CULTURAL COMPETENCE PLAN

FY 2020-2021

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH DEPARTMENT

COVER SHEET

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Introduction

The County of San Luis Obispo Behavioral Health Department is committed to developing a system of care which serves an increasing, changing and diverse population in the County. The system strives to ensure cultural competence is embedded at all levels of the organization.

To accomplish this goal, the Cultural Competence Committee was formed in 1996 and consists of staff members from the various programs of the Behavioral Health Department as well as community partners. These individuals continue to assess, implement, and monitor policies and practices to ensure effective services are provided in cross-cultural situations. The committee members, representing diverse cultural backgrounds with special interests, have provided input and insight to make the following report an active document which will inform the County's behavioral health system for years to come.

This document has been prepared to provide a snapshot of the Behavioral Health Department work toward becoming a more culturally competent organization, and to ensure that diverse populations in the county receive services that are culturally appropriate throughout the behavioral health system. This document is also inclusive of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) approach. Sections below provide information on which criteria applies to DMC-ODS SUD.

Cultural Competence

La Frontera Inc., a mental health organization based in Arizona, developed a cultural competence self-assessment tool titled "Building Bridges", which the Department and its Cultural Competence Committee continues to use. In this assessment manual, culture is defined as follows: "The term culture is used in a broad inclusive sense. It includes race, ethnicity, gender, sexual orientation, primary language, spiritual life, age, and physical condition. Culture is also a multifaceted concept. It incorporates cultural objects such as music, art and clothing; ways of living such as kinship patterns, communication styles and family roles; as well as beliefs or values such as religion, attitudes towards time and views of the natural world." Using this definition as a starting point, the committee continues to operationalize the concept of cultural competence for the mental health system.

According to the Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies, culturally competent organizations are ones which:

- ***Continually assesses organizational diversity****: Organizations should conduct a regular assessment of its members' experiences working with diverse communities and focus populations. It also regularly assesses the range of values, beliefs, knowledge, and experiences within the organization that would allow for working with focus communities.*
- ***Invests in building capacity for cultural competency and inclusion****: Organizations should have policies, procedures, and resources in place that make ongoing development*

of cultural competence and inclusion possible. It must also be willing to commit the resources necessary to build or strengthen relationships with groups and communities. Including representatives of the focus population within the organization's ranks is especially useful.

- ***Practices strategic planning that incorporates community culture and diversity**: Organizations are urged to collaborate with other community groups. Its members are also encouraged to develop supportive relationships with other community groups. When these steps are taken, the organization is seen as a partner by other groups and their members.*
- ***Implements prevention strategies using culture and diversity as a resource**: Community members and organizations must have an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to ensure they are accessible to and attuned to their community or focus population.*
- ***Evaluates the incorporation of cultural competence**: Community members must have a forum to provide both formal and informal feedback on the impact of all interventions.*

This Plan is part of the Department's efforts to remain and enhance access to culturally and linguistically appropriate services by embracing diversity, equity, and inclusion in cultural governance and service provision.

Key Objectives and Recommendations

In response to the Department of Health Care Services CCPR requirement and lessons learned from the social climate in our county, the SLOBHD aims to develop integrative strategies based on a diversity, equity, and inclusion lens that with the goal to impact internal practices and provide implementation guidance.

Based on the material presented herein, data analyses, CCPR planning and stakeholder discussions, and lessons learned, the following key objectives will be adopted and monitored over the next five years:

- The SLOBHD will complete a Diversity, Equity & Inclusion Proposal that is adaptable and will serve as the foundation for changes in the following four specific areas within the Behavioral Health Department:
    - Organizational Culture shift developed and driven under the leadership of the Behavioral Health Diversity, Equity & Inclusion (BH DEI) Committee, formally known as the Cultural Competence Committee. Efforts will include careful development of a clear identity statement (mission, vision, and core values) that will become part of internal operations and service provision.
    - Work in collaboration with Human Resources to address hiring and retention practices for Black, Indigenous, and People of Color (BIPOC) candidates and staff members. Some strategies include addition of culturally appropriate interview

questions for all positions ranging from managerial to frontline staff; as well as proper reporting incidents, and comprehensive exit interviews that promote a culture of inclusion and adaptation for transformative practices.
    - Diversity, Equity & Inclusion trainings for the entire behavioral health department staff. The BH DEI Committee will also broaden the approach to cultural competence training to include activities which improve the behavioral health system's capacity to serve various populations including specific trainings focused on LGBTQIA+, Veterans, consumers and family members.
    - Training assessments and organizational evaluations shall be performed annually to understand material apprehension and skill development. Additionally, the feedback collected will be used to make appropriate changes to address training materials, information, and topics. And will inform organizational change by reflecting on the continued work at various levels of the Behavioral Health Department.

- Revise the BH DEI Committee Bylaws and review membership to ensure that we meet the requirements and extend impact by incorporating key collaborative partner that will ensure a rich and engaging experience within the committee.
    - To enhance the diversity of the Committee, which serves to improve cultural competence principles across the SLOBHD's programs. The main strategy employed to accomplish this objective will be to develop a membership policy that requires the committee to have at least one seat filled by specific community members such as a clients or loved ones.

- The BH DEI Committee, as part of its mission to "ensure that cultural diversity is incorporated into all levels of San Luis County Behavioral Health Department," will develop a review and recommendation process of policies and procedures to ensure it meets specific standards for diversity, equity, and inclusion.
    - This objective will include an expansion of the BH DEI Committee's review process for documents and translation services aimed at the Spanish-speaking community; staffing recruitment and recommendations, and presentations made to various Department programs. A strategy to meet this objective involves establishing BH DEI Committee's review of all SLOBHD programs that serve diverse clients.

