California Department of Mental Health Cultural Competence Plan Requirements
CCPR Modification

COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due May 16, 2011 to:

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

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CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS MODIFICATION (2010) 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 COMMNITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM**

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

☒ **CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY**

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☒ **CRITERION 8: ADAPTATION OF SERVICES**

YOLO COUNTY
DEPARTMENT OF ALCOHOL, DRUG AND MENTAL HEALTH

CULTURAL COMPETENCY PLAN 2O11

(Modification 2010 Criteria)

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Criterion 1:

Commitment to Cultural Competence

I. County Mental Health System commitment to cultural competence
***The county shall have the following available on site during the compliance review**:*
A. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policy and Procedure Manuals;
5. Other Key Documents (Counties may chose to include additional documents to show system-wide commitment to cultural and linguistic competence).

Mission statement:

The mission of Yolo County Department of Alcohol, Drug and Mental Health (ADMH) is to initiate, support, administer, and provide direct and contracted services that enhance the recovery from alcohol/drug abuse and dependence and debilitating effects of serious mental illness and severe emotional disturbance; and, to promote the emotional wellbeing, wellness and overall health of individuals and families in our community.

To accomplish this goal, services must be delivered in the least restrictive, fiscally responsible, most accessible environment within a coordinated system of care that is respectful of a person's family, language, heritage, and culture.

The above-referenced documents are available at our clinics and offices. Copies will be readily available during compliance review.

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

*The CCPR Modification (2010) 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. **Note:** The DMH recognizes some very small counties do not have contracts.*

***The county shall include the following in the CCPR Modification (2010)**:*

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

Excerpts from the narrative descriptions of the original Mental Health Services Act (MHSA) Community Services and Supports (CSS) Three-Year Program and Expenditure Plan are included here as **ATTACHMENT A,** demonstrating Yolo's efforts and intentions to reach out to diverse populations, including Latino, African American, Russian, Native American, and groups with unique needs and identities, such as homeless persons; lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals; and isolated rural populations.
The four original CSS programs implemented in FY 2006-07 (one in each age group of Children's, Transition-Age Youth, Adults and Older Adults) remain operational. In FY 09-10, when ADMH began implementation of its MHSA Prevention and Early Intervention (PEI) plan, CSS Program #!, the *Greater Capay Valley Children's Pilot Program*, was modified; the program was expanded to include the entire western rural area of the county and the services were divided between CSS and PEI components. The direct mental health service aspect formed the *Rural Children's Mental Health Program* under CSS, and the PEI program serving the large rural western area of Yolo County became known as the *Rural Children's Resiliency Program*.

B. A one page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.

Yolo County ADMH continues to offer open opportunities for individuals of all racial, cultural and ethnic communities to participate in its MHSA community stakeholder process. MHSA meeting notices and stakeholder communications are regularly sent to over 150 consumers, family members, community leaders, agency representatives, other stakeholders and staff. Over 40 agencies are represented as well. All posted public notices offer translation services, the offer itself being put forward in Spanish and Russian (threshold) languages. . Public postings have continued at treatment centers and local libraries, local newspaper notices, along with e-mail distributions and posting on ADMH's Website have been utilized to inform stakeholders of activities, upcoming meetings, and events.

Through January of the current fiscal year, the ADMH Cultural Competency Coordinator attended many racial, ethnic and culturally related events throughout the community, including those sponsored by the African American Community, the Latino Community, the Native American Community, and the Consumer Community. From these events, the Coordinator sot participation in the departments planning and the Cultural Competency Committee meetings.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

The agency's effort to reach out to under-represented cultural groups in our community at the onset of our MHSA CSS program implementation was notably successful. However, those efforts have been more recently impacted by the circumstances of the California economy. Over the past 2-1/2 years, the department's county staff level decreased **in excess of 50%.** Providing direct

service to address the needs of the client community has remained a priority. Layoffs, which follow civil service rules of seniority, cost the department several culturally and linguistically competent staff, including family member and consumer employees hired in recent years through MHSA. These fiscal circumstances resulted in fewer opportunities for out reach to additional individuals in need of mental health and related services. Yet throughout this time, the departmental priorities remain in tact: to provide direct services to the most seriously mentally ill in the community of Yolo County

In large measure, lessons learned include (1) developing county job classifications that are specific to linguistic and cultural needs and thereby creating more flexibility in times of layoff by revising job classifications to require these skills; and (2) that continued opportunities be provide for staff members to participate in culturally related activities of interest to them in the community with community partners and staff reports of the activities to the Cultural Competency Committee. It is anticipated that this will assist staff in continuing to build interest in the agency's commitment to cultural appropriate and diverse services, investment in the process and planning, and increase the community's involvement in ensuring that culturally appropriate mental health services are provided.

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

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

The county shall include the following in the CCPR Modification (2010):

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

Presently, Yolo County has designated Joan Beesley as the Cultural Competence/Ethnic Service Manager. This assignment has been modified since January 2011, due to staff shortages. The previous ADMH Cultural Competency Coordinator was reassigned to a unit providing direct clinical services, in light of the hiring freeze instituted by Yolo County in 2009. The nine member ADMH Management Team (Director, Medical Director, Clinical Deputy, Fiscal/Operations Deputy, Adult Program Manager, Children's Program Manager, Data/QA/IT Manager, MHSA/Cultural Competence Coordinator and Business Services Officer) shares responsibility for culturally competent and appropriate services and for promoting development of services that will meet the needs of Yolo County's racial, ethnic, cultural and linguistic populations.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR Modification (2010):

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:

1. Budget amount spend on Interpreter and translation services;
2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
3. Budget amount allocated towards outreach to racial and ethnic county-identified target populations;
4. Special budget for culturally appropriate mental health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

The ADMH budget for the current fiscal year, FY 10-11, includes the following expenditures for culturally competent activities and full time equivalent (FTE) staff:

1. Interpreter Services: 19.5 FTE are paid a bilingual pay supplement which allows direct service and administrative support staff to provide culturally appropriate services; annual expenditure is $21,424.
2. One FTE Benefits Specialist, who is bilingual/bicultural Spanish-speaking is dedicated to assisting the un-served, un-insured and/or poor mentally ill consumers to access benefits and services, thereby removing barriers to mental health treatment. Of those individuals assisted with benefits access over the last twelve months, 21% were homeless; 14% were Spanish-speaking; 1% were Russian-speaking. Annual expenditure is $76,460.
3. Language Line Services annual expenditure is $5,095.
4. Grant funding and contracts for services to facilitate transition from homelessness for Veterans and other homeless populations; annual expenditure is $33,014.
5. The Service Utilization Review (SUR) multi-disciplinary team includes all local agencies that provide services to SMI adults are held biweekly, thereby facilitating communication among providers and promoting treatment access to homeless and high-risk SMI populations.
6. Bilingual training in Functional Family Therapy is provided, annual expenditure is $48,000.
7. Supportive housing and related services from Turning Point Community Programs for FSP homeless and high risk populations; annual expenditure is $450,000.
    a. In addition, supportive services are provided for two MHSA transitional housing cooperatives for homeless and at-risk SMI populations; annual expenditure is $40,000.
8. Children's Resiliency PEI Programs, Rural and Urban, which promote increased access to Spanish-speaking populations in both area. Annual expenditure is $180,000 for the Rural Children's Program, and $515,606 for the Urban Children's Program.
9. Clinical training on improving services to homeless mentally ill in the community, was provided by Mark Raggins, MD, of The Village in Los Angeles County, in partnership with the local Yolo Chapter of National Alliance for the Mentally Ill (NAMI); expenditure of $2,000.

10. Internet-based continuing educational opportunities are provided to clinical and support staff through Essential Learning, including translator training and cultural competency classes funded by MHSA Workforce Education and Training; annual expenditure is $5,734,.
11. Cultural Competency Coordinator, 0.5 FTE (first seven months of the fiscal year) plus Supervision at 0.1 FTE; annual expenditure$57,150.
12. NorCal Center for Deafness, American Sign Language translation services contract; annual expenditure is $1,500.
13. The Adult Wellness Center offers programs influenced by clients and their cultures, including many consumer-run programs, such as:
    i. Group learning about various cultures' holiday celebrations
    ii. Preparing and sharing ethnic foods
    iii. Group learning about faith and heritage in various cultures
    iv. Consumer art and textiles, with cultural influences
    v. Understanding and respecting consumer culture
    vi. Adjusting to being a transition age youth with SMI
    vii. TAY sexual identity (LGBTQ issues)
    viii. TAY parenting

    The Adult Wellness Center is open to mental health clients' weekdays until 4:00 p.m. Many groups and activities are led by clients and peer staff.
14. Assertive Community Treatment (ACT) Program services from TeleCare, Inc. for FSP clients, including homeless and high-risk SMI clients returning to community living, and including day center services with culturally diverse programs. Total annual expenditure is $909,300.

Yolo County ADMH requires its contracted service providers to report information relating to cultural competency activities and trainings, as well as staff linguistic and cultural diversity, on an annual basis. Contract terms are set forth in **ATTACHMENT B** hereto.

Criterion 2:

Updated Assessment of Service Needs

I. General Population

The county shall include the following in the CCPR Modification (2010):
A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. 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). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.

For all data pertaining to Criterion 2, see complete FIGURE 1 (page 9) – Yolo County Population, Poverty, Prevalence and Medi-Cal Data.

FIGURE 1 EXCERPT: Column A—Yolo County General Population

	Column A Yolo County General Population 2007	
Age Distribution		
0-17 years	48,798	24.9%
18-54 years	111,660	57.0%
55+ years	35,386	18.1%
Total	**195,844**	**100.0%**
Race Ethnicity Distribution		
Alaskan Native/American Indian	1,378	0.7%
Asian/Pacific Islander	23,917	12.2%
Black/African American	5,023	2.6%
Hispanic	54,766	28.0%
White	105,430	53.8%
Other/Unknown/Multiracial	5,330	2.7%
Total	**195,844**	**100.0%**
Gender Distribution		
Male	96,057	49.0%
Female	99,787	51.0%
	195,844	**100.0%**

As shown in Figure 1, the total Yolo County Population (2007 data) is 195,844. The age distribution shows that 24.9% are under the age of majority; 57.0% are between 18 and 54 years of age; and 18.1% are aged 55 or over. White Non-Hispanic, comprising 53.8%, and Hispanic, comprising 28.0%, represent the majority races in the county. Of the total county population, the majority are females (51% female; 49% male).

Figure 1 Yolo County Population, Poverty, Prevalence and Medi-Cal Data **DRAFT**

	A	B	C	D	E	F	G	H	I	J	K	L
	Yolo County Population 2007	Yolo County <200% of Poverty Population	Yolo County Medi-Cal Eligible Population FY 2009-10	SMI/SED Prevalence Estimate of <200% Poverty Reported 2004	ADMH Clients (All <200% of Poverty)	Ratio ADMH Clients to <200% of Poverty Population (E/B)	Ratio ADMH Clients to SMI/SED Prevalence Estimate (E/D)	ADMH Clients With Medi-Cal	Ratio ADMH Clients with Medi-Cal to Yolo County Total Medi-Cal Eligible Population (H/C)	ADMH Clients Without Medi-Cal (E-H)	<200% of Poverty Minus Total County Medi-Cal Eligible Population (B-C)	Ratio ADMH Clients w/out Medi-Cal to <200% of Poverty Minus Medi-Cal Eligible Population (J/K)
Age												
0-17 years	48,798	19,252	14,384	1,672	812	4.2%	48.6%	628	4.4%	184	4,868	3.8%
18-54 years	111,660	40,281	12,414	3,950	2,134	5.3%	54.0%	1,206	9.7%	928	27,867	3.3%
55+ years (See footnote 1)	35,386	8,074	4,473	509	598	7.4%	117.5%	387	8.7%	211	3,601	5.9%
Total	195,844	67,607	31,271	6,131	3,544	5.2%	57.8%	2,221	7.1%	1,323	36,336	3.6%
Race/Ethnicity												
AK, Native/American Indian	1,378	383	277	45	35	9.1%	77.8%	17	6.1%	18	106	17.0%
Asian/Pacific Islander	23,917	11,668	2,221	974	155	1.3%	15.9%	109	4.9%	46	9,447	0.5%
Black/African American	5,023	2,195	1,443	144	220	10.0%	152.8%	153	10.6%	67	752	8.9%
Hispanic	54,766	23,462	14,882	1,955	423	1.8%	21.6%	292	2.0%	131	8,580	1.5%
White	105,430	27,744	9,381	2,754	2,388	8.6%	86.7%	1,463	15.6%	925	18,363	5.0%
Other/Unknown/Multiracial	5,330	2,155	3,097	259	323	15.0%	124.7%	187	6.1%	136	-942	-14.5% See #3
Total	195,844	67,607	31,271	6,131	3,544	5.2%	57.8%	2,221	7.1%	1,323	36,336	3.6%
Gender Distribution												
Male	96,057	31,918	13,676	2,369	1,622	5.1%	68.5%	1,020	7.5%	602	18,242	3.3%
Female	99,787	35,689	17,595	3,762	1,922	5.4%	51.1%	1,201	6.8%	721	18,094	4.0%
Total	195,844	67,607	31,271	6,131	3,544	5.2%	57.8%	2,221	7.1%	1,323	36,336	3.6%
Primary Language See footnote #2												
English			17,727	55.6%	3,126	88.2%		1,937	87.2%	10.9%	1,189	
Spanish			9,630	30.2%	215	6.1%		134	6.0%	1.4%	81	
Russian			1,808	5.7%	39	1.1%		30	1.4%	1.7%	9	
Other/Unknown			2,713	8.5%	164	4.6%		120	5.4%	4.4%	44	
Total			31,878	100.0%	3,544	100.0%		2,221	100.0%	7.0%	1,323	

Data Sources:

Column A. http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/Population_by_County/Yolo.pdf
CPES Estimates of Need for Mental Health Services for California, Yolo County (113) Chron MH imp7 D120-Agesq (w1xmhm2asq_3) for 2007
Department of Health Care Services. Number of Beneficiaries by County, 2003-2009. Report date July 2010.
http://www.dof.ca.gov/research/demographic/state/e-3/documents/2010Yolo.xls

Column B. CPES Estimates of Need for Mental Health Services for California, Yolo County (113) Chron MH imp7 D120-Agesq (w1xmhm2asq_3) for 2007

Column C. APS Healthcare Medi-Cal Approved Claims Data for Yolo County MHP Calendar Year 2009. Report prepared 5/12/2010; Language data provided by California DMH, Data Management Analysis of Medi-Cal Beneficiaries By Primary Language, Oct. 2009.

Column D. http://www.dmh.ca.gov/News/Reports_and_Data/default.asp Prevalence Table 2 Prevalence Estimates for Persons in Households <200% Poverty for 2000 Census Updated to July 2004.

Column E. ADMH Client Data from FY 2009-10; internal Avatar report prepared 5/05/2011

Column H. ADMH Client Data from FY 2009-10; internal Avatar report prepared 5/05/2011

1. Adult client population is divided from Older Adult population at age 55 in this table, although ADMH in its programs identifies Older Adult clients as those aged 60 and over. Age 55 is used as the age division here in the int
2. There was insufficient data available to provide a complete analysis of the primary language.
3. Anamolous result possibly a result of comparing latest 2004 prevalence estimates with FY 2009-10 Medi-Cal eligibility numbers

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

The county shall include the following in the CCPR Modification (2010):

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

1. The county's Medi-Cal population

2. The county's client utilization data

FIGURE 1 EXCERPT: Columns A, C, H and I—Medi-Cal Eligible Individuals

Figure 1 Yolo County Population, Poverty, Prevalence and Medi-Cal Data

EXCERPTED COLUMNS:	A		C		H		I
	Yolo County Population 2007		Yolo County Medi-Cal Eligible Population FY 2009-10		ADMH Clients With Medi-Cal		Ratio ADMH Clients with Medi-Cal to Yolo County Total Medi-Cal Eligible Population (H/C)
Age							
0-17 years	48,798	24.9%	14,384	46.0%	628	28.3%	4.4%
18-54 years	111,660	57.0%	12,414	39.7%	1,206	54.3%	9.7%
55+ years	35,386	18.1%	4,473	14.3%	387	17.4%	8.7%
Total	**195,844**	**100.0%**	**31,271**	**100.0%**	**2,221**	**100.0%**	**7.1%**
Race/Ethnicity							
AK. Native/Am. Indian	1,378	0.7%	277	0.9%	17	0.8%	6.1%
Asian/Pacific Islander	23,917	12.2%	2,221	7.1%	109	4.9%	4.9%
Black/African American	5,023	2.6%	1,443	4.6%	153	6.9%	10.6%
Hispanic	54,766	28.0%	14,882	47.6%	292	13.1%	2.0%
White	105,430	53.8%	9,381	30.0%	1,463	65.9%	15.6%
Other/Unknown/Multiracial	5,330	2.7%	3,067	9.8%	187	8.4%	6.1%
Total	**195,844**	**100.0%**	**31,271**	**100.0%**	**2,221**	**100.0%**	**7.1%**
Gender Distribution							
Male	96,057	49.0%	13,676	43.7%	1,020	45.9%	7.5%
Female	99,787	51.0%	17,595	56.3%	1,201	54.1%	6.8%
Total	**195,844**	**100.0%**	**31,271**	**100.0%**	**2,221**	**100.0%**	**7.1%**
Primary Language							
English			17,727	55.5%	1,937	87.2%	10.9%
Spanish			9,630	30.2%	134	6.0%	1.4%
Russian			1,808	5.7%	30	1.4%	1.7%
Other/Unknown			2,713	8.5%	120	5.4%	4.4%
Total			**31,878**	**100.0%**	**2,221**	**100.0%**	**7.0%**

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

With regard to data on ages of Medi-Cal eligible individuals in Yolo County, the most noteworthy observations relate to children. Seventy-five percent (75%) of Yolo County children aged 0 to 17, living in families earning less than 200% of

poverty level, have Medi-Cal. Though children age 17 and under represent nearly half of Yolo County's Medi-Cal eligible population, they represent slightly more than a fourth of the Medi-Cal clients receiving mental health services. Further, the overall average number of mental health clients with Medi-Cal as compared to the total Medi-Cal eligibles in the county (average rate of penetration) is 7.1%, while the penetration rate among children 0 to 17 receiving mental health services is 4.4%, the lowest among the age groups noted.

The penetration rate for mental health clients with Medi-Cal over age 55 is 8.7%, falling above the county average of 7.1%, but is not remarkably high. Adults age 18 to 54 comprise 39.7% of the total Medi-Cal eligible individuals, though 54.3% of the mental health clients with Medi-Cal receive the highest percentage of mental health treatment. In this age group these older adult ADMH clients represent nearly one-tenth of the total Medi-Cal eligibles countywide.

When reviewing race and ethnicity distribution data among Medi-Cal eligible individuals and Medi-Cal eligible individuals receiving mental health services in Yolo County, of note is that the percentage of Medi-Cal clients receiving mental health services is much higher than average for Whites (at 15.6%) and somewhat higher than average for Blacks (at 10.6%). Although the percentage of Alaska Natives/Native Americans, Asian/ Pacific Islanders, and Other or Unknown populations is below average, the most remarkably low numbers are represented by the Hispanic population. Hispanic individuals who are Medi-Cal eligible, numbering 14,882, represent nearly half of the county's total eligibles, yet only 2% of these—fewer than 300 people—are mental health clients. Similarly, eligible individuals who indicate Spanish as their primary language represent 30.2% of the total Medi-Cal eligible clients, yet only 134 of those clients (1.4%) received mental health services last year.

As regards gender, given the health care needs and eligibility criteria of pregnant women, it is logical that a greater number of Medi-Cal eligible individuals are female (females represent 56.3% of the total). It is noted that the gender gap is somewhat smaller when it comes to ADMH clients with Medi-Cal (where females represent only 54.1%).`

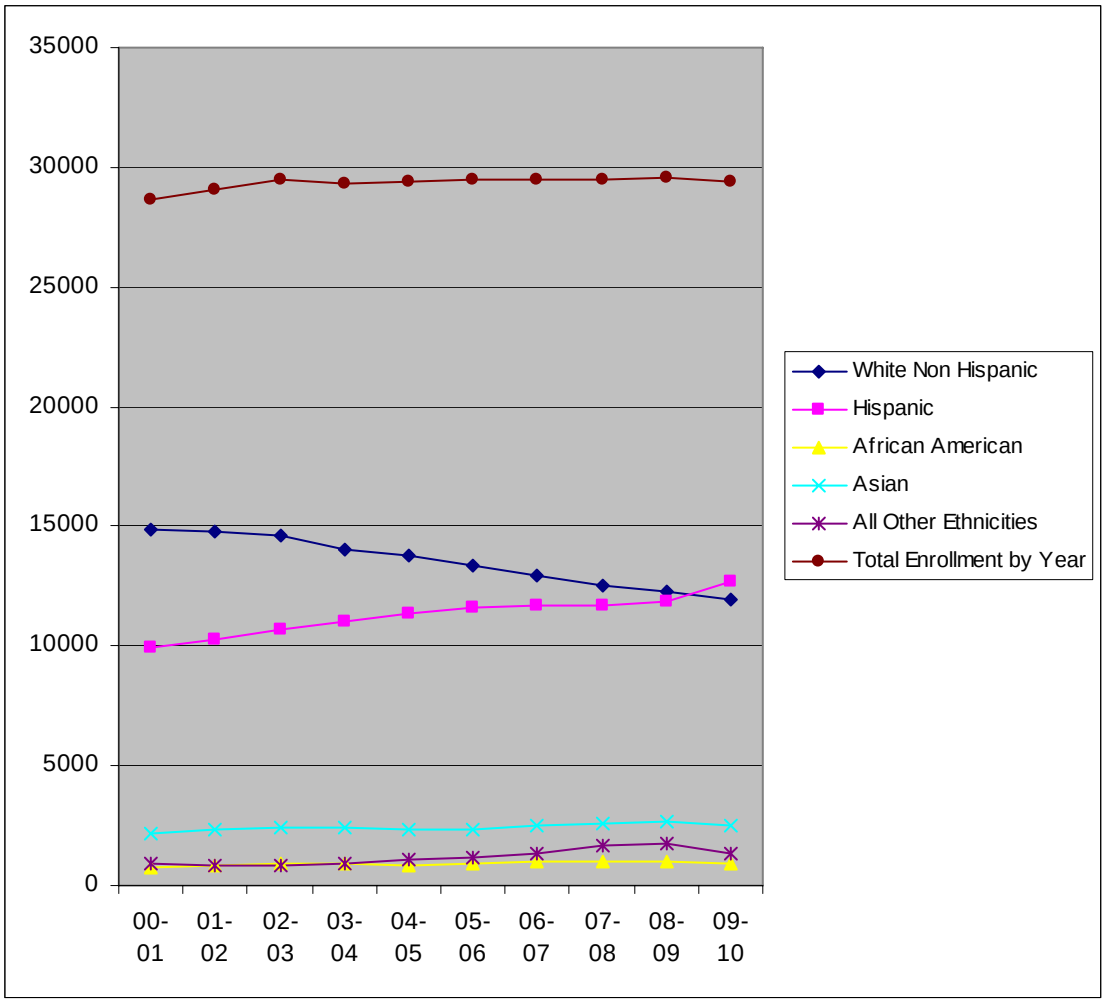
Clearly, in the distribution figures for Race/Ethnicity, Whites dominate the ADMH population (at 67.4%) whereas among the Yolo Medi-Cal population, Hispanics comprise 47.6% of the total eligible individuals. Of the possible factors, this discrepancy may be attributed to issues relating to access, identification of disability, Medi-Cal qualification, the economy, stigma around mental illness, and cultural beliefs.

An examination of Yolo County school enrollment data offers insight as to the ethnic makeup of the county's children. As set forth in **Figure 2: Yolo County School Enrollment by Ethnicity, 2000-2010**[1], in the 2009-10 school year, Hispanic children represented 12,683 of 29,440 total student enrollment (over 43%) in Yolo County schools, outnumbering all other ethnicities.

Figure 2

Yolo County School Enrollment by Ethnicity 2000-2010

Enrollment by Ethnicity	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10
White Non Hispanic	14866	14793	14577	14059	13743	13378	12980	12559	12285	11951
Hispanic	9907	10305	10716	10989	11368	11577	11704	11733	11860	12683
African American	768	834	915	904	876	930	1010	1007	1011	910
Asian	2184	2342	2433	2425	2369	2373	2492	2574	2649	2533
All Other Ethnicities	921	825	825	944	1073	1202	1297	1634	1786	1363
Total Enrollment by Year	28646	29099	29466	29321	29429	29460	29483	29507	29591	29440



[1] California Department of Education; Yolo County enrollment by ethnicity, school years 2000-01 through 2009-10, see http://data1.cde.ca.gov/dataquest/; reports extracted 5/4/11.

The accompanying graph of school enrollment by ethnicity over the past 10 years illustrates that countywide total annual enrollment is flat, with only about 2.7% growth since 2000. Noteworthy, however, are (1) the consistent increase in enrollment of Hispanic children (from 35% to 43% of total students—an 8% increase) over the past then years, and (2) the consistent decrease in enrollment of White Non Hispanic children (from 52% to just over 40% of total—an 8% decrease) in the corresponding period. In addition, over a comparable period, the U.S. Census Bureau estimates that in Yolo County, Hispanic residents of all ages comprised 25.9% of the total in 2000 and 28.5% in 2009—an increase from 43,707 residents to 54,933[2].

The preceding analysis suggests that in Yolo County, Hispanic children aged 17 and under, many of whom may be Spanish-speaking, are the most underserved population for mental health services among Medi-Cal eligible individuals. Enrollment trends among school-aged children show that the numbers of Hispanic students are on the rise, while other populations have either remained relatively stable or have decreased sharply (as with Non-Hispanic Whites). These trends suggest that among the most underrepresented age group of Medi-Cal eligible persons receiving mental health services (0 to 17), a dramatic demographic shift has occurred parallel to that among the student population. Among school-aged children, the Hispanic population is dramatically increasing and now represents the ethnic majority. Restated, this data suggests that in Yolo County, the most underrepresented age group among Medi-Cal clients receiving mental health services—children 0 to 17—is now dominated in number by the Hispanic population.

III. 200% of Poverty (minus Medi-Cal) population and service needs. (
The county shall include the following in the CCPR Modification (2010):

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

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[2] United States Census Bureau, http://factfinder.census.gov/home/saff/main.html?_lang=en; report updated 05/11/2011.

FIGURE 1 EXCERPT: Columns A through G – < 200% Poverty Population Including Medi-Cal Eligibles

Figure 1 Yolo County Population, Poverty, Prevalence and Medi-Cal Data

EXCERPTED COLUMNS:	A		B		C		D		E		F	G
	Yolo County Population 2007		Yolo County <200% of Poverty Population		Yolo County Medi-Cal Eligible Population FY 2009-10		SMI/SED Prevalence Estimate of <200% Poverty Reported 2004		ADMH Clients (All <200% of Poverty)		Ratio ADMH Clients to <200% of Poverty Population (E/B)	Ratio ADMH Clients to SMI/SED Prevalence Estimate (E/D)
Age												
0-17 years	48,798	24.9%	19,252	28.5%	14,384	46.0%	1,672	27.3%	812	22.9%	4.2%	48.6%
18-54 years	111,660	57.0%	40,281	59.6%	12,414	39.7%	3,950	64.4%	2134	60.2%	5.3%	54.0%
55+ years	35,386	18.1%	8,074	11.9%	4,473	14.3%	509	8.3%	598	16.9%	7.4%	117.5%
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	**6,131**	**100.0%**	**3544**	**100.0%**	**5.2%**	**57.8%**
Race/Ethnicity												
AK. Native/Am. Indian	1,378	0.7%	383	0.6%	277	0.9%	45	0.7%	35	1.0%	9.1%	77.8%
Asian/Pacific Islander	23,917	12.2%	11,668	17.3%	2,221	7.1%	974	15.9%	155	4.4%	1.3%	15.9%
Black/African American	5,023	2.6%	2,195	3.2%	1,443	4.6%	144	2.3%	220	6.2%	10.0%	152.8%
Hispanic	54,766	28.0%	23,462	34.7%	14,882	47.6%	1,955	31.9%	423	11.9%	1.8%	21.6%
White	105,430	53.8%	27,744	41.0%	9,381	30.0%	2,754	44.9%	2388	67.4%	8.6%	86.7%
Other/Unknown/Multiracial	5,330	2.7%	2,155	3.2%	3,067	9.8%	259	4.2%	323	9.1%	15.0%	124.7%
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	**6,131**	**100.0%**	**3,544**	**100.0%**	**5.2%**	**57.8%**
Gender Distribution												
Male	96,057	49.0%	31,918	47.2%	13,676	43.7%	2,369	38.6%	1,622	45.8%	5.1%	68.5%
Female	99,787	51.0%	35,689	52.8%	17,595	56.3%	3,762	61.4%	1,922	54.2%	5.4%	51.1%
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	**6,131**	**100.0%**	**3,544**	**100.0%**	**5.2%**	**57.8%**
Primary Language												
English					16,769	56.5%			3,126	88.2%		
Spanish					8,604	29.0%			215	6.1%		
Russian						0.0%			39	1.1%		
Other/Unknown					4,327	14.6%			164	4.6%		
Total					**29,700**	**100.0%**			**3,544**	**100.0%**		

A review of the demographic differences between populations living with household incomes under 200% of poverty (Column D) and the county's Medi-Cal eligible population (Column C) provides some interesting insights about levels of poverty in Yolo County. Note that among low income individuals, nearly 60% are in the 18 to 54 age group, the predominant race is White Non-Hispanic (41%) and there are somewhat more females than males. Among lower and no-income Medi-Cal eligibles, however, there is a bigger gap between the female and male populations (12.6%), the dominant age group is children 0 to 17, and the vast majority (47.6%) of individuals are Hispanic. When comparing the estimates of the prevalence of individuals with serious mental illness or serious emotional disturbances (SMI/SED) among the <200% of poverty population (Column D) to the total ADMH client population (Column E—note that income qualifications put all ADMH clients in the category of <200% of poverty), review of penetration figures (Column G—also an estimate) highlights that adults over age 55, Blacks and Whites, and males are over-represented relative to prevalence estimates. Stark by comparison is the gross underrepresentation of Asian-Pacific Islander (15.9%) and Hispanics (21.6%) among the ADMH population in

relation to SMI/SED Prevalence Estimates for the county. Overall, ADMH serves an estimated average of 57.8% of the estimated SMI/SED living on <200% poverty income.

