and standards.**

This revised CCPR (2010) includes listings of required Federal and *S*tate statutes, regulations, and DMH policy letters related to cultural and linguistic competence in the delivery of mental health services. These provisions are in addition to other Federal or State laws that prohibit discrimination based on race, color, or national origin (for more information see page 32).

**Timeframes**

The revised CCPR (2010) shall be submitted by each county to DMH on a staggered three year cycle (a comprehensive CCPR is submitted every three years and an Annual Update is submitted in the interim years). Annual updates will be required and DMH will select specific criteria for counties to report on for each update. The first revised CCPR (2010) will be due in July 2010; subsequent CCPRs will be due in 2013 and 2016. Annual updates will be due in 2011, 2012, 2014, and 2015. Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty MHS, Article 4., Section 1810.410 (c)-(d) states each Mental Health Plan (MHP) shall submit an annual CCPR update consistent with the requirements of this revised CCPR document, consistent with the plan reporting requirements, including the population assessment and organizational and service provider assessments.

Counties may direct all inquiries about this CCPR (2010) to the California Department of Mental Health, Office of Multicultural Services at 916-651-9524.

**Directions for completing the revised CCPR (2010)**

The DMH expects this revised CCPR (2010) to be completed by the county Department of Mental Health (referred in document as county). The county will provide the plan to all county contractor(s) providing mental health services and hold the contractor(s) accountable for reporting the information to be inserted into the CCPR. The CCPR must reflect the activities of the MHP (county and contractor) and both county and contractor are required to adhere to the plan. Throughout the revised CCPR (2010) are fields to be completed by the county, with recommendations for data to be submitted by both the county and the contractor.

The revised CCPR (2010) requires counties to include an analysis and tabulation of the contractors' deficiencies, strategies to address the deficiencies, and timeframes for implementing the strategies. This must be included in the overall county response to DMH, with timeframes for when the deficiencies will be addressed.

The DMH will review the revised CCPR (2010) submission and will provide a score and feedback to the counties.

An original, three copies, and a compact disc of this CCPR saved in PDF format (preferred) or Microsoft Word format 1997-2003 is due by July 28, 2010.

The CCPR's Cover Sheet shall be the first sheet of the submitted document. Submissions should follow the assigned format identifying each criterion by number, criterion title, and page numbers. Sections of the CCPR should be complete; however, if a section is incomplete (such as data is unavailable), identify the section and briefly explain when the section will be submitted to DMH. Counties must meet the submission deadlines. If submission timelines cannot be met, counties shall notify DMH ahead of time. Please call the Office of Multicultural Services at 916-651-9524 to discuss new CCPR deadline submissions.

**CRITERION 1**

**COUNTY MENTAL HEALTH SYSTEM**

**COMMITMENT TO CULTURAL COMPETENCE**

**Rationale:** An organizational and service provider assessment is necessary to determine the readiness of the service delivery system to meet the cultural and linguistic needs of the target population. Individuals from racial, ethnic, cultural, and linguistically diverse backgrounds frequently require different and individual Mental Health Service System responses.

**I. County Mental Health System commitment to cultural competence**

**The county shall include the following in the CCPR**:

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

**The county shall have the following available on site during the compliance review**:

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policy and Procedure Manuals;
5. Human Resource Training and Recruitment Policies;
6. Contract Requirements; and
7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

**II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system**

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

**The county shall include the following in the CCPR**:

A. A description, not to exceed two pages, of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

C. A narrative, not to exceed two pages, discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

D. Share lessons learned on efforts made on the items A, B, and C above.

E. Identify county technical assistance needs.

**III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence**

The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

**The county shall include the following in the CCPR:**

A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

**IV. Identify budget resources targeted for culturally competent activities**

**The county shall include the following in the CCPR:**

A. Evidence of a budget dedicated to cultural competence activities.

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

1. Interpreter and translation services;
2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
3. Outreach to racial and ethnic county-identified target populations;
4. Culturally appropriate mental health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

## CRITERION 2

## COUNTY MENTAL HEALTH SYSTEM

## UPDATED ASSESSMENT OF SERVICE NEEDS

**Rationale:** A population assessment is necessary to identify the cultural and linguistic needs of the target population and is critical in designing, and planning for, the provision of appropriate and effective mental health services.

