

## COVER SHEET<sup>1</sup>

An original hard copy, and a compact disc of this report  
(Saved in PDF and Microsoft Word format)

Due July 28, 2015

*Department of Health Care Services, Mental Health and Substance Use Disorder  
Division (MHSUDS), Quality Assurance Section  
1500 Capitol Ave.  
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 2014 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 COMMITTEE WITHIN THE COUNTY MENTAL HEALTH  
SYSTEM**
- **CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES**
- **CRITERION 6: COMMITMENT TO GROWING A MULTICULTURAL  
WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY  
COMPETENT STAFF**
- **CRITERION 7: LANGUAGE CAPACITY**
- **CRITERION 8: ADAPTATION OF SERVICES**

<sup>1</sup> DMH Information Notice No. 10-02

## Purpose

The Cultural Competence Plan Requirements (CCPR) per Title 9 California Code of Regulations §1810.410 provide updated 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 (2014) seeks to support full system planning and integration. This revised CCPR (2014) includes the most current resources and standards<sup>2</sup> 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/ inappropriately served populations.

The revised CCPRs (2014) work 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 "the 2010 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 (2014) serves as an outcome of these advances in the field of cultural competence. DHCS 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 (2014) serves to operationalize cultural competence at both the organizational and contractor(s) level.

The basis for the revised CCPR (2014) criteria is the U.S. Department of Health and Human Services, Office of Minority Health (2013) *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (CLAS) (See Federal Standards, page 40 of this CCPR). Specifically, the 15 standards of CLAS were cross-walked<sup>3</sup> with the CCPR. The revised CCPR (2014) criteria were developed from a compilation of the CCPR (2002) (2010), CLAS<sup>4</sup>, and other current cultural competence organizational assessment tools (see attached references). Combined, these documents incorporate eight domains that cover a system in its entirety:

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<sup>2</sup> <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

<sup>3</sup> CLAS and CCPR Cross-Walk (Attachment 1)

<sup>4</sup> Refer to References page 49-52

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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* <http://gaincc.org/data/files/CultCompProtocol.pdf>)

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  
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 identify areas the county need resources, supports, and leverage to support its efforts in operationalizing cultural competence.

The revised CCPR (2014) takes this into consideration and has focused on omitting reporting redundancies by improving the plan that will be applied to all programs throughout the system. Where applicable, the revised CCPR (2014) requires copies or updates of areas already addressed in the 2010 CCPR and 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 (2014).*

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

This revised CCPR (2014) includes listings of required Federal and State statutes, regulations, and DHCS 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 34, 39).

**Timeframes**

The revised CCPR (2014) shall be submitted by each county to DHCS by July 28, 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 (2014) to the California Department of Health Care Services, Mental Health Services Division at [dhcs.ccpr@dhcs.ca.gov](mailto:dhcs.ccpr@dhcs.ca.gov).

**Directions for completing the revised CCPR (2014)**

The DHCS expects this revised CCPR (2014) 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(s)) and both county and contractor(s) are required to adhere to the plan. Throughout the revised CCPR (2014) are fields to be completed by the county, with recommendations for data to be submitted by both the county and the contractor(s).

The revised CCPR (2014) 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 DHCS, with timeframes for when the deficiencies will be addressed.

The DHCS will review the revised CCPR (2014) submission and will provide feedback to the counties.

An original copy, and a compact disc of this CCPR saved in PDF format and Microsoft Word format is due by July 28, 2015.

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 DHCS. Counties must meet the submission deadlines. If submission timelines cannot be met, counties shall notify DHCS ahead of time. Please email DHCS, MHSD, QA office at [dhcs.ccpr@dhcs.ca.gov](mailto:dhcs.ccpr@dhcs.ca.gov) 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.

- **Advance and Sustain Governance and Leadership that Promotes CLAS and Health Equity.** *(Enhanced CLAS Standard 2)*
- **Infuse CLAS Goals, Policies, and Management Accountability throughout the Organization's Planning and Operation.** *(Enhanced CLAS Standard 9)*

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>5</sup>.

**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, cultural, and linguistic diversity within the County Mental Health System and to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

**The county shall have the following available on site during the Program Oversight and Compliance review:**

- B. Copies of the following documents to ensure the commitment to cultural and linguistic competent services are reflected throughout the entire system:
1. Mission statement;
  2. Statements of philosophy;
  3. Governance and Leadership
  4. Strategic plans;
  5. Policy and procedure manuals;
  6. Human resource training and recruitment policies;
  7. Accountability policies and procedures (e.g., continuous quality improvement)

<sup>5</sup> Use Calendar Year for data submission

8. Contract requirements; and
9. Other key documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence for example Request for Proposal RFP).

## **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 and linguistic 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 identified 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 and linguistic 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 and linguistic competence responsibilities of the designated CC/ESM.