CRITERION 1
COUNTY MENTAL HEALTH SYSTEM
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 1:

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization's planning and operations.
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

The County of San Luis Obispo Behavioral Health Department (SLOBHD) created a Cultural Competence Plan in 1998. That document, provided in response to State managed care requirements, was updated in 2003, 2004, 2010, 2018, and 2020 and continues to inform policy for the SLOBHD, which houses the County's behavioral health and drug and alcohol departments. This current plan will continue to provide a foundation for policies, procedures, and practices that reflect the SLOBHD's recognition and value of diversity, equity, and inclusion within entire health care system.

The County of San Luis Obispo Behavioral Health Department has recently revised and is in draft format, the following Mission Statement, which serves as a banner for all official public records, including the annual budget documents (Appendix 01):

To serve all individuals in our community affected by mental illness and/or substance abuse through culturally inclusive, diverse, strength-based programs centered around

clients and families to improve emotional and physical health, safety, recovery, and overall quality of life.

All county employees, including candidates for employment in the Behavioral Health Department, are provided the following statement by the County Administrative Officer at the onset of any human resources activity:

The County is an equal opportunity employer committed to a program of Affirmative Action. Objectives are directed toward assuring equal opportunity in selection/ promotion, pay, and job assignments. Recruitment and realistic selection procedures have been established to ensure non-discrimination on the basis of political or religious opinions or affiliations, age, sex, race, color, national origin, marital status, disability, sexual orientation or other non-merit factors. In addition, the County complies with the provisions of the Americans with Disabilities Act in hiring and retaining employees.

Mental Health Services policies include a statement of General Treatment Considerations (Appendix 02), which includes the following statement:

Client's unique cultural needs and strengths must be a primary factor in treatment formulation and ongoing care. The Recovery Model, based on optimism, wellness and client empowerment, should be used as a guiding principle for treatment.

As described throughout the rest of this document, training in diversity, equity, and inclusion is at the Department's core. SLOBHD's engagement in the Mental Health Services Act (MHSA) components and their planning processes has allowed for the development of training plans and policies with the goal to increase staff and community partner capacity around improved services which value the community's racial, ethnic, and cultural diversity. As demonstrated in the County's Workforce Education and Training Plan's (Appendix 03) "Action #5: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff:"

The purpose of cultural competence training is to develop understanding, skills and strategies to assist in embedding cultural competence into the MHSA implementation process and support of cultural competence integration in San Luis Obispo County. Our hope is that the training will provide the tools and skills necessary to increase the County's capacity for the delivery of culturally relevant services therefore resulting in better outcomes for the County's culturally diverse clients.

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

B. 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. Human Resource Training and Recruitment Policies;
6. Contract Requirements; and
7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

During the on-site compliance review, the State will be able to review documents which demonstrate the County's commitment to cultural and linguistic competence services reflected throughout the entire system, including the following:

- A new draft of The County Behavioral Health Department Mission Statement, as listed in the annual budget documents.
- Strategic Plans, including the aforementioned Managed Care Cultural Competence plans from 1998, 2003, and 2004, as well as the last Department CCPR from 2010; and MHSA plans which clearly outline the role of cultural competence in providing quality services.
- Policy and Procedure Manuals, including the Department's Cultural Competence Committee guidelines, meeting minutes, and newsletters.
- Human Resource policy documents including the County of San Luis Obispo Civil Service Commission Rules & Ordinances, Procedural Guidelines, and the San Luis Obispo County Policy Against Discriminatory Harassment.
- Contracts, which outline the requirements for culturally competent services.

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

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

The county shall include the following in the CCPR:

A. A description, not to exceed two pages of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of

diverse input to local mental health planning processes and services development.

The Cultural Competence Plan Requirement has been completed by staff in the County of San Luis Obispo Behavioral Health Department. Due to the agency's important partnerships with community providers and stakeholders, some sections were completed in collaboration with, or reviewed by, leadership and community partners.

SLOBHD has identified that mental health and substance use disorder services are often out of reach for some racial, ethnic, cultural, and linguistic communities in our county. Outreach and service provision to meet the needs of these communities is a key priority for the Department and its partners. Through the process of developing the county's Mental Health Services Act (MHSA) planning and implementation, SLOBHD and its partners have made access and engagement key targets for improvement within those communities with mental health disparities.

The most dominant disparity in San Luis Obispo County, which cuts across all the community issues identified in various MHSA community stakeholder processes, is the under representation of Latino/Latinx/Hispanic individuals. This imbalance in service accessibility is even more dramatic than it seems, considering the relatively high proportions of this community in the poverty population with the health and access problems associated with poverty status. The County has first and foremost sought to engage leaders of the Latino/Latinx/Hispanic community along with consumers and family members in MHSA planning activities. Meetings, focus groups, presentations, and conversations have been planned throughout the local Latino/Latinx/Hispanic community to give voice to the needs of many individuals detached from the mental health system by culture and language. Greater efforts have been put into practice to make hiring practices which engage Latino/Latinx/Hispanic professionals a priority, alongside targeted outreach and clinical operations which provide culturally competent health services.

Older adults represent another large and often underserved population – and one with a distinct cultural divide at the foundation of its disparities in accessing services. Again, the County has utilized the MHSA planning processes to better engage and build partnerships with the older adult community. Leaders of senior care organizations, retiree agencies, and senior consumers have participated in stakeholder processes sharing their unique concerns and needs. Responses have included efforts to increase prevention and early intervention activities, which seek to reduce depression and anxiety which debilitates many of our seniors, while clinical operations have expanded to include older adult Full-Service Partnerships (FSP) throughout the county.

County staff and stakeholders have also identified those groups often left out of age and ethnicity counts when assessing the under-served. Individuals experiencing homelessness, veterans, and the LGBTQ+ communities each have unique cultural qualities and are key

focus populations for SLOBHD. The population experiencing homelessness is fluid and difficult to engage for many reasons. Efforts have placed more emphasis on outreach in the field and utilizing existing infrastructure (i.e. shelters, Social Services, food banks) to get information and services to this community and their families. Recently, the County in partnership with the largest cities, established a partnership to address a county-wide approach to address homelessness and to develop a plan, which currently under development.