FIGURE 1 EXCERPT: Columns B, C, E, H, J, K and L – < 200% Poverty Population Excluding Medi-Cal Eligibles

Figure 1 Yolo County Population, Poverty, Prevalence and Medi-Cal Data

EXCERPTED COLUMNS:	B		C		E		H		J	K	L
	Yolo County <200% of Poverty Population		Yolo County Medi-Cal Eligible Population FY 2009-10		ADMH Clients (All <200% of Poverty)		ADMH Clients With Medi-Cal		ADMH Clients Without Medi-Cal (E-H)	<200% of Poverty Minus Total County Medi-Cal Eligible Population (B-C)	Ratio ADMH Clients w/out Medi-Cal to <200% of Poverty Minus Medi-Cal Eligible Population (J/K)
Age											
0-17 years	19,252	28.5%	14,384	46.0%	812	22.9%	628	28.3%	184	4,868	3.8%
18-54 years	40,281	59.6%	12,414	39.7%	2134	60.2%	1,206	54.3%	928	27,867	3.3%
55+ years	8,074	11.9%	4,473	14.3%	598	16.9%	387	17.4%	211	3,601	5.9%
Total	**67,607**	**100.0%**	**31,271**	**100.0%**	**3544**	**100.0%**	**2,221**	**100.0%**	**1,323**	**36,336**	**3.6%**
Race/Ethnicity											
AK. Native/Am. Indian	383	0.6%	277	0.9%	35	1.0%	17	0.8%	18	106	17.0%
Asian/Pacific Islander	11,668	17.3%	2,221	7.1%	155	4.4%	109	4.9%	46	9,447	0.5%
Black/African American	2,195	3.2%	1,443	4.6%	220	6.2%	153	6.9%	67	752	8.9%
Hispanic	23,462	34.7%	14,882	47.6%	423	11.9%	292	13.1%	131	8,580	1.5%
White	27,744	41.0%	9,381	30.0%	2388	67.4%	1,463	65.9%	925	18,363	5.0%
Other/Unknown/Multiracial	2,155	3.2%	3,067	9.8%	323	9.1%	187	8.4%	136	-912	-14.9%
Total	**67,607**	**100.0%**	**31,271**	**100.0%**	**3,544**	**100.0%**	**2,221**	**100.0%**	**1,323**	**36,336**	**3.6%**
Gender Distribution											
Male	31,918	47.2%	13,676	43.7%	1,622	45.8%	1,020	45.9%	602	18,242	3.3%
Female	35,689	52.8%	17,595	56.3%	1,922	54.2%	1,201	54.1%	721	18,094	4.0%
Total	**67,607**	**100.0%**	**31,271**	**100.0%**	**3,544**	**100.0%**	**2,221**	**100.0%**	**1,323**	**36,336**	**3.6%**
Primary Language											
English			17,727	55.6%	3,126	88.2%	1,937	87.2%	1,189		
Spanish			9,630	30.2%	215	6.1%	134	6.0%	81		
Russian			1,808	5.7%	39	1.1%	30	1.4%	9		
Other/Unknown			2,713	8.5%	164	4.6%	120	5.4%	44		
Total			**31,878**	**100.0%**	**3,544**	**100.0%**	**2,221**	**100.0%**	**1,323**		

Essentially, the review of the <200 Poverty "Minus Medi-Cal" populations reaffirms observations previously made. For example, ADMH Clients who do not have Medi-Cal (i.e., "Minus Medi-Cal" clients who are SMI/SED and earn <200% Poverty) are also predominately adults aged 18 to 54 and White. Slightly more are male. An examination of the penetrate rate of ADMH "Minus Medi-Cal" clients to the <200% Poverty "Minus Medi-Cal" population shows a poor overall average penetration rate of 3.6% (as compared to 5.2% for the "Medi-Cal Included" population) and Asian-Pacific Islanders and Hispanics show the greatest gap in representation.

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

The county shall include the following in the CCPR Modification (2010):

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.

See **FIGURE 3** (next page), an excerpt of the Yolo MHSA Community Services and Supports Plan, and refer to Figure 1 Excerpt of Columns D, E and G below.

FIGURE 1 EXCERPT: Columns D, E and G – SMI/SED Prevalence Estimates and ADMH Client Data

Figure 1 Yolo County Population, Poverty, Prevalence and Medi-Cal Data

EXCERPTED COLUMNS:	D		E		G
	SMI/SED Prevalence Estimate of <200% Poverty Reported 2004		ADMH Clients (All <200% of Poverty)		Ratio ADMH Clients to SMI/SED Prevalence Estimate (E/D)
Age					
0-17 years	1,672	27.3%	812	22.9%	48.6%
18-54 years	3,950	64.4%	2134	60.2%	54.0%
55+ years	509	8.3%	598	16.9%	117.5%
Total	**6,131**	**100.0%**	**3544**	**100.0%**	**57.8%**
Race/Ethnicity					
AK. Native/Am. Indian	45	0.7%	35	1.0%	77.8%
Asian/Pacific Islander	974	15.9%	155	4.4%	15.9%
Black/African American	144	2.3%	220	6.2%	152.8%
Hispanic	1,955	31.9%	423	11.9%	21.6%
White	2,754	44.9%	2388	67.4%	86.7%
Other/Unknown/Multiracial	259	4.2%	323	9.1%	124.7%
Total	**6,131**	**100.0%**	**3,544**	**100.0%**	**57.8%**
Gender Distribution					
Male	2,369	38.6%	1,622	45.8%	68.5%
Female	3,762	61.4%	1,922	54.2%	51.1%
Total	**6,131**	**100.0%**	**3,544**	**100.0%**	**57.8%**
Primary Language					
English			3,126	88.2%	
Spanish			215	6.1%	
Russian			39	1.1%	
Other/Unknown			164	4.6%	
Total			**3,544**	**100.0%**	

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

A review of Figure 3 (see page 17 at bottom), Yolo County client and information and prevalence estimates from FY 2004-05 (included as Fig. 4 in the MHSA CSS Plan), and a comparison to the information contained in Figure 1 Excerpt, Columns D, G and E, and other pertinent population data, invites the following observations:

Yolo County Department of Alcohol, Drug, and Mental Health Services

Figure 4
Prevalence Rates

		Prevalence Estimates <200% poverty		Percent of Total Mental Health Consumers	Percent of Mental Health Consumers compared to the prevalence estimates	
		2004		FY 2004/05	FY 2004/05	
Total		6,131	100.0%		3,716	60.6%
Gender Distributions						
Male		2,369	38.6%	45.4%	1,688	71.3%
Female		3,762	61.4%	54.5%	2,025	53.8%
Age Distributions						
Youth	00-17	1,672	27.3%	30.9%	1,148	68.7%
00-05		*585*				
06-11		*591*				
12-17		*496*				
Transition Age Youth	18-25	2,144	35.0%			
Transition Age Youth	16-25			19.3%	718	33.5%
18-20		*1,070*				
21-24		*1,074*				
25-34		*718*				
35-44		*804*				
45-54		*282*				
55-64		*202*				
Adults	18-64	4,150	67.7%			
Adults	18-59			63.9%	2,375	57.2%
Older Adults	65+	307	5.0%			
Older Adults	60+				193	62.9%
Race/Ethnicity Distributions						
White		2,754	44.9%	64.7%	2,406	57.4%
African American		144	2.3%	5.5%	203	141.0%
Asian/Pacific Islander		974	15.9%	4.5%	166	17.0%
Hispanic		1,955	31.9%	14.2%	526	26.9%
Native American		45	0.7%	1.6%	61	135.6%
Other		259	4.2%	9.5%	354	136.7%
Language Distributions *(not available for prevalence subpopulation analysis)*						
		Total Population			Mental Health Consumers	
		>5 years old			FY 2004/05	
English Only		107,131	67.9%		3,221	
Non -English		50,661	32.1%		495	15.4%
Spanish		*30,577*			*256*	
Russian		*n/a*	n/a		*42*	
Other		*20,084*			*197*	
Total Population>5 years old		157,792	100.0%			

FIGURE 3
[1-Page Excerpt from MHSA CSS Program and Expenditure Plan]

Mental Health Services Act Community Services and Supports Plan

- The population estimates for Yolo County increased 7.3%, from 185,850 in 2005 to 199,407 in 2009[3].
- The ADMH client population declined 4.6% from 3,716 in 2005 to 3,544 in 2010.
- The overall ratio of ADMH consumers to the SMI/SED prevalence estimates was 60.6% in 2005 and 57.8% in 2010; however, it should be noted that the same 2004 prevalence estimates were used in both comparisons.
- For children 0-17, the ratio of ADMH consumers to the SMI/SED prevalence estimate went from 71.3% in 2005 (more than 10 points above the average ratio) to 48.6% in 2010 (nearly 10 points below the average ratio), indicating a sharp decrease in the penetration rate of SED children over the five-year period.
- As to Race/Ethnicity figures, Asian/Pacific Islander and Hispanic clients are very underrepresented in both data sets.

These observations confirm earlier conclusions that Children aged 0 to 17, Asian/Pacific Islanders, and Hispanics are underrepresented among ADMH clients. Children aged 0 to17 appear to be far less prevalent among ADMH clients than they were in 2005.

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 Modification (2010):

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

The method of identification of PEI priority populations is set forth in **ATTACHMENT C** hereto, entitled *Yolo County Prevention and Early Intervention (PEI) Community Planning Process – Narrative Report of Findings* and submitted to ADMH by CIMH on May 15, 2008. ADMH included this report as an attachment to its original MHSA PEI plan. In particular, see pages 10 through 12 of the report, *Section III. Synthesis of Findings* for an outline of key community needs and priority populations.

The approved Yolo County MHSA PEI Plan projects and programs, and their corresponding priority populations are:

Project One: Yolo Wellness Project

- **Urban Children's Resiliency Program:** The community planning process identified children, youth and transition-aged youth (TAY), especially those in stressed families, at risk of school failure, or at risk of Juvenile Justice

[3] United States Census Bureau, http://quickfacts.census.gov/qfd/states/06/06113.html, report updated 05/09/2011.

involvement as priority populations, and recognized underserved cultural populations of Latino, Russian and LGBTQ as a priority.

- **Rural Children's Resiliency Program:** With access issues of rural populations as an overarching concern, the community planning process identified children, youth and transition-aged youth (TAY), especially those in stressed families, at risk of school failure, or at risk of Juvenile Justice involvement as priority populations, and recognized underserved cultural populations of Latino and LGBTQ as a priority.
- **Senior Peer Counselors:** The community planners recognized access issues for older adults, due in large part to health and aging issues and stigma relating to mental illness. Using trained volunteers, this program targets individuals experiencing onset of psychiatric illness, individuals at high risk for suicide and/or depression, as well as aging Russian immigrant populations.

Project Two: Early Signs Project

- **Early Signs Training and Assistance:** Recognizing the need to increase access to children, youth and TAY, and to reduce stigma and discrimination surrounding mental illness at any age, this program seeks to assist with early intervention support with first-break referral services and provide education and stigma-reduction services to the community through offering Mental Health First Aid certification.
- **Crisis Intervention Training:** Our community planners were adamant about the need for mental health education and evidence-based certification for law enforcement and other first-responders. The program includes components of cultural competence, encourages law enforcement to recognize symptoms of mental illness early on, and seeks to help all ages and all cultures access mental health treatment services when in crisis.

Criterion 3:

Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Mental Health Disparities

Note: *The purpose of this section is to use this CCPR Modification (2010) as a logic model by continuing the analyses from Criterion 2 and to correlate the county's defined disparities with targeted activities to address them.*

The county shall include the following in the CCPR Modification (2010):

I. List the target populations with disparities your county identified in Medi-Cal and all MHSA components (CSS, WET, and PEI)

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

With regard to the PEI population, to the extent that this information is not included in Criterion 2, Part V, see also Attachment C hereto: *Yolo County Prevention and Early Intervention (PEI) Community Planning Process Narrative Report of Findings.*

II. Then list disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

List of Identified Target Populations with Disparities (I and II):

- **Medi-Cal**
  A review of *Medi-Cal Approved Claims Data for Yolo County MHP Calendar Year 2009* provided by APS Health Care, attached hereto as **Figure 4** (next page), serves to confirm the target populations identified in Criterion 2.
  - Children 0-17
    - The Medi-Cal approved Claims Data also identifies children 0-5 as more underserved within the age classification.
    - School data in Criterion 2 (see Figure 2) also indicates a rapid increase in the Hispanic population within school-aged children.

Figure 4--APS Healthcare: Medi-Cal Approved Claims Data for Yolo County MHP Calendar Year 09

	YOLO					SMALL		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficia-ries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	31,271	2,008	$8,311,304	6.42%	$4,139	7.38%	$4,046	5.98%	$4,784
AGE GROUP									
0-5	5,842	46	$80,690	0.79%	$1,754	1.19%	$2,853	1.46%	$3,886
6-17	8,543	540	$2,916,451	6.32%	$5,401	9.84%	$5,304	7.71%	$6,316
18-59	12,415	1,222	$4,748,394	9.84%	$3,886	9.72%	$3,404	8.03%	$4,057
60+	4,473	200	$565,768	4.47%	$2,829	3.79%	$3,249	3.41%	$3,174
GENDER									
Female	17,596	1,126	$4,258,393	6.40%	$3,782	7.03%	$3,625	5.46%	$4,213
Male	13,676	882	$4,052,911	6.45%	$4,595	7.82%	$4,520	6.67%	$5,391
RACE/ETHNICITY									
White	9,382	1,136	$4,882,880	12.11%	$4,298	10.64%	$4,226	11.09%	$4,894
Hispanic	14,883	443	$1,666,373	2.98%	$3,762	3.92%	$3,309	3.46%	$4,580
African-American	1,443	133	$588,303	9.22%	$4,423	10.22%	$4,129	10.22%	$5,218
Asian/Pacific Islander	2,221	110	$344,406	4.95%	$3,131	5.53%	$2,847	4.25%	$3,493
Native American	277	17	$25,631	6.14%	$1,508	6.90%	$4,984	9.80%	$5,120
Other	3,067	169	$803,710	5.51%	$4,756	10.46%	$5,330	7.71%	$5,344
ELIGIBILITY CATEGORIES									
Disabled	5,420	1,149	$5,049,854	21.20%	$4,395	18.38%	$4,216	18.93%	$4,710
Foster Care	339	117	$711,878	34.51%	$6,084	50.16%	$7,596	61.11%	$7,619
Other Child	13,531	433	$1,645,110	3.20%	$3,799	5.14%	$3,914	4.06%	$4,661
Family Adult	6,644	286	$744,425	4.30%	$2,603	5.48%	$1,879	4.21%	$2,239
Other Adult	5,853	66	$160,037	1.13%	$2,425	1.42%	$3,054	0.96%	$3,324
SERVICE CATEGORIES									
24 Hours Services	31,271	176	$1,234,842	0.56%	$7,016	0.43%	$7,446	0.46%	$8,248
23 Hours Services	31,271	23	$27,880	0.07%	$1,212	0.25%	$1,526	0.31%	$1,601
Day Treatment	31,271	32	$412,146	0.10%	$12,880	0.06%	$14,396	0.10%	$11,632
Linkage/Brokerage	31,271	547	$514,586	1.75%	$941	2.83%	$1,152	2.61%	$898
Outpatient Services	31,271	1,324	$3,723,831	4.23%	$2,813	6.00%	$2,634	5.00%	$3,228
TBS	31,271	15	$233,267	0.05%	$15,551	0.03%	$14,952	0.06%	$13,830
Medication Support	31,271	1,439	$2,164,752	4.60%	$1,504	4.10%	$1,411	3.19%	$1,212

Date Prepared: 05/12/2010, Version 1.0. Data Sources: DMH Approved Claims and MMEF Data - Notes (1) and (2)
Prepared by: Hui Zhang, APS Healthcare / CAEQRO. Data Process Dates: 04/14/2010, 04/20/2010, and 04/07/2010 - Note (3)

Footnotes:

1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report

4 - County total number of yearly unduplicated Medi-Cal eligibles is 303,732

- Hispanic Consumers
  - APS Medi-Cal Data shows that the penetration rate for Hispanic Consumers (2.98%) is far lower than the county average of 6.42%, and lower than the small county and statewide averages.
  - As noted in Criterion 2, the U.S. Census Bureau estimates a 25% increase in Hispanic residents for Yolo County in the years 2000 to 2009.
- Spanish-speaking Consumers
  - Criterion 2 data demonstrates a very low penetration rate among Medi-Cal eligibles for mental health clients who list Spanish as their primary language (see Figure 1).
- Asian and Pacific Islander Populations
  - ADMH service data indicates a penetration rate for Asian/Pacific Islander populations which is below the average for the county, and which is amongst the lowest overall (see Figure 1).

- **Community Services and Supports (CSS)**
  - Yolo County's MHSA CSS Plan identified the following populations as being underserved, with some specific areas where disparities were more dramatic:
    - Children aged 0 to 17—below prevalence estimates
    - Hispanics, Adult and Children—well below prevalence estimates
    - Asian/Pacific Islanders—well below prevalence estimates
    - White Non Hispanic
    - Homeless—higher concentration of SMI individuals
    - Transition-Aged Youth (TAY) emancipating from Foster Care or Juvenile Hall—high risk populations with low penetration rate
    - Lesbian, Gay, Bisexual, Transgender or Questioning—no actual client count; no services for youth in rural areas; stigma can be greater in rural areas; information, education and support services are lacking; special cultural considerations are lacking.
    - Older Adults with Spanish, Russian or Southeast Asian languages as their primary languages—cultural issues; stigma issues.
    - Rural Populations, particularly non-English speaking and underinsured farm worker populations
    - SMI individuals with co-occurring substance abuse disorders

- **Workforce Education and Training**
  - WET Component affirms that Non-English speaking individuals are underserved, including:
    - Spanish
    - Russian
    - Ukrainian
    - Deaf/hearing impaired
  - Although the staff demographics are inclusive of these underserved groups, more bilingual/bicultural staff is needed.
    - LGBTQ special services are not available; staff is not recently trained to serve LGBTQ youth and adults.
    - Consumers and Family Member staff are underrepresented among staff.

- Prevention and Early Intervention
  - Access disparities, particularly among
    - Children and TAY
    - Individuals experiencing early signs and symptoms of mental illness
      - Stigma and discrimination issues
    - Underserved cultural populations/cultural barriers to treatment
      - Hispanic/Spanish-speaking, particularly rural poor and migrant populations
      - Russian/Ukrainian populations
        - Language issues
        - Older adult Russian immigrant
      - Southeast Asian populations
      - Lesbian, Gay, Bisexual, Transgender
        - Issue for TAY, particularly in rural communities

  - Stigma and its restrictive effect on access
    - Lack of mental health education among law enforcement and community members contributes to stigma and hampers access
    - Low community awareness regarding mental health contributes to stigma and reduces access opportunities to poor and disadvantaged

  - Children and Youth/TAY in high-risk circumstances
    - Children experiencing family stress
    - Children at risk of school failure
    - Children at risk of Juvenile Justice involvement

  - Individuals experiencing onset of mental illness
    - Delays in accessing treatment may enhance severity of illness

III. Then list strategies for the Medi-Cal population as well as those strategies identified in the MHSA plans (CSS, WET, and PEI) for reducing those disparities described above

Strategies Identified for Reducing Disparities:

- Medi-Cal
  Based on the information included here in *Criterion II: Updated Assessment of Service Needs*, ADMH is facing its most serious service disparity among two specific populations, Children 0-17 and Hispanics, with a more profound disparity where these populations overlap. Yolo County school enrollment figures over the past ten years reflect that overall enrollment rose less than 3%, while enrollment of Hispanic children increased an astounding 28%. Further, Hispanic children, represent our largest population of Medi-Cal eligibles, yet our lowest rate of penetration for mental health services. Strategies for bridging this gap should attack disparities from all angles.

Although Medi-Cal enrollment seems less of an issue for Hispanic children, specific access to mental health services must be addressed, along with cultural attitudes toward conventional Medi-Cal mental health care, opportunities for alternative traditional cultural methods, and stigma reduction through education of parents and students.

Given the apparent reluctance of all of Yolo County's underserved cultures and non-English speaking populations (Hispanic/Latino Spanish-speaking residents, Russian and Ukrainian immigrant residents, and Asian/Pacific Islander populations) to come forward for mental health treatment at ADMH clinics, current strategies should be revisited. Three examples of possible access outreach strategies are (1) taking more services to where the children are and the parents can be contacted (such as in schools and pre-schools or via primary health care); (2) offering bilingual/bicultural outreach services and parent education by paraprofessionals in schools and in the community to reduce stigma and enhance understanding of mental health issues; and (3) initiating efforts to bridge the cultural gaps relative to healing alternatives and collaborate with practitioners in serving these families.

- Community Services and Supports (CSS)
  Yolo County's CSS Plan includes one program for each of the four age divisions within MHSA Programs, and each program has noteworthy strategies for reducing disparities:
  - **Rural Children's Mental Health Program** (originally coupled with Capay Valley Children's Resiliency Program, later expanded under PEI) brings mental health services by a bilingual/bicultural clinician to the large western rural area of Yolo County.
  - **Pathways to Independence for Transition-Age Youth** provides blended CSS services to SMI youth in transition to adulthood, with strategies that include benefits assistance, housing support, vocational support, etc., as well as offering the camaraderie of other TAY at groups and Wellness Center activities. The intention is to increase stability and recovery-oriented services, while reducing episodes of the homelessness and lapses in benefits so often associated with SMI youth transitioning to adult mental health services.
  - **Wellness Alternatives for Adults Program** seeks to reduce homelessness and promotes independent living among our most disabled SMI adult population by offering community-based intensive services. Strategies include offering housing assistance, Wellness Center supports, substance abuse counseling, Wellness Recovery Action Plan (WRAP) opportunities, life skills, peer support and pro-social activities, with an overall aim of helping SMI clients stay in the community and avoid episodes of hospitalization and homelessness.
  - **Outreach and Assessment for Older Adults** strives to help those with serious mental illness to remain independent and in the community. Strategies involve reaching out to isolated seniors, offering mental health assessments, coordinating with senior peer counselors and local agencies such as Adult Protective Services. When economic conditions improve and hiring resumes, ADMH intends to refocus efforts to engage Russian-,

Ukrainian- and Spanish-speaking older adult groups using bilingual/bicultural staff.

- Workforce Education and Training
  - Hiring strategies to better meet the needs of its underserved populations include:
    - Targeted hiring of bilingual/bicultural Spanish-speaking and Russian-speaking clinical staff;
    - Screening at interview for developed skills and experience in serving LGBTQ clients

- Prevention and Early Intervention
  - **Yolo Wellness Project/Urban Children's Resiliency Program:** Services are provided by Victor Community Support Services, who employs Evidence Based Practices with urban children and youth, working through schools in the three urban districts, community programs that offer parenting support, and Juvenile Justice programs. Successful strategies include employment of bilingual/bicultural professionals and paraprofessionals who help children build interpersonal skills and increase resiliency. Staff identifies those who may need intensive services and refers as appropriate.
  - **Yolo Wellness Project/Rural Children's Resiliency Program:** Services are provided by RISE Inc. seeking to build resiliency among children 0 to17 living in the large western rural area of Yolo County, an area with a Hispanic population in excess of 65%. Strategies include employing paraprofessional staff comprised mostly of bilingual/ bicultural individuals, offering programs tailored to the needs of children in farm worker families, and using Evidence Based Practice programs in both Spanish and English, building interpersonal skills and increasing resiliency. This rural team also makes referrals for intensive services as appropriate.
  - **Senior Peer Counselors:** Services are provided by ADMH staff and volunteers for older adults with mental health issues. The single most effective strategy for reducing disparities is to offer direct contact with a peer or paraprofessional, in-home or in-community, to build trusting relationships with at-risk, "resistant" older adults in underserved communities.
  - **Early Signs Training and Assistance:** This program is provided by ADMH staff, volunteers and partner agencies, using the strategy of community outreach and mental health education to reduce stigma. Mental Health First Aid curriculum is available from certified instructors, some of whom are consumer and family member employees. Also, this program offers early intervention support with first-break referral services.
  - **Crisis Intervention Training:** This training is contracted out and offers mental health education through an evidence-based program certification for law enforcement and other first-responders. The program includes a cultural competence component, and trains law enforcement and other first responders to recognize symptoms of mental illness and intervene more appropriately, while promoting access for all ages and all cultures.

IV. Then discuss how the county measures and monitors activities/ strategies for reducing disparities.

Through use of the county's Practice Management and Electronic Health Record system, as well as the performance measurement and cultural competency requirements set forth in provider contracts, Yolo County ADMH is making an effort to measure client contacts in the level of detail that would eventually document changes which correlate to specific program attributes. Recent enhancements represent steps in the right direction. As staffing increases once again, opportunities for focusing on program evaluation increase as well. In the meantime, direct monitoring and observation (such as noting cultural inroads and missteps) may be anecdotal.

V. Share what has been working well and lessons learned through the process of the county's development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET, and PEI).

All ADMH programs, including Medi-Cal and MHSA funding, have demonstrated the efficacy of bilingual/bicultural staff. Working as professionals, paraprofessionals and clerical, in the clinic/office or field, all staff strive to reduce disparities while enhancing services to underserved cultural populations of all ages. One unfortunate reality was realized through the layoff process during tough budget times. MHSA programs proudly hired several effective bilingual/bicultural consumers, clinicians, and front desk staff. Unfortunately, many were lost due to the "last in—first out" civil service policies that govern county employment. ADMH looks forward to hiring future staff with bi-lingual skills and bi-cultural backgrounds.

ADMH will continue to review the effectiveness of each program, and looks forward to increasing the capacity to assemble and interpret data to use that additional information accordingly.

Criterion 4:

Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.

The county shall include the following in the CCPR Modification (2010):

A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), The so inclusive committee shall demonstrate how cultural competence issues are included in committee work.

The ADMH Cultural Competency Committee met throughout 2010, with its primary goal being the composition of a new Cultural Competency Plan.

The Committee included representatives of the African American, Latino, Asian-Pacific Islander, Russian, Gay/Lesbian/Bisexual/Transgender community, adult and older adult consumers, family members, and ADMH staff.

The Committee identified several issues relating to cultural competency:

- A "Comfort Agreement" was drafted, identifying the terms of group communication and promoting a safe and nonjudgmental atmosphere
- A presentation and discussion occurred on the topic of welcoming and improving services to LGBT clients
- Committee members agreed to encourage diversity by varying the location of Cultural Competency meetings and thereby expose members to key locations of interest in the county
- Russian and Slavic residents addressed to the committee and became committee members

The Coordinator worked to accommodate members' schedules by changing locations and times with limited success. Because participant attendance varied at each meeting, information and knowledge could not be built upon, making discussion and decision making somewhat

challenging from meeting to meeting. Queries from partner agencies and participants netted the following reasons: lower staffing and budget cuts, too many duties and not enough time, etc.

A change in the Cultural Competency Coordinator occurred in early 2011. To allow focus on drafting the plan the Committee agreed to suspend the meetings temporarily. Cultural Competency developments continued to be reported to the Committee members and stakeholders via e-mail; and to ADMH staff, the Local Mental Health Board, and the Quality Improvement Committee on a monthly basis.

Draft chapters of the Cultural Competency Plan were posted on the ADMH Documents website, and notice of this posting (and encouraging submission of comments) was sent to Cultural Competency Committee members, Local Mental Health Board Members, consumers, family members, providers, stakeholders and other persons of interest—over 150 individuals and agencies. The draft Cultural Competency Plan will remain posted and comments will be encouraged until the plan is finalized and approved by the California Department of Mental Health. Quarterly Cultural Competency Committee Meetings are expected to resume in FY 11-12.

B. *If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.*

Cultural Competency Committee members are community stakeholders, and as such they have a vested interest in all facets of MHSA implementation in Yolo County. Just as all MHSA stakeholders received notices relative to the development of the 2011 Cultural Competency Plan, Cultural Competency Committee members have been involved throughout the MHSA planning process, and have also receive updates and notices. As various facets of mental health services are integrated, it is important that committees integrate as well. Cross-communication and integration among Cultural Competency Committee Members, MHSA Stakeholders, and Quality Improvement Committee Members and their respective meetings appear to be a logical and efficient next step in community involvement.

Criterion 5:

Culturally Competent Training Activities

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

The county shall include the following in the CCPR Modification (2010):

A. The county shall develop a three year training plan for required cultural competence training that includes the following: (The county may submit information from the county's WET plan provisions for training. The county shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).