**Note:** All counties may access 2007 200% of poverty data at the DMH website on the following page: http://www.dmh.ca.gov/News/Reports_and_Data/default.asp within the link titled "Severe Mental Illness (SMI) Prevalence Rates".

Counties shall utilize the most current data offered by DMH.

Only small counties, as defined by California Code of Regulations 3200.260, may request Medi-Cal utilization data from DMH by submitting the appropriate form to DMH, no later than five calendar months before plan submissions are due. To complete the Data Request Form, counties must contact the Office of Multicultural Services at 916-651-9524 to have a DMH staff person assist in the completion of the proper form. Eligible counties may be provided data within thirty calendar days from the data request deadline; however, all requests are first-come first-serve and provided according to DMH staff availability and resources.

### I. General Population

**The county shall include the following in the CCPR**:

A. Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

### II. Medi-Cal population service needs (Use current CAEQRO data if available.)

**The county shall include the following in the CCPR**:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

**Note:** Objectives for these defined disparities will be identified in Criterion 3, Section III.

**III. 200% of Poverty (minus Medi-Cal) population and service needs**

**The county shall include the following in the CCPR**:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social /cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

**Note:** Objectives for these defined disparities will be identified in Criterion 3, Section III.

**IV. MHSA Community Services and Supports (CSS) population assessment and service needs**

**The county shall include the following in the CCPR:**

A. From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

**Note:** Objectives will be identified in Criterion 3, Section III.

**V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations**

**The county shall include the following in the CCPR:**

A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:
   1. Underserved cultural populations
   2. Individuals experiencing onset of serious psychiatric illness
   3. Children/youth in stressed families
   4. Trauma-exposed
   5. Children/youth at risk of school failure
   6. Children/youth at risk or experiencing juvenile justice involvement

B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

## CRITERION 3

## COUNTY MENTAL HEALTH SYSTEM

## STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

**Rationale:** "Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services, these communities are less likely to receive needed mental health services, and when they get treatment they often receive poorer quality of mental health care. Although they have similar mental health needs as other populations they continue to experience significant disparities, if these disparities go unchecked they will continue to grow and their needs continue to be unmet..." (U.S. Department of Health and Human Services, Surgeon General Report, 2001).

**Note:** As counties continue to use this CCPR as a logic model, counties will use their analyses from Criterion 2, to respond to the following:

**I. Identified unserved/underserved target populations (with disparities):**

**The county shall include the following in the CCPR:**

- Medi-Cal population
- Community Services Support (CSS) population: Full Service Partnership population
- Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

   1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

**II. Identified disparities (within the target populations)**

**The county shall include the following in the CCPR:**

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI's priority/targeted populations).

**III. Identified strategies/objectives/actions/timelines**

**The county shall include the following in the CCPR:**

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:
II. Medi-Cal population
III. 200% of poverty population
IV. MHSA/CSS population
V. PEI priority population(s) selected by the county, from the six PEI priority populations

**IV. Additional strategies/objectives/actions/timelines and lessons learned**

**The county shall include the following in the CCPR:**

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. **Note:** New strategies must be related to the analysis completed in Criterion 2.

1. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

**V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities**
(Criterion 3, Section I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

**The county shall include the following in the CCPR:**

A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

**Note**: Counties shall be ready in 2011 to capture and establish current baseline data to be used for ongoing quality improvement and qualitative analysis of the county's efforts to reduce identified disparities. Baseline data information and updates of the county's ongoing progression in the reduction of mental health disparities will be required in 2011 and in subsequent CCPR Annual Updates.

Additionally, in subsequent CCPR Annual Updates, counties will share what has been working well and lessons learned through the process of the county's planning and monitoring of identified strategies, objectives, actions, and timelines to reduce mental health disparities.

C. Identify county technical assistance needs.

**CRITERION 4**

**COUNTY MENTAL HEALTH SYSTEM**

**CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM**

**Rationale:** A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).

**I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community**.

**The county shall include the following in the CCPR:**

A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary;

C. Organizational chart; and

D. Committee membership roster listing member affiliation if any.

**II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.**

**The county shall include the following in the CCPR:**

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;
2. Provides reports to Quality Assurance/Quality Improvement Program in the county;
3. Participates in overall planning and implementation of services at the county;

4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;
5. Participates in and reviews county MHSA planning process;
6. Participates in and reviews county MHSA stakeholder process;
7. Participates in and reviews county MHSA plans for all MHSA components;
8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
9. Participates in revised CCPR (2010) development.

