Stars Behavioral Health Group

Cultural Competency Plan for **Starlight Adolescent Center**

FY 2005 to 2006

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Cultural Competency Plan for Starlight Adolescent Center

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I. MISSION

Program and Mission Statement

Within the SBHG continuum, *Starlight Adolescent Center* has the important distinction of offering to California the first Community Treatment Facility (CTF) for youth. Started in year 2000, the original CTF mission was to provide local and cost-effective treatment as an alternative to expensive state hospitalization. This mission was accomplished as state hospital populations declined and youth moved into community care. Subsequently, *Starlight* began to play a unique role in the continuum of services available throughout the state by providing a step-up for clients unable to succeed within an RCL Level 12-14 group home. CTFs also offer treatment – as distinct from detention -- to juvenile offenders with mental illness. *Starlight's* CTF and Non-Public School (NPS) make step-down and sustained safety, structure, treatment and education possible for youth coming from acute or sub-acute psychiatric facilities.

More recently, Starlight stepped up to the need for more services in Santa Clara County and now offers intensive day treatment, specialty outpatient mental health services, and therapeutic behavioral services to community clients in order to prevent the need for higher level placements or hospitalizations in the first place. As these are new programs, "ramping" up service delivery capacity, the community services client and staff data will not be analyzed at this time. Therefore, the current cultural competency plan focuses primarily on the services that are part of *Starlights'* Community Treatment Facility. Starlight's non-residential services will be included in the SBHG cultural competency planning process described below.

Starlight Adolescent Center expresses the distinctive mission and vision of residential and community outpatient treatment within the larger mission of *Stars Behavioral Health Group* (SBHG). The organizational mission is to…

"Develop and operate a full continuum of mental health services that reflect clinical excellence and continuous quality improvements, to maintain an unconditional commitment to assisting clients with mental illness to achieve and maintain their optimum level of functioning and quality of life, and to provide effective mental health treatment and cost-efficient services that involve and respect the diverse resources and talents available within the client, family, staff, and community".

Additionally, the *Starlight* policy on cultural competency (ADM 1.30) sets forth:

"To assure that the facility operates in every aspect from a framework of cultural competency recognizing the importance of awareness and respect for the cultural background of the clients we serve, the community we live in, and the staff who work for us."

Finally, the *Starlight Professional Services Plan* (program statement, under revision) articulates features of our service delivery model including cultural competency:

"Culture is the context in which youth and families develop identity and meaning. It is critical that Starlight's services

are sensitive and responsive to the diverse cultures represented in the service population which includes African American, Caucasian, Filipino, Hispanic/Latino, and Vietnamese people among other cultural groups."

Definition of Cultural Competency

The working definition of cultural competency is sourced from the seminal NIMH monograph *Toward a Culturally Competent System of Care*, Vol I, 1998, consistent with the framework of the *California Mental Health Master Plan: A Vision for California* (March, 2003) and referenced in the *California Department of Mental Health Mental Health Services Act* (MHSA) DRAFT (02/15/05) planning document:

"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, and among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."

SBHG Cultural Competency Planning Process

Starlight Adolescent Center is part of an SBHG state-wide planning process committed to providing services for children, youth and families that are driven by the values and principles of cultural competency. Starlight's Executive Director, who is Latino, will serve as a member of the SBHG *Cultural Competency Steering Committee* that is to provide overall direction, focus, and organization to cultural competency planning and quality improvement throughout SBHG companies. Potential areas of focus of the steering committee are presented in Appendix A.

Client and Family Outcomes (Program Goals)

The program goals and related outcome objectives of SBHG programs are for clients to be:

1. Safe in home or family like settings – including avoiding out-of-home placements, returning to lower levels of care, fostering permanency, positively impacting family functioning, and sustaining as family-like an environment as safely possible for youth during placement;
2. Attending and progressing in school or vocational endeavors – including improving school/vocational attendance and engagement, improving grades and grade-level advancement, and enhancing standardized achievement test scores;
3. Recovered and resilient – including improving access to needed health/mental health care, improved functioning in multiple life domains, reduced psychiatric risk (risk factors and risk behaviors), and building community supports around each client; and,
4. Out of trouble with the law – including reducing arrests, criminal detentions, and probation involvement.

The Santa Clara County mandated *Program Evaluation Profiles* provide an overview of services and desired outcomes related to the client population, jointly negotiated among like providers in the county for inclusion in program contracts. Additionally, Starlight's leaderships select at least one indicator from each of the four domains above to track and monitor client outcomes and related program performance on an annual basis.

Analyses

The SBHG/Starlight mission statement, while not specifically using the term cultural

competency, describes values consistent with cultural competency as well as with both host and referring counties' mission statements. Reviewing and updating the SBHG mission statement will be an initial task of the *SBHG Cultural Competency Steering Committee.*

The Starlight cultural competency policy statement and *Professional Services Plan* (program statement) further articulate, underscore, and operationally translate values of cultural competency applied to clients, community, and staff.

The NIMH monograph and state/county MH/MHSA plans, provide both broad and specific theoretical and practical guidelines for assessing, promoting, and implementing cultural competency. These are key resource documents for cultural competency planning from which SBHG derives their planning document: *SBHG Strategies to Increase Cultural Competency* (Appendix A).

The steering committee should commence as soon as possible in order to conduct planning for the next fiscal year. The planning process might include a standard program assessment tool and identify a set of cultural competency objectives/projects (with latitude for other good ideas) that programs select to enact. Draft criteria for such tools are provided in Appendix A. *Starlight* will be ahead of the overall SBHG planning curve, having developed and submitted this plan to the county. Subsequent information that comes from the SBHG planning process, (including more detailed demographic and services research findings) may compel a fine-tuning of the current Starlight plan.