1. *Steps the county will take to provide required cultural competence training to 100% of their staff over a three year period.*
2. *How cultural competence has been embedded into all trainings.*
3. *A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.*

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

1. *Cultural Formulation;*
2. *Multicultural Knowledge;*
3. *Cultural Sensitivity;*
4. *Cultural Awareness; and*
5. *Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).*
6. *Interpreter Training in Mental Health Settings*
7. *Training Staff in the Use of Mental Health Interpreters*

The Cultural Competency Training Calendars for FY 11-12 (**Figure 6**), FY 12-13 (**Figure 7**) and FY13-14 (**Figure 8**) included here outline the steps ADMH will take to provide appropriate Cultural Competency training to its staff. Biannually, ADMH will host trainings to which all staff, contractor providers, community members, Local Mental Health Board Members, Community-Based Organizations and other agency staff will be invited. Annually, in the first week of October, ADMH will acknowledge Mental Illness Awareness Week by hosting a

presentation by consumers and family members relating their personal experiences with the services they receive. Other open presentations will include trainings on experiences of clients who are Gay, Lesbian, Bisexual, Transgender and Questioning (LGBTQ), and how staff can work more effectively with trained Mental Health Interpreters.

Yolo County's approved MHSA Workforce Education and Training (WET) Component includes e-Learning for ADMH staff, consumers and family members. The library of courses contains instruction on the provision of services to the SMI/SED population, including several courses on the role of the mental health Interpreter and numerous courses focused on Cultural Competency (see **Figure 5** below). The training calendars also include cultural competency-related E-learning courses for Interpreters, as well as a course for members of the Local Mental Health Board.

Figure 5
On-Line Courses in Cultural Competency
Currently Available to ADMH Staff

Course Title	*Credit Hours*
Cultural Diversity	2.0
Cultural Diversity for Paraprofessionals	1.5
Cultural Issues In Mental Health Treatment	3.0
Cultural Issues in Mental Health Treatment for Paraprofessionals	3.0
Integrating Race and Culture into the Psychiatric Rehabilitation Assessment	1.5
Military Cultural Competence	3.0

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

The county shall include the following in the CCPR Modification (2010):

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities.

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.

Mental Illness Awareness Week (MIAW) occurs in the first week of October each year, during which NAMI of Yolo County holds a MIAW Rally at the County Courthouse, a community dinner, community outreach, and a prayer vigil. ADMH will join with NAMI in noting these annual efforts to raise awareness by hosting the following 90-minute "Consumer Experience" training presentations by consumers and family members to ADMH staff and all interested community stakeholders:

Oct. 6, 2011: *The Consumer Experience: Navigating the Mental Health System*
Oct. 4, 2012: *The Consumer Experience: Mental Health Recovery and Resiliency*
Oct. 3, 2013: *The Consumer Experience: Children, TAY and Family Perspective*

Figure 6: FY 2011-12 Cultural Competency Training Calendar

Training Event	Description of Training	How long and often	Attendance by Function	Est. of Attend-ees and Total	Date of Training	Name of Presenter
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Serv. Contractor/Supp. Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH ***78**	1st Qtr 11-12 On Line Education	Essential Learning
MH Interpreter Training	Pt 1 of 3—Role of BH Interpreter	Complete series this FY; repeat triennially	Interpreters	**18**	1st Qtr. 11-12 On Line Education	Essential Learning
Board Member Training	Board Members: Roles and Responsi-bilities	Triennially	Administration/Management LMHB/Commissions **Total**	2 15 **17**	1st or 2nd Qtr. 11-12 On Line Education	Essential Learning
The Consumer Experience: Navigating the MH System	Consumer/FM panel presen-tation; promote understanding; Mental Illness Awareness Wk	Annually; 90 min.	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 78* 4 2 6 2 2 **94**	Oct. 6, 2011 2nd Qtr 11-12	Live Presentation: Consumers/ Family Members
MH Interpreter Training	Pt 2 of 3—Role of Culture for BH Interpreter	Complete series this year	Interpreters	**18**	2nd Qtr. 11-12 On Line Education	Essential Learning
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH ***78**	3rd Qtr 11-12 On Line Education	Essential Learning
MH Interpreter Training	Pt 3 of 3—Communica-tion for BH Interpreters	Complete series this year	Interpreters	**18**	3rd Qtr. 11-12 On Line Study	Essential Learning
LGBTQ Culture	Meeting the needs of gay and lesbian clients	Biennially; 90 min	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 78* 4 2 6 2 2 **94**	4th Qtr 11-12	Live Presentation: Mental Health America
MH Interpreter Training	Complete if needed 3 pts. Role of BH Interpreter	Complete series this year	Interpreters	As needed to complete series	4st Qtr. 11-12 On Line Study	Essential Learning

Figure 7: FY 2012-13 Cultural Competency Training Calendar

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH ***78**	1st Qtr 12-13 On Line Education	Essential Learning
MH Interpreter Training	Complete all 3 parts-- Role of BH Interpreter	Complete series this FY	Interpreters	New hires	FY 12-13 On Line Study	Essential Learning
Board Member Training	Board Members: Roles and Responsi-bilities	Triennially	LMHB/Commissions	New LMHB Members	1st or 2nd Qtr. 12-13 On Line Education	Essential Learning
The Consumer Experience: MH Recovery and Resiliency	Consumer/FM panel presen-tation; promote understand MH recovery; Mental Illness Awareness Wk	Annually; 90 min.	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 78* 4 2 6 2 2 **94**	Oct. 4, 2012 2nd Qtr 12-13	Live Presentation: Consumers/ Family Members
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH ***78**	3rd Qtr 12-13 On Line Education	Essential Learning
Working with MH Interpreters	Coordination with MH Interpreters; how to best serve clients	Biennially 90 min.	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Serv, Contractor, Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 78* 1 2 1 1 1 **84**	4th Qtr 12-13	ADMH Trained Interpreters

Figure 8: FY 2013-14 Cultural Competency Training Calendar

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH *78	1st Qtr 13-14 On Line Education	Essential Learning
MH Interpreter Training	Complete all 3 parts-- Role of BH Interpreter	Complete series this FY	Interpreters	New hires	1st Qtr 13-14 FY 12-13 On Line Study	Essential Learning
Board Member Training	Board Members: Roles and Responsi-bilities	Triennially	LMHB/Commissions	New LMHB Members	1st or 2nd Qtr. 13-14 On Line Education	Essential Learning
The Consumer Experience: Children, TAY and Family Perspective	Consumer/FM panel presen-tation; promote understanding; Mental Illness Awareness Wk	Annually; 90 min.	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 78* 4 2 6 2 2 **94**	Oct. 3, 2013 2nd Qtr 11-12	Live Presentation: TAY Consumers and Family Members
Cultural Competency in MH	Staff Choice From CC E-Learning List	1 class during quarter	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	*All ADMH *78	3rd Qtr 13-14 On Line Education	Essential Learning
LGBTQ—How Are We Doing?	Review of progress in serving gay and lesbian clients	Biennially; 90 min.	Administration/Management* Direct Services ADMH Staff* Interpreters* Direct Services Contr/Support Community/Gen Public Community Event LMHB/Commissions CBO/Agency Bd. Dir. **Total**	ADMH* 88* 4 2 6 2 2 104	4th Qtr 13-14	Mental Health America

Criterion 6:
Yolo County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified un-served and underserved populations
The county shall include the following in the CCPR Modification (2010):
A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.

For the Workforce Needs Assessment included as Exhibit 3 to Yolo County's Workforce Education and Training Component of the MHSA Program and Expenditure Plan, see **ATTACHMENT D** hereto.

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data.

This comparison of data yielded the observations noted below. To facilitate this comparison, please see below (**Figure 1 Excerpt—Columns A, B, C** and accompanying **Figure 9**, WET Plan Data[4]).

Alaska Native/American Indian: Overall, Alaska Native and American Indian populations in Yolo County are low, representing less than 1% among the three groups shown. Concentrations appear to be highest among the Medi-Cal eligible population at 0.9%. The Yolo County workforce, as set forth in the WET Plan, includes 1.3% in this racial/ethnic group, indicating the group is adequately represented in the workforce.

Asian/Pacific Islander: Among Asian/Pacific Islander populations, it is noteworthy that concentrations are proportionately highest among the poor (17.3%) and lowest among the Medi-Cal eligible population (7.1%). At 7.7% of mental health workers, it appears this population is underrepresented among the county's mental health workforce.

Black/African American: The below data indicates that the Black/African Americans population comprises 2.6% of the county's residents, 3.2% of those living <200% of poverty, and 4.6% of the Medi-Cal eligible population. Workforce

[4] Yolo County MHSA Workforce Education and Training Component, Exhibit 3: Workforce Needs Assessment, page 11.

figures indicate 9.2% of the mental health workforce is Black/African American. Only about 4% of the ADMH staff is Black/African American, but both ADMH and the countywide totals indicate they are adequately represented in the mental health workforce.

Hispanic: The Hispanic population represents at least 28% of Yolo's residents (a figure that is rising, especially among children), representing over one-third of the <200% poverty population, and nearly one-half of the Medi-Cal eligibles in Yolo County. Relative to race/ethnicity correlating data, the county's total mental health workforce is 11.1% Hispanic, while for ADMH, the percentage is signifi-cantly higher, at 20.61%. This growing population widened the gap between the workforce and the beneficiary population during static budget times, with even greater disproportion occurring in the last 2-3 years due the budget cuts.

White: At 66.1% of the total mental health workforce, the percentage of White workforce members exceeds that of all service populations, continuing to remain the majority population in both the workforce and service populations.

FIGURE 1 EXCERPT: Columns A, B, C
Population, Poverty and Medi-Cal Data

FIGURE 9
WET Plan Data

Figure 1 - Yolo County Population, Poverty, Prevalence and Medi-Cal Data / Workforce Needs Assessment

	A		B		C		Race/Ethnicity Data			
	Yolo County Population 2007		Yolo County <200% of Poverty Population		Yolo County Medi-Cal Eligible Population FY 2009-10		Yolo ADMH Staff	All Other CBO's etc.	Total Yolo County MH Workforce	
Age										
0-17 years	48,798	24.9%	19,252	28.5%	14,384	46.0%	-	-	-	-
18-54 years	111,660	57.0%	40,281	59.6%	12,414	39.7%	-	-	-	-
55+ years	35,386	18.1%	8,074	11.9%	4,473	14.3%	-	-	-	-
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	-	-	-	-
Race/Ethnicity							**Race/Ethnicity**			
AK. Native/Am. Indian	1,378	0.7%	383	0.6%	277	0.9%	4.9	7.3	12.2	1.3%
Asian/Pacific Islander	23,917	12.2%	11,668	17.3%	2,221	7.1%	7.8	66.1	73.9	7.7%
Black/African American	5,023	2.6%	2,195	3.2%	1,443	4.6%	4.1	84.0	88.1	9.2%
Hispanic	54,766	28.0%	23,462	34.7%	14,882	47.6%	20.1	86.6	106.7	11.1%
White	105,430	53.8%	27,744	41.0%	9,381	30.0%	54.2	580.9	635.1	66.1%
Other/Unknown/Multiracial	5,330	2.7%	2,155	3.2%	3,067	9.8%	6.5	38.3	44.8	4.7%
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	**97.6**	**863.2**	**960.8**	**100.0%**
Gender Distribution										
Male	96,057	49.0%	31,918	47.2%	13,676	43.7%	-	-	-	-
Female	99,787	51.0%	35,689	52.8%	17,595	56.3%	-	-	-	-
Total	**195,844**	**100.0%**	**67,607**	**100.0%**	**31,271**	**100.0%**	-	-	-	-
Primary Language										
English					17,727	55.6%	-	-	-	-
Spanish					9,630	30.2%	-	-	-	-
Russian					1,808	5.7%	-	-	-	-
Other/Unknown					2,713	8.5%	-	-	-	-
Total					**31,878**	**100.0%**	-	-	-	-

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

In the two years since submitting its WET Plan, ADMH has experienced further staffing reductions, as have other counties across the state. When the plan was submitted in May 2009, ADMH decreased by 55 FTE's due to budget cuts, with a workforce of 97.6 FTE. By May of 2011, additional reductions netted 76.7 FTE. The MHSA WET Plan did not set specific target growth numbers for the multicultural workforce at that time. The following was noted:

> *Using data from our Needs Assessment and other surveys compared to data from our automated Electronic Health Record, we found very few disparities in race/ethnicity in our workforce compared to our consumers. However, by city and clinical site additional Spanish-speaking, Latino-culture members and Russian-speaking, Russian/Ukrainian-culture members are needed in our workforce. This is particularly true of clinical, direct-service staff.*[5]

Both the WET Plan and the Cultural Competency Plan note the need for more bilingual/bicultural Hispanic staff, as well as from Russian, Ukrainian, and Asian/Pacific Islander cultures. Along with other counties across the state and nation, ADMH hopes to hire bilingual/bi-cultural staff as the economy continues on the slow upward trajectory. Priority will be given to seek qualified direct service and first contact personnel who are bilingual and bicultural from these ethnicities.

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

Many bilingual/bi-cultural staff and consumers that spoke Spanish, Russian or Tagalog are no longer employees of ADMH. This lesson learned is related to job classification specifics as stated above, and in Criterion 2.

In addition, it is important to ensure capacity building for supervision to maximize the ability to utilize Student Interns and MHSA stipend volunteers, which can assist in bolstering service delivery. Maximizing dwindling resources by maintaining sufficient infrastructure to benefit from these volunteers, while potentially gaining future well-trained employees, will in the future greatly enhance the workforce.

E. Identify county technical assistance needs.

ADMH would benefit from technical assistance in two areas:

- Civil Service Positions including Titles, Minimum Qualifications, and Job Descriptions.

[5] Ibid., page 13.

- Development of a plan to rebuild the workforce prioritized to address the changes and needs of the consumers over time, and anticipates revenue flow, while accounting for succession planning.

Criterion 7:

Language Capacity

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR Modification (2010):

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

See WET Plan Workforce Needs Assessment (attached hereto as Attachment D) at page 13.

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.

As indicated in the most recent CSS update, ADMH is unable to expand staff at this time due to budget constraints; however, PEI programs serving both urban and rural children, which were implemented in FY 09-10, continue to require contractors to provide bilingual/bicultural Spanish-speaking staff.

3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

The total annual amount dedicated resources for interpreter services in addition to bilingual staff is $26,519.

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

The county shall include the following in the CCPR Modification (2010):

A. Evidence of policies, procedures, and practices 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 as resources are available 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 including staff training protocol.*

   See ADMH Policy and Procedure entitled **Language and Special Communications Needs**, incorporated in this plan as **ATTACHMENT E.** Staff is provided with annual demonstrations of language line access by the Quality Assurance Unit; training is also provided to staff on request.

   For clients with Limited English Proficiency (LEP) ADMH posts language identification charts in every waiting room. The charts use pictures to direct the client to point to their preferred language. Staff is reminded of the free language assistance availability during interpreter trainings, staff meetings and Cultural Competency trainings. Staff is reminded to inquire during the intake process by the prompt on the Acknowledgment of Receipt checklist.

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

All access, crisis, grievance and other informational materials are available in English and Yolo's two threshold languages, Spanish and Russian, in all ADMH reception and waiting room areas. Clients whose primary language is one other than English, Spanish or Russian are assisted through the procedure listed in the previous section.

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

Upon initial contact with a customer who has limited proficiency in English, but who does not speak a designated threshold language (Spanish or Russian), office support staff may use a Language Identification Chart to assist in identifying the person's language needs and summon a translator from an established list and schedule. If a translator for that language is not available, the language line is used. For return appointments, interpreters are scheduled in accordance with client appointments, and the language line is used if no interpreters are available in the client's preferred language.

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

The most significant challenged ADMH faced is related to after hours calls, both crisis and non-crisis type, which originally rolled over to Yolo County Dispatch. Occasions involving non-English callers failed to connect with translation services or appropriate mental health assistance. Over 1.5 years ago all after-hours calls were diverted via Contract to Yolo Community Care Continuum, who provide staff available on a 24/7 basis, well-versed in mental health issues and knowledgeable about use of translation services, through their other contracted programs. This

solution resolved this concern, with positive feedback from the consumer/family member community, including the Yolo Chapter of National Alliance for the Mentally Ill (NAMI) and the Local Mental Health Board.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

ADMH does not have language access technical assistance needs at this time.

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

Note: *The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. Counties should train their staff for the proper use of language lines but should seek other options such as training interpreters or training bilingual community members as interpreters.*

The county shall include the following in the CCPR Modification (2010):

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

Of the Front Desk Staff providing first contact, one-half are bilingual Spanish-English Speaking. Staff also has immediate access to the **ADMH Bilingual Staff List** which includes Spanish and Russian interpreters, and other available languages. ADMH maintains this list on its department website, so it is available to all staff. A copy is attached to this plan as **ATTACHMENT F.** In addition, Spanish-speaking interpreters are assigned during *prime time hours* on a fixed schedule to ensure availability, which the Office Support Supervisor maintains.

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

See documents included with Attachment E, specifically the document entitled, **Consumer Agreement to Interpreter Services**.

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

All ADMH staff has immediate access to the **ADMH Bilingual Staff List**, which includes the interpreter's phone extension and location. ADMH maintains this list on its department website, and is also sent electronically via email as updates occur, making it available to all staff (see above, and Attachment F). Again, the Office Support Supervisor maintains the schedule for Spanish interpreters.

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

See ADMH Policy and Procedure entitled **Training of Interpreters** and ADMH Policy and Procedure entitled **Cultural Competency and Training of Interpreters**; copies of both are included in this plan as **ATTACHMENT G.** In FY 11-12, all ADMH Interpreters will be required to enroll and pass three on-line courses for mental health interpreters from Essential Learning, to be repeated triennially (see Criterion 5, Culturally Competent Training Activities).

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 Modification (2010):

A. Policies, procedures, and practices 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.

See responses to Section III above.

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.

1. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements: 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

See document entitled, State Department of Mental Health Medi-Cal Oversight Fiscal Year (FY) 2008-2009 for written plan regarding service to clients with Limited English Proficiency, a copy of which is attached hereto as **ATTACHMENT H.**

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

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

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

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;

8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.
C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).
D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).
E. Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

These documents are currently available at all three (3) ADMH Clinic Sites: Davis, West Sacramento, and Woodland. Copies of the documents on this list will be available for review during the next compliance visit.

Criterion 8:

Adaptation of Services

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR Modification (2010):

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

Activities of both Transition-Age Youth and Adult Clients at the "Wellness Alternatives" Wellness Center are client-driven. Clients have access to their own bank of computers with Internet access and printers, which they can use to pursue personal enrichment or vocational services. Clients are provided with peer-run Wellness Recovery Action Planning "WRAP" group opportunities, as well as peer-run cooking, budgeting and other life skill classes. Clients now have the opportunity to utilize the on-line Essential Learning program, that provides access to a broad Community Access Library of mental health-related topics (several are recovery-oriented), and including courses on cultural competency, as well as general self-improvement topics. This opportunity is available to clients free of charge through the MHSA Workforce Education and Training (WET) Plan.

At the Wellness Center, which is open all weekdays, clients of all cultures share practices, beliefs, and ethnic foods, as well as games and other activities. Cultural holidays, such as *Cinco de Mayo,* are celebrated through activities of the Wellness Center. Consumers often engage in art projects involving painting, drawing, textiles, sculpture, jewelry, poetry and short stories. These projects reflect the cultural and religious diversity of the clientele, as well as their talents and imagination. A Consumer Art Show has been held for the last 2 years in late April, allowing opportunity for projects to be displayed.

This year's Consumer Art Show rendered 66 entries. Over 300 votes were cast by visitors to the art show, and nine prizes were awarded in all (1st, 2nd and 3rd in three categories). Many of the consumers had their art entries purchased. Two artists were featured at the Board of Supervisor's Meeting on May 3, 2011, where a Resolution was presented recognizing May as Mental Health Month. The resolution is displayed in the Wellness Center, with those from other years. Many consumers use the Consumer Art Show as preparation for entry in Yolo NAMI's Sunflower Art Show held each June.

Recovery-oriented vocational rehabilitation opportunities are offered to Wellness Center clients by Turning Point Community Programs. Cool Beans Coffee & Eats, a consumer-supervised, consumer-operated coffee station located at ADMH's Woodland Site is one among many paid training opportunities offered to consumers through Turning Point. There the consumers develop self-confidence, as well as experience with making espresso drinks, selling food and snacks, and cashiering.

II. Responsiveness of mental health services
The county shall include the following in the CCPR Modification (2010):

A. *Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.*
(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

See ADMH Policy and Procedure entitled **Alternative Healer Resources**, included in this plan as **ATTACHMENT I.**

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.*

ADMH is in the process of updating the member services brochure to include the list of Alternative Healer Resources.

C. *Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.*
*(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.)*

See the following documents collectively attached to this plan as **ATTACHMENT J:**

- Policy and Procedure: **Information Dissemination and Cultural Competency**

- Policy and Procedure: **Availability of Translated Materials**
- **Yolo County Guide to Mental Health Services**

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.)

All ADMH offices are ADA-compliant and close to public transportation. Offices are decorated with paintings, sculptures and other objects that include artwork and scenes from varied cultural groups, making the offices welcoming to clients and the community. Consumer artwork is prevalent, both in the hallways and in treatment rooms, reflecting the diversity of the clientele.

Due to budget constraints, ADMH relocated the Wellness Center to the main Woodland site in the Bauer Building in 2010. This has been more successful than anticipated, as attendance has increased and participation in Wellness Center activities has doubled. Besides planned attendance for specific center activities, early arrivals for appointments are now a bonus, as consumers now have a place to “hang out” with peers before and/or after their appointments. The Wellness Center enjoys a large space that is separate and distinct from clinic offices, decorated with comfortable, home-like furniture, and the walls display consumer artwork and awards, with a designated area for the Transitional Age Youth.

The contract provider CommuniCare Health Centers has co-located behavioral health treatment with physical health clinic offices, which may serve to reduce stigma. And Children’s Resiliency-Building PEI programs, both urban- and rural- with a staff of over 50% bilingual Spanish/English almost exclusively serving children and youth in their community, where they live, play and go to school. Bilingual/bicultural clinicians from ADMH’s Children’s Unit serve the large western rural area of Yolo County, to accommodate working parents.

III. 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 Modification (2010):

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

Upon receipt of a grievance from a consumer:

- Information is verified in the AVATAR Management Information System, including Medical Record Number, Address, Phone number
- If the grievance is related to service delivery, notes in the system are reviewed
- Medi-Cal is checked/verified
- Information is noted in the log, with the date.
- An acknowledgement of the grievance is mailed to the individual with contact information for Quality Management,
- Written response is sent within 60 days.

During the investigation phase, the QI officer gathers information by talking with the grieving party regarding the circumstances surrounding the grievance, learning what the party would like to have done to resolve the grievance. Other necessary parties (e.g., staff involved in the grievance, staff that might have information surrounding the circumstances) are interviewed. Finally, a plan to address the grievance is developed and implemented, with notification back to the grieving party.

In FY 09-10, ADMH received a total of 18 grievances/complaints from 16 different clients. Fifteen were Medi-Cal beneficiaries. Special note is made when any grievance is specifically related to cultural issues (such as language, religion, race/ethnicity, or other factors). Race/ethnicity is not currently one of the data points tracked, but will be added to the demographics for the future. Of the clients filing grievances, nine were female, seven were male.

ATTACHMENT A

EXCERPTS FROM THE ORIGINAL YOLO COUNTY MENTAL HEALTH SERVICES ACT (MHSA) COMMUNITY SERVICES AND SUPPORTS (CSS) PROGRAM AND EXPENDITURE PLAN FY 05-06, FY 06-07, FY 07-08

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: YOLO	Fiscal Years: 05/06, 06/07 and 07/08	Program Work Plan Name: Greater Capay Valley Children's Pilot Program
Program Work Plan #: 1		Estimated Start Date: April 2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	This MHSA program will provide culturally and linguistically competent mental health and related services to children, youth and their families in the greater Capay Valley region, focusing specifically in the Esparto Unified School District, with primary services offered in the towns of Esparto, Madison and other outlying areas in the Capay Valley. The Greater Capay Valley Children's Pilot Program will be integrated within the new and flourishing human services that are being developed in this region. The collaborative partners include RISE (Rural Innovations in Social Economics) Inc., Capay Valley Vision, Esparto Family Practice, the Esparto Unified School District and the Yolo County Department of Employment and Social Services. The goal of this program will be to: • Increase the level of participation and involvement of ethnically diverse and Caucasian families in all aspects of the public mental health system; • Support the development of a Family Resource Center that will provide mental health services to rural residents; • Provide outreach and expansion of services to client populations in order to eliminate ethnic disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates; • Increase the array of community supports for children and youth diagnosed with serious emotional disorders and their families, and • Allow these children and youth to enjoy greater success in school and at home, and help them avoid institutionalization and out of home placements.	
Priority Population: *Describe the situational characteristics of the priority*	The priority population for this program will be Yolo County children/youth aged 0-18 and their families who reside or attend school in the Esparto Unified School District and who have a psychiatric disability and unmet or under-met mental health treatment needs, and/or who are members	

population	of an ethnic group identified as underserved. These ethnically diverse and Caucasian children are living in rural environments with limited access to mental health treatment services. In addition, some may be members of an ethnic or cultural group that does not readily understand or accept mental health services.

9) *Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.*

This program will be two fold: designed to address the ethnic disparities of access to mental health care by the communities of color who are present in this region as well as reach out to the Caucasian community, which historically has been underserved.

As stated in the *Action Plan for the Capay Valley Region* (2003) this area has a 42% Latino population, a small Native American community, and a small population of African Americans. These cultural communities have historically been un-served and underserved for sometime.

To address the potential needs of monolingual Spanish-Speaking consumers, the GCVCPP team will be comprised of staff that speaks Spanish, thereby increasing access to care. Equally important is for the team to understand the socio-economic issues facing the community. Issues of acculturation and assimilation as it pertains to Latinos will be a critical training issue. For example, not all Latinos will be agricultural workers and not all will speak Spanish. Many times assumptions cause barriers to access.

In addition, the collaborative will extend efforts to connect and coordinate mental health services and education with the Tribal representatives of the small Native American population living on the reservation located in Capay Valley as appropriate. Given the success of tribal gaming in the region, these individuals are very self-sufficient. Tribal members address their own needs using their own resources. Nevertheless, we anticipate and welcome contact with Native American children and youth who participate in community activities outside of the reservation.

Interestingly, another cultural dynamic raised by the community leadership that will be addressed is how to welcome, invite, and serve the Caucasian members of the community, who (despite need) perceive such support services as being strictly for people of color.

10) *Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.*

Gay, lesbian, bisexual, transgender and questioning youth can experience greater stigma and personal difficulty in small, rural communities, and the Esparto-Capay region is no exception. A recent survey of the six major high schools in Yolo County revealed that those schools with student populations over 1500 had an active Gay-Straight Alliance club; only Esparto High School and Winters High School (both in rural areas) did not have any organized

activity to promote acceptance of GLBTQ students. Community stakeholders shared that they knew of youth in the community who are gay or questioning, but those youth are few in number and are afraid to identify themselves as such.

These youth need support. The GCVCPP mental health team will be working closely with partners to develop programming and supports that will be sensitive to issues relating to sexual orientation and gender identity. The point person at Esparto High School will be critical to assist with linkage to the available services elsewhere in the county. If needed, sub-contracts will be established to seek out consultation and education from agencies that specialized in the needs of GLBTQ youth. In addition, these contracts may include direct service provision to ensure that culturally competent services are provided.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Yolo	Fiscal Years: 05/06, 06/07 and 07/08	Program Work Plan Name: Transition Age Youth—Pathways to Independence
Program Work Plan #: 2		Estimated Start Date: April 1, 2005
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	This program will provide comprehensive and culturally competent community services to un-served and underserved Yolo County youth aged 16 to 25 coping with serious mental illnesses. Pathways to Independence will advance the goals of the MHSA by providing to young adults comprehensive community mental health services that are voluntary, client-directed, strength-based, built on principles of recovery and resilience, delivered responsively and respectfully in the community in a manner sensitive to the cultural needs of the individual served. The objectives of Pathways to Independence are: to assist each participating youth in establishing a Full Service Partnership agreement that identifies goals appropriate to the individual's needs and abilities; to assist the client in finding and maintaining secure and affordable housing; to assist clients to access community resources; to promote wellness, recovery and independent living; to capitalize on resilience in the individual; to assist client in readiness for and securing of employment, when appropriate; to promote and provide self-help services for youth; to offer integrated educational services and supports to assist emotionally disturbed youth to complete their high school diplomas and encourage the pursuit of higher education; to provide supportive services to youth with mental health treatment needs who are emancipating from Foster Care or from the Juvenile Hall; to assist youth with serious psychiatric disabilities to secure appropriate benefits; to assist clients in developing a network of family and friends in the community on whose support and encouragement the youth can rely. Program supports will include "24/7" access to services from our staff of personal service coordinators.	
Priority Population: *Describe the situational characteristics of the priority population*	Yolo County youth, aged 16-25, who have a psychiatric disability and who are coping with one or more of the following circumstances: homelessness or serious risk of homelessness; emancipation from Foster Care or Juvenile Hall without benefit of family supports; unmet or under-met mental health treatment needs and/or member of an ethic	

	group identified as underserved; so underserved as to be at risk of involvement in the criminal justice system; in need of assistance to complete high school or other educational or vocational program; or, transition-age youth who has experienced a first episode of major mental illness.

9) *Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.*

Yolo Services for Transition-Age Youth will adhere to the Yolo County Cultural Competency Plan. The program staff will be familiar, recognize and consider the specific needs, developmental issues, issues related to family of origin, practices related to individuation, and the concept of independence as it relates to the particular young person's culture. Every effort will be made to hire staff that can speak the language of each program participant or have available interpreters to assist with engagement and treatment Special emphasis will be placed on developing awareness of and sensitivity to the unique needs of youth consumers who are homeless; those who are gay, lesbian, bisexual, transgender, or questioning; those who are involved with the criminal justice system; and those who are dealing with co-occurring disorders. Strategies for meeting the needs of this population will include providing services within the person's own community.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff will be trained and oriented to be aware of and sensitive to all facets of cultural competence, including sexual orientation and gender-sensitive issues to sufficiently bridge and address these issues with the youth. Contracts and outreach to agencies and community professionals that are proficient in serving young people who are gay, lesbian, transgender, and questioning will be conducted. We recognize that issues relating to sexual orientation and gender sensitivity are particularly important for individuals aged 16 to 25—a period of intense self-discovery and realization relative to sexual identity. When working with consumers in this program, our staff will be especially aware of and sensitive to issues of sexual orientation.

