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September 1, 2011

Karen Hudson, Staff Mental Health Specialist
California Mental Health Planning Council
1600 9th Street, Room 420
Sacramento, CA 95814

Re: County of San Bernardino Behavioral Health Commission Data Report

Dear Ms. Hudson;

During a public data workshop on August 4, 2011, the County of San Bernardino Behavioral Health Commission (BHC) reviewed the county's performance outcome data for Fiscal Year 2009-2010. The enclosed report includes feedback received during the public workshop.

BACKGROUND

Pursuant to Welfare and Institutions Code, Section 5604.2 (a) (7), mental health boards and commissions are required to review and comment on the county's performance outcome data and communicate their findings to the California Mental Health Planning Council (CMHPC). To facilitate compliance with this mandatory statute, the CMHPC created a workbook with a report template to be completed by county mental health boards and commissions, including a set of questions to answer.

PROCESS

Utilizing the workbook report template the BHC held a public data workshop on August 4, 2011, to analyze the county's Fiscal Year 2009-10 data relating to mental health disparities. There were two types of performance indicators used in the workbook; one showing access (penetration), and one showing retention. These indicators were analyzed by race/ethnicity, age, and gender. Time was set aside for questions and comments. Attendees included representation from the Board of Supervisors, community mental health coalitions, consumer and family members, and county and contract agency staff.

CONCLUSION

During the last decade, the BHC has seen positive changes occur in county behavioral health programs due to the Mental Health Services Act (MHSA). The questions contained in the data workbook template may need to be revised to further incorporate culturally diverse groups; deaf and disabled, and sexual orientation. We recognize that Substance Abuse and Mental Health Services Administration (SAMHSA) is engaged in a gender study, and look forward to the results.

Additionally, workforce development efforts have helped San Bernardino County develop programs to encourage education and licensing for existing staff, address workforce issues in rural and shortage areas, and create a Training Institute to provide existing staff and partners with ongoing training related to providing quality, evidence-based services. These efforts should help build and sustain the public mental health workforce long term.

The BHC appreciates the opportunity to share information with our stakeholders. We also appreciate the support of the CMHPC for providing training to local mental health boards and commissions to ensure we can effectively carry out our duties. Should you have any questions regarding the enclosed data report, please contact our office.

SMS:MW:dp

Enclosure

Sincerely,

Susan McGee-Stehsel, Chair

Monica Wilson, Vice Chair

cc: Board of Supervisors
Gregory C. Devereaux, Chief Executive Officer
Linda Haugan, Assistant Executive Officer
Members, Behavioral Health Commission
Allan Rawland, Director Department of Behavioral Health
Executive Management Team, Department of Behavioral Health
Association of Community Based Organizations
Community Mental Health Coalitions

Report Template

Mental Health Boards and Commissions should use the following template to submit their report:

County Name: **San Bernardino County**

Contact Person: **Susan McGee-Stehsel, Chairperson Behavioral Health Commission**

Phone Number: **909-382-3134**

Email Address: **dpasco@dbh.sbcounty.gov**

Please provide your answers to each of the following questions:

RACE / ETHNICITY

Penetration Rates

1. What are your findings regarding access/penetration for mental health services by race/ethnicity? What racial/ethnic groups have higher access (penetration)?

Several racial/ethnic groups received services at rates that met or exceeded their proportions in the community, including:

- African Americans,
- Native Americans, and
- Persons describing themselves as having multiple or "other" ethnic backgrounds.

As has been stated in previous presentations, African Americans and Native Americans receive more episodes of services categorized as "higher levels of care," such as inpatient hospitalization, and crisis services than their Caucasian peers (Department of Behavioral Health (DBH), Research and Evaluation Division (R&E) 2009/2010). They also receive less episodes of what would be characterized as "lower levels of care" such as outpatient services and case management (R&E, 2009/2010).

- Asian /Pacific Islanders (API) were most underserved, with a penetration rate of only 26%.
- Latinos were also significantly underserved, with a penetration rate of 43%, compared to the Caucasian penetration rate of 78%.

