Solano County Health & Social Services
Mental Health Division

COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due September 8, 2010 to:

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

Name of County:	Solano County
Name of County Mental Health Director:	Glenda Lingenfelter, RN
Name of Contact:	Joseph Robinson
Contact's Title:	Mental Health Services Coordinator
Contact's Unit/Division:	Solano County Mental Health
Contact's Telephone:	(707) 784-8320
Contact's Email:	jfrobinson@solanocounty.com

CHECKLIST OF THE

2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

☒ **CRITERION 1: Commitment to Cultural Competence** — **Pages 1-16**

☒ **CRITERION 2: Updated Assessments of Service Needs** — **Pages 17-31**

☒ **CRITERION 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities** — **Pages 32-55**

☒ **CRITERION 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System** — **Pages 56-61**

☒ **CRITERION 5: Cultural Competent Training Activities** — **Pages 62-78**

☒ **CRITERION 6: County's Commitment to Growing a Multi-cultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff** — **Pages 79-85**

☒ **CRITERION 7: Language Capacity** — **Pages 86-89**

☒ **CRITERION 8: Adaptation of Services** — **Pages 90-92**

Solano County Health & Social Services Mental Health Division
2010 Cultural Competence Plan

Table of Contents

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE	Page No.
I. Solano County's Mental Health System Commitment to Cultural Competence	3
II. County Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System	5
III. Solano County's Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competence	12
IV Identified Budget Resources Targeted for Culturally Competent Activities	13
CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS	Page No.
I. General Population of Solano County by Region	17
II. Medi-Cal Population Service Needs	19
III. 200% of Poverty (minus Medi-Cal) Population and Service Needs	21
IV. Community Services and Supports (CSS) Population Assessment and Service	23
V. Prevention and Early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations	26
CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES	Page No.
I. Identified Unserved/Underserved Target Populations (with disparities) Within Medi-Cal, CSS, WET and PEI Populations	32
II. Identified Disparities	37
III. Identified Strategies/Objectives/Actions/Timelines	37
IV. Additional Strategies/Objectives/Actions/Timelines and Lessons Learned	48
V. Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities	51
CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTERGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM	Page No.
I. Solano County's Cultural Competence Committee That Addresses Cultural Issues and Is Reflective of the Community	56
II. SCMH Cultural Competence Committee's Integration within SCMH	56
CRITERION 5: SOLANO COUNTY'S CULTURALLY COMPETENT TRAINING ACTIVITIES	Page No.
I. Solano County's System to Require All Staff and Stakeholders to Receive Annual Cultural Competence Training Using the California Brief Multi-Cultural Scale (CBMCS)	62
II. Annual Cultural Competence Trainings	63
III. Relevance and Effectiveness of Solano County's Cultural Competence Trainings	73
IV. .Solano County's Process for the Incorporation of Client Culture	76
CRITERION 6: SOLANO COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING/RETAINING CULTURALLY & LINGUISTICALLY COMPETENT STAFF	Page No.
I. Solano County Mental Health's Recruitment, Hiring, and Retention of a Multicultural Workforce From, or Experienced with, the Identified Unserved and Underserved Populations	79
CRITERION 7: LANGUAGE CAPACITY	Page No.
I. Bilingual Workforce Capacity	86
II. Interpreter Services to Persons Who Have Limited English Proficiency (LEP)	87
III. Bilingual Staff and/or Interpreters for the Threshold Languages at All Points of Contact	88
IV. Services to All LEP Clients Not Meeting the Threshold Language Criteria Who Encounter the Mental Health System at All Points of Contact	88
V Required Translated Documents, Forms, Signage, and Client Informing Materials	89
CRITERION 8: LANGUAGE CAPACITY	Page No.
I. Client Driven/Operated Recovery and Wellness Programs	90
II. Responsiveness of Mental Health Services	90
III. Quality of Care: Contract Providers	91
IV Quality Assurance	91

CRITERION 1:
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

Solano County, Solano County Health & Social Services and the Solano County Mental Health division (SCMH) have a strong commitment to ensuring the provision of county-wide mental health services are delivered in ways which recognize, are sensitive to, and respectful of individual, cultural and linguistic differences as illustrated throughout this Cultural Competence Plan. Criterion one demonstrates SCMH's commitment to cultural competency by providing an overview of policies, procedures and/or practices related to cultural competency. Criterion one also provides an overview of relationships with community partners and their role in providing cultural competent services. Finally, Criterion one provides an overview of who in Solano County is responsible for cultural competency and how cultural competency activities are funded.

A. The following is a list of policies, procedures, and/or practices that reflect specific steps SCMH has taken to ensure racial, ethnic and cultural diversity is respected and valued throughout the public mental health system. Since Solano County's last cultural competence report, the division has made significant gains to integrate cultural competence standards throughout the mental health system, including:

1. Solano County Department of Health & Social Services, Solano County Mental Health
    a. **AAA 2.2 Providing Language Services** regarding the provision of linguistically appropriate services in order to ensure services are delivered in ways which recognize, are sensitive to and respectful of individual and cultural differences. (Attachment 1)
    b. **AAA 2.3 Ensuring the Provision of Multi-Cultural/Lingual Mental Health Services** ensures that services are available to all beneficiaries who need them in a manner that promotes, facilitates, and provides the opportunity for use of services. (Attachment 2)
    c. **AAA 2.14 Recruiting Culturally Sensitive Staff** regarding the recruiting, hiring, retaining and promoting of persons whose cultural/ethnic, experiential and/or linguistic backgrounds facilitate the provision of clinically responsive services to all population groups in Solano County. (Attachment 3).
2. SCMH Policies, Inclusion in Planning, Implementation Teams and Workgroups
    a. Mental Health Services Act (MHSA) Stakeholder and Steering Committee membership is inclusive of diverse and underserved populations, including consumers/family members, racial and ethnic groups, geographic areas, across the life span, gender, LBGTQ[1], etc. Also, MHSA meetings are held in various communities across the county (Attachment 4)
    b. SCMH strategic planning groups are required to be inclusive of the diverse populations and are representative of un-served and under-served populations within Solano County (Attachment 5)

---

[1] LBGTQ is an abbreviation for Lesbian, Bisexual, Gay, Transgender, and Questioning.

    c. SCMH process action teams were formed to address systemic challenges by involving staff at all levels and who represented the diverse populations served by SCMH. (Attachment 6)
    d. Solano County Local Mental Health Board membership is inclusive of diverse and underserved populations (Attachment 7), including consumers/family members, racial and ethnic groups, military personnel, geographic areas, across the lifespan, and etc.
3. <u>Mental Health Services Act (MHSA) Policies on Outreach & Engagement</u>
    a. Per Title 9 Chapter 14 Section 3315, SCMH has developed a community planning process to seek input and gather information from diverse stakeholders in order to inform MHSA Plans, Annual Updates, strategic planning and etc. (Attachments 4 & 5)
    b. Community planning process for the MHSA Innovation Plan included outreach in English and Spanish to underserved populations in geographically diverse parts of the county (Attachment 8)
    c. Per Title 9 Chapter 14 Section 3315, SCMH posts MHSA Plans, Annual Updates, MHSA Annual Update for a 30 day public comment period prior to presenting at a public hearing of the Local Mental Health Board. The 30 day public comment period and public hearing are advertised by way of the public posting, email notices, flyers in public locations, press releases, notices in news papers and etc. (Attachment 9)
    d. MHSA Fiscal Year (FY) 2009/10 Outreach & Engagement Strategic Plan included specific strategies to outreach to diverse and underserved populations (Attachment 10), including creating a Solano County Veterans' Resource Collaborative, a Latino Access Group, and collaboration with Native Americans.
4. <u>SCMH Division Practices and Training</u>
    a. In Fiscal Year (FY) 2009-10, SCMH began circulating cultural competence articles and information sheets to be reviewed monthly in SCMH staff meetings. Each topic addressed a community that is underserved in SCMH. Supervisors distributed the discussion material sent from the Cultural Competency Coordinator, initiated the conversation regarding the material in staff meetings, tracked attendance by sign in sheets and collected evaluation forms. (Attachment 11)
    b. In FY 2009-10, SCMH secured a contract agency to provide cultural competency training using the evidence based California Brief Multicultural Scale (CBMCS) to mental health staff and contractors. An overview of the CBMCS training was provided to 95% of SCMH staff. In future Fiscal Years, the SCMH system will identify trainers and train them to provide CBMCS training to the staff within the public mental health system. (Attachment 12)
    c. Cultural competency coordinator attends bimonthly Policy & Procedure Committee in order to provide input and expertise around cultural competency issues to policies and procedures being developed within SCMH. (Attachment 13)
    d. Cultural competency coordinator attends and provides monthly updates to the Quality Improvement Committee. (Attachment 14) The Quality Improvement Committee is a diverse group of staff,

contractors and consumers/family members that meet monthly to share information, raise issues, seek input and etc about system-wide issues, including cultural competency issues within Solano County Mental Health.

B. Below is a list of policies, procedures, and/or practices that reflect specific steps SCMH has taken to ensure racial, ethnic and cultural diversity is respected and valued throughout the public mental health system. Since Solano County's last cultural competence report, the division has made significant gains to integrate cultural competence standards throughout the mental health system, including:

1. Mission Statement
   a. Solano County
   b. Solano County Department of Health & Social Services
   c. Solano County Division of Mental Health
2. Statements of Philosophy
   a. SCMH Principles, Vision & Values
3. Strategic Plans
   a. MHSA Community Services & Support
4. Policy and Procedure Manuals
   a. Solano County
   b. Solano County Department of Health & Social Services
   c. Solano County Division of Mental Health
5. Human Resource Training and Recruitment Policies
   a. Solano County
   b. Solano County Department of Health & Social Services
6. Contract Requirements
   a. Solano County
   b. Solano County Department of Health & Social Services
7. Other key documents

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

A. Below is an overview of practices and activities that demonstrate Solano County Mental Health's community outreach, engagement, and involvement efforts to reduce disparities among identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. As illustrated below, SCMH has shows a commitment to outreach and engaging unserved and underserved populations in an effort to reduce disparities within these groups.

1. <u>Inclusive community program planning process</u>: Per Mental Health Services Act (MHSA) regulations, SCMH solicits diverse input into local mental health planning processes and services not only for MHSA specific programs and activities, but these principles are integrated throughout the SCMH system during planning, strategic planning and program development activities. For example, the MHSA Steering Committee, Local Mental Health Board, and strategic planning groups include diverse stakeholders, including representatives from: racial and ethnic groups; geographic locations of the

county; across the life span; and LBGTQ. In addition, consumers and family members, military personnel, veterans, monolingual speakers and various other stakeholders participate in system-wide planning processes. Particular attention is made to recruiting unserved and underserved populations to participate in the process.

2. <u>Outreach and engagement activities take place in the community</u>: SCMH seeks input from the community by going out into the community. Strategic planning, program planning and program design planning groups are held at locations where unserved and underserved may reside or receive services; including, planning sessions in various geographic locations; focus groups at wellness and recovery sites; planning sessions at Spanish speaking support groups; solicitations for input at various contractor locations; and presentations at various existing community meetings. Additionally, regularly, the director of mental health, cultural competency coordinator, consumer affairs liaison, and MHSA managers go to locations to meet or facilitate meetings with consumers and family members to seek and gather input about Solano County Mental Health services, plans and activities.
3. <u>Facilitate and coordinate meetings with unserved and underserved stakeholders to identify and address barriers to mental health services</u>: A Latino Access Committee was convened to identify and address barriers to services. This workgroup, many of whom are bi-lingual/cultural, is comprised of county and contract provider staff, consumers and family members and community members including clergy. The group meets bi-monthly and offered its first training, the Nepantla Project, on May 5 and 6, 2010. The committee continues to work towards increasing access and utilization of mental health services within the Hispanic and Latino community.
4. <u>Build collaborations and partnerships with unserved and underserved communities:</u> in FY 2009-10, Solano County Mental Health create the Solano County Veteran's Resource Collaborative, a group that meets quarterly to identify and share community resources about military and veterans' services in the region (Attachment 15). Also, the Collaborative aims to increase understanding about how to work with and provide services to veterans and military personnel in Solano County. Through collaboration with David Grant Medical Center (medical facility at Travis Air Force Base), training was provided about Post Traumatic Stress Disorder and Traumatic Brain Injury: more than 100 people registered for the event. In honor of Veteran's Day, another training is scheduled about *military and veterans culture* provided by the California National Guard.
   Also in FY 2009-10, Solano County Mental Health coordinated a meeting with Native American representatives to discuss how SCMH and Native Americans in Solano County can collaborate and partner together. As follow-up to the meeting, SCMH met with sixteen members of the Vallejo Intertribal Council to discuss how we may collaborate on future projects together. SCMH and Vallejo Intertribal Council has made a commitment to continue the fruitful partnership through program planning, training, outreach and education and etc.
5. <u>Through system design, develop programs to reach out to and engage underrepresented populations</u>: Through outreach and engagement activities and community program planning processes with diverse communities, Solano County has developed plans for community based programs targeting

unserved and underserved populations. For example, SCMH Prevention & Early Intervention (PEI) Partnership for Early Access to Kids (PEAK) Program targets children 0-5: the program served more than 2,000 children and families in Fiscal Year 2009-10. Of these, 40% were Latino/Hispanic and 34% spoke Spanish as their primary language. Also, the program was honored to receive the National Association of Counties (NACo) award. Additionally, through MHSA/SCMH contracts, SCMH required Request for Proposal Applicants to address how underrepresented groups will be reached out to and engaged in services, and as a result, Applicants proposed bilingual/bicultural mental health services that have not existed in the SCMH system in the past: one vendor will provide wellness and recovery bilingual/bicultural services in three cities in the county, and another vendor will provide integrated behavioral and primary care services in a bilingual/bicultural environment. Additionally, SCMH contracts set benchmarks for vendors to hire bilingual and bicultural staff in order to meet the diverse needs of the community.

B. Below is a narrative description addressing the county's current relationship with, engagement with, and involvement efforts to reduce disparities among identified racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions and community organizations in the mental health system's planning process. SCMH has a systematic approach to soliciting input and recommendations from diverse stakeholders in order to provide input; develop plans and strategies to identify and address barriers to mental health services.

1. Maintain diverse representation on SCMH committees and Board to inform strategic planning, program design, polices and practices: Solano County Mental Health recruits diverse members of the community to participate on advisory groups, planning committees, workgroups and the mental health board.
    a. The MHSA Steering Committee, which meets quarterly, includes representatives from underrepresented racial and ethnic groups, cultural groups, geographic locations and population age and gender groups as seen in Attachment 5: a concerted effort was made to recruit a diverse committee. The Committee participated in a six month strategic planning process to update the MHSA Community Services and Support Strategic Plan (Attachment 4). This Plan clearly identifies strategies to identify and address barriers to mental health services and informed the development of the MHSA Continuum of Care Request for Proposal issued later in the year.
    b. The Local Mental Health Board for Solano County represents diverse and underrepresented communities in Solano County, and the Board includes: African Americans, a Native American, a Latino, consumers, family members, representatives from consumer/family groups, military personnel, veterans, and other concerned citizens (Attachment 7). At meetings, system-wide information and updates are provided to committee members; recommendations and input is sought on program design, implementation, and policies to identify and address barriers to

services; and data and outcome measures are provided to inform decision-making.

c. The quarterly MHSA Stakeholder meeting is open to the public—the invite list includes 500 individuals representing unserved and underserved populations in Solano County and meeting locations move from city to city in Solano County, so that each community has an opportunity to provide feedback and input.
d. SCMH holds strategic planning meetings with diverse stakeholders to seek input and recommendations from them about significant changes that need to be made to the public mental health system due to budget reductions. SCMH secures participation from underrepresented stakeholders and contractors to participate in the meetings, as well as all levels of staff. This level of involvement from stakeholders has been key to making critical decisions about SCMH system-wide design and programs and including a diverse perspective in the process.
e. As a result of strategic planning meetings, workgroups have been formed and play important role in writing plans; conducting research; creating flow systems and etc. These workgroups have also represented Solano County's underrepresented communities and identify and address barriers to mental health services in Solano County.
f. Strategic planning informs SCMH Request for Proposals (RFP). SCMH has made it a policy that evaluation panels for RFPs include unserved and underserved populations, including ethnic and racial groups; cultural groups; consumer(s); family member(s); program expert(s); clinician(s); fiscal expert and etc. to evaluate Proposals and provide recommendations for awards.

2. <u>Coordination and collaboration with community groups to present at community meetings</u>: SCMH has sought to create partnerships with various community groups to have SCMH report out or participate in various community meetings in Solano County. For example, SCMH has a standing agenda item on the NAMI (National Alliance for Mental Illness); Consumer and Family Member Advisory Committee; Early Childhood Developmental and Mental Health Collaborative; Solano Coalition for Better Health's Health Access Committee; Clinic Alliance; Integrated Family Services Initiative; Transition Age Youth Collaborative; Senior Roundtable; and Community Action Partnership of Solano County quarterly and monthly meeting agendas (and other meetings).

3. <u>System design and quality improvement efforts include unserved and underserved communities</u>: Monthly, the Quality Improvement Committee meets to share and address issues within the SCMH system. Consumer and family members attend the meeting, as well as the cultural competency coordinator provides a report from the cultural competency committee at the meeting. Additionally, the Quality Improvement Policies and Procedures committee includes consumers, family members and representatives from unserved and underserved populations.
4. <u>Systematic approach to addressing system and program issues within SCMH</u>: Process Action Teams (PATs) play an important role in addressing system

and program issues within the public mental health system. PATs include a diverse representation from Solano County and SCMH system. PAT teams have address access to SCMH services; supported housing; crisis residential services; accounting, billing and reimbursement practices and etc (Attachment 6). The Teams are key in providing in depth research about an issue and developing recommendations and strategies for SCMH to address an issue.

C. Below is a narrative description of how SCMH is working on skills development, strengthening of community organizations involved in providing essential services.

1. SCMH MHSA Workforce Education and Training Plan includes key elements to increase capacity of community organizations to provide essential culturally appropriate services, including:
    a. <u>Improving mental health and workforce clinical and administrative competence</u>: SCMH continues to provide trainings in order to build clinical and administrative competency, including trainings about the Solano County Request for Proposal Process; developing logic models "Results Accountability Workshop;" Level of Care Utilization System (LOCUS) training; and 5150 training to health care providers, law enforcement and contractors. Additionally, in the coming year, SCMH staff will receive training about Transformational Care Planning, which aims to develop a client centered/wellness and recovery focused care planning, and staff will share this valuable information with contractors and community based organizations in order to transform how the system develops care plans for mental health consumers.
    b. <u>Expanding cultural competence training</u>: As mentioned above, SCMH is implementing the CBMCS evidence based training throughout the public mental health system. The overview training (already provided) and future trainings are open to the entire mental health system, as well as consumer and family groups; the Local Mental Health Board; and others. Additionally, SCMH provides annual consumer and family member panels in order for the public mental health system to increase cultural awareness about consumer and family member issues. Finally, SCMH, in this past FY, organized and coordinated 18 events in the community during May is Mental Health month to increase awareness and decrease stigma associated with mental health. Hundreds of people from community groups/organizations, contract agencies, policy makers and etc. attended the events that featured consumer and family member speakers.
    c. <u>Increasing Capacity of SCMH to use interpreter services</u>: SCMH is researching best practice trainings on the use of interpreter services within the mental health setting, and providing mental health services through interpreter services. Initially, SCMH has identified Mental Health Interpreter Training by the National Latino Behavioral Health Association training and exploring securing the training for the public mental health system in Solano County in order to build capacity of the system to utilize interpreter services and use the services appropriately.
    d. <u>Training for law enforcement personnel</u>: SCMH has worked this past year in developing Crisis Intervention Training curriculum specific to

Solano County in order to be state certified for law enforcement personnel (state approval is pending). SCMH is working with consumers, family members, contractors, community groups and others to provide a three day intensive training to law enforcement units in Solano County. Solano County Sheriff's Department has collaborated on this effort and will be the first unit to receive the training. Other Solano County law enforcement units have also expressed interest in receiving the training.

e. <u>Expanding training opportunities for PEI Initiatives</u>: SCMH's WET Plan and PEI Statewide Technical Assistance, Training and Capacity Building Plan designated training funds for the PEI Initiatives, including very young children; school age children; transition age youth; and older adults. In the past year, the PEAK project coordinated two, two day trainings focused on DC 0-3 R and Reflective Practice and Reflective Supervision. The former DC: 0-3R crosswalk serves as a tool to assist a behavioral health provider in assigning the correct diagnostic code when working with children in the first four years of life. This training was provided to the community providers serving children 0-5. The latter training was provided staff and supervisors a new model of working with consumers and staff to support children and families in recognizing their own solution. The Older Adult PEI Initiative trained community providers in mental health issues for older adults in order for providers to increase understanding and awareness of mental health issues facing older adults in Solano County.

f. <u>Loan Assumption Program</u>: SCMH has secured a contractor to help coordinate a Solano County loan assumption program for mental health professionals that provide services in Solano. The local loan assumption program will be launched in FY 2010-11, including outreach and education, training and technical assistance and selection of qualified candidates. The local loan assumption program will be providers providing services within the public health system and target bilingual and bicultural personnel in order to build the capacity within the system to serve diverse clientele.