B. Provide evidence that the Cultural Competence Committee participates in the above review process.

C. Annual Report of the Cultural Competence Committee's activities including:

1. Detailed discussion of the goals and objectives of the committee;
   a. Were the goals and objectives met?
      - If yes, explain why the county considers them successful.
      - If no, what are the next steps?
2. Reviews and recommendations to county programs and services;
3. Goals of cultural competence plans;
4. Human resources report;
5. County organizational assessment;
6. Training plans; and
7. Other county activities, as necessary.

**Sources of Information:**
Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department

## CRITERION 5

## COUNTY MENTAL HEALTH SYSTEM

## CULTURALLY COMPETENT TRAINING ACTIVITIES

**Rationale:** Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).

**I. The county system shall require all staff and stakeholders to receive annual cultural competence training.**

**The county shall include the following in the CCPR:**

A. The county shall develop a three year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.
2. Steps the county will take to provide required cultural competence training to 100% of their staff over a three year period.
3. How cultural competence has been embedded into all trainings.

**II. Annual cultural competence trainings**

**The county shall include the following in the CCPR:**

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function (If available, include if they are clients and/or family members):

1. Administration/Management;
2. Direct Services, Counties;
3. Direct Services, Contractors;
4. Support Services;
5. Community Members/General Public;
6. Community Event;
7. Interpreters; and
8. Mental Health Board and Commissions; and
9. Community-based Organizations/Agency Board of Directors

B. **Annual cultural competence trainings topics shall include, but not be limited to the following:**

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Mental Health Interpreter Training
7. Training staff in the use of mental health interpreters
8. Training in the Use of Interpreters in the Mental Health Setting

***Use the following format to report the above requirements:***

| **Training Event** | **Descrip-tion of Training** | **How long and often** | **Attendance by Function** | **No. of Attendees and Total** | **Date of Train-ing** | **Name of Present-er** |
|---|---|---|---|---|---|---|
| ***Example:***<br><br>*Cultural Competence Introduction* | *Overview of cultural competence issues in mental health treatment settings.* | *Four hours annually* | **Direct Services*<br>**Direct Services Contractors*<br>**Administratio n*<br>**Interpreters* | *15*<br>*20*<br><br>*4*<br>*2*<br><br>*Total: 41* | *1/24/10* | |

**III. Relevance and effectiveness of all cultural competence trainings**

**The county shall include the following in the CCPR:**

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;
2. Results of pre/post tests (Counties are encouraged to have a pre/post test for all trainings);
3. Summary report of evaluations; and
4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

**IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.**

**The county shall include the following in the CCPR:**

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:

- Culture-specific expressions of distress (e.g., nervios);
- Explanatory models and treatment pathways (e.g., indigenous healers);
- Relationship between client and mental health provider from a cultural perspective ;
- Trauma;
- Economic impact;
- Housing;
- Diagnosis/labeling;
- Medication;
- Hospitalization;
- Societal/familial/personal;
- Discrimination/stigma;
- Effects of culturally and linguistically incompetent services;
- Involuntary treatment;
- Wellness;
- Recovery; and
- Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.

**Note:** The following explanation is offered to assist counties in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer. Clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system, and their own ethnic culture. These personal experiences and beliefs can be used to empower clients to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency.

Use the following format to report the above requirements:

| **Training Event** | **Description of Training** | **How long and often** | **Attendance by Function** | **No. of Attendees and Total** | **Date of Train-ing** | **Name of Present-er** |
|---|---|---|---|---|---|---|
| ***Example***<br><br>*Cultural Com-petence Intro-duction* | *Overview of cultural competence issues in mental health treatment settings.* | *Four hours annually* | **Direct Services*<br>**Direct Services Contractors*<br>**Administration*<br>**Interpreters* | *15*<br><br>*20*<br><br>*4*<br>*2*<br><br>*Total: 41* | *1/24/10* | |

**CRITERION 6**

**COUNTY MENTAL HEALTH SYSTEM**

**COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF**

**Rationale:** The diversity of an organization's staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring diverse and bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).

