TRI·CITY
Mental Health

TRI-CITY MENTAL HEALTH THREE-YEAR CULTURAL COMPETENCE PLAN

FY 2020-21 – FY 2022-23

California Department of Mental Health Cultural Competence

COVER SHEET

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CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

X	**Criterion 1.** Commitment to Cultural Competence
X	**Criterion 2.** Updated Assessment of Service Needs
X	**Criterion 3.** Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
X	**Criterion 4.** Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System
X	**Criterion 5.** Culturally Competent Training Activities
X	**Criterion 6.** County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
X	**Criterion 7.** Language Capacity
X	**Criterion 8.** Adaptation of Services

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction to Tri-City Mental Health Authority

Since 1960, Tri-City Mental Health has served as the mental health provider for the tri-city area. Through a Joint Powers Authority, Tri-City serves in a "county" capacity for the purposes of delivering quality mental health services for the cities of Claremont, La Verne, and Pomona with a combined population which exceeds 220,000. While these three cities are considered integrated into a single "county", there are distinct differences in the demographics and populations of each city.

Through this Three-year Cultural Competence Plan, Tri-City Mental Health renews its commitment to deliver quality and individualized care tailored to the social, cultural and linguistic needs of clients and community members residing within the catchment area. As a culturally proficient health care provider, Tri-City distinguishes itself as a leader in health care services focused on recovery with a person-centered approach.

Tri-City engages with community members who contribute to the universal goals of reducing health care disparities and promote diversity within the agency and the community served. Through the development of active partnerships with cultural groups including the Cultural Inclusion and Diversity Committee (CIDC), the African American Family Wellness Advisory Council (AAFWAC), ¡Adelante! Latinx Wellness Advisory Council and the LGBTQ+ Advisory Council, Tri-City is able to address challenges related to accessing services including language barriers, health education and cultural differences in communication styles.

Ongoing cultural and humility training continue to be the collective thread that infuses the daily work of Tri-City staff. These comprehensive trainings contribute to the behaviors, attitudes and policies that support a climate of inclusion and respect for all. These efforts include addressing language barriers by providing bilingual clinicians and staff as well as interpreter services and multi-language materials. Through the collective impact of a diverse workforce, Tri-City is not only able to provide services to most clients in their own language, but also develop strong, reciprocal relationships with local cultural brokers.

Data collection and program outcomes continue to be a driving force behind the development of programs through the Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Workforce Education and Training (WET) plans. Community assessment surveys, focus groups and stakeholder meetings are just a few of the ways Tri-City has reached out to the community to request their input and insights into the current needs, desires, and challenges of the people we serve. Each of these options are delivered in both English and Spanish, which is the identified threshold language for this area.

The following document reflects a systematic update to Tri-City's previous Cultural Competence Plan (2010), includes new initiatives and focuses on leadership and delivery of culturally relevant services dedicated to the undisputable call for health care equity.

CRITERION 1. COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

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

A. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:
   1. Mission Statement;
   2. Statements of Philosophy;
   3. Strategic Plans;
   4. Policy and Procedure Manuals;
   5. Other Key Documents

As a culturally competent health care agency, Tri-City Mental Health recognizes its' important contribution to eliminating disparities and promoting health equity within the cities of Claremont, La Verne and Pomona. By acknowledging the importance of an individual's cultural beliefs and affiliations, Tri-City is better able to effectively deliver services across different cultural groups, better anticipate and respond to barriers to seeking treatment, and increase the likelihood of follow-through with aftercare. By consistently reviewing staff behaviors, attitudes and agency policies, Tri-City increases its capacity to understand, communicate with, and effectively interact with individuals across all cultures.

When considering the diverse needs and population of the three cities Tri-City serves, true cultural competence demands more than just an awareness of cultural differences, customs and values. It requires a higher level of commitment from Tri-City staff to critically reflect on their own personal world views, acknowledge any implicit biases they may have, and to treat each and every person who comes through our doors with the respect they are entitled to, while acknowledging their individual values and beliefs. The following statements reflect this assurance to our clients, family members and community partners.

Cultural Competence Committee

In July 2010, Tri-City Mental Health developed a comprehensive Cultural Competence Plan based on criteria provided by the Office of Multicultural Services/Department of Mental Health. At this time, Tri-City established the Cultural Competency Committee (CCC) to reduce mental health disparities and support the agency's assessment, evaluation and development of culturally competent and linguistically appropriate policies, programs and services offered within the three cities of Claremont, La Verne and Pomona.

See Criterion 4 for more information.

Outreach and Engagement

For over a decade, community outreach and engagement continue to be the driving force behind the creation and implementation of programming and services offered by Tri-City Mental Health. Acting on

behalf of unserved and underserved communities demands a commitment to building a lasting relationship with individuals who are looking for change but may not be able to voice their needs. Flyers and outreach materials are available in Spanish for community stakeholder events, as well as in Vietnamese and Korean for the annual Public Hearing. Advertisements for these public events are also circulated in the local bilingual newspaper, La Nueva Voz. Since COVID-19, Tri-City has continued to maintain a strong connection with the community through social media, informational webinars, telehealth, and personal phone calls.

Diverse Hiring Practices

Tri-City has long maintained a commitment to diverse hiring practices with the goal of attempting to match our staff with the diverse population of the cities we serve. By striving to implement bias-free hiring practices, candidates are considered based on merit with a focus on skills and abilities versus a candidate's age, race, gender, religion, sexual orientation, and other personal characteristics that are unrelated to their job performance.

Language Assistance and Interpreters

Bilingual staff are available to meet the language needs of our community members. Beginning with the receptionists, the first point of contact for our clients, these staff are trained to assist individuals whose native language is not English with the goal of avoiding communication barriers and reducing client frustrations. By communicating with clients in their preferred language, staff are better able to build rapport with consumers who may otherwise feel alienated or misunderstood. Spanish language interpreters as well as Spanish translated documents (flyers and presentation slides) are also available at public stakeholder meetings.

See Criterion 7: Language Capacity for more information

Mission Statement for Tri-City Mental Health

By understanding the needs of consumers and families, Tri-City provides high quality, culturally competent behavioral health care treatment, prevention, and education in the diverse cities of Pomona, Claremont, and La Verne.

Core Values

Tri-City Mental Health remains a steadfast community partner, supporting and sustaining an integrated system of care for individuals experiencing mental health conditions and their families. In the spirit of collaboration and accountability, Tri-City has developed a set of core values that reflects this commitment and provides the guidance necessary to meet the needs of the individuals and communities we serve:

Person and Family Centered

Tri-City Mental Health Services is dedicated to creating a safe and comprehensive approach to care, where individuals and their family members can access a full range of mental health services available through multiprogramming options based on each person's preferences and goals for recovery.

Recovery Focused

By embracing the belief that recovery is possible, Tri-City staff encourages individuals to identify and build upon their own strengths and abilities as they work to achieve their goals. By demonstrating a strong integrated approach to service, clients and family members are provided access to multiple levels of treatment and support through a collaborative system of care.

Culturally Responsive

By improving the accessibility of mental health programs for unserved and underserved communities and the diversity represented by quality staff, Tri-City's responsive approach is instrumental in overcoming cultural and economic barriers to service by respecting the values and beliefs embedded in each individual we serve.

Quality Based

Through a commitment to excellence in hiring practices and workforce enrichment, Tri-City staff continues to provide the highest quality care that is evidence-based, research-informed and client-driven. Tri-City staff are valued and supported in a quality work environment that focuses on the mental health needs of our clients and the professional requirements of our employees.

Community Guided

Through engagement and collaboration, Tri-City strives to strengthen relationships with people receiving services, their family members and local partners by evaluating and continuing to transform our integrated system of care. By systematically addressing stigma and community wellness, Tri-City is committed to providing educational opportunities and trainings in an effort to support this transformation.

Accountability Driven

Tri-City remains committed to the continuing and evolving needs of the community and the people we serve by practicing financial stewardship and accountability for the funding entrusted to us. Beginning with an internal commitment to excellence, Tri-City employees are offered a unique opportunity to serve with one of the leading agencies in community mental health.

Policies and Procedures

The following documents are available onsite during the compliance review:

- Beneficiary Complaint Grievance and Appeals
- Language Interpreters Policy
- The Recovery Model
- Code of Ethics
- Competency Development
- Employment Practices Regarding Individuals with Disabilities
- Employee Recruitment and Hiring Policy
- HIPPA Forms in Spanish Language
- Language Interpretation and Translation
- Cultural and Linguistic Inclusion and Competence
- Informing Materials Protocol
- Hearing Impaired Mental Health Access Policy
- Program Service Delivery
- The Recovery Model
- Advanced Health Care Directives
- Issue Resolution Process for Complaints, Grievances and Appeals
- Complaint Procedure Against Harassment, Discrimination & Retaliation
- Code of Ethics
- Competency Development
    - Employment Practices Regarding Individuals with Disabilities
    - Employee Recruitment and Hiring Policy

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

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.
B. A one-page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.
C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

Community Outreach and Engagement Activities for CSS Plan (2009)

In preparation for the Community Service and Supports (CSS) Plan, Tri-City staff reached out to consumers, family members and community leaders across the region, and began fostering relationships that were generating contacts from people from traditionally unserved/underserved groups and others who were interested in learning more about supports that may be available to them. A total of 48 delegates participated in the CSS planning processes, representing a wide array of constituencies and stakeholders. Tri-City solicited applications for the delegate positions through early outreach efforts, particularly targeting representation from unserved and underserved constituencies. Tri-City also publicized the application through local newspapers to help attract candidates who might not already have a relationship with Tri-City Mental Health. Staff then analyzed the final roster of nominations to maximize diversity of representation before submitting it to the Tri-City Governing Board for approval.

Of the 48 delegates:

- At least 17% had received mental health services, and at least 21% were family members;
- 19% were African American, 6% were Asian and/or Pacific Islander, 21% were Latinx, 1 delegate was Native American, and 46% were White;
- 6 delegates were fluent in Spanish, 2 in Tagalog, and 1 in Chinese Mandarin and Taiwanese;
- 35% were men and 65% were women;
- 52% lived in Pomona, 23% in Claremont, 19% in La Verne, and 6% lived outside the three cities;
- 4 were children's advocates, 4 were transition age youth (TAY) advocates, and 3 were older adult advocates.

Other represented constituencies included persons with co-occurring disorders; persons experiencing homelessness or unemployment; immigrants; people with disabilities; and people identifying as LGBT. City

and county departments represented included law enforcement, probation, LA County Board of Supervisors, LA County Department of Mental Health, and Congressman David Dreier's office.

Identifying Cultural Communities with Mental Health Disparities

Demographic data suggest that boys and young men receive more services than girls and young women (ages 0-25), though we have no data to suggest a disproportionate prevalence of mental health conditions among boys. Moreover, across all age groups there is essentially a 50/50 split between males and females in the three cities. Therefore, Tri-City created slightly higher targets for girls and young women than boys and young men. Demographic data indicate Asian and Pacific Islander (API) residents across all age groups receive fewer services than their population numbers would indicate; this is also true for Latinx adults and older adults. White and African Americans residents receive more services than their population numbers would indicate, though unmet need is substantial across all populations. Therefore, we are creating slightly higher targets for API residents across all age groups, and Latinx adults and older adults, than their population numbers would indicate. The numbers and percentages for non-English speaking people are included in the totals for each gender, and therefore do not separately contribute to the total for each category.

The following observations noted in Tri-City's Community Services and Supports Plan (2009) reflect the service patterns among the different ethnic and age groups in the tri-city area at that time:

- Significant percentages of people of all ages who likely qualify for publicly funded services are not receiving any service: 84.47% of children, 70.79% of TAY, 49.39% of adults, and 91.81% of older adults.
- The Asian and Pacific Islander ethnic population is underrepresented in the mental health system across all age groups. Asian and Pacific Islanders comprise almost 8% of the total population, and 7% of the population under 200% of the federal poverty threshold, but are only 3% of the population receiving children's services, 2% of the population receiving TAY services, 4% of the population receiving adult services, and currently receive no older adult services.
- Latinx children and TAY are served at rates almost equal to their percentage representation within the 200% Federal Poverty population. Latinx adults and older adults, however, are proportionately underrepresented in the mental health system. Latinx adults are 64% of the adult federal poverty population, but only 39% of the adults receiving mental health services. For Latinx older adults, the percentages are 64% and 40% respectively.
- African American representation within the mental health system is consistently higher for all age groups than the group's representation among the population below 200% of Federal Poverty guidelines. These higher utilization rates, as noted in the Tri-City Mental Health System's Community Services and Support Plan April 2009, may suggest that African

Americans are receiving disproportionate referrals to the mental health system, or are being inappropriately served.

- African American adults are 21%, and white adults are 31%, of the adult population receiving mental health services in the tri-city area. According to the 2008 San Gabriel Valley Regional Homeless Services Strategy Phase I Report, however, African-Americans comprise 36%, and Whites 37%, of the homeless population in the region that includes Claremont, La Verne, and Pomona. This data suggests that, taking homelessness into account, African American and White adults may actually be underserved.
- Native Americans represent a small percentage of the 200% poverty population in the tri-city area, approximately 2%. Frequently, however, Native Americans are significantly underreported or misreported in the census data. For example, many Native Americans identify themselves as Hispanic thereby understating the Native American population. Interestingly, the Los Angeles metropolitan area is home to the largest urban concentration of Native Americans in the United States, and Pomona is one of six cities in Los Angeles County with the highest clusters of Native Americans in Los Angeles. These bits of information suggest that there may be more Native Americans in the tri-city area than captured by current census data. Even at 2% of the area's 200% poverty population, however, only Native American adults are receiving commensurate services at 3%.

County's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee

In conjunction with the development of the Cultural Competence Three-Year Plan, Tri-City hosted five focus groups during the months of October and November 2020, consisting of the individuals representing the top cultural populations, many considered to be unserved and underserved, residing in the cities of Claremont, La Verne, and Pomona. The objective was to engage cross-cultural individuals within the tri-city area to provide feedback regarding their experience and perception of the cultural competency and diversity of programming and delivery of services by Tri-City Mental Health. These individuals provided solid recommendations that target unserved and underserved communities, including Black, Indigenous and People of Color (BIPOC) and LGBTQ+, by informing this agency's plan to meet their cultural and linguistic needs.

Cultural Inclusion and Diversity Committee

The Cultural Competency Committee (CCC) reconvened in January 2017 and redefined their structure and mission as the agency's leading body for cultural competence. In recognition of the agency's growth and diversity, the CCC broadened to include staff from all departments within Tri-City's System of Care including Clinical services, MHSA programs, Operations and Facilities and Best Practices.

African American Family Wellness Advisory Council (AAFWAC)

The African American Family Wellness Advisory Council (AAFWAC) was established in December 2019. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral.

¡Adelante! Latinx Wellness Advisory Council

¡Adelante! Latinx Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to instill hope and wellness by empowering community members within the Latinx community to advocate and share their experience, knowledge and feedback.

LGBTQ+ Wellness Advisory Council

The LGBTQ+ Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback.

Asian American and Pacific Islanders (AAPI) and Native Indigenous Communities

Asian American and Pacific Islanders (AAPI) and Native Indigenous communities have also been identified as unserved and underserved populations in the Tri-City service area. Over the next three years, the CIDC plans to outreach and engage with these communities to develop advisory councils, with the intention to empower members to advocate their community's mental health needs and bridge gaps in delivery and access to services.

Lessons learned on efforts made and identified county technical assistance needs

Tri-City acknowledges the difficulty in outreaching to community members and organizations to engage in participation during the COVID-19 pandemic. Meetings are offered virtually given current physical distancing and preventative measures, which may be a challenge to members with limited or no access to technology. As the Tri-City advisory councils are in the early developmental stages, we have recognized the importance of having feedback and recommendations from each of these targeted communities. Advisory councils have shared crucial feedback regarding the enhancement of culturally competent services at Tri-City and have participated in a multitude of focus groups and surveys.

Community Input and Recommendations for Cultural Inclusion

Cultural Competence Survey and Focus Group

In 2020, Tri-City engaged Black, Indigenous People of Color (BIPOC) and LGBTQ+ community members to participate in Cultural Competence Focus groups with the intention of providing this agency with a clearer

window into the cultural disparities and inequities that make up their daily lives. Many of these individuals come from a position of strength and resilience mixed with a history of trauma and discrimination. With the recent tragic events involving racism and civil unrest, Tri-City extended a sincere invitation to people of color and LGBTQ+ advisory groups to share their perceptions and frustrations as Tri-City looks to rewrite our action plan for cultural competence and inclusion within this agency. The findings of these groups are documented below.