2. <u>Creating a data driven mental health system</u>: SCMH is continuing to move towards becoming a data driven system. As a result, each SCMH program is in the process of completing a logic model/scope of work for each project/program within SCMH. The first phase of this effort included all new contracts for FY 2009-10. Consequently, SCMH staff worked with community based organizations to: 1) provide an overview training about what is a logic model and the benefits of using it for program management; 2) provide technical assistance on how to develop a logic model; 3) create data management system to report out on outcome measures; and 4) utilize data and outcome measures to inform program design and implementation.
3. <u>Increasing capacity of the community to screen, identify and address mental health issues</u>. Through three MHSA projects, SCMH is increasing the capacity of the community to screen identify and address mental health issues in the community, including the PEI 0-5 PEAK Initiative, PEI Older Adult Initiative; and MHSA Innovation program. PEI 0-5 PEAK Initiative trains community provides to use the Ages & Stages Questionnaire (ASQ) in order

to screen and identify developmental and mental health issues in young children (in FY 2009-10 606 people). Also, the PEI Older Adult Initiative provides the Gatekeeper training for community providers to screen, identify and refer older adults to appropriate mental health services (in FY 2009-10, 500 community members and 150 medical professionals). Finally, in FY 2010-11, the MHSA Innovation program, Community Access to Resources and Education (CARE), will provide Mental Health First Aid training to various community providers (2,300 people over three years) to identify mental health issues and refer appropriately.

D. Through the strategies of: outreach and engagement practices and activities; maintaining relationships and engagement with diverse communities; and community capacity building, SCMH has identified the following lessons learned.

1. *Recruit and recruit often* for members to sit on committees, the LMHB, strategic planning groups and etc. Throughout the year, people sitting on committees often leave committees due to unforeseen issues: accepted a new position; retired; moved to another city; term on the Board expired; deployment; and etc. So, there is a need to have new members for the committees continuously. Also, resist using the same people for multiple projects (to prevent burnout) and future participants.
2. *Go out to the community* to reach unserved and underserved populations. For example, meet with underrepresented populations where they may already be meeting; where they already receive services and etc. It builds trust and communities unfamiliar with SCMH are more likely to participate in outreach and engagement activities in their own setting.
3. *Reflect input from underrepresented communities* in reports, plans, strategic plans and program design. Once the community has provided input into these items clearly reflect the feedback in the reports and highlight for them that the reports included their feedback. Also, continuously report to the community the progress of plans, reports, strategic plans and programs to illustrate that their feedback was valuable.
4. *Provide on-going feedback and information about SCMH programs through various means*: SCMH has developed various communication means to keep the community abreast of SCMH activities, including an annual report, a monthly report to the LMHB, a monthly report to the QIC, Network of Care web site, and email updates.
5. *Schedule regular meeting times for the community to come together and discuss SCMH services*. An annual schedule is developed and distributed widely notifying the public and committee members about when meetings will occur and the purpose of the meeting (Attachment 4 - MHSA stakeholder and steering committees, and Attachment 15 - veteran's collaborative). As a result, community members know that they may attend the meetings and provide input. Also, SCMH holds meetings at convenient locations and times of day. Finally, the meetings follow the provisions of the Brown Act.
6. *Provide training and education at various locations throughout the county*. Solano County is a mix of an urban and rural county and as many counties does not have an extensive transportation system. As a result, SCMH provides trainings and educations events at various locations throughout the county.
7. *Become a data driven mental health system*. Given that mental health resources are shrinking, the community and the public mental health system

want to know that limited resources are directed towards programs that help consumers and family members with mental health issues (e.g. people are getting better). Consequently, SCMH provides on-going data and outcome reports to the community, and as mentioned above, is expanding these efforts, through logic model development, throughout the mental health system.

E. SCMH has not identified any additional county technical needs at this time.

III. SCMH Has A Designated Cultural Competence Person Responsible for Cultural Competence

SCMH has a designated cultural competence/outreach and engagement coordinator that is responsible for cultural competence within the public mental health system. This position reports to the MHSA coordinator (senior health services manager) and has direct access to the mental health director. Additionally, the QIC meeting, held monthly, is an opportunity for the cultural competence/outreach and engagement coordinator to provide updates about cultural competency issues to the mental health director, managers, supervisors, line staff, consumers and family members. A similar report is provided the LMHB each month as well. Additionally, the cultural competence/outreach and engagement coordinator is an important member of the Quality Improvement team, policies and procedures team, and MHSA team (among others). This role is a staff person to public meetings held with the community and conducts outreach to various community meetings in Solano County.

A. As noted in Attachment 16, SCMH has a designated cultural competency coordinator. This position is key to promoting the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural and linguistic populations.
B. As noted in Attachment 17, SCMH cultural competence coordinator's responsibilities include:
    1. Coordinating and developing the annual Cultural Competency Plan for Solano County and monitoring the strategies, activities, and outcome measures.
    2. Creating an outreach and engagement strategy to reach out to and engage unserved and underserved populations in Solano County.
    3. Convening the cultural competency committee for SCMH.
    4. Participation in Cultural Competency (CC)/Ethnic Services Managers (ESM) meetings.
    5. Member of the quality improvement team in order to integrate cultural competency issues throughout SCMH.
    6. Serving as the primary county contact to the Department of Mental Health's (DMH) Office of Multicultural Services

IV. SCMH Targets Cultural Competency Activities through Budget Resources

SCMH has dedicated resources to cultural competence activities within the public mental health system. As explained in Criterion 1, section III a significant amount of SCMH staff resources are dedicated to cultural competency activities for outreach and engagement activities; maintaining partnerships with diverse communities; and building capacity of the community to better serve the community. These activities are integrated throughout the public mental health system and

are performed by many staff within the system, if not all. In addition to staff resources, SCMH has dedicated significant resources to cultural competent activities.

A. Below are highlights of resources dedicated to cultural competency activities (Attachments 18-27):
   1. **Solano County budget** unit 7741 includes $183,175 for cultural competency and outreach and engagement activities.
      a. This budget unit includes a 1 Full Time Equivalent (FTE) employee: cultural competency and outreach and engagement coordinator (.5/.5 FTE)
   2. **Solano County** budget includes $49,010 for bilingual pay differential (approximately $1,690) for 29 SCMH staff who provide bilingual support to SCMH consumers and families.
   3. **Solano County** budget includes $904,727 for personnel expenses: MHSA coordinator, three project managers, three office assistants, one accounting clerk who dedicate a significant amount of time to cultural competency activities mentioned throughout this report.
   4. **Solano County** budget includes $1,393,015 for personnel expenses for Quality Improvement staff who dedicate a significant amount of time to cultural competency activities mentioned throughout this report.
   5. **Solano County** budget includes $608,986 for the mental health director and administrator personnel expenses who dedicate a significant amount of time to cultural competency activities mentioned throughout this report.
   6. **Solano County** budget unit 7734 includes $400,000 for the foster family bilingual support program (MHSA CSS funds expanded this program—mentioned below)
   7. **Solano County** budget unit 7730 includes $7,630,330 for MHSA CSS activities, including intensive mental health services for children, transition age youth, adults at risk for incarceration (or recently incarcerated), and older adults. These funds also provide consumer support services (or flexible funds) identified in the individual service plan, including food, shelter, clothing, alternative medicine, dental care, health care, and etc.
      a. **Solano County** budget unit 7730 (CSS) includes $11,500 for food and refreshments to provide at various outreach meetings, focus groups, community meetings, and planning meetings.
      b. **Solano County** budget unit 7730 (CSS) includes $1.5 million for contracts to providers providing bilingual and bicultural wellness and recovery and integrated behavioral health services.
   8. **Solano County** budget includes $3,680,260 for PEI Initiatives that focus on unserved and underserved populations and build the capacity of the community and the public mental health system to provide services to the target populations, including very young children, school age children, transition age youth and older adults.
   9. **Solano County** budget unit 7782 includes $413,172 for WET program from June 1, 2010 to November 30, 2012 to increase capacity of providers to serve underrepresented populations; diversify the workforce in order to address the diverse needs of the community; and expand consumers and family members in the public mental health system.

   a. **Solano County** budget unit 7782 (WET) includes $342,000 a contract with a qualified vendor to facilitate, coordinate and provide some trainings in the WET program.
   b. **Solano County** budget unit 7782 (WET) includes $50,000 for a local loan assumption program to diversify personnel within the public mental health system.
10. **Solano County** budget unit 7751 includes $1,837,360 from September 1, 2010 through June 30, 2013 for the Innovation program to co-locate services in geographic locations where no or little SCMH services exist; build capacity of providers in remote geographic locations to provide mental health services; and provide basic training to providers around mental health issues (mental health first aid).

B. Below is a discussion of the funding allocations included in the identified budgets mentioned above (C1.IV.A) and other additional items:

1. **Solano County** budget funds for cultural competency and outreach and engagement activities to underserved and unserved populations in Solano County.
   a. This budget unit includes a 1 Full Time Equivalent (FTE) employee: cultural competency and outreach and engagement coordinator (.5/.5 FTE) who works to integrate cultural competent practices throughout the system and outreach to and engage underrepresented populations.
2. **Solano County** budget funds various budgets units within SCMH to provide bilingual support to SCMH consumers and families. These staff provide bilingual/bicultural services to children and adult consumers and family members receiving services within SCMH.
3. **Solano County** budget funds personnel expenses: MHSA coordinator, three project managers, three office assistants, and one accounting clerk who dedicate a significant amount of time to cultural competency activities mentioned throughout this report. These staff conduct community planning meetings throughout the county; contract managed contracts that build the capacity of providers to provide cultural competent services and/or provide multi-cultural/multi-lingual mental health services.
4. **Solano County** funds personnel expenses for Quality Improvement (QI) staff who dedicate a significant amount of time to cultural competency activities mentioned throughout this report. QI staff develop policies and procedures for cultural competent issues; oversee and coordinate the grievance process; coordinate and facilitate cultural competent trainings (e.g. 5150, consumer/family panels; and appropriate care plan documentation); and oversee the implementation of quality improvement efforts throughout the system to increase the capacity of the system to provide cultural competent services.
5. **Solano County** budget funds the mental health director and administrator who dedicate significant amount of time to cultural competency activities mentioned throughout this report, including outreach and engagement to community providers, stakeholders, underrepresented populations, consumers, and family members; facilitate community program planning meetings; oversee the implementation of key cultural competency activities within the public mental health system.

6. **Solano County** budget supports the foster family/bilingual support program (MHSA CSS funds expanded this program—mentioned below). This program provides bilingual/bicultural mental health services to children and families.
7. **Solano County** budget unit 7730 includes $7,630,330 for MHSA CSS activities, including intensive mental health services for children, transition age youth, adults at risk for incarceration (or recently incarcerated), and older adults. These funds also provide consumer support services (or flexible funds) identified in the individual service plan, including food, shelter, clothing, alternative medicine, dental care, health care, and etc.
   a. **Solano County** budget funds foster family bilingual support program funded by MHSA CSS funds and expanded the SCMH system to provide these services.
   b. **Solano County** budget funds food and refreshments to provide at various outreach meetings, focus groups, community meetings, and planning meetings.
   c. **Solano County** budget funds $1.5 million for contracts to providers providing bilingual and bicultural wellness and recovery and integrated behavioral health services.
8. **Solano County** funds PEI Initiatives that focus on unserved and underserved populations and build the capacity of the community and the public mental health system to provide services to the target populations, including very young children, school age children, transition age youth and older adults.
   a. As mentioned above, the PEAK initiative provides bilingual/bicultural services to very young children and families. As a result, the Initiative has successfully served more than 2,000 children and families in Fiscal Year 2009-10. Of these, 40% were Latino/Hispanic and 34% spoke Spanish as their primary language (Attachment 28—PEAK budget).
   b. The Older Adult PEI Initiative provides the Gatekeeper training to community providers; trains health care professionals around issues of older adults and mental health issues; and provides case management services to older adults with mental health issues. This Initiative aims to build the capacity of the community to serve this underserved population and provides direct services to them. (Attachment 29—PEI Older Adults budget)
9. **Solano County** budget funds the WET program to increase capacity of providers to serve underrepresented populations; diversify the workforce in order to address the diverse needs of the community; expand consumers and family members in the public mental health system; and reduce racial, ethnic, cultural, and linguistic mental health disparities. Some activities were contracted out to a qualified vendor (Attachment 26—CiMH budget).
   a. Improve mental health and workforce clinical and administrative competence
   b. Expand cultural competence training
   c. Increase capacity of SCMH to use interpreter services
   d. Train law enforcement personnel
   e. Expand training opportunities for PEI Initiatives
   f. Implement local loan assumption program
   g. Expand internship and supervision program focused on bilingual/bicultural interns

10. **Solano County** budget funds the Community Access for Resources and Education (CARE) Program (under the Innovation Plan). This initiative provides a new framework for building the capacity of community partners by providing a flexible, wellness focused model to support their needs in addressing the mental health of various target populations. CARE will bring mental health services, including assessment, medication support, case management, and brief treatment, to locations throughout Solano County where people are already accessing other health and social services, such as family resource centers, homeless shelters, and primary care sites. (Attachment 27—Aldea budget)
11. Solano County Health & Social Services has contracted with CTS LanguageLink to ensure mental health services are accessible to all persons who have limited English language proficiency. (Attachment 30)

The overview of community partners, policies, procedures, practices and funding related to cultural competency in Criterion 1 has demonstrated SCMH continuing commitment to providing county-wide mental health services that are delivered in ways which recognize, are sensitive to and respectful of individual, cultural and linguistic differences.

CRITERION 2:
UPDATED ASSESSMENT OF SERVICE NEEDS

Criterion 2 highlights demographic information of Solano County residents, Medi-Cal beneficiaries and consumers of mental health services in Solano County. These data are analyzed and used to target strategies that reduce the disparities among underserved populations of mental health services in Solano County.

I. Solano County General Population Data

A. Table 2.1 shows the seven major cities in Solano County divided into two regions, north and south county. Ninety-five percent of Solano County's population resides in these two regions. Three out five residents (59.9%) lives in the north region, which includes the cities of Dixon, Fairfield, Rio Vista, Suisun City, and Vacaville, and the south region includes the cities of Benicia, and Vallejo and represents more than two-thirds of the Solano County population.

Table 2.1: Solano County Land Area and Population by Region, 2008

Region	Square Miles	Population	Percentage
North			
Dixon	5	17,030	4.2%
Fairfield	33	103,135	25.2%
Rio Vista	4	6,948	1.7%
Suisun City	4	26,449	6.5%
Vacaville	21	91,117	22.3%
Regional Total		*244,679*	*59.9%*
South			
Benicia	14	26,398	6.5%
Vallejo	65	117,227	28.7%
Regional Total		*143,625*	*35.2%*
Unincorporated Areas	761	20,156	4.9%
Total	**907**	408,460	

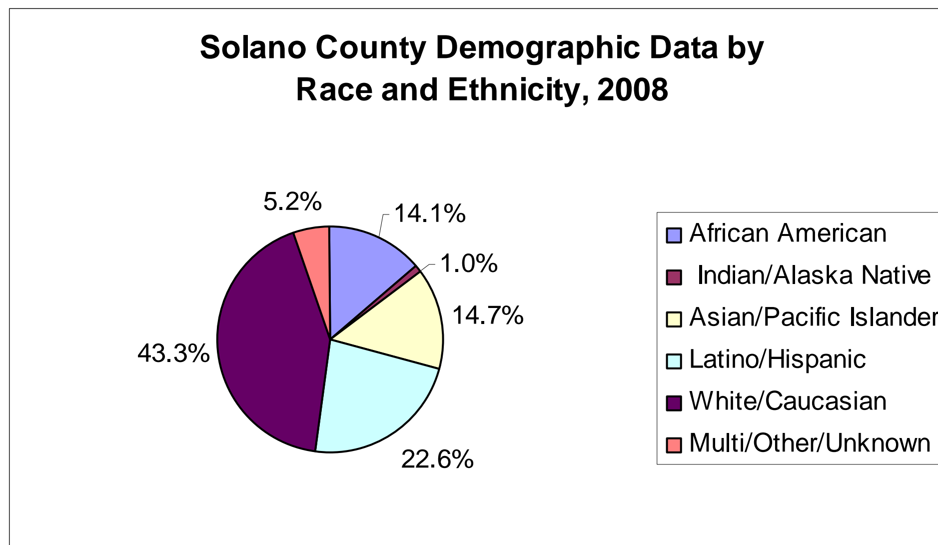
Source: County of Solano, California: Facts and Figures 2008; Solano County Department of Environmental Management

In 2008, the United States Census Bureau, American FactFinder General Demographic Characteristics reported that Solano County has a total population of 407,515 residents, and of this amount, half are female (49.8%) and half are male (50.2%). Additionally, about a quarter (25.2%) of residents are under age 18 (102,650); nearly two-thirds (62.9%) are between the ages of 18-64 (256,181); and more than one out of ten (11.2%) residents are 65 years of age or older (45,684). Table 2.2 highlights the racial and ethnic demographics for Solano County and Table 2.3 provides language demographics.

Table 2.2: Solano County Demographic Data by Race and Ethnicity, 2008

Race and Ethnicity	Number	Percentage
African American	57,622	14.1%
Am Indian/Alaska Native	380	1%
Asian/Pacific Islander	59,750	14.7%
Latino/Hispanic	92,094	22.6%
White/Caucasian	176,317	43.3%
Multi/Other/Unknown	21,352	5.2%
Total	**407,515**	

Source: United States Census Bureau, American FactFinder General Demographic Characteristics, 2008 (note, data exclude children less than five years of age)



More than half of the residents in Solano County represent a racial/ethnic group other than White (56.7% compared to 43.3%). More than two out five residents are White; followed by more than one out of five residents (22.6%) are Latino/Hispanic, one out of seven are Asian/Pacific Islander (14.7%) or African American (14.1%); and the remaining populations are multiracial/other (5.2%) and American Indian/Alaska Native (1%).

Table 2.3: Solano County Demographic Data by Language, 2008

Language Spoken At Home	Number	Percentage
Asian/Pacific Islander	39,751	10.5%
English	267,559	70.4%
Spanish	61,905	16.3%
Other	11,062	2.9%

Source: United States Census Bureau, American FactFinder General Demographic Characteristics, 2008 (note, data exclude children less than five years of age)

According to the US Census Bureau, nearly three-quarters (70.4%) of Solano County residents speak English at home. One out of six residents (16.3%) speaks Spanish at home. The US Census Bureau collapsed Asian/Pacific Islander languages and for Solano County the source reports that more than one out of ten residents (10.5%) speaks these languages at home. Finally, three percent (2.9%) of the population speak another language other than English, Spanish and Asian/Pacific Islander at home.

II. Solano County Demographic Data and Medi-Cal Population Service Needs

Below, Table 2.4-2.7 provides demographic data for Solano County's Medi-Cal population and SCMH's Medi-Cal consumers by gender, age, race, ethnicity and language per the instructions in Criterion 2.II.A. Additionally, (as noted in Criterion 2.II.B) Solano County provides analysis of the disparities between Solano County Medi-Cal beneficiaries and SCMH Medi-Cal Beneficiaries. These data inform the overall planning of services in reducing disparities among un/under-served populations throughout Solano County Mental Health.[2]

Table 2.4: Demographic Data for Solano County's Medi-Cal Population and SCMHs Medi-Cal Consumers (gender), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		Solano County Medi-Cal Beneficiaries	
Total Population	**4,272**	**100%**	**62,794**	**100%**
Gender				
Female	1,863	43.6%	36,227	57.7%
Male	2,409	56.4%	26,567	42.3%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; Solano County Department of Social Services.

More than half of Medi-Cal beneficiaries are female (57.7%) and less than half are male (42.3%). Compared to the total Medi-Cal beneficiaries in Solano County who are female (57.7%), SCMH serves nearly a third (32.3%) fewer females with Medi-Cal coverage (57.7% compared to 43.6%). Conversely, SCMH serves more males than females, and over serves males by fourteen percentage points when comparing SCMH Medi-Cal consumers to Solano County Medi-Cal beneficiaries (56.4% compared to 42.3%).

[2] About 1,000 more consumers are served through Solano County's Provider Network and data are not included data management system. Additionally, consumers served by wellness and recovery programs are not included in these data (500 consumers). Furthermore, PEI Initiative data are excluded from this data set (1,800 people).