The SBHG outcome indicators are consistent with system of care, state/county master plans, and MHSA themes and are selected precisely because they have broad currency to multiple stakeholders including agency partners, diverse client/family populations, and the taxpayer (important for advocacy and ultimately, to resource availability for underserved and minority populations). SBHG organizations are committed to outcomes tracking and informing practice through empirical evidence. Both quantitative and qualitative methods are embraced. Outcomes and client satisfaction data, collected at the individual level over an adequate period of time, and in combination across like programs, can be analyzed further for subgroup (e.g., age, gender, ethnicity, diagnoses, etc.) variation in response to treatment, the process of service, and desired outcomes. Outcome and other quality assurance data are applied to continuous quality improvement within the SBHG Total Quality Management (TQM) system. Leadership strongly believes data should not be collected unless it is applied to understanding and improving the quality of services.

II. CLIENTS

The youth served in the *Starlight Community Treatment Facility* (CTF) suffer from severe emotional disturbance and must meet medical necessity criteria for enrollment in a structured treatment environment. The youth entering the CTF residential program have a history of troubled behavior including aggressive, oppositional, provocative, impulsive, and self-destructive behaviors, often accompanied by intense negativism and social withdrawal. Along with these behaviors, the youth typically suffer from strained or impaired interpersonal and family relationships, resulting in an absence of vital social support. The residential youngsters have experienced one or more treatment failures in outpatient, extended care management, or less restrictive settings. If not in the stable and intensive treatment environment of the Starlight CTF, the youth would be in psychiatric hospitals or continue to move among placements, treatment settings, shelters, and juvenile detention. Their behavior may represent a potential danger to self, others and/or property, and their treatment requires comprehensive evaluation, close staff supervision, intensive therapy, remedial education, and monitoring of the need for psychopharmacological intervention.

CTF Client Demographics

Starlight Adolescent Center serves adolescents of both genders that come from a variety of backgrounds. During program FY 03-04, youth were 53% male and 47% female. The majority of youth (78%) were ages 13 to 17 years old; the rest were 18 to 21 years old at enrollment. The ethnicities of clients (Appendix B, Table One) are: 41% European ancestry, 29% Latino, 22% African American, 6% Asian (3% Vietnamese, 3% Other Asian), and 1% each Native American and Other/Unknown. A little over 50% of clients come from Santa Clara County and 34% come from Alameda.

Demographic Comparisons

At Starlight, in-county youth are more diverse and have a higher portion of Latino youth compared to out-of-county youth (Appendix B, Table Two). Starlight's out-of-county youth are predominately European and African American. They come primarily from Alameda County which has a higher proportion of African Americans in the school age, as well as general population (Appendix B, Table Six) when compared to Santa Clara and statewide. (California statistics are: 46.0% Hispanic, 32.5% European, 8.1% African America, 8% Asian, 2.5% Filipino, 1.4% Unknown, .8% American Indian.).

In comparison to other contexts of mental health service delivery to youth in Santa Clara county (Appendix B, Table Three), the Starlight CTF (which includes day treatment and outpatient billing for services provided in a residential context) delivers care to more European and African American youth and fewer Asians and Latinos. The Starlight CTF client profile approximates that of Santa Clara Day Services with respect to the high numbers of European youth served. Generally, except for Vietnamese clients, Starlight has not served the numbers and variety of Asian groups represented in Santa Clara County's mental health programs (Appendix B, Table Four) or the county's school age population (Appendix B, Table Six). Starlight's gender breakdown matches Santa Clara Day Services, whereas males are more often seen in Santa Clara's outpatient and 24-hr services.

Analyses

The very disturbed clinical profile of the Starlight CTF population[1] underscores the central importance of helping these youth build strong, positive, pro-social identities that integrates and helps them come to peace with all aspects of their personhood. Starlight clients are on a path to recover from trauma and move beyond adverse life events. Gender, ethnicity, family, community, sexual identity and the exercise of choice around identity issues are all building blocks of resiliency and higher functioning that need to be explored and mined during treatment. While there is no one way to do this (in fact there are very many), a common foundation is respect and tolerance coupled with the expectation that *every* person can improve themselves and *no one* has to do it alone.

Starlight's demographic data show an increase in Asian youth served in FY 03-04 compared to the prior year (from 1% to 6% combined, 3% being Vietnamese). This is consistent with the shifting demographics of Santa Clara County (Appendix B, Table Five) which now reports 4 threshold language groups (Spanish, Mandarin, Tagalog and Vietnamese). In light of the demographics of Starlight's home county, as well as statewide, it will become more and more important for Starlight staff to master an understanding of different Asian cultures and the cross-generational acculturation dynamics of Asian youth and families, starting with Vietnamese. It will also be required that Starlight have staff language capacity in the Santa Clara threshold languages, and/or capacity to bring in interpreters when needed (see next section on services and staff).

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[1] The *Starlight Annual Report* to be published soon provides more information about the client clinical profile.

Half of Starlight CTF clients come from Santa Clara County (Appendix B, Table Two). Other counties refer and contract with Santa Clara County so their adolescents can also be admitted and treated at Starlight CTF. The mix of clients from different counties is a unique challenge Starlight faces, different from most county programs that provides services in only one county. Staff must safely manage group living/schooling dynamics among youth from different age, gender and ethnic groups who are mentally ill and whom do not usually know each other before admission to Starlight. Added to the basic inter-group dynamics of the CTF is the fact that one ethnic group (Latino) comes primarily from one county (Santa Clara) and another (African American) comes from a different county (Alameda). One of the arts of milieu management is assisting each individual and group to forge a positive identity while at the same time minimizing inter-group rivalry (avoiding us/them thinking and inter-group aggression). Much thought must be given constantly to therapeutic, rehabilitative and recreational programming.

Effecting outreach, family building, and transition planning is always challenging with a high-end service population (and is even more challenging with out-of-county youth). Permanency or emancipation planning is difficult and requires every ounce of staff resourcefulness. Many families are ill-equipped and need much help to receive and maintain troubled youth in the home. Poor and mentally disturbed young adults struggle with a shortage of safe, low-cost housing in the Bay Area. Educational options are often limited and ongoing support may be needed to help youth stay focused and on track with educational or vocational endeavors. Cultural competency implies we help youth and families with these kinds of everyday life challenges, yet Starlight staff must sometimes "hand-off" youth to their next situation without confidence in knowing whether adequate supports are in place and will "stick." A review of Santa Clara county demographic facts as they pertain to general life issues of county residents (Appendix B, Table Five) underscores the above points.