Veterans are often at high risk for suicide and depression and although they have distinct cultural needs, efforts have been made to increase the County's outreach and engagement for these communities. Local veterans have been engaged in the creation of MHSA programming to offer unique approaches to combat the impending influx of soldiers returning to the community. San Luis Obispo County has a large concentration of National Guard personnel who are not provided with the same level of behavioral health care made available to regular military. In 2014 the department launched a Veterans Outreach program which paired physical outdoor activities with on-site therapeutic engagement, to increase access for local service men and women. Additionally, the Department established a therapist to best serve veterans within a culturally competent, comfortable setting.

The Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community representing youth, transitional aged youth, adults, and older adults are part of the stakeholder committee. In 2018, the County launched an LGBTQ Mental Health Needs Assessment countywide in partnership with Cal Poly SLO to better understand the experiences and needs of this community within the mental health system. A larger effort has been made to develop social marketing strategies which address suicide prevention, substance use and abuse, and increasing wellness and resiliency. For college aged students, in 2015, the Department launched a Residential Wellness Counseling program with SAMHSA funds. This program addressed First Episode Psychosis (FEP) issues among college students at California Polytechnic State University, San Luis Obispo. The community has identified a rising need for culturally competent services which address student populations and the increased issues of suicide and substance use disorders.

In each of these identified communities, youth are a focus for outreach and engagement. Latino/Latinx/Hispanic youth are underserved and in need of both prevention and treatment strategies which addresses the issues of ethnicity and development. County programs address families at various stages of acculturation and construct skills for managing the pressures and stress of school, work and community, all while building knowledge around the signs and symptoms of mental illness. The goal is to increase access to these services. Youth are met in schools, churches, community centers, and in response to the COVID-19 pandemic, via virtual methods that are safe, welcoming, and culturally and linguistically appropriate.

Although older adults are a focus for outreach, many older adults and retirees in the county have taken on the responsibility of raising children and teens. These arrangements are often strained, and outreach programs and support groups have been developed with community partners to build skills among those aging adults having to navigate the ever-changing youth culture.

Youth consumers and community members also take part in MHSA stakeholder activities and are given a strong voice in County planning. Transitional Age Youth have helped craft Innovation plans, and within the behavioral health community, many youths have participated as members of Boards and Advisory committees addressing and affecting issues ranging from adolescent substance use, to suicide prevention, to school-based policy.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

San Luis Obispo County's Behavioral Health is strengthened by its foundation which is made up of partnerships amongst many diverse organizations, individuals, providers, families, and clients. These partnerships reflect the County's ethnic and linguistically diverse makeup. SLOBHD partners include other county agencies such as Probation and Social Services, while community partners include agencies which serve the same clients and families within our county's behavioral health system. These organizations, along with clients and family members, and other local government and community-based providers, are engaged in system planning for behavioral health services.

The County's Behavioral Health Board helps the SLOBHD meet mandates as outlined in the Welfare and Institution Code 5604.2. This states that the local behavioral health board shall do the following: review and evaluate the community's behavioral health needs, services, facilities and special programs, and advise the governing body (Board of Supervisors) and the local behavioral health director regarding any aspect of the local behavioral health program. The Behavioral Health Board supports the countywide goal of a healthy community through its actions and recommendations.

The local Behavioral Health Board has representatives including behavioral health providers and practitioners, professionals from the County Office of Education, law enforcement agencies, local recovery and wellness organizations, community advocates, and members of the local NAMI chapter. To assure engagement with consumers and their families, the Board's bylaws require the following:

At least one-half of the seated membership shall be consumers of the public mental health system or family members of consumers. The Board membership should reflect the ethnic diversity of the client population of San Luis Obispo County.

The current Board membership does not include any bilingual individuals. Ongoing recruitment efforts are focused on promoting the need for a Board which accurately reflects the ethnic, racial, and cultural diversity of the county. Efforts include the Membership Committee's role in identifying new, potential members to replace members who exit due to resignation or term-limits. The Board is currently seeking strategies which increase exposure to diverse populations and individuals who may provide new perspectives to the Board.

Another key programming opportunity for this type of partnership is evident in the MHSA community planning and stakeholder processes. Each of the County's required stakeholder meetings have included consumers, family members, and professionals representing the ethnic and linguistic diversity of the County. Because of the efforts of the County to include all voices in its MHSA planning, each approved plan (CSS, PEI, WET, and Innovation) has identified the cultural and linguistic needs of the community and target populations.

The SLOBH Diversity, Equity & Inclusion Committee, formerly known as Cultural Competence Committee, is made up of staff, partner providers, and behavioral health clients. The Committee seeks to provide the County's behavioral health system with guidance and oversight to assure policies and procedures are in place to improve diversity, equity, and inclusion efforts. The group meets quarterly and reviews agency processes, forms, and programs to provide input towards increasing the County's capacity to deliver services which reduce disparities. The Committee produces a quarterly newsletter (Appendix 04) for staff and providers which includes training information and articles on specific wellness and recovery strategies in addition to features that provide deeper insight into the cultural needs of consumers throughout San Luis Obispo County.

The mission of the DEI Committee is to ensure that cultural diversity is incorporated into all levels of the County of San Luis County Behavioral Health Department. Given that since the year 2000, ethnic minorities exceed 50% of the population in California, and that the state demographics include diverse racial, ethnic and cultural communities, the Cultural Competence Committee is dedicated to eliminating cultural, linguistic, racial and ethnic disparities in the populations served by the SLOBHD.

C. A narrative, not to exceed two pages, discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

The County's Workforce Education and Training (WET) component of the Three-Year Program and Expenditure Plan addresses the shortage of qualified individuals who provide services in this County's public behavioral health system. This includes community-based

organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise this County's Public Behavioral Health System workforce. The Workforce Education and Training component is consistent with and supportive of the vision, values, mission, goals, objectives and proposed actions of California's MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan), and this County's current MHSA component plans.