Table 2.5: Demographic Data for Solano County's Medi-Cal Population and SCMHs Medi-Cal Consumers (age), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		Solano County Medi-Cal Beneficiaries	
Total Population	**4,272**	**100%**	**62,794**	**100%**
Age				
0-17	1511	35.4%	28,765	45.8%
18-64	2600	60.9%	27,238	43.4%
65+	161	3.8%	6,791	10.8%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; Solano County Department of Social Services.

Children ages 0-17 represent the largest age group of Medi-Cal beneficiaries in Solano County; followed by adults 18-64 (43.4%); and older adults (10.8%). Of SCMH Medi-Cal beneficiaries, children represent a third (35.4%) of those served. Adults receiving services in SCMH and are Medi-Cal beneficiaries are the largest population served (60.9%). The smallest population served in SCMH is older adults (3.8%). Compared to Solano County Medi-Cal beneficiaries, SCMH under serves children by 10.4 percentage points; over serves adults by 17.5 percentage points; and under serves older adults by seven percentage points.

Table 2.6: Demographic Data for Solano County's Medi-Cal Population and SCMHs Medi-Cal Consumers (race/ethnicity), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		Solano County Medi-Cal Beneficiaries	
Total Population	**4,272**	**100%**	**62,794**	**100%**
Race				
American Indian/Alaska Native	54	1.3%	353	0.6%
Asian/Pacific Islander	273	6.4%	7,365	11.7%
Black/African American	1417	33.2%	16,617	26.5%
White/Caucasian	1781	41.7%	14,495	23.1%
Multi-Racial/Other	86	2.0%	3,952	6.3%
Ethnicity				
Hispanic/Latino (of any race)	661	15.5%	20,012	31.8%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; Solano County Department of Social Services.

Hispanics/Latinos represent the largest percentage of Solano County Medi-Cal beneficiaries; followed by African Americans (26.5%), Whites (23.1%) Asian/Pacific Islander (11.7%), Multi-Racial/Other (6.3%); and American Indian/Alaska Native (.6%). Within SCMH, Whites represent the largest percentage of consumers served (41.7%); followed by African Americans (33.2%), Hispanic/Latinos (15.5%), Asian/Pacific Islanders (6.4%), Multi-Racial/Other (2%) and American Indian/Alaska Native (1.3%).

Compared to all Solano County Medi-Cal beneficiaries, SCMH serves half the amount of Hispanic/Latinos enrolled in Medi-Cal (31.8% compared to 15.5%). When compared to Solano County Medi-Cal beneficiaries, SCMH over serves: Whites by 44% (41.7% compared to 23.1%); and African Americans by nearly seven percentage points (33.2% compared to 26.5%). Finally, American Indians/Alaska Natives are over served by more than half (1.3% compared to .6%).

Table 2.7: Demographic Data for Solano County's Medi-Cal Population and SCMHs Medi-Cal Consumers (language spoken), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		Solano County Medi-Cal Beneficiaries	
Total Population	**4,272**	**100%**	**62,794**	**100%**
Language				
English	3953	92.5%	43,424	69.2%
Filipino Dialects	33	0.8%	1,392	2.2%
Spanish	196	4.6%	13,927	22.2%
Unknown/Other	90	2.1%	4051	6.5%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; Solano County Department of Social Services.

Most Solano County Medi-Cal beneficiaries speak English, followed by Spanish (threshold language) (22.2%), unknown/other languages (6.5%), and Filipino Dialects (2.2%). Within SCMH Medi-Cal beneficiaries group, nearly all consumers speak English (92.5%), followed by Spanish (4.6%), unknown/other languages (2.1%) and Filipino dialects (.8%).

III. 200% of Poverty (minus Medi-Cal) Population and Service Needs

Tables 2.8-11 provides the 200% of Federal Poverty Level (FPL) data (minus the Medi-Cal population data) and SCMH Medi-Cal beneficiary data and provides these data gender, age, race, ethnicity and language per the instructions under Criterion 2.III.A. Additionally, as requested under Criterion 2.III.B, Solano County highlights the differences between these two populations.

Table 2.8: 200% of Federal Poverty Level (FPL) data (minus the Medi-Cal population data) and SCMH Medi-Cal Beneficiary Demographic Data (Gender), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		200% of the FPL in Solano County (minus Medi-Cal Population)	
Total	4,272	100%	59,733	100%
Gender				
Female	1,863	43.6%	33,657	56.3%
Male	2,409	56.4%	26,076	43.7%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; Solano County Department of Social Services.

More than half of the population 200% of the FPL (minus Medi-Cal population) are female (56.3%) and less than half are male (43.7%). Compared to the category of 200% of the FPL who are female (56.3%), SCMH serves significantly fewer females with Medi-Cal coverage (56.3%

compared to 43.6%)—nearly 13 percentage points difference. Conversely, SCMH disproportionately serves more males than females when comparing SCMH Medi-Cal consumers to the population of 200% of the FPL (minus Medi-Cal population) (56.4% compared to 43.7%).

Table 2.9: 200% of Federal Poverty Level (FPL) data (minus the Medi-Cal population data) and SCMH Medi-Cal Beneficiary Demographic Data (Age), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		200% of the FPL in Solano County (minus Medi-Cal Population)	
Total	4,272	100%	59,733	100%
Age				
0-17	1,511	35.4%	4,959	8.3%
18-64	2,600	60.9%	34,167	57.2%
65+	161	3.8%	20,607	34.5%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; 2007 California Health Interview Survey.

Solano County Adults, in the population of 200% of the FPL (minus Medi-Cal population), represent the largest percentage (57.2%); followed by adults 65 years of age or older (34.5%); and children represent the smallest percentage (8.3%). When these data are compared to SCMH Medi-Cal beneficiaries, adults in both populations have similar data (57.2% compared to 60.9%); children are significantly different (35.4% in SCMH compared to 8.3% in the 200% of the FPL population); and older adults are also significantly different (3.8% in SCMH compared to 34.5% in the 200% of the FPL population). The differences in the data between children receiving services under SCMH versus children under 200% of the FPL population may be explained, in part, by the fact that children are more likely to qualify for Medi-Cal services than adults and older adults because Medi-Cal income eligibility levels are higher for young children.

Table 2.10: 200% of Federal Poverty Level (FPL) data (minus the Medi-Cal population data) and SCMH Medi-Cal Beneficiary Demographic Data (Race/Ethnicity), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		200% of the FPL in Solano County (minus Medi-Cal Population)	
Total	4,272	100%	59,733	100%
Race/Ethnicity				
Am Indian/ Alaska Native	54	1.3%	586	1.0%
Asian/Pacific Islander	273	6.4%	6,329	10.6%
Black/ African American	1417	33.2%	13,616	22.8%
Latino/ Hispanic	661	15.5%	7,348	12.3%
White/ Caucasian	1781	41.7%	17,884	29.9%
Multi/ Other/Unknown	86	2.0%	13,970	23.4%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; 2007 California Health Interview Survey.

The White/Caucasian group represents the largest percentage of those in the 200% of the FPL in Solano (29.9%); followed by Multi-Racial/Other (23.4), African Americans (22.8%), Latino/Hispanic (12.3%), Asian/Pacific Islander (10.6%); and American Indian/Alaska Native (1%). Within SCMH, Whites represent the largest percentage of consumers served (41.7%); followed by African Americans (33.2%), Hispanic/Latinos (15.5%), Asian/Pacific Islanders (6.4%), Multi-Racial/Other (2%) and American Indian/Alaska Native (1.3%).

Compared to the population of 200% of the FPL, SCMH disproportionately has more African Americans (33.2% compared to 22.8%), Latinos (15.5% compared to 12.3%), and Whites (41.7% compared to 29.9%). Conversely, SCMH disproportionately has less Asian/Pacific Islanders (6.4% compared to 10.6%) and Multi-Racial/Other (2% compared to 23.4%) than the population of 200% of the FPL. Finally, American Indians/Alaska Natives in both populations have no significant differences (1.3% compared to 1%).

Table 2.11: 200% of Federal Poverty Level (FPL) data (minus the Medi-Cal population data) and SCMH Medi-Cal Beneficiary Demographic Data (Language), FY 2008-09

Demographics	SCMH Medi-Cal Consumers		200% of the FPL in Solano County (minus Medi-Cal Population)	
Total	4,272	100%	59,733	100%
Language				
English	3,953	92.5%	53,043	88.8%
Filipino Dialects	33	0.8%	2,210	3.7%
Spanish	196	4.6%	4,420	7.4%
Other	90	2.1%	60	0.1%

Source: Solano County Department of Health & Social Services Mental Health Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; 2007 California Health Interview Survey.

For both SCMH Medi-Cal consumers and the population of 200% of the FPL, people speaking English represent the highest percentages (92.5% and 88.8% respectively); followed by Spanish speakers (4.6% and 7.4% respectively). Within the SCMH Medi-Cal consumers, *other* languages (2.1%) represents the third highest category followed by Filipino Dialects (.8%). Comparatively, under the population of 200% of the FPL, the third highest category is Filipino Dialects (3.7%) followed by other languages (.1%).

IV. MHSA Community Services and Supports (CSS) Population Assessment

Table 2.12-15 provides a population assessment for the CSS population and SCMH Medi-Cal beneficiaries' demographic data by race, ethnicity, language, age, and gender. Per the instructions under Criterion 2.IV.A, Solano County provides an updated population assessment for 2005. Additionally, per the terms of Criterion 2.IV.B, SCMH provides an analysis of the disparities.

Table 2.12: SCMH Medi-Cal Beneficiaries Compared to Solano County CSS Population Assessment Data, Demographic Data (Gender), FY 2008-09 and 2005

Demographics	SCMH Medi-Cal Consumers		Solano County CSS Population Assessment 2005	
Total	4,272	100%	395,426	100%

Gender				
Female	1,863	43.6%	201,929	51.1%
Male	2,409	56.4%	193,497	48.9%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; United States Census Bureau, American FactFinder General Demographic Characteristics, 2005

The Solano County CSS Population Assessment for 2005 reports that more than half are females (51.1%) and less than half are males (48.9%). Conversely, within SCMH (Medi-Cal beneficiaries), males represent significantly more than half (56.4%) and females significantly less than half (43.6%). When compared to the CSS Population Assessment data from 2005, women disproportionately receive fewer services in SCMH (43.6% compared to 51.1%): by seven percentage points.

Table 2.13: SCMH Medi-Cal Beneficiaries Compared to Solano County CSS Population Assessment Data, Demographic Data (Age), FY 2008-09 and 2005

Demographics	SCMH Medi-Cal Consumers		Solano County CSS Population Assessment 2005	
Total	4,272	100%	395,426	100%
Age				
0-17	1,511	35.4%	113,146	28.6%
18-64	2,600	60.9%	242,100	61.2%
65+	161	3.8%	40,180	10.2%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients,10/30/09; United States Census Bureau, American FactFinder General Demographic Characteristics, 2005

The Solano County CSS Population Assessment for 2005 reports that highest percentage population is adults (61.2%); followed by children (28.6%) and older adults (10.2%). Similarly, within SCMH Medi-Cal consumers, adults are the highest percentage served (60.9%); followed by children (35.4) and older adults (3.8%).

There is no significant difference between SCMH Medi-Cal Consumer population and the CSS Population Assessment (2005) under adults (60.9% and 61.2% respectively). However, when comparing the two populations, children disproportionately receive more SCMH services (35.4% compared to 28.6%), and older adults receive less (3.8% compared to 10.2%).

Table 2.14: SCMH Medi-Cal Beneficiaries Compared to Solano County CSS Population Assessment Data, Demographic Data (Age), FY 2008-09 and 2005

Demographics	SCMH Medi-Cal Consumers		Solano County CSS Population Assessment 2005	
Total	4,272	100%	395,426	100%
Race/Ethnicity				
Am Indian/Alaska Native	54	1.3%	1,661	.4%
Asian/Pacific Islander	273	6.4%	59,812	15.1%
Black/African American	1417	33.2%	55,959	14.2%
Latino/Hispanic	661	15.5%	84,121	21.3%
White/Caucasian	1781	41.7%	176,872	44.7%
Multi/Other/Unknown	86	2.0%	17,001	4.3%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; United States Census Bureau, American FactFinder General Demographic Characteristics, 2005

Within SCMH, Whites represent the largest percentage of consumers served (41.7%); followed by African Americans (33.2%), Hispanic/Latinos (15.5%), Asian/Pacific Islanders (6.4%), Multi-Racial/Other (2%) and American Indian/Alaska Native (1.3%). For the Solano County CSS Population Assessment for 2005, Whites represent the largest percentage of the population (44.7%); followed by Latinos (21.3%), Asian/Pacific Islanders (15.1%), African Americans (14.2%), Multi-Racial/Other/Unknown (4.3%), and American Indian/Alaska Native.

When comparing the two populations (SCMH and CSS Population Assessment), Whites are slightly underserved in SCMH (41.7% compared to 44.7% respectively). Also, Latinos disproportionately receive SCMH when compared to the CSS Population Assessment (15.5% compared to 21.3%). The disparity between SCMH and the CSS Population Assessment for Asian/Pacific Islanders and Multi-Racial/Other is greater than 100% (6.4% compared to 15.1% respectively) and (2% compared to 4.3% respectively). American Indian/Alaska Native, as reported in the data above, disproportionately receive more services (1.3% compared to .4%).

Table 2.15: SCMH Medi-Cal Beneficiaries Compared to Solano County CSS Population Assessment Data, Demographic Data (Age), FY 2008-09 and 2005

Demographics	SCMH Medi-Cal Consumers		Solano County CSS Population Assessment 2005	
Total	4,272	100%	395,426	100%
Language				
English	3,953	92.5%	267,641	73.2%
Filipino Dialects	33	0.8%	32,191	8.8%
Spanish	196	4.6%	54,486	14.9%
Other	90	2.1%	11,430	3.1%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 10/30/09; United States Census Bureau, American FactFinder General Demographic Characteristics, 2005

For SCMH Medi-Cal consumer population and the CSS Population Assessment for 2005, English speakers represent the largest percentage of languages spoken (92.5% and 73.2%). Within SCMH, English is followed by Spanish (4.6%), other languages (2.1%) and Filipino Dialect (.8%). On the other hand, under the CSS Population Assessment, English is followed by Spanish as well (14.9%); however, Filipino Dialects (8.8%), and other languages (3.1%) follows.

English speakers disproportionately receive SCMH services when compared to the CSS population assessment (92.5% compared to 73.2%). Conversely, Spanish speakers, other languages, and Filipino Dialects disproportionately receive fewer services. For example, Spanish speakers are three times less likely not to receive SCMH services (4.6% compared to 14.9%), and Filipinos are ten times less likely not to receive SCMH services (.8% compared to 8.8%).

V. Identifying Priority Populations for the Prevention and Early Intervention (PEI) Plan:

A. Table 2.16 shows that the four projects included in the PEI Plan, Early Childhood Mental Health, School Age Youth, Education, Employment and Family Support for At-Risk Transition Age Youth and Older Adult, all address underserved racial/ethnic and cultural populations as well as at least one additional priority population.

Table 2.16 - Solano County PEI Priority Populations by Program/Work Plan

PEI	Program/Work Plan			
Six PEI Priority Populations	**Early Childhood Mental Health**	**School Age Youth**	**Education, Employment & Family Support for At-Risk Transition Age Youth**	**Older Adult**
1. Underserved Racial/Ethnic and Cultural Populations	X	X	X	X
2. Trauma Exposed Individuals	X			X
3. Individuals Experiencing Onset of Serious Psychiatric Illness			X	
4. Children and Youth in Stressed Families	X			
5. Children and Youth at Risk for School Failure	X	X		
6. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		

B. The Solano County PEI Community Planning Process through which the priority populations were selected included orientation to PEI, broad general outreach, community forums in all seven cities in Solano County, targeted outreach (to ethnic minorities and underserved populations), community forums, a public stakeholder process, creation of community-based workgroups, and the mobilization of existing mental health staff and advisory groups.

1. **Orientation to PEI of existing mental health advisory groups and staff. (September-November, 2007).** All of the following groups received orientation and training to PEI and dedicated time at their regular meetings to identify prevention and early intervention needs and best practices. They were also kept informed of the progress of PEI planning and continued to offer input on the process:
    a. **The Health and Social Service (HSS) Executive Staff**, which includes top management of health, mental health, social services, substance abuse treatment, employment/eligibility, and research and planning.
    b. **The Cultural Competency Committee,** which includes the mental health director and mental health managers, supervisors and line staff, as well as community partners such as Latino Family Services and National Association for the Advancement of Colored People (NAACP).
    c. **Adults System of Care Planning Group**, which includes Health & Social Services (HSS) adult services managers, supervisors and line staff; crisis services staff; contractors for adult mental health services; in-patient mental health treatment providers; vocational rehabilitation, community college staff, homeless service providers; substance abuse providers and adult consumers.
    d. **Children's System of Care Planning Group**, which includes HSS children's services managers, supervisors and line staff; Child Welfare Services (CWS); contractors for children's mental health services; Special Education Local Planning Area (SELPA) and other school-based children's services; and community child advocates.
    e. **Consumer and Family Advisory Committee,** which includes adult consumers, family members of adult and child consumers of mental health services, as well as representatives of National Alliance on Mental Illness (NAMI) and the Bi-Polar Support Group. This group monitors implementation of MHSA, identifies service gaps and recommends service strategies. The group regularly discussed and provided feedback to the PEI planning process.
2. **Outreach** – Information on PEI and the PEI Community Planning Process, as well as flyers inviting all community members to attend local PEI Community Forums, was provided through e-mail and mailing lists to more than 100 community organizations, contractors, consumers, school districts, law enforcement and social service agencies, and associations such as Health Access, the Clinic Alliance, the Early Childhood Mental Health Collaborative, the Senior Coalition, etc. Flyers were distributed at the advisory committees listed above, and information was posted on the Solano County MHSA website.
3. **Community Forums** – In October and November 2007, Community Forums were held in each of the seven Solano County cities, from Dixon in the north

county, to Vallejo and Rio Vista in the southwest and southeast. The agenda of each forum included opportunities for local residents to share personal situations where early intervention could have made a significant difference, and discussion of the following questions:

a. Who are the people who are most underserved? Who would benefit the most from prevention and early intervention services?
b. Who needs to be enabled to respond to the underserved?
c. What are the elements of an intervention program?
d. Where do we deliver the services?

Over 90 people attended the forums, ranging from six in Fairfield to twenty-two in Vallejo. Participation in the smaller communities of Dixon (10 participants), Benicia (14), Suisun (10) and Rio Vista (16) was particularly noteworthy. Attendees represented every segment of the community, from residents and consumers to cities, schools, libraries, churches, and non-profit and county employees. In addition, a focus group for the Filipino and Pacific Islander community was held in May 2008 with approximately twenty participants.

4. **Stakeholders Group Meetings (September 2007- May 2008).** Members of the Community Services and Support (CSS) Stakeholders Group were re-convened in September 2007 to provide input and oversight to the PEI process. The Stakeholder Group included representatives from all major Solano ethnicities (Caucasian, Latino, Asian-Pacific Islander/Filipino, African-American), as well as other groups. All required categories of stakeholders, and members of all cultural/ethnic communities in the county were included in this group. Over the course of the seven months of meetings, this core group expanded to include additional individuals and groups specifically providing prevention and early intervention services to individuals across the span of age groups. The six Stakeholders Meetings were announced on the Solano County MHSA website and through e-mails to all attendees, and were open to all. The Stakeholders Group met six times to review information gathered from the community forums, the CSS planning process and CSS implementation; to determine county PEI needs and target populations; to establish workgroups; to develop and refine workgroup projects; and to develop criteria to select projects to be included in the PEI plan. Discussion and questions were invited from all participants, and decisions were made by consensus.
5. **Workgroups (October 2007-May 2008):** In order to develop projects, the stakeholders formed five workgroups. Based on needs and target populations identified in community forums and meetings of advisory groups and the Stakeholders Group, five workgroups were originally established, each chaired by a member of the Stakeholders Group. The original five groups were:
   a. Underserved Populations
   b. Stressed Families/Early Childhood
   c. Children and Youth at Risk of School Failure
   d. Children and Youth at Risk of Juvenile Justice Involvement
   e. First Break/Transition-Aged Youth (TAY)

   The groups were open to all interested community members, and included a variety of public and private members. Each group was charged with

conducting outreach and research to determine specific needs of their population and target groups, and developing projects to include in the PEI plan.

By February, it became clear that the School Failure and Juvenile Justice Groups were recommending similar projects, so the two groups were combined. In addition, the Underserved Populations Group, which had had difficulty in defining both its membership and target populations, was beginning to focus more on older adults. In March, all workgroups were charged with addressing the needs of underserved populations, and a new Older Adult Group replaced the Underserved Populations workgroup.

6. **Selection of Projects. (May 2008)** A subcommittee of the chairs of the 4 workgroups, the county's consumer liaison, the Director of Mental Health and the Interim MHSA program manager, was appointed to determine whether projects met the state's and county's criteria for PEI, and to determine funding allocations.