The availability of accessible, culturally competent, clinically appropriate and community-based services to support family stability and the ongoing treatment needs of youth returning from high-end services is shaped by state and local policy (political will), funding, and resource allocation. Starlight's clients and their families (of origin or destination) are impacted by poverty[2]. They return to a broad cultural context characterized by low mental health service utilization rates (Appendix B, Table Seven). In California and many Bay Area counties[3], comparatively low service utilization rates are characteristic of youth compared to adults, non-foster youth compared to foster youth, females compared to males, female transition age youth (ages 18-20) compared to male transition age youth, and Asian and Latinos compared to others. The implications of these facts are far-ranging for every group served and society at large.

Consider the prospect of a female of transition age leaving an intensive treatment setting to find her way in life. Ideally (over her next decade), she will be able to finish school, obtain a job, continue her recovery from psychiatric trauma, take medications (if needed), stay free of alcohol and drugs, experience supportive family relationships, create positive friendships, find love, and avoid pregnancy (until she is emotionally and financially secure enough to be a parent if she wants to). Does transition planning go far enough to increase her probability of success? Are adequate resources available to create a valid transition plan? These are the kinds of challenges Starlight staff struggle with for every discharge.

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[2] KIDS COUNT data (Annie E. Casey Foundation) for 2004 shows California exceeds the national rate of: a) percent of children whose parents lack full-time work; and, b) percent of children in poverty.

[3] Although rates of use are low most everywhere, Santa Clara County is doing better than the state average with respect to: a) percent of total eligible population served; b) percent of eligible non-foster care youth served; c) percent of MH expenditures on non-foster care youth; d) average MH expenditure per unduplicated client; and, e) services to ethnic groups..

III. SERVICES AND STAFF

CTF Services

Programming for clients residing in the Community Treatment Facility (CTF) includes:

1. Residential board and care with 7 day, 24 hour nursing and psychiatric oversight, youth counselors, and recreational activities;
2. Five day, full day, special education Non-Public School (NPS);
3. Seven day, over 4 hours daily of Day Treatment Intensive (DTI) programming with psychotherapy and rehabilitative group services; and,
4. Therapeutic Behavioral Services (TBS) to support specific behavioral improvements necessary to stably maintain youth in the residential setting and support step-down to a lower level of care.

The program model for milieu treatment is an evidence-based practice that integrates social learning theory into an overall bio-psycho-social approach. Visiting and on-call Psychiatrists provide evaluation, medical oversight, and medication support services. Nurses maintain professional standards for daily medical management. Both Nurses and Youth Counselors serve as coaches (encouraging, motivating), teachers (modeling, guiding), counselors (listening, intervening), house-parents (scheduling, monitoring), and limit-setters (enforcing, disciplining) to the youth. The ratio of direct treatment staff to clients is at least 1:5 daytime and 1:10 nighttime, per *California State Department of Human Services* Community Care Licensing Standards.

A *Points and Levels (P&L) System* allows youth to start immediately to earn privileges beyond basic care. Clients entering residential treatment are typically seriously impaired in almost all areas of living. In order to regain normal levels of social, emotional, behavioral, and educational functioning, they need to learn a number of skills and change a number of behaviors. The P&L System breaks down this process into a series of "small steps". To encourage clients to make these steps, privileges and rewards are given to "reinforce" desired behaviors. "Catch a kid doing something right" is the motto. Each skill mastered is called a "merit badge." The P&L System is the most effective way for clients to learn and practice changing maladaptive behaviors -- when staff applies creative, positive incentives with kindness and respect, not as a means of punishment. Our training programs and handbooks emphasize the correct use of P&L.

The safety of all clients, staff, and visitors is always a primary concern. Programmatically, Starlight promotes very high standards of staff compliance and ethical conduct, such as with respect to preventing institutional abuse or neglect. Both clients and staff receive information about their rights and responsibilities to maintain safe, respectful relationships.

Both the *Starlight High School* and the *Day Treatment Intensive Program* nested within the CTF apply a graded and individualized approach to programs and services in order to meet the student/client "where they are" developmentally, academically, functionally, and in terms of time in program. The *Stars Behavioral Health Group* (SBHG) "Program in a Box" provides clinicians and rehabilitation specialists with a multitude of specifically focused rehabilitative groups to meet the treatment needs of youth presenting with different diagnoses, risk factors, or skill development needs. The groups are organized into one of four types: 1) Adjunctive Therapy; 2) Process Groups; 3) Psychotherapy; and, 4) Skill-Building. Evidence-based practices such as cognitive behavior therapy (CBT) or EQUIP (an aggression replacement training program) are intervention models. The overall mix and scheduling of groups must be carefully matched to meet the needs of the current client population. Additionally, Starlight staff plan and provide recreational activities,

holidays, and special events that recognize and celebrate the ethnic diversity of clients. For more information on Starlight's program components -- including non-public schooling, day treatment, therapeutic behavioral services, service planning, care coordination and transition planning -- please refer to the *Professional Services Plan* (program statement).

CTF Staffing

Starlight's direct care staff is 60% female and 40% male. The racial/ethnic composition of all staff is shown in Appendix B, Table Twelve. Separated out, direct care staff (clinical, nursing, rehab, social services, school, therapeutic behavioral services combined) is 21% African American, 21% Asian/Pacific Islander, 32% European, and 26% Latino. The language capacity of staff (Appendix B, Table Twelve) includes Mandarin, Spanish, Tagalog and Vietnamese which are Santa Clara threshold languages.