SLOBHD WET component continues to make extensive use of community, consumer/family members, and ethnic minority stakeholders to inform our decisions. To identify workforce education and training needs, San Luis Obispo County continues a planning process that includes open dialogue with several ethnic, cultural, and linguistic groups, meetings, and interviews with key stakeholders. These practices are also part of the role of the Cultural Competence Committee.

SLOBHD continues to consider the workforce development needs of the behavioral health system throughout San Luis Obispo County and to develop strategies and educational programs that meet the needs of the community and support the key concepts of the MHSA. In preparation of the Workforce Education and Training component, San Luis Obispo attended meetings held by the Southern Region Workforce Collaborative. These meetings helped identify regional trends in workforce shortages, addressed the specific needs of consumers and family members, discussed the lack of parity amongst underserved ethnic minority populations receiving behavioral health services, and introduced educators who would later become key stakeholders in the planning process. Workshops sponsored by California Institute of Behavioral Health Solutions (CIBHS) also provided opportunities for collaboration.

As originally designed, one of our very first activities included a survey to all Behavioral Health Department staff to obtain their input on workforce needs, the direction of the workforce education and training plan, and their personal educational and career goals. A 20-question Staff Education and Training Survey was distributed to all mental health staff. Staff was grouped by level of education to address their specific needs and pathways. Staff feedback was incorporated into meetings with colleges to address workforce needs and potential educational program capacity. Additional planning meetings were held with educational stakeholders including Cuesta College and California Polytechnic State University. Workforce needs and educational institution capacity were discussed, and as a result, new career pathway programs have been added to benefit San Luis Obispo County. This required coordinating and convening several key decision makers and organizational leaders to make informed decisions without the delay of extensive preparatory or follow up meetings that their schedules did not allow. The results of these collaborations were not only strong regional partnerships, but new certificate programs at Cuesta College.

Additional focus groups, interviews, and information sessions were held with our Community Based Organizations (CBO), such as Transitions-Mental Health Services (T-MHA)

and Family Care Network, Inc. (FCNI), the Behavioral Health Board, MHSA Latino Outreach Program, and local Spanish-speaking support groups. Ideas and recommendations concerning workforce development received throughout the process have been incorporated or addressed in the Workforce Education and Training plan.

In 2020-2021, over 2,000 hours of training were completed electronically which were offered to Behavioral Health staff, community partners, consumers, and their family members focused in the following topics: community inclusion, supporting adults in the grieving process, and strategies for prevention and intervention for bullying. Through the Southern Counties Regional WET Partnership, SLOBHD has joined other counties, including Ventura, Kern, and Santa Barbara, in providing intensive training for behavioral health interpreters. This training has benefitted the community's Promotores program, which serves Latinos throughout the County.

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

In reviewing the documents and practices identified above, the County has outlined areas of success and areas where more attention is needed to assure cultural competence is embedded in the mission and vision of each SLOBHD service. It is the County's intention to develop further Statements of Philosophy across divisions and programs that accurately capture the SLOBHD's commitment to culturally and linguistically competent services reflected through the entirety of the system.

The DEI Committee, formerly known as the Cultural Competence Committee, (as outlined and described in Criterion IV) has made a strong effort in recent years to expand its membership beyond ethnic group representation. Current representation includes members from underserved populations such as the LGBTQ+ community, the Veteran community, older adults, educators meeting WET targets, and clients. However, client representation has been the most difficult to recruit and maintain. This is partly due to needed support for clients and loved ones attending the meetings, and partly due to a need for more training. The Committee is dedicated to expanding the role of clients and their loved ones in the Cultural Competence activities of the Department and the overall behavioral health community.

Another area for expansion in the Department, as well as the Diversity, Equity & Inclusion Committee, is the engagement of other sub-populations and cultures, such as the spiritual community. Many consumers and family members find their way to services through spiritual outreach, and the SLOBHD has begun exploring more avenues for partnerships. Media contact and advocacy is an additional area where growth is needed, and training is underway with staff to increase the Department's public dialogue around mental health issues.

The Workforce, Education, and Training (WET) efforts of the County have included successful strategies which have already demonstrated improvements in building a culturally competent workforce. The use of E-Learning to increase cultural competence training has been the Department's most consistent and popular tool. SLOBHD contracts with Relias Learning to provide electronic access to a Behavioral Health Library of curricula for 500 San Luis Obispo County behavioral health providers, consumers, and family members. In FY 15-16 a total of 2,779 hours of training were completed electronically, and 3,699 hours were completed in FY 16-17.

The use of online evaluation tools to assess training have proved useful as well. These surveys have had far higher rates of return than paper/pencil methods of the past, and administrative staff have employed these tools in the development of pre and post testing to further assess the skill development and retention of core competency training.

The WET 3-year training plan has been implemented. The plan addressed some of the lessons learned, including the need to expand training across the service delivery system. Cultural competence training for clerical and administrative staff was created to further improve the Department's service responses. Outreach is still being performed to build partnerships with other community organizations that offer relevant training. Finally, the Department is an active member of the Southern Counties Regional Partnership and will benefit from training opportunities, including upcoming events for interpreter and Mental Health First Aid training.

E. Identify county technical assistance needs

Staff and partner provider training needs are currently being met through the County's WET plan and Cultural Competence Committee. The Behavioral Health Department is presently developing core competency training utilizing "e-learning" tools. Technical assistance in the form of core competency policy development, and baseline training standards for mental health professionals, would provide the Department with key objectives for future cultural competence plans.

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

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

The county shall include the following in the CCPR:

A. Evidence that the County Mental Health System has a designated CC/ESM who is 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.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

In the 2020-2021 fiscal year, the MHSA Advisory Committee met and discussed the addition of the Diversity, Equity & Inclusion Program Manager for the Behavioral Health Department, which is previously known as the Cultural Competence/Ethnic Services Manager (CC/ESM). The DEI Program Manager meets with, and has direct access to, the Behavioral Health management team and the Director. The DEI Program Manager will update the Behavioral Health Department's policy and procedures, training, community outreach, and hiring and recruitment practices to ensure the ability to provide culturally and linguistically affirmative treatment for the entire community.