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

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

- A. Evidence of a budget dedicated to cultural and linguistic competent 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 county-identified racial, ethnic, culturally, and linguistically target populations;
  - 4. Culturally and linguistically appropriate mental health services; and
  - 5. If applicable, financial incentives for culturally and linguistically competent providers including non-traditional providers and/or natural healers.

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**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.

- **Collect and Maintain Demographic Data.** (Enhanced CLAS Standard 11)

**Note:** All counties may access 2007 200% of poverty data at the DHCS website on the following page: <http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf> within the link titled "Severe Mental Illness (SMI) Prevalence Rates" or more updated information if the MHP have locally.

Counties shall utilize the most current data offered by DHCS External Quality Review Organization (EQRO)([www.caleqro.com](http://www.caleqro.com)).

Counties may contact DHCS, Quality Assurance office, with questions or comments regarding EQRO data request. Please contact the department via email to [dhcs.ccpr@dhcs.ca.gov](mailto:dhcs.ccpr@dhcs.ca.gov).

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>6</sup>.

**I. General Population**

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

Summarize the county's general population<sup>7</sup> by race/ethnicity, age, gender, and language. 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).

**2.1 Total Population of (County's name)**

| <b>Gender</b>           | <b>Population</b> | <b>Percent</b> |
|-------------------------|-------------------|----------------|
| Male                    |                   |                |
| Female                  |                   |                |
| <b>Ethnicity</b>        | <b>Population</b> | <b>Percent</b> |
| White/Caucasian         |                   |                |
| Hispanic/Latino         |                   |                |
| Asian, Pacific Islander |                   |                |
| Black/African           |                   |                |

<sup>6</sup> Use Calendar Year for data submission

<sup>7</sup> Counties are encouraged to include TAY (16-25) population

|                         |  |  |
|-------------------------|--|--|
| American                |  |  |
| Native American         |  |  |
| Multi Race              |  |  |
| <b>Total Population</b> |  |  |

2.2 Total Population by Age Group

| <b>Age Group</b>              | <b>Population</b> | <b>Percent</b> |
|-------------------------------|-------------------|----------------|
| Youth Total Population (0-17) |                   |                |
| Adult Total Population (18+)  |                   |                |
| <b>Total Population</b>       |                   |                |

2.3 Youth Population (0-17)

| <b>Age</b>              | <b>Population</b> | <b>Percent</b> |
|-------------------------|-------------------|----------------|
| (00-05)                 |                   |                |
| (06-11)                 |                   |                |
| (12-17)                 |                   |                |
| <b>Gender</b>           | <b>Population</b> | <b>Percent</b> |
| Male                    |                   |                |
| Female                  |                   |                |
| <b>Ethnicity</b>        | <b>Population</b> | <b>Percent</b> |
| White/Caucasian         |                   |                |
| Hispanic/Latino         |                   |                |
| Asian, Pacific Islander |                   |                |
| Black/ African American |                   |                |
| Native American         |                   |                |
| Multi Race              |                   |                |
| Youth Total Pop.        |                   |                |

2.4 Adult Population (18+)

| <b>Age (18+)</b>         | <b>Population</b> | <b>Percent</b> |
|--------------------------|-------------------|----------------|
| 18-20                    |                   |                |
| 21-24                    |                   |                |
| 25-34                    |                   |                |
| 35-44                    |                   |                |
| 45-54                    |                   |                |
| 55-64                    |                   |                |
| 65+                      |                   |                |
| Total                    |                   |                |
| <b>Gender</b>            | <b>Population</b> | <b>Percent</b> |
| Male                     |                   |                |
| Female                   |                   |                |
| <b>Ethnicity</b>         | <b>Population</b> | <b>Percent</b> |
| White/Caucasian          |                   |                |
| Hispanic/Latino          |                   |                |
| Asian, Pacific Islander  |                   |                |
| Black / African American |                   |                |
| Native American          |                   |                |
| Multi Race               |                   |                |
| Adult Total Pop.         |                   |                |

2.5 Language

| <b>Language Name<sup>8</sup></b> | <b>Population</b> | <b>Percent</b> |
|----------------------------------|-------------------|----------------|
| Arabic                           |                   |                |
| Armenian                         |                   |                |
| Cambodian                        |                   |                |
| Cantonese                        |                   |                |
| English                          |                   |                |
| Farsi                            |                   |                |
| Hmong                            |                   |                |
| Korean                           |                   |                |
| Mandarin                         |                   |                |
| Other Chinese                    |                   |                |
| Russian                          |                   |                |
| Spanish                          |                   |                |
| Tagalog                          |                   |                |
| Vietnamese                       |                   |                |
| <b>Grand Total</b>               |                   |                |

- [http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB\\_Issue\\_Brief\\_Annual\\_Threshold\\_Language\\_Report.pdf](http://www.dhcs.ca.gov/dataandstats/statistics/Documents/RASB_Issue_Brief_Annual_Threshold_Language_Report.pdf)
- <http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf>
- <http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl2.pdf>
- <http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl3.pdf>

**II. Medi-Cal population service needs (Use current CAEQRO<sup>9</sup> data if available.)**

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

- A. Summarize Medi-Cal population and client utilization data by race, ethnicity, age, gender and language as published in most recent CAEQRO reports. Additional demographic categories, social/cultural groups and languages may be addressed as data is available and collected locally).