Analyses

Culture is a critical element of treatment. In order to be effective, interventions and services need to be tailored and focused within the cultural context of the youth and their family. Programmatically, both youth and family are invited to engage in open dialogue with treatment staff about the meaning and significance of behavior, communication, role relationships, history, norms and expectations from their unique cultural perspective. Each youth and family is entitled to services within their own language; currently, arrangements are made to provide translations and/or interpreters when staff does not know the language (for information on staff language capacity, see Appendix B, Table Thirteen). Not all key consumer documents are translated into all the threshold languages so this needs to be a cultural competency goal.

A review of trainings provided in 2004 (Appendix B, Table Nine) shows that the majority of direct care staff, during new hire orientation, is exposed to training on how to acknowledge, respect, and celebrate the ethnicity, faith, gender, sexual identity, family traditions and cultural norms of youth and family within the framework of the treatment program. There were delays in cultural diversity training during one quarter (spring) that were later (mostly) made up. How effective the cultural competency trainings are at helping staff navigate the challenges of the CTF treatment context needs to be assessed carefully. In addition to assuring cultural competency training of 100% of staff, more training needs to focus on the specific cultural groups found in the Starlight service population (i.e., African American, specific Asian cultures such as Vietnamese, and Latinos).

One important indicator of Starlight's cultural competency is the perspective of clients themselves. Starlight participates in the *California State Department of Mental Health* (DMH) performance measurement surveys. The most recent survey data (November, 2004) collected from 100% of CTF clients (enrolled at the time) are shown in Appendix B, Table Eight. Starlight's results could be better. To be consistent with program design, the fundamental item of "Treated with Respect" must approach 100% and other items related to cultural competency need to achieve over 80% client agreement. Currently, little is know about how distinct ethno-cultural groups perceive and experience the separate, core components of CTF programming: for example, the use of medications, nursing monitoring, points and levels, and rehab groups. Although in-house satisfaction surveys inquire about specific program elements, the data have not been tracked so that subgroup analyses (e.g., by ethnicity and gender) can be performed.

There is leadership consensus that a significant dynamic that impacts client perceptions of being treated respectfully relates to the use of physical interventions to prevent clients from harming themselves and others. The agency has committed significant resources to reduce the use of physical

restraints and seclusion in the management of dangerous behavior, including training, coaching, and debriefing interventions with staff. One success is that the use of mechanical restraints was completely eliminated in 2004 (Appendix B, Table Nine). Policies have been revised and updated to conform to changes in state law (SB 130) regarding risk assessment, client preferences, and staff training in de-escalation.

There are many proficient and effective employees at Starlight. At the same time, staff turn-over (Appendix B, Table Eleven) is a difficulty related to the broader workforce environment, as well as the challenges of recruiting, training, and retaining staff to work in an intensive and restrictive treatment setting where staff are personally at-risk of physical harm. Reducing and stabilizing staff turn-over will make it more likely that Youth Counselors' learning from trainings and incident debriefings impacts their ability to manage client behaviors with less use of physical interventions. Reduced turn-over among social services, rehab, nursing and school staff will make it more likely that learning the program model impacts their ability to deliver services with a high degree of fidelity to evidence-based practices.

As with all SBHG programs, the leadership of Starlight makes every effort to recruit, retain, and develop diverse staff which represents the diversity of youth and families involved with treatment. The result is that Starlight staff is diverse with the ethnicities of clients well represented, except for Native American clients (of which there were two in the time period). More diverse staff should be recruited for the school and rehab departments.

Another aspect of managing dangerous behavior is the racial and ethnic dynamics of difference that may impact staff and client perceptions of their interactions, especially staff responses to client risk behaviors. On any given shift, or period of encounter between staff and clients, it is not managerially feasible to have staff fully reflect clients' ethnic and gender composition. There is always a potential for cross-cultural misperception and communication problems. Staff may be new, inexperienced in parenting or mentoring, and/or not fully prepared for the level of aggression and other risk behaviors of the client population. This is compounded by different cultural norms with respect to the expression of needs, emotions, and the exercise of personal control (let alone the realities of clients' mental illness). It is essential that staff training deal very directly and thoroughly with issues of cross cultural perception regarding aggression, behavioral risk, and behavioral control. Reducing high risk behaviors through culturally competent preventative interventions is an important treatment outcome in its own right and makes it possible for clients to take advantage of all other aspects of service provision.

IV. STARLIGHT CULTURAL COMPETENCY OBJECTIVES

The following are specific objectives for Starlight. Starlight will also join the SBHG agency-wide cultural competency planning process and therefore be involved with one or more of the areas of focus identified in Appendix A, *SBHG Cultural Competency Steering Committee.* The objectives below are listed in order of priority within broad topic areas of: management, staff training, clinical services, and quality assurance. Objectives earmarked for FY 05-06 implementation are identified and highlighted in bold; others are also identified that may be added as time/resources become available, or to be taken up in future years.

Management

FY 05-06 OBJECTIVES:

1. All SBHG/Starlight consumer documents will be translated into Santa Clara county threshold languages (Mandarin, Spanish, Tagalog and Vietnamese).

2. Significant focus of attention will be paid to retention, including retention of ethnically diverse staff and those with threshold language capacity. Program managers will partner with HR to review staff survey data, exit interview data, and other analyses to understand the factors driving staff turn-over. A specific plan for decreasing turn-over will be written that will address training, supervision, performance feedback, general communication/information flow, and team-building needs by department.

OTHER OBJECTIVES:

3. Human resources will recruit more diverse staff to school and rehab positions as they open.

4. Data gathering and analyses related to client demographics and cultural variables will be developed to enable interpretation of outcomes and client satisfaction data by subgroups of the Starlight service population.

Staff Training

FY 05-06 OBJECTIVES:

5. Staff trainings are to be assessed with respect to effectiveness in increasing understanding of threshold cultural groups and then be further developed and delivered for specific cultural groups found in the service population (i.e., African American, Latino, and Vietnamese for starters). 100% of new staff is to be trained.

6. More cultural content and cross-cultural examples will be added to staff training curriculum on the management of dangerous behavior. Client to staff and client to client aggression will be addressed in training from a cross-cultural perspective.