**I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations**

**The county shall include the following in the CCPR:**

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. **Rationale:** Will ensure continuity across the County Mental Health System.

B. Compare the WET Plan assessment data with the general population, Medical population, and 200% of poverty data. **Rationale:** Will give ability to improve penetration rates and eliminate disparities.

C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

F. Identify county technical assistance needs.

## CRITERION 7

## COUNTY MENTAL HEALTH SYSTEM

## LANGUAGE CAPACITY

**Rationale:** Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the language of the client that includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). The DMH will provide threshold language data to each county.

**I. Increase bilingual workforce capacity**

**The county shall include the following in the CCPR:**

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.
2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.
3. Total annual dedicated resources for interpreter services.

**II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.**

**The county shall include the following in the CCPR:**

A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.
2. Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.
3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.
4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

C. Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

   1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

E. Identify county technical assistance needs.

**III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.**

**Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

**The county shall include the following in the CCPR:**

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

**IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.**

**The county shall include the following in the CCPR:**

A. Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and
3. Minor children should not be used as interpreters.

**V. Required translated documents, forms, signage, and client informing materials**

**The county shall have the following available for review during the compliance visit:**

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

**CRITERION 8**

**COUNTY MENTAL HEALTH SYSTEM**

**ADAPTATION OF SERVICES**

**Rationale:** Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).

**I. Client driven/operated recovery and wellness programs**

**The county shall include the following in the CCPR:**

A. List and describe the county's/agency's client-driven/operated recovery and wellness programs.

1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.
2. Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

**II. Responsiveness of mental health services**

**The county shall include the following in the CCPR:**

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

*C.* Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. *(Outreach requirements as per Section 1810.310, 1A and 2B, Title 9)*

(Counties may include **a.)** Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services; or **b.**) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas;
2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and
3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

**III. Quality of Care: Contract Providers**

**The county shall include the following in the CCPR:**

A. Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

**IV. Quality Assurance**

**Requirement:** A description of current or planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:

**The county shall include the following in the CCPR:**

A. List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

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

C. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

**California State Statute**

**Welfare and Institutions Code (WIC), Section 4341** -- relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: "Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state."

**WIC, Section 5600.2** -- relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable…"

**WIC, Section 5600.2(g)** -- "Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups. (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

**WIC, Section 5600.3**—Relates to populations targeted for services. This section details the target populations that shall be served by mental health funds. Target populations include the following: Seriously emotionally disturbed children and adolescents, adults and older adults who have serious mental disorders, adults or older adults who require or are at risk of requiring acute treatment, and those persons who need brief treatment as a result of natural disaster or severe local emergency.

**WIC, Section 5600.9(a)** -- "Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs."

**WIC, Section 5802. (a)(4)** -- relates to Adult and Older Adult Mental Health System of Care. "System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes."

**WIC, Section 5807**. – relates to Human Resources, Education, and Training Programs. Requires counties to work in an interagency collaboration (and public and private collaborative programs) to effectively serve target populations to assure service effectiveness and continuity and help set priorities for services.

**California State Statute Cont.**

**WIC, Section 5813.5 (d)(3)** – relates to distribution of funds, services to adults and seniors, funding, and planning for services. "Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers…to reflect the cultural, ethnic and racial diversity of mental health consumers."

**WIC, Section 5820**. – relates to Human Resources, Education, and Training Programs. This section details "the intent to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses." A needs assessment is required of the mental health programs in each county that detail anticipated staff shortages where the county will need to fill positions in order to meet requirements in reducing discrimination and improving services for underserved populations as detailed in WIC, Section 5840.

**WIC, Section 5822 (d) and (i)** – relates to Human Resources, Education, and Training Programs. Relates to the State Department of Mental Health. Section 5822 (d) requires an establishment of regional partnerships among mental health and educational systems to expand outreach to multicultural communities and increase the diversity of the mental health workforce. Section 5822 (i) requires promotion of the inclusion of cultural competency in training and educational programs.

**WIC, Section 5840 (b) and (b)(4) and (e)**– relates to Prevention and Early Intervention Programs. This section requires programs to reduce discrimination and improve services for underserved populations. Additionally, this section requires the department to revise elements of the program to reflect lessons learned. "The program shall emphasize improving timely access to services for underserved populations." "Reduction in discrimination against people with mental illness." "In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors."