2.6

|                         | County Pop | Medi-Cal Eligible | Medi-Cal Beneficiaries Served | Penetration Rate Statewide | Penetration Rate |
|-------------------------|------------|-------------------|-------------------------------|----------------------------|------------------|
| <b>Race/Ethnicity</b>   |            |                   |                               |                            |                  |
| White/Caucasian         |            |                   |                               |                            |                  |
| Hispanic/Latino         |            |                   |                               |                            |                  |
| Black/African American  |            |                   |                               |                            |                  |
| Asian, Pacific Islander |            |                   |                               |                            |                  |
| Native American         |            |                   |                               |                            |                  |
| Multi Race              |            |                   |                               |                            |                  |
| <b>Total</b>            |            |                   |                               |                            |                  |
| <b>Age</b>              |            |                   |                               |                            |                  |
| 0-5                     |            |                   |                               |                            |                  |
| 6-17                    |            |                   |                               |                            |                  |

<sup>8</sup> Counties may include other language

<sup>9</sup> [calegro.com](http://calegro.com)

|                 |  |  |  |  |
|-----------------|--|--|--|--|
| 18-59           |  |  |  |  |
| 60+             |  |  |  |  |
| <b>Gender</b>   |  |  |  |  |
| Female          |  |  |  |  |
| Male            |  |  |  |  |
| <b>Language</b> |  |  |  |  |

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 Additional demographic categories , social/cultural groups and languages may be addressed as data is available and collected locally).

Counties may include a description of the county’s demographic categories, including but not limited to size of the county, threshold languages, unique characteristics, age, gender, and race/ethnicity.

2.7

| <b>Race/Ethnicity</b>   | <b>200% Poverty (minus Medi-Cal)</b> | <b>Clients Served “not covered by Medi-Cal”</b> |
|-------------------------|--------------------------------------|---|
| White/Caucasian         |                                      |   |
| Hispanic/Latino         |                                      |   |
| Black/African-American  |                                      |   |
| Asian, Pacific Islander |                                      |   |
| Native American         |                                      |   |
| <b>Age</b>              |                                      |   |
| 0-17                    |                                      |   |
| 18+                     |                                      |   |
| <b>Gender</b>           |                                      |   |
| Female                  |                                      |   |
| Male                    |                                      |   |
| <b>Language</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.

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

From the county’s FY 2014-2015, FY 2016-2017, 3 year program and expenditure CSS plan, extract a copy of the population assessment. If updates have been made to this adopted assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, age, gender, and language (other social/cultural groups may be addressed as data is available and collected locally).

Counties can provide an analysis of disparities as identified in the above summary.

2.8

| Ethnicity              | County Wide Estimated Total Population |   |   |   | County Wide Estimated Population Living at or Below 200% FPL |   |   |   |
|------------------------|--|---|---|---|--|---|---|---|
|                        |  |   |   |   |  |   |   |   |
|                        | N                                      | % | N | % | N  | % | N | % |
| Black/African American |  |   |   |   |  |   |   |   |
| Asian/Pacific Islander |  |   |   |   |  |   |   |   |
| Hispanic/Latino        |  |   |   |   |  |   |   |   |
| Native American        |  |   |   |   |  |   |   |   |
| White/Caucasian        |  |   |   |   |  |   |   |   |
| Total                  |  |   |   |   |  |   |   |   |

2.9

| Age Group    | County Wide Estimated Total Population |   |   |   | County Wide Estimated Population Living at or Below 200% FPL |   |   |   |
|--------------|--|---|---|---|--|---|---|---|
|              |  |   |   |   |  |   |   |   |
|              | N                                      | % | N | % | N  | % | N | % |
| Children     |  |   |   |   |  |   |   |   |
| TAY          |  |   |   |   |  |   |   |   |
| Adults       |  |   |   |   |  |   |   |   |
| Older Adults |  |   |   |   |  |   |   |   |
| Total        |  |   |   |   |  |   |   |   |