   Each of the final four workgroups: Stressed Families/Early Childhood, Children and Youth at Risk of School Failure and Juvenile Justice Involvement, First Break/Transition-Aged Youth, and Older Adult, reviewed Stakeholder input and relevant local data to identify the priority populations for each project and strategies to address the populations' needs.

   In addition to the steps outlined above, the PEI planning process was informed by extensive data gathering and analysis of mental health needs, services and underserved populations during the CSS planning process. SCMH made a commitment both to including underserved populations in the planning process, and to addressing the needs of these groups. The information below describes how specific populations were represented in the PEI Community Planning Process.

   a. **Asian/Pacific Islanders:** CSS data analysis showed that Asian/Pacific Islanders across all age ranges were underserved. Solano County, and particularly the city of Vallejo, is home to a significant underserved population of Filipinos. Although several Asian and Filipino representatives attended the Stakeholders meetings, Asian/Pacific Islander representatives were asked but declined to participate in the Underserved Populations workgroups. To ensure direct input and feedback from the community, however, a Filipino/Asian focus group was held midway through the planning process at a Filipino Community Center in Suisun. The forum, which drew approximately twenty community leaders, was co-led by a member of the Filipino community and offered translation in Tagalog. The focus group offered participants the opportunity to comment on PEI projects developed by the workgroups and to offer revisions to ensure that the projects addressed their needs.
   b. **Children:** While analysis showed that few prevention or early intervention mental health services were available to *any* children, the greatest service disparities were identified among Asian/Pacific Islander and Hispanic English learners, and Hispanic children (often from undocumented or farm worker families living in remote areas). Children were represented on the Stakeholders Group by three community based organizations dedicated to serving children and families, public schools, the Special Education Local Planning Area,

juvenile probation, the Solano Parent Network, and family members. In addition, the Early Childhood/Stressed Families workgroup included representatives of the Early Childhood Mental Health Collaborative which conducted an extensive needs assessment across the county, gathering data from all underserved populations.

c. **Consumers/Family Members:** Consumers and family members were specifically invited by county staff to attend the community forums, and actively participated, offering anecdotes to educate participants and offering their perspectives on needs and existing services. SCMH staff, including a family advocate and a parent/consumer advocate were charged with outreach to consumers and family members. These staff members discussed PEI at Consumer Family Advisory Committee (CFAC), National Alliance on Mental Illness (NAMI) and the Bi-Polar support meetings. They also collected information from family and consumers, which they brought back to the larger stakeholder meetings, and conferred with the workgroups.

d. **Ethnic/Cultural Groups with Higher Rates of Service:** The CSS research revealed that, overall; Caucasians and African Americans received disproportionately more mental health services than other populations. These groups were well represented in the Stakeholders Group and workgroups. The small Native American Community in Solano County was invited to participate in the PEI planning process but we were not able to engage them to do so.

e. **Gender:** The Stakeholders Group and workgroups were well-balanced for gender.

f. **Geographic Location:** participants attending PEI community forums reported that residents in outlying areas of the county and in the small communities of Rio Vista, Benicia and Dixon had less access to mental health prevention and early intervention services. To ensure representation of these communities, members of the Stakeholders Group included a city councilmember and police chief from Rio Vista, the Director of Special Education from Dixon and a representative of the Dixon Police Department.

g. **Hispanic and Spanish-speaking residents of all ages were found to be underserved:** Most underserved were those living in remote areas, undocumented residents and farm worker families. Because of immigration issues and language barriers, this population is less likely to seek mental health services. Frequently these families do not have private transportation to areas with more services. The needs of these populations were represented in the Stakeholders Group and workgroups by leaders of the Hispanic Community including the Latino county staff representative and the Executive Directors of Latino Family Services, Faith in Action, La Clinica Vallejo and Crestwood, a contract agency providing mental health services to Hispanic clients in Dixon under the CSS plan.

h. **Lesbian, Gay, Bisexual, Transgender, Questioning (LBBTQ):** the Stakeholders Group included a representative of the LGBTQ community.

i. **Older Adults:** Analysis of population and mental health data during the CSS process indicated that older adults in Solano County of *all*

ethnicities and cultural groups were underserved. During the initial phase of PEI Community Planning, Older Adults were included as one of several potential target populations by the Underserved Populations workgroup. After that workgroup was disbanded, an Older Adult workgroup was formed to focus on older adult issues and services. This new workgroup was composed of older adult activists, service providers, family members, consumers and community members as well as representatives of the Hispanic community and service providers to the Filipino Community. To better pinpoint the needs of the Older Adult Community, the Older Adult workgroup reviewed significant research and focus group results, all conducted within the past three years.

j. **Transition Age Youth (TAY):** CSS data indicated that TAY youth of all ethnicities, cultural groups and geographic communities were underserved. To gain a better understanding of the needs of this population, three Transition Age Youth including a Hispanic youth served on the PEI TAY/First Break workgroup and the Steering Committee, and made a presentation to the Steering Committee. The TAY workgroup discussed potential projects with thirty-three TAY county clients to identify activities/services which might have prevented or reduced the impact of their illness.

Criterion 2 provides data that SCMH analyzes to target strategies to reduce disparities among underserved populations within the public mental health system. SCMH is expanding its efforts to become a data driven system. SCMH closely monitors key data sources reporting on disparities, and monitors outcome data that provide indicators of mental health consumers wellness and recovery. Additionally, managers submit a monthly dashboard of data and information that is reviewed by senior administration and the Quality Improvement Committee (QIC) monthly in order to inform decision-making. (Attachment 31)

CRITERION 3:
STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL AND LINGUISTIC MENTAL HEALTH DISPARITES

Building on the information gathered in Criterion 2, Criterion 3 further examines who is accessing mental health services in Solano County. This section then highlights specific strategies to lessen disparities among underserved populations.

I. Identified Unserved/Underserved Target Populations (with disparities):

Medi-Cal Population

Criterion 2 detailed Solano County's unserved/underserved populations within the Medi-Cal population. Medi-Cal populations with disparities that were identified include: women, children ages 0-17, older adults, Hispanics/Latinos, Asian/Pacific Islanders, and Spanish speakers.

Community Service and Supports: Full Service Partnership Population

Solano County's Full Service Partnership population for FY 08/09 is reflected in Table 3.1 & 3.2.

Table 3.1: Solano County's Full Service Partnership Population by Gender and Age

Demographics	SCMH CSS FSP Population		SCMH Medi-Cal Consumers	
Total Population	**287**	**100%**	**4,272**	**100%**
Gender				
Female	118	41.1%	1,863	43.6%
Male	169	58.9%	2,409	56.4%
Age				
0-17	56	19.5%	1511	35.4%
18-64	197	68.6%	2600	60.9%
65+	34	11.8%	161	3.8%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 7/21/10.

The gender breakdown for Full Service Partnership clients is similar to the gender breakdown for SCMH Medi-Cal consumers with more males than females served. Solano County Full Service Partnerships serve a lower rate of children 0-17 and a higher rate of adults and older adults as compared to SCMH Medi-Cal Consumers.

Table 3.2: Solano County's Full Service Partnership Population by Race, Ethnicity, and Language

Demographics	SCMH CSS FSP Population		SCMH Medi-Cal Consumers	
Total Population	**287**	**100%**	**4,272**	**100%**
Race				
American Indian/Alaska Native	9	3.1%	54	1.3%
Asian/Pacific Islander	21	7.3%	273	6.4%
Black/African American	95	33.1%	1417	33.2%
White/Caucasian	131	45.7%	1781	41.7%
Multi-Racial/Other	3	1.0%	86	2.0%
Ethnicity				
Hispanic/Latino (of any race)	28	9.8%	661	15.5%
Language				
English	286	99.7%	3953	92.5%
Filipino Dialects	1	0.3%	33	0.8%
Spanish	0	0%	196	4.6%
Unknown/Other	0	0%	90	2.1%

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients, 7/21/10.

Solano County Full Service Partnerships serve roughly the same racial/ethnic population as SCMH Medi-Cal. Exceptions include Full Service Partnerships serving slightly more white/Caucasian consumers and fewer Hispanic/Latino consumers. Solano County Full Service Partnerships serve primarily English speakers with only one consumer having a primary language other than English.

Workforce, Education, and Training Population

Solano County's Workforce Education and Training population as identified in Solano County's Workforce Needs Assessment included in Solano WET Plan is found in Tables 3.3 & 3.4 below.

Table 3.3: Solano County and Contract Mental Health Staff by Race/Ethnicity

Race/Ethnicity	# of Staff: (Full Time Equivalents)	% of Total Staff
American Indian/Alaska Native	1.0	0.2%
Asian/Pacific Islander	38.6	8.3%
Black/African American	70.9	15.2%
White/Caucasian	233.6	50.4%
Hispanic/Latino	49.1	10.5%
Multi/Other	72.6	15.6%
Total	465.8	100%

Source: Solano County WET Plan as approved by DMH May 2009.

The rate of black/African American and Hispanic/Latino staff in Solano County and contract mental health staff is less than the rates of SCMH Medi-Cal consumers for these populations (Black/African American: 15.2% staff as compared to 33.2% of the consumer population;

Hispanic/Latino:10.5% staff as compared to 15.5% of the consumer population). The rate of white/Caucasian mental health staff is higher than the rate of SCMH consumers (50.4% staff as compared to 41.7% of the consumer population).

Table 3.4: Solano County and Contract Mental Health Positions by Race/Ethnicity

Race/ Ethnicity	**Positions (Full Time Equivalents)**				
	Unlicensed Mental Health Staff	Licensed Mental Health Staff	Managerial/ Supervisory Staff	Support Staff	Other Health Care Staff
Am Indian/ Alaska Native	0.5	0	0	0.5	0
Asian/Pacific Islander	21.0	10.6	0	5.5	1.5
Black/African American	37.0	14.4	3.0	14.5	2.0
White/ Caucasian	66.1	91.7	37.4	33.4	10.0
Hispanic/ Latino	27.0	9.0	2.0	10.0	1.0
Multi/Other	12.3	36.7	10.0	10.1	3.5
Total	163.9	162.4	52.4	74	18

Source: Solano County WET Plan as approved by DMH May 2009.

The Solano County WET needs assessment indicates that there are no Asian/Pacific Islander management/supervisory staff in Solano County. In addition, there are significantly lower rates of licensed (8.9%) and management (5.7%) staff for Blacks/African Americans compared to the rates SCMH Medi-Cal consumers accessing services (33.2%). There are also significantly lower rates of licensed (5.5%) and management/supervisory (3.8%) staff for Hispanic/Latino as compared to the rate of SCMH Medi-Cal consumers for this population (15.5%). There are higher rates of licensed (56.5%) and management/supervisory (71.4%) staff for white/Caucasian staff than SCMH Medi-Cal consumers (41.7%).

The Solano County WET needs assessment also indicates that 59.8 direct service staff and 19.0 non-direct service staff are proficient in Spanish, but an addition 15.7 direct service staff are needed to meet the needs of the population who are accessing services through Solano County Mental Health.

Prevention and Early Intervention priority populations

As discussed in Criterion 2, Solano selected all 6 PEI priority populations within one or more of the target populations selected.

A. The target populations for SCMH with disparities are as follows:

Medi-Cal

- Children ages 0-17
- Older adults ages 65+
- Hispanics/Latinos
- Spanish speakers

Community Services and Supports

- Hispanics/Latinos
- Spanish speakers

Workforce, Education, and Training

- Hispanics/Latinos
- Spanish speakers

Prevention and Early Intervention

- Children ages 0-5
- Children grades 4-12
- Older adults ages 65+

Table 3.5 identifies PEI priority populations by target age group.

Table 3.5: PEI Priority Populations by Target Age Group

	Target Populations			
PEI Priority Populations	**Children Ages 0-5**	**School aged youth Grades 4-12**	**Transition Aged Youth Ages 18-25**	**Older Adults Ages 60+**
1. Underserved Racial/Ethnic and Cultural Populations	X	X	X	X
2. Trauma Exposed Individuals	X			X
3. Individuals Experiencing Onset of Serious Psychiatric Illness		X		
4. Children and Youth in Stressed Families	X			
5. Children and Youth at Risk for School Failure	X	X		
6. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement		X		

The process and recommended strategies Solano County used to identify and target strategies for the PEI priority populations with disparities including children ages 0-5, school age youth grades 4-12, and older adults ages 60+ is described below. Each of these PEI workgroups utilized stakeholder input, workgroups and review of data sources to identify and target PEI priority populations.

1. Early Childhood Mental Health: Each of the seven PEI community forums were held in major cities throughout Solano County identified young children and their families as underserved populations. A workgroup was convened including twenty-one representatives of public and private agencies and departments working with the 0-5 population and their families. Participants included representatives of health care providers, public health, foster care, children's collaboratives, teen parent services, childcare planners and

providers, child welfare services, early mental health services, child care and preschools, First 5, and others. The group brought diverse opinions and concerns to the table and eventually came to consensus on the priority strategies to be addressed for this population. In addition, the group researched and compiled a 0-5 Best Practices list of evidence- and research-based screening, assessment, and treatment models to bring into the projects as well as the collaborative group of 0-5 providers.

2. School Aged Youth: Each of the seven PEI community forums also identified specific needs for School-Aged children, and recommended greater access to services for residents in Dixon, Benicia, Suisun and Rio Vista. Two separate workgroups, one addressing children at risk for school failure and one addressing children at risk of experiencing juvenile justice involvement, were charged with identifying PEI priority populations and services based on the needs identified in local statistical data and the planning process. The workgroup addressing students at risk of entering the juvenile justice system included a local Chief of Police, probation officers, a parent of youth with juvenile justice involvement, and school district and community agency leaders. The workgroup addressing children at risk of school failure included parents of students referred for student support services, site, district and county level public school agencies from all district represented, community agencies, and family resource support services. The work group reviewed school district demographic information, data on special needs, educational programs, drop-out and truancy rates, and court school data. Additionally, school district and Solano County Office of Education strategic planning committee findings were reviewed for input from parents, students and other community stakeholders in the areas of prevention and early intervention needs and services.
3. Older Adults: All seven of the PEI community forums identified older adults as an underserved population. Participants in two cities identified the elderly as the most underserved while participants in two other cities identified chronically ill older adults as being at greatest risk of mental health issues. The Older Adult workgroup reviewed demographic data on older adults, findings from a November 2007 focus group of providers serving older adults, and findings of a 2008 report of the Solano County Seniors Coalition.

   In all these three PEI age groups, plus the transition age youth age group which was also identified as a target population, there was vast stakeholder input, remarkable effort within work groups and extensive review of data. This information was used to create specific interventions (described in section III below) to lessen disparities identified within un/under-served populations.

II. Identified Disparities (within the target population)

A. The disparities within the target populations are identified in Table 3.6 below.

Table 3.6: Disparities in Solano County Mental Health target populations

Population	Target Population	Disparity
SCMH Medi-Cal	Children ages 0-17	10.4% underserved as compared to the Medi-Cal population
	Older adults ages 65+	7% underserved as compared to the Medi-Cal population
	Hispanics/Latinos	16.3% underserved as compared to the Medi-Cal population
	Spanish speakers	17.6% underserved as compared to the Medi-Cal population
CSS	Hispanics/Latinos	5.7% underserved as compared to the SCMH Medi-Cal population and 22.0% underserved as compared to the overall Medi-Cal population
	Spanish speakers	4.6% underserved as compared to the SCMH Medi-Cal population and 22.2% underserved as compared to the overall Medi-Cal population
WET	Hispanics/Latinos	5% underserved as compared to the SCMH Medi-Cal population and 21.3% underserved as compared to the overall Medi-Cal population
	Spanish speakers	15.7 additional staff is needed to meet the needs of the populations served.
PEI	Children ages 0-5 Children grades 4-12 Older adults ages 65+	Disparity rates for the population served by PEI are unknown as these initiatives began in FY 09/10, but children ages 0-17 in SCMH Medi-Cal are 10.4% underserved as compared to the Medi-Cal population and older adults ages 65+ are 7% underserved as compared to the Medi-Cal population.

Source: Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients,10/30/09; Solano County Department of Health & Social Services Mental Health Division Database (InSyst) Fiscal Year 2008-09 Medi-Cal clients,7/21/10, Solano County WET Plan as approved by DMH May 2009,

III. Identified strategies/objectives/actions/timelines

A. Solano County's CSS, WET, and PEI Plans include multiple strategies for reducing the identified disparities.

Community Services and Supports

A six month long community planning process was held in 2009 to update the Community Services and Supports Strategic plan for Solano County. Stakeholders recommended services be reorganized into a coordinated, seamless Continuum of Care, which includes:

- Full Service Partnerships for four population specific age groups: children, transition age youth, adults, and older adults
- Individualized personal/family-centered services
- In-home/in-school services (especially for older adults and children)
- Wellness & recovery services to support return to everyday life

- Peer support & mentoring
- Training for consumers
- Assisting consumers in discovering their purpose and passion
- Linkages to families and community
- Collaborative relationship among all partners, including goal setting, and program design and operation to encourage customers to flow:
- Among county programs, such as Mobile Crisis, Full Service Partnerships, inpatient and outpatient services
- Between medical and mental health services to allow flow between different levels of service
- Among county and community partners, such as hospitals, law enforcement, private providers, and networks
- Clear and seamless referral process among all partners
- Training for County staff and partners (including contractors) in:
    - Best practices, especially for children and older adults
    - Customer service and cultural sensitivity
- Increase outreach and information about mental health services and access to services.

These strategies are intended to allow consumers to flow seamlessly through the system to their needed level of care, reducing barriers in access to services for all consumers. These strategies were integrated into the services and programs offered as part of Solano County Mental Health Community Services and Supports Plan.

The two examples below from Solano County's Wellness & Recovery Services demonstrate how these strategies are being utilized in Solano County and combined with the needs of the identified underserved populations with disparities to create program scopes of work that will increase access to services.

SCMH is securing services with the California Hispanic Commission to provide Wellness & Recovery services to mental health consumers in North Solano County (cities of Fairfield, Vacaville, and Dixon) which has higher populations of Latinos/Hispanics and Spanish speakers. California Hispanic Commission program services offer key elements that research has found to be appropriate and effective in services for Latino consumers. These include spirituality as a recovery support tool, significant family inclusion, and systems anchored in the community. In addition, California Hispanic Commission will utilize a high rate of consumer staff. Specific objectives, activities/timelines, outcomes and evaluation tools related to these services are included in the project scope of work shown in Table 3.7 below.

Table 3.7: California Hispanic Commission Wellness & Recovery Services Scope of Work

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Staff program to meet needs of underserved populations.	Hire program staff by 11/1/10 which represents the cultural, ethnic, and linguistic diversity of Solano County and the population served. Train staff in Wellness and Recovery Action Plan (WRAP) management and core components of services.	At least 25% of staff will be fluent in threshold languages. 100% of staff is trained prior to providing services.	Personnel records California Brief Multi-Cultural Scale (CBMCS). Pre/post training knowledge tests.
Objective	**Activities & Timeline**	**Expected Outcome**	**Evaluation Tools**
2. Outreach to underserved populations	Conduct neighborhood outreach activities to reach consumer families through face-to face contact, materials, and presentations at community events. Conduct outreach to 10 community providers annually. Host three community events per year targeted for outreach to underserved communities.	More people from underserved communities will be aware of mental health services Increased referrals from community. Stronger collaborations with community partners.	Outreach logs.
3. Wellness and Recovery Consumer Services	Provide ongoing person centered, family oriented, and recovery oriented services including: • Emotional support groups • Informational workshops • Case management • Social integration support • WRAP training • Peer one-on-one mentoring • Consumer employment counseling.	85% decrease in symptomology for consumers. 75% of consumers will report greater connection with the community.	Changes in baselines using the MORS. Pre/post tests. Case files

SCMH has also secured Wellness and Recovery services with Faith in Action to provide older adult peer counseling. Faith in Action program service elements that are specialized for older adults include in home visits, which addresses both physical and transportation restrictions and stigma, peer-to-peer support from one senior to another, and engaging older adults to age appropriate services in their community. In addition, specific outreach measures will be taken to engage Hispanic/Latino and Spanish speaking older adults. Specific objectives, activities/ timelines, outcomes and evaluation tools related to these services are included in the project scope of work shown in Table 3.8 below.

Table 3.8: Faith in Action Wellness and Recovery Services Scope of Work

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Provide Senior Peer Counseling:	Recruit and train 30 senior peer counselors annually based on best practice model. Provide homebound seniors 1:1 counseling services on a weekly basis for 1 hour. Establish peer counseling groups established by March 31, 2011.	Decrease in level of depression, anxiety, or stress as recorded in pre/post scores on the Geriatric Depression Scale (GDS) for seniors receiving peer counseling.	Care recipient oral interviews with volunteers/staff Care recipient completes GDS Scale with peer counselor
2. Coordinate/ collaborate with other agencies in provision of services	Meet with prospective partners to learn about services, develop strategies and establish cross-referral protocols.	Contacts made and partnerships formed with agencies within continuum of care Referral forms created Care recipients cross referred as needed	List of contacts and partners Interagency working documents, such as: referral plan/process; policies and procedures, etc.