**WIC, Section 5848**– relates to the development of prevention and early intervention plans with local stakeholders. This section requires stakeholder participation in the development of the PEI plan.

**WIC, Section 5855. (f)** -- relates to Children's Mental Health System of Care. "Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery."

**California State Statute Cont.**

**WIC. Section 5865. (b)** -- relates to the county System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. "(b) A method to screen and identify children in the target population including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent."

**WIC Section 5878.1**—relates to establishing programs that assure services are culturally competent. "It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family."

**WIC. Section 5880. (b)(6)** -- relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. "To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation."

**WIC, Section 14683 (b)** -- requires the department establish minimum standards of quality and access for managed mental health care plans. This section sets forth a requirement that managed mental health care plans include a system of "outreach to enable beneficiaries and providers to participate in and access mental health services under the plans, consistent with existing law."

**WIC, Section 14684 (h)** -- "Each plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate."

**California Government Code (CGC) Section 7290-7299.8** – "This chapter may be known and cited as the Dymally-Alatorre Bilingual Services Act." Relates to the Legislature's findings and declarations regarding rights and benefits to those precluded from utilizing public services because of language barriers. This section details the need for effective community between the government and its citizens and describes legislative intention to provide for effective communication to those that either do not speak or write English at all or their primary language is other than English.

**California Code of Regulations**

**California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 10, Medi-Cal Psychiatric Inpatient Hospital Services, Article 1, Section 1704** "Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings."

**CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.310 1(a-b)** Implementation Plan. This section discusses how an MHP must submit an Implementation Plan with procedure details for screening, referral and coordination with other necessary services and "Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP."

**CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410 (a-e)**, Cultural and Linguistic Requirements. This section provides an in-depth listing of cultural and linguistic requirements. "Each MHP shall develop and implement a Cultural Competence Plan that includes…" provisions of the CCPR that work to improve cultural and linguistic competence. "The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. "The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually."

Cultural Competence Plan provisions in this section include but are not limited to the following: strategies and objectives, cultural and linguistic assessments, resource listing of linguistically appropriate services, and cultural and linguistic training for mental health workers. MHPs shall have a statewide, toll-free number, oral interpreters available, referrals for linguistic and cultural services the MHP does not provide, policies and procedures to assist beneficiaries who need interpreters in non-threshold languages, and general program literature in threshold languages

**CCR, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2: Definitions, Section 3200.100.** Cultural Competence. This section provides an in depth definition of "Cultural Competence". It identifies nine goals to incorporate in all aspects of policy-making, program design, administration and service delivery and assist in the development of an infrastructure of a service, program or system, as necessary in achieving these goals.

**California State Statute Cont.**

**CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2, Definitions, Section 3200.210.** "Linguistic Competence" means organizations and individuals working within the system are able to communicate effectively and covey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures, and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy needs of the populations being served.

**CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 3, General Requirements, Section 3300.** Community Program Planning Process. This section provides requirements related to designated positions for community planning processes and details minimum Community Program Planning Process requirements. The planning process shall include opportunities for stakeholder participation of "unserved and/or underserved populations" and their family members as well as to "stakeholders who reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity."

**California Code of Regulations Cont.**

**CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 6, General Requirements, Section 3610 (b)(1).** General Community Services and Supports. "The County shall conduct outreach to provide equal opportunities for peers who share the diverse race/ethnic, cultural, and linguistic characteristics of the individuals/clients served."

**MHSA Component Guidelines**

Prevention and Early Intervention: Cultural Competence
"Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore cultural competence must be emphasized in PEI programs."
Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, and administration and service delivery. (Source: PEI, 2007, p. 2).

Workforce Education and Training: Cultural Competence
Guides counties for the "development and implementation of recruitment, retention and promotion strategies for providing equal employment opportunities to administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic cultural and linguistic characteristics of individuals with severe mental illness/emotional disturbance in the community." "Staff, contractors and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and /or linguistic population or community they serve." (Source: WET, 2007, p.4-5)

Workforce Education and Training: Objectives in the Five Year Plan
Guides counties in the "development of strategies for the meaningful inclusion of individuals with mental health client and family member experience, and incorporate their viewpoints and experiences in all training and education programs." (Source: WET, 2007, p.6)

Workforce Education and Training: Workforce Needs Assessment
Guides counties to "establish a current, standardized baseline set of workforce data that depicts personnel shortages and the needs of ethnic/racial and culturally underrepresented populations." (Source: WET, 2007, p.11)

**Federal Statute**

Title VI of the Civil Rights Act of 1964-"No person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (42 U.S.C. 2000d).