2. What factors in your county account for differences in access (penetration) by race/ethnicity? e.g. transportation, geography, mental health literacy, stigma?

In general, geography and transportation are major challenges. Our county is over 20,000 square miles in size, much of which is either mountains or desert. People in need of services often have difficulty getting to provider sites (Submitted DBH Cultural Competency Plan Requirements (CCRP), 2010).

For African Americans, as stated above, there is a disproportionate access to DBH services. This is an alarming national trend that has been noted at the Federal level (Substance Abuse Mental Health Services Administration (SAMHSA), 2011) to be associated with institutionalized racism, lack of cultural specific intervention, lack of cultural knowledge and lack of providers who mirror the population being served.

In 2009, the Mental Health Services Act (MHSA) funded PROJECT ACCESS, administered by the Latino Health Collaborative, looked specifically at the identification of factors that influenced access and use of behavioral health services for a number of ethnic populations:

For African Americans, the report states issues of access were related to:

- Language barriers—not being able to understand English as a Second Language (ESL) providers.
- Feelings of not being understood on a cultural level which also includes language.
- Perception of poor services provided (difficulty scheduling appointments, lack of quality time with providers, long waits, sense of insincerity from providers).
- Lack of insurance coverage.

For Native Americans, a separate parallel study was also funded by MHSA for the Native community, by the Native community (Fontana Native American Indian Center (FNAIC), 2009). The report states that:

- Lack of Native providers.
- Lack of respect for traditional healing practices/beliefs negatively impact access to timely services.
- Access due to stigma.
- Lack of resources on the reservation for Tribal communities specific to behavioral health.

Asian Pacific Islanders (API) may have issue with:

- Access due to stigma.
- Lack of linguistic resources.
- Lack of cultural knowledge by providers.
- Per the PROJECT ACCESS study report, all previously stated factors were mentioned, as well as the lack of behavioral health educational material in the various Asian dialects, difficulty using interpreter services, the experience of being a refugee and Post Traumatic Stress Disorder (PTSD) that impacts Western service delivery, lack of knowledge regarding the culture of the Elder, lack of linkage with primary care, lack of linkage with Faith Based Organizations (FBO), and financial barriers.

For Latinos, factors affecting access include:

- Lack of linguistically proficient providers.
- Lack of cultural knowledge.
- Fear.
- Lack of funding to support care.
- Per the PROJECT ACCESS report, stigma, views on medication, the perception of the ineffectiveness of the mental health professional, cultural beliefs on mental health/illness, collectivism, gender, lack of linkage with FBO, and immigration issues were all cited as factors negatively impacting access to services.

3. What barriers exist in your county to increasing access (penetration) for mental health services for the identified underserved race/ethnic groups?

The PROJECT ACCESS report cited both attitudinal barriers, such as racism, as well as structural barriers, such as lack of insurance coverage as barriers to access. Please refer to above question/answer for details.

4. What is your understanding of what your county is doing to increase access (penetration) for mental health services by race/ethnicity; e.g. implementing the Mental Health Services Act (MHSA) and your county's Cultural Competency Plan?

- Implementation of MHSA, based on the inclusive stakeholder process.
- Dedicated Office of Cultural Competence & Ethnic Services.
- Inclusion into Department of Behavioral Health (DBH) processes of the Cultural Competency Advisory Committee and corresponding cultural specific sub-committees and coalitions: African American Sub-Committee, Asian Pacific Islander Coalition, Disabilities Sub-Committee, Latino Health Coalition; LGTBQ Sub-Committee, Native American Sub-Committee, Co-Occurring and Substance Abuse Committee, Spirituality Sub-Committee, Transitional Age Youth Sub-Committee, Women's Sub-Committee, and Consumer and Family Members Sub-Committee.
- Funding of culture-specific projects such as the African American Resilient Child Program, Promotoras, Native American Indian Center.
- Outreach and engagement of cultural groups throughout the County.
- Policies and procedures that focus on the provision of culturally/linguistically appropriate services.
- Training for all staff that is mandated on cultural/linguistic competency to ensure cultural understanding and awareness on ethnic as well as cultural groups including consumers as culture. All direct service staff are required to have 4 hours of cultural competency training a calendar year and all support staff and administration staff are required to have 2 hour of cultural competency training a calendar year. Staff personnel files are audited by the Office of Cultural Competence & Ethnic Services to ensure compliance.
- Mental wellness promotion in diverse communities.
- Contract requirement for all DBH providers that requires cultural/linguistic providers and services, training, as well as adhering to the latest State approved Cultural Competency Plan (CCP) for San Bernardino County (DBH Contract Department, 2011).
- Inclusion of the Cultural Competency Officer position as part of the Executive Management Team to ensure cultural competency at all levels of programming throughout DBH.