2.10

| Gender  | County Wide Estimated Total Population |   |   |   | County Wide Estimated Population Living at or Below 200% FPL |   |   |   |
|---------|--|---|---|---|--|---|---|---|
|         |  |   |   |   |  |   |   |   |
|         | N                                      | % | N | % | N  | % | N | % |
| Males   |  |   |   |   |  |   |   |   |
| Females |  |   |   |   |  |   |   |   |
| Total   |  |   |   |   |  |   |   |   |

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

2.11

| Clients Served by MHSA from FY to FY by Ethnicity |              |              |
|---|--------------|--------------|
| Ethnicity   | # of Clients | % of Clients |
| Black/African American                            |              |              |
| Asian/Pacific Islander                            |              |              |
| Hispanic/Latino                                   |              |              |
| Native American                                   |              |              |
| White/Caucasian                                   |              |              |
| Other than specified                              |              |              |
| Total   |              |              |

2.12

| Clients Served by MHSA from FY to FY by Age Group |              |              |
|---|--------------|--------------|
| Age Group   | # of Clients | % of Clients |
| Children  |              |              |
| TAY   |              |              |
| Adults  |              |              |
| Older Adults                                      |              |              |
| Total   |              |              |

2.13

| Clients Served by MHSAs from FY to FY by Gender |              |              |
|---|--------------|--------------|
| Gender  | # of Clients | % of Clients |
| Males   |              |              |
| Females   |              |              |
| Other   |              |              |
| Total   |              |              |

**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 and linguistic 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).

- **Conduct Organizational Assessments.** (*Enhanced CLAS Standard 10*)
- **Collect and Maintain Demographic Data.** (*Enhanced CLAS Standard 11*)
- **Conduct Assessments of Community Health Assets and Needs.** (*Enhanced CLAS Standard 12*)

**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:

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>10</sup>.

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

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

- A. Medi-Cal population
- B. Community Services Support (CSS) population: including Full Service Partnership population
- C. Workforce, Education, and Training (WET) population: Targets and achievements to grow a multicultural workforce
- D. Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations
- E. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).
- F. 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).

<sup>10</sup> Use Calendar Year for data submission

**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. MHS/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.*

- B. 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 2014 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 2014 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.

DRAFT

**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).

- **Partner with the Community.** *(Enhanced CLAS Standard 13)*
- **Communicate the Organization’s Progress in Implementing and Sustaining CLAS.** *(Enhanced CLAS Standard 15)*

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>11</sup>.

**I. The county has a Cultural Competence Committee, or other group that addresses cultural and linguistic 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 (place within the county organizational structure, organizational structure of the committee, 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

4.1

| Linguistic Access - Person Responsible Title | Workforce Development, Education & Training - Person Responsible Title | Partnership with Multicultural Communities - Person Responsible Title | Work Environment - Person Responsible Title | Governance, Systems and Policy - Person Responsible Title | Data Collection - Person Responsible Title | Inclusion Initiative (LGBTQ) - Person Responsible Title |
|--|--|---|---|---|--|---|
|  |  |   |   |   |  |   |

<sup>11</sup> Use Calendar Year for data submission

D. Committee membership roster listing member affiliation if any.

4.2

| Name | Organization/Agency | Email | Phone# | Self-Identified Membership Affiliation |
|------|---------------------|-------|--------|--|
|      |                     |       |        |  |

**II. The Cultural Competence Committee, or other group with responsibility for cultural and linguistic 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 (2014) 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?
      - a. If yes, explain why the county considers them successful.
      - b. If no, what are the next steps?
  - 2. Reviews and recommendations to county programs and services;
  - 3. Goals of cultural and linguistic competence plans;
  - 4. Human resources report;
  - 5. County organizational assessment;
  - 6. Training plans; and
  - 7. Other county activities, as necessary.

4.3

| Goals and Objectives | Tasks | Deliverable(s) | Timeline |
|----------------------|-------|----------------|----------|
|                      |       |                |          |
|                      |       |                |          |
|                      |       |                |          |

**Sources of Information:**

Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department.

DRAFT

**CRITERION 5****COUNTY MENTAL HEALTH PLAN 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).

- **Educate and Train Governance, Leadership, and Workforce in CLAS.** (*Enhanced CLAS Standard 4*)

**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.*

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>12</sup>.

**I. The county Mental Health Plan shall encourage all staff and contractors to receive cultural competence trainings.**

**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.

<sup>12</sup> Use Calendar Year for data submission

**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): (Include asking for the specific year the trainings were conducted?)

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
10. Religious and Spiritual population.