As pertains to language access: Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, all MHPs must ensure that all Medi-Cal LEP members have equal access to all mental health care.

**Federal Statute (Cont.)**

Executive Order 13160 of June 23, 2000. Nondiscrimination on the Basis of Race, Sex, Color, National Origin, Disability, Religion, Age, Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs. To ensure that persons with limited English skills can effectively access critical health and social services, the Office of Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills.
As pertains to language assistance to persons with limited English proficiency (LEP). The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of

1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law.

Title 42 – The Public Health and Welfare, Chapter 126, Equal Opportunity For Individuals with Disabilities Section 12101. Findings and Purpose. [Section 2}
-- to provide a clear and comprehensive national mandate, and a strong, consistent, enforceable standard, for the elimination of and addressing discrimination against individuals with disabilities. The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.

**Federal Standards/Guidelines**

U. S. Department of Health and Human Services, Office of Minority Health (OMH), National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. These national standards were to respond to: 1) the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, and 2) a means to correct inequities that currently exist in the provision of health service and to make these services more responsive to the individual needs of all consumers. CLAS mandates (Standards 4, 5, 6, and 7) are current federal requirements for all recipients of Federal funds. Standards 1,2,3,8,9,10,11,12, and 13 are CLAS guidelines and are recommended by OMH for adoption as mandates for Federal, State, and national accrediting agencies. OMH recommends CLAS Standard 14 for adoption by healthcare organizations.

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/underrepresented Racial/Ethnic Groups –Final report from working groups on cultural competence in managed Mental Health Care Services. Prepared by Western Interstate Commission for Higher Education. (These standards have not been mandated by CMHS.)

**DMH Letter**

DMH Information Notice: 94-17 issued on December 7, 1994 -- requests all counties applying to become a Mental Health Plan to submit a written Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation by January 1, 1995. Counties were required to describe the process they would implement to improve cultural competence and age-appropriate services to Medi-Cal beneficiaries.

**Federal Waiver Request**

DMH Waiver Request Submission to Health Care Financing Administration (HCFA) states: MHPs will be required to develop and implement a plan for the provision of culturally competent and age appropriate services to beneficiaries. At a minimum this plan must include maintaining a statewide 800 number with linguistic capability that is available 24 hours a day, and must include goals for improving cultural competence. DMH will establish a task force to address linguistic and cultural competence issues and may set additional statewide requirements for MHPs as a result of task force findings and recommendations.

## DEFINITIONS

### BILINGUAL STAFF
Bilingual staff members have language capacity in both English and the specific non-English languages used by cultural groups in the target community.

### CLIENT/CONSUMER
Client/consumer is a person with lived experience of mental health issues. (*Source: California Network of Mental Health Clients*, 2002).

### COMMUNITY-DEFINED EVIDENCE
"Community-defined evidence" is a "set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community." *(Source: Martinez (2008), The Newsletter of the National Latina/o Psychological Association, page 9).*

### COMMUNITY ENGAGEMENT
Community engagement has been defined over the last two decades in multiple, evolving ways (1). One definition of community engagement is "the process of working collaboratively with relevant partners who share common goals and interests" (2). It involves "building authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the 'win-win' possibility" in the collaborative project (3). The emphasis on community engagement promotes a focus on common ground and recognizes that communities have important knowledge and valuable experience to add to the public stakeholder input debate.

### CULTURAL BROKERS
Cultural brokers may be State and county officials working within county Mental Health Departments (such as Cultural Competence/Ethnic Service Managers) or outside county Mental Health Departments (such as public health, social services, and education) who have prior knowledge and trusting relationships with particular communities. In addition, cultural brokers may be community activists, advocates working at the State or county level, as well as county or State level non-governmental organizations (with established trust and credibility in particular communities). For Native American communities in particular, contact with appropriate tribal organization leaders is a critical first-step (*Source:* University of California, Davis, Center for Reducing Health Disparities and CA Department of Mental Health (2007). *Building Partnerships: Key Considerations When Engaging Underserved Communities Under the MHSA, UC Davis CRHD and DMH,* Page 3).