Similarly, staff will need to recognize the special needs of this age group. By virtue of their youth, these consumers may manifest a greater incidence of high-risk behavior, they may need more intensive assistance and therefore, we expect that Full Service Partnership clients will require a lower client-to-staff ratio than other age groups.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: Yolo	Fiscal Years: 05/06, 06/07 and 07/08	Program Work Plan Name: Consumer Wellness Alternatives (for Adults)
Program Work Plan #: 3		Estimated Start Date: April 1, 2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Consumer Wellness Alternatives program will help advance the goals of the MHSA by providing to adults with serious mental illnesses comprehensive community mental health services that are voluntary, client-directed, strength-based, built on principles of recovery and wellness, and delivered responsively and respectfully in the community in a manner sensitive to the cultural needs of each individual served. Whenever appropriate, these services will include the family, as defined by the client. Those "Wellness Alternatives" available to consumers will include opportunities to access housing, self-help programs, employment supports, family involvement, substance abuse treatment, assistance with criminal court proceedings, and crisis stabilization assistance, thereby offering several alternatives to support the individual client's prospects for wellness and recovery. A center will be developed to interface the various supports and services as well as have available transitional housing for a limited number of consumers. This center will be strategically located for easy access to other mental health and county resources and will be available for all consumers. Unique to this program will be services and supports teams that will provide comprehensive and coordinated services to consumers facing difficulties in specialized areas. Primary target populations for this program will be (1) adults with serious mental illnesses who are homeless or at risk of homelessness in Woodland and Davis (Yolo County has established AB 2034 services in West Sacramento); (2) adults with serious mental illnesses who are involved in the criminal justice system countywide. Priority consideration for services will also be given to adults with mental illnesses who have co-occurring substance abuse disorders or other serious health problems, and to adults who are frequent users of psychiatric hospital and emergency room services but are not otherwise served by the mental health system. Efforts to engage non-English speaking consumers among these priority populations will be enhanced, and emphasis	

	will be placed on hiring bi-lingual Personal Service Coordinators. Community services and supports teams will provide intensive services to clients (and when appropriate, to their families) on a 24/7 basis. Personal Service Coordinators from all MHSA services and supports teams will collaborate to provide after-hours services to MHSA Full Service Partnership clients. As part of his or her Full Service Partnership Plan, each client will participate in drafting a detailed stabilization plan, to which all staff performing after-hours services will have access when needed. All MHSA Full Service Partnership clients will be offered regular opportunities to become acquainted with any staff member who may provide them with after-hours services.
Priority Population: *Describe the situational characteristics of the priority population*	The Consumer Wellness Alternatives program priority population will be adults age 18 and older who have a serious and persistent mental illness, with special emphasis on un-served or underserved cultural groups. Priority will be given to those individuals who are currently un-served, such as those who are homeless or at risk of homelessness; those who are underserved, such as those adults with serious mental illnesses involved in the criminal justice system, or those who have a co-existing diagnosis of substance abuse; those who are inappropriately served, such as those adults who are frequent users of hospital and emergency room services but are otherwise not served by the mental health system.

9) *Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.*

The program offering services to adults with serious mental illnesses will adhere to the Yolo County Cultural Competency Plan. Additionally, moving from "teacher to student", the department and program staff will seek out knowledge and information regarding the specialized culture-specific needs, cultural complexities and language of each program participant. Emphasis will be placed on developing awareness of and sensitivity to the unique needs of consumers who are homeless, involved with the criminal justice system, and/or who are dealing with co-occurring disorders. Perhaps the most critical way in which the program addresses ethnic and cultural disparities is by engaging clients and reaching out to them where they live—seeking out consumers who need services but who have not (for whatever reason) sought services directly from us. Strategies for meeting the needs of diverse populations include providing services within the person's own community, offering services in the client's native language, building trust within the context of the consumer's culture and beliefs, and placing a high value on the relationships CSS team members have with each consumer. Staff will take the time to learn about the individual consumer's culture and try to understand that culture relative to the culture of the larger community.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff will be trained and oriented to be aware of all facets of cultural competence, including those relating to sexual orientation and gender. Contracts and linkages with agencies and professionals in the area and region successfully serving and creating programming for gay lesbian, bisexual, transgender, or questioning clients will be developed. Consistent with the principles of cultural competency, the department and staff will assess current practices, lack thereof and behaviors that may have contributed or that are contributing to limiting access to care for this cultural group. The focus will be to improve the quality and effectiveness of care for individuals from varying sexual orientations. In addition, programming and services will incorporate gender-sensitive practices. The overarching principles of service delivering will be embedded in cultural competency strategies that will focus on the consumers' needs to encourage independence, sustain wellness, promote recovery and effectively treat all consumers with sensitivity and respect.

EXHIBIT 4: COMMUNITY SERVICES AND SUPPORTS WORK PLAN SUMMARY		
County: YOLO	Fiscal Years: 05/06, 06/07 and 07/08	Program Work Plan Name: Older Adult Outreach and Assessment Program
Program Work Plan #: 4		Estimated Start Date: April 2006
Description of Program: *Describe how this program will help advance the goals of the Mental Health Services Act*	The Older Adult Outreach and Assessment Program (OAOAP) will expand the existing services Yolo County ADMHS is presently providing for older adults. Currently, the department offers assessment services and linkage to resources for older adults experiencing mental health problems that interfere with their ability to live independently in the community. The expansion of this program will help advance the goals of the Mental Health Services Act by allowing ADMHS to expand services to older consumers and extend them to un-served and underserved older adults belonging to certain ethnic groups and to those living in the rural areas of Yolo County. The OAOAP will continue to provide mental health assessments to older adults who are at risk of institutionalization or hospitalization due to mental health problems and who need case coordination with services. In addition, the OAOAP will include in its program an out of home crisis stabilization component for older adults. This component will be voluntary and offered as one option in the continuum of choices for the client which will include remaining at home with supports, skilled nursing facility, or crisis residential. This new service component will involve close collaboration with hospital emergency rooms and other community agencies to provide comprehensive assessments, integrated case coordination, individualized care planning, and housing options. Our Older Adult Senior Peer Mentors Program participants and additional outreach workers will provide opportunities for earlier interventions to avoid crisis situations for the older adults and create more opportunities for support through companionship and counseling. Services will continue to be voluntary, client-directed and strength-based. Staff will employ wellness and recovery principles, addressing both immediate and long-term needs of program members, and they will deliver services in a timely manner	

	that is sensitive to the cultural needs of those served.
Priority Population: *Describe the situational characteristics of the priority population*	The Older Adult Outreach and Assessment Program will serve adults 60 years of age and older who are at risk of losing their independence and being institutionalized due to mental health problems. These individuals may have underlying medical problems and co-occurring substance abuse issues. Priority will be given to underserved rural populations of older adults, and to those of ethnic and cultural backgrounds who are identified as underserved.

9) *Discuss how the chosen program/strategies will be culturally competent and meet the needs of culturally and linguistically diverse communities. Describe how your program and strategies address the ethnic disparities identified in Part II Section II of this plan and what specific strategies will be used to meet their needs.*

The Program will adhere to the Yolo County Cultural Competency Plan. Perhaps the most critical way in which the OAOAP addresses ethnic and cultural disparities is by conducting outreach and engagement in the community where the target populations live. Outreach will take place in western Yolo County, which includes several small towns in rural areas. Similarly, ethnically sensitive outreach will be performed for the Latino and Russian communities in other parts of the county. We will attempt to hire individuals that are bi-lingual (Spanish/English and Russian/English), and all staff will be trained in principles of cultural competence and in understanding the specific needs of older adults. All staff will have linguistic resources available to aid them in communicating with non-English speaking consumers.

10) Describe how services will be provided in a manner that is sensitive to sexual orientation, gender-sensitive and reflect the differing psychologies and needs of women and men, boys and girls.

Staff will be trained and oriented to all facets of cultural competence, including those relating to sexual orientation and gender. In areas such as treatment, employment, housing and residential treatment, appropriate advocacy and accommodations will be made based on these matters.

Older adult consumers who are gay, lesbian, bi-sexual or transgender will be offered opportunities to access the support of other consumers. Whenever possible, the consumer's needs will be met in such a manner as to encourage independence, sustain wellness, and promote recovery. Staff will treat all consumers with sensitivity and, above all, respect.

Attachment B—ADMH Contract Language

Contracts to all ADMH Service Providers include the following requirements with regard to Cultural Competency:

Required **annual reports** for each fiscal year include:

- Training Summary
  This report summarizes all training provided to Contractor's staff and all outreach training performed by Contractor's staff.
  Due date: July 31

- Cultural Ethnicity & Linguistic Competency Report
  Due date: July 31

- Cultural Competency Training Report
  Due date: July 31

- Staff/Volunteer Ethnicity Survey
  Due date: Upon Request

Section VI, CULTURAL COMPETENCY

A. Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals which enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations.

B. Contractor recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. Providing medically necessary specialty behavioral health, substance abuse, and co-occurring disorder services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost-effective services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

C. Contractor shall assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health, substance abuse, and co-occurring disorder services.

D. Contractor shall provide cultural competency training on an annual basis to staff providing mental health services. This training shall address the ethnic, cultural, and language needs of clients. Training can be provided by County on a space available basis or obtained by Contractor from an independent source(s). As outlined in Exhibit C, Terms and Conditions,, Contractor shall provide the County with documentation of cultural competency training. This annual Culture Competency Training Report is due by July 31 each year and will cover the period July 1 through June 30 of the previous fiscal year

E. Contractor shall complete and submit to the County a Cultural, Ethnicity, and Linguistic Competency Report at the times and in the manner requested by the Director. Annually, the report shall include the date of the training, names of those trained, training topic, and copies of handouts. This annual report is due by July 31 each year and will cover the period July 1 through June 30 of the previous fiscal year.

F. Contractor shall also submit to the County copies of the Staff/Volunteer Ethnicity Survey for all staff hired during the previous fiscal year. Copies of this survey are due upon request each year and will cover the period July 1 through June 30 of the previous fiscal year.

Yolo County

Prevention and Early Intervention (PEI)

Community Planning Process

Narrative Report of Findings

Submitted by California Institute for Mental Health (CiMH)

May 15, 2008

ATTACHMENT C

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I. Introduction: The Information Gathering Process

In support of Yolo County efforts to plan for Prevention and Early Intervention services utilizing MHSA funding, a community engagement and data collection process was initiated to collect input and information from a variety of sources.

Compiled Data:

"Data Brief": A data brief was compiled for use in framing the issues pertinent to the Yolo County region and constituents. Dr. Sarah Taylor initially compiled this brief, with M. Anne Powell, MSW, PhD Candidate and Will Rhett-Mariscal, PhD (CiMH) on March 10th. An updated version on April 28th, 2008 was informed by a community stakeholder meeting on April 7th and by data sources shared by stakeholders within Yolo County *(See Attachment One, "Data Brief - Revised April 28, 2008"; Attachment Two, "Yolo County Probation Department 2008/2008 Comprehensive Multiagency Juvenile Justice Plan).*

New Data:

Key Informant Interviews (KII) – Twenty-five (25) key informant interviews were conducted, including: Eighteen (18) service providers, six (6) community members or entities (includes education), and one (1) target population (LGBT) respondent.

Focus Groups – Four (4) focus groups were conducted reaching a total of fifty (50) individuals, with ten (10) to fourteen (14) attendees per group. Focus groups were conducted in community settings to facilitate outreach and engagement of targeted ethnic and cultural communities, as well as consumers and family members (African American adult and elders community; Russian elders and Russian adult support group [AOD]; and NAMI).

Target Population Survey – One survey was conducted in Esparto at the farmers' market to outreach to the Latino community and a total of nine (9) respondents participated.

Target Populations – KIIs, Focus Groups and Surveys yielded input from specific ethnic, racial and cultural communities including: Russian; African American; Asian; tribal; LGBT. Additionally, interviewees represented homeless; TAY; adults; older adults and faith-based communities.

Methods - Interviews were conducted in person and through telephone interviews, as well as facilitating surveys distribution and receipt via fax or email, to suit the convenience of the interviewee and to maximize response rate. A survey tool was developed and used to collect data, and adapted for use with community *(see Attachment Three, Key Informant Interview-Community)*, service

providers *(Attachment Four, Key Informant Interview-Service Provider)*, and target populations *(Attachment Five, Key Informant Interview-Target Population)*.

Community Stakeholder Meetings – A total of eight community meetings have been held to date (through May 14, 2008), with a ninth scheduled for May 21, 2008. These meetings were open to the public, held between 5pm-8pm in county facilities in community room settings.

Three initial informational meetings were conducted in February 2008 in Woodland, Davis and West Sacramento to facilitate community awareness of the PEI planning process underway in Yolo County. These locations represent the three major cities in Yolo County. Subsequent meetings addressed: Initial Needs Assessment Reporting (March 10, 2008); Needs Assessment Update (March 27, 2008); Education on PEI Strategies and Programs (April 7, 2008); Summary of Input: PEI Strategies (April 22, 2008); and Discussion of PEI Strategies (May 5, 2008). The meeting scheduled for May 21, 2008 will address: Summary of Input; Facilitation and Consensus *(See Attachment Six, Yolo County PEI Meeting Schedule)*.

II. Findings

The community input process (see Part I. above) yielded the following identified Barriers; Existing Resources and Community Strengths; Preliminarily Recommended Strategies to address barriers; Other Concerns.

a. Barriers

Isolation – There were a number of factors indicating actual or potential isolation of individuals in Yolo County who may benefit from access to services related to PEI. General barriers included: Rural geographic areas; Poverty; Limited or lack of transportation in urban and rural areas. For the elderly, in particular, there was an identified lack of health coverage for hearing aides that impacts some individuals' ability to communicate with others or to ask for help. Barriers directly related to mental health care and needs included stigma and fear of labeling related to mental illness (thereby limiting ability to access services without a diagnosis). For youth, in particular, there was acknowledgement that some youth are able to access counseling through school settings; however, are limited outside of school due to fear of "being out" (LGBT), lack of insurance (youth without family insurance, living with friends or on their own) and the requirement of parental consent for counseling services.

Funding – Two themes emerged around funding issues: Discussion of limitations to funding, both locally (e.g. for TAY) and statewide for mental health care and regarding concerns about individuals and families ability to access care due to "funding issues". For individuals and families, it was identified that some people do not meet criteria for funded services. As well, some people either have private insurance that is not comprehensive (thereby excluding needed services) or lack insurance entirely. Alternatively, there are people who may qualify for public services (e.g. Section 8), but those funds or services are "closed to applications" due to system funding limitations.

Service Delivery – According to the data, two chronic concerns related to service delivery included: Difficulty accessing services and shortage of providers.

Access barriers to services included: Lack of transportation, specifically related to public transportation in remote areas and poor frequency of transportation; Lack of awareness of existing mental health or related services, as well as poor understanding about process to access services; Stigma related to asking for assistance; Insufficient community based services; Cultural norms precluding getting "mental health" help (e.g. Latino community); Ethnic and cultural groups not feeling welcomed by existing services; and fear of repercussions to seeking formal services, specifically around "documentation" issues.

Barriers related to providers included: Lack of providers to meet specific needs, such as psychiatrists to work with geriatric community issues ("only one Medicare psychiatrist" per one KII); Inadequate referral resources in communities

to meet needs; Fragmentation of existing services, with poor communication between providers; and a sense of people who could benefit from services *not* being identified for services (i.e. maternal depression impacting care of infants, but no treatment offered).

Lack of Services - Additional barriers identified were related to families with children. Specifically, low-income, new immigrants and those families with generational gang involvement were of concern to those providing community input.

An absence of providers to provide prevention and early intervention services to families with infants and young children "at risk" - or for those young children experiencing psycho/social/behavioral problems who may benefit from early childhood mental health services at onset – was identified. Outreach to parents of such children also was felt to be absent. Engagement of school staff, counselors and administrators in being "at the table" for planning mental health care was considered critical as schools are ready points of access for reaching children in need. It was also noted that children exhibiting behavioral issues tended to be the primary beneficiaries of school-based services (e.g. truancy programs) and there was a lack of community resources to refer all children to outside of school.

In particular, transition-age youth (TAY) programs were felt to be lacking among community-based organizations. There was also reported to be an absence of mental health services, one-on-one counseling, substance abuse counseling and intervention, family / parent counseling, counseling related to gang involvement and depression. The absence of such services was believed to contribute to an increased likelihood that youth will enter the juvenile justice system or that their mental health problems would intensify.

Other notable concern – It was a noted concern that the community perceives Probation as Law Enforcement; thereby impacting community trust in and reliance on probation.

Need for Culturally Relevant Services – Language barriers posed a large cultural barrier for individuals and families. Specifically, challenges identified included: Difficulty "finding" (employ, enlist help of) individuals who speak the language of those seeking help; Need for children to interpret for parents with providers; and a need to provide interpreter training and quality assurance.

Immigration and refugee issues also were identified as cultural concerns, particularly related to the Post-Traumatic Stress Disorder (PTSD) experienced by many individuals in refugee or immigrant communities.

Ethnic- and cultural-specific services were also reported as necessary (e.g. Drug treatment for Latinos, group homes for Russians, LGBT youth).

b. Existing Resources / Community Strengths

Following is an inventory of: Agencies; Programs; Strategies; Funding sources; Staffing and Training assets existing within Yolo County. These were reported by stakeholders and may be considered for leveraging future services.

Agencies

Family Service Agency
CASA
Communicare
Yolo Family Resource Center (with bilingual, bicultural staff)
Esparto Family Practice
First 5 Yolo Children and Families Commission
Yolo County Children's Alliance
Yolo ADMH
Winters Healthcare Foundation
RIZE, Inc.
Yolo Crisis Nursery
Suicide Prevention Agency
FamiliesFirst, Inc.

Programs

DESS – ILP for TAY
Youth MIOCR program
The Gay-Straight Alliance (GSA) clubs in all large high schools except West Sacramento – create supportive environment for lesbian, gay, bisexual, transgender and allied youth at school.
Teaching Tolerance curriculum from Southern Poverty Law Center – provides good activities for school sites to teach respect for all youth.Same is true of Gay-Straight Alliance (GSA) Network in SF.
"Adopt a social worker" (and their caseload!) happens in some churches.
NAMI "Beginnings" newsletter for children and families.
UC Davis
Sacramento City College - has satellite campuses in Yolo County.
Woodland Community College
Faith Communities
Grace In Action
Families and Self Help in West Sacramento
Older Adult Mobile Access Team
Older Adult Program
Eleanor Roosevelt Circle
Rehab House in Russian Community in West Sacramento
Wellness Center
Collings Teen Center, West Sacramento (not a program, but could serve as an access point for services)
Slavic Parents Association
School District Mental Health Services-

Special Education
School District Mental Health Services (continued)
Outreach for truancy and substance abuse
Counseling at one school through partnership with CSUS
Parenting and substance abuse classes
Access to Counseling without parental consent while on school (k-12) campuses
Prevention Program in school
Parenting classes: Parent Project through Davis Police Department and FRCs; Court-mandated for parents (FSA and Families First); Communicare; FRC (Plan to lead, Pi, Mega skills, Teen Parent classes; County (Nurturing Parenting, Making Parenting a Pleasure).
Woodland Truancy Mediation referred to FRC
Davis Truancy Program

Existing Strategies

Partnerships with community-based organizations (CBOs)
People use church for help in crises
Probation case-management with youth
Probation now doing mental health screen on every referral who could go to juvenile hall
Parent-Child Interactional Therapy (PCIT)
Good rapport of agency with schools, police departments and hospitals
Parent groups, information groups, 24/7 crisis lines for suicide prevention/intervention.

Funding Sources

First 5 Children and Families Commission
Access to SSI, MediCal, Medicare
Individual community donations fund Christmas program.
Child Protective Services (CPS) and other resources have received grants to support auxiliary services for families.
Davis Community Foundations
United Way
Winters Healthcare Foundation

Staff

Public Health Nurses, Nurses with mental health expertise
Student volunteer for services
Bilingual/Bicultural staff at Family Service Agency and Family Resource Center.

Training

UCD infant mental health training (from Napa)
NAMI Provider Training Program

Migrant education for children, emancipated youth and parents; health and social welfare services, capacity building focus.
CAARES Providers Training – UCD

c. Strategies

Outreach – Recommended outreach provided in the stakeholder process revolved around the concept of outreach to "where people are, instead of having them come to you." Ideas for successful outreach included home visits; use of community-based outreach workers; stationing of staff in rural areas; development of school-based services for youth and parents; and noted adolescents and college-age youth are most important for establishing improved ways to outreach, demystify and de-stigmatize asking for help.

Additionally, integration of mental health care into primary health care settings and use of the UCD PCIT training

Engagement in Services – Stakeholders provided the following recommendations relative to engagement of individuals, families and communities in mental health services: Use of relation-based approaches, family centered services, building rapport with consumers. Case-management services and peer support groups in communities were suggested vehicles for engaging people in care, as well as potential partnerships with ADMH and community agencies with Probation. Important nuances in how services are delivered to increase engagement addressed the need to "be there when people ask for help" and to provider for "walk-ins". Promotoras in Winters was also specified as important for engagement.

Providing training and education related to Stigma – In order to reduce the stigma experienced by those seeking, receiving or who may benefit from services, the following recommendations were made: Have education ready for families of children and for children with identified needs; Provide data and statistics to further community education; Provide education to reduce harassment of LGBT youth beginning in grade school, through high school; and Providing education via health fairs and community events.

Training of non-mental health professionals – The need for training in a variety of settings underscored the relevance of various disciplines and professions to be poised to refer those in need of mental health care. Schools, childcare settings teachers, school counselors, psychologists, foster parents, special education teachers and parents were initially identified. Additional targeted professionals for training to recognize mental health symptoms included: Primary care physicians, pediatricians, nurses and home visitors. Promotoras was, again, specified as a critical method to be utilized.

Provision of Culturally Appropriate Services – This area of concern addressed needs for culturally relevant services. Specifically: Interpreters for Russian

b. Age Focus of Key Community Needs

Community members, community organizations and service providers all identified the following age groups:

Community Members and Organizations:
TAY (16-25 years)
Infant, children and youth (0-15)
Adults (26-59)
Older Adults (60+)

Service Providers:
Infant, children and youth (0-15)
TAY (16-25 years)
Adults (26-59)
Older Adults (60+)

c. Priority Populations

Community members, community organizations and service providers all identified the following priority populations:

- Children, youth and TAY at risk for/experiencing juvenile justice involvement
- Children, youth and TAY at risk for school failure
- Individuals exposed to Trauma
- Infants, children and youth in stressed families
- Individuals with First Onset of Serious Psych. Illness
- Underserved Cultural Populations

Age groups for the Priority Populations were identified as:

- TAY (16-25)
- Infants, children and youth (0-15)
- Adults (26-59)
- Older Adults (60+)

IV. Summary Key Needs and Priority Populations

Based upon the community input and needs assessment conducted in the community planning process the following Top Key Community Mental Health Needs were identified to be:

- Disparities in Access (Rural areas; Lack of insurance; Lack of transportation; Lack of awareness of services; Lacking services, providers and staff);
- Stigma and Discrimination (within cultural communities [Russian, Latino, LGBT] as well as mental health); and
- Psychosocial impact of Trauma (victims of assault, child and elder abuse; domestic violence, refugees).

speaking, Pakistani, Urdu/Punjab communities; Support groups for LGBT youth and adults; Social acceptance of LGBT community members and organizations; Rural-specific design of rural services; and community-based cultural competence were recommended strategies.

Recommended Types of Services - Recommendations included One-Stop services; Evidence-based practices (EBP); Non-literacy based services; After school programs; Strength-based care; and Adult Protective Services workers who could assist when older adults are exploited to decrease risk of exploitation and prevent elder abuse.

System-level Recommendations – Stakeholders encouraged the development of relations, collaborations and coordination between agencies and schools, as well as between agencies and community. Provision of local services, flexible services and tapping into existing agency expertise was also promoted. A practical first step for the stakeholders, themselves, was for the county to share the roster of attendees in the planning process to facilitate networking.

Additional Strategies to leverage funding, partnerships and programs included: Leveraging MHSA money with First 5 funds; Working with transportation programs to coordinate services among special needs populations; Linking EDAP with UC Davis; Transferring two (2) CSS programs into the PEI category (Older Adults and early detection of depression) and use CSS funds for employment services; and considering prevention services for children who reside in RCL 14 and below.

d. Other Considerations related to Strategies - The following questions and concerns were also posed in the stakeholder process related to strategies:

- Probation not funded under Yolo CSS.
- Will CBOs really have a chance to receive funding under MHSA PEI?
- Parentification of children is a big contributing factor to "infant, children and youth in stressed families" and can lead to behavior issue for youth.
- Increased resources needed to help people learn English.
- Employment needs of community.
- Imperative to take resources into account when planning mental health services.
- Need for LGBT-affirming youth development opportunities.

III. Synthesis of Findings

a. Key Community Needs

Community members, community organizations and service providers all identified the following needs in the same order of priority: Disparities in Access; Stigma and Discrimination (Mental Health); Psychosocial impact of Trauma; At-risk infants, children and youth and TAY; Suicide Risk.

Based upon the community input and needs assessment conducted in the community planning process the following Primary Age Groups were identified relative to the Community Mental Health Needs: TAY (16-25 years) and Infants, children and youth (0-15).

In summary, priority populations were found to be:

- "Children, youth and TAY at risk for /experiencing juvenile justice involvement" that include youth experiencing behavioral and substance abuse problems and not getting help;
- "Children, youth and TAY at risk for school failure" that include those requiring services not available at school or in the community;
- "Individuals exposed to Trauma" which includes victims of assault, child and elder abuse, domestic violence, refugees;
- "Infants, children and youth in stressed families" including those lacking prevention services, within isolated families experiencing stress and those with parents who are currently receiving mental health treatment or otherwise "in the system";
- Individuals with First Onset of Serious Psych. Illness, noting those without access to medical care who are less likely to have their symptoms of mental illness recognized;
- Underserved Cultural Populations, noting families and individuals unaware of services and those needing mental health education.

The age groups are, as previously noted, prioritized to be TAY (16-25) and Infants, children and youth (0-15).