5. What recommendations do you have for increasing the access (penetration) for mental health services for the identified underserved racial/ethnic groups in your county?

- Increase the ability to hire bilingual and/or bicultural staff.
- Increase education in the community through collaboration with cultural brokers.
- Continued support for cultural competence.
- District Advisory Committee meetings, established by the Behavioral Health Commission to increase diverse stakeholder connectivity.
- Continued partnerships, which includes capacity building for cultural specific, community based organizations such as the Elevate Academy through Prevention and Early Intervention (PEI), and the California Institute of Mental Health Capacity Building three year project

Retention Rates

1. What are your findings regarding retention in mental health services by race/ethnicity? What racial/ethnic groups have higher retention in mental health services?

With retention defined as having received more than one outpatient service in the fiscal year,

- Asian Pacific Islander group is most strongly represented in this category, with 80% of those receiving one service, returning for one or more service.
- African Americans and Latinos returned for more than one service at a rate of 73%.
- Caucasian consumers returned for more than one service at a rate of 70%.
- Native Americans returned for more than one service at a slightly lower rate of 66%.

2. What factors in your county account for differences in retention by race/ethnicity? e.g., transportation, geography, mental health literacy, stigma?

- Asian Pacific Islanders (API) have the highest retention rate—cultural factors may account for differences in retention. Cultural norms may prevent a consumer from leaving midsession. API not only focus on saving face for themselves, but due to the collectivism inherent in the culture, the norm is also to save face for you, avoiding any embarrassment on the provider (Sue & Sue, 1990).
- Native Americans may also have cultural factors involved, which could prevent a Native American from remaining in treatment if there is disrespect (intentional or unintentional) of cultural beliefs (FNAIC Report, 2009).
- African Americans, per the previous data, may be receiving higher levels of crisis services which could result in treatment, resolution, crisis, and then treatment again, etc. which could lead to greater retention (R&E 2009/2010).

3. What barriers exist in your county to increasing the retention in mental health services for the identified underserved racial/ethnic groups?

Retention, per the definition, does not address the entire picture of service delivery, but rather if an individual is seen at all in the system. Native Americans have the lowest retention rate.

- This could be due to those same reasons listed in previous items, such as lack of Native providers, so that once assigned to a non-Native therapist/doctor, the consumer does not return.
- Additionally, for Native Americans, lack of respect by providers in the initial session/assessment/intake process, could result in them not returning (FNAIC Report, 2009).
- Again, it is essential to understand that increasing retention does not necessarily address issues surrounding access to services, as retention does not address quality nor the appropriateness of care, which is the ultimate goal of DBH.

4. What is your understanding of what your county is doing to increase retention in mental health service by race/ethnicity; e.g. implementing Mental Health Services Act and your county's Cultural Competency Plan?

Again, it is essential to understand that increasing retention does not necessarily address issues surrounding access to services, as retention does not address quality or appropriateness of care, which is the ultimate goal of DBH.

Native Americans:

- The development of a community based Native American Resource Center as part of the MHSA Prevention and Early Intervention (PEI) initiatives.
- A focus on respect for indigenous beliefs and healing practices as evidenced by the partnership with the Native American Resource Center in an annual celebration of Native Heritage that includes Elders and Tribal spokespeople who speak of mental wellness and sobriety from a Native perspective.