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
3. Outreach to underserved seniors	Recruit and enroll seniors aged 85+ into peer counseling program Establish bilingual 1:1 counseling. Form partnerships with agencies serving monolingual seniors. Work to establish Peer Counseling services in underserved geographical areas.	Increase of seniors who are 85+ to access services. Increase number of monolingual, non-English speaking seniors accessing services. Increase number of seniors who live in underserved geographical areas accessing services.	Quarterly review of statistics of demographics served
4. Involve mental health consumers and/or family members	Enroll consumers/ family members as peer counselors. Seek input from consumers and family members on ongoing program development.	Retention of consumer and family members for > 6 months as active volunteers.	Active consumer and/or family members volunteer files to track retention Consumer and/or family evaluation surveys

These are two examples of how the Continuum of Care strategies identified in the Community Services and Supports Strategic Plan have been implemented to address disparities for underserved populations in Solano County, including disparities in access for Hispanics/Latinos and Spanish speakers. Many other Community Services and Supports programs, including the four Full Service Partnerships, Bilingual/Foster Family Support, and other Wellness & Recovery Services include strategies from the Continuum of Care to target disparities for underserved populations.

<u>Workforce Education and Training:</u>

The WET plan identifies the following strategies for reducing identified disparities:

- Research successful strategies to reach out to identified underserved populations, including conducting focus groups, surveys, etc.
- Identify, develop, and deliver mental health core competencies to train mental health staff, contractors, consumers/family members, and other stakeholders. Core competencies will increase awareness of MHSA principles of wellness, recovery and resiliency and address the needs of identified unserved and underserved populations, including Filipino, Latino, and Spanish speaking populations.
- Develop a plan to increase recruitment and retention of staff within the public mental health system from identified unserved/underserved populations.

- Train and empower consumers and family members to work in the mental health system.
- Recruit bilingual and bicultural interns within Solano County Mental Health.
- Increase the number of bicultural and bilingual staff in the SCMH system by administering a student loan assumption program for mental health professionals from unserved/underserved populations employed by the County or contract providers.
- Develop outcome measures to evaluate retention rates of staff who are bilingual, bicultural or persons of color in county and contract positions.

Table 3.9 illustrates how some of these strategies will be accomplished to reduce identified disparities.

Table 3.9: WET Plan activities to reduce mental health disparities

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Provide Cultural Competency Training system wide using the California Brief Multi-Cultural Scale (CBMCS) Training Program	All county and contract staff completes 8 hour overview of CBMCS by July 31, 2010. At least ten Solano County and contractor staff are trained to provide cultural competency training using the CBMCS model by June 30, 2011. All county and contract staff complete 8 hour cultural competency training (1 CBMCS module) annually.	Completion of CBMCS training will lead to increase cultural sensitivity of staff.	Scores on CBMCS evaluation tool will indicate increase sensitivity.
2. Provide training in mental health core competencies.	Provide a minimum of four core competency trainings annually, which increase awareness of MHSA principles of wellness, recovery and resiliency and address the needs of identified unserved and underserved populations.	80% of participants will identify how their knowledge has increased and will report an increase in competencies; 60% will identify how they have changed at least one practice	On-line training records, Pre and post surveys, Training evaluation forms, Quarterly program reports

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
3. Develop program to recruit and retain individuals for hard to fill and/or retain positions	Develop loan assumption work plan, policies and procedures, marketing materials, application and appeals process that is customized to meet specific needs of Solano County	A clear, transparent loan assumption program development and execution plan, selection criteria and application process	Marketing materials, application form, policies and procedures

Prevention and Early Intervention

Solano County's Prevention and Early Intervention Plan identifies numerous strategies that address reducing disparities in Solano's PEI priority populations and underserved populations. Solano's plan targets four age groups, three of which have been identified as underserved populations in this cultural competency plan: Children ages 0-5, school age children (grades 4-12), and older adults (ages 60+). Below are descriptions of these strategies and how they aim to reduce disparities in underserved populations.

Early Childhood Mental Health

Solano PEI Early Childhood Mental Health Project is jointly funded by PEI and First 5 Solano which maximizes funding for this target population. The project provides screening, assessment, and referral for children ages 0-5, parent and caregiver education and parent coaching for family intervention, and provider outreach, education and training. Strategies to increase access to services and quality of services include:

- A standard referral form and referral access point for all providers
- Participation in the Early Childhood Developmental Health Collaborative to strategically plan for and address the needs of the target population
- Provision of services at a lower level of care for children and families who do not meet medical necessity (e.g. parent coaching)
- Evidence-based screening tools and curriculum, including Ages and Stages Questionnaire (ASQ-3, ASQ-SE), Parent Child Interaction Therapy (PCIT), Incredible Years, and Nurturing Parenting Program
- Extensive bilingual/bicultural services. In FY 09/10, 40% of families served were Hispanic/Latino, and 33% spoke Spanish as their primary language.

Table 3.10 details the scope of work for the PEI Early Childhood Mental Health Project

Table 3.10: PEI Early Childhood Mental Health Scope of Work

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Screen and identify children for mental or development health risk factors.	Screen a minimum of 700 children ages 0-5 annually using the Ages and Stages Questionnaire (ASQ-3 and ASQ-SE). Train providers, such as pediatricians and childcare providers in using the ASQ-3 and ASQ-SE.	At least 10% of children screened show significant concerns needing referrals to addition services. Providers demonstrate competency in using the ASQ-3 and ASQ-SE.	ASQ-3 and ASQ-SE results. Post-training test/survey.
2. Improve child behavior and parent-child relationships.	Provide parent coaching through Parent Child Interaction Therapy (PCIT), Nurturing Parenting Program, and Incredible Years.	Families served demonstrate an improvement in the parent-child relationship, improved child mental health, and improved caregiver mental health.	Evidence based post- intervention assessment.
3. Increase parents' knowledge of parenting topics.	Provide parent workshops on a variety of parenting topics, including nutrition, discipline, stress management, etc.	Parents/caregivers demonstrate increased knowledge of the goal topics covered in the workshop	Post-workshop test/survey.

<u>School Age Youth</u>

Solano's PEI School Age Youth Program serves children in grades 4-8 through a school-based targeted student assistance program. This program is based on the evidence-based Response to Intervention model, which is a framework for targeting resources by utilizing a three tier system: 1. School-wide interventions for all students; 2. Short-term targeted intervention for students with behavioral or social/emotional issues that are interfering with school success; 3. Intensive, specialized, individual services for students with mental health or other disabilities. Solano PEI plan provides funding for Tier 2 services in 17 schools throughout the county. Students with behavioral or social/emotional issues are identified from their teachers and the schools' Student Study Teams to receive short term group and individual counseling at their school site. Counselors also work with parents and teachers to reinforce skills taught in counseling. During the first year of services (FY 09/10), students who completed counseling had a 70% decrease in office referrals from the period before they began counseling.

Table 3.11 details the scope of work for the PEI School Age Youth Project

Table 3.11: PEI School Age Youth Scope of Work

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Increase students' ability to handle personal/family situations interfering with educational success.	Provide group and individual counseling to students in 17 schools throughout Solano County.	Decrease in office referral for participating students.	School records.
2. Increase parental competence in handling difficult behaviors.	Provide parent workshops and parent consultations to reinforce skills taught in counseling.	Parents participate in workshops and consultations.	School records.
3. Increase teachers' ability to prevent and handle class discipline and to support students' emotional needs.	Small-group and/or individual consultation for teachers of participating students to reinforce skills taught in counseling.	Teachers report an ability to respond to classroom issues and create a positive environment.	Post-consultation survey.

<u>Older Adult Identification and Linkage Program</u>

Solano's PEI Older Adult Identification and Linkage Program has three components aimed to both increase the capacity of the community and community providers to provide support to older adults and to provide direct services to older adults to link them to services. The Gatekeeper Program trains community members and provider to screen and identify seniors who are experiencing signs of early mental illness or who need other support. The Navigator program provides case management to seniors who have been identified, including linkage to community supports, such as primary care doctors, transportation, and senior centers, and problem solving skill development. The Navigator program relies heavily on referrals from the trained Gatekeepers. The final component is Health Provider Education which increases the capacity of healthcare providers in Solano County to meet the needs of Older Adults. Topics of trainings include: depression, substance abuse, stress reduction, and evidence based screening tools for older adults.

Table 3.12 details the scope of work for the PEI Older Adult Identification and Linkage Program

Table 3.12: PEI Older Adult Identification and Linkage Program Scope of Work

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Screen older adults for risk of mental health needs.	Recruit & train Gatekeepers to screen older adults and disseminate mental health resource information and educational materials. Gatekeepers will screen older adults.	Gatekeepers will have an increased knowledge of signs of mental illness and resources. Gatekeepers will identify older adults who are at risk of mental illness and refer them to services.	Pre/post-test. Screening tool.
2. Connect older adults to needed services.	Navigators will case manage older adults and connect them to services, such as primary care providers, senior centers, transportation, etc.	Older adults will access services in the community. Older adults will report increased feelings of support.	Case files. Exit survey.
3. Train healthcare providers on mental health issues for older adults.	Provide 6 trainings annually to healthcare providers on issues concerning older adults and mental health.	Health providers demonstrate knowledge of issues related to mental health in older adults. Six month post training survey will measure systemic change in practice, policies and procedures.	Pre-post test surveys.

B. Disparities in mental health services occur in Solano County among women, children and older adults, Asian/Pacific Islanders, Latinos, Filipino dialects and Spanish speakers. Disparities in these populations occur within the Medi-Cal, 200% of poverty level, MHSA/CSS populations, and PEI priority population. Therefore, the following strategies have been developed *system-wide* to assist all consumers from underserved populations in a concerted effort to improve their access to and quality of mental health services in Solano County.

Strategy 1: Ensure all services are culturally competent. Culturally competent services throughout the mental health system are the basis to reducing disparities in underserved populations. Providing culturally competent services at all levels allows all consumers to have the same opportunity for access, successful treatment, and

wellness and recovery within the mental health system. Components of a culturally competent system, including but are not limited to:

- All staff, including office staff, clinicians, psychiatrists, administrative staff, and contractors, are trained in cultural competence through a minimum of annual 8 hour training. (See WET strategy in Criterion 3 Section IIIA and Cultural Competence Training in Criterion 5 Section IA.)
- Policies and procedures at all levels reflect culturally appropriate practices. (See Policies and Procedures in Criterion 1 Section IB.)
- Case files, including electronic files in the future Electronic Health Records system, reflect culturally competent services and practices.
- Services are available in consumers' primary language(s). (See Language Capacity Criterion 7 I-V.)

Strategy 2: Partner with community agencies who are effecting at reaching and serving underserved populations. Community agencies are key players in providing mental health services and other supportive services to mental health consumers. Partnerships with community agencies can range from referring parties to collaborators to contractors. Solano County Mental Health can benefit from partnering with community agencies because community agencies often have an increased level of flexibility and increased ability to penetrate into the community, especially with groups who may have a distrust of government services. Community agencies can benefit from partnering with the County by increasing access to County services for their consumers and ensuring their consumers' priority needs are identified in community program planning. Activities that are associated with this strategy include:

- Identify, outreach to, and collaborate with community agencies who provide services to underserved populations. (See outreach and engagement strategies in Criterion 1 Section IIA & B)
- Provide clear expectations in Requests for Proposals and resulting contracts of what culturally appropriate services look like for underserved populations. Provide clear rating criteria to review panels of Requests for Proposals on culturally appropriate services for underserved populations. (See Criterion 8 Section IIIA)

Strategy 3: Become a data driven system where outcomes inform decision making. Solano County Mental Health has made a commitment to become a data driven system where all programs gather and report on outcome data. This includes outcome data related to cultural competency.

- Train program staff in Results and Performance Accountability to assist staff in identifying appropriate effort and effect outcome measures. (Attachment 32)
- Develop appropriate outcome measures for all SCMH programs. Include outcome measures that are culturally relevant related to access to and quality of services. (See select outcome measures for highlighted programs in Criterion 3 Sections III &IV.)
- Systematically track outcomes measures.
- Utilize data and outcome measures in program review and program planning.

Strategy 4: Integrate behavioral health and primary care services. Mental health consumers die on average 20+ years earlier than the general population. The majority

of these deaths are from chronic disease, such as heart disease, diabetes, stoke, etc. In addition, many underserved populations, such as Latinos and Filipinos access physical health services at a higher rate than mental health services making physical health sites key locations for screening and linking to mental health services. Lastly, in some populations mental health concerns manifest as physical health problems, such as headaches or stomach aches. These reasons together create a compelling argument for the integration of behavioral health and primary care services. Solano County is working on behavioral health primary care integration in two distinct ways:

- Provide behavioral health services in primary care clinics where underserved population access health services. This includes providing behavioral health specialists (Licensed Clinical Social Workers) at Solano County Public Health Family Health Services clinics in Fairfield and Vallejo, along with providing behavioral health specialists at community clinic sites, such as La Clinica de La Raza in Vallejo.
- Provide physical health services to mental health consumers through a Federal Qualified Health Center with a focus on behavioral health. Solano County Mental Health is in the process of integrating the services of a primary care nurse practitioner into the behavioral health setting.

These four strategies together create a multi-faceted system-wide approach to addressing disparities in unserved populations for the Medi-Cal population, 200% of poverty population, MHSA/CSS population, and PEI priority populations.

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

A. An additional strategy to providing services to the identified underserved populations is Solano's Community Access to Resources and Education (CARE) project funded by MHSA Innovation. The goal of the project is to increase the community's capacity, including that of health care professionals, first responders, community-based health and social services providers, teachers and the lay public, to respond to underserved populations with mental health issues through education, training, consultation, and co-location of treatment services. In the process of implementing community based mental health services, the project aims to learn about the best methods for partnering with community providers in building their capacity to provide mental health services.

Solano County has contracted with Aldea, Inc. who will implement this project by providing a multi-pronged strategy, which includes:

- Extensive outreach and survey of community agencies to determine locations, based upon identified needs, where the County can partner to provide services
- Mental Health First Aid Training for staff at community agencies and the general public to increase their ability to recognize and take appropriate actions for people experiencing mental health issues
- A system navigator who will work with community providers to better coordinate care for individuals, including screening referrals, determining eligibility for services, and making referrals to appropriate community providers
- Co-location of mental health services at a minimum of four sites throughout the county that serve underserved populations

- Psychiatric services, including direct services and consultation to providers.

Specific objectives, activities/timelines, outcomes and evaluation tools related to these services are included in the project scope of work shown in Table 3.13 below.

Table 3.13: CARE Program strategies to reduce mental health disparities

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
1. Increase knowledge & ability of the community regarding mental health.	Provide evidence-based Mental Health First Aid (MHFA) Training to wide variety of community members. Priority will be given to those who serve underserved population(s).	At least 60% of people who complete the MHFA Training will be from an underserved community.	Contractor will track & report demographic info of MHFA Training participants
2. Co-locate clinicians at community based sites who serve underserved populations, including geographically isolated and racial/ethnically underserved populations.	Mental health services will include individual, group, & family therapy, case management, and support groups. Services will link clients to community resources for ongoing wellness and recovery. Priority will be given to clients who are not eligible for or who are unable to access other mental health services. To the extent feasible, clinicians will represent the cultural and linguistic diversity of clients served.	80% of clients served will be from an underserved cultural population or geographic location. 60% of clients achieve 1 or more goals in treatment plan. 75% of clients are satisfied with services. 75% of clients report on Ohio Scales a decrease in symptom severity.	Ohio Scales Client satisfaction surveys with feedback incorporated into service provision

Objective	Activities & Timeline	Expected Outcome	Evaluation Tools
3. Provide psychiatric services to underserved populations.	Clients who are accessing psychiatric services will be case managed to assist them in identifying and accessing long term psychiatric services, as necessary. The psychiatrist will consult with multiple sites throughout the county, including primary healthcare providers, community based staff and clinicians.	75% of clients keep appointments with the psychiatrist. 75% of clients who complete follow up will report reduction in symptom severity using the Ohio Scales. 75% of clients are satisfied with services.	Case notes/files. Outcome and client satisfaction data using Ohio Scales. Client satisfaction surveys Provider post consultation survey

1. Key lessons learned by Solano County through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI are described below:

Lessons learned in the community planning process of developing new programs

Lesson #1: The process must be transparent and inclusive.
During the development of MHSA Plans, significant attention was paid to transparency and inclusivity, in the following ways:

- *Broad invitation to participate.* All community members were invited to attend and participate in the Stakeholders meetings, workgroups and community forums. In some cases, special forums were convened during the process when it became apparent that representation from particular communities was inadequate. For example, in PEI planning, a special meeting was held to involve the Filipino community.
- *Flexibility*. When particular groups voice that their needs are not being addressed through the existing workgroup structure, changes in the workgroups are made to ensure that everyone's needs are addressed. For example, during the recent CSS strategic planning process, a family member voiced her difficulty in attending meetings held during traditional work hours. The MSHA Steering Committee changed the hours of come meetings to accommodate working family members.
- *Substantial active involvement.* Stakeholders need to be directly involved in development of projects and kept informed as plans evolved, not just during public comment periods. In addition, stakeholders need to continue to be involved in the implementation of the plans.

Lesson #2: Stakeholders must make the key decisions. Throughout the planning process for all MHSA plans, stakeholders made the key decisions.

- Projects were developed primarily by workgroups with limited representation by county staff.

- Criteria for selection of projects above and beyond the criteria required by MHSA guidelines were discussed with stakeholders and stakeholders were given the opportunity to weigh in on key decisions.

Lesson #3: Close attention must be paid to providing realistic and inclusive project plans and cost estimates in the plans.

- Several programs approved within Solano's initial CSS plan had to be substantially scaled back because administrative and personnel costs had not been accurately calculated. This leads to expectations that programs are unable to fulfill due to reduced budgets.
- Stakeholders and county staff closely review proposed budgets for projects to prevent a repeat of this error.

Lesson #4: Have meetings in locations and at times that accommodate participants.

- MHSA Stakeholder and community planning meetings are conducted in locations throughout the county to allow stakeholders with limited travel capacity to attend.
- Engaging consumers for planning and input is especially effective when meetings are brought to locations where they are already attending, such as Wellness and Recovery program sites.
- Many MHSA Steering Committee Meetings are now conducted late afternoon/early evening to accommodate working family members, per their request. In addition, participants requested a light dinner as they are often coming straight from work.

Lessons learned in the implementation of new programs

Lesson #1: *Implementation of new programs takes a significant amount of time*.

- Programs must be allowed adequate time for staffing and drafting and implementing policies and procedures. Staffing may take even additional time if recruiting for bilingual/bicultural staff.
- If programs are being implemented through contracts, a minimum of 6 months must be allotted for the County Request for Proposals and contracting processes.

Lesson #2: *Even with the implementation of MHSA, funds cannot address all mental health needs in our community.*

- Despite our community's best effort to complete thoughtful and thorough planning processes, priorities must be ranked and not every need is able to be met.
- This has become even more challenging in light of the recent economic downturn. Planning that was done previous to the downturn may not meet the needs of the current system.

Lesson #3: *Implementation of new programs requires building relationships and successful partnering with other County Divisions and Departments, contractors, and community partners.*

- Programs are most success when they include in their scope of work outreach and community collaboration.

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

A. Table 3.14 below outlines the implementation status of each strategy and activity highlighted in Sections III and IV of Criterion 3.