OTHER OBJECTIVES:

7. In addition to drawing upon from the ethnic diversity of program staff, external resources will be cultivated and applied to meet staffs' cultural competency training needs.

8. All staff will be knowledgeable about procedures for using interpreters when needed with clients and/or family members. This item will be added to the cultural competency training content on the staff in-service calendar.

Clinical Services

FY 05-06 OBJECTIVES:

9. On a quarterly basis (as the service population shifts), resident managers along with treatment staff will reflect upon and develop specific guidelines to: a) assist staff in managing inter-group dynamics on the units; b) provide multi-cultural content interesting to teenagers for DTI/Rehab/Recreational/School groups as well as special events/holidays; and, c) foster culturally competent interventions with clients.

OTHER OBJECTIVES:

10. Clinical and social services staff will develop transition and aftercare plans that reflect culturally specific strengths and needs of clients. These will be observable and measurable on the plans, as reviewed by QA staff.

Quality Assurance

FY 05-06 OBJECTIVES:

11. Client risk behavior and incident management data will be analyzed by ethnic/culture groups for potential differential staff responses and rates of use of restrictive interventions.

OTHER OBJECTIVES:

12. A quality assurance review will be conducted to assure that client/family cultural strengths and needs are identified during assessment and service plan development and that related goals are addressed throughout treatment.

V. APPENDICES

Starlight Cultural Competency Plan_Appendix A

SBHG Cultural Competency Steering Committee
POTENTIAL AREAS OF FOCUS FOR FY 05-06

1. Review the organizational mission and program statements for possible editing to further emphasize culture. The committee will review the NIMH monograph on cultural competency, the Surgeon General's Report on Mental Health, Culture, Race and Ethnicity (USDHHS, 2001), California MH/MHSA Planning documents, and state and county cultural competency plans as key resource documents, among others brought forward by committee members.

2. Analyze SBHG service program (N=10), related county (N=6), and state demographic trends, patterns and research findings with respect to service need, access, retention, and treatment outcomes of specific culture groups (i.e., by age, gender, threshold ethnicity/language groups, special needs, and poverty). This process will involve application of SBHG research personnel to compile and present information and analyses to the committee. Focus groups can be held to flesh out quantitative data with the narrative experiences and perspectives of persons from different cultural groups.

3. Apply a lens of multi-cultural awareness and relevance to a systematic review and update of agency policies and procedures related to governance/administration, service environments, program practices, quality assurance, and treatment outcome tracking. As examples, agency policies ADM 1.30 "Cultural Competency" and NSG 3.10 "Cultural Awareness" have not been reviewed and updated since 2000. As another example, the SBHG Total Quality Management (TQM) "probes" (quality control checklists) include elements related to cultural competency, consumer voice and choice, personal dignity, and family work, but these could be improved upon.

4. Review and then enhance avenues for diverse consumer (client and family) voice and choice at all levels of the agency including involvement in governance and policy; program development, service and treatment processes and outcome evaluation. SBHG currently promotes, and applies resources to consumer involvement in multiple arenas. This includes (as examples): a) development and expansion of the TEAMMATES wraparound program in Los Angeles with multi-layers of consumer involvement; b) stable funding of ethnically diverse Parent Partner positions (N=18) in many programs; c) youth and family involvement in treatment goal setting as well as with individual, family, group and milieu interventions; d) collection and application of client, family and agency partner satisfaction survey data to continuous quality improvement; and, e) maintenance of myriad mechanisms for informal and formal feedback, including complaint procedures, in all programs. There may be opportunities to disseminate successful methods more widely as well as to develop additional avenues for consumer input.

5. Brainstorm and then develop opportunities for increasing community partnerships for multiple purposes including (as examples): sharing of staff trainers; connectivity of clients/families to aftercare, stable homes and community resources; joint community advocacy efforts; program/service development projects; and, mutual sharing between parent partners and consumer groups.

Stars Behavioral Health Group

STRATEGIES TO INCREASE CULTURAL COMPETENCE

Across Levels of a System of Organization

POLICY

- Engage the participation of relevant minority and community groups in all aspects of service system development and enhancement;
- Set standards for cross-cultural service delivery and professional licensure;
- Create training policies that sanction or require development of cultural knowledge and skills;
- Ensure funding for enactment of such training, and require it of policy-making board members themselves;
- Use research and evaluation data to guide decision making, collect data on minority populations, and monitor research for cultural bias or intrusion; and,
- Use funding mechanisms and pathways to create incentive to improve services for minority children.

ADMINISTRATION

- Assessment and monitoring for cultural bias – the administrator sets the tone and context for the evolution of cultural competence in an agency;
- Clearly define target populations based upon good demographic data on service areas;
- Increase access to and retention in services through consideration of compatibility of belief systems, geographic proximity of services, flexible hours, etc.;
- Recruit and maintain minority and non-minority culturally competent persons on staff;
- Provide training in cultural competence; and,
- Make sure that diverse cultural and community groups are involved in agency activities and process.

SERVICES

- Develop services with community and professional minority participation and consultation;
- Serve the whole person within the context of their community and culture;
- Individualize case planning;
- Utilize natural helping systems when relevant;
- Provide unconditional care;
- Use least restrictive placement alternatives; and,
- Seek normalization, including home-based and family preservation.

PRACTITIONERS

- Develop cultural competence by learning to acknowledge, appreciate, and make use of cultural variables in the treatment process (e.g., cultural concepts of "family" and "health");
- Seek information and develop understanding adequate to bridging communication gaps. Communication gaps may arise from the "dynamics of difference" between practitioner and client;
- Avoid projecting one's own cultural assumptions and values onto the child and family; and,
- *Toward a Culturally Competent System of Care* provides an outline of the personal attributes, knowledge, and skills of culturally competent providers (see NIMH Monograph, Cross, Bazron, Dennis & Isaac, 1988, p. 35-37).