**CULTURAL COMPETENCE**
Cultural competence is a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations (Adapted from Cross et al, 1989). (See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.100, Cultural Competence)

**ENGLISH PROFICIENCY**
Level at which a person can understand English and respond in English to explain their behavioral healthcare problems, express their treatment preferences and understand the treatment plan.

**ETHNIC DISPARITY**
The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**EVIDENCE BASED PRACTICE**
Evidence based practice is a prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**FAMILY MEMBER**
A family member is a parent or caretaker of a child, youth, adult, or older adult, who is currently utilizing, or has previously, utilized mental health services. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**GATEKEEPER**
“Gatekeeper” means those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk for mental health problems or suicide and refer them to treatment or supporting services as appropriate.

**HISTORICAL DISPARITIES**
Historical disparities have been consistently found in and continue to exist among California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American. Any other population group(s) targeted in a county plan must be clearly defined with demonstrated evidence and supporting data to target them as having historical disparities in unserved, underserved and inappropriately served in mental health services. (Source: MHSOAC, (2008). *Cultural & Linguistic Competence Technical Resource Group Workplan*.)

**INTERPRETERS**
Interpreters are individuals with specific language skills and knowledge of health care terminology who are trained to communicate effectively with persons with limited proficiency with the English language.

**INTERPRETER SERVICES**
Interpreter services are methods in place to assist persons with limited English proficiency. This includes telephone interpreter services ("language lines"), interpreters obtained from a central listing maintained by agency or other source, trained volunteers from a target community with identified language skills.

**KEY POINTS OF CONTACT (MANDATED/NON-MANDATED)**
"Common points of access to Specialty Mental Health Services from the MHP, including, but not limited to, the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP." (Source: CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410, Cultural and Linguistic Requirements)

**LIMITED ENGLISH PROFICIENT (LEP)**
A diminished level of English language skills that calls into question the person's ability to understand and respond to issues related to their treatment.

**LINGUISTIC COMPETENCE**
The capacity of an organization and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of LEP, those who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that the structures, policies, procedures and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy and language needs of the population being served. *(*See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.210, Linguistic Competence.)

**LINGUISTICALLY PROFICIENT**
A linguistically proficient person is a person who meets the level of proficiency in the threshold languages as determined by the MHP.

**MEDI-CAL BENEFICIARIES**
Any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001.

**NON-TRADITIONAL MENTAL HEALTH SETTINGS**
"Non traditional mental health settings" means systems and organizations not traditionally defined as mental health; i.e., school and early childhood settings, primary health care systems including community clinics and health centers, and community settings with demonstrated track records of effectively serving ethnically diverse and unserved or underserved populations.

**PENETRATION RATE**
The total number of persons served divided by the number of persons eligible.

**PREVALENCE**
The number of cases of the condition present in a defined population at a specified time or in a specified time interval (e.g., the total number of cases with a specific disease or condition, such as ischemic heart disease, at a given time divided by the total population at that time) (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**PRIMARY LANGUAGE**
That language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

**PROMISING PRACTICE**
"Promising Practice" means programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. It has an evaluation design in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

**RECOVERY**
Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**RESILIENCE**
Resilience means the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school, and in the community, mental health programs, and interventions that teach good problem solving skills, optimism, and hope can build and enhance resilience in children. *(Source: California Family Partnership Association, (2005).* (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**RETENTION RATE**
A retention rate is the percent of new clients who receive 2, 3, 4, etc. follow-up day or outpatient services following an initial non-crisis contact with the mental health system. This measures the rate at which new clients in general are retained in the system for treatment.

**SMALL COUNTY**
Per California Code of Regulations Section 3200.260, "'Small County' means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance data."

**SPECIALTY MENTAL HEALTH SERVICES**
Includes the following: rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

**STAFF DIVERSITY**
Staff who are representative of the diverse demographic population of the service area and including the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. (*Source: CLAS, Final Report, Page 8*).

**TARGET POPULATION**
That part of the general population designated as the population to be served by the administrative or service delivery entity. (*Source: Chambers, Final Report: 2008: Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care, Page 42)* **Note**: DMH recognizes each MHSA component has its own identified target population(s).