Table 3.14: Implementation Status of Strategies and Activities to decrease disparities

Plan	Strategy	Activity	Implementation Status
Community Services and Supports	Continuum of Care	Wellness and Recovery targeting Latinos and Spanish speakers.	Contract negotiations in process. Contract anticipated October 2010. Services anticipated December 2010.
	Continuum of Care	Wellness and Recovery targeting Older Adults	Contract negotiations in process. Contract anticipated October 2010.
Workforce Education and Training	Provide Cultural Competency Training using the California Brief Multi-Cultural Scale (CBMCS) Training Program.	Provide annual CBMCS Training to all staff. Train local CBMCS trainers.	County and contract staff received an 8 hour CBMCS overview June-July 2010. Currently identifying appropriate Solano County and contractor staff to become trainers. Ten staff will become trainers by June 30, 2010. County and contract staff will receive 1 module (8 hours) of CBMCS training annually 2010-2015.
	Provide training in mental health core competencies.	Provide 4 trainings annually.	Completed core competency training in mental health administrative activities, such as contracts, board items, budgets, etc. Currently completing a needs assessment to identify further Solano County training needs. Currently recruiting Training Committee members to sort and prioritize future training needs. Four trainings will be held annually beginning in FY 10-11.
	Develop program to recruit and retain individuals for hard to fill and/or retain positions.	Develop local loan assumption program.	Initiating development of local loan assumption program.
Plan	**Strategy**	**Activity**	**Implementation Status**
Prevention	Early Childhood	Screening, assessment,	Request for Proposals and

and Early Intervention	Mental Health Program	referral, and early intervention for children ages 0-5 and their families.	contract negotiations took place in FY 08/09. FY 09/10 was the first full year of services. Currently in the second full year of services.
	School Age Youth Program	Short term targeted intervention in the form of group and individual counseling for students grades 4-8 who are at risk of school failure.	Request for Proposals and contract negotiations took place in FY 08/09. Contracts began August 2009. Full services began January 2010. Currently in the first full year of services.
	Older Adult Older Adult Identification and Linkage Program	Gatekeeper training and screening, Navigator case management, and health provider training.	Request for Proposals and contract negotiations took place in end of FY 08/09 and early FY 09/10. Contract began October 2009. Full services began January 2010. Currently in the first full year of services.
System-wide Strategies	Ensure all services are culturally competent	Staff is trained in cultural competence. Policies and procedures, files, Electronic Health Records, etc., reflect culturally competent services. Services are available in consumers' primary language.	See above for cultural competence training timeline. On-going. On-going for bilingual staff. New translation contract began April 2010. Training will be on-going.
	Partner with agencies who reach and serve underserved populations.	Collaborate with community agencies. Provide appropriate	On-going. Current partnerships include Vallejo Intertribal Counsel, Solano Veterans Resource Collaborative, Early Childhood Developmental Collaborative, Senior Coalition, First 5 Solano. On-going. Included in all RFPs.

		documentation in Requests for Proposals.	
	Become a data driven system.	Train staff in Results and Performance Accountability. Develop outcome measures for all programs. Track outcome measures. Utilize data in program review and planning.	Initial training held June 2010. A second training expected fall 2010. Developed outcome measures for PEI and WET contracts during contract negotiations in FY 08/09 and 09/10. Currently finalizing outcome measures for CSS contracts. In FY 10/11, develop outcome measures for all MHSA programs. In FY 11/12, develop outcome measures for all SCMH programs. Begin tracking outcome measures as they are developed. Utilize current systems such as FSP DCR data, as applicable. Utilize new Electronic Health Record system which will be implemented beginning 2011 to track data, as applicable. On-going, as needed.
	Integrate behavioral health and primary care.	Provide behavioral health services in primary care clinics. Provide physical health services to mental health consumers.	Behavioral health services have been provided in Solano County Family Health Services Clinics in Fairfield and Vallejo since 2004. Contract negotiations are in process to increase behavioral health services at 2 La Clinica de La Raza primary care and urgent care sites. Contract anticipated to begin October 2010. Solano County Mental Health FQHC anticipating having a physical health component through the addition of a primary care nurse practitioner in FY 10/11.

Innovation	Community Access to Resources and Education	Multi-pronged approach to supporting community partners in providing mental health services to underserved groups, including outreach, training, co-location of mental health treatment services, psychiatric consultation.	Request for Proposals and contract negotiations FY 09/10. Contract to begin September 2010. Community survey/outreach will take place September-December 2010. All strategies will be implemented by January 2010.

B. Solano County utilizes the outcomes data and evaluation tools pertinent to each strategy, activity, and underserved population to measure the effects of the current strategies, objectives, actions, and timelines for reducing disparities identified in Section II of Criterion 3. Examples of these outcomes and tools can be found in Sections III & IV of Criterion 3 in the tables with columns labeled Outcome Data and Evaluation Tools.

In addition, through previous and current planning processes, including CSS, PEI, WET, Electronic Health Records, Capital Facilities, and cultural competency plans, Solano County has gathered extensive baseline data which will be used to monitor changes in identified disparities. Changes in this data will be monitored and analyzed on an on-going basis for reduction or elimination of disparities.

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

The SCMH Cultural Competency Committee addresses cultural issues; is responsible for cultural competence to be integrated throughout the system; and reflects the diversity of Solano County. Through information gathering, the Committee provides recommendations and input to the QIC and SCMH senior management, as well as other key decision-makers. The Committee also played a key role as an advisory committee during the development of SCMH's Cultural Competence Plan.

I. Solano County Mental Health's Cultural Competence Committee Addresses Cultural Issues and Is Reflective of the Community.

A. The Solano County Cultural Competency Committee reflects the diversity of Solano County. As seen in Attachment 35, Committee members represent various ethnic, racial and cultural groups, including consumers/family members, community partners, and contractor providers. The Committee, chaired by the Cultural Competency Coordinator, meets monthly for ninety minutes and provides monthly reports to the Solano County Local Mental Health Board, the Solano County Quality Improvement Committee, Solano County Consumer and Family Member Advisory Committee (CFAC), and the Solano County Chapter of the National Alliance on Mental Illness (NAMI). Additional Cultural Competence Committee reports are provided within the monthly Mental Health Services Act (MHSA) Report (Attachment 33), Monthly Mental Health Director Report (Attachment 34), and Monthly Dashboard Report (Attachment 31).

B. SCMH makes efforts to recruit and retain a diverse group of individuals for the Cultural Competence Committee as seen in Attachment 35. Current practice ensures that the Cultural Competence Committee is comprised of representation from seventeen community populations. A policy to formalize this practice is currently being written with anticipated approval date by December 31, 2010. (A draft version should be available to view when the California Department of Mental Health (DMH) visits Solano County.)

C. In Attachment 36 is SCMH's organizational chart.

D. In Attachment 35 is SCMH's membership roster including member affiliation.

II. The SCMH Cultural Competence Committee is Integrated within the SCMH System.

A. SCMH current practices demonstrate that the Cultural Competence Committee reviews policies and procedures for cultural inclusiveness as an extension of the Mental Health Policy & Procedure Committee as seen in Attachment 13. Additionally, SCMH practices included that the Committee has wide range participation and input into SCMH system to assure cultural competence is integrated throughout the public mental health system as evidence by the following:[3]

   1. As seen in Attachment 5 and 37, the Cultural Competence Committee was involved in the development of and provided feedback on approved MHSA

[3] SCMH is developing a policy and procedure to formalize this practice and a draft version should be available when DMH visits Solano County to review Solano County's Cultural Competence Plan, 2010.

plans, including the Workforce, Education and Training (WET), Innovation, Prevention, Early Intervention (PEI), and Community Services and Support (CSS). Additionally, the Committee provided input and recommendations to the updated MHSA CSS Strategic Plan. Furthermore, Committee members are involved in SCMH strategic planning efforts (as discussed in Criterion 1). Finally, the Committee provides on-going feedback about SCMH programs and projects through the Cultural Competence Committee reports mentioned above and through meetings with managers and contractors. (Attachment 5 and 37)

2. As seen in Attachment 38, the Committee provides monthly reports to Quality Improvement Committee.
3. As seen in Attachment 39, participates in overall planning and implementation of services in the county.
4. Reports recommendations directly to the mental health executive level by transmitting recommendations to the MHSA Coordinator and/or Mental Health Director. (Attachment 40)
5. Participates in and reviews county MHSA planning process; (Attachment 5 and 37)
6. Participates in and reviews county MHSA stakeholder process. (Attachment 41)
7. Participates in and reviews county MHSA plans for all MHSA components (Attachment 5 and 37)
8. Participates in and reviews client developed programs (Attachment 5 and 37)
9. Participates in revised CCPR (2010) development (Attachment 42).

B. As noted in Criterion 4, section A, 1-9, SCMH practices includes the Cultural Competence Committee's participation in the review process of Criterion 4, section A, 1-9 as evidence by the attachments noted above.

C. Cultural Competence Committee FY 2009-10 Annual Report.

Annually, SCMH develops and annual report and each program reports goals, objectives, achievements and progress towards meeting goals and objectives, as well as goals and objectives for the coming Fiscal Year.

1. Cultural Competency Committee Goals and Objectives: The goals of the Solano County Cultural Competency Committee are to increase knowledge of disparities in mental health care and to identify and promote strategies to actively address disparities throughout the SCMH Plan. Specific objectives designed to meet these goals include:
    a. Conduct comprehensive cultural competency trainings that establish a baseline understanding of cultural competency to measure individual and system wide progress over time.
    FY 2009-10 Update: SCMH successfully implemented cultural competent training throughout the mental health system using the CBMCS as the framework, and developed training plan to provide each training module throughout the mental health system.
    b. Promote system wide dialogue regarding cultural competency through discussion topics.

FY 2009-10 Update: SCMH successfully coordinated and implemented a monthly cultural training topic for units to discuss during staff meetings.

c. Meet regularly to identify and review disparities and strategize interventions.
FY 2009-10 Update: The Cultural Competence Committee met monthly and provided input, recommendations, and strategies for SCMH Strategic Planning efforts, MHSA Plans and Plan Updates.

d. Produce an Annual Report which includes:
   - o Reviews/Recommendations of previous Fiscal Year
   - o Human Resources Report
   - o County Organizational Assessment
   - o Training Plan
   - o Other County Activities.

FY 2009-10 Update: The Cultural Competence Coordinator drafted an update for the SCMH FY 2009-10 Annual Report (to be released December 2010). The Cultural Competence Committee drafted the Solano County Cultural Competence Plan for 2010, which included these items.

e. Goals and objectives are regularly reviewed at the:
   - o Local Mental Health Board
   - o Quality Improvement Committee
   - o Solano County Chapter of the NAMI
   - o MHSA Stakeholder and Steering Committees.

2. Reviews and provides recommendations to programs and services: The Cultural Competency Committee meets monthly to review progress towards established goals and to discuss system-wide issues related to cultural competence. In the past year, the highlights include:

a. Cultural Competency Discussion Topics**:** County mental health units and numerous contract agencies were provided discussion topics dealing with cultural competency. Each unit was supplied a binder to organize articles or summaries, sign in sheets and evaluation forms from each meeting. The Cultural Competency Committee regularly reviewed the discussion topics and made recommendations as to which articles, summaries were electronically distributed to managers and supervisors for discussion. The binders were regularly reviewed by the Cultural Competency Committee which helped to determine future discussion topics.

b. Addressing County Personnel Issues**:** During county wide layoffs in February 2010 the Cultural Competency Committee reviewed employee seniority lists and recognized that many of the bilingual (Spanish speaking) staff were more recent hires and at high risk of being laid off if/when there were additional layoffs. In July 2010, the Cultural Competence Committee reviewed job listings and noticed two Clinical Supervisor vacancies. In both instances, the Committee drafted formal memorandums to the Mental Health Director outlining concerns and recommendations including specific questions regarding experience monitoring staff's ability to be provide cultural sensitive

care that could be asked during the interviews for the clinical supervisor vacancies. (Attachment 40)

c. May is Mental Health Month**:** The Cultural Competency Committee regularly reviewed activities related to May is Mental Health Month. Many of the activities which targeted underserved communities and contained training components were recommended by the Cultural Competency Committee. Specifically, the Nepantla Project which was a targeted outreach effort to Spanish speaking consumers, family members and providers and the Solano County Board Proclamation acknowledging May as Mental Health Month were Cultural Competency Committee recommended activities. (Attachment 43)

3. Goals of Cultural Competence Plan: The primary goal of the FY 2009/10 Cultural Competency Committee was to ensure system wide cultural competency training using the evidenced based California Brief Multi-Cultural Scale (CBMCS) Training Program.
   This goal was accomplished through six all day cultural competency trainings held in three cities within Solano County. The training taught by master trainers provided an overview of the evidenced-based CBMCS model and was attended by county/contract provider mental health and community partner staff and consumers/family members.
4. Human Resources Report: the last Human Resources Report completed by SCMH was in 2007 for the WET Plan (see Criterion 3). This Report is scheduled to be updated and a draft version will be available upon request when OMC/DMH conducts its site visit.
5. County Organizational Assessment: In FY 2010-11, the Solano County Cultural Competence Plan will be Solano's County Organizational Assessment.
6. SCMH Training Plan: As mentioned in Criterion 5, Solano County has developed an extensive training plan for FY 2010-11 through WET implementation and in consultation with the Cultural Competence Committee (Attachment 44). These training plans include:
   a. CBMCS: in FY 2009-10, SCMH trained 95% of staff using CBMCS as the framework. In FY 2010-11, SCMH will train ten trainers to provide CBMCS training throughout the public mental health system, and provide CBMCS training to public mental health system staff in Fiscal Years 2010-11 and 2011-12.
   b. Interpreter Training: train SCMH system on how to access interpreter services and how to work with interpreters to provide mental health services.
   c. Consumer and Family Member Panel: continue annual training focusing on a consumer and family member panel for SCMH staff and contractors.
   d. Transition Care Planning: trained 12 staff members on how to integrate TCP principles and practices into care plan development—focus is on client centered/wellness and recovery care plans. In FY 2010-11, SCMH will integrate TCP throughout the system through training and supervision.
   e. Results Accountability Workshop: completed one Results Accountability Workshop for staff and contractors to build capacity of

SCMH to be a data driven system. SCMH will host second training in 2010.

f. Continuous Quality Improvement (CQI): through PEI Technical Assistance and Training funds, SCMH will provide training to staff and contractors about CQI and how to integrate CQI principles into SCMH program development and implementation.
g. Cultural Competence Discussion Topics: Cultural Competence Coordinator will provide topics on a quarterly basis to SCMH units and contractors to discuss during staff meetings.
h. SCMH Managed Care's External Network Advisory Committee: The Cultural Competence Coordinator presented cultural competent issues at the quarterly meeting. This practice will continue in FY 2010-11.
i. SCMH County & Contract Providers Monthly Clerical Meeting: The Cultural Competency Coordinator will present a topic related to cultural competency at this quarterly meeting. The topic will be reviewed and approved by the Cultural Competency Committee. The Cultural Competency Committee will review the evaluation forms from the training and at least one Cultural Competency Committee member will attend each of the trainings in order to provide feedback to the coordinator and other committee members.
j. PEI Trainings: PEI initiatives (as mentioned in criterion 1 and 5) will continue to build capacity of the community to screen, identify and address mental health issues in the community and refer to appropriate services.

7. Other Activities: SCMHs other activities which support cultural competence include:
   a. Solano County Equal Employment Opportunity Committee (EEOC): The Cultural Competency Coordinator for SCMH is the Gay, Lesbian, Bisexual, Transgendered (LGBT) county wide representative of this committee. This committee actively reviews county organizational plans and reviews strategies to lessen disparities.
   b. Solano County Multicultural Fair: This Fair organized by the EEOC takes place annually and provides county employees an opportunity to experience components of other cultures. The Cultural Competency Coordinator and Committee members are key to coordination of the event annually.
   c. Cultural Competency Overview at New Employee Orientation: The Cultural Competency Coordinator provides a quarterly overview of health disparities, emphasizing mental health disparities, to all new Solano County Health & Social Services employees.
   d. Mentoring Programs: SCMH staff have access to two mentoring programs: county wide and departmental. These programs are designed to assist staff with professional development and provide many training opportunities. These programs are representative of entry level staff and people of color.

Criterion 4 detailed the work of the SCMH Cultural Competency Committee by describing how the committee is organized, detailing the specific data analyzed, reporting on activities for FY 2009-10; and identifying specific goals and activities for Fiscal Year 2010/11.

CRITERION 5:
CULTURALLY COMPETENT TRAINING ACTIVITIES

Solano County Mental Health (SCMH) believes that staff education and training are crucial to ensuring culturally and linguistically appropriate services. Criteria 5 provides a comprehensive overview of cultural competency related trainings provided in Fiscal Year (FY) 2009/10 and outlining trainings planned for FY 2010/11.

I. SCMH Provides Annual System-wide Cultural Competence Training

A. SCMH has developed a multi-year training plan, including required cultural competence training using the California Brief Multicultural Competence Scale (CBMCS).

1. SCMH currently has one hundred and seventy-five filled positions and twenty three vacancies.[4] Therefore, SCMH anticipates implementing the following three year cultural competency training plan for up to one hundred and ninety eight employees.
2. Below is the timeline for providing cultural competence training to 100% of staff over a three year time period:
   - Phase I
     Content: CBMCS overview and establishing baseline CBMCS scale
     When: By July 31, 2010
     Who: County and contract provider staff, consumers/family members, and community partners.
   - Phase II
     Content: CBMCS Modules 1-4 (eight hours of each of the four modules)
     When: By June 30, 2011
     Who: Thirty five trainees including county/contract provider staff, consumers and family members
   - Phase III
     Content: CBMCS Training for Trainers
     When: By June 30, 2011
     Who: At least ten Solano County Mental Health/contract provider staff
   - Phase IV
     Content: Completion of Module I facilitated by CBMCS certified SCMH Trainers
     When: By June 30, 2011
     Who: County and contract provider staff, consumers/family members, community partners
   - Phase V
     Content: Completion of Module II facilitated by CBMCS certified SCMH Trainers
     When: By June 30, 2012
     Who: County and contract provider staff, consumers/family members, community partners

---

[4] At this time Solano County will fill only a limited number of vacant positions.

- Phase VI
  Content: Completion of Module III facilitated by CBMCS certified SCMH Trainers
  When: By June 30, 2013
  Who: County and contract provider staff, consumers/family members, community partners

3. SCMH has embedded cultural competency into all trainings. SCMH has contracted with California Institute for Mental Health (CiMH) to design trainings and a technical assistance program that will be infused with principles of hope, wellness and recovery/resiliency. The trainings will comprise multiple mental health related subject areas for SCMH staff, providers, consumers and family members. The training curriculum will incorporate the following features (Attachment 44—CiMH SOW):
   a. People with lived experience will participate in the planning, instruction, and evaluation of training and technical assistance. Members of specific cultural groups and other experts will serve as co-trainers with traditional "expert" trainers.
   b. Annual outreach and education to the Local Mental Health Board/MHSA Steering Committee regarding training evaluation plans. These evaluation plans will incorporate principles of continuous quality improvement.

II. Annual Cultural Competence Trainings

Per Criterion 5, section II, A-B, SCMH Cultural Competency Fiscal Year 2009-10 trainings are categorized in **Table 5.1** by training events, description, time/frequency, attendance, date and presenter of trainings.