As a mental health agency, Tri-City has strived to deliver culturally and linguistically appropriate services for the past 60 years. However, as community members respond to the current COVID-19 restrictions and uncertainty of the political climate, Tri-City has chosen to take a careful look internally and examine current therapeutic practices and personal biases to evaluate how our BIPOC communities are served. This commitment to reassess this Agency and rewrite our Best Practices is long overdue. Over the next three-year, Tri-City Mental Health will continue to encourage and host these crucial conversations with BIPOC communities until we are able to balance our approach to treatment to better serve the needs of these individuals.

Recommendations to Tri-City staff by participants regarding steps that would improve cultural linguistic competence when creating programs and delivering services include:

- Continue fostering the development of the four cultural advisory councils and encourage community participation.
- Engage community partners who serve and support targeted unserved and unserved community to build an alliance and bridge access to services offered by Tri-City.
- Provide cultural-sensitivity trainings for community members with a focus on mental health.
- Ensure all collateral materials (flyers, forms, resources, website) are available in all threshold languages.
- *Research and model best practices from other community agencies to obtain client/community feedback. What are their best practices we can learn from? What is working and what is not?*
- *Host focus groups in English/Spanish throughout the community to learn what they think about Tri-City and how we can better serve their members.*
- *Be consistent with these focus groups. Building trust and establishing solid relationships with the community through these focus groups can contribute to establishing a level of trust and knowledge demonstrating that Tri-City cares about their needs.*
- *It is important for Tri-City to understand what culture means to each individual and be aware of how culture plays an important component in daily lives.*

Being able to effectively communicate with a client is vital to establishing and maintaining a positive therapeutic relationship. When asked to share what elements of their culture they feel are critical to share with therapist, participants responded with the following:

- African Americans may avoid eye contact with those in authority. Eye contact may appear as a sign of aggression.
- Eye contact is limited among Asian American and Pacific Islanders. This is a sign of respect. Staring may be perceived as rude or challenging.
- *Help the client to feel comfortable by extending a warm and friendly manner and approach. Asking the client how they would want to be addressed as (example: Sir, Ma'am, etc.).*
- *Confidentiality is very important.*
- *Understanding family roles. In the Hispanic culture, the father is seen as someone very important in the family. Even if the services are for their children or wife, always taking the father into consideration is very important because he is seen as the head of the home.*
- *Asking if the client wants services in-person or virtually.*
- *Understanding the history and trauma of the client.*
- *Honoring the family relationships and cultural difference, not judging the clients. Understand why a Sikh client would wear a turban and why uncut long hair is so important to him or her.*
- *Understanding that Black Lives Matter and we were not brought here by choice.*

Language is a one of the most critical components of any culture. Focus group participants offered suggestions on how a therapist's language style or approach to questions can be altered to limit unintended cultural insensitivity.

- Use person-centered language.
- Ask about gender pronouns to avoid mislabeling.
- Practice the approach of not assuming, and being open-minded.
- Language literacy level – Language should be jargon free and at a 5th grade literacy level when communicating with consumers (i.e. both print and verbal communication).
- Limit the use of acronyms and technical terminology.

See Criterion 4 for additional information.

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

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

Rimmi Hundal, MA
Director of MHSA and Ethnic Services
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2001 N. Garey Ave
Pomona, CA 91767

Rimmi Hundal has served as the Ethnic Services Manager for Tri-City Mental Health since 2010. Over the past decade, she has sustained a career-long commitment to developing and disseminating culturally and inclusive trainings, practices and policies for the community we serve. Ms. Hundal is responsible for overseeing all non-clinical MHSA programs and to insure Tri-City's adherence to the Mental Health Services Act include effective and sustained engagement of its community stakeholders; the development of culturally appropriate and community-endorsed programming; and ensuring the tracking and reporting of quality improvement data include performance measures and consumer satisfaction surveys and annual reporting to State agencies. Her experience includes working with under achieving youth, integrated behavioral health care, addressing mental health disparities and training others in cultural humility.

Through her strong community connections and compassion for unserved and underserved individuals, Ms. Hundal was instrumental in the creation of Tri-City's original Cultural Competence Plan focusing on empowering community members of color to be a voice of change while contributing to the direction of program development and service delivery. In addition, Ms. Hundal sits on the California Behavioral Health Directors' Association Committee on Social Justice and Equity.

Job duties for the Ethnic Services Manager include but are not limited to:

- Responsible for the development and implementation of the Agency's Cultural Competency Plan; oversee and coordinate training and development of staff regarding issues of cultural competence.
- Develop and implement strategies to achieve a culturally competent system of care.
- Identify behavioral health needs of ethnically and culturally diverse populations as they impact Tri-City's system of care, make recommendations to the Executive Team, coordinate and promote quality and equitable care.
- Develop and implement translation and interpretation services

- Attend regional and state meetings related to MHSA and Cultural Competency planning and implementation.
- Provides routine performance analysis of the Agency as it relates to Cultural Competency.

IV. Identify budget resources targeted for culturally competence activities

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:
   1. Budget amount spent on Interpreter and translation services;
   2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
   3. Budget amount allocated towards outreach to racial and ethnic county-identified target populations;
   4. Special budget for culturally appropriate mental health services; and
   5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

Culturally competence activities and services continue to be a priority at Tri-City. As it is an integral part of our system of care, Tri-City annually incorporates various types of costs within its budget. Examples of costs dedicated to cultural competency, including costs associated with activities and programs supported by Tri-City, are listed as follows:

- Interpreter and Translation Services: On an annual basis, Tri-City dedicates approximately $10,000 on services that assist with the translation of documents, advertisement in local newspapers, and in having translators available for various public community meetings.
- Training: Annually, Tri-City makes available various training opportunities for staff. Training may include on-site guest speakers, in-person training courses including conferences, and mandatory annual online cultural competency courses for all staff. Tri-City annually budgets roughly $15,000 to $20,000 for guest speakers that focus on cultural diversity and inclusion. In addition, Tri-City currently renews its annual subscription to an online suite of training courses with a variety of topics, including cultural competency. The costs of this e-learning subscription, which is made available to all staff, is approximately $30,000 per year.
- Outreach and Culturally Appropriate Mental Health Services: Tri-City's totally annual budget is approximately $27 million which includes the operations for its Outpatient Clinics for Children, Transition Age Youth, Adults and Older Adults that deliver mental health services to the residents of Claremont, La Verne and Pomona. Tri-City also offers an array of services and has developed various programs, all of which include and are centered around reaching targeted populations. For example, the focus of Tri-City's Community Capacity Building Programs is to support unserved and underserved populations within the cities of Claremont, La Verne and Pomona. These diverse communities include children, adults,

older adults and families of various ethnicities, socioeconomic backgrounds, religious affiliations, and experiences. Tri-City's Wellness Center sponsors support groups and is a community hub for activities that promote recovery, resiliency and wellness for residents of the Tri-City area. The various programs and services made available by Tri-City include these programs and their annual budget for Fiscal Year 2020-21 are as follows:

- The Wellness Center: $1,466,863
- Community Navigators: 474,626
- Supplemental Crisis Services/Intensive Outreach and Engagement: $738,863
- Field Capable Clinical Services for Older Adults: $108,178
- Community Capacity Building: $489,813
- Peer Mentor, Family Wellbeing and Community Wellbeing Programs: $383,019
- Therapeutic Community Gardening: $316,594
- Housing Stability: $316,594

CRITERION 2. UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected: locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.

Tri-City Mental Health was established in 1960 through a Joint Powers Authority (JPA) Agreement between the cities of Claremont, La Verne, and Pomona to deliver mental health services to the residents of the three cities. Claremont is located 30 miles east of downtown Los Angeles in the Pomona Valley, at the foot of the San Gabriel Mountains. Claremont is home to the Claremont Colleges, tree-line streets and numerous historic building. Located to the west of Claremont is the city of La Verne. Originally named Lordsburg, La Verne was known as the "Heart of the Orange Empire" due to the flourishing citrus trees

which dominated the area until World War II. The largest city to make up the Tri-City area is Pomona, which is located just south of the city of La Verne. The Tri-City area is also home to seven colleges and universities.

The following is a description of the general population for these three cities.

Selected Data for Tri-City (Pomona, Claremont, La Verne) U.S. Census Data	Tri-City (Pomona, Claremont, La Verne)
Population	
Population estimates, July 1, 2019, (V2019)	219,931
Population estimates base, April 1, 2010, V2019)	215,035
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	2.3%
Population, Census, April 1, 2010	215,047
Age and Sex	
Persons under 5 years, percent	6.8%
Persons under 18 years, percent	23.8%
Persons 65 years and over, percent	12.9%
Female persons, percent	51.2%
Race and Hispanic Origin	
White alone, percent	56.2%
Black or African American alone, percent	5.5%
American Indian and Alaska Native alone, percent	1.6%
Asian alone, percent	10.6%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%
Two or More Races, percent	4.8%
Hispanic or Latinx, percent	58.8%
White alone, not Hispanic or Latinx, percent	23.0%
Population Characteristics	
Veterans, 2014-2018	6769
Foreign born persons, percent, 2014-2018	29.0%

Housing	
Owner-occupied housing unit rate, 2014-2018	57.5%
Median value of owner-occupied housing units, 2014-2018	$525,033
Median selected monthly owner costs -with a mortgage, 2014-2018	$2,350
Median selected monthly owner costs -without a mortgage, 2014-2018	$579
Median gross rent, 2014-2018	$1,450
Families and Living Arrangements	
Households, 2014-2018	62,200
Persons per household, 2014-2018	3.54
Living in same house 1 year ago, percent of persons age 1 year+, 2014-2018	86.0%
Language other than English spoken at home, percent of persons age 5 years+, 2014-2018	53.9%
Computer and Internet Use	
Households with a computer, percent, 2014-2018	92.2%
Households with a broadband Internet subscription, percent, 2014-2018	84.8%
Education	
High school graduate or higher, percent of persons age 25 years+, 2014-2018	60.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2014-2018	26.9%
Health	
With a disability, under age 65 years, percent, 2014-2018	7.0%
Persons without health insurance, under age 65 years, percent	11.9%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2014-2018	62.2%
In civilian labor force, female, percent of population age 16 years+, 2014-2018	55.4%
Total accommodation and food services sales, 2012 ($1,000)	108,300
Total health care and social assistance receipts/revenue, 2012 ($1,000)	501,808
Total manufacturers' shipments, 2012 ($1,000)	436,916
Total merchant wholesaler sales, 2012 ($1,000)	891,550

Total retail sales, 2012 ($1,000)	527,015
Total retail sales per capita, 2012	$9,221
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2014-2018	29.9
Income and Poverty	
Median household income (in 2018 dollars), 2014-2018	$79,416
Per capita income in past 12 months (in 2018 dollars), 2014-2018	$34,017
Persons in Poverty, percent	16.4%

II. Medi-Cal population service needs

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:
   1. The county's Medi-Cal population (County may utilize data provided by DMH. See the Note at the beginning of Criterion 2 regarding data requests.)
   2. The county's client utilization data

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

The area served by the Tri-City Mental Health is not included in the CAEQRO data collection and TCMH is considered a medium county. Additionally, none of the three cities (Claremont, La Verne and Pomona) currently collect Medi-Cal population and client utilization data. For these reasons, Tri-City has limited information available for the Medi-Cal population. As of May 2020, there were 88,752 beneficiaries and 53% were women and 47% were men. There is no additional demographic information available for beneficiaries.

Data on Tri-City's clinical population is also provided. This represents all active clients in our clinical programs for FY 19-20 which is a total of 2,816 unduplicated clients:

- **Race and Ethnicity:** For clients in the past fiscal year 19-20, 16% were White/Caucasian, 62% were Hispanic/Latinx, 14% were African American, 3% were Asian/Pacific Islander, 1% were Native American/Indian, and the remaining 5% were other/unknown.
- **Gender:** For clients, 55% were women and 45% were men.
- **Age:** In the past fiscal year, 16% of clients were ages 0-15, 19% were in the age group of 16-25, 56% were in the age group of 26-59, and 10% were 60 years and above.

- **Language:** The most commons languages for our clients were English 87% and Spanish 11%.

The following compares the number of clients served and Medi-Cal eligible. Gender is the only demographic variable available to the Tri-City area.

Gender	Medi-Cal Eligible	Clients Served	Penetration Rate
Men	41,364	1,270	3.0%
Women	47,388	1,544	3.3%
Total	88,752	2,816	3.1%

Analysis of disparities as identified in the above summary

Not Applicable. This information is not available for the Tri-City area.

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

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.
B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

As previously stated, the area served by the Tri-City Mental Health is not included in the CAEQRO data collection and TCMH is considered a medium county. Additionally, none of the three cities (Claremont, La Verne and Pomona) currently collect Medi-Cal population and client utilization data. For these reasons, Tri-City has limited information available for the Medi-Cal population.

An analysis of disparities is not applicable. This information is not available for the Tri-City area.

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

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.
B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Tri-City Mental Health has not conducted a CSS population assessment since 2009. Data presented here from the original CSS plan may not accurately reflect the current population and utilization data. However, Tri-City plans to reassess the CSS population and services needs over the next three years.

The following information was taken from the original CSS plan (2009):

The total population for the tri-city area is approximately 229,473 residents. Nearly equal numbers of individuals live in the cities of La Verne and Claremont. Pomona has more than twice the population of the other two cities combined.

TOTAL POPULATION BY CITY				
	La Verne	Claremont	Pomona	Tri-City Area
Total population	35, 614	36,561	157,298	229,473
Source: United Way 2007 Zip Code Data Book San Gabriel Valley				

The following tables indicate the total population by age group and ethnicity:

TOTAL POPULATION BY AGE GROUP					
City: / Age group:	La Verne	Claremont	Pomona	Tri-City Area	% by age
0-15	7,524	6,191	46,910	60,625	26.42%
16-25	4,734	4,854	21,884	21,472	13.71%
26-59	16,124	17,341	68,084	101,549	44.25%
60+	7,232	8,175	20,420	35,827	15.61%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley + extrapolation					

TOTAL POPULATION BY ETHNICITY					
City: / Ethnicity:	La Verne	Claremont	Pomona	Tri-City Area	% by ethnicity
African American	1,155	1,774	11,735	14,664	6.39%
Asian Pacific Islander	2,474	4,479	10,634	17,587	7.66%
Hispanic/Latinx	8,790	6,338	111,330	125,458	54.67%
Native American	156	94	634	884	0.39%
White	22,243	22,886	21,882	66,951	29.18%
Other	46	93	149	288	0.13%
Two or more races	750	897	1,994	3,641	1.58%
Totals	**35,614**	**36,561**	**157,298**	**229,473**	**100.00%**
Source: United Way 2007 Zip Code Data Book San Gabriel Valley					

Chart A: Estimate of Service Utilization by Race/Ethnicity [CSS Plan, 2009]

Children and Youth (Ages 0-15)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	3	55	58	21%	2,818	9%	3,874	6%

Asian Pacific Islander	6	1	7	3%	2,132	7%	4,646	8%
Hispanic/Latinx	28	144	172	62%	20,023	64%	33,145	55%
Native American	0	1	1	0%	506	2%	234	0%
White	3	30	33	12%	3,903	12%	17,688	29%
Other	0	5	5	2%	1,999	6%	1,038	2%
Totals	**40**	**236**	**276**	100%	**31,381**	100%	**60,625**	100%
Source: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Transition Age Youth (Ages 16-25)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	1	60	61	18%	1,382	9%	2,011	6%
Asian Pacific Islander	3	4	7	2%	1,045	7%	2,412	8%
Hispanic/Latinx	8	220	228	66%	9,817	64%	17,206	55%
Native American	0	3	3	1%	248	2%	121	0%
White	2	40	42	12%	1,914	12%	9,182	29%
Other	0	2	2	1%	980	6%	540	2%
Totals	**14**	**329**	**343**	100%	**15,386**	100%	**31,472**	100%
Source: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Adults (Ages 25-59)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	0	233	233	21%	2,498	9%	6,489	6%
Asian Pacific Islander	3	38	41	4%	1,890	7%	7,783	8%
Hispanic/Latinx	4	434	438	39%	17,750	64%	55,519	55%
Native American	0	30	30	3%	448	2%	391	0%
White	1	349	350	31%	3,460	12%	29,628	29%
Other	0	23	23	2%	1,772	6%	1,739	2%
Totals	**8**	**1,107**	**1,115**	100%	**27,818**	100%	**101,549**	100%
Source: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

Older Adults (Ages 60 and older)	Fully Served	Less than Fully Served	Total Served		200% Poverty Population		Tri-City Area Population	
			#	%	#	%	#	%
African American	0	5	5	14%	594	9%	2,289	6%
Asian Pacific Islander	0	0	0	0%	450	7%	2,746	8%
Hispanic/Latinx	0	14	14	40%	4,223	64%	19,587	55%
Native American	0	1	1	3%	107	2%	138	0%

White	0	12	12	34%	823	12%	10,453	29%
Other	0	3	3	9%	422	6%	614	2%
Totals	**0**	**35**	**35**	100%	**6,619**	100%	**35,827**	100%
Source: U.S. 2000 Census, United Way 2003, 2007 Zip Code Data Book San Gabriel Valley + extrapolation								

As previously stated, Tri-City Mental Health has not conducted a CSS population assessment since 2009. Data presented here from the original CSS plan may not accurately reflect the current population and utilization data. However, Tri-City plans to reassess the CSS population and services needs over the next three years.