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

1. Communicating with and interviewing diverse individuals and families
2. Multicultural knowledge;
3. Cultural Sensitivity and awareness
4. Cultural formulation including diagnosis and treatment planning; 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

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

5.1

| Training Event | Description of Training | How long and often | Attendance by Function | Governance and Leadership | Non-direct Clinical Staff | No. of Attendees and Total | Date of Training | Name of Presenter |
|----------------|-------------------------|--------------------|------------------------|---------------------------|---------------------------|----------------------------|------------------|-------------------|
|                |                         |                    |                        |                           |                           |                            |                  |                   |

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

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

A. A Cultural Competence 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/posttests (Counties are encouraged to have a pre/posttest for every training);
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.(It isn't clear what this is supposed to mean or how counties would measure improvement of staff skills other than staff self-reporting, which would be subjective).

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/Family Member 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:
  1. Cultural concepts of distress (e.g., nervios);
  2. Explanatory models and treatment pathways (e.g., indigenous healers);
  3. Cultural features of the relationship between client and mental health provider;
  4. Trauma;
  5. Economic impact;
  6. Housing;
  7. Diagnosis/labeling;
  8. Medication;
  9. Hospitalization;
  10. Societal/familial/personal;
  11. Discrimination/stigma;
  12. Effects of culturally and linguistically incompetent services;
  13. Involuntary treatment;
  14. Wellness;
  15. Recovery; and
  16. Culture of being a mental health client, including the experience of having a mental illness and of 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:**

5.2

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

**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).

- **Recruit, Promote, and Support a Diverse Governance, Leadership, and Workforce.**  
( *Enhanced CLAS Standard 3* )

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>13</sup>.

**I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations<sup>14</sup>**

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

**Recruitment**

- I. Advertise job opportunities in targeted foreign language and minority health professional associations' job boards, publications, and other media (e.g., social media networks, professional organizations' email Listservs, etc.), and post information in multiple languages (QSource, 2005).
- II. Develop relationships with local schools, training programs, and faith-based organizations to expand recruitment base (QSource, 2005).
- III. Recruit at minority health fairs (QSource, 2005).
- IV. Collaborate with businesses, public school systems, and other stakeholders to build potential workforce capacities and recruit diverse staff. In particular, linkages between academic and service settings can help identify potential recruits already in the educational "pipeline" and provide them with additional academic support and resources necessary to meet job requirements (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004).

<sup>13</sup> Use Calendar Year for data submission

<sup>14</sup> <http://www.dhcs.ca.gov/services/MH/Documents/CCPRWETFindings.pdf>

- V. Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters.

**Promotion and Support**

The Joint Commission’s Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (2014) provides the following implementation strategies for the promotion and support of a diverse governance, leadership, and workforce:

- I. Create a work environment that respects and accommodates the cultural diversity of the local workforce.
  - II. Develop, maintain, and promote continuing education and career development opportunities so all staff members may progress within the organization.
  - III. Cultivate relationships with organizations and institutions that offer health and human service career training to establish volunteer, work-study, and internship programs.
- A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to Office of Statewide Health Planning and Development (OSHPD) for the Workforce Education and Training (WET) component.  
**Rationale:** Will ensure continuity across the County Mental Health System.

6.1

| Major Group and Positions                                       | Estimated # FTE authorized | Position hard to fill?<br>1=Yes<br>0 =No | # FTE estimated to meet in addition to # FTE authorized | Race/Ethnicity of FTEs currently in the workforce              |                 |                        |                         |                 |                     | # FTE filled | Threshold Language |
|---|----------------------------|--|---|--|-----------------|------------------------|-------------------------|-----------------|---------------------|--------------|--------------------|
|   |                            |  |   | White/Caucasian  | Hispanic/Latino | Black/African American | Asian, Pacific Islander | Native American | Multi Race or other |              |                    |
| 1   | 2                          | 3  | 4   | 5  | 6               | 7                      | 8                       | 9               | 10                  | 11           |                    |
| <b>B. Licensed Mental Health Staff (direct service):</b>        |                            |  |   |  |                 |                        |                         |                 |                     |              |                    |
| <b>County (employees, independent contractors, volunteers):</b> |                            |  |   |  |                 |                        |                         |                 |                     |              |                    |
| <b>Governance and Leadership</b>                                |                            |  |   |  |                 |                        |                         |                 |                     |              |                    |
| <b>Non-direct Staff</b>   |                            |  |   |  |                 |                        |                         |                 |                     |              |                    |
|   |                            |  |   | (Licensed Mental Health Direct Service Staff; Sub-Totals Only) |                 |                        |                         |                 |                     |              |                    |
| Sub-total, B (County)   |                            |  |   |  |                 |                        |                         | ↓               |                     |              |                    |

- 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.