TABLE 5.1: SCMH FY 2009/10 Cultural Competency Trainings

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 Overview at Health & Social Services New Employee Orientation	Overview of healthcare disparities with special emphasis on mental health care	One hour; Quarterly (March 2010 training was cancelled)	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	0 0 1 0 1 50 0 5 **57**	Septembe r 2 & December 2, 2009 June 2, 2010	Joseph Robinson, LCSW CADC II
History of Filipinos in Solano County	Author/historian provided an overview of Filipinos in Solano County	One time, 45 minutes	Exact attendance for this training unknown. Over 500 people attended the Solano County Multi-Cultural Fair. **Total**	**Unknown**	October 8 2009	Mel Ophelia
Overview of State Administered Services to Military Personnel	Solano County Veterans Collaborative presentation to providers of	Two hours; Quarterly	Consumer or Family member Direct Services- Contractors	 5	January 19, 2010	Ted Puntillo

	mental health services to military personnel		Direct Services- County Manager/Supervisor-Contractor Manager/Supervisor-County Other H&SS /Other Support services-Contractors Support services- County **Total**	4 2 4 1 **16**		
Spirituality in Mental Health Care + Network of Care Website	SCMH Plan Managed Care's External Network Advisory Council	Forty five minutes; Quarterly	Consumer or Family member Direct Services-Contractors Direct Services- County Manager/Supervisor-Contractor Manager/Supervisor-County Other H&SS /Other Support services-Contractors Support services- County **Total**	0 6 7 0 2 1 0 5 **21**	January 22, 2010	Joseph Robinson, LCSW CADC II

Mental Health Symptoms in Older Adults	Panel presentation of early mental health warning signs and different treatment options for older adults	Annually; Four hours	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	93 2 3 0 1 2 0 0 **101**	March 11, 2010	Kelli Kekki, LCSW Jacqueline Patterson, MSW Peggy Pellon, BSW Joseph Robinson, LCSW CADC II
Reflective Practice in Working with Early Childhood Mental/Developmental Health Part I & II	Provided specifics about the skills needed to support reflective practice. A clear conceptual model was presented that supported participants in expanding their skills in their own roles with families & (Part 2) Provided	Eight hours; Two part training	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total (Not available by function.)**	**75**	April 5 & May 3, 2010	Donna Davidowitz. PhD

	opportunities to explore critical issues in reflective supervision.					
Post Traumatic Stress Disorder and mild Traumatic Brain Injury	Solano County Veterans Collaborative presentation to providers of mental health services to military personnel; military personnel and their families	Two hours; Quarterly	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	13 26 15 2 5 9 0 1 **71**	April 19, 2010	Captain Joel Foster, PhD
Nepantla Project Days 1 & 2	Training to assist staff in providing culturally appropriate health care with emphasis on mental health to Latinos living in Solano County.	Eight hours- Day #1 & Four hours- Day #2	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County	83 16 17 6 6 6	May 5 & 6, 2010	Santa Barazza

			Other H&SS /Other Support services- Contractors Support services- County **Total**	3 5 **142**		
The DC: 0-3R Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood Part 1 & 2	An introduction featuring an overview of the system, and chances to use the DC: 0-3R materials interactively to assess and diagnosis & (Part 2) Advanced information featuring an in depth look at assessment and diagnostic criteria in determining the best diagnoses and intervention for high risk infants and their primary relationships.	Eight hours; Two part training	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total (Not available by function.)**	**69**	May 18, 2010	Mary Claire Heffron, PhD

Wellness & Recovery Through Employment	Focus on the culture of employment as recovery in action	Two hours; One time training	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	7 15 2 3 5 3 0 1 **36**	May 20, 2010	Panel presentation including clinical supervisors, Vocational rehabilitation counselors, consumers and job developers
Mental Health Consumer & Family Member Panel	Panel presentation by consumers & family members of what has/has not worked in their personal recovery journeys.	Two hours; Annual training offered twice this year	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County	15 2 5 0 1 0 1 0	May 24 & July 30 2010	Panel presentation of consumers and family member

			Total	**24**		
Ages and Stages Questionnaire (ASQ 3), and Ages and Stages Questionnaire- Social Emotional ASQ SE) Taught in Spanish	Course discussed social, emotional development, red flags, communicating with families and accessing resources in addition to becoming familiar with a developmental screening questionnaire.	Two and one half hours over two days	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	0 13 0 0 0 0 0 0 **13**	May 25 & June 1, 2010	Minerva Nunez
Screening of film entitled Eternal High on Teen Suicide	Educational presentation focusing on suicide and teen culture	Three hours; One time event	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors	18 2 2 1	May 27, 2010	Panel presentation of two clinicians and a family member

			Support services- County **Total**	**23**		
Overview of Lesbian, Gay, Bisexual, Transgendered, Questioning (LGBTQ)	Raising awareness of cultural sensitivity of working with LGBTQ population	Two hours; One time	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total**	0 0 13 0 2 0 0 0 **15**	June 13, 2010	Barbara Cornell, LMFT
California Brief Multi-Cultural Scale (CBMCS) Training	Completion of cultural competency self assessment scale and overview of CBMCS	Eight hours; CBMCS Overview was provided on seven dates in three cities. Cultural competency training using CBMCS Training Program will be provided	Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors	3 39 87 11 16 20 1	June 17, 24 &30 July 1, 2 & 15, 16 2010	Jei Africa, PhD, Robbin Huff-Musgrove, PhD, and/or Gloria Morrow, PhD

		annually	Support services- County **Total**	42 **219**		
Gatekeeper Training for Older Adults. Taught in Rio Vista.	One of three components of the Prevention and Early Access for Seniors (PEAS) Program which teaches strategies of connecting Older Adults to needed services.		Consumer or Family member Direct Services- Contractors Direct Services- County Manager/Supervisor- Contractor Manager/Supervisor- County Other H&SS /Other Support services- Contractors Support services- County **Total (Not available by function.)**	**34**	June 24, 2010	Dennis McCracken, Phd, Peggy Pellon, & Tracee Stacee

III. Relevance and Effectiveness of Cultural Competence Trainings

A. Please find below a Training Report from SCMH regarding the relevance and effectiveness of cultural competence training per the instructions for Criterion 5, section III, 1-3. Currently, SCMH does not provide a pre and post test at each Solano County training event. Additionally, evaluation forms for training event are provided at *some* training events, but not all. Through the contract with CiMH, Solano County is developing pre and post tests for training events and evaluations, including the CBMCS training events. Moreover, SCMH will develop a policy and procedure for SCMH training events, including provisions in it to develop evaluations and provide pre/post tests at training events by the end of FY 2010-11.

TABLE 5.2: SCMH FY 2009/10 & FY 2010-/11 Cultural Competency Trainings, Relevance and Effectiveness

Training Event	Results of Pre and Post Tests	Summary of Evaluations
Cultural Competency Overview at Health & Social Services New Employee Orientation	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
History of Filipinos in Solano County	A community training event which was open to the public and SCMH staff/contractors: not appropriate setting for pre/post tests or evaluations.	A community training event which was open to the public and SCMH staff/contractors: not appropriate setting for pre/post tests or evaluations.
Overview of State Administered Services to Military Personnel	Did not provide pre/post test at this event.	Results not available.
Spirituality in Mental Health Care + Network of Care Website	Training event provided by other organization.	Training event provided by other organization.
Mental Health Symptoms in Older Adults	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
Reflective Practice in Working with Early Childhood Mental/Developmental Health Part I & II	Did not provide pre/post test at this event.	90% respondents indicated that they are using reflective practice and/or reflective supervision in their agencies at least some of the time. 80% of participants have integrated what they learned during trainings into practice. All respondents indicated that they hope to further integrate reflective practice into their work with colleagues as well as clients. (number = 20)

Training Event	Results of Pre and Post Tests	Summary of Evaluations
Post Traumatic Stress Disorder and mild Traumatic Brain Injury	Did not provide pre/post test at this event.	90% of surveys reported training was excellent or good. 84% of surveys reported that the information about PTSD and TBI was excellent or good. 86% respondents found the meeting format excellent or good.
Nepantla Project Days 1 & 2	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
The DC: 0-3R Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood Part 1 & 2	Did not provide pre/post test at this event.	More than two out of three (68%) respondents indicated they currently utilize DC 0-3R within their agency. All indicated that they hope to incorporate more of the DC 0-3R instruments and philosophy into their practice settings.
Wellness & Recovery Through Employment	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
Mental Health Consumer & Family Member Panel	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
Ages and Stages Questionnaire (ASQ 3), and Ages and Stages Questionnaire- Social Emotional ASQ SE) Taught in Spanish		Overall for PEAK provider trainings, 91% of providers trained demonstrate an increased knowledge of birth to age 5 developmental milestones, and an ability to identify indicators for early intervention. In addition, 91% of providers trained demonstrate competency in using the ASQ and ASQ-SE.
Screening of film entitled Eternal High on Teen Suicide	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
Overview of Lesbian, Gay, Bisexual, Transgendered, Questioning (LGBTQ)	Did not provide pre/post test or evaluation at this event.	Did not provide pre/post test or evaluation at this event.
California Brief Multi-Cultural Scale (CBMCS) Training	80.6% of CBMCS assessment scales were completed. One hundred sixty-six respondents completed the CBMCS Scoring Form and the results are: o Multicultural	More than four out five respondents (83%) thought information was presented in a way that increased their knowledge of cultural competence. Nearly four out of five (79%)

	knowledge: 59% percentile rank o Sensitivity and Responsiveness to Consumers: 81% percentile rank o Awareness of Cultural Barriers: 80% percentile rank o Sociocultural Diversity: 64% percentile rank.	of respondents thought that the quality of the training was excellent or good. (number = 166)
Gatekeeper Training for Older Adults. Taught in Rio Vista.	Did not provide pre/post test at this event.	88% of Gatekeepers trained by Area Agency on Aging indicated an increased knowledge of mental health concerns for seniors and resources for at risk seniors.

4. In June and July 2010, SCMH began system-wide cultural competency training using the California Brief Multicultural Scale (CBMCS) Training Program as a strategy to increase capacity of cultural competence within the public mental health system. The initial rollout of this program was offered six different dates in three Solano County cities and provided participants with: 1.) an overview of the CBMCS Model and 2.) an opportunity to establish a baseline number using the CBMCS. By directly linking a self reporting cultural competency scale to comprehensive multicultural training, this program can effectively bridge the gap between research based psychological science and applications for community practice. SCMH will be able to assess the impact of cultural competency training over time by both variations in self reporting scales.

   SCMH has contracted with California Institute for Mental Health (CiMH) to coordinate CBMCS training and evaluation. CiMH has designed an evaluation plan for training to ensure accountability and to assess effectiveness. CiMH is using a uniform post-training activity survey form which asks participants to assess the effectiveness of the activity. The survey asks about the following:
   - How well the conference or training covered the stated objectives
   - For each presenter or trainer:
     1) Knowledge of the content area
     2) Information presented in a way that increased understanding or topic
     3) Consistency of content with objectives.

   - Satisfaction with the overall activity, whether the participant would attend a subsequent activity or recommend it to a friend
   - Overall value and whether the training met expectations
   - Ease of registration and adequacy of facility

- Things the participant liked the most and the least (open-ended questions) about the training (Attachment 45—CBMCS (scale tool) and evaluation forms).

CiMH will provide quarterly training reports that include purpose of training, results of pre/post test, summary of evaluations, how training will advance staff skills and how these new skills will continue to be utilized and monitored over time. (Attachment 46)

Education and training regarding cultural competence is a crucial component building the capacity of the organization to serve diverse populations. Significant staff time has been dedicated to organizing and providing the trainings highlighted in this Criteria. Through the SCMH Training Committee and collaboration with CiMH, measures will be created to quantify the impact trainings offered throughout FY 10/11 have on increasing capacity of SCMH to provide cultural competent services.

5. As mentioned above, in collaboration with the SCMH Training Committee and through the contract with CiMH, SCMH is developing methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned. Currently, SCMH practice is that staff requesting to attend a training event make a commitment in their request ("Travel Request Form" available upon request) to report back to fellow colleagues a summary of the training and provide training to staff about the subject matter (if appropriate). For example, recently, twelve SCMH clinicians attend the Transition Care Planning (TCP) training provided by CiMH: staff were approved to attend the training contingent that they would come back and train other staff about TCP and work with the WET project manager and Quality Improvement Unit to work to integrate TCP throughout the SCMH system.

IV. SCMH Process to Incorporate Client Culture Training Throughout the Mental Health System

A. SCMH hosted two trainings in FY 2009/10 (May 24 and July 30) which provided an overview of the consumer/family member experience. The first training event included three panelists: one Caucasian woman consumer, an African American male consumer and a Caucasian mother of two Transitional Aged Youth (TAY), one of whom is co-diagnosed with a developmental disability. In addition to the same family member on the second panel, panelists included a Latina/Hispanic woman consumer, a Caucasian woman consumer and a Latino/Hispanic TAY male consumer. All panelists reviewed their presentations with the Solano County consumer affairs liaison to ensure the inclusion of the following components:
   - Culture specific expressions of distress
   - Explanatory models and treatment pathways
   - Relationship between client and mental health providers from a cultural perspective
   - Trauma
   - Economic impact

- Housing
- Diagnosis/labeling
- Medication
- Hospitalization
- Societal/familial/personal
- Discrimination/stigma
- Effects of culturally and linguistically incompetent services
- Involuntary treatment
- Wellness
- Recovery
- Culture of being a mental health consumer, including the experience of having a mental illness and of the mental health system.

In addition to the aforementioned consumer/family member panels, SCMH promoted two community-based organizations consumer panel presentations (Caminar on May 19th and Neighborhood of Dreams on May 25th) as part of county wide May is Mental Health Month activities. (Highlighted on Attachment 43)

B. As mentioned above in section IV, A, the first training event included three panelists: one Caucasian woman consumer, an African American male consumer and a Caucasian mother of two Transitional Aged Youth (TAY), one of whom is co-diagnosed with a developmental disability. In addition to the same family member on the second panel, panelists included a Latina/Hispanic woman consumer, a Caucasian woman consumer and a Latino/Hispanic TAY male consumer. Both of the FY 2009/10 consumer/family member training events included a family member who addressed:
    - Family focused treatment
    - Navigating multiple agency services, and
    - Resiliency.

Table 5.3: Consumer and Family Member Training Event, 2010

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees	Date of Training	Name of Presenter(s)
Mental Health Consumer & Family Member Panel	Panel presentation by consumers & family members of what has/has not worked in their personal recovery journeys.	Two hours; Annual training offered twice this year	Consumer or Family member	15	May 24 & July 30 2010	Eugene Tyler Patricia Yelton Liz De la Torre Ariel Ramos, and Rachel E. Ford
			Direct Services-Contractors	2		
			Direct Services-County	5		
			Manager/Supervisor-Contractor	0		
			Manager/Supervisor-County	1		
			Other H&SS /Other	0		
			Support services-Contractors	1		
			Support services-County	0		
			Total	**24**		

Annually, SCMH will coordinate and facilitate at least one mandated consumer/family member training event/panel. Panelists will represent the diversity of Solano County and will work closely with the consumer affairs liaison to ensure that topic areas aforementioned will be included in their presentations.

CRITERION 6:
COUNTY MENTAL HEALTH SYSTEM COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

I. Recruitment, Hiring, and Retention of a Multi-Cultural Workforce from, or Experienced with, Identified Un/Underserved Populations

Criterion 6 highlights Solano County Mental Health's recruitment, hiring, and retention of a multicultural workforce representing, or experienced with, the identified unserved and underserved populations. SCMHs practices illustrate the division's commitment to growing a multicultural workforce through hiring and retention efforts.

A. **Table 6.1** provides workforce assessment data included in the state approved Solano County Workforce, Education and Training (WET) Plan. This table is followed by a brief summary of the data.

Table 6.1: Solano County and Contract Mental Health Staff by Race/Ethnicity (Workforce Assessment Data from Solano County WET Plan, 2008)

Race/Ethnicity	No. of Staff: (Full Time Equivalents)	Percentage of Total Staff
American Indian/Alaska Native	1.0	0.2%
Asian/Pacific Islander	38.6	8.3%
Black/African American	70.9	15.2%
White/Caucasian	233.6	50.4%
Hispanic/Latino	49.1	10.5%
Multi/Other	72.6	15.6%
Total	465.8	100%

Source: Solano County WET Plan as approved by DMH May 2009.[5], [6]

Nearly half of SCMH (49.6%) consumers represent people of color, including multi-racial/other (15.6), African American (15.2%), Hispanic/Latino (10.5%), Asian/Pacific Islander (8.3%) and American Indian/Alaska Native (.2%). The largest racial/ethic group within SCMH is White/Caucasian (50.4%).

B. Table 6.2-6.4 compares the workforce assessment data included in the state approved Solano County WET Plan to various populations, including Solano County Population, Medi-Cal Population, and 200% of the Federal Poverty Level (FPL) data (families with household income of $44,100 for a family of four).[7],[8]

[5] These data include both Solano County Mental Health staff and staff within contract agencies.
[6] Since the Solano County WET Plan was drafted and approved, SCMH staff numbers have significantly decreased. As of August 31, 2010, SCMH had 175 staff employed: about 50 less staff members when the WET Plan was submitted to DMH.
[7] The category of *200% of the FPL* is actually the number of Solano County residents under 200% of the FPL subtracted by the number of Solano County Medi-Cal beneficiaries.
[8] US Department of Health and Human Services*: 2009/2010 HHS Poverty Guidelines* retrieved on August 31, 2010 from http://liheap.ncat.org/profiles/povertytables/FY2010/popstate.htm.

Table 6.2: SCMH Workforce Assessment Data Compared to Solano County Demographic Data (Race and Ethnicity Data), 2008 and 2008 (respectively)

Race and Ethnicity	WET Plan: # of Staff: (Full Time Equivalents)	WET Plan: % of Total Staff	Solano County Population Number	Solano County Percentage
African American	70.9	15.2%	57,622	14.1%
Am Indian/Alaska Native	1.0	.2%	380	1%
Asian/Pacific Islander	38.6	8.3%	59,750	14.7%
Latino/Hispanic	49.1	10.5%	92,094	22.6%
White/Caucasian	233.6	50.4%	176,317	43.3%
Multi/Other/Unknown	72.6		21,352	5.2%
Total	**465.8**		**407,515**	

Source: Solano County WET Plan as approved by DMH May 2009 and United States Census Bureau, American FactFinder General Demographic Characteristics, 2008

Comparing the SCMH workforce assessment data to the Solano County demographic data (race and ethnicity) reveals that SCMH and Solano County have similar rates of African Americans (15.2% compared to 14.1% respectively). SCMH has significantly more personnel representing the racial/ethnic group of multi-racial/other (more than three times the rate of the Solano County population) (15.6% compared to 5.2%). On the other hand, SCMH has significantly less Asian/Pacific Islanders when compared to the Solano County population (8.3% compared to 14.7%). Additionally, SCMH also has about half the rate of Latino/Hispanics when compared to the rate of the Solano County population (10.5% compared to 22.6%). Finally, statistically, no comparison can be made between American Indian/Alaska Native in SCMH workforce assessment data and Solano County population (low number event).

Table 6.3: SCMH Workforce Assessment Data Compared to Medi-Cal Population (Race and Ethnicity Data), 2008 and FY 2008-09 (respectively)

Race/Ethnicity	WET Plan: # of Staff: (Full Time Equivalents)	WET Plan: % of Total Staff	Solano County Medi-Cal Beneficiaries	
	Number	**Percentage**	**Number**	**Percentage**
American Indian/Alaska Native	1.0	0.2%	353	0.6%
Asian/Pacific Islander	38.6	8.3%	7,365	11.7%
Black/African American	70.9	15.2%	16,617	26.5%
White/Caucasian	233.6	50.4%	14,495	23.1%
Hispanic/Latino	49.1	10.5%	20,012	31.8%
Multi/Other	72.6	15.6%	3,952	6.3%
Total	465.8		62,794	

Source: Source: Solano County WET Plan as approved by DMH May 2009 and Solano County Social Services Data.

Comparing the SCMH workforce assessment data to the Solano County Medi-Cal beneficiaries (race and ethnicity) illustrates differences between SCMH and Medi-Cal population

demographic data. For example, SCMH has double the rate of White/Caucasian and multi-racial/other than the Solano County Medi-Cal Beneficiary population (50.4% compared to 23.1% and 15.6% compared to 6.3%). On the other hand, SCMH's rate of Asian/Pacific Islanders, African Americans, Hispanic/Latinos is less than the rate of Solano County Medi-Cal beneficiaries. Additionally, in the case of ethnicity Hispanic/Latino, Solano County Med-Cal Beneficiaries are twice as likely to be Hispanic/Latino compared to SCMH workforce assessment data. Finally, statistically, no comparison can be made between American Indian/Alaska Native in SCMH workforce assessment data and Solano County Medi-Cal beneficiaries (low number event).

Similar to the comparisons above (e.g. Solano County population data), SCMH workforce assessment data show that the rate of multi-racial/other is higher than Solano County population and Solano County Medi-Cal beneficiaries. Conversely, as seen below, when SCMH workforce assessment data are compared to 200% of the FPL (minus Medi-Cal population) the SCMH rate for multi-racial/other is less than rate stated for the 200% of the FPL category.

Table 6.4: SCMH Workforce Assessment Data Compared to 200% of the FPL[9] (Race and Ethnicity Data), 2008 and FY 2008-09 (respectively)

Race/Ethnicity	WET Plan: # of Staff: (Full Time Equivalents)	WET Plan: % of Total Staff	Solano County 200% of the FPL (minus Medi-Cal Population)	
	Number	Percentage	Number	Percentage
American Indian/Alaska Native	1.0	0.2%	586	1.0%
Asian/Pacific Islander	38.6	8.3%	6,329	10.6%
Black/African American	70.9	15.2%	13,616	22.8%
White/Caucasian	233.6	50.4%	17,884	29.9%
Hispanic/Latino	49.1	10.5%	7,348	12.3%
Multi/Other/Unknown	72.6	15.6%	13,970	23.4%
Total	465.8		59,733	

Source: Source: Solano County WET Plan as approved by DMH May 2009 and 2007 California Health Interview Survey retrieved from http://www.askchis.com/.

Comparing the SCMH workforce assessment data to the Solano County 200% of the FPL (minus Medi-Cal population) (race and ethnicity) illustrates differences between SCMH workforce assessment data and Solano County 200% of the FPL (minus Medi-Cal population) category. SCMH White/Caucasian staff represent a higher rate than the rate of Solano County 200% of the FPL (50.4% compared to 29.9%). Conversely, SCMH Asian/Pacific Islander, African American, Hispanic/Latino, and multi-racial/other rates are less than Solano County 200% of the FPL rates. Interestingly, unlike the comparison between SCMH and Solano County Medi-Cal beneficiaries, SCMH rate for multi-racial/other is less than Solano County's 200% of the FPL rate. Also, interestingly, the difference between the rates of SCMH Hispanic/Latinos and Solano County 200% of the FPL is not as significant (only 1.8 percentage points) than the gaps mentioned in the other two tables. Finally, statistically, no comparison can be made between American Indian/Alaska Native in SCMH workforce assessment data and Solano County 200% of the FPL (low number event).

[9] Ibid. Household income of $44,100 for a family of four.