The following information was taken from the original CSS plan (2009) and has been utilized when considering the development of current CSS programming.

We offer the following observations about service patterns among the different ethnic and age groups in the tri-city area:

- Significant percentages of people of all ages who likely qualify for publicly funded services are not receiving any service: 84.47% of children, 70.79% of TAY, 49.39% of adults, and 91.81% of older adults (see table at the bottom of p. 26).
- The Asian and Pacific Islander population is underrepresented in the mental health system across all age groups. Asian and Pacific Islanders comprise almost 8% of the total population, and 7% of the population under 200% of the federal poverty threshold, but are only 3% of the population receiving children's services, 2% of the population receiving TAY services, 4% of the population receiving adult services, and currently receive no older adult services.
- Latinx children and TAY are being served at rates almost equal to their percentage representation within the 200% Federal Poverty population. Latinx adults and older adults, however, are proportionately underrepresented in the mental health system. Latinx adults are 64% of the adult federal poverty population, but only 39% of the adults receiving mental health services. For Latinx older adults, the percentages are 64% and 40% respectively.
- African American representation within the mental health system is consistently higher for all age groups than the group's representation among the population below 200% of Federal Poverty guidelines. These higher utilization rates, as noted in the Tri-City Mental Health System's Community Services and Support Plan (April 2009), may suggest that African Americans are currently receiving disproportionate referrals to the mental health system, or are being inappropriately served.
- African American adults are 21%, and white adults are 31%, of the adult population receiving mental health services in the tri-city area. According to the 2008 San Gabriel Valley Regional Homeless Services Strategy Phase I Report, however, African-Americans

comprise 36%, and Whites 37%, of the homeless population in the region that includes Claremont, La Verne, and Pomona. This data suggests that, taking homelessness into account, African American and White adults may actually be underserved.

- Native Americans represent a small percentage of the 200% poverty population in the tri-city area, approximately 2%. Frequently, however, Native Americans are significantly underreported or misreported in the census data. For example, many Native Americans identify themselves as Hispanic thereby understating the Native American population. Interestingly, the Los Angeles metropolitan area is home to the largest urban concentration of Native Americans in the United States, and Pomona is one of six cities in Los Angeles County with the highest clusters of Native Americans in Los Angeles. This information suggests that there may be more Native Americans in the tri-city area than captured by current census data. Even at 2% of the area's 200% poverty population, however, only Native American adults are receiving commensurate services at 3%. The total number of Native Americans receiving services across all other age groups was only 7 individuals: 3 children, 3 TAY, and 1 older adult.

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

The county shall include the following in the CCPR Modification:

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

PEI Priority Populations Identified in PEI Plan (2010)

1. Trauma-Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations

PEI Priority Populations Selection Method and Rationale

In 2010, Tri-City staff and consultants engaged almost 3,000 community members in the PEI community planning effort by using four inter-related processes: focus groups, surveys, staff presentations, and stakeholder deliberations. Tri-City staff members partnered with trusted community leaders, and staff members from community agencies to help insure that these processes meaningfully engaged individuals

and families from traditionally unserved and underserved communities, including individuals with serious mental illness (SMI) and severe emotional disorders (SED).

For the on-line survey, respondents were asked to identify their top three priority populations. Of the 635 survey respondents:

- 19.29% chose individuals experiencing onset of serious psychiatric illness;
- 22.88% chose children and youth in stressed families;
- 17.05% chose trauma-exposed individuals;
- 13.59% chose children and youth at risk of or experiencing juvenile justice involvement;
- 14.23% chose children and youth at risk for school failure; and
- 12.95% chose underserved cultural populations.

When the delegates went through their own exercise of prioritizing the top three populations, their percentages differed slightly from those of the online survey respondents. Specifically:

- 29.90% of delegates chose individuals experiencing the onset of serious psychiatric illness;
- 23.04% of delegates chose children and youth in stressed families;
- 20.59% chose trauma-exposed individuals;
- 9.80% chose children and youth at risk of or experiencing juvenile justice involvement;
- 8.83% chose children and youth at risk for school failure; and
- 7.84% chose underserved cultural populations.

Delegates also reviewed past data that indicated discernible, and in many cases significant, increases in domestic violence calls, violent crime, suicide attempts, and other indicators of mental and emotional distress within families and communities across the three cities. Delegates understood that these and other indicators of mental and emotional distress are increasing at precisely the time when local governments, schools, foundations, and service providers are suffering escalating and devastating budget cuts. Indeed, the funding streams that support this plan under the Mental Health Services Act have declined significantly, and will likely continue to do so over the next several fiscal years. Ultimately, however, delegates concluded that many of the root causes affecting the mental wellbeing of these different populations are the same, and many of the strategies that could promote the mental wellbeing of these populations would also be similar. For example, delegates reasoned that children and youth in stressed families are likely to be at higher risk for experiencing juvenile justice involvement and school failure. They also inferred that the imperative to serve underserved cultural populations was a priority for all other priority populations. They therefore sought to create projects that could benefit as many of these identified populations as possible.

CRITERION 3. STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

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

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

The following are the target populations with disparities within the above selected populations:

- Medi-Cal population: None identified due to lack of access to data.
- CSS/Full-Service Partnership population: Children ages 0-15, Transition age youth (16-25), Adults ages 26-59, and Older adults 60 years and older.
- WET population: Tri-City's mental health workforce includes; 1) professionals, clinical staff providing treatment services, staff who provide wellbeing supports, and volunteers and caregivers, both paid and unpaid; 2) local high school and college students who are interested in careers in community mental health, particularly in the Tri-City area.
- PEI population: Individuals experiencing onset of serious psychiatric illness, children and youth in stressed families and trauma-exposed individuals.

Over a period of several months, Tri-City staff and consultants collaborated with nearly 3,000 community members of the three cities as a part of the PEI community planning efforts. During this time several tools were utilized to engage these individuals in this process. These tools included focus groups, surveys, staff presentations and stakeholder deliberations. The delegates were invited to review the data collected through these tools and methods, and were asked to consider their own preference in selecting the priority populations addressed by PEI plan.

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

The following are the disparities from the above-identified populations who are underserved:

- Asian and Pacific Islanders of all ages
- Latinx adults and older adults
- Native Americans of all ages
- Individuals experiencing onset of serious psychiatric illness
- Children and youth in stressed families
- Trauma-exposed individuals

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

The following strategies are identified in the CSS plan for reducing the disparities identified:

- The data examined previously in this plan suggests several significant disparities in access to services by ethnic groups, particularly for Asian and Pacific Islanders across all age groups, Latinx adults and older adults, and Native Americans, among others. Access to services can be even more difficult when the primary language of the individual or family seeking services is not English.
- Understanding these dynamics, Tri-City set ambitious targets for Full-Service Partnerships (FSPs) to reach people of all ethnic groups, including people for whom English is not a primary language.
- Specifically, staff conducted persistent outreach to Vietnamese and Latinx communities to ensure that monolingual individuals who experience SMI/SED can benefit from Full-Service Partnerships and the other services funded by the CSS plan.

The following strategies are identified in the WET plans for reducing disparities identified:

All topics for learning covered by the WET Plan will help to further the intent of MHSA. Examples include:

- Cultural competency awareness, skills about specific ethnic and cultural groups in the Tri-City area, and foreign language instruction;
- Evidence-based practices, best practices, and promising practices grounded in recovery and resiliency
- Co-occurring disorders and advanced skills needed for developing treatment plans and strength-based engagement, particularly for TAY
- Effective engagement of communities, especially unserved and underserved groups to reduce stigma and support wellbeing;
- Essential skills for working effectively within diverse groups such as presenting and group facilitation; and,
- Sharing “stories from the field” by seasoned clinicians and volunteers, including individuals with lived experience and family members to deepen understanding about effective engagement and recovery processes.

The following strategies are identified in the PEI plans for reducing the disparities identified:

As delegates reflected on the purposes of the PEI plan several guiding values and strategies emerged:

- A focus on communities, defined as a group of people who have sufficiently strong relationships that they provide tangible support to each other and can act together. With culturally appropriate support and encouragement, communities can leverage and extend these strengths and assets to improve and sustain the wellbeing of their members over time.
- A commitment to strengthen the capacities of communities to promote the mental and emotional wellbeing of their members. This commitment reflects an understanding that communities have the primary responsibility for promoting and sustaining the mental and emotional wellbeing of their members. No service system, no matter how efficient and effective, can ever be a complete and permanent substitute for the care and nurturing that becomes available to individuals and families through their natural communities of support.
- A commitment to sustainability. Given the volatile and highly unstable economic environment, and the resulting uncertainty around MHSA funding, delegates committed to invest in strategies that would strengthen community capacity for caring and action that could continue regardless of future funding realities.
- A commitment to community-defined results. Too often data about effectiveness is unavailable, incomprehensible to anyone but program experts, or irrelevant to communities and families striving to decide on courses of action culturally appropriate to their contexts. Transformative action within communities will more likely emerge when community leaders can design their own rigorous assessment plan, and access data they care about in a timely manner, to help them assess whether actions they are taking are having a positive impact.
- A commitment to learning. Too often within complex systems, data is used to enforce compliance with static and predetermined program guidelines, and/or to affix blame if something goes wrong. These two values—compliance and blame—profoundly diminish the capacity of communities to adapt to complex and shifting realities. Many of the challenges confronting local communities, including those that undermine their health and wellbeing, defy simple analyses and responses. What is needed are structures of support and learning that help communities learn from each other, even cross-culturally, to expand their respective repertoires of effective action.

Strategies for addressing identified disparities are imbedded within the programs and services Tri-City offers. These strategies include, but are not limited to: hiring more bicultural and bilingual staff that reflect the populations with disparities; hiring consumers with lived experience; providing cultural competence training to staff members; and engaging the three cities' communities in creating plans for improving and measuring their own wellbeing.

Please see the chart below for a breakdown of which programs and services described serve which populations with disparities:

CURRENT CSS AND PEI PROGRAMS	Asian Pacific Islanders of all ages	Latinx Adults and Older Adults	Native Americans of all ages	Individuals experiencing onset of serious psychiatric illness	Children and Youth in Distressed Families	Trauma-exposed Individuals
Full Service Partnerships	X	X	X	X	X	X
Community Navigators	X	X	X	X	X	X
Wellness Center	X	X	X		X	X
Supplemental Crisis Services; Intensive Outreach and Engagement	X	X	X	X	X	X
Field Capable Services for Older Adults	X	X	X			X
Community Capacity Building Project	X	X	X	X	X	X
Older Adult Wellbeing Project	X	X	X			
TAY Wellbeing	X		X	X	X	X
Family Wellbeing	X	X	X		X	
Early Psychosis				X	X	X
Therapeutic Community Garden	X	X	X		X	X

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

Reports are prepared by the Quality Improvement team every six months. Demographic data is collected from all programs and for all program referrals. Each program reviews the report to see how the program is performing overall, and also reviews the demographics to see if additional outreach, training, and communication is needed to increase referrals and program participation among our underserved populations. Surveys are also completed throughout the year to learn about satisfaction and feedback from program participants and clients.

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

Hiring bicultural and bilingual staff that reflect the populations with disparities

The following chart reflects a comparison between Tri-City staff and the demographics of the cities we serve. The Hispanic/Latinx, Black/African American and Native Hawaiian/Pacific Islander populations are successfully represented by Tri-City staff while the Asian and Native American/Alaska Native continue to be a focus for recruitment.

Average Demographic for Cities of Claremont, La Verne and Pomona	
White	42%
Hispanic/Latinx	34%
Asian	10%
Black/African American	5%
Native American/Alaska Native	1%
Native Hawaiian/Pacific Islander	0.33%
Other	4%
Two or More Races	3.67%

Average Demographics for Tri-City Mental Health Staff	
White	16.35%
Hispanic/Latinx	54.33%
Asian	8.17%
Black/African American	9.62%
Native American/Alaska Native	0.48%
Native Hawaiian/Pacific Islander	0.48%
Other	9.62%
Two or More Races	0.96%

Hiring consumers with lived experience:

Consumers are a critical part of Tri-City's workforce and provide valuable insight in the development of programming and delivery of mental health services. These individuals known as Wellness Advocates, serve in a variety of positions including facilitating support groups, acting as advocates for clients, attending stakeholder meetings, and participating on Tri-City's cultural competence committees.

Providing cultural competence training to staff members:

In a recent survey conducted among Tri-City staff, participants reported the following as a result of the ongoing cultural competence training required of all staff members.

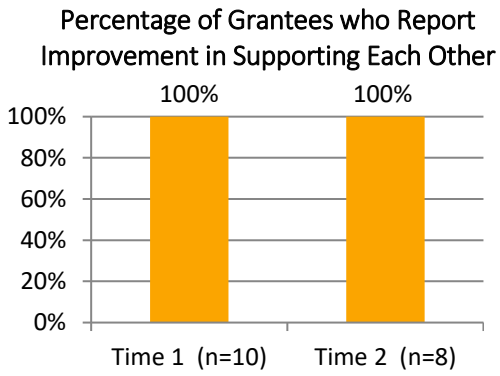
- **86%** of respondents agreed that groups with various cultural differences, experiences, and backgrounds are respected.
- **58%** of respondents agreed that they have the knowledge to effectively engage and support BIPOC and LGBTQ+
- **67%** of respondents agreed that they felt comfortable initiating meaningful and sometimes difficult conversations with colleagues.

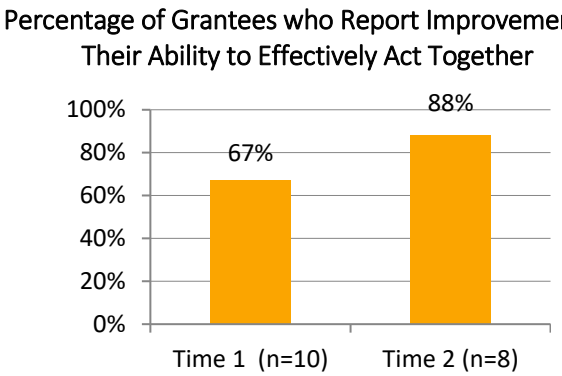
- **58%** of respondents agreed that they felt comfortable initiating meaningful and sometimes difficult conversations with supervisor, manager, or leadership.

[See *Cultural Inclusion and Diversity Committee Staff Survey October 2020*, Summary of Exhibits, Page 88]

Engaging the three cities' communities in creating plans for improving and measuring their own wellbeing:

The Community Wellbeing program provides small grants up to $10,000 and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. These grantees provided an array of services such as afterschool learning activities, tutoring, gardening, parenting classes, support groups, public speaking skills, and STEM clubs, that improved the wellbeing of their communities. Below reflects the outcomes for 11 community grantees and their members (2,941 members represented through the grants) for FY 2019-20.





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

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

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

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

In July 2010, Tri-City Mental Health developed a comprehensive Cultural Competence Plan based on criteria provided by the Office of Multicultural Services/Department of Mental Health. At this time, Tri-City established the Cultural Competency Committee (CCC) to reduce mental health disparities and support the agency's assessment, evaluation and development of culturally competent and linguistically appropriate policies, programs and services offered within the three cities of Claremont, La Verne and Pomona. The committee consisted of management and executive-level staff.

The Cultural Competency Committee (CCC) reconvened in January 2017 and redefined their structure and mission as the agency's leading body for cultural competence. In recognition of the agency's growth and diversity, the CCC broadened to include staff from all departments within Tri-City's System of Care including Clinical services, MHSA programs, Operations and Facilities and Best Practices. Through staff feedback, the Cultural Competence Committee (CCC) changed its name to the Cultural Inclusion and Diversity Committee (CIDC) in January 2019 to reflect the agency's current mission and vision. The CIDC is now composed of staff members from different levels of leadership, experience and perspective, each with a strong commitment to racial equity and inclusion. The CIDC is committed to ongoing staff development in the areas of cultural humility, mental health equity, consumer recovery and resiliency.