In July 2008, Nancy Mancha-Whitcomb, LMFT, was assigned to be the Cultural Competence/Ethnic Services Manager (CC/ESM) for the SLOBHD. This assignment was made by Dr. Karen Baylor, the County Behavioral Health Director. In April 2017, Nestor Veloz-Passalacqua MPP, became the new Cultural Competence/Ethnic Services Manager under direction of Anne Robin, the County Behavioral Health Director. Under a rigorous selection process, in November 2021, Nestor Veloz-Passalacqua, MPP was selected as the permanent Diversity, Equity & Inclusion Program Manager.

In his capacity, Mr. Veloz-Passalacqua is required to participate in monthly teleconferences hosted by the CMHDA Ethnic Services Committee/Southern Region. He attends meetings of the Southern Region Ethnic Services Group, as well as quarterly Statewide meetings for the Ethnic Services Committee in Sacramento. Mr. Veloz-Passalacqua has attended various trainings and conferences that addressed diversity, equity, and inclusion. As the DEI Program Manager, Mr. Veloz-Passalacqua is responsible for disseminating information gained from these meetings and trainings to staff in county clinics as well as participating Community Based Organizations in the County of San Luis Obispo.

In addition, Mr. Veloz-Passalacqua is active in the Cultural Competency Committee in reviewing policy and practices. He has focused on services for the primary threshold populations receiving behavioral health services, which in San Luis Obispo County is primarily the Spanish speaking population and other underserved populations. Mr. Veloz-Passalacqua is an active leader in assuring MHSA practices remain culturally competent.

The Director recognizes the role and function of the now DEI Program Manager within the organization by allocating sufficient time for the performance of job responsibilities and duties. Additionally, the Director promotes the staff influence in policy and program change

by considering and following the recommendations for change in human resources, ethnic and culturally specific services, and all other related areas.

B. The responsibilities of the designated CC/ESM are as follows:

- Develop department policies and procedures aimed at addressing health disparity and achieving health equity.
- Work with Human Resources to inform hiring and recruitment practices, and to guide the development of hiring committees that are culturally competent and trained in implicit bias.
- Support treatment providers and other department staff through training and mentoring, while monitoring and measuring the outcome of these training interventions.
- Develop mechanisms and strategies for outreaching to underserved communities, and track outcomes to analyze and quantify the impact of these efforts.
- Inform and direct communication strategies to ensure messaging is inclusive and demonstrates our department's commitment to cultural competence.
- Collect and maintain accurate and reliable demographic data of our county residents and Medi-Cal beneficiaries, to inform service delivery and meet all reporting requirements.
- Takes lead responsibility for the development and implementation of cultural competence planning within the organization.
- Participates and advises on planning, policy, compliance, and evaluation components of the county system of care, and makes recommendations to the County Director or management team that assure access to services for ethnically and culturally diverse groups.
- Tracks penetration and retention rates of racially and ethnically diverse populations and develops strategies to eliminate disparities.
- Maintains an active advocacy, consultative, and supportive relationship with consumer and family organizations, local planning boards, advisory groups and task forces, the State, and other mental health advocates.
- Assists in the development of system-wide training that addresses enhancement of workforce development and addresses the training necessary to improve the quality of care for all communities and reduce mental health disparities.
- Attends trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system.
- Responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC). The BCC Committee shall be made of the DEI Program Manager and three bilingual staff members, at least two of whom will be a native speaker of the threshold languages within the county.

The BCC will be responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-100 for each of the areas described below. The checklist will include, but not be limited to:

1. Fluency; the ability to communicate with ease, verbally and non-verbally.
2. Depth of vocabulary including the ability to communicate complex psychiatric/psychological concepts, which may or may not have direct corollaries in the language in question.
3. Grammar; appropriate use of tense and grammar.
4. Cultural considerations related to the potential client.

The certification process will be conducted by two bilingual committee members, one of whom will be the committee's identified native speaker. The certification interview will follow a standard initial assessment format. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate will be given an opportunity to make any remarks she or he may wish for clarification.

The SLOBHD Diversity, Equity & Inclusion Program Manager Areas of Responsibilities 2020-2021, is a written description of the responsibilities of the designated staff and is provided in Appendix 05.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

1. Interpreter and translation services;
2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
3. Outreach to racial and ethnic county-identified target populations;
4. Culturally appropriate mental health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

The County is committed to providing necessary fiscal resources to support cultural competence activities:

A. Below are activities included in the FY 2020-21 Actual Budget for SLOBHD:

- The SLOBHD has spent $765,289 for Mental Health Services Act (MHSA) Latino Outreach and Therapy Services (Community Services and Supports program). This program includes 5.47 FTE permanent positions.
- The SLOBHD has not spent funds for Cultural Competence Training under the MHSA Workforce Education and Training (WET) program, but under INNovation.
- The SLOBHD has spent $2,428 for the Clinical Bilingual Internship action in the MHSA WET program for bilingual Interns to work in three separate clinics.
- The SLOBHD has spent one-time funding of $13,525 to support the initial expense and low maintenance cost for electronic equipment and internet costs to support the Promotores Mental Health Interpreters for use by all clinics.
- The SLOBHD has appropriated $36,720 for bilingual differential pay for the Mental Health Core Budget ($22,747) and Mental Health Services Act Budget ($14,207). Of the $14,207 for MHSA bilingual pay, $9,216 is reported above for the Latino Outreach and Therapy Services program, and $638 is included above for the Clinical Bilingual Internship action.
- The SLOBHD has spent $4,706 for Crisis Intervention Training in the MHSA WET program.
- The SLOBHD has spent $36,720 for Promotores interpretation services in the MHSA WET program as part of providing additional interpretation services in all clinics.
- The SLOBHD has spent $24,661 for the Peer Advisory and Advocacy Team (PAAT) in the MHSA WET program as part of the continued effort to highlight the work and reach of peers and their loved ones in the mental health system.
- The SLOBHD has spent $403,425 for MHSA Veterans Outreach Program (VOP) Therapy Services (CSS) and Veteran Outreach and Engagement Services (PEI). This program includes 1 FTE Behavioral Health Clinician and 1 FTE Outreach Coordinator/Case Manager.