SCMH workforce assessment data when compared to all three populations illustrate that there is a higher rate of White/Caucasian in SCMH than the rate in the other three populations. Also, in all three comparisons, the SCMH workforce assessment data rates for Asian/Pacific Islander and Hispanic/Latino are lower than the Solano County population, Medi-Cal beneficiaries, and Solano County 200% of the FPL (minus Medi-Cal population) rates for these same categories. SCMH recognizes that a diverse workforce is an important component to providing culturally and linguistically appropriate services. SCMH also recognizes that diversity does not only include race and ethnicity (as Tables 6.2-4 suggest). For Solano County, as mentioned in Criterion 1, diversity includes language spoken, consumer and family members, geographic location, across the life span, and sexual orientation. As such, SCMH is implementing strategies to increase the diversity of the SCMH workforce (mentioned below).

C. As noted on the California Department of Health web site page, http://www.dmh.ca.gov/Multicultural_Services/CCPR.asp, at the Bay Area Ethnic Services Manager Regional meeting on May 27, 2010 counties were to receive brief consultation focused on Cultural Competence Plan integration of the WET Plan and strategies to grow a multicultural workforce and retain culturally and linguistically competent staff. As a result, counties would have a better understanding to respond to this Criterion 6, section I.C. At the May 27, 2010 meeting, this consultation did not occur, but rather, a discussion ensued about how WET Plans and Cultural Competence Plans are integrated (or not integrated). Within SCMH, the coordination, development and implementation of the WET Plan is coordinated with cultural competence activities. Additionally, the WET project manager and the cultural competence coordinator work closely on implementation of both projects and meet regularly to collaborate on activities (evidence is available upon request).

D. Solano County's WET Plan was approved May 2009 and funds were secured in the first quarter of FY 2009-10. Implementation of the WET Plan started in the second quarter of FY 2009-10, including the development of a Request for Proposal (RFP) to secure a vendor to implement WET strategies, coordinate training events and the local loan assumption program. The RFP was issued January 2010, and the contract with CiMH was secured June 2010. During the start-up phase of WET implementation, the following targets were reached to grow a multicultural workforce. Of course, the WET Plan is a three-year plan and activities are on-going throughout the three years of the project.

   1. <u>Workforce Staffing and Support</u>: SCMH has achieved most of the targets for this program, including hiring staff; developing and issuing a RFP; managing and coordinating the WET components and contract(s), establishing a training committee; coordinating trainings; and developing an evaluation plan (evaluation plan is in development).
   2. <u>Develop Recruitment and Training Plans for Specific Underserved Populations</u>: SCMH has achieved some of the targets for this program and/or implementing strategies including:
      - Identify successful strategies to reach out to un/underserved populations, including focus groups, surveys and etc. Focus groups were held with consumers and Latinos; multiple surveys were conducted with staff, contractors, stakeholders, and etc.
      - Develop plan to recruit and retain un/underserved populations: plan developed and being implemented over three year period, including implementing state and local loan assumption program; building intern/volunteer pool; and hiring additional consumer staff for SCMH.

   - Create learning collaboratives: Latino bilingual or bicultural clinicians meet regularly to provide support, discuss resources, and share cases. Other learning collaboratives will be established over the three-year period.
3. Expand Cultural Competence Training: SCMH has achieved this target and is planning to implement the expansion further through CBMCS (California Brief Multi-Cultural Scale training) and consumer/family panels. The following is an update:
   - Identified SCMH staff cultural competence baseline using the CBMCS tool.
   - Provided overview of CBMCS to SCMH (95% of SCMH staff attended).
   - Developed plans to implement train the trainer component.
   - Developed plans to implement CBMCS training modules over next two years.
   - Coordinated and provided Consumer/Family panels system-wide.
4. Building capacity of SCMH to provide bilingual services: SCMH has partially met this target and is currently implementing plans for it:
   - Provided training to SCMH staff on how to use CTS LanguageLink to access interpreter services.
   - Identified training on how to increase skills, knowledge and abilities in providing bilingual mental health services to consumers and family members: SCMH will implement training module in year 2 or 3 of WET Plan.
   - Identified training to build skills, knowledge and abilities to use interpreter services when providing mental health services.
5. Train Law Enforcement Personnel: SCMH developed Crisis Intervention Training curriculum specific for Solano County law enforcement units in collaboration with the Solano County Sherriff's Department. State approval of the curriculum is pending. Afterwards, SCMH will train the Solano County Sherriff's Department.
6. Expand PEI Initiatives Education and Training: as mentioned above in Criteria 5 and 6, SCMH met this target by providing numerous education and training events in the PEI Initiatives.
7. Mental Health Career Pathway: SCMH has met this target and is implementing strategies over the three years of the WET Plan. SCMH awarded contracts to a community based organizations providing wellness and recovery services in order to provide jobs, mentorship, training, and supervision to consumers and family members. Through these contracts at least six consumers and family members will gain employment.
8. Expand Internship and Supervision Program: SCMH has met this target and increased the number of interns in the public mental health system and secured additional Memorandums of Understanding (MOUs) with universities and colleges, including University of California, Berkeley; California State University, Sacramento; Argosy University, and Touro University.
9. Loan Assumption Program: SCMH partially met this target by securing a contract with CiMH to coordinate and implement the local loan assumption program to recruit and retain bilingual and bicultural mental health providers within the system. The Solano County loan assumption program will be implemented in FY 10-11 and 11-12. Additionally, SCMH had more than 20

applications for the State Loan Assumption program and most awardees were bilingual/bicultural staff.

10. <u>Improve Mental Health Workforce Clinical and Administrative Competence</u>: SCMH has partially met this target and plans to continue implementing strategies unders this program over the three-years of WET implementation. In Year One, SCMH provided training to staff and contractors on: how to issue a RFP; how to secure a county contract; and how to draft a Board item. Additionally, SCMH received the Results Accountability workshop training on how to develop logic models and use the tool to monitor program outcomes. Finally, staff attended the Transformational Care Plan (TCP) training, which will be implemented and integrated throughout the system.

E. Below are the lessons learned from rolling out the Solano County WET Plan and implementing the programs noted above in Criterion 6.D.1-10:

Lesson #1: *Recruitment of bilingual and bicultural staff is difficult during these budget times.* Since the WET Plan was submitted, approved and implemented SCMH lost about 50 County positions. During these difficult economic times, counties are losing staff due to lay-offs and if staff leave positions, the positions are not filled. Recruitment of bilingual/bicultural staff is nearly impossible at this time. SCMH has focused efforts on increasing bilingual and bicultural staff through contract services by setting benchmarks in contract agreements with vendors.

Lesson #3: *Hard to expand internship program and supervision during difficult budget times.* SCMH staff size has decreased significantly over the past two years. Many staff are asked to do more with less. Some staff find it difficult to supervise an intern in addition to their current responsibilities.

Lesson #4: *CIT training curriculum to meet the standards of the State of California is a lengthy process.* SCMH chose to develop CIT curriculum specific to Solano County and met with consultants and experts about the guidelines for the curriculum. Still, developing the curriculum for CIT has been a lengthy process.

Lesson #5: *It is hard to balance providing mental health services and implementing WET strategies.* Counties have less mental health services to provide, and at the same time, SCMH is asking staff to attend additional training events and committee meetings. Additionally, other MHSA activities are being implemented that pull staff from providing mental health services, including the implementation of the Electronic Health Record system.

Lesson #6: *Include Human Resources in planning and implementation.* Develop means of communication between Solano County Health & Social Services, Mental Health Division and Solano County Human Resources department. Currently, SCMH is using a monthly meeting between Human Resources and the departments to provide WET updates.

F. SCMH has identified technical assistance needs with identifying best practice or evidence based training for the following areas:

- Using interpreter services effectively while providing mental health services.
- Increasing interpreter skills to provide appropriate bilingual and bicultural mental health services.
- Creating practices to verify bilingual abilities, especially providing bilingual mental health services.

SCMH also recommends that DMH provide technical assistance to counties on how to secure approval of CIT curriculum through California Department of Justice, Commission on Peace Officer Standards and Training. SCMH recommends that DMH and California Department of Justice, Commission on Peace Officer Standards and Training create a collaborative relationship in order to increase awareness, understanding and communication about the process.

Final Thoughts and Vision

SCMH can create a workforce that reflects the diversity of the individuals and families and communities served that are culturally and linguistically competent; embeds wellness and recovery in training and educational programs; bases employment on the competencies needed in mental health roles; and creates career pathways from entry-level positions to leadership roles. Lastly SCMH can create avenues for individuals with lived experience and their families, expanding employment opportunities for employment at every level of the mental health system; and sharing in a vision that wellness represents an individual's ability to live their life fully integrated in their community.

CRITERION 7:
COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

Accurate and effective communication is crucial to successful mental health treatment. Effective communication can help raise awareness of risks, solutions, provide the motivation and skills needed to reduce these risks, help individuals find support from other people in similar situations, and affect or reinforce attitudes according to multiple studies regarding general health communication. Consumers and family members must be able to convey their needs and concerns in the language of their choice for the most effective communication. In addition, SCMH recognizes the benefit bilingual/bicultural staff provide establishing effective means of communication. Criterion 7 details how Solano County Mental Health (SCMH) meets the linguistic needs of Limited English Proficiency (LEP) individuals seeking mental health services.

I. Building Capacity of Bilingual Workforce

A. SCMH is implementing a number of strategies to increase the capacity of the public mental health system to provide bilingual services to consumers and family members in their preferred language. For example, Workforce Education & Training (WET) Plan, Community Service and Support Plan (CSS), Prevention and Early Intervention, and Innovation integrate bilingual services into implementation strategies. Below are details about these strategies.

1. As seen in attachment 47, SCMH WET Plan includes specific strategies to build bilingual staff capacity within SCMH to address language needs within the system, including:
    a. Develop Recruitment and Training Plans for Specific Underserved Populations: this program aims to outreach to and engage specific un/underserved populations, including bilingual/multilingual populations. Additionally, this program aims to recruit bilingual/multilingual staff through the state and local loan assumption program and an expanded intern/volunteer program. Finally, this program creates learning collaboratives among bilingual staff to provide support, share resources, and discuss cases.
    b. Build capacity of SCMH to provide bilingual services: this program includes three main strategies: provide training to SCMH staff on how to use the CTS LanguageLink to access and utilize interpreter services; provide education, training, and assessment to SCMH staff providing bilingual mental health services; and provide training to staff to develop skills in using interpreters to provide mental health services.
    c. Expand Internship and Supervision Program: under this program, SCMH has expanded and will continue to expand internship opportunities within the public mental health system, including expanding the number of bilingual interns.
    d. Loan Assumption Program: The state and local loan assumption programs forgive a portion of mental health providers' educational loans. Most awards for the state loan assumption program were granted to bilingual staff. The local loan assumption program will start this Fiscal Year (FY), and target bilingual and bicultural staff.

2.1 Currently, 29 SCMH staff members receive bilingual pay (pay differential): all but one speak Spanish (Solano County's threshold language). Bilingual staff are required to provide at least 50% of their time providing bilingual services in order to receive

the pay differential (or one time a day). Specifically, CSS has implemented the following strategies to increase bilingual staff:

a. Expanded Foster Family and Bilingual Support Program: under system development SCMH expanded resources and services for foster family children/families and bilingual children/families.
b. Mental Health Services Act Continuum of Care Contracts: Six CSS contracts, which include the following services: Older Adult Full Service Partnership, Transitional Age Youth Full Service Partnership, and Wellness and Recovery Services were awarded earlier this year. The Request for Proposal included requirements for bilingual services. Consequently, two agencies that provide bilingual/bicultural services were awarded. Additionally, all contracts included benchmarks for contractors to hire bilingual and bicultural staff.

2.2 Additionally, all PEI Initiatives include bilingual services as a strategy to reach out to and engage un/underserved populations. Hence, of the people served by the 0-5 PEI Initiative, 34% spoke Spanish as their primary language.

2.3 The Innovation Plan will provide mobile mental health services to un/underserved populations; consequently, the contractor will hire bilingual/bicultural staff to serve underrepresented populations.

3. In Fiscal Year (FY) 2010-11, Solano County budget includes $35,944 for interpreter services (Attachment 30) through CTS LanguageLink and $42,250 for pay differential for SCMH staff (Attachment 19).

II. SCMH Provides Interpreter Services to Persons who Have Limited English Proficiency (LEP)

A. SCMH has established policies, procedures, and practices to meet clients' language needs, including the following:

1. SCMH operates a 24-hour phone line with statewide toll-free access that has linguistic capability including use of the California Relay Service and TDD. (Attachment 48).
2. SCMH's Electronic Health Records (EHR) steering committee meets monthly, and regularly consults with the Cultural Competency Coordinator to ensure new technologies builds SCMH capacity to increase language access to underserved populations.
3. SCMH developed and implemented a protocol for implementing language access through the 24-hour phone line with statewide toll-free access. (Attachment 49)
4. CTS LanguageLink provided initial training for SCMH on the use of their interpreter services. (Attachment 50). The Cultural Competency Coordinator provided additional training and will facilitate quarterly system-wide interpreter trainings in Fiscal Year 2010/11 in order to ensure new staff are trained and all staff are able to access this essential service.
5. SCMH policy and procedure AAA 2.2 (attachment 1) Providing Language Services includes provisions to make services available to all consumers who need them in a manner that promotes, facilitates, and provides the opportunity for their use.
6. SCMH policy and procedure AAA 2.3 Ensuring the Provision of Multi-Cultural/Lingual Mental Health Services includes provisions that services are available to all beneficiaries who need them in a manner that promotes, facilitates, and provides the opportunity for use of services. (Attachment 2)

7. SCMH policy and procedure AAA 2.14 Recruiting Culturally Sensitive Staff includes provisions to recruit, hire, retain and promote persons whose cultural/ethnic, experiential and/or linguistic backgrounds facilitate the provision of clinically responsive services to all population groups in Solano County. (Attachment 51).

B. SCMH informs consumers of their right to services in their primary language through posters at each of the clinic sites. (Attachment 51)

C. SCMH accommodates persons who have LEP by using bilingual staff and interpreter services. (Attachment 46)

D. Lessons learned and historical challenges include:
   - Monolingual Spanish speaking families often have some psychosocial stressors e.g. legal/immigration concerns, isolation from family support, lack of insurance, underemployment which results in increased need of comprehensive case management. Often the provision of these services takes additional time and presents unique challenges to staff. Staff providing services to bilingual/bicultural (Spanish speaking) consumers have established a biweekly clinical support meeting to share community resources and professional support.

E. SCMH does not have technical assistance needs for this issue at this time.

III. SCMH Provides Bilingual Staff and/or Interpreters for the Threshold Languages at all Points of Contact.

A. SCMH notifies all consumers of mental health services that services are available in the language of their choice through posters that are placed in clinics throughout the mental health system. (Attachment 51)
B. Consumers are offered interpreter services. The acceptance or refusal of this service is then documented in their chart. (Attachment 52)
C. Bilingual SCMH staff complete a log documenting any services provided in a language other than English. (Attachment 53)
D. SCMH staff must pass written and spoken literacy exams in order to be deemed bilingual and receive bilingual differential pay.

IV. SCMH Provides Services to all LEP clients not Meeting Threshold Language

A. SCMH policies, procedures, and practices include the capacity to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g. LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.
B. SCMH has a written plan to assist consumers who do not meet the threshold language criteria secure culturally and linguistically appropriate services. (Attachment 49)
C. SCMH policies, procedures and practices comply with Title VI of the Civil Rights Act of 1964 (Attachment 49)

V. SCMH Provides Required Translated Documents, Forms, Signage, and Client Informing Materials

A. SCMH has the following culturally and linguistically appropriate written information for threshold languages available for review during the compliance visit:
   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
   9. Evidence of appropriately distributed and utilized translated materials.

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

C. SCMH provides the consumer satisfaction survey translated in the threshold language, including a summary report of the results.

D. SCMH has developed mechanism for ensuring accuracy of translated materials in terms of both language and culture

E. SCMH has developed mechanism for ensuring translated materials is at an appropriate reading level

Spanish is the threshold languages for Solano County. SCMH provides information and mental health services in the language requested.

CRITERION 8:
COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

Criterion 8 details how consumers of mental health services in Solano County are ensured effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and in their preferred language.

I. SCMH Has Client Driven/Operated Recovery and Wellness Programs

A. Solano County Mental Health's (SCMH) client-driven/operated recovery and wellness programs are listed and described below:

- Forensic Assessment Community Treatment (FACT) Program uses Moral Recognition Treatment (MRT) which focuses heavily on personal responsibility. A standard is that one treatment goal of consumers in the FACT program is specifically wellness/recovery related.
- Neighborhood of Dreams provided Wellness & Recovery services to consumers throughout Fiscal Year 2009/10 at sites in Dixon, Fairfield and Vallejo. Each of these sites conducted regular classes on Wellness & Recovery Action Plans (WRAP) development and maintenance. Regular co-facilitated meetings were held at each of these sites to elicit members' feedback regarding central issues such as programming. Each site employed consumers who were encouraged to share members' feedback in staff meetings.
- There are a number of consumer employees including Parent Partners in Children's Units who work throughout the SCMH system. Notably the Consumer Affairs Liaison who is a consumer is a respected member of management and participates in key meetings throughout the system.
- Faith in Action's Senior Peer Counseling Program trains seniors as peer counselors to provide in-home counseling to homebound seniors and to facilitate group counseling sessions. Faith in Action programs are staffed primarily by volunteers who are actively involved at all levels throughout the organization. As a result Faith in Action is largely consumer operated. Specific strategies to outreach to underserved seniors including those over eighty five have been included in the scope of work.

II. Responsiveness of Mental Health Services

A. SCMH has documented evidence that contractors have available alternatives and options that accommodate individual preference or cultural and linguistic preferences as highlighted below:

- Forty percent of consumers served by the SCMH Prevention & Early Intervention's (PEI) Partnership for Early Access for Kids (PEAK) initiative have been Latino and 34% have been Spanish speakers. Services, including groups and classes, offered in Spanish by bicultural staff will continue to attract Latino/Spanish speakers.
- In Fiscal Year 2009/10 Neighborhood of Dreams provided Wellness & Recovery services by bilingual/bicultural (Spanish speaking) in Dixon which has a high population of Latino/Spanish speakers.

- Two new contractors, California Hispanic Coalition and La Clinica de la Raza, have expertise in providing services to Spanish speakers. Both agencies have high percentages of bilingual/bicultural (Spanish speaking) staff.

B Consumers of mental health services in Solano County are informed of the availability of alternative treatment options in the member services brochure. (Attachment 54)

C. SCMH informs Medi-Cal beneficiaries of available services through outreach and educational events. (Attachment 55)

D. The north county city of Vacaville has a high rate of Spanish speaking residents. Consequently, more Spanish speaking county mental health service providers are stationed in Vacaville. To better meet the need of this community by identifying gaps in services and available resources, county mental health staff have established a collaborative meeting of Spanish speaking community providers. This has increased access to mental health and supportive services for Spanish speaking consumers/families living in Vacaville.

III. SCMH Quality of Care: Contract Providers

A. SCMH takes into account contractors' ability to provide culturally competent mental health care when selecting contract providers. Participants who reviewed the Request For Proposals (RFP) submitted for Mental Health Services Act Continuum of Care services were given explicit guidelines regarding the evaluation of proposals. They were instructed to evaluate proposals according to the following criteria:

- How key activities will be targeted to specific populations
- How outreach and education will be provided to community providers
- How services provided will be culturally competent and offered in appropriate language(s) for the populations served
- How disparities in access to mental health services throughout the county, including disparities in access for cultural populations and geographic locations will be addressed.
- How stigma and discrimination faced by those at risk of or experiencing mental health issues will be addressed.

IV. SCMH Quality Assurance

A./B. SCMH values the input of consumers/family members, and staff and uses this data for continuous quality improvement. Specifically, SCMH distributes consumer/family member and staff satisfaction surveys twice a year. (Attachment 56) The satisfaction survey distributed to SCMH staff includes two questions designed to gauge staff opinion regarding the provision of cultural and linguistic services. (Highlighted in Attachment 57) The results of these surveys are reviewed at manager's meetings, Quality Improvement Committee, Consumer/ Family Member Advisory Committee (CFAC),

Solano County Chapter of the National Alliance on Mental Illness (NAMI), Cultural Competency Committee and at the Local Mental Health Board.

C. SCMH grievances and complaints are reviewed and reported on at the monthly Quality Improvement Committee (QIC). Trends regarding programs and types of grievances are closely monitored and reported to QIC and SCMH administration. Currently, the demographic information of consumers filing grievances and complaints is not collected. This is currently being reviewed for possible inclusion moving forward.

Solano County, similar to many counties in California and much of the United States, is a diverse and multicultural community. The provision of effective county mental health services must include clear policies, procedures, guidelines, practices, trainings, and etc. that teach, direct and oversee the efforts of SCMH staff to respond effectively to the needs of individuals and families from racially, ethnically, culturally and linguistically diverse groups. SCMH is committed to reducing the mental health disparities of underserved populations thereby improving the mental health outcomes of all of Solano County.