FAMILIES

- Become effective advocates for their children;
- Develop the skills needed to articulate the importance of culture;
- Prepare for the ways in which the dynamics of deference and the reality of being bi-cultural might effect children's mental health and family member's interactions with service providers;
- Serve as training resource to agencies and community groups; and,
- Alert helping professionals to natural network and resources available within the ethnic community.

Stars Behavioral Health Group
Program Cultural Competency Objectives
Planning Tool for Selecting Annual Goals

Each program must complete Objective A and Objective B, and select two projects from Objective C.

Objective A: Staff Cultural Competency Training

Every workforce member shall participate in a minimum of 3 hours of cultural competency training annually. The training may be provided by the agency, or externally. External curricula must meet with the approval of the supervisor. Employees must sign an attendance log that is to be kept on file with the Training Department.

Objective B: Multicultural Programming for Clients

Every program shall submit an annual calendar of relevant, diverse multi-culturally-focused events and/or celebratory activities that will be available to their clients. A report on prior year events, including dates, foci, and attendance numbers, along with the coming year's proposal, shall be provided to the Research, Compliance and Quality Management Department by June 30.

Objective C: Elective Cultural Competency Projects

Please select two projects, which may include other topics you propose:

_____ 1. Identify and obtain funding for development and/or expansion of services to one or more additional cultural groups.

_____ 2. Engage the participation of relevant minority and community groups in planning and implementing a consumer driven service development and/or enhancement project.

_____ 3. Articulate in program policies, procedures, and training curricula the ways in which particular program features and/or practice standards are used to enhance the dignity, normalization, social inclusion, and independence of cultural groups.

_____ 4. Review program policies, procedures, and/or consumer forms for cultural bias and/or cultural relevance and make corrections as indicated.

_____ 5. Organize and procure translations of program consumer documents into the multiple languages of clients.

_____ 6. Assess outreach to different population groups, establish an outreach goal for one or more groups, and implement strategies to positively affect outreach.

_____ 7. Consider the ways in which the program addresses the objective of stimulating the natural resources and helping systems available to clients, and develop strategies to increase attainment of this objective.

_____ 8. Assess access to services of different population groups, establish an access goal for one or more groups, and implement strategies to positively affect access.

_____ 9. Thoroughly assess and revamp program facilities, particularly public/consumer areas, to make them maximally friendly and comfortable to diverse population groups, or target client populations.

_____ 10. Assess the retention of different population groups in services, establish a retention goal for one or more groups, and implement strategies to positively affect retention.

_____ 11. Examine the effects of cultural variables on specific intervention strategies – e.g., potential differential results as a function of client demographics and then refine or tailor the interventions to better meet the needs of the demographic.

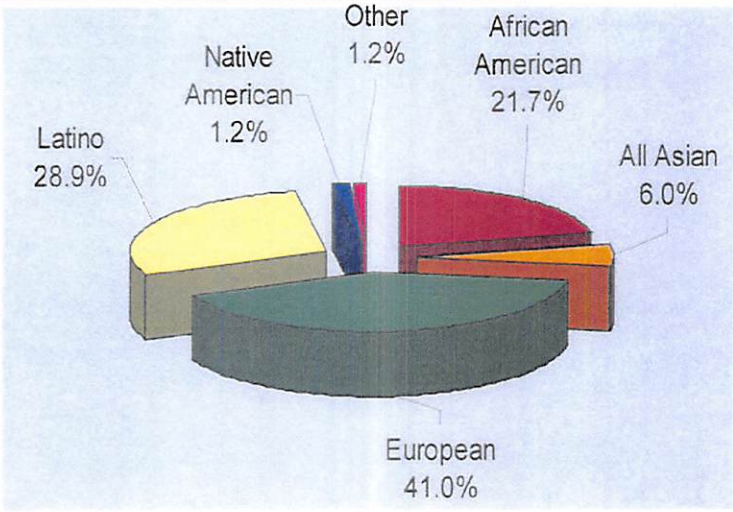
12. Assess service outcomes (success) of different population groups in services, establish an outcome goal for one or more groups, and implement strategies to positively affect outcomes.
13. More formally integrate review of cultural dynamics into the supervision/coaching of direct care staff (e.g., projection of cultural assumptions and values onto the child and family). Articulate the ways such supervision/coaching is provided in program policies and procedures.
14. Have each direct care staff assess themselves in light of the personal attributes, knowledge, and skills of culturally competent providers (see Cross and Bazron manuscript, p. 35-37), set one or more professional development goals related to the desired attribute(s), and submit a plan for goal attainment that is monitored during supervision.
15. Using positive outreach and other non-discriminatory strategies, increase recruitment and retention of minority, bi-lingual, and culturally competent persons on staff.
16. Assist and promote culturally competent staff and clients to serve as training and advocacy resources to diverse community groups.
17. Develop and support a multi-cultural consumer support, advocacy, and/or advisory group(s) related to population needs/issues.
18. Other Idea:

_____

_____

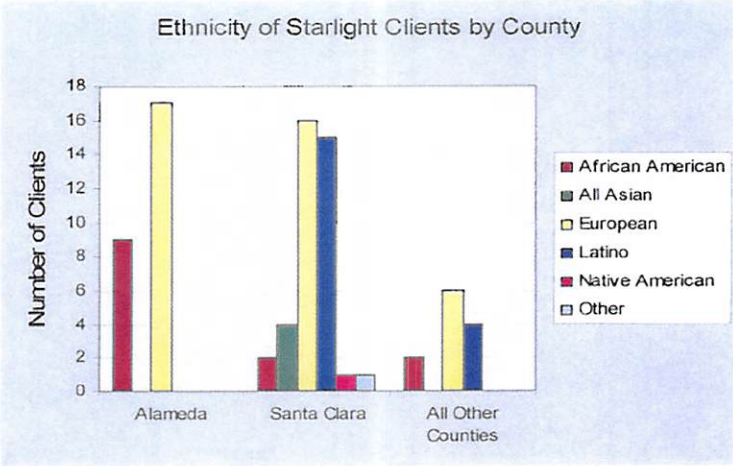
_____

Table One: Starlight CTF Client Ethnicity



Prior FY percentages were: European 45%, Latino 34%, African American 18%, Asian American 1%.