ATTACHMENT D

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category – page 1

SUMMARY OF COMPLETE COUNT AND EXTRAPOLATED ESTIMATES: ALL SEGMENTS

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers)										
Mental Health Rehabilitation Specialist	15.3	0	0.0							
Case Manager/Service Coordinators	0.0	0	0.0							
Employment Services Staff	0.0	0	0.0							
Housing Services Staff	0.0	0	0.0							
Consumer Support Staff	0.0	0	0.0							
Family Member Support Staff	0.0	0	0.0							
Benefits/Eligibility Specialist	1.6	0	0.0	(*Unlicensed* Mental health Direct Service Staff; Sub-Totals only)						
Other *Unlicensed* MH Direct Service Staff	0.0	0	0.0							
Sub-total, A (County)	16.9	0	0.0	16.9	0.0	0.0	0.0	0.0	0.0	16.9
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Mental Health Rehabilitation Specialist	14.6	2	5.5							
Case Manager/Service Coordinators	11.0	2	0.0							
Employment Services Staff	0.0	0	3.7							
Housing Services Staff	3.7	0	3.7							
Consumer Support Staff	21.9	0	3.7							
Family Member Support Staff	4.4	0	0.0							
Benefits/Eligibility Specialist	1.8	2	3.7	(*Unlicensed* Mental health Direct Service Staff; Sub-Totals and Total only)						
Other *Unlicensed* MH Direct Service Staff	165.4	4	12.8							
Sub-total, A (All Other)	222.8	9	32.9	82.2	32.9	51.1	45.7	3.7	7.3	222.8
Total, A (County & All Other)	239.7	9	32.9	99.1	32.9	51.1	45.7	3.7	7.3	239.7

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category – page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-Panic/ Latino	African-Ameri-Can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers)										
Psychiatrist, general, child/adolescent, or geriatric	0.0	0	0.0							
Psychiatric or Family Nurse Practitioner	1.6	0	0.0							
Clinical Nurse Specialist or Licensed Psych Technician	0.0	0	0.0							
Licensed Clinical Psychologist	0.0	0	0.0							
Psychologist, registered intern (or wavered)	0.0	0	0.0							
Licensed Clinical Social Worker (LCSW)	0.0	0	0.0							
MSW, registered intern (or waivered)	0.0	0	0.0							
Marriage and Family Therapist (MFT)	0.0	0	0.0							
MFT registered intern (or waivered)	0.0	0	0.0							
Other *Licensed* MH Staff (direct service)	27.6	0	0.0							
Sub-total, B (County)	29.2	0	0.0	5.8	13.6	1.6	4.9	0.0	3.2	29.2
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Psychiatrist, general	2.7	2	3.7							
Psychiatrist, child/adolescent	0.2	0	0.0							
Psychiatrist, geriatric	0.0	0	0.0							
Psychiatric or Family Nurse Practitioner	0.0	0	0.0							
Clinical Nurse Specialist	0.0	0	0.0							
Licensed Psychiatric Technician	16.4	2	9.1							
Licensed Clinical Psychologist	0.0	0	0.0							
Psychologist, registered intern (or waivered)	0.0	0	0.0							
Licensed Clinical Social Worker (LCSW)	86.8	2	1.8							
MSW, registered intern (or waivered)	30.1	5	5.5							
Marriage and Family Therapist (MFT)	64.4	4	1.8							
MFT registered intern (or waivered)	11.0	4	3.7							
Other *Licensed* MH Staff (direct service)	0.0	2	1.8							
Sub-total, B (All Other)	211.7	20	27.4	187.1	15.5	0.0	1.8	0.0	7.3	211.7
Total, B (County & All Other)	241.0	20	27.4	192.9	29.2	1.6	6.7	0.0	10.6	241.0

(*Licensed* Mental health Direct Service Staff; Sub-Totals only)

(*Licensed* Mental health Direct Service Staff; Sub-Totals and Total only)

ATTACHMENT D

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category – page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	His-Panic/ Latino	African-Ameri-Can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers)										
Physician	3.9	0	0.0							
Registered Nurse	0.0	0	0.0							
Licensed Vocational Nurse	0.0	0	0.0							
Physician Assistant	0.0	0	0.0							
Occupational Therapist	0.0	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)	0.0	0	0.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0.0	0	0.0							
Sub-total, C (County)	3.9	0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	3.9
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Physician	1.8	2	1.8							
Registered Nurse	54.8	2	0.0							
Licensed Vocational Nurse	25.6	4	1.8							
Physician Assistant	1.8	2	0.0							
Occupational Therapist	0.0	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)	11.0	0	0.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	100.4	0	0.0							
Sub-total, C (All Other)	195.4	9	3.7	140.6	20.1	20.1	0.0	1.8	9.1	191.7
Total, C (County & All Other)	199.3	9	3.7	144.5	20.1	20.1	0.0	1.8	9.1	195.6

(Other Health Care Staff, Direct Service; Sub-Totals Only)

(Other Health Care Staff, Direct Service; Sub-Totals and Total Only)

ATTACHMENT D

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category – page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	His-Panic/ Latino	African-Ameri-Can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers)										
CEO or manager above direct supervisor	9.4	0	0.0							
Supervising psychiatrist (or other physician)	0.0	0	0.0							
Licensed supervising clinician	0.0	0	0.0							
Other managers and supervisors	13.4	0	0.0							
Sub-total, D (County)	22.8	0	0.0	14.9	3.2	0.0	2.9	1.6	0.0	22.7
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
CEO or manager above direct supervisor	53.5	9	12.8							
Supervising psychiatrist (or other physician)	0.0	0	0.0							
Licensed supervising clinician	8.3	7	2.3							
Other managers and supervisors	52.8	4	14.6							
Sub-total, D (All Other)	114.6	20	29.7	91.0	3.5	3.7	3.7	0.0	11.0	112.8
Total, D (County & All Other)	137.4	20	29.7	106.0	6.7	3.7	6.6	1.6	11.0	135.5
E. Support Staff:										
County (employees, independent contractors, volunteers)										
Analysts, tech support, quality assurance	2.9	0	0.0							
Education, training, research	0.0	0	0.0							
Clerical, secretary, administrative assistants	3.2	0	0.0							
Other support staff (non-direct services)	18.7	0	0.0							
Sub-total , E (County)	24.8	0	0.0	12.6	3.2	2.4	0.0	3.2	3.2	24.8
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Analysts, tech support, quality assurance	0.0	0	0.0							
Education, training, research	3.7	0	0.0							
Clerical, secretary, administrative assistants	46.7	2	5.5							
Other support staff (non-direct services)	77.4	2	0.0							
Sub-total , E (All Other)	127.8	4	5.5	80.0	14.6	9.1	15.0	1.8	3.7	124.2
Total, E (County & All Other)	152.6	4	5.5	92.6	17.9	11.6	15.0	5.1	6.9	149.0

(Managerial and Supervisory; Sub-Totals Only)

(Managerial and Supervisory; Sub-Totals and Total Only)

(Support Staff; Sub-Totals Only)

(Support Staff; Sub-Totals and Total Only)

ATTACHMENT D

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category – page 5

GRAND TOTAL WORKFORCE (A+B+C+D+E)

Major Group and Positions	Estimated # FTE authorized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	Race/ethnicity of FTEs currently in the workforce -- Col. (11): White/ Caucasion	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	Multi Race or Other	# FTE filled (5)+(6)+(7)+(8)+(9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
County (employees, independent contractors, volunteers) (A+B+C+D+E)	97.7	0	0.0	54.2	20.1	4.1	7.8	4.9	6.5	97.6
All Other (CBOs, CBO sub-contractors, network providers, and volunteers (A+B+C+D+E)	872.3	62	99.1	580.9	86.6	84.0	66.1	7.3	38.3	863.2
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	970.0	62	99.1	635.1	106.7	88.1	73.9	12.2	44.8	960.7

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

Major Group and Positions				Race/ethnicity of individuals planned to be served -- Col. (11): White/ Caucasion	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	Multi Race or Other	All individuals (5)+(6)+(7)+(8)+(9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			58.4%	17.5%	5.8%	3.9%	1.4%	13.0%	99.9%

NOTE: Detail may not add to total, due to rounding.

ATTACHMENT D

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by consumers or family members	Position hard to fill with consumers or family members? 1=Yes; 0=No	# additional consumer or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	1.6	2	3.7
Family Member Support Staff	6.5	0	0.0
Other *Unlicensed* MH Direct Service Staff	1.6	0	0.0
Sub-total, A:	9.7	2	3.7
B. *Licensed* Mental Health Staff (direct service)	0.0	2	0.0
C. Other Health Care Staff (direct service)	4.9	2	0.0
D. Managerial and Supervisory	16.2	2	0.0
E. Support Staff (non-direct services)	1.8	2	0.0
GRAND TOTAL (A+B+C+E+E)	32.7	9	3.7

ATTACHMENT D

III. Language Proficiency

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the langue, 93) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3)

Language, other than English		Number who are proficient	Additional number who need to be proficient	TOTAL (2)+(3)
(1)		(2)	(3)	(4)
1. Spanish	Direct Service Staff	65	15	80
	Others	23	0	23
2. Russian	Direct Service Staff	9	2	11
	Others	3	0	3
3. German	Direct Service Staff	7	0	7
	Others	3	0	3
4. Chinese	Direct Service Staff	13	0	13
	Others	0	0	0
5. Other	Direct Service Staff	2	0	2
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	96	17	113
	Others	29	0	29

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

A. Shortages by occupational category: According to the Needs Assessment and past experience, Yolo County has had difficulty recruiting and retaining direct service providers such as Psychiatric Nurse Practitioners and a sufficient number of Licensed Clinicians. The current economy, the financial status of counties in general, and Yolo County specifically, in addition to our need to stay financially stable often preclude us from hiring individuals for some of these positions, even when deemed necessary. Due to economic short falls in the past fiscal year our workforce was reduced by 55 Full-Time Equivalents (FTE). In order to introduce and/or host interns and volunteers to provide necessary services in our county while enhancing our reduced workforce, additional Licensed Supervising Clinicians are desperately needed.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services: Using data from our Needs Assessment and other surveys compared to data from our automated Electronic Health Record, we found very few disparities in race/ethnicity in our workforce compared to our consumers. However, by city and clinical site additional Spanish-speaking, Latino-culture members and Russian-speaking, Russian/Ukrainian-culture members are needed in our workforce. This is particularly true of clinical, direct-service staff.

C. Positions designated for individuals with consumer and/or family member experience: (There were a number of respondents who had difficulty completing this portion of the survey—the results on some provider surveys included numbers that mimicked exactly the numbers in the previous portion of the survey. The totals in these areas may be skewed for this reason.) The current fiscal economy and recent workforce reduction via civil service rules resulted in the lay off several individuals holding positions that were filled by consumers and/or family members. Our priority, however, is to increase the number of staff members in our workforce to include more consumer and family members as soon as possible.

D. Language proficiency: Besides English, the two other prevalent languages spoken in our communities are Spanish and Russian. The percentages of our direct providers that speak these languages mirror our consumer percentages. These bilingual providers travel to various sites to provide their language skills to consumers. But travel is costly in both time and resources. We must have a large enough workforce, particularly direct service staff members, which speak Spanish and Russian to be assigned to our three (3) primary sites. Interpreters trained for psychotherapy appropriate interaction are rare and expensive if available; however, through cost analysis, we would like to research the feasibility of this service, as well.

E. Other, miscellaneous: According to a training survey of staff members and providers, many requested more training in promoting wellness, recovery and resiliency while allowing them to maintain their required Continuing Education Units. (See a summary of results under Exhibit 4, Action # 4, "Mental Health Professional Development.") When we are able to hire more consumer and family members, they, too, will need training regarding wellness, recovery and resiliency. All staff members need more training on cultural competence, especially relative to Latino and Russian cultures. Stakeholders shared concerns with the number of African American and Asian mental health service providers in our workforce, as well. Yolo County ADMH can use training for staff members who have had Alcohol and Drug experience to learn to be more wellness-focused. ADMH staff members also need training to become equipped with the tools necessary to provide services to the large community of consumers with co-occurring disorders.

ATTACHMENT D

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Language and Special Communications Needs**

POLICY

The Yolo County Alcohol, Drug & Mental Health Department (ADMH) is committed to ensure that all consumers have equal access to information and services. Individuals who require language assistance or who have other special communication needs will be accommodated in an appropriate and effective manner.

Clients have a right to access these language assistance services at no charge. Clients shall be notified of their rights through staff report and ADMH informing materials.

PROCEDURE

A. Language Assistance

1. Communication assistance will be available, at no cost, to all consumers through bilingual staff, client selected interpreters, or the Universal Language Line.

2. ADMH staff may access Language Line services by using any phone or the Language Line dual handset phone (see Attachment PP-501-A).

3. Quality Improvement will provide clinical and support staff with a list of interpreters and bilingual staff. ADMH will use the Language Line when bilingual staff or client-selected interpreters are not available. Language Line interpreters will be used as a last resort.

4. ADMH will not expect family members to provide interpreter services for consumers. Family members may, however, be used as interpreters in the following limited circumstances:

   a. At point of contact to initiate intake and to request an interpreter

   b. When it is the consumer choice to use a family member

5. Upon entry to services, and as made known to or recognized by clinical staff, interpreter arrangements will be made. Working with the client at the first point of entry, clinical staff will complete the "Consumer Agreement to Interpreter Services," indicating that the consumer has been offered an ADMH interpreter and has either accepted or has elected to use a non-ADMH interpreter (see Attachment B).

6. If the consumer selects a non-ADMH interpreter, this individual shall sign the ADMH Confidentiality Agreement prior to providing services. The signed Agreement

ATTACHMENT E

will be placed in the consumer's file.

7. If the treating clinician determines that the interpreter selected by the client is not suitable, whether for proficiency or other reasons, either an ADMH interpreter or Language Line services will be used.

8. Quality Improvement will provide information and training, using material provided by Language Line, to train staff in using the service. Instructions for use of the Language Line will also be made available to all staff (see Attachment C).

B. Hearing and/or Speech Impairment

1.. Face-to-Face Contact

Whenever possible, ADMH will use staff trained in American Sign Language (ASL) for face-to-face contact.

a. In urgent situations, staff shall use written communication with the individual rather than coordinating ASL services.

b. In routine situations when ASL-trained staff is unavailable, arrangements for sign language interpretation services will be made through the NorCal Center on Deafness. Due to the demand for communication services, NorCal recommends that requests for services be made at least five (5) days in advance. Staff may schedule an appointment by calling 916-349-7525. All requests for NorCal services will be provided based on staff and subcontractor availability.

2. Telephone Contact

ADMH staff shall use the California Relay Service (CRS) to communicate with individuals who are deaf, hard of hearing or speech-impaired. Staff will both receive and place calls through CRS. The CRS may be reached by dialing 711. For more information on placing and receiving calls through CRS, see Attachment D. Staff is encouraged to place a practice call with CRS prior to using this service with a client for the first time.

C. Visual Impairment

1. ADMH will assure that verbal communication is accessible to individuals who are visually impaired.

2. Whenever an individual requesting services presents as having a visual impairment, ADMH staff will assure that the individual is informed of all basic ADMH written information commonly distributed to consumers who are requesting services. In addition, staff will be available to help consumers complete required written documentation.

3. Intake staff shall offer audio tapes to the individual which have recordings of the written information contained in the following brochures:

a. Guide to Medi-Cal Mental Health Services

b. Client Problem Resolution Guide

c. Notice of Privacy Practices

ATTACHMENT E

d. Advance Health Care Directives Brochure

e. EPSDT and TBS brochures, as appropriate

4. The individual shall be loaned an audio tape player with headphones to listen to the tapes.

ATTACHMENTS

PP 500-A Language Line Services Instructions
PP 500-B Consumer Agreement to Interpreter Services
PP 500-C Language Line Dual Handset Phone Instructions
PP 500-D Using the California Relay Service (CRS)

APPROVED BY:

ADMH Director

11-3-08
Date

ATTACHMENT E

LANGUAGE LINE SERVICES INSTRUCTIONS

OUTBOUND CALLS:

1. Dial Language Line Services: 1-800-523-1786
2. Tell the Answer Point the language you need and provide:

   Client ID#: 901655
   Organization Name: Yolo County Alcohol, Drug & Mental Health Department
   Personal Code: Yolo County Employee Number
3. Wait for the Answer Point to conference in the Interpreter.
4. Brief the Interpreter on the purpose of the call. Summarize what you want to accomplish and give any special instructions.
5. Put the Interpreter on HOLD by pressing the "Flash" Button once.
6. Dial 3 for an outside line and then dial the client's number. Press the "Flash" Button one more time to initiate a three-way conference call. If you have a WALK-IN, you can either have the consumer go to another phone in the office or you can put the client on the SPEAKER with you and the Interpreter.
7. When finished, inform the Interpreter that you are ending the call.

INBOUND CALLS:

1. Client's call comes in…
2. Put the consumer on HOLD by pressing the "Flash" Button once
3. Dial Language Lines Services: 1-800-523-1786
4. Tell the Answer Point the language you need and provide:

   Client ID#: 901655
   Organization Name: Yolo County Alcohol, Drug & Mental Health Department
   Personal Code: Yolo County Employee Number
5. Wait for the Answer Point to conference in the Interpreter.
6. Brief the Interpreter on the purpose of the call. Summarize what you want to accomplish and give any special instructions (Consumer will still be on hold).
7. Hit "Flash" Button one more time to bring the consumer back and initiate a three-way conference call.
8. When finished inform the Interpreter that you are ending the call.

PP 501-A Language Line Services Instructions

ATTACHMENT E

YOLO COUNTY ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT

Consumer Agreement to Interpreter Services

The Yolo County Alcohol, Drug & Mental Health Department (ADMH) provides trained interpreters at no cost to all consumers who need such service. This service is provided to limited-English speakers, non-English speakers and persons with a hearing impairment. All consumers have the right to accept or decline this service. All consumers also have the right to select an interpreter, in which case the consumer will bear any costs associated with using such an interpreter. ADMH prohibits the use of minors as interpreters.

I have been advised of my right to use either a trained Yolo County interpreter, at no cost to me, or to select my own interpreter and bear any costs associated with this selection. This information has been provided to me in my primary language.

My primary language is:

☐ Cambodian ☐ Russian ☐ Hmong ☐ Mien ☐ Spanish ☐ Chinese ☐ Tagalog ☐ Farsi
☐ Vietnamese ☐ Cantonese ☐ Mandarin ☐ Arabic ☐ Armenian ☐ Other: _____

Check applicable box:

☐ I agree to use a Yolo County Interpreter.

☐ I request and agree to use an interpreter who is not employed by or affiliated with Yolo County, at my own cost. I release Yolo County from any liability for errors or inconsistencies associated with the use of an interpreter who is not employed by or affiliated with Yolo County.

Consumer Signature: _____ Date: _____

Name of Interpreter Selected by Consumer: *(First and Last Name)* _____

For Office Use Only

Name of Yolo County Interpreter who will assist the Consumer: _____

All interpreters who are not employed by or affiliated with Yolo County must sign the Oath of Confidentiality before providing interpreter services. The signed Oath will be placed in the consumer's file.

PP 501-B Consumer Agreement to Interpreter Services

ATTACHMENT E

LANGUAGE LINE DUAL HANDSET PHONE INSTRUCTION SHEET

FOR FACE-TO-FACE CALLS WITH NON-ENGLISH SPEAKER:

Phone Set-up:

Ask Crisis or Support staff for the white Language Line phone. Connect the phone line cord into an analog wall outlet. The analog wall outlet, if not clearly marked, is one where a brown phone may already be plugged in. (**DO NOT PLUG THE DUAL HANDSET PHONE INTO A DIGITAL LINE**, where a multi-line black phone is connected, as this may destroy the language line phone.)

Use of Phone:

- Lift the handset from the cradle on the RIGHT and press "**3**" to obtain an outside line.
- Press the red "INTERPRETER" button. (This will dial the Language Line 800 number automatically.)
- After the "Welcome" message, follow the language prompt: "Press **1** for Spanish; press **2** for all other languages."

1. If you pressed "1," you will be taken to the next paragraph (below) by an automated system. If you pressed "2," a voicemail system will prompt you for the language, and you will state your choice of language. Whether or not the system recognizes your choice of language, an operator will come on the line to ask the questions below.
2. You will be asked for a 6-digit client ID number. Enter "**101038**" or press the white "CLIENT ID" button to the right of the red interpreter button if you are being prompted by an automated system, or verbally give the "**101038**" ID to the operator if he/she has already come on the line. If asked for our company name, answer "**Yolo County Alcohol Drug and Mental Health.**"
3. You will be asked for your access code. State or punch in your county **employee number.**
4. After verifying your choice of language, the operator will link you up with the appropriate interpreter.
5. When the interpreter comes on the line, brief him/her on the purpose of the call, summarizing what you want to accomplish and provide any special instructions.
6. Have the non-English speaker pick up the LEFT handset, and proceed with the conversation.

Language Line Customer Service may be reached at 1-800-752-6096 ext 1.

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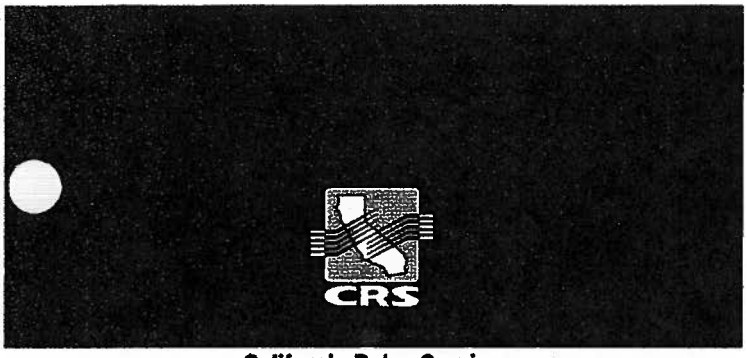
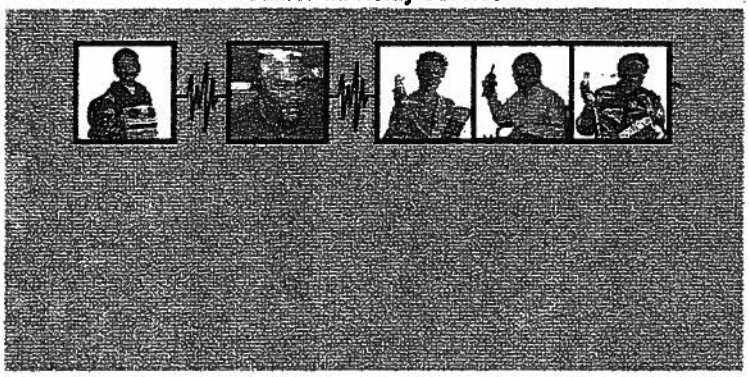


California Relay Service



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What is the California Relay Service (CRS?)

CRS is the California State program which meets Federal mandates for Telecommunication Relay Service (TRS).

The California Relay Service (CRS) enables a person using a TTY* to communicate by phone with a person who does not use a TTY (*Telecommunication device with keyboard and visual display, for people who are deaf, hard of hearing or speech disabled). The service also works in reverse – allowing a non-TTY user to call a TTY user.

Specially trained relay operators are online to relay your conversation as it takes place. The operator reads the TTY text to non-TTY user, and types the spoken response to the TTY user. CRS is available 24 hours a day, 7 days a week, to assist with your calls. You can make as many calls as you wish and talk as long as you like. There is no extra charge to use the relay service; you pay only the regular charge for the call to the other person. All TTY operator services, including directory assistance, are available through CRS.

Who can use CRS?
Both TTY and voice callers may initiate and/or receive calls through CRS.

In what languages is CRS available?

- English
- English to Spanish
- Spanish to Spanish
- Spanish to English
- ASL (American Sign Language) to English
- Not available in other languages at this time

What about confidentiality and ethics?
Federal regulations specify very strict confidentiality requirements for the operators of all relay services. No part of the conversation that takes place between the callers is revealed or recorded in written, verbal or any other form. CRS operators do not participate in the conversation and acquire no benefit from information relayed.

How is CRS administered?

CRS and the California Telephone Access Program (CTAP)* are mandated by California state laws. Both are administered by the Deaf and Disabled Telecommunications Program (DDTP), established by The California Public Utilities Commission (CPUC).

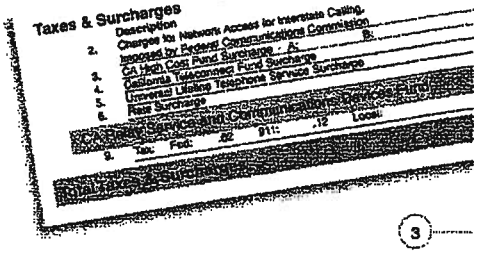
If you have problems or concerns related to CRS, please contact your CRS provider's Customer Service Center (see telephone numbers on the back of this brochure). If you have filed your complaint with a CRS Customer Service representative but are not satisfied with the results, you may contact the DDTP Consumer Affairs Specialist at 1-800-867-4323 TTY/voice.

How is CRS funded?

CRS is funded by a surcharge on all California telephone bills.

The line item states "California Relay Service & Communications Devices Fund."

* For more information about California Telephone Access Program, call the CTAP Call Center at: Voice 1-800-806-1191 or TTY 1-800-806-4474



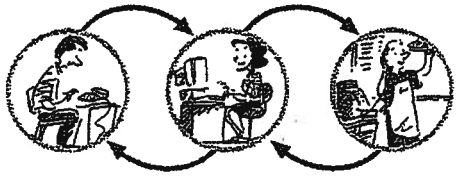
ATTACHMENT E

How do I use CRS?

TTY to Non-TTY (Voice or Hearing) User

1. TTY users dial your CRS provider's TTY number. (See telephone numbers on the back page of this brochure.)
2. The CRS operator will answer by stating ID number and gender (F/M) in text.
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Give the operator the area code and telephone number you wish to call.
   EXAMPLE:
   TTY Caller: "HELLO PLEASE CALL 916-555-5555, GA"
4. When the person you are calling answers, the operator will start relaying the call by typing what the person says.
5. When you are finished with your call, type "BYE SK." You may either instruct the operator to make another call or hang up your telephone/TTY.

* See Glossary on page 20

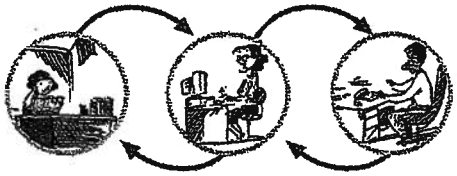


TTY User — CRS Operator — Non-TTY User

How do I use CRS?

Non-TTY to TTY User

1. Non-TTY (voice or hearing) users dial your CRS provider's voice number. (See telephone numbers on the back of this brochure.)
2. The CRS operator will answer by the voice and state ID number.
   EXAMPLE:
   CRS operator: "CALIFORNIA RELAY OPERATOR 0001 GO AHEAD"
3. Give the operator the area code and number you wish to call.
   EXAMPLE:
   Non-TTY User: "PLEASE CALL 916-555-5555, GO AHEAD"
4. When the person with the TTY answers, the CRS operator will begin relaying the call by speaking what the TTY user types.
5. When you are finished with your call, say "BYE SK". You may either instruct the operator to make another call or hang up your telephone.



Non-TTY User — CRS Operator — TTY User

How do I use CRS?

One-Line Voice Carry Over (VCO) Call

- If you use a TTY, and prefer to use your own voice rather than type, VCO allows you to speak, but still receive responses in text on your TTY display.

VCO calls require use of a TTY and telephone or VCO telephone.

1. VCO users dial your CRS provider's TTY number or VCO number. (See telephone numbers on the back of this brochure.)
2. The CRS operator will answer by stating the ID number and gender (F/M) in text
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Type to the operator that you will be using VCO.
   EXAMPLE:
   VCO user types: "VCO PLEASE, GA" (This step is not necessary if you use the VCO number.)

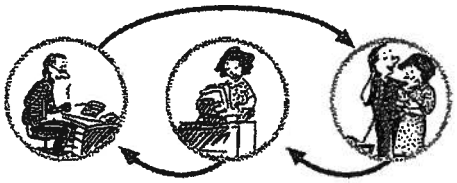
Tell the CRS operator the number you wish to call; the operator will dial the number.

When the other party is connected, the person's greeting will appear on your display followed by "GA".

You may speak directly into the telephone, as the other person will be listening to your voice. Remember to say "GO AHEAD" or "GA" when it is the other person's turn to speak.

4. Everything spoken by the other person will by typed to you by the CRS operator and will appear on your display.
5. When you are finished, say "BYE SK". You may either instruct the operator to make another call or hang up your phone and turn off your TTY.

* See Glossary on page 20



VCO User — CRS Operator — Non-TTY User

ATTACHMENT E

How do I use CRS?

Two-Line Voice Carry Over (VCO) Call

If you have residual hearing, you may find Two-Line VCO an option. While using Two-Line VCO, you may be able to hear at least part of what the hearing party is saying while you are watching the TTY text.

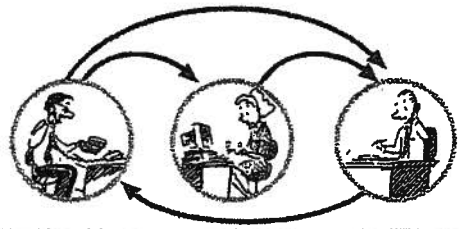
In order to use Two-Line VCO, you must have two separate telephone lines and subscribe to 3-Way Calling with your local telephone service provider. One telephone line is dedicated to a TTY or VCO telephone and the second line is dedicated to a (standard) voice telephone.

How it works:
VCO users dial your CRS provider's TTY number or VCO number from your TTY telephone and type to the operator that you will be making a Two-Line VCO call. (See the telephone numbers on the back page of this brochure.) Tell the operator to dial the number of your voice telephone line.

EXAMPLE
VCO user: "TWO-LINE VCO, PLEASE CALL 916-555-5555, GA"*

1. Answer the voice phone and tell the operator to type only what the third party says.
2. While the operator is still on the line, make the 3-way call from the voice phone to the other party.
   a. Press and release the hangup button or the "FLASH" button to put operator on hold.
   b. Wait for approximately 2-3 seconds.
   c. Dial the number of the other party and wait for an answer. When the hearing party answers, you need to explain the call procedure or have the operator announce the call.
   d. To bring the operator who is on hold back into the conversation, press the hangup button or the "FLASH" button for one second and all three of you should be connected.
3. During the telephone call, speak directly to the other person; the other person responds directly to you. The operator listens in on the conversation and types what the other person is saying.

* See Glossary on page 20



Two-Line VCO User CRS Operator Non-TTY User

How do I use CRS?

Voice Carry Over to Voice Carry Over Call (VCO to VCO)

- If you use VCO, you may call someone who also uses VCO.

VCO calls require use of a TTY and telephone or VCO telephone.

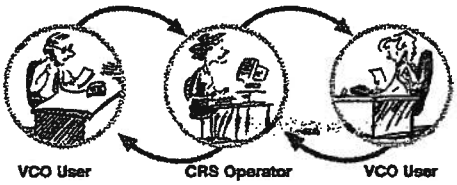
1. VCO users dial your CRS provider's TTY number or VCO number. (See telephone numbers on the back page of this brochure.)
2. The CRS operator will answer by stating ID number and gender (F/M) in text.
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Tell the operator that you will be calling VCO to VCO.
   EXAMPLE:
   VCO user: "VCO TO VCO PLEASE, GA"

Tell the CRS operator the number you wish to call. When the other party is connected, that person's greeting will appear on your display followed by "GA". You may speak directly into the phone. Remember to say "GO AHEAD" or "GA" when it is the other person's turn to speak.

4. Everything spoken by the other person will be typed to you by the CRS operator and will appear on your display.

When you are finished, say "BYE SK". You may either instruct the operator to make another call or hang up your phone and turn off your TTY.

* See Glossary on page 20



VCO User CRS Operator VCO User

How do I use CRS?

Voice Carry Over (VCO) to TTY/TTY to Voice Carry Over (VCO)

- If you use VCO, you may call someone who uses a TTY.
- If you use a TTY, you may call someone who uses VCO.

VCO calls require use of a TTY and telephone or VCO telephone.

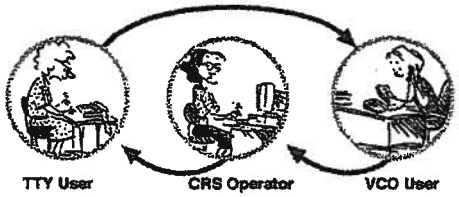
1. VCO and TTY users dial your CRS provider's TTY number or VCO number for VCO users. (See telephone numbers on the back page of this brochure.)
2. The CRS operator will answer by stating ID number and gender (F/M) in text.
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Tell the operator that you will be calling VCO to TTY (or TTY to VCO).