The CIDC was established as an advisory committee and is an essential component to Tri-City service planning and delivery. The role of this committee is to provide a forum to focus on disparities in access, quality and behavioral health outcomes as well as the ongoing enhancement and transformation of staff personal and professional growth. The CIDC is committed to ensuring the responsive integration and

respect of the culture, heritage, spirituality, behaviors, attitudes, language and values that embody the individuals and families Tri-City serves.

The CIDC consists of a Chairperson, Vice-Chairperson, 23 staff members, and three Advisory Councils. The CIDC Leadership consists of the Director of Ethnic Services, the CIDC Chairperson, the CIDC Vice-Chairperson and Advisory Council Chairpersons. The CIDC meets on the second Thursday of each month from 11:00 AM to 12:00 PM.

The CIDC membership is chosen in such a way as to represent the various departments within Tri-City's System of Care, with membership appointed by the Tri-City Leadership Team. Members will have demonstrated a sincere interest in cultural diversity and an expressed commitment in promoting the CIDC mission and values. Staff members are charged with acting as liaisons between this committee and the respective departments and are responsible for conveying information, announcements, resources, and shared learning between the committee and Tri-City programs.

As per the CIDC mission, "the Cultural Inclusion and Diversity Committee (CIDC) is committed to the advancements of quality mental health services that are culturally compatible and respectful of the diverse healthcare beliefs of the people we serve. It is the mission of this CIDC to guide and support the staff of Tri-City to ensure culturally and linguistically appropriate programs and services are available for community members residing in the cities of Pomona, Claremont and La Verne. By building strong and collaborative relationships through partnerships and community engagement, the CIDC will effectively review and evaluate the polices, practices, and programs provided by Tri-City to ensure the highest standards of care is accessible to all regardless of race, religion, disability, gender, language or ethnicity."

The main goals and objectives of the CIDC include:

1. To increase awareness of and access to mental health resources.
2. To promote the inclusion and representation of unserved and underserved communities.
3. To reduce mental health stigma within identified unserved and underserved communities.
4. To build cross-departmental responsibility with the Tri-City System of Care to share resources
5. To improve community access to public meetings/events via virtual platforms.
6. To provide cultural competency, inclusion, and behavioral health equity trainings for staff and community members with the intended goal to better serve and address the needs of targeted unserved and underserved communities.
7. To develop and improve culturally competent and linguistically appropriate services, policies and materials.

The CIDC activities held through Fiscal Years 2017 through 2021 included culturally relevant, informative and educational trainings, webinars and activities focused on unserved and underserved communities [refer to *Cultural Inclusion and Diversity Committee (CIDC) FY 2017-2020 Activity Chart* for a complete list

of past CIDC activities]. In order to achieve this, the CIDC members helped plan, research and develop informative material and trainings for both Tri-City staff and the general public. Activities include:

- Identifying and planning cultural competency educational opportunities for staff and consumers.
- Reviewing current training programs through Tri-City's online learning software (i.e. Relias) and identifying trainings that support and enhance employee cultural competency.
- Reviewing Tri-City surveys for culturally appropriate language and demographics, and identifying strategies to reduce disparities targeting specific groups.
- Planning and developing innovative ways to promote cultural awareness and stigma reduction efforts among staff and the general public.

The projected objectives and activities for the CIDC, subject to available staff and resources, include the following:

- Establish additional advisory council representatives of targeted unserved and underserved communities. This may include Older Adults, Transition Age Youth (TAY), Asian American and Pacific Islander (AAPI), and Native and Indigenous Communities.
- Continue to develop staff and community trainings and learning opportunities focusing on systemic racism, implicit bias, micro-aggressions, and behavioral health equity for Black, Indigenous and People of Color (BIPOC) and LGBTQ+ communities.
- Continue to identify, assess and improve outreach strategies to unserved and underserved communities.
- Continue to support linguistic access by providing appropriate linguistic materials and services.
- Develop and deliver internal and external (i.e. staff and community) needs assessments and surveys to evaluate practices, policies and service delivery, current efforts, and plan actions steps, all with the intended goal to address cultural competency, racism, mental health disparities and advance mental health equity and inclusion more systematically, strategically, and successfully.

Committee integration with the county mental health system by participating in and reviewing MHSA planning process

Since it's inception, the Cultural inclusion and Diversity Committee (CIDC) has reviewed and commented on a variety of documents, sureys, presentations and MHSA documents. Although this committee consists of primarily Tri-City staff, it still representes a cross-section of departments and cultural backgrounds.

In addition, many of these individuals attend MHSA Stakeholder meetings and workgroups and provide input regarding the future direction of many MHSA projects.

Beginnng in 2020, three advisory councils were created:

1. African American Family Wellness Advisory Council (AAFWAC)
2. ¡Adelante! Latinx Wellness Advisory Council; and
3. LGBTQ+ Wellness Advisory Council

These individuals were invited to participate in stakeholder meetings and MHSA workgroups which were launched in September 2020. In addition, these critical representatives participated in cultural competence focus groups which were designed to solicit responses that will help direct the path to equity within this plan.

Implementation of advisory councils to reduce mental health disparities for targeted unserved and underserved communities

The Tri-City's advisory councils listed above were created to form a joint alliance with community partners to advocate for the mental health needs of the diverse communities of Claremont, La Verne and Pomona. Through this collaborative action, these advisory councils expand membership to include community participants who can share new perspectives for the CIDC and provide input to be considered by Tri-City Mental Health. Tri-City advisory councils thrive on inclusivity and collective partnership, with membership consisting of department staff, clients, consumers, families, advocates, community members and representatives of local organizations and service providers. Membership in these advisory councils is open to any person who resides within or is affiliated with the Tri-City catchment area.

The main objectives of the advisory councils are to:

1. Engage and empower local communities and members to share their voices, knowledge and collective experiences to better identify the greatest needs and priorities related to mental health in their community.
2. Develop strategic partnerships and facilitate/encourage cooperative action among local organizations, agencies, consumers and communities that serve targeted populations with the goal of improving access, coordination and collaboration among traditional and nontraditional system partners.
3. Increase awareness of and access to mental health resources for targeted unserved and underserved communities.
4. Reduce mental health stigma in targeted unserved and underserved communities.
5. Recognize, respect and incorporate the history, culture, language and traditions of targeted unserved and underserved communities into Tri-City programming and services.
6. Outreach, educate and empower targeted unserved and underserved communities to engage in the MHSA community stakeholder process.

Tri-City advisory councils are crucial to Tri-City's mission to increase consumer representation, respond to gaps in services and increase workforce diversity. Advisory councils participate in the MHSA community stakeholder process, and overall planning, implementation, evaluation and delivery of services for targeted unserved and underserved communities. This may include advocating for culturally competent services and providing guidance and recommendations to management and executive-level staff and Tri-City governing bodies. Through advisory council input and feedback received on cultural competency and equity, Tri-City will be able to continue to effectively represent and serve diverse communities in our catchment area.

All meetings are open to the public and widely promoted across various communication channels, including mass distribution emails, social media, print media, and the Tri-City Mental Health website.

Current Tri-City advisory councils and their goals and objectives are listed as follows:

African American Family Wellness Advisory Council (AAFWAC)

The African American Family Wellness Advisory Council (AAFWAC) was established in December 2019. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to nurture hope and wellness within the African American community through mental health advocacy and treatment referral. The council meets the fourth Thursday of each month from 10:30 AM to 11:30 AM, and all meetings are open to the public and available through video teleconferencing. In addition to the objectives listed above, the AAFWAC aims to:

- Create and host community engagement activities that honor and recognize Black and African American culture. This may include Black History Month in February, Juneteenth celebration, BIPOC Mental Health Awareness Month in July, Martin Luther King Day and other significant cultural events and holidays recognized and celebrated within the African American community.
- Develop strategic partnerships with local organizations, school districts and faith-based communities serving Black and African American communities.
- Develop trainings, town hall meetings and presentations throughout the year focused on implicit bias, cultural inclusion, racial equity, family-oriented values and cultural competency strategies during clinical screening, intake and treatment planning for Black and African American individuals and families.
- Improve recruitment and hiring practices of Black and African American employees through participation and outreach in career and college job fairs and expos.
- Continue recruitment efforts of AAFWAC members.

¡Adelante! Latinx Wellness Advisory Council

¡Adelante! Latinx Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to instill hope and wellness by empowering community members within the Latinx and Hispanic community to advocate and share

their experience, knowledge and feedback. The council meets the second Thursday of each month from 2:30 PM to 3:30 PM, and all meetings are open to the public and available through video teleconferencing. In addition to the objectives listed above, the ¡Adelante! Latinx Wellness Advisory Council aims to:

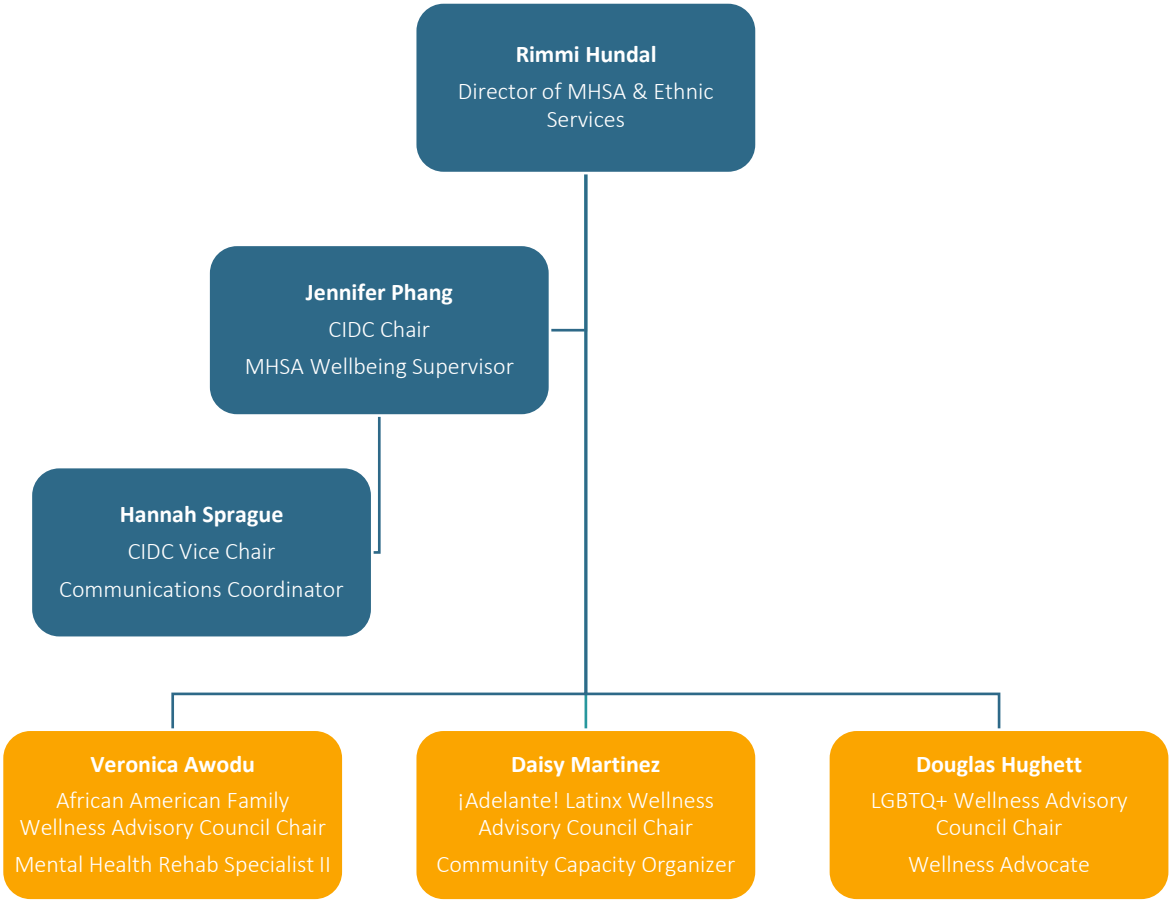
- Promote services that integrate Latinx/Hispanic holistic (i.e. mind, spirit and body) and traditional practices that nurtures and strengthens the wellbeing of individuals and families as a whole.
- Increase bilingual collateral material to improve access for monolingual residents and promote Tri-City services and resources.
- Develop outreach and engagement strategies to better reach undocumented individuals and families, with the intended goal to foster trust and reduce fear of seeking mental health care.
- Continue recruitment efforts of ¡Adelante! members, with an emphasis on monolingual Spanish community members, consumers and families.

LGBTQ+ Wellness Advisory Council

The LGBTQ+ Wellness Advisory Council was established in September 2020. As a result, this advisory council and its goals are still in the early development stages. Its primary goal is to give a voice to LGBTQ+ communities by empowering members to advocate and share their experience, knowledge and feedback. The council meets the third Tuesday of each month from 11:00 AM to 12:00 PM, and all meetings are open to the public and available through video teleconferencing. The LGBTQ+ Wellness Advisory Council's main objectives include:

- Create a safe space for LGBTQ+ community members to come together and engage in open dialogue and discussion around equity and inclusion.
- Outreach and engage with local high schools and colleges to promote resources and build on-campus support and/or linkages to support for LGBTQ+ youth.
- Outreach to unserved and underserved LGBTQ+ communities, including queer and transgender Black, Indigenous, and People of Color (QTBIPOC) communities.
- Develop strategic partnerships with local organizations that support LGBTQ+ communities to promote awareness, reduce stigma and foster mental health support.
- Continue recruitment efforts of LGBTQ+ Wellness Advisory Council members, with an emphasis on TAY, older adults and QTBIPOC.

Organizational Chart [Cultural Inclusion and Diversity Committee, CIDC]



Cultural Inclusion and Diversity Committee (CIDC) Membership Roster listing department affiliation

Name	Title	Affliiation	Contact Info
Rimmi Hundal	Director of MHSA and Ethnic Services	Tri-City Mental Health	rhundal@tricitymhs.org
Jennifer Phang	CIDC Chair; MHSA Wellbeing Supervisor	Tri-City Mental Health	jphang@tricitymhs.org
Hannah Sprague	CIDC Vice Chair; Communications Coordinator	Tri-City Mental Health	hsprague@tricitymhs.org
Veronica Awodu	AAFWAC Chair; Mental Health Rehabilitation Specialist II, Wellness Center	Tri-City Mental Health	vawodu@tricitymhs.org

Daisy Martinez	¡Adelante! Latinx Wellness Advisory Council Chair; Community Capacity Organizer	Tri-City Mental Health	dmartinez@tricitymhs.org
Douglas Hughett	LGBTQ+ Wellness Advisory Council Chair; Wellness Advocate I, Wellness Center	Tri-City Mental Health	dhughett@tricitymhs.org
Dana Barford	MHSA Projects Manager	Tri-City Mental Health	dbarford@tricitymhs.org
Kitha Torregano	Human Resources Manager	Tri-City Mental Health	ktorregano@tricitymhs.org
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Trevor Bogle	Controller	Tri-City Mental Health	tbogle@tricitymhs.org
Isela Moreno	MHSA Program Supervisor, Community Navigator	Tri-City Mental Health	imoreno@tricitymhs.org
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Richard Franco	Community Navigator	Tri-City Mental Health	rfranco@tricitymhs.org
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Charmayne Bowens	Clinical Therapist I, FSP TAY	Tri-City Mental Health	cbowens@tricitymhs.org
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Elva Neyoy	Mental Health Rehabilitation Specialist I, FSP Children	Tri-City Mental Health	eneyoy@tricitymhs.org

CRITERION 5. CULTURALLY COMPETENT TRAINING ACTIVITIES

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

A. The county shall develop a three-year training plan for required cultural competence training that includes the following: (The county may submit information from the county's WET plan provisions for training. The county shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).
   1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three- year period.
   2. How cultural competence has been embedded into all trainings.
   3. A report list of annual trainings for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

B. Annual cultural competence trainings topics shall include, but not be limited to the following:
   1. Cultural Formulation;
   2. Multicultural Knowledge;
   3. Cultural Sensitivity
   4. Cultural Awareness; and
   5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
   6. Interpreter Training in Mental Health Settings
   7. Training Staff in the Use of Mental Health Interpreters

In 2012, Tri-City staff and stakeholders joined together to develop the MHSA Workforce Education and Training (WET) Plan. This critical plan seeks to improve the effectiveness of all staff currently providing services for our clients and community members as well as strengthen the pool of individuals who may be available to provide support in the future. Learning activities identified in this plan include:

- Formal courses and training sessions facilitated by current staff, volunteers, and/or consultants to meet an identified learning priority;
- Informal learning sessions to focus on particular practices or topics in a more relaxed way—e.g., one-time workshops, drop-in periodic activities, ongoing "Lunch and Learn" sessions for staff and volunteers;

- Online learning activities—e.g., self-guided and interactive tutorials focusing on particular skill sets and practices; and
- Periodic Learning Summits for staff, volunteers, and/or the larger public to educate, share resources and best practices, recognize outstanding contributors, and celebrate successes through story-telling and other activities.