African Americans:

- Increase quality of services to African Americans. This includes working with The African American Health Institute, for which the County has provided additional resources to produce a County specific report – for African Americans, to assist the County in providing more culturally appropriate interventions as defined by the community. Additionally, San Bernardino County has worked directly with each of the other California Reducing Disparities Project vendors, hosting focus groups and key informant interviews: Pacific Clinics for Asian Pacific Islanders, UC Davis for Latinos, Equality California for LGBTQ and Native Vision for Native Americans.

For all communities:

- Cultural Competency training that addresses awareness and understanding of cultural/linguistic needs of the communities we serve, as well as increasing the understanding of ethnic specific theories that are often not addressed in professional trainings that are mandated for staff.
- Focus on inclusion of Community Defined Practices being studied by the Statewide Reducing Disparities project within the current Medi-Cal system.
- Utilizing various methods such as client surveys, focus groups, town hall meetings, working with cultural brokers, community and providers to obtain information about life satisfaction from individuals, families and communities.

5. What recommendations do you have for increasing retention in mental health services for the identified underserved racial/ethnic groups in your county?

This question addresses underserved groups, which have been identified per the 2009 PROJECT ACCESS study as Native American communities.

- Increased partnership with Native providers to improve retention in treatment.
- Inclusion of parallel practices/interventions that use both Western and traditional approaches to wellness.

Other factors to consider:

- 1. Do certain race/ethnic communities access mental health services through other community resources; e.g. community health clinics, federally qualified health clinics, acute care hospitals serving indigent persons?**

All racial/ethnic groups also utilize their own traditional supports.

Latinos:

- This may be more evident in those who do not access our DBH services such as Latinos. This population may be receiving their care in the primary care area (Community Clinics, Public Health).
- Many Latinos, per the PROJCT ACCESS report, access services through their Faith Based Organizations (FBOs). Some also report accessing services via traditional healers such as Sabadores (healing massage), Curanderos (medicine people), Yerberos (herbalists) (Surgeon General's Report, 2001).

African Americans:

- May access FBOs within their own communities as well as medical doctors (Surgeon General's Report, 2001).

Asian Pacific Islander:

- May receive care as well by the FBOs both in and outside of their immediate communities due to stigma, via primary care physicians, through traditional healers such as herbalists (Surgeon General's Report, 2001).

Native Americans

- May access care via an Indian Health Center (verification required if federally funded for Tribal affiliation) as well as via FBO's and traditional healers including Elders in the community (Surgeon General's Report, 2001).

- 2. Are there additional factors that your county could analyze if race/ethnicity were broken down into more detailed categories, such as subcategories used for Asian/Pacific Islanders in the Client Services and Information System (CSI); e.g. Chinese, Japanese, Hmong, etc?**

Department of Behavioral Health does break down ethnicity to sub groups. For example, Asian Pacific Islander is further broken down with the larger populations seen in San Bernardino County as:

- Vietnamese
- Thai, and
- Cambodian

Cultural beliefs on healing differ from group to group and are heavily influenced by religion and spirituality. For example, many Vietnamese identify as Buddhist, and just as many identify as Catholic.

- Many Vietnamese Catholics seek pastoral counseling through the church, and
- Vietnamese Buddhists through the Temple.

The same can be said for the two other API groups (Truong, 2011).

AGE

Penetration Rates

1. What are your findings regarding access/penetration for mental health services by age? What age groups have higher access (penetration)?

Among the four MHSA-based age groups:

- Transitional Age Youth (15-24 years) has the highest penetration rate at 111%. Caution is given here regarding correlating penetration with appropriate access. While there has been a concerted effort to target TAY, it may be that the TAY in our system are African American and Native American accessing services at a higher rate than their presence in the community, which is more related to inappropriate services (higher levels of care, etc).
- Adults (25-59 years) penetration rate is 68%.
- Children (0-14 years) penetration rate is 47%.
- Older adults (60+ years) penetration rate is 24% (most underserved).