   EXAMPLE:
   VCO user: "VCO TO TTY PLEASE, GA"
   (TTY user types: "TTY TO VCO PLEASE, GA") Tell the CRS operator the number you wish to call. When the other party is connected, that person's greeting will appear on your display followed by "GA". The VCO user may speak directly on the telephone. Remember to say "GO AHEAD" or "GA" when it is the other person's turn to speak.

4. Everything typed by the other person will appear on your display.

When you are finished, say "BYE SK". You may either instruct the operator to make another call or hang up your phone and turn off your TTY.

* See Glossary on page 20



TTY User CRS Operator VCO User

ATTACHMENT E

How do I use CRS?

Computer ASCII Call

When making calls using ASCII, the phone receiver cannot be picked up or the connection will break. If your telephone service has the "call waiting" feature, it must be temporarily turned off prior to making your call through ASCII. (Check with your local telephone service provider for "call waiting" instructions.)

Computer users dial your CRS provider's ASCII number using your telecommunications software with the prescribed settings. (See telephone numbers on the back page of this brochure.)

For Computer settings, see the back page of this brochure.

After dialing the CRS provider, wait at least 100 seconds for the computer to connect before the operator answers.

* See Glossary on page 20

2. The operator will answer by stating ID number and gender (F/M) in text.
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Give the operator the area code and telephone number you wish to call.
   EXAMPLE:
   ASCII caller: "PLEASE CALL 916-555-5555, GA"
4. When the person you are calling answers, the operator will start relaying the call by typing what the person says.
5. When you are finished with your call, type "BYE SK". You may either instruct the operator to make another call or hang up.

Computer ASCII User | CRS Operator | Non-TTY User

How do I use CRS?

Internet/Video calls

Another option for customers making relay calls is to use the Internet. Customers go to a web address and place their relay calls from there. For more information, go to:

MCI: **www.ip-relay.com**
Sprint: **www.sprintrelayonline.com**

Customers can also make relay calls using a web cam (video) through their computers. Customers contact a web address and place their relay calls by communicating with a sign language fluent operator through their web cam on the computer monitor. For more information, go to **www.cresvrs.com.**

Web Cam User | CRS Operator | Non-TTY User

How do I use CRS?

Hearing Carry Over (HCO) Call

- If you can hear on your telephone, but need to type on a TTY instead of speaking, you may wish to use HCO.

  HCO calls require use of a TTY and a telephone.

1. HCO users dial your CRS provider's TTY number.
   (See telephone numbers in back of this brochure.)
2. The CRS operator will answer by stating ID number and gender (F/M) in text.
   EXAMPLE:
   CRS operator: "CRS 0001F GA"*
3. Type to the operator that you are using HCO.
   EXAMPLE:
   HCO user types:
   "PLEASE CALL
   916-555-5555 HCO, GA"
4. The CRS operator will verbally acknowledge that HCO is being used.
   EXAMPLE:
   CRS operator: "HCO ON, GO AHEAD"

   The CRS operator will voice to the other person what you type. When you are finished typing, you may listen on the phone. The other party will be speaking directly to you on the phone. The CRS operator will voice all of your responses to the other party.
5. When you are finished, type "BYE SK". You may either instruct the operator to make another call or hang up your phone.

* See Glossary on page 20

Non-TTY User | CRS Operator | HCO User

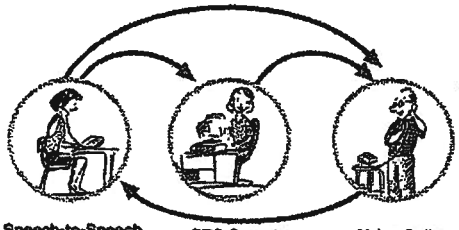
How do I use CRS?

Speech to Speech Call

This service is provided for individuals with speech disabilities and/or those who have difficulty being understood on the telephone. The CRS operator is trained to listen carefully and voice what is spoken to the other party. Calls may be initiated by either the Speech to Speech user or the Voice Caller.

1. Speech to Speech callers dial 1-800-854-7784.
2. The CRS operator answers by stating ID number
   EXAMPLE:
   CRS operator: "CALIFORNIA SPEECH TO SPEECH OPERATOR 0001"
3. Give the operator the area code and number you wish to call.

   EXAMPLE:
   Speech to Speech user: "PLEASE CALL 916-555-5555"
4. The CRS operator will voice what you say to the other person. The other person will be speaking directly to you.
   Note: You may instruct the operator to voice only the parts of the call the other party does not understand.
5. When you are finished with your call, you may either instruct the operator to make another call or hang up your phone.



Speech-to-Speech User | CRS Operator | Voice Caller

ATTACHMENT E

Caller Preference

You can let CRS know exactly how you want your calls handled. CRS will link your preferences to your telephone number. In doing so, all calls to CRS from your telephone number will be handled according to preference(s) automatically. This is called a "Customer Profile."

Check with your relay provider to set up a Customer Profile including one or more of the following preferred options:

- Request that the call not be announced as a relay call or change how the call is announced.
- Set up your calls for VCO or HCO.
- Set up for Two-Line VCO.
- Ask that your local and long distance calls be billed to your carrier of choice (see description on this page).
- Pre-specify other preferences in how your conversations are conveyed (for example, requesting the operator to describe background noises or type at a different speed).
- Request a male or female operator.
- Check with your CRS provider for any additional Customer Profile options not listed here.

Carrier of Choice
Choose your preferred telephone service provider or "carrier of choice." You must inform the CRS operator of your carrier of choice prior to placing your call. Your call will be billed by the provider you select.

State-to-State and International Calls
Using the California Relay Service you can place and receive calls from anywhere in the United States or worldwide, to and from California. For more information about international relay calls, contact your relay provider and request Customer Service. See the back page of this brochure for a complete listing of telephone numbers.

TTY Operator Service (TOS)

CRS provides the following operator services:

- Directory Assistance (telephone and address information).
- TTY operator assisted calls (i.e. person to person, collect calls, billing to third party or calling card).

Billing

There is no additional charge for using the California Relay Service. You may be charged standard rates for Directory Assistance calls or operator assisted calls.

Long distance, operator assisted, and toll calls will be billed to your carrier of choice upon request.

If you do not select your carrier of choice, your calls will be billed by the relay service provider. You must inform the relay operator of your carrier of choice **before** the calls are made.

Emergency Assistance

DO NOT CALL 911 THROUGH CRS.

1. In an emergency, TTY users must dial 911 directly.
2. Tap the space bar several times to show that it is a TTY call.
3. **Remember, calls made directly and immediately to 911 can save valuable time in emergency situations. CRS is available to dial 911.**

Calling Tips

General Calling Tips

1. Have telephone area code and number(s) ready when you call CRS.
2. Do not add side comments to the CRS operator during conversation because these comments will be relayed to the other person. This can cause confusion to the CRS operator and/or the other person.
3. Answering Machines/Voice Mail systems:
   a. You may leave messages on answering machines or voice mail systems through CRS.
   b. When you leave a message, you may want to mention that you have called through CRS, and leave the CRS telephone number along with your own area code and telephone number.
   c. If you think you might get an answering machine when you call and don't want the greeting relayed word for word, ask the CRS operator to either summarize the message or ignore it, so you may simply leave your message. You may also give your message to the CRS operator before she/he makes the call.

Automated Telephone Systems

Many business organizations now use automated systems to answer and route calls to the correct person or department.

EXAMPLE: "Press #1 for customer service, #2 for sales department," or "Please press the extension number you wish to call."

To make calling easier, if you know the option or extension number you wish to reach, you may tell the CRS operator before she/he makes the call.

Pay Telephones

1. When making a pay telephone call within a local calling area, there is no charge for your call.

   Note: Pay telephone calling areas vary in price throughout the state.

2. If your call is outside the local calling area, you will be required to use one of the following billing options:
   a. Pre-paid calling card
   b. Telephone calling card (check with your telephone service provider)
   c. Collect call (bill to the person you are calling)
   d. Bill to another telephone number (e.g. home or office)

ATTACHMENT E

ADMH-Bilingual Staff List
11/2/2010

Name	License	Location	Contact info:
Spanish-Level II-Advanced			
1. Elena Jaime	Specialist (Spanish)	W Benefits Specialist	8346
2. Sagrario Landin	Support (Spanish)	W	8630
Russian-Level II-Advanced			
1. Svitlana Shramenko-	Support	W – PAP	8634
Spanish-Level I-Conversational			
1. Maria Alaniz	Specialist	W	8790
2. Debbie Clifford-Carrion	Specialist	W-Prevention	8715
3. Donilu Guerrero	Support	W-DUI	9562
4. Linda Hernandez-Fogle	IMF	Esparto	530-787-4110
5. Sandra Holguin	Specialist	W-Older Adult	8785
6. Rebecca Lansburgh-	Support	W Adult Serv, Auth.	8789
7. Monique Marin	ASW	W- MDIC	8306
8. Geoffrey Prenter	ASW	W, Crisis	8542
9. Sandra Serrano	Supervisor	W-DUI	8970
10. Aimee Williams,	Specialist	W	8524
American Sign Language			
1. Blaire McAnelly	Specialist	Esparto	4863
Cambodian			
1. Lynn Ly	ASW	W-WS-D	6361
Hindi			
1. Harpreet Gill	RN	W, WS, D	9171
Mandarin/Cantonese			
1. Ming Looi M/C	Adult, Med. Support	WS	6350
Punjabi			
1. Harpreet Gill	RN	W, WS, D	9171

USE THE LANGUAGE LINE – if you cannot find anyone to interpret for you. See support staff at front desk of our clinics to assist you with the portable dual handset phone/system. (Anne @ 530-666-8945)
AZO

ATTACHMENT F

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Training of Interpreters**

POLICY

ADMH interpreters are trained to have the skills necessary to provide culturally and linguistically competent services.

PROCEDURE

Training shall be made available to persons employed as interpreters at the Yolo County Alcohol, Drug and Mental Health Department. Initial training will be mandatory for new County staff employed as interpreters, with existing staff being encouraged to attend on a refresher basis.

Interpreter training can be a collaborative effort between ADMH with the State Department of Mental Health, the State Department of Health Services, and Yolo County Department of Public Health, to make training available to interpreters.

The interpreter training will include but not be limited to a discussion of the following topics:

1. Confidentiality and HIPAA requirements;
2. Legal and ethical consequences of poor communication;
3. Development of listening skills to achieve accurate and impartial interpretation;
4. Mental health terminology;
5. Language transposition, literal translation, and contextual interpretation;
6. Client culture as related to the impact and integral relationship between the consumer's personal experience of mental illness and the mental health system.

REFERENCES

CCR, Title 9, Chapter 11, Section 1810.410 (a);
DMH Information Notice No. 02-03, Page 17.

APPROVED BY:

ADMH Director — Date: 11-3-08

ATTACHMENT G

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Cultural Competency and Training of Interpreters**

POLICY

County employees who perform the duties of an interpreter shall be provided training to enhance their interpreter skills. This training will prepare interpreters to provide consumers with culturally and linguistically competent mental health services.

PROCEDURE

In collaboration with other counties, Quality Management will provide training for interpreters. The training shall be mandatory for all new County and provider staff employed as interpreters, and will include, but not be limited to, a discussion of the following topics:

1. Definitions and differences between cultural and linguistic competence standards.
2. The relationship between culture/ethnicity/language and barriers to treatment.
3. The relationship between culture/ethnicity/language and decisions to seek treatment. When/how to make culture specific provider referrals.
4. Yolo County geographic and socio-economic profile, including demographic composition and population trends of Medi-Cal beneficiaries by ethnicity, age, gender, and primary language.
5. Distribution of culturally and linguistically appropriate written information for threshold languages.
6. Interpreter choice and prohibition of expectation that family members will provide interpreter services (consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.)
7. Client Culture: impact and integral relationship between the consumer's (adult, child, adolescent) personal experience of mental illness, including diagnosis/labeling, medication, societal/familial stigma, economic impact, the procedures implemented by the mental health system related to cultural competency, and the consumer's ethnicity.

ATTACHMENT G

REFERENCES

9 CCR § 1810.410(a)
DMH Information Notice 02-03, Page 17.

APPROVED BY:

ADMH Director

12-30-08
Date

ATTACHMENT G

DEPARTMENT OF ALCOHOL, DRUG AND MENTAL HEALTH

Kim Suderman, LCSW, Director

ADMINISTRATION

137 N. Cottonwood Street, Suite 2500
Woodland, Ca 95695
Office – 530-666-8516
Fax – 530-666-8294

Mark Bryan, Deputy Director
Christina Hill-Coillot, Deputy Director
Michael P. Tucker, Deputy Director

STATE DEPARTMENT OF MENTAL HEALTH
MEDI-CAL OVERSIGHT
FISCAL YEAR (FY) 2008-2009

DATE: January 12-16, 2009

TO: DMH Review Team

FROM: ADMH

SECTION: A – ACCESS

SUBJECT: Response for Item No. A.20.

Is there evidence that Limited English Proficient (LEP) individuals are informed of the following in a language they understand:

a. *LEP individuals have a right to free language assistance services?*

Yes. This information is indicated on posters in each waiting room. There is the "point to a language" sign to indicate what language a person speaks so that the staff can successfully use the language line. Staff are reminded of the free language assistance availability during interpreter trainings, All staff meetings, Cultural Competency meetings and trainings. Staff is also reminded to ask this during the intake process by the prompt on the Acknowledgment of Receipt checklist. Information can also be found in the ADMH CCP.

Language Line; Interpreters; Interpreter trainings - All staff; Informing materials

b. *LEP individuals are informed how to access free language assistance services?*

See a. above.

ATTACHMENT H

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Information Dissemination and Cultural Competency**

POLICY

There are established procedures outlining steps for the distribution of linguistically appropriate brochures, notices, and posters.

PROCEDURE

1. Quality Management shall ensure that the Yolo County Guide to Mental Health Services brochure, the Consumer Rights and Problem Resolution brochure, and Grievance Report Forms are made available, in the Yolo County threshold languages at all lobbies and offices where consumers could reasonably be expected to request them, and during any regular meetings where clients or community-based organizations could request the documents and/or other informing materials.
2. Quality Management shall distribute linguistically appropriate materials to County and provider service locations.
3. Quality Management shall monitor that all organizational providers have properly displayed brochures, posters, and notices in the threshold languages.
4. Quality Management shall instruct providers to request materials as needed by faxing the request for brochures, notices or posters to the Quality Management Supervisor at (530) 666-8637 or by sending an e-mail request to ADMH-FAQ@yolocounty.org.
5. At the point of access to services, and periodically throughout treatment, consumers at County and Provider locations shall receive the Mental Health Services and Problem Resolution Process brochures.
6. Quality Management shall analyze State MEDS file data on an annual basis to determine changes in ethnic groups constituting the 5% threshold level in accordance with DMH Information Notice 08-18.
7. Quality Management will attempt, as such needs are made known, to make culturally and linguistically appropriate materials available in languages that do not meet the 5 % threshold. When needed, bilingual staff will read information to consumers who speak a language outside the threshold. As needs arise, bilingual staff will read information to consumers to ameliorate language barriers.

ATTACHMENT J

8. Staff will assist consumers who have Limited English Proficiency by informing, through posters, flyers, and other means, that free language services are available.

REFERENCES

9 CCR § 1810.410 Cultural and Linguistic Requirements
DMH Information Notice 08-18.

APPROVED BY:

ADMH Director

12-31-08
Date

ATTACHMENT J

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

YOLO COUNTY
ALCOHOL, DRUG AND MENTAL HEALTH DEPARTMENT
POLICY AND PROCEDURES MANUAL

SUBJECT: **Availability of Translated Materials**

POLICY

The Yolo County Alcohol, Drug and Mental Health Department (ADMH) is committed to providing written materials in English and, at a minimum, in the county's threshold language(s). These translated materials will allow individuals who are requesting services, as well as the community in general, to be informed about the availability of mental health services and how to access these services.

ADMH informing materials shall be written in a manner and format that is easy to read and understand. Materials will be made available to ensure equal access to services.

PROCEDURE

1. At intake and upon request, clients will receive information about written materials which include, but are not limited to, the following:
   - Medi-Cal Guide to Mental Health Services
   - Beneficiary Problem Resolution Brochure
   - Service Provider List
   - Advance Health Care Directives Brochure
   - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Information, when applicable
   - Therapeutic Behavioral Services Information, when applicable
   - CHDP and Healthy Families programs

   These ADMH brochures provides written information about the services offered to individuals who are requesting services, as well as providing information to aid individuals in the resolution of a problem or complaint.
2. In an outreach effort to the community, ADMH shall assure that relevant written information is also available at key points of contact.
3. Quality Management staff shall assure that an adequate supply of the ADMH written materials are available for distribution. All brochures listed above shall be made available in English and, at a minimum, in the Yolo County threshold languages, as determined by the California Department of Mental Health and Yolo County ADMH.

ATTACHMENT J

4. ADMH staff shall respond to requests for additional supplies of written information.

REFERENCES

CCR, Title 9, Chapter 11, Section 1810.110(a) and Section 1810.410(c)(3)
CFR, Title 42, Section 438.10(c)(3) and Section 438.10(d)(1)(i)
DMH Information Notice No. 02-03, Page 17 and No. 07-10
MHP Contract, Exhibit A, Attachment 1, Section J

APPROVED BY:

ADMH Director

11-3-08
Date

ATTACHMENT J

GUIDE TO
Medi-Cal Mental Health Services

If you are having an emergency, please call 9-1-1 or visit the nearest hospital emergency room.

If you would like additional information to help you decide if this is an emergency, please see the information on State of California page 6 in this booklet.

Important Telephone Numbers

Emergency	911
Yolo County Mental Health Services	(888) 965-6647 24 hours/toll-free
MHP Clinics	
Davis	(530) 757-5530
West Sacramento	(916) 375-6350
Woodland	(530) 666-8630
Local Hospitals	
Woodland Memorial Hospital	(530) 662-3961
Sutter Davis Hospital	(530) 756-6440
Patients' Rights Advocate	(888) 857-7776

How To Get A Provider List:

You may ask for and your Mental Health Plan (MHP) should give you a directory of people, clinics and hospitals where you can get mental health services in your area. This is called a 'provider list' and contains names, phone numbers and addresses of doctors, therapists, hospitals and other places where you may be able to get help. You may also access your MHP's website. Before you go to any help, call your MH's 24 hour toll-free number above to request a provider list and to ask if you need to accompany the MHP before going to a service provider's office, clinic or hospital for help.

In What Other Languages And Formats Are These Materials Available?

Esta folleto de información está disponible en Español. Usted puede solicitar ejemplares de manera gratuita, mediante una llamada telefónica.

Данная брошюра также доступна на русском языке. Вы можете попросить предоставить ее вам, позвонив по бесплатному номеру телефона, указанному выше.

Introduction to Medi-Cal Mental Health Services

Why Did I Get This Booklet And Why Is It Important?

You are getting this booklet because you are eligible for Medi-Cal and need to know about the mental health services that Yolo County offers and how to get these services if you need them.

If you are now getting services from Yolo County, this booklet just tells you more about how things work. This booklet tells you about mental health services, but does not change the services you are getting. You may want to keep this booklet so you can read it again.

If you are not getting services right now, you may want to keep this booklet in case you, or someone you know, need to know about mental health services in the future.

Please call the MHP at (888) 965-6647 to find out about other ways you can get this important information.

What Is A Mental Health Emergency?

An emergency is a serious mental or emotional problem, such as:

- Where a person is in danger to himself, herself, or others because of what seems like a mental illness, or
- When a person cannot get or use the food, shelter, or clothing they need because of what seems like a mental illness.

In an emergency, please call 9-1-1 or take the person to a hospital emergency room.

How Do I Use This Booklet?

This booklet will help you know what specialty mental health services are, if you may get them, and how you can get help from the Yolo County MHP.

This booklet has two sections. The first section tells you how to get help from the Yolo County MHP and how it works.

The second section is from the State of California and gives you more general information about specialty mental health services. It tells you how to get other services, how to resolve problems, and what your rights are under the program.

This booklet also tells you how to get information about the doctors, clinics and hospitals that the Yolo County MHP uses to provide services and where they are located.

Please see the Table of Contents on page 2 for the Table of California Section of this booklet for more information.

What Is My County's Mental Health Plan (MHP)?

Mental health services are available to people on Medi-Cal, including children, young people, adults and older adults in Yolo County.

Sometimes these services are available through your regular doctor. Sometimes they are provided by a specialist, and called 'specialty' mental health services. These specialty services are provided through the Yolo County "Mental Health Plan" or MHP, which is separate from your regular doctor. The Yolo County MHP operates under rules set by the State of California and the federal government. Each county in California has its own MHP.

If you feel you have a mental health problem, you may contact the Yolo County MHP directly at (888) 965-6647. This is a toll-free telephone number that is available 24 hours a day, 7 days a week. Written and verbal interpretation of your rights, benefits and treatments is available in your preferred language. You do not need to see your regular doctor first or get permission or a referral before you call.

If you believe you would benefit from specialty mental health services and are eligible for Medi-Cal, the Yolo County Mental Health Plan will help you find out if you may get mental health treatments and services. If you would like more information about specific services, please see the sections on 'Services' on the State of California page 9 in this booklet.

What If I Have a Problem Getting Help?

If you have a problem getting help, please call the Yolo County MHP's 24 hour, toll-free phone number at (888) 965-6647. You may also call your county's Patients' Rights Advocate at (888) 857-7776.

If that does not solve your problem, you may call the State of California's Ombudsman for help:

1-800-896-4042 - CA Only
1-916-654-3890
1-800-896-2312 TTY
FAX: 1-916-653-9194
EMail: ombudsmn@dmhhq.state.ca.us

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Medi-Cal Mental Health Services

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Welcome to the Yolo County Mental Health Plan

We welcome you to Yolo County Mental Health Services, and to the Medi-Cal Mental Health Plan. We provide specialty mental health services for people who live in Yolo County and are eligible for Medi-Cal. Please read this brochure carefully. It contains important information you need to know.

As Your Mental Health Services Plan, We Will:

- Get answers to your questions about mental health treatment
- Tell you what mental health services are covered by Medi-Cal
- Determine what types of mental health services you need and help you get them
- Treat you with respect
- Ensure you receive services in a safe environment
- Help you get culturally competent care

As A Participant, You Also Have Specific Responsibilities:

- Give honest and complete information about your mental health needs
- Take an active part in your mental health treatment
- Keep your appointments as scheduled
- Call if you cannot keep your appointment
- Work on treatment goals with your provider

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Important Telephone Numbers

Emergency	911
Yolo County Mental Health Services	(888) 965-6647 24 hours toll-free (800) 735-2929 TDD
MHP Clinics	
Davis	(530) 757-5530
West Sacramento	(916) 375-6350
Woodland	(530) 666-8630
Local Hospitals	
Woodland Memorial Hospital	(530) 662-3961
Sutter Davis Hospital	(530) 756-6440
Patients' Rights Advocate	(888) 857-7776

How Do I Know If Someone Needs Help Right Away?

Even if there is no emergency, a person with mental health problems needs help right away if one or more of these things is true:

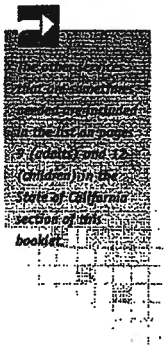
- Hearing or seeing things others believe are not there
- Extreme and frequent thoughts of, or talking about, death
- Giving away their things
- Threatening to kill themselves (suicide)
- Wanting to hurt themselves or others

If one or more of these things is true, call 911 or the Yolo County MHP at (888) 965-6647 (24 hours toll-free). Mental Health workers are on-call 24 hours a day.

What Specialty Mental Health Services Does Yolo County Provide?

The Yolo County Mental Health Plan (MHP) provides mental health services to residents of Yolo County who receive Medi-Cal benefits and meet medical necessity. Most people who receive services usually have mental health problems that interfere with daily living. Services vary from person to person, depending on individual need, and many services are time-limited. Services are provided by a variety of mental health specialists, including multidisciplinary and culturally diverse teams of county and provider staff.

The amount, duration, and scope of services are determined by assessment for services. The following services are available to assist you in meeting your mental health needs when the medical necessity criteria are met.



Outpatient Services

- **Therapy - individual, group, and family:** Short-term and goal-directed services will focus on you or your child's mental health needs. Staff will work with you, your family, or other important people in your life to learn more about your illness, how to address your problems, and how to help maintain your highest level of functioning.
- **Case Management:** Helps to connect you with services and supports needed for daily living, including housing and job assistance. Case management helps support a child or youth to be more successful in school, at home and in the community.
- **Medication Support:** Psychiatrists and nurses provide evaluations, medication management, and medication education to help manage you or your child's symptoms and to understand how medication can help make you feel better.
- **Day Treatment/Rehabilitative Day Treatment:** Services include education and support to help you or your child remain in the community. These services can include various groups, individual therapy, and living skills education. Services help you and your child to develop skills to better deal with life problems.
- **Residential:** 24 hour housing when you, or your child, have more serious treatment needs. The scope and duration depend upon the need, and is typically intended to increase functioning to allow you or your child to return to the community.

The services listed above are the services that the Yolo County MHP at (888) 965-6647 thinks are most likely to help people who need services from us. Sometimes other services may be needed. The other services that are sometimes needed are included in the list on pages 9 (adults) and 12 (children) in the State of California section of this booklet.

How Do I Get These Services?

Call us at (888) 965-6647. During regular business hours, from 8:00 a.m. to 5:00 p.m., you may also call the following local numbers for information on mental health and treatment needs:

Davis ..... (530) 757-5530
West Sacramento... (916) 375-6350
Woodland ..... (530) 666-8630

Crisis services may also be accessed on a walk-in basis at the addresses listed on page 5 of this booklet.

In What Other Languages And Formats Are These Materials Available?

Cambodian, Japanese, Korean, Mien/Hmong, Russian, and Spanish. Materials will also be made suitable for those with limited English and visual or hearing impairments.

What Does It Mean To Be "Authorized" To Receive Mental Health Services And What Is The Amount, Duration And Scope Of Services Provided?

You, your provider and the Yolo County MHP are all involved in deciding what services you need to receive through the MHP, including how often you will need services and for how long.

The Yolo County MHP may require your provider to ask the MHP to review the reasons the provider thinks you need a service before the services is provided. The Yolo County MHP uses a qualified mental health professional to do the review. This review process is called an MHP payment authorization process.

The state requires the Yolo County MHP to have an authorization process for day treatment intensive, day rehabilitation, and therapeutic behavioral services (TBS). The Yolo County MHP follows state rules for our MHP payment authorization process, which are described on page 3 in the State of California section of this booklet. If you would like more information on how the Yolo County MHP does MHP payment authorizations, or on when we require your provider to request an MHP payment authorization for services, please contact the Yolo County MHP at (888) 956-6647.

How Do I Get More Information About Yolo County's Mental Health Services Including Doctors, Therapists, Clinics And Hospitals?

If you would like additional information on the structure and operation of the Yolo County MHP, please contact the Quality Management Unit at (530) 666-8542.

How Can I Get A Copy Of The "Provider List"?

Provider lists are available by contacting the Quality Improvement Department at (530) 666-8542.

Can I See Any Doctor, Therapist, Clinic Or Hospital On Yolo County's "Provider List?"

We require that you contact us first because we want to make sure that

1) Your services are authorized and
2) The provider you choose is accepting new Medi-Cal beneficiaries.

Please call the Access and Crisis line at (888) 965-6647.

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What If I Want To Change Doctors, Therapists, Or Clinics?

To the greatest extent possible, we try and accommodate your choice of providers. Please call us at (888) 965-6647 for more information.

Can I Use The "Provider List" To Find Someone To Help Me?

You may access services using the "Provider List" by contacting the county at (888) 965-6647, or by walking into an MHP site listed in this booklet. If you contact a provider directly, you will be referred to the Yolo County MHP for intake and authorization.

What If I Want To See A Doctor, Therapist, Clinic Or Hospital That Is Not Listed On Yolo County's "Provider List?"

If another provider wishes to provide Medi-Cal services to you, they can call the Access line at (888) 965-6647 and fill out the appropriate form. If you meet medical necessity for the service(s) you need, service can be covered by the MHP.

What If I Need Urgent-Care Mental Health Services On A Weekend Or At Night?

You may speak to a crisis worker 24 hours a day, 7 days a week, by calling: (888) 965-6647, or TDD (800) 735-2929.

You may also walk in to or call one of our clinics:

Davis
600 A Street, Davis, CA 95616
(530) 757-5530

West Sacramento
500 B Jefferson Blvd., Suite 150, West Sacramento, CA 95605
(916) 375-6350

Woodland
137 N. Cottonwood Street, Woodland, CA 95695
(530) 666-8630

Calls received when the Yolo County MHP offices are closed, on weekdays from 5:00 p.m. to 8:00 a.m., and weekends and holidays, will be forwarded to on-call staff for crisis response.

How Do I Get Mental Health Services That My Mental Health Provider Does Not Offer?

Call the Yolo County MHP at (888) 965-6647 to receive authorization for additional services. The Yolo County MHP can then assist you in finding a provider to meet you additional needs.

What If I Need To See A Doctor For Something Other Than Mental Health Treatment? How Are People Referred To Medi-Cal In Yolo County?

Call us at (888) 965-6647 to see if you can be referred to the appropriate physician.

What Can I Do If I Have A Problem Or I Am Not Satisfied With My Mental Health Treatment?