These methods of training staff and community members continue to be the roadmap for ensuring the highest level of cultural competence and self-awareness. Staff are required to complete a minimum of two cultural competence courses annually and participation is tracked through our Human Resources Department. In addition, mandatory trainings are offered throughout the year based on current events and community issues.

As mental healthcare professionals, Tri-City is committed not only to developing strong clinical skills but to ensure each individual who represents this agency values diversity and is competent to understand and respond to cultural differences with each client. This commitment requires all trainings to include a cultural component that can contribute to the delivery of culturally and linguistically inclusive services.

Cultural Inclusion and Diversity Committee (CIDC) FY 2016-2020 Activity Chart

Fiscal Year 2016-17		
Date	Activity	Activity Type
08/09/2016	*Spirituality in Mental Health* All Agency Training	Staff Training
01/10/2017	Cultural Competency Committee Meeting	Meeting
02/14/2017	Cultural Competency Committee Meeting	Meeting
03/27/2017	LGBTQ+ Pride Panel	Community Event
04/11/2017	Cultural Competency Committee Meeting	Meeting
05/24/2017	Launch of LGBTQ+ Support Group: *Proud to be Me*	Community Event
06/13/2017	Cultural Competency Committee Meeting	Meeting
06/26/2017	LGBTQ+ Community Social	Community Event
06/29/2017	*Providing Culturally Responsive Services to LGBTQ+ Individuals and Intergenerational Issues Faced Among the LGBTQ+ Community* The California Endowment Center, Los Angeles	Staff Training
Fiscal Year 2017-18		
08/15/2017	Cultural Competency Committee Meeting	Meeting
10/17/2017	Cultural Competency Committee Meeting	Meeting

12/13/2017	Cultural Competency Committee Meeting	Meeting
02/13/2017	Cultural Competency Committee Meeting	Meeting
04/10/2017	Cultural Competency Committee Meeting	Meeting
06/12/2017	Cultural Competency Committee Meeting	Meeting
07/11/2017	MHSA Cultural Potluck in Celebration of Minority Mental Health Month	Staff Education & Awareness
07/19/2017	*Bunny Bear* Book Reading By Author Andrea J. Loney	Community Event
08/03/2017	*Filipino Culture and Mental Health* Lunch & Learn	Staff Education & Awareness
08/15/2017	Cultural Competency Committee Meeting	Meeting
10/10/2017	Cultural Competency Committee Meeting	Meeting
10/18/2017	Diwali Holiday and Traditions E-Newsletter	Staff Education & Awareness
11/22/2017	*Culture, Violence and Mental Wellbeing: Exploring Culture's Double-Edged Sword* Webinar	Staff Training
12/05/2017 - 12/17/2017	*Holidays and Cultures Around the World* Decorating Contest	Staff Education & Awareness
12/13/2017	Cultural Competency Committee Meeting	Meeting
01/29/2018	*Celebrating Italian Culture* Mindfulness Event Hosted by the Therapeutic Community Garden	Community Event
02/13/2018	Cultural Competency Committee Meeting	Meeting
02/26/2018	*Practical Role of Cultural Psychiatry in Promoting Global Mental Health Equity* Webinar	Staff Training
02/27/2018	*Black History, Mental Health and Culture* Black History Month Presentation Hosted by the Therapeutic Community Garden	Community Event
03/20/2017 - 03/21/2017	*Person-Centered Engagement Strategies: Difficult to Engage Populations Conference* Southern Counties Regional Partnership (SCRP)	Staff Training
03/22/2018	*Cultural Diversity* Relias Online Training	Staff Training

03/27/2018	*SAGECare Training: Improving Aging Services for LGBT Older Adults* Community Senior Services, Claremont	Staff Training
03/27/2018	*A Taste of Ireland* Mindfulness Event Hosted by the Therapeutic Community Garden	Community Event
04/10/2018	Cultural Competency Committee Meeting	Meeting
04/17/2018	*Songkran (Thai New Year) and Mental Health* Mindfulness Event Hosted by the Therapeutic Community Garden	Community Event
04/26/2018	*Cambodia: A Community Built on Resiliency* Lunch & Learn	Staff Education & Awareness
05/29/2018	*Mexico and Mexican Mother's Day* Mindfulness Event Hosted by the Therapeutic Community Garden	Community Event
06/06/2018	*Unraveling the Rainbow-Embracing Diversity* LGBTQ12-S Mental Health Conference The California Endowment Center, Los Angeles	Staff Training
06/07/2018	*Gen Silent* Film Screening Documentary on LGBTQ Older Adults The University of La Verne	Community Event
06/12/2018	Cultural Competency Committee Meeting	Meeting
06/13/2018	*Rainbow Social* LGBTQ+ Pride Month and Celebration	Community Event
06/19/2018	*Exploring Korea* Mindfulness Event Hosted by the Therapeutic Community Garden	Community Event
Fiscal Year 2018-19		
07/03/2018	*Social Media Contest* Minority Mental Health Month	Staff Education & Awareness
07/03/2018	Minority Mental Health Month Infographic	Staff Education & Awareness
08/14/2018	Cultural Competency Committee Meeting	Meeting
09/26/2018	*Hispanic & Latino Heritage Celebration* Lunch & Learn	Staff Education & Awareness

10/11/2018	Cultural Competency Committee Meeting	Meeting
10/23/2018 - 10/24/2018	Cultural Competence Summit *Honoring California Diversity: A Call to Action*	Staff Training
10/30/2018	Italian American Heritage Month Infographic	Staff Education & Awareness
11/26/2018	*Native American Heritage Month* Lunch & Learn	Staff Education & Awareness
12/06/2018	Cultural Competency Committee Meeting	Meeting
12/07/2018	*My Cultural Lens* Staff Decorating Contest	Staff Education and Awareness
01//16/2019	*Shaping the Future for Mental Health and Aging* 13th Annual Promising Practices Conference	Staff Training
01/10/2019	*The Impact of Culture on Mental* Health Infographic	Staff Education & Awareness
02/14/2019	Black History Month Infographic & Display Board	Staff Education & Awareness
02/22/2019	*The Hidden Biases of Good People: Implications for Mental Health Professionals and the Communities They Serve* Rev. Dr. Bryant T. Marks, Sr.	Staff Training
03/14/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
03/19/2019 – 03/20/2019	*Person-Centered Engagement Strategies: Difficult to Engage Populations Conference* Southern Counties Regional Partnership (SCRP)	Staff Training
04/11/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
04/10/2019	Mental Health in the Transgender Community Lunch & Learn	Staff Education & Awareness
05/09/2019	*Reconnecting to Your Resources* May Mental Health Awareness Month Lunch & Learn	Staff Education & Awareness
05/13/2019	*AAPI & Mental Health Infographic and Resources* Asian American and Pacific Islander (AAPI) Heritage Month	Staff Education & Awareness
06/13/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
06/12/2019	*Love Has No Labels*	Community Event

	LGBTQ+ Pride Month	
Fiscal Year 2019-20		
07/11/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
07/25/2019	*Enhancing Cultural Humility* Jonathan Martines, PhD, CSUN	Staff Training
07/30/2019	Community Inclusion, Diversity and Wellness Fair	Community Event
08/05/2019	*Improving Behavioral Health for Latino Population* Webinar	Staff Training
08/15/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
09/04/2019	*Latinx Intersectionality: Strength, Power & Change* 2019 Latino Mental Health Conference California Endowment Center, Los Angeles	Staff Training
09/12/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
09/18/2019	*Latino and Hispanic Heritage Celebration* Staff Video	Staff Activity for Community
10/02/2019	*Allies Ally Advocacy Training* Dr. D M Hunter	Staff Training
10/07/2019	*Family History Month Toolkit* E-Newsletter	Staff Education & Awareness
10/10/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
10/31/2019	*Tri-City Fall Harvest Festival* CIDC Cultural Booth	Community Event for Clients & Consumers
11/08/2019	*Honoring Our Veterans* Veterans Day Staff Video	Staff Education & Awareness
11/14/2019	Cultural Inclusion and Diversity Committee Meeting	Meeting
12/09/2019	*Overcoming the Holiday Blues* Self-Care E-Newsletter for Staff and Clients	Staff and Community Education & Awareness
12/19/2019	Launch of *African American Family Wellness Advisory Council (AAFWAC) Meeting*	Meeting
01/04/2020	January/February CIDC Staff Newsletter	Staff Education & Awareness
01/09/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting

01/14/2020	CIDC Presentation Tri-City Mental Health Commission	Meeting
01/30/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
02/13/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
02/20/2020	*African American Heritage* Lunch & Learn	Staff Training & Education
02/27/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
03/26/2020	*COVID-19 Resource and Support Guide* Website Resource Page	Community Awareness
03/26/2020	*The Impact of COVID-19 on the LGBTQ+ Community* Webinar by the National Coalition LGBT Health	Staff Training
03/26/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
04/30/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
05/04/2020	*Working with Older Adults During COVID-19* City of Pomona, Neighborhood Services Department Presented by Tri-City Mental Health	Community Training
05/14/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
05/21/2020	*AAPI & Mental Health Infographic and Resources* Asian American and Pacific Islander (AAPI) Heritage Month	Staff Education & Awareness
05/21/2020	*Countering Stigma During May Mental Health Month* Advertorial in La Nueva Voz Pomona Newspaper	Community Awareness
05/27/2020	*Lessons from the Past: Yellow Peril and COVID-19 Times* Webinar The Japanese American Citizens League, the Asian American Psychological Association, the South East Asian Resource Center, the National Council of Asian Pacific Americans, and the Heart Mountain Wyoming Foundation	Staff Education & Awareness
05/28/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
06/08/2020	*Maintaining Positive Emotions During Tough Times*	Staff and Community

	Tri-City Mental Health Webinar *Tri-City's African American Family Wellness Advisory Council (AAFWAC)* *Dr. Gloria Morrow*	Education & Awareness
06/11/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
06/24/2020	*The ABC's of LGBTQ+* Tri-City Mental Health Webinar	Staff and Community Education & Awareness
06/11/2020	*LGBTQ+ Mental Health Resources Newsletter* LGBTQ+ Pride Month	Staff Education & Awareness
06/25/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
07/14/2020	*Minority Mental Health Month* Tri-City Mental Health Webinar	Staff and Community Education & Awareness
07/17/2020	*Black, Indigenous and People of Color (BIPOC) & LGBTQ+ Mental Health Resource Guide* Minority Mental Health Month	Staff and Community Education & Awareness
07/23/2020	*What Cultural Lens Do You Wear?* Tri-City Mental Health, Virtual Community Connections	Staff and Community Education & Awareness
07/23/2020	*Navigating the Mental Health System* Tri-City Mental Health Webinar Tri-City's African American Family Wellness Advisory Council (AAFWAC)	Staff and Community Education & Awareness
07/23/2020	*Be a Voice for Your Community: Become a Member of Tri-City's Advisory Councils* Advertorial for La Nueva Voz Pomona Newspaper	Community Education & Awareness
07/30/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
08/06/2020	*Cultural Competency and a Nation in Crisis: Dealing with the Effects of Racism and Sexism in our Practice During the COVID Crisis* Webinar by New York Association of Psychiatric Rehabilitation Services, Inc (NYAPRS)	Staff Training
08/10/2020	*Innovative Solutions to Address Social Isolation in Older Adults During the COVID-19 Pandemic* Webinar by the Office of Disease Prevention and Health Promotion (ODPHP) and the Administration for Community Living (ACL) Office of Nutrition and Health	Staff Training

	Promotion Programs (ONHPP)	
08/11/2020	*What is Racial Trauma? Understanding How Trauma Affects the Black Community* Relias Webinar	Staff Training
08/13/2020	*Cultural Inclusion and Diversity Committee Meeting*	Meeting
08/22/2020 – 09/17/2020	*Eliminating Inequities in Behavioral Health Care Webinar Series* California Institute for Behavioral Health Solutions (CIBHS) and the California Department of Health Care Services	Staff Training
08/27/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
09/10/2020	Launch of *¡Adelante! Latinx Wellness Advisory Council Meeting*	Meeting
09/17/2020	*Cultural Inclusion and Diversity Committee Meeting*	Meeting
09/22/2020	Launch of *LGBTQ+ Wellness Advisory Council Meeting*	Meeting
09/24/2020	*A Call to Action: The Impact of Systemic Racism on Mental Health* Tri-City Mental Health Webinar Jei Africa, PsyD, MSCP, CATC-V, Director of Behavioral Health and Recovery Services (BHRD) at Marin County	Staff and Community Education & Awareness
09/24/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
10/05/2020	*The Impact of Racial Inequity and Affordable Housing on Mental Health and Community Wellbeing* Tri-City Webinar Jed Leano, Claremont City Councilmember and Vice Chair of Tri-City's Governing Board	Staff and Community Education & Awareness
10/08/2020	¡Adelante! Latinx Wellness Advisory Council Meeting	Meeting
10/13/2020	CIDC Presentation of Advisory Councils Tri-City Mental Health Commission	Meeting
10/20/2020	LGBTQ+ Wellness Advisory Council Meeting	Meeting
10/22/2020	*Moving Forward Together for an Equitable and Inclusive Community* Advertorial for La Nueva Voz Pomona Newspaper	Community Education & Awareness

10/22/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting
11/05/2020	*Veterans and Mental Health: Understanding Common Challenges and Learning How to Provide Support* Tri-City Mental Health Webinar	Staff and Community Education & Awareness
11/10/2020	*Mental Health and Wellness in the African American Community* Tri-City Mental Health Virtual Townhall Tri-City's African American Family Wellness Advisory Council (AAFWAC) Dr. Allen Lipscomb, PsyD, LCSW	Staff and Community Education & Awareness
11/12/2020, 12/03/2020, 12/04/2020	*Tri-City Mental Health Mandatory Cultural Training* Dr. Allen Lipscomb, PsyD, LCSW	Staff Training
11/12/2020	¡Adelante! Latinx Wellness Advisory Council Meeting	Meeting
11/17/2020	LGBTQ+ Wellness Advisory Council Meeting	Meeting
11/19/2020	Cultural Inclusion and Diversity Committee Meeting	Meeting
11/19/2020	African American Family Wellness Advisory Council (AAFWAC) Meeting	Meeting

Cultural Competence Online Trainings

Tri-City staff are also assigned online training electives through the e-Learning Training platform, Relias. Relevant trainings include:

- A Culture-Centered Approach to Recovery
- Behavioral Health Services and the LGBTQ+ Community
- Best Practices for Working with LGBTQ Children and Youth
- Building a Multicultural Care Environment
- Cultural Awareness and the Older Adult
- Cultural Competence
- Cultural Competence and Sensitivity in the LGBTQ Community - California
- Cultural Dimensions of Relapse Prevention
- Cultural Issues in Treatment for Paraprofessionals
- Cultural Responsiveness in Clinical Practice
- Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans
- Implementation Guidelines for Telehealth Practitioners

- Individual and Organizational Approaches to Multicultural Care
- Military Cultural Competence
- Overview of DSM-5
- Substance Use Disorder Treatment and the LGBTQ Community
- The Impact of Deployment and Combat Stress on Families and Children, Part II: Enhancing Resilience
- The Role of the Behavioral Health Interpreter
- A Culture-Centered Approach to Recovery

Every member of Tri-City staff completed at least one course from the above list between July 1, 2019 and June 30, 2020. All staff were assigned the course entitled, *Cultural Competence*, and completed it within the time frame. Staff also completed trainings as assigned by supervisors based on relevance to individual job duties or as indicated by goals for personal and professional growth.

In addition to the above trainings, which will continue to be offered in the next fiscal year, Tri-City Mental Health has entered into an agreement with Dr. Allen Lipscomb, PsyD, LCSW, who will facilitate a series of trainings mandated for all Tri-City staff in the next year. The training will consist of an initial three-and-a-half-hour session aimed at raising critical consciousness when engaging in conversations about implicit biases and microaggressions within the organization. The training will provide tools, techniques, and skills to utilize to hold oneself and others accountable as it relates to truly practicing justice, equity, diversity, and inclusion and will build upon existing knowledge on implicit and explicit biases to shift behavior. Participants will engage in small group experiential activities to practice skills learned during the training. Subsequent training sessions will build on this training, allowing for staff to be better able to meet the needs of our diverse client population.

All new staff will also receive training from the perspective of our team of peers about the value that peers bring to our workforce and the support that they offer to our clients in the form of navigating the mental health system.