The total budget for cultural competence activities is $1,287,708

B. The majority of cultural competence activities in the FY 2021-22 Projected Budget for SLOBHD are funded by MHSA. Below are details by program:

- The Latino Outreach and Therapy Services program is funded by the MHSA Community Services and Supports allocation ($555,561) and Medi-Cal ($216,194) for a total of $771,755.
- The Cultural Competence Training is funded by the MHSA WET allocation ($3,000).
- The Clinical Bilingual Internship action is funded by the MHSA WET allocation ($47,618), Medi-Cal ($7,447).

The interpreter services provided by Language Line are funded by County General Fund Support and Realignment ($20,375).

The bilingual differential pay for County staff assigned to Mental Health core is funded by County General Fund ($21,903). The MHSA bilingual pay ($14,402) is funded by Community Services and Supports allocation ($11,544 is included above in the Latino Outreach and Therapy Services program).

Crisis Intervention training ($66,700), Promotores interpretation services ($37,454), and PAAT ($27,275) are funded by MHSA WET funds. The Veterans Outreach Program ($429,295) is funded by MHSA CSS ($280,923) for therapy services, and by MHSA PEI ($148,372) for outreach and engagement services.

Total funding required for cultural competence activities is $1,447,224. Note: this does not include the WET regional allocation (to be determined) for cultural competency training.

CRITERION 2
COUNTY MENTAL HEALTH SYSTEM
UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population
The county shall include the following in the CCPR:

A. Summarize the county's general population by race, ethnicity, age, and gender. 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).

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 2:

11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service. A new CCP is revised and written annually, which include new data collection reporting and strategies identified, determined, and adopted for the year.

A. **Table 1** displays the most recent published Census data (*www.census.gov*, and *American Community Survey*) for San Luis Obispo County. According to the most recent estimated census data there are 283,111 residents, 105,981 households, with an average of 2.51 persons per household in the county. The racial makeup of the county is 88.8% White, 2.0% Black or African American, 1.4% American Indian or Alaska Native, 4.0% Asian, 0.2% Hawaiian and Pacific Islander, and 3.6% from two or more races. The county's Latino/Latinx/Hispanic community represents 22.9% of the population identifying as Latino/Latinx/Hispanic of any race. 17.7% are of Mexican descent, 0.4% are of Central American descend, 0.3% are of South American descend and 1.9% are of Spanish ancestry. The percentage of those speaking only English has decreased to 81% while the population of Spanish speaking individuals has grown to 18.6%. Foreign-born, non-citizens make up 10.2% of the total population.

Of the currently estimated 105,981 households in the County, 61.6% are owner-occupied housing units, with an average of 2.51 persons per household. Regarding the COVID-19 impact, 82.2% of individuals reported that they have lived in the same house the prior year, which includes persons one year old and above. 24.3% report households with children, and 75.7% report household without children (Kidsdata.org). And about 18% of households speak other languages besides English, which include persons age five years and above.

The population age spread is comprised of 22% under the age of 18, 57.1% from 19 to 64, and 20.9% are 65 years of age or older – a figure that is steadily increasing.

TABLE 1. San Luis Obispo - Estimated Demographics	
POPULATION	
Population estimates, July 1, 2019, (V2019)	283,111
Population estimates base, April 1, 2010, (V2019)	269,597
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	5.0%
Population, Census, April 1, 2020	282,424
AGE & SEX	
Persons under 5 years, percent	4.5%
Persons under 18 years, percent	17.5%
Persons 65 years and over, percent	20.9%
Female persons, percent	49.4%
RACE & HISPANIC ORIGIN	
White alone, percent (a)	88.8%
Black or African American alone, percent (a)	2.0%
American Indian and Alaska Native alone, percent (a)	1.4%
Asian alone, percent (a)	4.0%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.2%
Two or More Races, percent (a)	3.6%
Hispanic or Latino, percent (b)	22.9%
White alone, not Hispanic or Latino, percent	68.5%
POPULATION CHARACTERISTICS	
Veterans, 2012-2016	16,767
Foreign born persons, percent, 2015-2019	10.1%
HOUSING	
Housing units, July 1, 2019, (V2019)	123,963
Owner-occupied housing unit rate, 2015-2019	61.6%
FAMILIES & LIVING ARRAGEMENTS	
Households, 2015-2019	105,981
Persons per household, 2015-2019	2.51
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	82.2%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	18.0%

Fact Notes

(a) Includes persons reporting only one race

(b) Hispanics may be of any race, so also are included in applicable race categories

Source: U.S. Census Bureau, 2019 Estimates

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

The county shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

Using current CAEQRO and CenCal data, the following section demonstrates the County's Medi-Cal population service needs and disparities in terms of race/ethnicity, age group, and gender.

A. **Table 1** is taken from the calendar year 2020 CenCal Health report for San Luis Obispo County and identifies the utilization rate of White (4.12%), Latino/Latinx/Hispanic (1.41%), Asian/Pacific Islander (1.10%), African American (4.11%), Native American (2.81%) and other (5.62%) races which make up the County's Medi-Cal population.