You may file a Grievance if dissatisfied with mental health services at the Yolo County MHP office, or Appeal a decision when services are denied, terminated, suspended, or reduced, by calling (888) 965-6647 or completing a Grievance/Appeal form. Grievance/Appeal forms are available at all MHP and Contract Provider locations. You may also contact Quality Improvement staff at (530) 666-8542 to discuss the Grievance and Appeal processes

If you have a concern or problem, or are not satisfied with your mental health services, the MHP wants to be sure your concerns are resolved simply and quickly. Please contact the MHP at (888) 965-6647 to find out how to resolve your concerns.

There are three ways you can work with the MHP to resolve concerns about services or other problems. You can file a Grievance verbally or in writing with the MHP about any MHP-related issue. You can file an Appeal verbally (and follow up in writing) or in writing with the MHP. You can also file for a State Fair Hearing with the Department of Social Services.

For more information about how the MHP Grievance and Appeal processes and the State Fair Hearing process work, please turn to the section about Grievances, appeals and State Fair Hearings on page 22 of the State of California section of this booklet.

Your problem will be handled as quickly and simply as possible. It will be kept confidential. You will not be subject to discrimination or any other penalty for filing a Grievance, Appeal or State Fair Hearing. You may authorize another person to act on your behalf in the Grievance, Appeal, or State Fair Hearing Process.

Who Is Yolo County's Patients' Rights Advocate, What Do They Do, And How Do I Contact Them?

Yolo County Patients' Rights Advocacy Services:

- Investigates and resolves Grievances received from mental health clients about rights violations, neglect, abuse, or confidentiality issues, and
- Monitors mental health programs for compliance with patients' rights laws, regulations, and policies

Anyone may contact the Patients' Rights Advocate with a problem concerning mental health issues. If you cannot file the Grievance, someone else may file the Grievance on your behalf.

To contact Yolo County Patients' Rights Advocacy Services call (888) 857-7776.

Does Yolo County Keep My Mental Health Records Private?

You have a right to privacy. Your provider cannot tell anyone outside of the provider network any clinical information you give Yolo County unless you supply written permission or a court deems it acceptable.

General Statewide Information

Why Is It Important To Read This Booklet?

The first section of this booklet tells you how to get Medi-Cal mental health services through your county's Mental Health Plan.

This second section of the booklet tells you more about how the Medi-Cal program works, and about how Medi-Cal specialty health services work in all counties of the state.

If you don't read this section now, you may want to keep this booklet so you can read it later.

County Mental Health Plans

What Are Specialty Mental Health Services?

Specialty Mental health services are special health care services for people who have a mental illness or emotional problems that a regular doctor cannot treat.

Some specialty mental health services include:

- Crisis counseling to help people who are having a serious emotional crisis
- Individual, group, or family therapy
- Rehabilitation or recovery services that help a person with mental illness to develop coping skills for daily living
- Special day programs for people with mental illnesses
- Prescriptions for medicines that help treat mental illness
- Help managing medicines that help treat mental illness
- Help to find the mental health services you need

Where Can I Get Mental Health Services?

You can get mental health services in the county where you live. Each county has a Mental Health Plan for children, teens, adults and older adults. Your county Mental Health Plan has mental health providers (doctors who are psychiatrists or psychologists, and others).

How Do I Get Services At My County Mental Health Plan?

Call your county Mental Health Plan and ask for services. You do not need to ask your regular doctor for permission or get a referral. Just call the number for your county in the front of this booklet. The call is free.

You can also go to a federally qualified health center, a rural health center or an Indian health clinic in your area for Medi-Cal mental health services. (These are official names for different kinds of clinics in your area. If you are not sure about a clinic in your area, ask the clinic workers. These kinds of clinics generally serve people who do not have insurance.)

As part of providing mental health services for you, your county Mental Health Plan is responsible for:

- Figuring out if someone is eligible for specialty mental health services from the MHP.
- Providing a toll-free phone number that is answered 24-hours a day and 7 days a week that can tell you about how to get services from the MHP.
- Having enough providers to make sure that you can get the specialty mental health services covered by the MHP if you need them.
- Informing and educating you about services available from your county's MHP
- Providing you services in the language of your choice or by an interpreter (if necessary) free of charge and letting you know that these interpreter services are available.
- Providing you with written information about what is available to you in other languages or forms, depending upon the needs in your county.

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Important Information About Medi-Cal

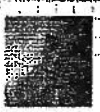
Who Can Get Medi-Cal?

You may qualify for Medi-Cal if you are in one of these groups:

- 65 years old, or older
- Under 21 years of age
- An adult, between 21 and 65 with a minor child living with you (a child who is not married and who is under the age of 21)
- Blind or disabled
- Pregnant
- Certain refugees, or Cuban/Haitian immigrants
- Receiving care in a nursing home

If you are not in one of these groups, call your county social service agency to see if you qualify for a county-operated medical assistance program.

You must be living in California to qualify for Medi-Cal. Call or visit your local county social services office to ask for a Medi-Cal application, or get one on the Internet at **www.dhs.ca.gov/mcs/medi-calhome/MC210.htm**



Do I Have To Pay For Medi-Cal?

You may have to pay for Medi-Cal depending on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for Medi-Cal services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or mental health services. The amount that you pay is called your **'share of cost.'** Once you have paid your 'share of cost,' Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don't have medical expenses, you don't have to pay anything.
- You may have to pay a 'co-payment' for any treatment under Medi-Cal. You may have to pay $1.00 each time you get a medical or mental health services or a prescribed drug (medicine) and $5.00 if you go to a hospital emergency room for your regular services.

Your provider will tell you if you need to make a co-payment.

Always have your Benefits Identification card and health plan card (if you have one) when you go to the doctor, clinic, or hospital.

How Do I Get Medi-Cal Services That Are Not Covered By The Mental Health Plan?

There are two ways to get Medi-Cal services:

1. **By joining a Medi-Cal managed care health plan.**

   If you are a member of a Medi-Cal managed care health plan:
   - Your health plan needs to find a provider for you if you need health care.
   - You get your health care through a health plan, an HMO (health maintenance organization) or a primary care case manager.
   - You must use the providers and clinics in the health plan, unless you need emergency care.
   - You may use a provider outside your health plan for family planning services.
   - You can only join a health plan if you do not pay a share of cost.

2. **From individual health care providers or clinics that take Medi-Cal.**
   - You get health care from individual providers or clinics that take Medi-Cal
   - You must tell your provider that you have Medi-Cal before you first get services. Otherwise, you may be billed for those services.
   - Individual health care providers and clinics do not have to see Medi-Cal patients, or may only see a few Medi-Cal patients.
   - Everyone who has a share of cost (see page 3, State of California) will get health care this way.

If you need mental health services that are not covered by the Mental Health Plan:

- And you are in a health plan, you may be able to get services from your health plan. If you need mental health services the health plan doesn't cover, your primary care provider at the health plan may be able to help you find a provider or clinic that can help you.
- Except in San Mateo County, your health plan's pharmacies will fill prescriptions to treat your mental illness, even if the prescriptions were written by the mental health plan's psychiatrist, or will tell you how to get your prescription filled from a regular Medi-Cal pharmacy. (In San Mateo County, the mental health plan will fill your prescriptions.)
- And you are not in a health plan, you may be able to get services from individual providers and clinics that take Medi-Cal. Except in San Mateo County, any pharmacy that accepts Medi-Cal can fill prescriptions to treat your mental illness, even if the prescriptions were written by the MHP's psychiatrist. (In San Mateo County, the mental health plan will fill your prescriptions.)
- The Mental Health Plan may be able to help you find a provider or clinic that can help you or give you some ideas on how to find a provider or clinic.

If you have trouble getting to your medical or mental health appointments, the Medi-Cal program can help you find transportation.

If you have trouble getting to your medical appointments or mental health appointments, the Medi-Cal program can help you find transportation.

- For children, the county Child Health and Disability Prevention (CHDP) program can help. Or, you may wish to contact your county's social services office. These phone numbers can be found in your local telephone book in the 'County Government' pages. You can also get information online by visiting **www.dhs.ca.gov**, then clicking on 'Services' and then on 'Medi-Cal Information.'
- For adults, your county social services office can help. You can get information about your county's social services office by checking your local telephone book. Or you can get information online by visiting **www.dhs.ca.gov**, then clicking on 'Services' and then on 'Medi-Cal Information.'

What Is The Child Health And Disability Prevention (CHDP) Program?

The CHDP program is a preventive health program serving California's children and youth from birth to age 21. CHDP makes early health care available to children and youth with health problems, as well as to those who seem well. Children and youth can receive regular preventive health assessments. Children and youth with suspected problems are then referred for diagnosis and treatment. Many health problems can be prevented or corrected, or the severity reduced, by early detection and prompt diagnosis and treatment.

CHDP works with a wide range of health care providers and organizations to ensure that eligible children and youth receive appropriate services. These may include private physicians, local health departments, schools, nurse practitioners, dentists, health educators, nutritionists, laboratories, community clinics, nonprofit health agencies, and social and community service agencies. CHDP can also assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

You can find out more about CHDP by contacting your local county health department or visiting **www.dhs.ca/gov.pcfh/cms/chdp/directory.htm.**

Where Can I Get More Information?

You can get more information about mental health services by visiting the California Department of Mental Health's website at **www.dmh.ca.gov.** You can get more information about Medi-Cal by asking your county eligibility worker or by visiting **www.dhs.ca.gov/mcs/medi-calhome.**

ATTACHMENT J

Basic Emergency Information

In case of an emergency medical or psychiatric condition, call 9-1-1 or go to any emergency room for help.

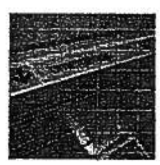
Are You Having An Emergency?

An emergency medical condition has symptoms so severe (possibly including severe pain) that an average person could expect the following might happen at any moment:

- The health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) could be in serious trouble.
- Serious problems with bodily functions.
- Serious problems with any bodily organ or part.

An emergency psychiatric condition occurs when an average person thinks that someone:

- Is a current danger to himself or herself or another person because of what seems like a mental illness.
- Is immediately unable to provide or eat food, or use clothing or shelter because of what seems like a mental illness.



In case of an emergency medical or psychiatric condition, call 9-1-1 or go to any emergency room for help.

The Medi-Cal program will cover emergency conditions, whether the condition is medical or psychiatric (emotional or mental). If you are on Medi-Cal, you will not receive a bill to pay for going to the emergency room, even if it turns out to not be an emergency.

If you aren't sure if the condition is really an emergency, or if you're not sure whether the condition is medical or psychiatric, you may still go to the emergency room and let qualified medical professionals make the decision about what is needed. If the emergency room professionals decide there is a psychiatric emergency, you will be admitted to the hospital to receive immediate help from a mental health professional. If the hospital doesn't have the kind of services necessary, the hospital will find a hospital that does have the services.

A person may be helped through a mental health crisis by services from your county's Mental Health Plan (MHP) in ways other than going into the hospital. If you think you need help but don't think you need to go into the hospital, you can call your county MHP's toll-free phone number and ask for help.

What Kind Of Emergency-Related Services Are Provided?

Emergency services are paid for by Medi-Cal when you go to a hospital or use outpatient services (with no overnight stay involved) furnished in a hospital emergency room by a qualified provider (doctor, psychiatrist, psychologist or other mental health provider). They are needed to evaluate or stabilize someone in an emergency.

Your county's Mental Health Plan (MHP) should provide specific information about how emergency services are administered in your County. The following state and federal rules apply to emergency services covered by the MHP:

- The hospital does not need to get advance approval from the MHP (sometimes called "prior authorization") or have a contract with your MHP to get paid for the emergency services the hospital provides to you.
- The MHP needs to tell you how to get emergency services, including the use of 9-1-1.
- The MHP needs to tell you the location of any places where providers and hospitals furnish emergency services and post-stabilization services.
- You can go to a hospital for emergency care if you believe there is a psychiatric emergency.
- Specialty mental health services to treat your urgent condition are available 24-hours a day, seven days per week. (An urgent condition means a mental health crisis that would turn into an emergency if you do not get help very quickly.)
- You can receive these inpatient hospital services from the MHP on a voluntary basis, if you can be properly served without being involuntarily held. The state laws that cover voluntary and involuntary admissions to the hospital for mental illness are not part of state or federal Medi-Cal rules, but it may be important for you to know a little bit about them:
  1. **Voluntary admission:** This means you give your OK to go into and stay in the hospital.
  2. **Involuntary admission:** This means the hospital keeps you in the hospital for up to 72 hours without your OK. The hospital can do this when the hospital thinks that you are likely to harm yourself or someone else or that you are unable to take care of your own food, clothing and housing needs. The hospital will tell you in writing what the hospital is doing for you and what your rights are. If the doctors treating you think you need to stay longer than 72 hours, you have a right to a lawyer and a hearing before a judge and the hospital will tell you how to ask for this.

[illegible] within the MHP's provider list or coverage area. Your MHP will pay for such services if they are pre-approved by an MHP provider or other MHP representative.

Post-stabilization care services are covered services that are needed after an emergency. These services are provided after the emergency is over to continue to improve or resolve the condition.

Your MHP is financially responsible for (will pay for) post-stabilization care services to maintain, improve, or resolve the stabilized condition if:

- The MHP does not respond to a request from the provider for pre-approval within 1 hour
- The MHP cannot be contacted by the provider
- The MHP representative and the treating physician cannot reach an agreement concerning your care and an MHP physician is not available for consultation. In this situation, the MHP must give the treating physician the opportunity to consult with an MHP physician. The treating physician may continue with care of the patient until one of the conditions for ending post-stabilization care is met. The MHP must make sure you don't pay anything extra for post-stabilization care.

When Does My County MHP's Responsibility For Covering Post-Stabilization Care End?

Your county's MHP is NOT required to pay for post-stabilization care services that are not pre-approved when:

- An MHP physician with privileges at the treating hospital assumes responsibility for your care.
- An MHP physician assumes responsibility for your care through transfer.
- An MHP representative and the treating physician reach an agreement concerning your care (the MHP and the physician will follow their agreement about the care you need).
- You are discharged (sent home from the facility by a doctor or other professional).

Services

ADULTS AND OLDER ADULTS

How Do I Know When I Need Help?

Many people have difficult times in life and may experience mental health problems. While many think major mental and emotional disorders are rare, the truth is one in five individuals will have a mental (psychiatric) disorder at some point in their life. Like many other illnesses, mental illness can be caused by many things.

The most important thing to remember when asking yourself if you need professional help is to trust your feelings. If you are eligible for Medi-Cal and you feel you may need professional help, you should request an assessment from your county's MHP to find out for sure.

What Are Signs I May Need Help?

If you can answer 'yes' to one or more of the following AND these symptoms persist for several weeks AND they significantly interfere with your ability to function daily, AND the symptoms are not related to the abuse of alcohol or drugs. If this is the case, you should consider contacting your county's Mental Health Plan (MHP).

A professional from the MHP will determine if you need specialty mental health services from the MHP. If a professional decides you are not in need of specialty mental health services, you may still be treated by your regular medical doctor or primary care provider, or you may Appeal that decision (see page 23).

You may need help if you have SEVERAL of the following feelings:

- Depressed (or feeling hopeless or helpless or worthless or very down) most of the day, nearly every day
- Loss of interest in pleasurable activities
- Weight loss or gain of more than 5% in one month
- Excessive sleep or lack of sleep
- Slowed or excessive physical movements
- Fatigue nearly every day
- Feelings of worthlessness or excessive guilt
- Difficulty thinking or concentrating or making a decision
- Decreased need for sleep – feeling 'rested' after only a few hours of sleep
- 'Racing' thoughts too fast for you to keep up with
- Talking very fast and can't stop talking
- Feel that people are 'out to get you'
- Hear voices and sounds others do not hear
- See things others do not see
- Unable to go to work or school

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[illegible] this way for several weeks, you may want to be assessed by a professional. If you are not sure, you should ask your family doctor or other health care professional for their opinion.

- Do not care about personal hygiene (being clean)
- Have serious relationship problems
- Isolate or withdraw from other people
- Cry frequently and for 'no reason'
- Are often angry and 'blow up' for 'no reason'
- Have severe mood swings
- Feel anxious or worried most of the time
- Have what others call strange or bizarre behaviors

What Services Are Available?

As an adult on Medi-Cal, you may be eligible to receive specialty mental health services from the MHP. Your MHP is required to help you determine if you need these services. Some of the services your county's MHP is required to make available, if you need them, include:

Mental Health Services – These services include mental health treatment services, such as counseling and psychotherapy, provided by psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists and psychiatric nurses. Mental health services may also be called rehabilitation or recovery services, and they help a person with mental illness to develop coping skills for daily living. Mental health services can be provided in a clinic or provider office, over the phone, or in the home or other community setting.

- These services may sometimes be provided to one person at a time (individual therapy or rehabilitation), two or more people at the same time (group therapy or group rehabilitation services), and to families (family therapy).

Medication Support Services – These services include the prescribing, administering, dispensing and monitoring of psychiatric medicines; medication management by psychiatrists; and education and monitoring related to psychiatric medicines. Medication support services can be provided in a clinic or provider office, over the phone, or in the home or other community setting.

Targeted Case Management – This service helps with getting medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with mental illness to do on their own. Targeted case management includes plan development; communication, coordination, and referral; monitoring service delivery to ensure the person's access to service and the service delivery system; and monitoring of the person's progress.

Crisis Intervention and Crisis Stabilization – These services provide mental health treatment for people with a mental health problem that can't wait for a regular, scheduled appointment. Crisis intervention can last up to eight hours and can be provided in a clinic or provider office, over the phone, or in the home or other community setting. Crisis stabilization can last up to 20 hours and is provided in a clinic or other facility site.

Adult Residential Treatment Services – These services provide mental health treatment for people who are living in licensed facilities that provide residential services for people with mental illness. These services are available 24-hours a day, seven days a week. Medi-Cal doesn't cover the room and board cost to be in the facility that offers adult residential treatment services.

Crisis Residential Treatment Services – These services provide mental health treatment for people having a serious psychiatric episode or crisis, but who do not present medical complications requiring nursing care. Services are available 24-hours a day, seven days a week in licensed facilities that provide residential crisis services to people with mental illness. Medi-Cal doesn't cover the room and board cost to be in the facility that offers adult residential treatment services.

Day Treatment Intensive - This is a structured program of mental health treatment provided to a group of people who might otherwise need to be in the hospital or another 24-hour care facility. The program lasts at least three hours a day. People can go to their own homes at night. The program includes skill-building activities (life skills, socialization with other people, etc.) and therapies (art, recreation, music, dance, etc.), as well as psychotherapy.

Each county's MHP may have slightly different ways of making the services available, so please consult the front section of this booklet for more information, or contact your MHP's toll-free phone number to ask for additional information.

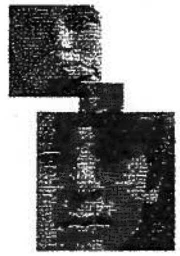
Day Rehabilitation – This is a structured program of mental health treatment to improve, maintain or restore independence and functioning. The program is designed to help people with mental illness learn and develop skills. The program lasts at least three hours per day. People go to their own homes at night. The program includes skill-building activities (life skills, socialization with other people, etc.) and therapies (art, recreation, music, dance, etc.).

Psychiatric Inpatient Hospital Services – These are services provided in a hospital where the person stays overnight either because there is a psychiatric emergency or because the person needs mental health treatment that can only be done in the hospital.

Psychiatric Health Facility Services – These services are provided in a hospital-like setting where the person stays overnight either because there is a psychiatric emergency or because the person needs mental health treatment that can only be done in a hospital-like setting. Psychiatric health facilities must have an arrangement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility.

These services also include work that the provider does to help make the services work better for the person receiving the services. These kinds of things include assessments to see if you need the service and if the service is working; plan development to decide the goals of the person's mental health treatment and the specific services that will be provided; and "collateral", which means working with family members and important people in the person's life (if the person gives permission), if it will help the person improve or maintain his or her mental health status.

CHILDREN, ADOLESCENTS AND YOUNG PEOPLE



How Do I Know When A Child Needs Help?

For children from birth to age 5, there are signs that may show a need for specialty mental health services. These include:

- Parents who feel overwhelmed by being a parent or who have mental health problems
- A major source of stress in the family, such as divorce or death of a family member
- Abuse of alcohol or other drugs by someone in the house
- Unusual or difficult behavior by the child
- Violence or disruption in the house

If one of the above conditions is present in a house where a child up to age 5 is living, specialty mental health services may be needed. You should contact your county's MHP to request additional information and an assessment for services to see if the MHP can help you.

For school-age children, the following checklist includes some signs that should help you decide if your child would benefit from mental health services. Your child:

- Displays unusual changes in emotions or behavior
- Has no friends or has difficulty getting along with other children
- Is doing poorly in school, misses school frequently or does not want to attend school
- Has many minor illnesses or accidents
- Is very fearful
- Is very aggressive
- Does not want to be away from you
- Has many disturbing dreams
- Has difficulty falling asleep, wakes up during the night, or insists on sleeping with you
- Suddenly refuses to be alone with a certain family member or friend or acts very disturbed when the family member or friend is present
- Displays affection inappropriately or makes abnormal sexual gestures or remarks
- Becomes suddenly withdrawn or angry
- Refuses to eat
- Is frequently tearful

You may contact your county's MHP for an assessment for your child if you feel he or she is showing any of the signs above. If your child qualifies for Medi-Cal and the MHP's assessment indicates that specialty mental health services covered by the MHP are needed, the MHP will arrange for the child to receive the services.

How Do I Know When An Adolescent Or Young Person Needs Help?

Adolescents (12-18 years of age) are under many pressures facing teens. Young people aged 18 to 21 are in a transitional age with their own unique pressures and, since they are legally adults, are able to seek services as adults.

Some unusual behavior by an adolescent or young person may be related to the physical and psychological changes taking place as they become an adult. Young adults are establishing a sense of self-identity and shifting from relying on parents to independence. A parent or concerned friend, or the young person may have difficulty deciding between what "normal behavior" is and what may be signs of emotional or mental problems that require professional help.

Some mental illnesses can begin in the years between 12 and 21. The checklist below should help you decide if an adolescent requires help. If more than one sign is present or persists over a long period of time, it may indicate a more serious problem requiring professional help. If an adolescent:

- Pulls back from usual family, friend and/or normal activities
- Experiences an unexplained decline in school work
- Neglects their appearance
- Shows a marked change in weight
- Runs away from home
- Has violent or very rebellious behavior
- Has physical symptoms with no apparent illness
- Abuses drugs or alcohol

A young person aged 18 to 21 should look at the list to the right and at the list of issues for adults on pages 9 and 10 to help decide if mental health services may be needed.

Parents or caregivers of adolescents, or the adolescent may contact the county's MHP for an assessment to see if mental health services are needed. As an adult, a young person (age 18 to 20) may ask the MHP for an assessment. If the adolescent or young person qualifies for Medi-Cal and the MHP's assessment indicates that specialty mental health services covered by the MHP are needed, the MHP will arrange for the adolescent or young person to receive the services.

What Services Are Available?

The same services that are available for adults are also available for children, adolescents and young people. The services that are available are mental health services, medication support services, targeted case management, crisis intervention, crisis stabilization, day treatment intensive, day rehabilitation, adult residential treatment services, crisis residential treatment services, psychiatric inpatient hospital services, and psychiatric health facility services. MHPs also cover additional special services that are only available to children, adolescents and young people under age 21 and eligible for full-scope Medi-Cal (full-scope Medi-Cal means that Medi-Cal coverage isn't limited to a specific type of services, for example, emergency services only).

Each county's MHP may have slightly different ways of making these services available, so please consult the front section of this booklet for more information, or contact your MHP's toll-free phone number to ask for additional information.

Are There Special Services Available For Children, Adolescents And Young Adults?

There are special services available from the MHP for children, adolescents and young people called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health services. These EPSDT services include a service called Therapeutic Behavioral Services or TBS, which is described in the next section, and also include new services as they are identified by experts in mental health treatment as services that really work. These services are available from the MHP if they are needed to correct or ameliorate (improve) the mental health for a person under the age of 21 who is eligible for full-scope Medi-Cal and has a mental illness covered by the MHP (see page 10 for information on the mental illnesses covered by the MHP).

The MHP is not required to provide these special services if the MHP decides that one of the regular services covered by the MHP is available and would meet the child, adolescent, or young person's needs. The MHP is also not required to provide these special services in home and community settings if the MHP determines the total cost of providing the special services at home or in the community is greater than the total cost of providing similar services in an otherwise appropriate institutional level of care.

What Are Therapeutic Behavioral Services (TBS)?

TBS are a type of specialty mental health service available through each county's MHP if you have serious emotional problems. You must be under 21 and have full-scope Medi-Cal to get TBS.

- If you are living at home, the TBS staff person can work one-to-one with you to reduce severe behavior problems to try to keep you from needing to go to a higher level of care, such as a group home for children, adolescents and young people with very serious emotional problems.
- If you are living in a group home for children, adolescents and young people with very serious emotional problems, a TBS staff person can work with you so you may be able to move to a lower level of care, such as a foster home or back home. TBS will help you and your family, caregiver or guardian learn new ways of controlling problem behavior and ways of increasing the kinds of behavior that will allow you to be successful. You, the TBS staff person, and your family, caregiver or guardian will work together very intensively for a short period of time, until you no longer need TBS. You will have a TBS plan that will say what you, your family, caregiver or guardian, and the TBS staff person will do during TBS, and when and where TBS will occur. The TBS staff person can work with you in most places where you are likely to need help with your problem behavior. This includes your home, foster home, group home, school, day treatment program and other areas in the community.

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Who Can Get TBS?

You may be able to get TBS if you have full-scope Medi-Cal, are under 21 years old, have serious emotional problems AND:

- Live in a group home for children, adolescents and young people with very serious emotional problems. (These group homes are sometimes called Rate Classification Level [RCL] 12, 13 or 14 group homes); OR
- Live in a state mental health hospital, a nursing facility that specializes in mental health treatment or a Mental Health Rehabilitation Center (these places are also called institutions for mental diseases or IMDs), OR
- Are at risk of having to live in a group home (RCL 12, 13 or 14), a mental health hospital or IMD; OR
- Have been hospitalized, within the last 2 years, for emergency mental health problems.

Are There Other Things That Must Happen For Me To Get TBS?

Yes. You must be getting other specialty mental health services. TBS adds to other specialty mental health services. It doesn't take the place of them. Since TBS is short-term, other specialty mental health services may be needed to keep problems from coming back or getting worse after TBS has ended.

TBS is NOT provided if the reason it is needed is:

- Only to help you follow a court order about probation
- Only to protect your physical safety or the safety of other people
- Only to make things easier for your family, caregiver, guardian or teachers
- Only to help with behaviors that are not part of your mental health problems

You cannot get TBS while you are in a mental health hospital, an IMD, or locked juvenile justice setting, such as a juvenile hall. If you are in a mental health hospital or an IMD, though, you may be able to leave the mental hospital or IMD sooner, because TBS can be added to other specialty mental health services to help you stay in a lower level of care (home, a foster home or a group home).

How Do I Get TBS?

If you think you may need TBS, ask your psychiatrist, therapist or case manager, if you already have one, or contact the MHP and request services. A family member, caregiver, guardian, doctor, psychologist, counselor or social worker may call and ask for information about TBS or other specialty mental health services for you. You may also call the MHP and ask about TBS.

Who Decides If I Need TBS And Where Can I Get Them?

The MHP decides if you need specialty mental health services, including TBS. Usually an MHP staff person will talk with you, your family, caregiver or guardian, and others who are important in your life and will make a plan for all the mental health services you need, including a TBS plan if TBS is needed. This may take one or two meetings face-to-face, sometimes more. If you need TBS, someone will be assigned as your TBS staff person.

What Should Be In My TBS Plan?

Your TBS plan will spell out the problem behaviors that need to change and what the TBS staff person, you and sometimes your family, caregiver or guardian will do when TBS happens. The TBS plan will say how many hours a day and the number of days a week the TBS staff person will work with you and your family, caregiver or guardian. The hours in the TBS Plan may be during the day, early morning, evening or night. The days in the TBS Plan may be on weekends as well as weekdays. The TBS plan will say how long you will receive TBS. The TBS Plan will be reviewed regularly. TBS may go on for a longer period of time, if the review shows you are making progress but need more time.

'Medical Necessity' Criteria

What Is 'Medical Necessity' And Why Is It So Important?

One of the conditions necessary for receiving specialty mental health services through your county's MHP is something called 'medical necessity.' This means a doctor or other mental health professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

The term 'medical necessity' is important because it will help decide what kind of services you may get and how you may get them. Deciding 'medical necessity' is a very important part of the process of getting specialty mental health services.

What Are The 'Medical Necessity' Criteria For Coverage Of Specialty Mental Health Services Except For Hospital Services?

As part of deciding if you need specialty mental health services, your county's MHP will work with you and your provider to decide if the services are a 'medical necessity,' as explained above. This section explains how your MHP will make that decision.

You don't need to know if you have a diagnosis, or a specific mental illness, to ask for help. Your county MHP will help you get this information with an 'assessment.'

There are four conditions your MHP will look for to decide if your services are a 'medical necessity' and qualify for coverage by the MHP:

(1) You must be diagnosed by the MHP with one of the following mental illnesses as described in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

Only the Court or Juvenile Probation Officer can tell you what kind of mental illness you have, so ask the MHP for an assessment to see if you need specialty mental health services from the MHP.

AND

(2) You must have at least one of the following problems as a result of the diagnosis:

- A significant difficulty in an important area of life-functioning
- A probability of significant deterioration in an important area of life functioning
- Except as provided in the section for people under 21 years of age, a probability that a child will not progress developmentally as individually appropriate

AND

(3) The expectation is that the proposed treatment will:

- Significantly reduce the problem
- Prevent significant deterioration in an important area of life-functioning
- Allow a child to progress developmentally as individually appropriate

AND

(4) The condition would not be responsive to physical health care based treatment.