Mental Health First Aid (MHFA) Training

Tri-City Mental Health has invested in the curricula the National Council for Behavioral Health created called Mental Health First Aid (MHFA). Mental Health First Aid is a course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives participants the skills they need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Mental Health First Aid takes the fear and hesitation out of starting conversations about mental health and substance use issues by improving understanding and providing an action plan that teaches people to safely and responsibly identify and address a potential mental illness or substance use disorder.

Tri-City Mental Health currently has four staff certified as MHFA Instructors who can provide the following versions of MHFA to our staff as well as community members and partners.

Training	Description	How Long	Audience	Delivery
MHFA: Adult [English & Spanish]	This is the original curriculum that was created to be delivered to adults in non-behavioral health settings or backgrounds.	8hrs	Staff and community partners	In-person & virtually [webinar]
MHFA: Youth	Youth MHFA was created because there was a need to train parents, caretakers and adults who work with youth on how to respond to a mental health crisis. We know the onset of mental health challenges starts early in child development. The earlier we're aware, the earlier we can intervene and provide support and services.	8hrs	Staff and community partners	In-person & virtually [webinar]
MHFA: Law Enforcement and First Responders	Law Enforcement is usually called to respond to a mental health crisis, but may not have adequate training on how to respond. This curriculum was created to meet that need, provide the tools to respond, and share resources that they can utilize during or after a crisis.	8hrs	Staff and community partners	In-person
MHFA: Military, Veterans, & Families	Our active military, veterans and their families are all impacted by the military duty they provide and their mental health is an area of impact that has gone unaddressed. This curriculum brings attention and awareness that is much needed to provide support.	8hrs	Staff and community partners	In-person
MHFA: Older Adults	The older adult community has higher rates of suicide, isolation and loss that leads to mental health challenges or crisis. This curriculum is for caregivers, senior service providers, and family members of older adults to share how to identify the signs and symptoms older adults may display.	8hrs	Staff and community partners	In-person

MHFA: Higher Education	College students are at a pivotal time in their lives making, for their first time, adult decisions and taking on responsibilities. These decisions can be stressful and, without proper support or guidance, can lead to mental health challenges and crisis. Suicide is the 2nd leading cause of death for college students, substance use/abuse is on the rise, and drop-out rates due to these challenges has increased. This curriculum is for college students, educators, faculty, and parents.	8hrs	Staff and community partners	In-person

Southern Counties Regional Partnership (SCRP)

Since 2017, Tri-City Mental Health has been an active member of the Southern Counties Regional Partnership (SCRP) Collaborative, focusing on the Workforce Education and Training (WET) plan activities. This Partnership consists of ten separate Southern California counties, agencies, and organizations who are committed to expanding California's public mental health workforce through education and training programs and activities listed in the SCRP WET plan. This plan was developed with input from the SCRP WET Coordinators for each county.

In 2017, 2018 and 2019, Tri-City co-hosted the SCRP *Person-Centered Engagement Strategies: Difficult to Engage Populations* Conference. This popular conference, which included Tri-City staff as attendees, provided a venue for participants to 1) Review best practices in a collaborative environment; 2) Better understand the difficult to engage/reach populations; and 3) Reach a better awareness of common biases. Presentations included *Engaging Latinos with Early Psychosis in Mental Health Services* and *Gender Dysphoria: Beyond the Diagnosis.*

In 2018, Rimmi Hundal, Ethnic Services Manager for Tri-City Mental Health, served as co-chair on the planning committee for a statewide conference on Cultural Competence titled *Honoring California's Diversity: A Call to Action*. The summit took place in October 2018 with over 400 county mental health professionals in attendance.

Cultural Inclusion and Diversity Committee Staff Survey

In October 2020, Tri-City Mental Health surveyed their staff in preparation for the agency-wide training, *Engaging in Difficult Conversations Centered Around our Own Implicit Biases*, with Dr Allen Lipscomb, PsyD, LCSW. The purpose of the survey was to establish a baseline understanding of how staff currently feel about several topics related to cultural difference and comfort level with difficult conversations.

Sample results include the following:

- **86%** of respondents agreed that *groups with various cultural differences, experiences, and backgrounds are respected.*
- **58%** of respondents agreed that they *have the knowledge to effectively engage and support BIPOC and LGBTQ+.*
- **67%** of respondents agreed that they *felt comfortable initiating meaningful and sometimes difficult conversations with colleagues.*
- **58%** of respondents agreed that they *felt comfortable initiating meaningful and sometimes difficult conversations with supervisor, manager, or leadership.*

[See Cultural Inclusion and Diversity Committee Staff Survey October 2020, Summary of Exhibits, Page 88]

Tri-City Mental Health engaged the services of Dr Allen Lipscomb, PsyD, LCSW. Dr. Lipscomb provided an all-staff training focused on building on the working knowledge of staff based on their lived experiences (both professionally and personally). In addition, this training was aimed at raising critical consciousness by increasing cultural humility in professional exchanges with colleagues and clients.

Following these trainings, Dr. Lipscomb will facilitate multiple focus groups where staff and management will begin the process of addressing racism, implicit biases, and microaggressions, and how these factors may impact our clients and the services delivered by Tri-City Mental Health.

Cultural Competence Training Topics FY 2020-21 – FY 2022-23

- Working with a Limited English Proficient (LEP) Community
- Effective Use of Interpreters in a Mental Health Setting
- How to Effectively Access Language Services for Clients
- Understanding the Americans with Disabilities Act (ADA) and How it Impacts BIPOC Communities
- Cultural Sensitivity Training for Individuals with Disabilities
- Self-awareness and Implicit Bias
- Understanding Consumer and Family Culture
- Cultural Awareness: Becoming an Ally
- Cultural Competence vs Cultural Humility
- Effective Outreach and Engagement of the LGBTQ+ and Transgender Community
- LGBTQ+ Mental Health
- Peer Mentor Orientation
- An Introduction to Cultural Competence
- Cultural Competence: Implicit Bias and Microaggression
- Motivational Interviewing
- Healthy Boundaries and Safety

- Self-Care
- Adverse Childhood Experiences (ACEs)
- Suicide Talk
- Community Resiliency Model™ (CRM)
- Working with Older Adults
- Mental Health First Aid (MHFA)
- Healthy Relationships
- Stigma Reduction
- Life Transitions and Change
- Human Trafficking
- Zoom Fatigue and Coping During the COVID-19 Pandemic
- Veterans and Mental Health

Additional trainings will be identified and developed over the next three years based on the needs of the community and current COVID 19 conditions.

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

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:
   1. Family focused treatment;
   2. Navigating multiple agency services; and
   3. Resiliency

Client Culture Trainings and Activities		
Date	Activity	Activity Type
3/27/2017	LGBTQ Pride Panel	Community/Staff Training Event
8/3/2017	Filipino Culture and Mental Health	Staff Education and Awareness
2/27/2018	Black History, Mental Health and Culture	Community/Staff Training Event
4/26/2018	Cambodia: A Community Built of Resiliency	Staff Education and Awareness

6/19/2018	Exploring Korea	Community/Staff Training Event
9/26/2018	Hispanic and Latino Heritage Celebration-Lunch and Learn	Staff Education and Awareness
11/26/2018	Native American Heritage Month-Lunch and Learn	Staff Education and Awareness
4/10/2019	Mental Health in the Transfer Community Lunch and Learn	Staff Education and Awareness
5/13/2019	AAPI and Mental Health	Staff Education and Awareness
9/18/2019	Latino and Hispanic Heritage Celebration	Staff Activity for Community
2/20/20	African American Heritage – Lunch and Learn	Staff Training and Education
5/21/2020	AAPI and Mental Health	Staff Education and Awareness
6/24/2020	The ABC's of LGBTQ+	Staff and Community Education and Awareness
7/17/2020	BIPOC and LGBTQ Mental Health Resource Guide	Staff and Community Education and Awareness

The following courses are offered through Relias, an e-Learning platform utilized by Tri-City for supplemental staff trainings. Cultural inclusion is a critical component for all of Tri-City's trainings and Relias was recognized by the Triangle Business Journal (TBJ) as a winner of its 2020 Leaders in Diversity Award.

The courses listed below support the topics indicated and are considered culturally competent:

Family Focused Treatment

- Calming Children in Crisis
- Crisis Planning with Families
- Evidence-Based Practices in Family Psychoeducation
- Family Assessment and Intervention
- Family Psychoeducation: Advanced Evidence-Based Practices
- Family Therapy in Substance Use Treatment
- Overview of Family Therapy
- Parenting Styles and Theories
- Positive Behavior Support for Children
- Promoting Normalcy for Youth in Foster Care

- Strengths Based Approach in Working with At-Risk Youth
- Structural and Strategic Family Therapy
- Substance Use and Misuse in the Family
- Substance Use and the Family for Paraprofessionals
- The Impact of Deployment and Combat Stress on Families and Children, Part I: Families and Deployment
- The Impact of Deployment and Combat Stress on Families and Children, Part II: Enhancing Resilience
- The Impact of Parental Substance Use Disorders

Navigating Multiple Agency Services

- Best Practices for Youth with Behavioral Health Needs involved with the Juvenile Justice System
- Integrating Primary and Behavioral Healthcare
- WEBINAR: Exploring Best Practices in Integrated Care
- Working with Court-ordered Individuals in Substance Use Treatment

Resiliency

Trainings for children, adolescents, transition age youth, parents and caretakers, that focuses on Resiliency, will be provided through *Adverse Childhood Experiences (ACEs*) and *Community Resiliency Model (CRM)*. Tri-City has invested in both of these curricula and have had several program staff trained in both curriculums to provide them out in the community to each of the specific populations listed above. Both trainings are delivered with content in an age appropriate learning format utilizing charts, graphics, videos, and language that is appropriate to the population we serve. Through our internal clinical staff, community partners, and local organizations, Tri-City will be able to outreach and provide these much-needed trainings to our clients, participants and community members.

Training	Description	How Long	Audience	Delivery
ACEs: English & Spanish	Provides background on ACEs study, defines what is trauma, impact on physical and mental health, and how we can thrive through adversity by being resilient.	2-4 hours long	TAY, Parents, Caretakers, & Service Providers	In-person & virtually [webinar]

CRM: English & Spanish	What is toxic stress, impact of stress on our brain and body, define what is Resiliency, and how we build our resiliency utilizing six skills. Practice of the skills is done throughout the training so participants can start applying them in their daily lives.	Varies; Can be adapted 2-6 hours	TAY, Parents, Caretakers, & Service Providers	In-person & virtually [webinar]

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

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

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health System.
B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.
C. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.
D. Share lessons learned on efforts in rolling out county WET implementation efforts.

Tri-City's current workforce represents a culturally diverse reflection of the community we serve. The current breakdown of our workforce (as of 10/07/2020) is represented in the chart below.

Total Tri-City Staff:	208
% Hispanic or Latinx:	54.33%
% White:	16.35%
% Black or African American:	9.62%
% Other:	9.62%
% Asian:	8.17%

% Two or more races	0.96%
% American Indian or Alaska Native:	0.48%
% Native Hawaiian or Pacific Islander	0.48%

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

As previously stated, the area served by the Tri-City Mental Health is not included in the CAEQRO data collection. Additionally, none of the three cities (Claremont, La Verne and Pomona) currently collect Medi-Cal population and client utilization data.

Summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts

With regard to recruitment and selection, Tri-City's Human Resources Department actively seeks out recruitment advertisement opportunities with a variety of culturally specific organizations and associations. To ensure that our workforce demographics is comparable to those of our client demographics, we advertise with and participate in employment fairs with the Network of Social Workers, CBDHA, CIBHA, the African American Mental Health Conference, the Latino Behavioral Health Conference and Mental Health America.

Additionally, Tri-City WET program staff actively outreaches to students from high schools and universities within our service area. The goal of this outreach is to educate and encourage students about the potential of working within the community mental health system generally, and Tri-City Mental Health specifically. Through student career fairs, class specific presentations, Tri-City staff engage residents and students of the three cities to participate as Service-Learners, a volunteer program to support Tri-City staff and departments to meet the needs of consumers and community members. As part of the volunteer commitment, Service-Learners are educated about the culturally diverse populations within the service area.

Tri-City has emphasized the value of those with lived experience within our workforce and has made a concerted effort to include peers throughout our system of care. Peers, representative of the population we serve and our clients are also included in our Service-Learner program.

Ongoing County WET Implementation Efforts

The parity between the Tri-City workforce and the population we serve suggests that WET implementation efforts have been largely successful. The implementation of the WET program stresses the importance of learning – a relevant goal of cultural inclusion and humility – and incorporates our ongoing efforts to inform,

engage and educate volunteers and peers about opportunities and careers in the community mental health system. Several positions within our organization had been filled by peers and volunteers, but in an effort to increase the percentage, Tri-City has instituted the Peers 2 Careers (P2C) program.

The Peers 2 Careers program is a self-paced structured program that is optional and based on the individual goals of the client/volunteer. The P2C program offers a selection of educational and experiential opportunities that promote knowledge of mental health and contribute to a greater desire to work or volunteer in the mental health system through three different pathways:

Pathway 1: Wellness Center

H.O.P.E Transition/Graduation

Helping-Oneself-Positively-Empowers (HOPE) is a seven-week group that focuses on helping individuals who are receiving formal mental health treatment services at Tri-City and are in the process of transitioning to lower level of care. Participants identify and discuss positive coping skills to help alleviate and deescalate unwanted mental health symptoms. The group provides rapport, non-judgment and a listening ear to those who attend.

Wellness Center

Participants are expected to sit in on at least two support groups from the four programs available at the center: Family Wellbeing, TAY Resource Center, Older Adult Wellbeing, and Community Services and Supports. Each group is designed to share basic concepts of recovery, and peer support.

Employment Curriculum

Participants are expected to complete the eight-week employment curriculum to learn basic expectations and responsibilities of an employee.

Computer Classes

This is a 24-week computer class that focuses on basic computing skills that individuals can utilize to be able to perform basic job-related tasks/duties.

Wellness Recovery Action Plan (WRAP)

Wellness Recovery Action Plan (WRAP) focuses on taking care of one's mental wellbeing. Participants learn how to create a wellness tool to help identify specific situations, early warning signs that the situation/event has worsened and develop an action plan to help get them through it.

Pathway 2: Service-Learning

Service-Learner

Service-Learners (formerly called volunteers) provides support in many of the MHSA programs offered by Tri-City. Service-Learners participate in various community events throughout the year such as community meetings, holiday parade, and stigma reduction events such as Tri-City's Green Ribbon Week.

Working Independence Skills Helping (WISH)

Working Independence Skills Helping (WISH) program helps individuals build their self-confidence and self-esteem while gaining viable skills to further their professional and employment growth. The eight-week program emphasizes team building, conflict resolution, communication and employment skills building.

Summer Camp

Summer Camp provides a unique opportunity for individuals ages 16 and over who are interested in working with children to volunteer and provide support to a four-week day camp facilitated by Tri-City Wellness Center staff.

Peer Mentor Program

The program runs annually from September through May. The program is comprised of a committed diverse group of individuals with various backgrounds, culture, identities and lived experiences age 18 and over. Participants gain hands-on experience working with individuals in community mental health while experiencing personal growth. The program provides extensive training and supervision on numerous topics focusing on mental health and mental wellbeing.

Pathway 3: Relias Training

Relias is an online e-learning system that contains over 400 behavioral health courses. Participants can enroll in courses and take them at their own pace online. Once a course is complete, participants can print out a certificate of completion.

CRITERION 7. LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

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

B. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

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

When the WET plan was approved in 2012, the following statement were made regarding staff language capacity.

Tri-City has a high degree of diversity and capacity to serve its communities:

- Three direct service staff speak Tagalog;
- One manager who also does some direct service speaks Japanese;
- Two direct service staff speak Kutchi, a dialect of Sindhi;
- Three direct service staff speak Hindi;
- One manager speaks Punjabi;
- Two staff speak Urdu; and
- One supervisor (who also provides direct services) speaks Mandarin and Taiwanese

Regarding the constraints that limit the capacity to increase bilingual staff, Tri-City found it hard to fill clinical positions with staff who speak Vietnamese or Spanish.