6.2

| Race/Ethnicity          | County Population | Medi-Cal Population | 200% Population | WET Assessment   |              |                |                    |
|-------------------------|-------------------|---------------------|-----------------|------------------|--------------|----------------|--------------------|
|                         |                   |                     |                 | Consumers Served | County Staff | Direct Service | Non-Direct Service |
| White /Caucasian        |                   |                     |                 |                  |              |                |                    |
| Hispanic /Latino        |                   |                     |                 |                  |              |                |                    |
| Black/African-American  |                   |                     |                 |                  |              |                |                    |
| Asian, Pacific Islander |                   |                     |                 |                  |              |                |                    |
| Native American         |                   |                     |                 |                  |              |                |                    |
| Other                   |                   |                     |                 |                  |              |                |                    |

- C. If applicable, the county shall include in the CCPR Report , 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 Office of Statewide Health Planning and Development (OSHPD) (if applicable).
- D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

6.3

| Funding Category                       | Action Items | WET Strategies/Objectives |
|--|--------------|---------------------------|
| Workforce Staffing Support             |              |                           |
| Training & Technical Assistance        |              |                           |
| Mental Health Career Pathways Programs |              |                           |
| Residency, Internship Programs         |              |                           |
| Financial Incentive Programs           |              |                           |

- 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). Counties can access data for threshold language on DHCS website (<http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl2.pdf>).

- **Offer Communication and Language Assistance.** *(Enhanced CLAS Standard 5)*
- **Inform Individuals of the Availability of Language Assistance.** *(Enhanced CLAS Standard 6)*
- **Ensure the Competence of Individuals Providing Language Assistance.** *(Enhanced CLAS Standard 7)*
- **Provide Easy-to-Understand Materials and Signage.** *(Enhanced CLAS Standard 8)*
- **Increase bilingual workforce capacity.** *(Enhanced CLAS Standard 5)*

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**I. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.**

**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.

<sup>15</sup> Use Calendar Year for data submission

7.1

| Languages        | County Staff<br>(All FTE's <sup>16</sup> ) | CBO/Network<br>(All FTE's) | Total<br>Staff<br>(FTE's) | Total<br>Direct<br>Service<br>Staff<br>(FTE's) | Total<br>Clients | Total<br>Staff<br>FTE:<br>Client<br>Ratios | Direct<br>Service<br>Staff Only<br>FTE Client<br>Ratios |
|------------------|--|----------------------------|---------------------------|--|------------------|--|---|
| Arabic           |  |                            |                           |  |                  |  |   |
| Armenian         |  |                            |                           |  |                  |  |   |
| Cambodian        |  |                            |                           |  |                  |  |   |
| Cantonese        |  |                            |                           |  |                  |  |   |
| English          |  |                            |                           |  |                  |  |   |
| Farsi            |  |                            |                           |  |                  |  |   |
| Hmong            |  |                            |                           |  |                  |  |   |
| Korean           |  |                            |                           |  |                  |  |   |
| Mandarin         |  |                            |                           |  |                  |  |   |
| Other<br>Chinese |  |                            |                           |  |                  |  |   |
| Russian          |  |                            |                           |  |                  |  |   |
| Spanish          |  |                            |                           |  |                  |  |   |
| Tagalog          |  |                            |                           |  |                  |  |   |
| Vietnamese       |  |                            |                           |  |                  |  |   |

**II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services. “CLAS Standard 7 (2013) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided”.**

**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.

<sup>16</sup> FTE – Full Time Equivalent

- 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.**

***“CLAS Standard 6 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing”.***

***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. “CLAS Standard 8, Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area”.**

**The county shall have the following available for review during the Program Oversight and Compliance visit:**

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.
- A. Documented evidence in the clinical chart, that clinical findings/reports are communicated in
- a. Clients’ preferred language.
- B. Consumer satisfaction survey translated in threshold languages, including a summary report of
- a. The results (e.g., back translation and culturally appropriate field testing).
- C. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).
- D. 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).

- **Provide Effective, Equitable, Understandable, and Respectful Quality Care and Services.** (*Enhanced CLAS Standard Principle 1*)
- **Create Conflict and Grievance Resolution Processes.** (*Enhanced CLAS Standard 14*)

**Optional Demographic Data:** In this document DHCS requirement general demographic information as collected and published by the Mental Health Plans (MHPs), depending on the source of their information. We understand that Mental Health Plans (MHPs) may collect additional, more in-depth demographic information not reflected in the broader categories, examples are provided in the Proposed Prevention and Early Intervention Regulations, such as sub categories for Hispanic/Latino and non-Hispanic/Latino Ethnicities, sexual orientation, gender identity, veteran status, disability, or any other data the county consider relevant. We encourage MHPs to please submit additional demographic information and attach them to the CCPR in the appendix section<sup>17</sup>.