If you do NOT meet these criteria, it does not mean that you cannot receive help. Help may be available from your regular Medi-Cal doctor, or through the standard Medi-Cal program.

When the requirements of this 'medical necessity' section are met, you are eligible to receive specialty mental health services from the MHP.

What Are The 'Medical Necessity' Criteria for Specialty Mental Health Services For People Under 21 Years of Age?

If you are under the age of 21, have full-scope Medi-Cal and have one of the diagnosis listed in (1) above, but don't meet the criteria in (2) and (3) above, the MHP would need to work with you and your provider to decide if mental health treatment would correct or ameliorate (improve) your mental health. If services covered by the MHP would correct or improve your mental health, the MHP will provide the services.

What Are The 'Medical Necessity' Criteria For Reimbursement Of Psychiatric Inpatient Hospital Services?

One way that your MHP decides if you need to stay overnight in the hospital for mental health treatment is how 'medically necessary' it is for your treatment. If it is medically necessary, as explained above, then your MHP will pay for your stay in the hospital. An assessment will be made to help make this determination.

When you and the MHP or your MHP provider plan for your admission to the hospital, the MHP will decide about medical necessity before you go to the hospital. More often, people go to the hospital in an emergency and the MHP and the hospital work together to decide about medical necessity. You don't need to worry about whether or not the services are medically necessary if you go to the hospital in an emergency (see State of California page 6 for more information about how emergencies are covered).

If you need the hospital services your MHP pays for an admission to the hospital if you meet the conditions to the right, called medical necessity criteria.

You have a mental illness or symptoms of mental illness and you cannot be safely treated at a lower level of care, and, because of the mental illness or symptoms of mental illness, you:

- Represent a current danger to yourself or others, or significant property destruction
- Are prevented from providing for or using food, clothing or shelter
- Present a severe risk to your physical health
- Have a recent, significant deterioration in ability to function, and
- Need psychiatric evaluation, medication treatment, or other treatment that can only be provided in the hospital

Your county's MHP will pay for a longer stay in a psychiatric inpatient hospital if you have one of the following:

- The continued presence of the 'medical necessity' criteria described above
- A serious and negative reaction to medications, procedures or therapies requiring continued hospitalization
- The presence of new problems which meet medical necessity criteria
- The need for continued medical evaluation or treatment that can only be provided in a psychiatric inpatient hospital

Your county's MHP can have you released from a psychiatric inpatient (overnight stay) hospital when your doctor says you are stable. This means when the doctor expects you would not get worse if you were transferred out of the hospital.

Notice of Action

What Is A Notice of Action?

A Notice of Action sometimes called an NOA, is a form that your county's Mental Health Plan (MHP) uses to tell you when the MHP makes a decision about whether or not you will get Medi-Cal specialty mental health services. A Notice of Action is also used to tell you if your Grievance, Appeal, or expedited Appeal was not resolved in time, or if you didn't get services within the MHP's timeline standards for providing services.

When Will I Get A Notice of Action?

You will get a Notice of Action:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. See page 17 for information about medical necessity.
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service. Most of the time you will receive a Notice of Action before you receive the service, but sometimes the Notice of Action will come after you already received the service, or while you are receiving the service. If you get a Notice of Action after you have already received the service, you do not have to pay for the service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP does not provide services to you based on the timelines the MHP has set up. Call your county's MHP to find out if the MHP has set up timeline standards.
- If you file a Grievance with the MHP and the MHP does not get back to you with a written decision on your Grievance within 60 days. See page 28 for more information on Grievances.
- If you file an Appeal with the MHP and the MHP does not get back to you with a written decision on your Appeal within 45 days, or if you filed an expedited Appeal within three working days. See page 23 for more information on Appeals.

Please see the next section in this booklet on the Problem Resolution Processes for more information on Grievances, Appeals and State Fair Hearings.

Will I Always Get A Notice of Action When I Don't Get The Services I Want?

There are some cases where you may not receive a Notice of Action. If you and your provider do not agree on the services you need, you will not get a Notice of Action from the MHP. If you think the MHP is not providing services to you quickly enough, but the MHP hasn't set a timeline, you won't receive a Notice of Action.

You may still file an Appeal with the MHP or request a State Fair Hearing when these things happen. Information on how to file an Appeal or request a State Fair Hearing is included in this booklet starting on page 22. Information should also be available in your provider's office.

What Will The Notice of Action Tell Me?

The Notice of Action will tell you:

- What your county's MHP did that affects you and your ability to get services.
- The effective date of the decision and the reason the MHP made its decision.
- The state or federal rules the MHP was following when it made the decision.
- What your rights are if you do not agree with what the MHP did.
- How to file an Appeal with the MHP.
- How to request a State Fair Hearing.
- How to request an expedited Appeal or an expedited State Fair Hearing.
- How to get help filing an Appeal or requesting a State Fair Hearing.
- How long you have to file an Appeal or request a State Fair Hearing.
- If you are eligible to continue to receive services while you wait for a State Fair Hearing decision.
- When you have to file your State Fair Hearing request if you want the services to continue.

You should decide if you agree with what the MHP says on the form. If you decide that you don't agree you can file an Appeal with your MHP or request a State Fair Hearing, being careful to file on time. Most of the time, you will have 90 days to request a State Fair Hearing or file an Appeal.

What Should I Do When I Get A Notice of Action?

When you get a Notice of Action you should read all the information on the form carefully. If you don't understand the form, your MHP can help you. You may also ask another person to help you.

If the Notice of Action form tells you that you can continue services while you are waiting for a State Fair Hearing decision, you must request the State Fair Hearing within 10 days from the date the Notice of Action was mailed or personally given to you or, if the Notice of Action is sent more than 10 days before the effective date for the change in services, before the effective date of the change.

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Problem Resolution Processes

What If I Don't Get the Services I Want From My County MHP?

Your county's MHP has a way for you to work out a problem about any issue related to the specialty mental health services you are receiving. This is called the problem resolution process and it could involve:

1. **The Appeal Process** - review of a decision (denial or changes to services) that was made about your specialty mental health services by the MHP or your provider.
2. **The State Fair Hearing Process** - review to make sure you receive the mental health services which you are entitled to under the Medi-Cal program.
3. **The Grievance Process** - an expression of unhappiness about anything regarding your specialty mental health services that is not one of the problems covered by the Appeal and State Fair Hearing processes.

Your MHP will provide Grievance and Appeal forms and self-addressed envelopes for you at all provider sites, and you should not have to ask anyone to get one. Your county's MHP must post notices explaining the Grievance and Appeal process procedures in locations at all provider sites, and make language interpreting services available at no charge, along with toll-free numbers to help you during normal business hours.

You will not be punished for filing a Grievance, Appeal or State Fair Hearing. When your Grievance or Appeal is complete, your county's MHP will notify you and others involved of the final outcome. When your State Fair Hearing is complete, the State Hearing Office will notify you and others involved of the final outcome.

The State's Mental Health Ombudsman Services can be reached at (800) 896-4042 (interpreter services are available) on TTY (800) 896-2512, by sending a fax to (916) 653-9194, or by e-mailing to ombudsmn@dmhhq.state.ca.us.

Can I Get Help To File An Appeal, Grievance Or State Fair Hearing?

Your county's MHP will have people available to explain these processes to you and to help you report a problem either as an Appeal, a Grievance, or as a request for State Fair Hearing. They may also help you know if you qualify for what's called an 'expedited' process, which means it will be reviewed more quickly because your health or stability is at risk. You may also authorize another person to act on your behalf, including your mental health care provider.

What If I Need Help To Solve A Problem With My MHP But Don't Want To File A Grievance Or Appeal?

You can get help from the State if you are having trouble finding the right people at the MHP to help you find your way through the MHP system. The State has a Mental Health Ombudsman Services program that can provide you with information on how the MHP system works, explain your rights and choices, help you solve problems with getting the services you need, and refer you to others at the MHP or in your community who may be of help.

THE Appeals PROCESSES (Standard and Expedited)

Your MHP is responsible for allowing you to request a review of a decision that was made about your specialty mental health services by the MHP or your providers. There are two ways you can request a review. One way is using the standard Appeals process. The second way is by using the expedited Appeals process. These two forms of Appeals are similar; however, there are specific requirements to qualify for an expedited Appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A Standard Appeal is a request for review of a problem you have with the MHP or your provider that involves denial or changes to services you think you need. If you request a standard Appeal, the MHP may take up to 45 days to review it. If you think waiting 45 days will put your health at risk, you should ask for an 'expedited Appeal.'

The standard Appeals process will:

- Allow you to file an Appeal in person, on the phone, or in writing. If you submit your Appeal in person or on the phone, you must follow it up with a signed, written Appeal. If you do not follow-up with a signed written Appeal, your Appeal will not be resolved. However, the date that you submitted the oral Appeal is the filing date.
- Ensure filing an Appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the MHP might ask you to sign a form authorizing the MHP to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical record, and any other documents or records considered during the Appeal process, before and during the Appeal process.
- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the Appeal.
- Let you know your Appeal is being reviewed by sending you written confirmation.
- Inform you of your right to request a State Fair Hearing at any time during the Appeal process.

When Can I File An Appeal?

You can file an Appeal with your county's MHP:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. (See page 17 for information about medical necessity.)
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP doesn't provide services to you based on the timelines the MHP has set up.
- If you don't think the MHP is providing services soon enough to meet your needs.
- If your Grievance, Appeal or expedited Appeal wasn't resolved in time.
- If you and your provider do not agree on the services you need.

How Can I File An Appeal?

See the front part of this booklet for information on how to file an Appeal with your MHP. You may call your county MHP's toll-free telephone number (also included in the front part of this booklet) to get help with filing an Appeal. The MHP will provide self-addressed envelopes at all provider sites for you to mail in your Appeal.

How Do I Know If My Appeal Has Been Decided?

Your MHP will notify you or your representative in writing about their decision for your Appeal. The notification will have the following information:

- The results of the Appeal resolution process
- The date the Appeal decision was made
- If the Appeal is not resolved wholly in your favor, the notice will also contain information regarding your right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

Is There A Deadline To File An Appeal?

You must file an Appeal within 90 days of the date of the action you're Appealing when you get a Notice of Action (see page 20). Keep in mind that you will not always get a Notice of Action. There are no deadlines for filing an Appeal when you do not get a Notice of Action, so you may file at any time.

When Will A Decision Be Made About My Appeal?

The MHP must decide on your Appeal within 45 calendar days from when the MHP receives your request for the Appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the MHP thinks it might be able to approve your Appeal if the MHP had a little more time to get information from you or your provider.

What If I Can't Wait 45 Days For My Appeal Decision?

The Appeal process may be faster if it qualifies for the expedited Appeals process. (Please see the section on Expedited Appeals below.) You have the right to request a State Fair Hearing at any time during the Appeals process.

What Is An Expedited Appeal?

An expedited Appeal is a faster way to decide an Appeal. The expedited Appeals process follows a process similar to the standard Appeals process. However,

- Your Appeal has to meet certain requirements (see below).
- The expedited Appeals process also follows different deadlines than the standard Appeals process.
- You can make a verbal request for an expedited Appeal. You do not have to put your expedited Appeal request in writing.

When Can I File an Expedited Appeal?

If you think that waiting up to 45 days for a standard Appeal decision will jeopardize your life, health or ability to attain, maintain or regain maximum function, you may request an expedited Appeal. If the MHP agrees that your Appeal meets the requirements for an expedited Appeal, your MHP will resolve your expedited Appeal within 3 working days after the MHP receives the expedited Appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is in your interest. If your MHP extends the timeframes, the MHP will give you a written explanation as to why the timeframes were extended.

If the MHP decides that your Appeal does not qualify for an expedited Appeal, your MHP will notify you right away orally and will notify you in writing within 2 calendar days. Your Appeal will then follow the standard Appeal timeframes outlined earlier in this section. If you disagree with the MHP's decision that your Appeal doesn't meet the expedited Appeal criteria, you may file a Grievance (see the description of the Grievance process below).

Once your MHP resolves your expedited Appeal, the MHP will notify you and all affected parties orally and in writing.

THE State Fair Hearing PROCESSES (Standard and Expedited)

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the specialty mental health services to which you are entitled under the Medi-Cal program.

What Are My State Fair Hearing Rights?

You have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.
- Be told about the rules that govern representation at the State Fair Hearing.
- Have your benefits continued upon your request during the State Fair Hearing process if you ask for a State Fair Hearing within the required timeframes.
- Ask for a State Fair Hearing whether or not you use the MHP's Appeal process and whether or not you have received a Notice of Action as described earlier in this booklet.

When Can I File For A State Fair Hearing?

You can file for a State Fair Hearing:

- If your MHP or one of the MHP's providers decides that you do not qualify to receive any Medi-Cal specialty mental health services because you do not meet the medical necessity criteria. (See page 17 for information about medical necessity.)
- If your provider thinks you need a specialty mental health service and asks the MHP for approval, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service.
- If your provider has asked the MHP for approval, but the MHP needs more information to make a decision and doesn't complete the approval process on time.
- If your MHP doesn't provide services to you based on the timelines the MHP has set up.
- If you don't think the MHP is providing services soon enough to meet your needs.
- If your Grievance, Appeal or expedited Appeal wasn't resolved in time.
- If you and your provider do not agree on the services you need.

How Do I Request a State Fair Hearing?

You can request a State Fair Hearing directly from the California Department of Social Services. You can ask for a State Fair Hearing by writing to:

State Hearing Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

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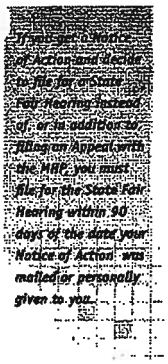
To request a State Fair Hearing, you may also call (800) 952-5253, send a fax to (916) 229-4110, or write to the Department of Social Services/State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento, CA 94244-2430.

Is There A Deadline For Filing For A State Fair Hearing?

If you didn't receive a Notice of Action or file an Appeal with the MHP, you may file for a State Fair Hearing at any time.



If you get a Notice of Action and decide to file for a State Fair Hearing instead of, or in addition to, filing an Appeal with the MHP, you must file for the State Fair Hearing within 90 days of the date your Notice of Action was mailed or personally given to you.

If you file an Appeal with the MHP and want to file for a State Fair Hearing after you get the MHP's decision on your Appeal, you must file for the State Fair Hearing within 90 days of the postmark date of the MHP's Appeal decision.

Can I Continue Services While I'm Waiting For A State Fair Hearing Decision?

You can continue services while you're waiting for a State Fair Hearing decision if your provider thinks the specialty mental health service you are already receiving need to continue and asks the MHP for approval to continue, but the MHP does not agree and says "no" to your provider's request, or changes the type or frequency of service the provider requested. You will always receive a Notice of Action from the MHP when this happens. Additionally, you will not have to pay for services given while the State Fair Hearing is pending.

What Do I Need To Do If I Want To Continue Services While I'm Waiting For A State Fair Hearing Decision?

If you want services to continue during the State Fair Hearing process, you must request a State Fair Hearing within 10 days from the date your Notice of Action was mailed or personally given to you.

What If I Can't Wait 90 Days For My State Fair Hearing Decision?

You may ask for an expedited (quicker) State Fair Hearing if you think the normal 90-day timeframe will cause serious problems with your mental health, including problems with your ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within 3 working days of the date your request is received by the State Hearings Division.

THE Grievance PROCESS

What Is A Grievance?

A Grievance is an expression of unhappiness about anything regarding your specialty mental health services that are not one of the problems covered by the Appeal and State Fair Hearing processes (see pages 23 and 26 for information on the Appeal and State Fair Hearing processes).

The Grievance process will:

- Involve simple, and easily understood procedures that allow you to present your Grievance orally or in writing.
- Not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the MHP might ask you to sign a form authorizing the MHP to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous levels of review or decision-making.
- Identify the roles and responsibilities of you, your MHP and your provider.
- Provide resolution for the Grievance in the required timeframes.

When Can I File A Grievance?

You can file a Grievance with the MHP if you are unhappy with the specialty mental health services you are receiving from the MHP or have another concern regarding the MHP.

How Can I File A Grievance?

You may call your county MHP's toll-free telephone number to get help with a Grievance. The MHP will provide self-addressed envelopes at all the providers' sites for you to mail in your Grievance. Grievances can be filed orally or in writing. Oral Grievances do not have to be followed up in writing.

How Do I Know If The MHP Received My Grievance?

Your MHP will let you know that it received your Grievance by sending you a written confirmation.

When Will My Grievance Be Decided?

The MHP must make a decision about your Grievance within 60 calendar days from the date you filed your Grievance. Timeframes may be extended by up to 14 calendar days if you request more time, or if the MHP feels there is a need for additional information and that the delay was for your benefit. An example of when a delay might be for your benefit is when the MHP thinks it might be able to approve your Grievance if the MHP had a little more time to get information from you or other people involved.

How Do I Know If The MHP Has Made A Decision About My Grievance?

When a decision has been made regarding your Grievance, the MHP will notify you or your representative in writing of the decision. If your MHP fails to notify you or any affected parties of the Grievance decision on time, the MHP will provide you with a Notice of Action advising you of your right to request a State Fair Hearing. Your MHP will provide you with a Notice of Action on the date the timeframe expires.

Is There A Deadline To File To Grievance?

You may file a Grievance at any time.

Your Rights

What Are My Rights?

As a person eligible for Medi-Cal, you have a right to receive medically necessary specialty mental health services from the MHP. When accessing these services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Receive information on available treatment options and alternatives, and have them presented in a manner you can understand.
- Participate in decisions regarding your mental health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment or retaliation as specified in federal rules about the use of restraints and seclusion in facilities such as hospitals, nursing facilities and psychiatric residential treatment facilities where you stay overnight for treatment.
- Request and receive a copy of your medical records, and request that they be amended or corrected.
- Receive the information in this booklet about the services covered by the MHP, other obligations of the MHP and your rights as described here. You also have the right to receive this information and other information provided to you by the MHP in a form that is easy to understand. This means, for example, that the MHP must make its written information available in the languages that are used by at least 5 percent or 3,000, whichever is less, of Medi-Cal eligible people in the MHP's county and make oral interpreter services available free of charge for people who speak other languages. This also means that the MHP must provide different materials for people with special needs, such as people who are blind or have limited vision or people who have trouble reading.
- Receive specialty mental health services from a MHP that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. The MHP is required to:
  - Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible individuals who qualify for specialty mental health services can receive them in a timely manner.
  - Cover medically necessary services out-of-network for you in a timely manner, if the MHP doesn't have an employee or contract provider who can deliver the services. "Out-of-network provider" means a provider who is not on the MHP's list of providers. The MHP must make sure you don't pay anything extra for seeing an out-of-network provider.
  - Make sure providers are qualified to deliver the specialty mental health services that the providers agreed to cover.

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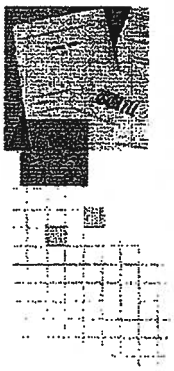
- Make sure that the specialty mental health services the MHP covers are adequate in amount, duration and scope to meet the needs of the Medi-Cal eligible individuals it serves. This includes making sure the MHP's system for authorizing payment for services is based on medical necessity and uses processes that ensure fair application of the medical necessity criteria.
- Ensure that its providers perform adequate assessments of individuals who may receive services and work with the individuals who will receive services to develop a treatment plan that includes the goals of treatment and the services that will be delivered.
- Provide for a second opinion from a qualified health care professional within the MHP's network, or one outside the network, at no additional cost to you.
- Coordinate the services it provides with services being provided to an individual through a Medi-Cal managed care health plan or with your primary care provider, if necessary, and in the coordination process, to make sure the privacy of each individual receiving services is protected as specified in federal rules on the privacy of health information.
- Provide timely access to care, including making services available 24-hours a day, 7 days a week, when medically necessary to treat an emergency psychiatric condition or an urgent or crisis condition.
- Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Your MHP must ensure your treatment is not adversely affected as a result of you using your rights. Your Mental Health Plan is required to follow other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act) as well as the rights described here. You may have additional rights under state laws about mental health treatment and may wish to contact your county's Patients' Rights Advocate (call your county mental health department listed in the local phone book and ask for the Patients' Rights Advocate) with specific questions.

ADVANCE DIRECTIVES

What Is An Advance Directive?



You have the right to have an advance directive. An advance directive is a written instruction about your health care that is recognized under California law. It usually states how you would like health care provided, or says what decisions you would like to be made, if or when you are unable to speak for yourself. You may sometimes hear an advance directive described as a living will or durable power of attorney.

California law defines an advance directive as either an oral or written individual health care instruction or a power of attorney (a written document giving someone permission to make decisions for you). All MHPs are required to have advance directive policies in place. Your MHP is required to provide any adult who is Medi-Cal eligible with written information on the MHP's advance directive policies and a description of applicable state law, if the adult asks for the information. If you would like to request the information, you should call your MHP's toll-free phone number listed in the front part of this booklet for more information.

An advance directive is designed to allow people to have control over their own treatment, especially when they are unable to provide instructions about their own care. It is a legal document that allows people to say, in advance, what their wishes would be, if they become unable to make health care decisions. This may include such things as the right to accept or refuse medical treatment, surgery, or to make other health care choices. In California, an advance directive consists of two parts:

1. Your appointment of an agent (a person) making decisions about your health care, and
2. Your individual health care instructions.

If you have a complaint about advance directive requirements, you may contact the California Department of Health Services, Licensing and Certification Division, by calling (800) 236-9747, or by mail at P.O. Box 997413, Sacramento, California 95899-1413.

CULTURAL COMPETENCY

Why Are Cultural Considerations And Language Access Important?

A culturally competent mental health system includes skills, attitudes and policies that make sure the needs of everyone are addressed in a society of diverse values, beliefs and orientations, and different races, religions and languages. It is a system that improves the quality of care for all of California's many different peoples and provides them with understanding and respect for those differences.

Your county's MHP is responsible for providing the people it serves with culturally and linguistically competent specialty mental health services. For example: non-English or limited English speaking persons have the right to receive services in their preferred language and the right to request an interpreter. If an interpreter is requested, one must be provided at no cost. People seeking services do not have to bring their own interpreters. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. Information is also available in alternative formats if someone cannot read or has visual challenges. The front part of this booklet tells you how to obtain this information. Your county's MHP is required to:

- Provide specialty mental health services in your preferred language.
- Provide culturally appropriate assessments and treatments.
- Provide a combination of culturally specific approaches to address various cultural needs that exist in the MHP's county to create a safe and culturally responsive system.
- Make efforts to reduce language barriers.
- Make efforts to address the culturally specific needs of individuals receiving services.
- Provide services with sensitivity to culturally specific views of illness and wellness.
- Consider your world view in providing you specialty mental health services.
- Have a process for teaching MHP employees and contractors about what it means to live with mental illness from the point of view of people who are mentally ill.
- Provide a listing of cultural/linguistic services available through your MHP.
- Provide a listing of specialty mental health services and other MHP services available in your primary language (sorted by location and services provided)
- Provide oral interpretation services available free of charge. This applies to all non-English languages.
- Provide written information in threshold languages and alternative formats, in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

- Provide a statewide, toll-free telephone number available 24-hours a day, 7 days a week, with language capability in your language to provide information to you about how to access specialty mental health services. This includes services needed to treat your urgent condition, and how to use the MHP problem resolution and State Fair Hearing processes.
- Find out at least once a year if people from culturally, ethnically and linguistically diverse communities see themselves as getting the same benefit from services as people in general.

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How Services May be Provided to You

How Do I Get Specialty Mental Health Services?

If you think you need specialty mental health services, you can get services by asking the MHP for them yourself. You can call your MHP's toll-free phone number listed in the front section of this booklet. The front part of this booklet and the section called "Services" on page 9 of the booklet give you information about services and how to get them from the MHP.

You may also be referred to your MHP for specialty mental health services in other ways. Your MHP is required to accept referrals for specialty mental health services from doctors and other primary care providers who think you may need these services and from your Medi-Cal managed care health plan, if you are a member. Usually the provider or the Medi-Cal managed care health plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there's an emergency. Other people and organizations may also make referrals to the MHP, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.

How Do I Find A Provider For The Specialty Mental Health Services I Need?

Some MHPs require you to receive approval from your county's MHP before you contact a service provider. Some MHPs will refer you to a provider who is ready to see you. Other MHPs allow you to contact a provider directly.

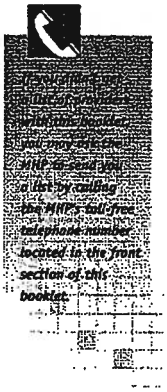
The MHP may put some limits on your choice of providers. Your county's MHP must give you a chance to choose between at least two providers when you first start services, unless the MHP has a good reason why it can't provide a choice (for example, there is only one provider who can deliver the service you need). Your MHP must also allow you to change providers. When you ask to change providers, the MHP must allow you to choose between at least two providers, unless there is a good reason not to do so.

Sometimes MHP contract providers leave the MHP on their own or at the request of the MHP. When this happens, the MHP must make a good faith effort to give written notice of termination of a MHP-contracted provider within 15 days after receipt or issuance of the termination notice to each person who was receiving specialty mental health services from the provider.

Once I Find A Provider, Can The MHP Tell The Provider What Services I Get?

You, your provider and the MHP are all involved in deciding what services you need to receive through the MHP by following the medical necessity criteria and the list of covered services (see pages 17 and 10). Sometimes the MHP will leave the decision to you and the provider. Other times, the MHP may require your provider to ask the MHP to review the reasons the provider thinks you need a service before the service is provided. The MHP must use a qualified mental health professional to do the review. This review process is called an MHP payment authorization process. The State requires the MHP to have an authorization process for day treatment intensive, day rehabilitation, and therapeutic behavioral services (TBS).

The MHP's authorization process must follow specific timelines. For a standard authorization, the MHP must make a decision on your provider's request within 14 calendar days. If you or your provider request information or if the MHP thinks it is in your interest to get more information from your provider, the timeline can be extended for up to another 14 calendar days. An example of when an extension might be in your interest is when the MHP thinks it might be able to approve your provider's request for authorization if the MHP had additional information from your provider and would have to deny the request without the information. If the MHP extends the timeline, the MHP will send you a written notice about the extension.



If your provider or the MHP thinks your life, health or ability to attain, maintain or regain maximum function will be jeopardized by the 14-day timeframe, the MHP must make a decision within 3 working days. If you or your provider request information or if the MHP thinks it is in your interest to get more information from your provider, the timeline can be extended up to an additional 14 calendar days.

If the MHP doesn't make a decision within the timeline required for a standard or expedited authorization request, the MHP must send you a Notice of Action telling you that the services are denied and that you may file an Appeal or ask for a State Fair Hearing (see page 26).

You may ask the MHP for more information about its authorization process. Check the front section of this booklet to see how to request the information. If you don't agree with the MHP's decision on an authorization process, you may file an Appeal with the MHP or ask for a State Fair Hearing (see page 26).

Which Providers Does My MHP Use?

Most MHPs use four different types of providers to provide specialty mental health services. These include:

Individual Providers: Mental health professionals, such as doctors, who have contracts with your county's MHP to provide specialty mental health services in an office and/or community setting.

Group Providers: These are groups of mental health professionals who, as a group of professionals, have contracts with your county's MHP to offer specialty mental health services in an office and/or community setting.

Organizational Providers: These are mental health clinics, agencies or facilities that are owned or run by the MHP, or that have contracts with your county's MHP to provide services in a clinic and/or community setting.

Hospital Providers: You may receive care or services in a hospital. This may be as a part of emergency treatment, or because your MHP provides the services you need in this type of setting.

If you are new to the MHP, a complete list of providers in your county's MHP follows this section of the booklet and contains information about where providers are located, the specialty mental health services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers. If you have questions about providers, call your MHP's toll-free telephone number located in the front section of this booklet.

Notes

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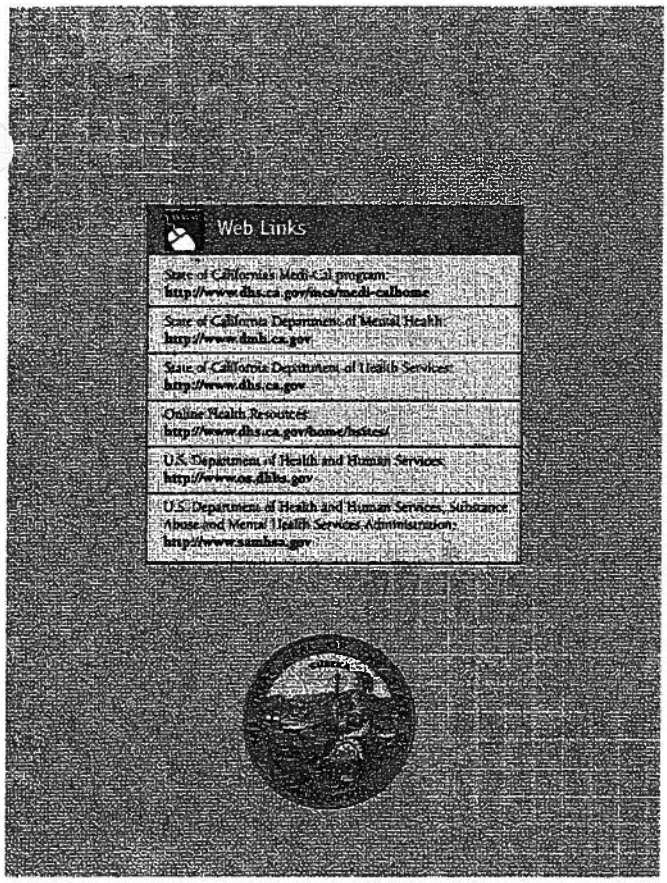

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