Table 1.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY2020, by Race and Ethnicity					
Race/Ethnicity	**Average # of Eligibles per Month**	**# Clients Served**	**Penetration Rate**	**Medium Counties Penetration Rate**	**Statewide Penetration Rates**
White	19,204	792	4.12%	2.29%	1.96%
Latino/Latinx/Hispanic	12,630	178	1.41%	0.73%	0.69%
African American	535	22	4.11%	1.73%	1.34%
Asian/Pacific Islander	1,088	12	1.10%	0.31%	0.17%
Native American	249	7	2.81%	1.79%	1.84%
Other	11,001	618	5.62%	1.71%	1.41%
Total	**44,707**	**1,629**	**3.64%**	**1.29%**	**1.03%**

Table 2 displays data which gives a snapshot of utilization and penetration rates for age. Adults ages 18-64 make up the largest eligible group, with 44,706 enrollees. Youth ages 12-17 make up 7,226; and lastly ages 65+ make up 4,693 of eligibility in the county. The table also demonstrates that penetration rates are higher than the state's average.

Disparities and analysis will be described in the next section.

Table 2.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY2020, by Age					
Age	**Average # of Eligibles per Month**	**# Clients Served**	**Penetration Rate**	**Medium Counties Penetration Rate**	**Statewide Penetration Rates**
12-17	7,226	79	1.09%	0.25%	0.25%
18-64	32,787	1,475	4.50%	1.55%	1.26%
65+	4,693	75	1.60%	1.19%	0.77%%
Total	**44,706**	**1,629**	**3.64%**	**1.29%**	**1.03%**

Table 3 below displays data of utilization and penetration rates based on gender. Females represent the larger number of those eligible with 28, 490 enrollees, whereas males represent a total of 25, 727 enrollees.

Table 3.

San Luis Obispo MHP Medi-Cal Enrollees and Penetration Rates in CY2020, by Gender			
Gender	**CenCal Population Enrollees**	**% Enrollees**	**Penetration Rates**
Males	26,937	47%	8.36%
Females	30,216	53%	6.97%
Total	**57,153**	**100%**	**7.66% Average**

B. As **Table 1 and 2** clearly demonstrates that individuals identifying as white are the largest group of eligibles and beneficiaries. White people make up about 43% of the eligible population and about 49% of them receive services. This creates a disparity for other racial groups which make up an inequity between eligibility and service. The largest inequity is among Latino/Latinx/Hispanic persons who comprise 28% of the eligible population and receive about 11% of services. Another disparity exists for Asian/Pacific Islanders who make up about 2.5% of the eligible population yet receive less than 1% of services. In contrast, African Americans make up about 1.20% of the eligible population while receiving 1.35% of the County's services. Less than half of the eligible Latino and Asian/Pacific Islander Medi-Cal eligible populations are served.

Both evident disparities possess a common denominator: language. While the Latino population faces a larger disparity, it is also important to note the inequity which exists for Asian and Pacific Islander clients who make up the County's second largest non-white ethnicity. In both cases, language and the lack of linguistic and culturally competent providers may be barriers for service. As outlined in other sections of this report, the County has made continuous efforts and strides towards building a culturally and linguistically competent workforce. The most critical factor in doing so is to have the ability to serve clients

in their native language, and to establish solid trust and communication between them. It is apparent that the lack of bilingual staff available to provide services in a variety of Asian languages is also a barrier in the County.

The County continues to examine the disparity with the Latino/Latinx/Hispanic community and has identified issues of poverty, geographic barriers, transportation, and cultural beliefs as being major factors in determining access. The county also has a large subpopulation of migrant farm workers, and due to recent national events, less clients have searched for or accessed services. Local school districts and cultural organizations in the county held various community meetings in the North and South County regions to inform the community of the support and continuity of services. This same approach may be important to assess the disparity with Asian/Pacific Islanders, although many of the same barriers will exist. The county's tourism, agriculture, and seasonal economies support opportunities for monolingual Asian immigrants representing many languages not spoken by providers in the behavioral health system. Also, the local colleges and University have increased Asian populations in the past ten years due to school acceptance for out-of-state and out-of-county students, which has contributed to the overall subpopulation growth. While language may not be a factor in all issues of disparity with Latino/Latinx/Hispanic and Asian eligibles, it can be assumed that cultural beliefs, stigma, and lack of outreach serve as barriers to access.

Table 2 also demonstrates a disparity amongst the county's 12-17 years of age population and oldest (65+) eligibles. Both age categories have a penetration rate of less than 2%. This disparity is being addressed in various County programs which have identified issues such as outreach for older, withdrawn adults as being a strategy to combat this barrier to service while expanding services for the youth in the educational setting. A strategy includes the implementation of the Mental Health Services Student Act (MHSSA) to increase mental health services in schools countywide.

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

The county shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social /cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.

The following table should be viewed in the context of data collected for Medi-Cal and uninsured clients as they are the population at or below the 200% poverty line:

A. According to the California Health and Human Services Open Data website (Poverty Rate (<200% FPL) and Child (under 18) Poverty Rate by California Regions - Datasets - California Health and Human Services Open Data Portal) from 2011-2016 there is a total of 18,995 individuals in our county under the 200% of poverty calculation. With the implementation of the Affordable Care Act in 2010 and with the Medi-Cal expansion of 2014, this sharply increased the reach of health care coverage, and shifted individuals to have medical insurance and access to services through the open health care market. Due to the impact of these changes, SLOBHD has no access to utilization data since individuals who are part of the 200% poverty population gain access outside the Medi-Cal service coverage the county provides. The table below details information only for race and ethnic groups under the 200% poverty population, but not receiving Medi-Cal in San Luis Obispo County. SLOBHD is hoping for state direction and a new Cultural Competence Plan Template with updated criteria that will cover pertinent information.

B. As pointed out, there is a higher representation of poverty in the Latino/Latinx/Hispanic population. Although they represent about 22% of the entire county population, within the 200% poverty population they represent over 55% of that entire group, followed by the white population who represent about 89% of the entire county population, and about 37% within the 200% poverty rate. This disparity is apparent regionally as the Latino/Latinx/Hispanic population live in the north and south county regions which is most rural and have less access to services. Comparably, the African American, Asian, American Indian and multiple races/ethnicities groups face similar disparities in which their overall population rate resembles an higher number of them as part of the 200% poverty population and with equal or less access to services countywide.