**THRESHOLD LANGUAGE**
The annual numeric identification on a countywide basis, of 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

**TRANSLATION SERVICES**
Translation services are those services that require "The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language. **Note:** Translation refers to written conversions from one language into a second language, while interpreting refers to the conversion of spoken or verbal communication from one language into a second language.)" (Source: California Healthcare Interpreters Association, 2002)

**UNDERSERVED**
Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences (Source: Department of Mental Health *(2002) Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**UNSERVED**
Persons who may have serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of underserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth existing the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian Rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**WELLNESS**
A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

**REFERENCES**

California Department of Mental Health, (2002). *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*. Retrieved from http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf

California Family Partnership Association (2005). *Definitions and Acronyms*. Retrieved at http://www.co.tulare.ca.us/civica/filebank/blobdload.asp?BlobID=3871

California Healthcare Interpreters Association (2002). *California Standards for Healthcare Interpreters Ethical Principles, Protocols, and Guidance on Roles & Intervention. Retrieved from http://www.fachc.org/pdf/mig_ca_standards_healthcare_interpreters.pdf*

California Institute for Mental Health (2002). *Many Voices, One Direction: Building A Common Agenda For Cultural Competence In Mental Health – A Report to the Community*

California Mental Health Directors Association (2005) *Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities*

California Mental Health Planning Council (2003). *California Mental Health Master Plan: A Vision for California*

Chambers, Ethel D., Haugland, Gary, & Siegel, Carole (2002). *Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care: A Project to Select and Benchmark Performance Measures of Cultural Competency*

Chambers, Ethel D., Haugland, Gary, & Siegel, Carole (2004). *Cultural Competency Assessment Scale with Instructions: Outpatient Service Delivery Agency Level*

Cross et. al & CASSP Technical Assistance Center & Georgetown University Child Development Center (1989). *Towards a Culturally Competent System of Care, Volume I: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*

Fernandopulle, Anushka & Satterwhite, Frank J. Omowale (2007). *Cultural Competency in Capacity Building*

Harper, Maya, Hernandez, Mario at al, (2006) *Organizational Cultural Competence: A Review of Assessment Protocols.*

Institute of Medicine of the National Academies (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*

Institute of Medicine of the National Academies (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*

Jackson, Vivian H., Lopez, Luisa (1999). *Cultural Competency in Manager Behavioral Healthcare*

Lonner, Thomas D. (2007). *Encouraging More Culturally & Linguistically Competent Practices in Mainstream Health Care Organizations: A Survival Guide for Change Agents*

Martinez, K., Community Defined Evidence Project Writing Group (2008). *Community Defined Evidence: What is it? And what can it do for Latinas/o? The Newsletter of the National Latina/o Psychological Association*

Mayeno, Laurin Y. (2007). *Multicultural Organizational Development: A Resource for Health Equity*

MHSOAC, (2008). *Cultural and Linguistic Competence Technical Resource Group Workplan February 2008.* Retrieved at http://www.dmh.ca.gov/MHSOAC/docs/OversightAcctCommittee/CLCTRG_WrkplnFinal.pdf

National Center for Cultural Competence, 2006 *A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument*

PEI (2007). *Mental Health Services Act Proposed Guidelines Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan.* Retrieved at http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure1.pdf

Sue, Derald Wing, et al. (1998). *Multicultural Counseling Competencies: Individual and Organizational Development*

The Lewin Group, Inc. (2002). *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*

The President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*

University of California, Davis, Center for Reducing Health Disparities and CA Department of Mental Health (2007). *Building Partnerships: Key Considerations When Engaging Underserved Communities Under the MHSA.*

University of South Florida (2006). *Organizational Cultural Competence: A Review of Assessment Protocols*

U.S. Department of Health and Human Services (2001). *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*

U.S. Department of Health and Human Services, Office of Minority Health (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary*

U.S. Department of Health and Human Services, Office of Minority Health (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*

WET (2007). *Mental Health Services Act Workforce Education and Training Proposed Guidelines: Workforce Education and Training Component of the Three-Year Program and Expenditure Plan for Fiscal years 2006-07, 2007-08, 2008-09*. Retrieved at http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-14_Enclosure1A.pdf