Table Two: Starlight CTF Client Ethnicity by Referral County



Alameda County enrolls more African American youth while Santa Clara County (SCC) clients are more ethnically diverse with a greater proportion of Latino youth.

Table Three: Starlight CTF Client Ethnicity Compared to Other SCC Youth MH Services

	African American	All Asian	European	Latino	Native American	Other	Unknown
Starlight CTF	21.7%	6.0%	41.9%	28.9%	1.2%	1.2%	0.0%
SCC 24 Hour Services	9.9%	14.3%	38.0%	34.1%	0.2%	1.5%	1.9%
SCC Day Services	8.5%	10.2%	46.3%	31.4%	0.4%	1.9%	1.3%
SCC Outpt Services	8.5%	12.7%	28.9%	46.1%	0.9%	1.4%	1.5%
SCC Youth MH Pop	9.8%	9.7%	31.5%	45.3%	1.8%	0.9%	1.1%

[4] Data represent FY 03-04 unless otherwise indicated and are derived from a Santa Clara county data set, Starlight information tracking, and aggregate state databases. State information sources include the *California Department of Mental Health* website www.dmh/.cahwnet.gov, County Administrator and Provider Information, Statistics and Data Analyses, June 2001 (note: data posted on the state site are pre-2000 figures and may be out-dated); and, *California State Department of Education* website www.cde.ca.gov, Data and Statistics, 2004.

Table Four: Starlight CTF Asian Clients Compared to SCC Youth MH Asian Clients

	Asian Indian	Cambodian	Chinese	Filipino	Other Asian	Pacific Islander	Vietnamese
Starlight	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	3.0%
Santa Clara	0.2%	1.0%	1.0%	1.7%	2.1%	0.4%	3.3%

Table Five: Santa Clara County Demographic Facts

Santa Clara has a Majority-Minority Population:

	African American	All Asian	European	Latino	Native American	Other
Santa Clara	2.8%	25.6%	44.0%	24.0%	.7%	5.6^%

Key Facts for Planning Mental Health Services:

- The child population of the county is increasing at a rate double that of adults.
- The rate of legal immigration (per 1,000 population) is the highest in California.
- There are additional high rates of undocumented residents, first generation immigrants, and persons for whom English is a second language or not acquired.
- There is a strong relationship between immigrant status and being uninsured.
- Compared to national statistics, there is a high job loss rate and a poor economic forecast.
- One in seven children live in poverty and the percentage of families below self-sufficiency (income indexed to prices) is higher than in all other Bay Area counties.
- Fair market housing rental rates are higher than any other county in the state.
- There are higher levels of environmental contamination compared to most counties in the country.
- Standards were met or exceeded for many Healthy People 2010 objectives; however, they were not met for suicide, drug-induced deaths, incidence of AIDS, and prenatal care among other health outcomes.

Table Six: Ethnicity, Special Programs and Languages of School Age Youth (SCC, Ala)

Students by Ethnicity
Santa Clara County, 2003-04

	County	
	Enrollment	Percent of Total
American Indian	1,614	0.60%
Asian	58,865	23.40%
Pacific Islander	1,840	0.70%
Filipino	12,817	5.10%
Hispanic	87,397	34.80%
African American	8,743	3.50%
White	75,495	30.10%
Multiple/No Response	4,437	1.80%
Total	**251,208**	**100%**

Students by Ethnicity
Alameda County, 2003-4

	County	
	Enrollment	Percent of Total
American Indian	1,310	0.60%
Asian	40,946	18.90%
Pacific Islander	3,102	1.40%
Filipino	10,900	5.00%
Hispanic	56,870	26.20%
African American	39,352	18.10%
White	60,311	27.80%
Multiple/No Response	4,031	1.90%
Total	**216,822**	**100%**

Special Programs
Santa Clara County, 2003-04

	County	
	Participants	Percent of Enrollment
English Learners	63,389	25.20%
Free/Reduced Price Meals	81,640	32.20%
CalWORKs[1]	12,748	5.00%
Compensatory Education	62,752	25.00%

Special Programs
Alameda County, 2003-04

	County	
	Participants	Percent of Enrollment
English Learners	45,067	20.80%
Free/Reduced Price Meals	75,873	35.70%
CalWORKs[1]	26,440	12.40%
Compensatory Education	70,231	32.40%

Languages of English Learners
Santa Clara County, 2003-04

	Number of Students	Percent of Enrollment
Spanish	41,394	16.50%
Vietnamese	7,790	3.10%
Tagalog	2,187	0.90%
Other non-English	1,843	0.70%
Mandarin (Putonghua)	1,732	0.70%
All Other	8,443	3.40%
Total	**63,389**	**25.20%**

Languages of English Learners
Alameda County, 2003-04

	Number of Students	Percent of Enrollment
Spanish	28,093	13.00%
Cantonese	3,300	1.50%
Vietnamese	2,040	0.90%
Tagalog	1,786	0.80%
Mandarin (Putonghua)	1,350	0.60%
All Other	8,498	3.90%
Total	**45,067**	**20.80%**

Table Seven: State and Referral County Mental Health Service Enrollment Rates[5]

Percent of Eligibles Receiving MH Services			
	Total Population	Foster Care	All Other Youth
Alameda	7.00%	27.13%	2.61%
Santa Clara	7.84%	39.19%	4.32%
Statewide	6.21%	46.68%	2.80%

Percent of Total MH Expenditures by Aid Group			
	Adult MH Client	Foster Care	All Other Youth
Alameda	77.20%	10.18%	12.62%
Santa Clara	68.00%	10.16%	21.84%
Statewide	70.04%	12.27%	17.69%