2. What factors in your county account for differences in access (penetration) by age?

Older adults:

- Often have physical health issues.
- May live in rural or mountain areas, or lack reliable transportation and assistance, face special challenges with isolation and limited social support (Gilmer & Garcia, Journal of Geriatric Psychiatry, 2009, 24(3) 313-318).
- Grew up without immunizations and antibiotics.
- Needing medication to address behaviors and thoughts may be culturally incongruent.
- Great deal of stigma surrounding behavioral health issues in older adults (Surgeon General's Report, 1999).
- May be impacted by poverty, with little insurance coverage, especially for medication.
- May be impacted by other cultural factors such as ethnicity and sexual orientation and gender identity (California Mental Health Director's Association (CMHDA) Older Adult System of Care 2010 Report).

Children:

- Hesitancy to seek assistance with a severely emotional disturbances (SED) child due to lack of developmental understanding on the part of the caregiver, the educational system or the medical field.
- Children with mental health needs depend on the attentiveness and reliability of caregivers (National Institute of Mental Health (NIMH), 2011).

3. What barriers exist in your county to increasing access (penetration) for mental health services for the identified underserved age groups?

Older adults:

- Lack of programs that focus on the cultural needs of this population and that are provided in the areas in which they reside, including geographically isolated areas.

Children:

- Lack of easy to navigate systems for behavioral health that the caregiver can access quickly.

4. What is your understanding of what your county is doing to increase access (penetration) for mental health services by age?

San Bernardino County has developed and funded numerous MHSA programs:

Older adults:

- Circle of Care, which includes some Full Service Partnership programming for older adults, and an expansion to the High Desert region for geographically isolated elders.
- Older Adult Community Services program that focuses on the needs of the older adult community, which is one of the populations with a high percentage of disparities in service, particularly in preventative programs.
- The Department of Behavioral Health collaborates with the Department of Aging and Adult Services and other partners in an effort to promote services to older adults.

Children/families - focus has been placed on prevention and early intervention for both children and their families/caregivers:

- Integrated Health and Health Education.
- Student Assistance Program (SAP) focuses on disparity reduction with the high risk population for school failure, which heavily impacts African American and Latino children at greater proportions.
- Resilience Promotion in African American Children which addresses and mediates Post Traumatic Stress Disorder (PTSD) in high risk trauma populations and focuses on Afro centric prevention services that address risk of juvenile justice involvement and school failure.
- Pre-School Project addresses the needs of high risk, disproportionately underserved children and caregivers/parents.
- Family Resource Centers that provide prevention and early intervention for family systems.
- Child and Youth Connection which addresses prevention and early intervention in children. This program focuses on foster children.
- Nurse Family Partnership, which addresses pregnant and parenting high risk first time moms and their children with a focus on cities where there is great disparity in need (provided in the home of the mother).
- Military Services and Family Support addresses military families, who also have a higher disparity in needs and access to services.

5. What recommendations do you have for increasing the access (penetration) for mental health services for the identified underserved age groups in your county?

- Strong outreach at Senior Centers.
- Continued support for the programs developed under (MHSA) for older adults and children; advocate for program expansion.
- Decrease of MHSA funding would result in huge gap in service delivery.

Retention Rates

1. What are your findings regarding retention in mental health services by age? What age groups have higher retention in mental health services?

As mentioned in previous sections, with "retention" defined as having received more than one outpatient service in the fiscal year,

- Children have the highest retention rate at 85%.
- Adults (25-59 years) have the lowest retention rate at 67%.

2. What factors in your county account for differences in retention by age?

Children have the highest retention rate.

- Children by definition would be less likely to leave a session due to parental/caregiver control.
- Adults would have the most ability to decide to leave voluntary treatment.

3. What barriers exist in your county to increasing the retention in mental health services for the identified underserved age groups?

Many of the potential barriers for adults could be related to ethnicity/language data (Submitted DBH Cultural Competency Plan Requirements (CCRP), 2010).

4. What is your understanding of what your county is doing to increase retention in mental health service by age?

Programs are developed to address the culture of age, at times providing age specific programming in separate locations, such as at the Transitional Age Youth (TAY) centers:

- Only youth age 15-25 are treated.
- Culture specific location allows for increased focus of cultural needs by embracing age appropriate interventions and norms.