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

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

- A. List and describe the county's/agencies 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(s) 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(s) and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

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<sup>17</sup> Use Calendar Year for data submission

(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:**

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. Grievance and Appeals Resolution Processes<sup>18</sup>: The county should describe their beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve Grievance and Appeals. They should both develop a clear process to address instances of appeals and grievances that include follow-up and ensures that the individual is contacted with a resolution and next steps as well as monitor the beneficiary problem resolution processes as part of the quality assurance program. For example, describe how data is analyzed and any comparison rates between the general beneficiary population and the county identified racial, ethnic, cultural, and linguistic beneficiaries. MHPs may follow strategies for implementation as referenced in the enhanced CLAS standard:
- Provide cross-cultural communication training, including how to work with an interpreter, and conflict resolution training to staff who handle conflicts, complaints, and feedback.
  - Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance.
  - Develop a clear process to address instances of conflict and grievance that includes follow-up and ensures that the individual is contacted with a resolution and next steps (QSource, 2005).
  - Obtain feedback via focus groups, community council or town hall meetings, meetings with community leaders, suggestion and comment systems, open houses, and/or listening sessions.
  - Hire patient advocates or ombudspersons (QSource, 2005).
  - Include oversight of conflict and grievance resolution processes to ensure their cultural and linguistic appropriateness as part of the organization's overall quality assurance program.

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<sup>18</sup> This regulation refers to the Beneficiary Problem Resolution Process defined in Title 9, Sections 1850.206, 1850.207, 1850.208, 1850.209

**Title 9, CCR Section 1810.410 (b) (c) (d )(e)**

(b) Each MHP shall comply with the cultural competence and linguistic requirements included in this Section, the terms of the contract between the MHP and the Department, and the MHP's Cultural Competence Plan established pursuant to Subsection (c). The terms of the contract between the MHP and the Department may provide additional requirements for the Cultural Competence Plan, including a description of the acceptable data sources and requirements for arraying data for the components of the Cultural Competence Plan.

(c) Each MHP shall develop and implement a Cultural Competence Plan that includes the following components:

(1) Objectives and strategies for improving the MHP's cultural competence based on the assessments required in Subsection (c)(2) and the MHP's performance on the standards in Subsection (d).

(2) A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.

(3) A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services, pursuant to Section 1810.360 (f)(1).

(4) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

(d) The Department shall establish timelines for the submission and review of the Cultural Competence Plan described in Subsection (b) either as a component of the Implementation Plan process described in Section 1810.310 or as a term of the contract between the MHP and the Department. 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.

(e) Each MHP shall have:

(1) A statewide, toll-free telephone number as required by Section 1810.405(d).

(2) Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

(A) The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

(B) The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

(3) Policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the specialty mental health services or related services available through that key point of contact.

(4) General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.

**Note:** Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code. Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

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## California State Statute

**Welfare and Institutions Code (WIC), Section 4341** – “(d) The program shall give particular attention to areas of specific expertise where local programs and state hospitals have difficulty recruiting qualified staff, including programs for forensic persistently severely mentally ill children and youth, and severely mentally ill elderly persons. 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 service to the diverse population of the state.”

**WIC, Section 5600.2** – “To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable, and which include the following factors:...”

**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**—“To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority: .....

**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.** – “The State Department of Health Care Services shall require counties which receive funding to develop interagency collaboration with shared responsibilities for services under this part and achievement of the client and cost outcome goals and interagency collaboration goals specified”.

**WIC, Section 5813.5 (d)(3)** – “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.”

**WIC, Section 5820.** – “(a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses. (b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.....”

**California State Statute Cont.**

**WIC, Section 5822.** – “(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques. (i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.”

**WIC, Section 5840 (b)** – “The program shall include the following components: (4) Reduction in discrimination against people with mental illness. (e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.”

**WIC, Section 5848**– “(a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans...”

**WIC, Section 5855.** – “(f) Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery.

**WIC. Section 5865.** – “(b) A method to screen and identify children in the target population. County mental health staff shall consult with the representatives from special education, social services, and juvenile justice agencies, the mental health advisory board, family advocacy groups, and others as necessary to help identify all of the persons in the target populations, 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**—“(a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children’s system of care established pursuant to this part. 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 his or her family.”

**WIC. Section 5880.** -- (b) System development and operation measures, as follows: (6) 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) That mental health plans include a system of outreach to enable Medi-Cal beneficiaries and providers to participate in and access Medi-Cal specialty mental health services under the plans, consistent with existing law.”

**WIC, Section 14684** -- “(a) (9) Each mental health plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The mental health plan shall assess the cultural competency needs of the program. The mental health plan shall include, as part of the quality assurance program required by Section 14725, a process to accommodate the significant needs with reasonable timeliness. 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 State Statute Cont.**

**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.

**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 convey 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.”

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## 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.

**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.”

**Enhanced National CLAS Standards (2013)**

*The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)* are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United State. Think Cultural Health - CLAS & the CLAS Standards. (n.d.). Retrieved November 13, 2014, from <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

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## **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.

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

A term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter but, by itself, does not ensure the ability to interpret.