Workforce Needs Assessment [WET Plan, 2012]

Language Proficiency				
Language, other than English		Number who are proficient	Additional number who need to be proficient	Total (2) + (3)
(1)		(2)	(3)	(4)
Spanish	Direct Service Staff	47	8	55
	Others	1	0	1
Vietnamese	Direct Service Staff	6	5	11
	Others	0	0	0
Cantonese	Direct Service Staff	2	3	5
	Others	1	0	1

Hmong	Direct Service Staff	1	0	1
	Others	0	0	0
Farsi	Direct Service Staff	0	0	0
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	56	16	72
	Others	2	0	2

Language Proficiency

Below are data presented to delegates for the WET planning process, taken from the original WET plan (2012):

	Total Population			Relative %		
	La Verne	Claremont	Pomona	% La Verne	% Claremont	% Pomona
English	25,571	26,572	52,163	75.9%	76.1%	35.0%
Spanish	4,547	3,310	83,136	14.6%	9.4%	55.8%
API	782	2,696	12,120	2.5%	7.7%	8.1%
Other	2,163	2,347	1,639	6.9%	6.7%	1.1%

	Tri-Cities population primary language spoken at home	Tri-City staff language capacity in addition to English	# of Tri-City staff
Monolingual English	47.6%	42.4%	53
Spanish	42.3%	38.4%	48
API	6.7%	12.0%	15
Other*	3.5%	7.2%	9
Total	100.0%	100.0%	125

Updates from MHSA, CSS, or WET Plans on bilingual staff members who speak the languages of the target populations

The most commons languages for our clients are English 87% and Spanish 11%. Approximately 50% of the Tri-City Workforce is bilingual. Approximately 45% of the Tri City work force is qualified to provide bilingual interpretation services, in the threshold Language Spanish.

# of Staff Certified/Qualified for Bilingual Interpretation		
Language	# Bilingual	% Bilingual
Spanish (Threshold Language)	95	46%
Vietnamese	2	1%
French	2	1%
Khmer	1	0%
Mandarin & Shanghainese	1	0%
Mandarin & Chinese	1	0%
Tagalog	1	0%
Total Bilingual	103	49.5%

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

On an annual basis, Tri-City dedicates approximately $10,000 on services that assist with the translation of documents, advertisement in local newspapers, and in having translators available for meetings with the community.

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

A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:
   1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.
   2. Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available Use new technology capacity to grow language access.
   3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol.

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

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

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

E. Identify county technical assistance needs.

Evidence of policies, procedures, and practices for meeting clients' language needs

4.4 TCMHA shall also ensure 24/7 access to language interpretation services in primary or preferred language (including TTD and California Relay Services), for all individuals that call the toll-free 24/7 agency phone line (866) 623-9500.

[See *Language Interpretation and Translation Policy and Procedure* and *Language Line Protocol Guide*, Summary of Exhibits, Page 88]

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

3.2a Clients receiving mental health services, will be informed in writing (in their primary language) of their right to language assistance services at no cost and how to access these services.

[See *Language Interpretation and Translation Policy and Procedure,* Summary of Exhibits, Page 88]

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

4.4 TCMHA shall also ensure 24/7 access to language interpretation services in primary or preferred language (including TTD and California Relay Services), for all individuals that call the toll-free 24/7 agency phone line (866) 623-9500.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

Historical challenges on efforts made on the items above and lessons learned

One lesson learned is that there needs to be a clear distinction between direct service staff and interpreters. All staff (including Psychiatrists) need to have this understanding. Also, interpreters for mental health services benefit from basic trauma training and training in mental health first aid to both reduce secondary trauma and to increase effectiveness of translation.

Identified county technical assistance needs

The people that Tri-City serves do not have appropriate access to the technology needed to accommodate video translation services. So, the agency needs assistance in linking clients to appropriate technology including good internet service, new computer equipment, and safe storage. Also, the agency would benefit from technical assistance on how to access funding for the clients to pay for the internet, computers, etc.

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

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.
B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.
C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.
D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

Evidence of availability of interpreter and/or bilingual staff for the languages spoken by community

4.2 Each service site shall post a flyer (in threshold and non-threshold languages) identifying the language assistance services and the auxiliary aids (including Teletypewriter/Telecommunications Device for the Deaf - TTY/TDD) available to non-English speaking, LEP, and deaf or hearing-impaired clients, participants, and Stakeholders.

[See *MHP and Language Line Posters,* Summary of Exhibits, Page 88]

Approximately 45% of the Tri City workforce is qualified to provide bilingual interpretation services, in the Threshold Language Spanish. The most commons languages for our clients are English 87% and Spanish 11%.

Evidence that interpreter services are offered and provided to clients and the response to the offer is recorded

4.7 TCMHA workforce members shall document when free language services are offered and/or provided, in the client's primary or preferred language. Documentation of language interpreter services shall be completed in accordance with the guidelines in the Los Angeles County Mental Health Plan - Short Doyle/Medi-Cal Organizational Provider's Manual.

[See *Primary Language Screening Tool,* Summary of Exhibits, Page 88]

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

4.8 Interpreter Services by Bilingual Workforce Member (Primary Resource): All departments and programs shall utilize internal bilingual workforce members as a primary resource for clients, participants, and stakeholders requesting/needing interpreter services in their primary or preferred language.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence

4.8a Human Resources will maintain a list of the workforce members certified to interpret and the languages they are certified to interpret.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

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

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

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

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

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

4.1c A coordinated referral and transfer to a similar agency shall be offered, for clients and participants with non-threshold primary/preferred languages, that may better be served by another agency provider with more optimal culturally or linguistically available services. The referral process shall allow latitude for clinical judgment in some cases.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88, for Section IV: A and B]

Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964

4.1 TCMHA shall provide verbal or sign language assistance services in threshold and non-threshold languages for specialty mental health clients, participants, and stakeholders.

a. In accordance with requirements of Title VI of the Civil Rights Act of 1964, the expectation that family members provide interpreter services is prohibited. Participant, or stakeholder insists on using a family member or friend as an interpreter, they may do so only after being informed of the availability of free interpreter services.

b. Minor children shall not be used as interpreters.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

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

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

1.9 TCMHA shall respond to the cultural linguistic needs of clients and stakeholders, across the system of care by ensuring that verbal and written language assistance services are provided by certified bilingual employees or through qualified language translation and interpretation services (CCPR Criterion 7).

a. TCMHA shall make available written materials (i.e. brochures, forms, signage, provider directories, beneficiary handbooks, appeal and grievance notices, denial, and termination notices) that are easily understandable to meet the language (threshold languages) and communication needs of clients and stakeholders.
b. TCMHA shall work with vendors to translate written materials and field test the qualify and cultural meaningfulness of vendor-translated products with bilingual certified staff and constituents.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

Tri-City will make the following documents available for review during the compliance visit:

- Member service handbook or brochure;
- General correspondence;
- Beneficiary problem, resolution, grievance, and fair hearing materials;
- Beneficiary satisfaction surveys;
- Informed Consent for Medication form;
- Confidentiality and Release of Information form;
- Service orientation for clients;
- Mental health education materials,
- Evidence of appropriately distributed and utilized translated materials;
- Cultural and Linguistic Inclusion and Competence Policy and Procedure;

- Tri-City Official Protocol: Informing Materials; and
- Client Acknowledgment of Receipt of Informing Materials;

General	MHSA Stakeholder

• Tri-City Official Protocol: Informing Materials
  • Guide to Medi-Cal Mental Health Services [English, Spanish, Vietnamese]
  • Tri-City Beneficiary/Client Problem Solution Guide [English, Spanish, Vietnamese]
  • DMH LA County Service Area 3 Provider Directory
  • LA County DMH Mental Health Client Resource Directory
  • LA County DMH Grievances and Appeals Procedures: A Consumer Guide [English, Spanish, Vietnamese]
  • LA County Patient's Rights Grievances or Appeal and Authorization Form
• Client Acknowledgment of Receipt of Informing Materials
	• MHSA Stakeholder Meeting Flyer(s) [English, Spanish]
	• MHSA Stakeholder News Advert, La Nueva Voz Pomona Newspaper [English, Spanish]
	• MHSA Notice of Public Hearing Advert, La Nueva Voz Pomona Newspaper [English, Spanish]
	• Notice of Public Hearing of the Mental Health Commission and MHSA Annual Update Flyer [English, Spanish, Vietnamese]

	Miscellaneous
	• Staying Resilient and Compassionate During COVID-19 [English, Spanish] • Protect Yourself and Your Family from COVID-19 Flyer [English, Spanish] • Community Health Resource Fair [English, Spanish]
MHSA Programs and Services	**Forms/Documents**
• Tri-City Mental Health: A Guide to Our System of Care [English, Spanish] • Tri-City Resource Guide [English, Spanish] • Intensive Outreach and Engagement Team (IOET) Informational Brochure [English, Spanish] • Wellness Center Brochure [English, Spanish, Vietnamese] • Wellness Center Monthly Calendar [English, Spanish] • Community Navigator Informational Flyer [English, Spanish] • Supplemental Crisis Services Flyer [English, Spanish]	• Notice of Privacy Practices [English, Spanish, Vietnamese] • Notice of Privacy Practices Acknowledgement of Receipt [English, Spanish, Vietnamese] • HIPAA Privacy Complaints Form [English, Spanish, Vietnamese] • Authorization for the Release/Disclosure of Information and/or Mental Health Records from Tri-City Mental Health [English, Spanish] • Authorization for the Release of Information and/or Mental Health Records to Tri-City Mental Health [English, Spanish] • Authorization for the Release/Disclosure of Information PHI and/or Mental Health

• Community Mental Health Training (CMHT) Flyers for Wellness Webinars during COVID-19 [English, Spanish]
• Wellness Webinar Flyers [English, Spanish]
  • COVID-19 Considerations for the Workplace
  • Everyday Mental Health; Motivational Interviewing
  • Stress Relief During COVID-19
  • Adverse Childhood Experiences (ACEs) and Toxic Stress
  • Fostering Resilience, Hope and Compassion During COVID-19
• CMHT Adverse Childhood Experiences (ACEs) Training Flyer [English, Spanish]
• Therapeutic Community Garden (TCG) Support Group Flyer [English, Spanish]
• Spanish Senior Socialization Group Flyer
	Records Pertaining to Alcohol-Substance Abuse [English, Spanish]
	• Authorization for the Release/Disclosure of Information and/or Mental Health Records PHI Pertaining to HIV/AIDS [English, Spanish]
	• Consent for Medication [English/Spanish]
	• Advance Health Care Directive Information Acknowledgment Form [English, Spanish, Vietnamese]
	• Consent for Groups or Family Sessions conducted via Telehealth or Telephone MH 739 [English, Spanish]
	• Consent for Services [English, Spanish, Vietnamese]
	• Crisis Intervention Plan [English, Spanish, Vietnamese]
	• Notice of Action (Assessment) [English, Spanish]
	• Notice of Action (Lack of Timely Service) [English, Spanish]
	• Therapeutic Community Garden Consent Form [English, Spanish, Vietnamese]
	• [WET Program] Service-Learning Program Application [English, Spanish]

Cultural Inclusion and Diversity Committee	**Quality Assurance**
• Cultural Competence Focus Group Questions Survey [English, Spanish] • ¡Adelante! Hispanic and Latino Wellness Advisory Council Flyer [English, Spanish] • Community Inclusion, Diversity and Wellness Fair Flyer [English, Spanish]	• Collaborative Documentation Brochure [English, Spanish] • Coordination and Rehabilitation Enhanced Services (CARES) Brochure [English, Spanish]

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

4.10 Translation of Written Materials: TCMHA shall ensure that written materials provided to clients, participants, and stakeholders (i.e. informing materials, surveys, program information, flyers and announcements, brochures, signage, consents and authorizations, documents and forms, directories,

beneficiary handbooks, appeal and grievance notices, denial, and termination notices, and other essential notices, letters and reports) are translated into the threshold languages (essential written materials shall be interpreted at minimum for non-threshold languages) and made available to clients, participants, and stakeholders and needed and/or required.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

Consumer satisfaction survey translated in threshold languages, including a summary report of the results

See Summary of Exhibits, Page 88:

Consumer Survey Letter [English]

Consumer Survey Letter [Spanish]

Survey Adult/Older Adult/Families/Youth [English]

Survey Adult/Older Adult/Families/Youth [Spanish]

The following is a brief synopsis of the survey results for June 2020. Complete survey results are available upon request.

Adult Outpatient Services	
General Satisfaction	• 97% liked the services they received.
Participant Treatment Goals	• 94% felt comfortable asking questions about their treatment and medications.
Appropriateness and Quality of Services	• 87% felt staff helped them obtain the information needed so that they could take charge of managing illness.
Perceived Outcomes	• 71% can better control their life.
Perception of Access	• 97% reported staff was available at times that were good for client.
Child and Family Outpatient Services	
General Satisfaction	• 76% were satisfied with the services their child is receiving.
Participant Treatment Goals	• 90% (agree/strongly agree) that they helped choose their child's treatment goals.
Appropriateness and Quality of Services	• 93% (agree/strongly agree) staff was sensitive to their cultural/ethnic background.
Perceived Outcomes	• A majority of parents (77%) report that their child is doing better in school.

Perception of Access	• 77% (agree/strongly agree) that their family got the help they wanted for their child.
Adult/Older Adult – FSP and FCCC	
General Satisfaction	• 100% liked the services they received.
Participant Treatment Goals	• 95% felt comfortable asking questions about their treatment and medications.
Appropriateness and Quality of Services	• 95% felt encouraged to use consumer-run programs such as support groups, drop-in centers, crisis phone lines, etc.
Perceived Outcomes	• 92% can better control their life.
Perception of Access	• 97% reported services were available at times that were good for client.
CTAY- FSP	
General Satisfaction	• 94% were satisfied with the services their child is receiving.
Participant Treatment Goals	• 92% (agree/strongly agree) that they helped choose their child's treatment goals.
Appropriateness and Quality of Services	• 100% (agree/strongly agree) staff was sensitive to their cultural/ethnic background.
Perceived Outcomes	• A majority of clients (88%) report that they are able to cope when things go wrong.
Perception of Access	• 93% (agree/strongly agree) that they received services that were right for the family.

Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture

4.10 Translation of Written Materials: TCMHA shall ensure that written materials provided to clients, participants, and stakeholders (i.e. informing materials, surveys, program information, flyers and announcements, brochures, signage, consents and authorizations, documents and forms, directories, beneficiary handbooks, appeal and grievance notices, denial, and termination notices, and other essential notices, letters and reports) are translated into the threshold languages (essential written materials shall be interpreted at minimum for non-threshold languages) and made available to clients, participants, and stakeholders and needed and/or required.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade)

4.10b Translated materials shall be written at a 6th grade reading level and go through a review mechanism for ensuring accuracy and cultural competency of the translation (e.g., back translation and field testing) ensures that the translated document has meaning beyond a literal translation.

[See *Language Interpretation and Translation Policy and Procedure*, Summary of Exhibits, Page 88]

CRITERION 8. ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

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

Wellness Center (CSS Plan):

The Tri-City Wellness Center (WC) was conceived as a place of support for people who experience mental health issues so that they could accelerate their movement toward independence, recovery and wellness. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families. The Wellness Center provides self-help groups, peer and family support services, educational resources, recreational and cultural activities, assessment and linkage services, and other services to promote increasing independence. It also provides specialized services for transition age youth (TAY). Acting as a "dynamic hub" for activities for the three cities of Pomona, Claremont, and La Verne, staff members at this site include peer advocates, family members, clinical staff, and others. They provide a range of culturally competent, person and family-centered services and supports designed to promote independence and increase wellness.

All services at the Wellness Center are free and open to people of all ages. Visitors to our drop-in center are welcomed and met with support. Trained staff, including peer advocates, volunteers and clinical staff, help create an environment of community and self-discovery where individuals and families alike can reach their personal goals. Through Mental Health Services Act (MHSA) funding and collaboration with community partners, visitors to the Wellness Center can engage in an array of holistic services and supports designed to promote independence and increase wellness. These services include but are not limited to:

- Over 50 peer support groups
- Peer and family support

- Specialized services for children, transition age youth (TAY) ages 16-25 and older adults (ages 60+)
- Employment and vocational support
- Educational resources and workshops
- Computer lab
- Recreational, social and culturally competent activities
- Assessment, linkage and referral

Peer Mentor Program/TAY and Older Adult Wellbeing Program (PEI Plan):

Trained volunteers (peer mentors) from the Tri-City area provide support to peers (mentees) who are in emotional distress. Peer mentors offer both individual and group support, and additional assistance through linkage to community resources that are both age and culturally matched to each individual mentee. Individuals attending the TAY and Older Adult programming located at the Wellness Center benefit from specialized support groups and activities targeting their specific needs.