5. What recommendations do you have for increasing retention in mental health services for the identified underserved age groups in your county?

- Continued support for the Mental Health Services Act (MHSA) programs with possible expansion for the children and older adult populations.
- Loss of MHSA funding would result in a huge gap in service delivery.

Other factors to consider:

- 1. Are there other service systems that may be meeting the mental health needs of clients in certain age groups; e.g. some clients over age 65 receive mental health services through Medicare instead of the public mental health system; some children receive mental health services from Healthy Families, Healthy Start, Head Start, or First 5 programs?**

Older adults:

- May access services through Medicare providers and/or private insurance.
- For cultural reasons, older adults may access primary care physicians to treat some of their disorders as well as the FBOs (Surgeon General's Report, 1999).

Children:

- May access services through Healthy Families, Head Start, First 5 community programs as well as through a primary care physician (Children's Network, 2010).
- May access services through the County of San Bernardino Children and Family Services, especially children in the foster care system.
- May access services through the schools (Educationally Related Mental Health Services).

GENDER

Penetration Rates

1. ***What are your findings regarding access/penetration for mental health services by gender? Do males or females have higher (penetration)?***

Almost exactly half of our county is male and the other half female. Some percentage of residents are of mixed gender, but this figure is not included in available reports.

- About 53% of clients served by the public mental health system in our county are male. Among the group of persons in need, 67% of males were provided with at least one service in FY2009/2010.
- For female persons in need, this percentage was slightly less, at 60%.

2. ***What factors in your county account for differences in access (penetration) by gender?***

Possible hypotheses for the disparity between the genders:

Male:

- Juvenile and adult males are more likely to be served in the justice system (LWV, 1996).

Female:

- We know that less money is spent per client for females than males, which may be based on institutionalized sexism, meaning that most mental health treatments may have been designed by men for men, and then altered to fit women (External Quality Review Organization (EQRO) Report, 2010).
- Women tend to be the caregivers in the family and may have the primary responsibility for taking care of both children and elderly parents, impacting their ability to make and keep appointments with behavioral health (World Health Organization (WHO), 2011).
- Women may have the need to bring small children with them to services, for which there is no childcare available on site, with the exception of our Alcohol and other Drug (AOD) programming in Perinatal Services.

3. ***What barriers exist in your county to increasing access (penetration) for mental health services for the identified underserved gender group?***

There is a shortage of female-specific treatment programs outside of AOD Programs, as well as the factors listed above.

4. ***What is your understanding of what your county is doing to increase access (penetration) for mental health services by gender?***

- Funding PEI programs to enable women to receive programming with their children via Family Resource Centers, Preschool Services programs and Nurse Family Partnership.
- Development of a Women's subcommittee of the Cultural Competency Advisory Committee (CCAC), which is addressing the disparity in services.

5. **What recommendations do you have for increasing the access (penetration) for mental health services for the identified underserved gender group in your county?**

Continued funding for MHSA funded programs for women and children.

Retention Rates

1. **What are your findings regarding retention in mental health services by gender? What gender has a higher retention in mental health services?**

Again with "retention" defined as having received more than one outpatient service in the fiscal year, there is no significant difference between the retention rates of males and females, at 71% and 73%, respectively.

2. **What factors in your county account for differences in retention by gender?**

The differences in retention are negligible between males and females.

3. **What barriers exist in your county to increasing the retention in mental health services for the identified underserved gender group?**

The differences in retention are negligible.

4. **What is your understanding of what your county is doing to increase retention in mental health service by gender?**

San Bernardino County continues to examine the needs of women in our system via the Cultural Competency Advisory Committee (CCAC) Women's sub-committee which has been utilizing resources from SAMHSA to evaluate current programs for woman-centered focus.

5. **What recommendations do you have for increasing retention in mental health services for the identified underserved gender group in your county?**

Continued support for CCAC subcommittee on Women's issues.