### 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.

[http://www.dhcs.ca.gov/services/MH/Documents/BP\\_Key\\_Considerations.pdf](http://www.dhcs.ca.gov/services/MH/Documents/BP_Key_Considerations.pdf)

### 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 DHCS, Page 3*).

[http://www.dhcs.ca.gov/services/MH/Documents/BP\\_Key\\_Considerations.pdf](http://www.dhcs.ca.gov/services/MH/Documents/BP_Key_Considerations.pdf)

### 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).

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

### 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*).

### **Ethnicity**

The Office of Management and Budget requires federal agencies to use a minimum of two ethnicities: Hispanic or Latino and Not Hispanic or Latino. Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*

## **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 Work plan.*)

## **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)**

Persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP person will benefit from an interpreter who will translate to and from the person’s primary language. An LEP person may also need documents written in English translated into his or her primary language.

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/>

## **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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

## **MEDI-CAL BENEFICIARIES**

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

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

## **NON-TRADITIONAL MENTAL HEALTH SETTINGS**

“Nontraditional 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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

## **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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

## **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*).

## **Race**

The Department of Health and Human Services and its agencies follow the racial categories developed by the Office of Management and Budget and used by the U.S. census. These categories generally reflect a social definition of race recognized in this country and are not an attempt to define race biologically, anthropologically, or genetically. People may choose to report more than one race to indicate their racial mixture, such as “American Indian and White.”

People who identify their origin as Hispanic, Latino, or Spanish may be of any race. Racial categories can include national origin or sociocultural groups.

Information on race is required for many federal programs and is important for making policy decisions, particularly for civil rights. States use these data to meet legislative redistricting principles. Race data also are used to promote equal employment opportunities and to assess environmental risks and racial disparities in health.

*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*

## **RACE/ETHNICITY**

### **White/Caucasian**

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

### **Hispanic/Latino**

The Census Bureau's 2010 census does provide a definition of the terms Latino or Hispanic and is as follows: "Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

### **Black/African American**

A person having origins in any of the Black racial groups of Africa.

### **Asian, Pacific Islander**

A person having origins in any of the original peoples of the Far East, Southeast Asian, the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

### **Native American**

A person having origins in any of the original peoples of North America, and who maintains a tribal affiliation or community attachment.

### **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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

### **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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

### **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:** DHCS recognizes each MHPA component has its own identified target population(s).

## **TAY**

Individuals between the ages of 16 and 25 years. They have unique service challenges because they are too old for child services but are often not ready or eligible for adult services. Individuals technically become adults at age 18 years, yet many young people today live with their parents into their 20s. Individuals who experience homelessness at this time in their lives do not have the same social supports as other youth and are usually on their own. Many do not have the skills needed to secure employment and housing.

<http://pathprogram.samhsa.gov/ResourceFiles/cyw4m4nr.pdf>

## **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.

[http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03\\_Enclosure.pdf](http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf)

## **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**

Clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of home placement or other serious consequences; members of ethnic racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American Rancherias and/or reservations who are not receiving sufficient services. Title 9, CCR, 3200.300

[http://www.mhsoac.ca.gov/meetings/docs/Meetings/2014/April/CFLC\\_041514\\_Tab3\\_WET5YrPlan.pdf](http://www.mhsoac.ca.gov/meetings/docs/Meetings/2014/April/CFLC_041514_Tab3_WET5YrPlan.pdf)

## **UNSERVED**

Those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved. Title 9, CCR, 3200.310.

[http://www.mhsoac.ca.gov/meetings/docs/Meetings/2014/April/CFLC\\_041514\\_Tab3\\_WET5YrPlan.pdf](http://www.mhsoac.ca.gov/meetings/docs/Meetings/2014/April/CFLC_041514_Tab3_WET5YrPlan.pdf)

## **UNSERVED/UNDERSERVED/INAPPROPRIATELY SERVED POPULATIONS**

Consumers of any age who have been diagnosed with a severe mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. These consumers

include, but are not limited to those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor engagement and outreach, limited language access and lack of culturally competent services. Example: African-American, Asian Pacific Islander (API), Hispanic, Native American, South and Southeast Asian, Lesbian Gay Bi-Sexual Transgender Intersex Queer Questioning 2-Spirit (LGBTIQQ2-S), Transitional Age Youth (TAY) and Older Adults.

[http://www.acbhcs.org/Internships/docs/2014/Grad Intern Stipend Application.pdf](http://www.acbhcs.org/Internships/docs/2014/Grad_Intern_Stipend_Application.pdf)

## **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*).

DRAFT

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**Principal Standard:**

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

**Governance, Leadership, and Workforce:**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Communication and Language Assistance:**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred

language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

**Engagement, Continuous Improvement, and Accountability:**

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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