Language is often times identified as a barrier to services. With this in mind, the Peer Mentoru program has worked diligently to recruit individuals who have multilingual skills. This group has seen a 6% increase in mentors who identify as bilingual English/Spanish speaking. Other languages utilized during this fiscal year include Cantonese and Vietnamese. With the addition of these languages, the peer mentors were able to provide culturally appropriate services to an older adult Cantonese speaker who previously had limited support. Special presentations focused on underserved populations were facilitated by Peer Mentors. These critical communities include LGBTQ+ and Veterans. This has been accomplished in part because 3% of the peer mentors identify as transgender male and can make a connection through their own personal experience. In addition to providing one-on-one support, mentors are trained to facilitate groups based on the needs of the community. Proud to Be Me, a support group for LGBTQ+ participants, provides a safe and supportive environment for individuals struggling with their identity. One participant who identifies as a Transwoman, disclosed having a limited support system due to coming out. Through this support group, she was able to socialize and connect with others and increase her own self-awareness; it was through this group that she learned to regain her voice, advocate for herself and reconnect with her family.

Help@Hand/Tech Suite (INN Plan):

The primary purpose of this INN project is to increase access to mental health care by providing a nontraditional system for individuals who may be reluctant to access services through a more formal clinical setting. Through the use of computers, tablets and smartphones, community members will be able to access a suite of technology-based mental health services focused on prevention, early intervention, and family and social support with the intent to: decrease emergency care services; reduce psychiatric hospitalizations; and reduce the duration of untreated mental illness. Project Funding Amount: $1,674,700.00 Project Dates: Sept 28, 2018 to June 30, 2021 Revised Project Dates: Jan 1, 2019 to Jan 1,

2024 – Originally designed to be a three-year project, the Collaborative as a whole voted to extend the project to five years to allow adequate time to complete the implementation phase and learning goals for this project. No additional funds are requested or required at this time.

Target Population:

- Transition age youth and college students (up to age 25) who are seeking peer support or who are interested in offering their support as trained peer listeners.
- Older adults (ages 60+) who lack transportation or are unable to access traditional services.
- Non-English-speaking clients and community members who may be facing stigma and language barriers.

II. Responsiveness of mental health services and substance use disorder services

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

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

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

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:
    1. Location, transportation, hours of operation, or other relevant areas;
    2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs);
    3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings.

The ability to provide culturally competent mental health services is an important criterion in our selection of contractors. Tri-City currently has only one contractor, NAMI Pomona Valley. NAMI Pomona Valley, the local chapter of National Alliance on Mental Illness, offers community support groups, programs, and trainings in both English and Spanish. In addition, materials are also available in Spanish.

Trainings offered in Spanish include Family to Family, Family Support Groups, and NAMI Basics. NAMI also provides community resources that are culturally appropriate and available in Spanish.

Available alternatives and options of cultural/linguistic services

Tri-City has also engaged with community partners in order to identify culturally appropriate resources that support our BIPOC and LGBTQ+ populations. These resources include:

Bienestar

A community-based social services organization based in the Greater Los Angeles area. Their focus is on identifying and addressing emerging health issues faced by the Latino and LGBTQ populations.

Black Infant Health

A prevention program offered through Prototypes' Pomona Outpatient Behavioral Health Center and an integral component of their continuum of care. The goal of the program is to assist African-American women in maintaining healthy pregnancies and to provide support services for the first two years of their baby's life.

The Asian Pacific Resource Center

The Asian Pacific Resource Center hosts programs and exhibits to celebrate the cultural heritage of the Asian and Pacific Islander Americans.

Due to COVID-19, many community programs are currently closed or in danger of closing their doors. Once the pandemic is over, Tri-City Community Navigators (responsible for linkage and referrals) will reassess community resources and update agency materials/brochures.

Policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services

Tri-City Mental Health Website and Social Media

Through Tri-City's website and social media platforms, community members are able to access information on a variety of mental health services and programs. These programs include: Access to Care; Child and Transition-Age Youth and Family Services; Adult and Older Adult Services; Crisis Support; Wellness Center programming; Prevention and Wellbeing Programs; Community Support Programs; MHSA Housing; and Client Resources.

Community Navigator Program

Community Navigators assist community members to connect with both formal and informal supports based on their individual clinical, cultural, and wellness needs. All Community Navigators are bilingual (Spanish and English) and bicultural and understand the diverse cultural and linguistic needs of our communities and the current resources available to meet those needs. In addition to providing resources, the CN's are at the forefront of outreach and engagement efforts including presenting at community

meetings (pre-COVID) and distributing flyers and brochures throughout the three cities, targeting locations that support the unserved and underserved populations.

Community Stakeholder Process

Community members, including clients and staff, are encouraged to attend stakeholder meetings where MHSA programs and services are presented in great detail. In addition, these participants are able to share their voice in the planning and implementation of programming designed to support their clinical, cultural and linguistic needs.

[See *Community Planning Process Policy*, Summary of Exhibits, Page 88]

County has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services

Tri-City Mental Health has five locations within the tri-city area. Four of these locations are centered within the city of Pomona, which holds the highest number of unserved and underserved populations based on 2010 census.

Each of these locations offers flexible hours, after-hours support staff, bilingual receptionists and staff.

Location - Pomona	Services Provided	Population Served
Tri-City Adult Outpatient Clinic	Client Outpatient Therapy	Adults and Older Adults
Tri-City Child and Family Outpatient Clinic	Client Outpatient and Family Therapy	Child, Transition Age Youth, and Family
MHSA Administration	MHSA stakeholder meetings, housing staff, PEI staff	All community members and community partners
Wellness Center	Support Groups, Employment Support, Computer Lab, Family Events	All community members and community partners

Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds

- Restrooms are gender neutral.
- All locations are wheelchair accessible.
- Signs and posters in all site locations are in threshold languages.
- Signs are posted throughout Agency facilities promoting Tri-City as an LGBTQ+ Safe Space.

Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings

Each of our clinics are positioned in a community setting. The Adult Outpatient clinic is located adjacent to our Therapeutic Community Garden where staff and clients are able to take advantage of this outdoor setting for support groups, individual sessions or to participate in the therapeutic gardening activities. This site is located in Pomona and was selected based on population and easy access to public transportation.

Our Child and Family Outpatient clinic is positioned in a community neighborhood which includes an abundance of trees and an atrium with a variety of plants and foliage which also supports a natural setting for clients and staff to enjoy. This site is also located in Pomona and was selected based on population and easy access to public transportation.

The location of the Wellness Center was determined by a committee of MHSA delegates, community representatives and Tri-City Mental Health staff and assisted by a consultant. They mapped out a distribution of where current clients lived, public transit routes, visibility from the street and proximity to mental health clinics. They also wanted the location to be accessible to all three cities. After meeting for three months, they settled on a location that met all of the criteria and is located at the center point for all three cities.

Hours of operation for each of these settings are staggered and include both morning, afternoon and evening, depending on the day. Support groups and Wellness Center activities take place throughout the day and evening to allow participants to join depending on their own schedule and availability. Support groups and activities are available in English and Spanish, with bilingual staff available on site.

III. Quality of Care: Contract Providers Responsiveness of mental health services and substance use disorder services

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

The following clauses related to cultural competence are included in contracts and/or Memorandum of Understanding (MOU) when engaging the services of local providers:

- Contractor/(Name of Contractor) shall provide evidence of its capacity to provide culturally competent trainings to culturally diverse participants.

- Trainings provided by Contractor/(Name of Contractor) shall be staffed with personnel who can communicate in participants preferred language, or Contractor shall provide interpretation services.
- Contractor/(Name of Contractor) is responsible for providing evidence of cultural competence trainings attended by all NAMI training staff. If Contractor/(Name of Contractor) is unable to provide said training, training staff must arrange to participate in a minimum of two cultural competence trainings per year provided by Tri-City Mental Health.

IV. Quality Assurance

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

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

Process Development

The Quality Assurance and Quality improvement departments work together in order to provide services that are consistent with the Department's Cultural Competence Plan and all applicable Federal, State and local regulations, manual, guidelines and directives. All this is done by the following.

When a new process is being developed or modified, a collaboration between the process owner and manager of Best Practices is established in order to ensure the process is congruent with Client Needs, Agency Needs, Regulations, Agency Policy, and Industry Standards.

- The goal is to identify and develop goals and outcome measures in order to evaluate efforts.
- Ensure that Process Owner is developing and documenting the process.
- Ensure that process/program design is congruent with purpose and need.
- Determine standards and develop process for tracking and documentation & provide initial training.

Once the process has been established, collaboration with Quality Improvement supervisor is established to determine if any training is needs for documentation regulations and standards to reflect the culture,

language, ethnicity, age, gender sexual orientation, and other social characteristics of the community that our program serves.

A continued collaboration with the process owner is ensured in order to maintain that workflow process/training is established, implemented and fully launched. Once the new process is established the process is presented to the monitoring team, so that they can create a system of ongoing review.

Quality Assurance

The Quality Assurance department ensures that Tri-City staff are trained and documents reflect the cultural, language, age, gender, sexual orientation and other social characteristics of the community that different department serve in our agency.

Policy/Procedure/Protocol Implementation:

Create and Implement Policies, Procedures, and Protocols, based on: Laws, Clinical Ethics, Clinical Standards of Practice, Payer Guidelines & Requirements, and Internal Standards.

Training and Education:

Tri-City Mental Health is committed to compliance and communicates compliance rules and procedures to all service providers through mandatory training programs at orientation.

Other means of communicating compliance information include distribution of educational materials, emails, bulletins, etc., as often as needed.

The goals of the training/education program are:

- Introduce clinical service providers to Documentation Compliance Policies and the role each is expected to play in ensuring compliance.
- Introduce and reinforce shared values with regard to ethics and compliance issues.
- Update all employees/Tri-City agents on changes in rules, regulations, law, and policy.
- Provide resources for current regulations, coding, documentation and billing.
- Failure to attend mandatory compliance trainings and unwillingness/inability to comply with any aspect of Documentation Compliance Policy will follow the normal process of counseling and discipline as outlined in the Tri-City Mental Health Employee Handbook.

The quality and quantity of trainings will be monitored through obtaining training sign-in sheets to track quantity of trainings, and through administering post-training surveys, to track quality of trainings.

General Documentation Standards

Medical records are permanent documents of the reporting system. Documentation guidelines have been developed to promote the integrity of Tri-City Mental Health's Consumer Medical Records, which are periodically examined by regulatory, funding, and legal agencies.

[For more information about QA protocol on Clinical Records, see *Clinical Records Guidelines: Contents and General Documentation Requirements CL.I02* and *Medical Records Chart Order,* Summary of Exhibits, Page 88]

Initial Intake/Assessment Documentation

During the intake process, information is gathered to determine eligibility for services, based on: 1) Residency Requirements, 2) Medical Necessity and 3) Financial Obligation/Ability to Pay.

The following forms must be completed at first intake contact:

- Consent for Services/Treatment
- Notice of Privacy Practices Acknowledgement (HIPAA)
- Informing Materials Acknowledgment
    - Guide to Medi-Cal
    - Mental Health Provider Directory SPA 3
    - Mental Health Resource Directory
    - Grievance and Appeal Rights Tri-City
    - Grievance and Appeal Procedure-Consumer Guide
- Safety Guidelines Acknowledgement
- Request for Interpretation/Translation
- Advanced Health Care Directive Acknowledgement (18+)
- PFI Payer Financial Information
- Authorization for Reimbursement of Benefits
- Financial Obligation Agreement
- Baseline OMA – FSP
- C.A.R.E.S. screening form (age 21 and under)
- CANS (age 21 and under)/PSC-35 (age 19 and under)
- EHR Submission Form

The following forms must be completed by the end of the Assessment Period:

- Full Assessment/ Co-Occurring screenings, evaluations, and assessments

- Crisis Intervention Plan
- Client Treatment Plan/Welligent Treatment Plan
- NOAA – If the client does not meet medical necessity

Treatment Plan Documentation

- Client's preferred language other than English and language is documented
- Plan was interpreted and into what language is documented
- Client was offered a copy of treatment plan is documented
- Client/Family involvement is documented for each goal
- Type of intervention and interventions are documented for each goal
- Goal and goal implementation date are documented
- Client/guardian signature and staff/AMHD signature are required for each goal

Progress Note Documentation

All Tri-City staff are required to document all services and/or activities that are provided for the benefit of the consumer. All services will be documented in the progress notes in the consumer's medical record immediately. Progress note requirements include:

- Each entry for services should identify the date and time of contact, type of contact (e.g. telephone contact, face to face contact, etc.), procedure code, type of service rendered, the length of time, and the persons involved.
- Each entry is to be signed by the rendering provider(s), with the full signature and credentials.
- Services must be documented using the following format:

MHS and TCM Progress Notes include:

- Visual and Hearing Impairments
- Session Language
- Present for Session
- Travel Time
- Session Goal
- Treatment Plan Goal
- Symptoms
- Intervention
- Response

- Progression/Regression
- Plan

Consumer Access to Own Medical Record

If a consumer wishes to inspect her/his own records, a Client Request to Access Records form must be obtained from and submitted to the Medical Records' Supervisor. Prior to the review:

- The AMHD will review the request with their supervisor and primary psychiatrist.
- If, upon review of the record by the consumer's psychiatrist, case AMHD, Program Supervisor, or Privacy Officer, it is determined that no harm would come from the consumer's review of his medical record, the consumer will be given access to his record. This will always be done in the presence of a professional staff member who will be able to explain or interpret the contents of the record.
- If it is determined that harm could come from the consumers review, then the service provider, and supervisor, should follow up with the Chief Operations officer for further direction.

Quality Improvement

The Quality Improvement department shares the responsibility with different departments to maintain and improve the quality of services and delivery infrastructure. In addition to being required by the State and Federal mandates, a regular assessment of consumers' experiences of services provided and their providers is essential to improve and innovation within Tri-City Mental Health.

Performance Measurement is the process of regularly assessing the results produced by a program, department, or division. It involves identifying processes, systems and outcomes that are integral to the performance of the service delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Continuous Quality Improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

Measurement and assessment process:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance measures for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.

- Taking action to address performance discrepancies when indicators indicate that a process is not stable, is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

The Quality Improvement department ensures data analysis of performance measures for quality improvement of all agency program programs. It also collaborates with the Quality Assurance department for quality improvement activities across the agency. The quality improvement team prepares and analyzes data for the following:

- Timeliness of Services
  - Access to Care data
- Beneficiary and participant satisfaction
  - Consumer Perception surveys and program surveys
- Service delivery analysis
  - Access to Care data
- Performance Improvement projects
  - Programs developed and implemented by the Quality Improvement Committee
- Consumer Outcomes
  - Consumer Perception surveys and program surveys

Tri-City is committed to becoming a behavioral health center of excellence, which is also aligned with the Triple Aim:

- Improve Health
- Reduce Costs
- Positive Client Experience

Tri-City has invested in expanding and enhancing our current system capabilities to more thoroughly track, evaluate and report on the effectiveness of services provided. Service outcome reporting is critical in assuring that Tri-City will be able to update, modify and develop new projects based on valid, reliable, and objective data. This method helps contribute to Tri-City's vision to successfully analyze outcome data, identify trends and provide reporting that will support future program improvement and development.

Protocol for Reports

The Quality Improvement department collaborates with all Tri-City programs and departments to prepare reports on a biannual basis: six months and one year.

Purpose of the Six-Month and Annual Update Reports:

- To provide programs with up-to-date information on their departments/programs.
- To identify whether changes need to be made to the performance measures.
- To maintain accountability for data collection.
- Report Timeframes
    - July 1 through December 31 for the Six-Month Reports
    - July 1 through June 30 for the annual update

Below is a flow chart of the process:

SUMMARY OF EXHIBITS AVAILABLE UPON REQUEST

- Mission Statement for Tri-City Mental Health
- Core Values for Tri-City Mental Health
- Mission Statement for Cultural Inclusion and Diversity Committee (CIDC)
- Mission Statement for African American Family Wellness Advisory Council (AAFWAC)
- Mission Statement for ¡Adelante! Latino and Hispanic Wellness Advisory Council
- Mission Statement for LGBTQ+ Wellness Advisory Council
- Ethnic Services Manager Job Description
- Cultural Inclusion and Diversity Committee Staff Survey October 2020
- Language Interpretation and Translation Policy and Procedure
- Language Line Protocol
- Request for Interpretation and Translation Form
- Language Line Guide and Access Codes
- Informing Materials Checklist [English]
- Informing Materials Checklist [Vietnamese]
- Informing Materials Checklist [Spanish]
- Language Line Poster
- MHP Language Poster
- Consumer Survey Letter [English]
- Consumer Survey Letter [Spanish]
- Adult Survey [English]
- Adult Survey [Spanish]
- Older Adult Survey [English]
- Older Adult Survey [Spanish]
- Youth Service Survey for Families [English]
- Youth Service Survey for Families [Spanish]
- Youth Service Survey for Youth [English]
- Primary Language Screening Tool
- Community Planning Process Policy
- Clinical Records Guidelines: Contents and General Documentation Requirements CL. 102
- Medical Records Chart Order