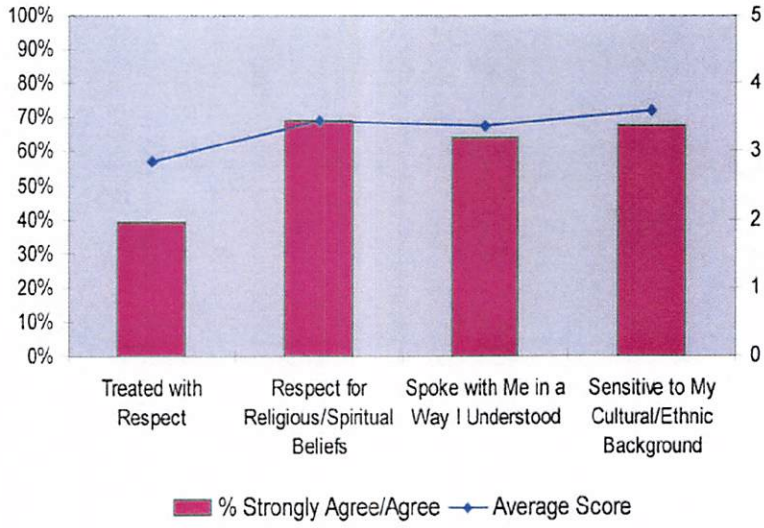
Average MH Expenditures per Unduplicated Client			
	MH Population	Foster Care	All Other Youth
Alameda	$3,734.44	$4,748.26	$2,957.95
Santa Clara	$7,169.11	$8,342.31	$6,161.32
Statewide	$2,531.91	$2,263.45	$2,090.47

Percent of Eligibles Receiving MH Services by Race/Ethnicity						
	African American	All Asian	European	Latino	Native American	Other/ Unknown
Alameda	6.80%	1.78%	10.50%	1.91%	5.36%	14.66%
Santa Clara	9.92%	3.18%	14.16%	3.08%	10.27%	14.85%
Statewide	6.42%	1.95%	9.47%	1.64%	4.34%	16.71%

Percent of Eligibles Receiving MH Services by Age & Gender				
	Ages 0-17		Age 18-20	
	Males	Females	Males	Females
Alameda	5.07	2.99	9.36	4.35
Santa Clara	6.66	4.50	8.44	3.96
Statewide	5.27	3.68	7.14	3.79

[5] These data are from the state DMH website which provides annual county data from 1991 through 1998. The trend from 1991 through 1998 is a small, steady increase in MH Medi-Cal penetration rates -- likely continued through the present, along with immigrant population influxes in the Bay Area.

Table Eight: State Survey Results (Client Items Related to Cultural Competency)



Responses are rated on a five point scale, with five being "Strongly Agree" with a positively worded statement (desirable).

Table Nine: 2004 Staff Cultural Competency Training

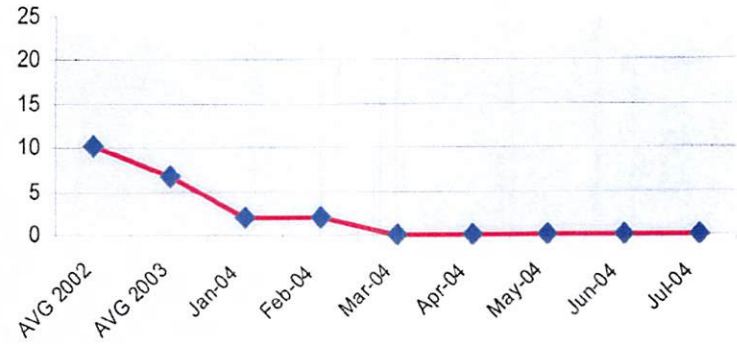
Diversity Training By Quarter

Quarter	# New Staff	# Trained	% Trained
Jan-Mar	21	13	62%
Apr-Jun	25	0	0%
Jul-Sep	23	20	87%
Oct-Nov	19	33	171%
Total:	88	66	75%

Trainings are to be provided to 100% of new staff. There are other topics of training that include cultural content, thus, most staff are exposed to at least some relevant training.

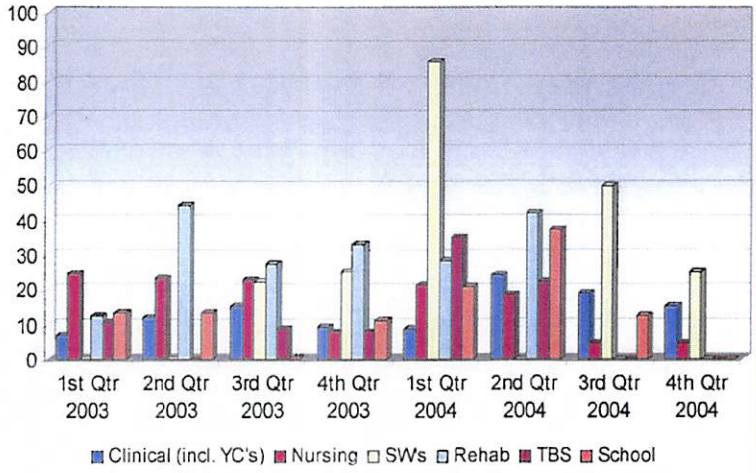
Table Ten: Elimination of Use of Mechanical Restraints

Starlight Use of Mechanical Restraints



Starlight leadership committed to and then succeeded in eliminating us of mechanical restraints with CTF youth.

Table Eleven: Staff Turn-Over



Turnover has been especially problematic among social work and rehab staff.

Table Twelve: Racial/Ethnic Composition of Starlight CTF Staff

Staff Type	African American	All Asian	European	Latino
Administration/Support	0%	8%	58%	34%
Clinical/Soc. Services	32%	19%	18%	31%
Nursing	26%	36%	19%	19%
Rehabilitative	8%	8%	76%	8%
School	7%	7%	72%	14%
Therapeutic Beh. Srvs.	0%	19%	27%	54%

Table Thirteen: Staff Languages in Addition to English

Language Spoken	% of Staff
Basic Spanish	28%
Other (Not Specified)	11%
French	3%
Mandarin Chinese	3%
Tagalog	5%
Vietnamese	3%