Table 4.

San Luis Obispo 200% Poverty Population		
Race/Ethnicity	**Count of 200% Poverty**	**Percentage of Total Group**
White	7,175	37.78%
Mexican American/ Chicano/Latino/Latinx/Hispanic	10,502	55.28%
African American	320	1.68%
Asian	419	2.20%
Multiple Races/Ethnicities	466	2.46%
American Indian & Alaska Native	113	0.60%
Total	**18,995**	**16.66% Average**

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

The county shall include the following in the CCPR:

A. From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

Note: Objectives will be identified in Criterion 3, Section III.

Data provided in this section should be reviewed within the County's Community Services and Supports (CSS) population assessment and service needs and current service access. The original Plan was submitted to the State in 2005 and revised in 2006.

A. The following data table, which reflects fiscal year 2020-2021, is a summary of client utilization data by age, gender, and race/ethnicity. The table should be viewed in the context of the estimate Census report as it relates to access to services: San Luis Obispo County's population is 88.9% White, 2.0% Black or African American, 1.4% American Indian or Alaska Native, 4.0% Asian, 0.2% Hawaiian and Pacific Islander, and 3.5% from two or more races.

Table 5.

Race/Ethnicities & Gender	0-25 y/o	26-59 y/o	60+ y/o	Grand Total
Asian/Asian Pacific Islander	**9**	**12**	**1**	**22/0.98%**
Female	5	3	1	9
Male	4	8	0	12
Nonbinary	0	1	0	1
Black/African American	**9**	**26**	**7**	**42/1.87%**
Female	3	9	4	16
Male	6	17	3	26
Mexican American	**244**	**205**	**24**	**473/21.16%**
Female	131	89	16	236
Male	112	116	8	236
Nonbinary	1	0	0	1
Other Hispanic	**82**	**55**	**6**	**143/6.39%**
Female	39	28	1	68
Male	42	26	5	73
Nonbinary	1	1	0	2
White	**256**	**556**	**164**	**976/43.66%**
Female	138	245	93	476
Male	114	311	71	496
Nonbinary	2	0	0	2
Transgender	2	0	0	2
Other/Unknown	**188**	**290**	**101**	**579/25.90%**

Female	105	138	53	296
Male	76	148	48	272
Nonbinary	0	1	0	1
Unknown	7	3	0	10
Grand Total	**788**	**1,144**	**303**	**2,235/100%**

B. In analyzing disparities among mental health recipients, the selected populations were compared across race/ethnic groups, age, and gender. In overall, the Mexican American and Latino/Latinx/Hispanic groups represent about 28% of enrolled clients for services, although they represent over 22% of the total county population, which is an increase but still a disparity in services. The County continues to increase our pool of bilingual and bicultural direct service staff under the Latino Outreach Program and throughout outpatient clinics. Older adults construct a population that receives limited access to services representing about 13.55%. Early Intervention strategies allow us to engage with this population, but intensive outreach and communication is needed to close the gap of insufficient access.

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

The county shall include the following in the CCPR:

A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:
   1. Underserved cultural populations
   2. Individuals experiencing onset of serious psychiatric illness
   3. Children/youth in stressed families
   4. Trauma-exposed
   5. Children/youth at risk of school failure
   6. Children/youth at risk or experiencing juvenile justice involvement

B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

A. The County chose to address all six of the PEI priority populations in its plan. Priority populations were not ranked, and the PEI plan serves all six groups. The County has worked in collaboration with new stakeholders and new populations have been identified. The County has conducted, through a contract, an LGBTQ Needs Assessment that will impact service provision and other strategies in the future.

B. Stakeholders in the PEI Planning Process reviewed and analyzed the community's needs and desires expressed though data collection, focus and work groups, and surveys. The stakeholders reviewed over a thousand surveys that gathered public opinion and gauged professional experience around mental health issues. The stakeholders determined the key

community needs for response and narrowed priority services to the targeted populations. In order to gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. Each group then addressed the specific nature and needs of the PEI priority populations within each age cohort. Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, and to target groups and strategies that were realistic, feasible, and the best use of PEI funds. Their recommendations were brought to the full PEI Community Planning Team to develop the projects included in the final PEI plan.

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

I. Identified unserved/underserved target populations (with disparities):

The county shall include the following in the CCPR:

- Medi-Cal population
- Community Services Support (CSS) population: Full-Service Partnership population
- Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 3:

1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

14) Create conflict and grievance-resolution processes that are culturally and linguistically appropriate to identity, prevent and resolve conflicts or complaints.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service. A new CCP is revised and written annually, which include new data collection reporting and strategies identified, determined, and adopted for the year.

In recent years, mainly due to the MHSA Planning Processes, the County has collected data and stakeholder input to identify unserved and underserved target populations. This process has also yielded information regarding disparities which adversely affect their ability to access services, and strategies which improve access for those populations.

A. The following responses identify the target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Medi-Cal population:

- As per the SLOBHD's description of "Medical Necessity" (Appendix 06), the County observes California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services. Medi-Cal beneficiaries must meet criteria outlined below to be eligible for services:

  1. Be diagnosed by SLOBHD with a criteria diagnosis in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association.

  2. Must have at least one of the criteria impairments because of the mental disorder(s) listed in subdivision (1) above.

  3. Must meet each of the intervention criteria listed within the listed Code.

  4. Minor beneficiaries are eligible when criteria listed in Section 18310.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age (Appendix 06) are met.

- There is a barrier for those who do not meet required eligibility to access primary Medi-Cal services from the County Behavioral Health Department.

Community Services Support (CSS) Full-Service Partnership population:

- As per the SLOBHD's Full-Service Partnership (FSP) Program Description (Appendix 07), the County provides several Full-Service Partnerships (FSP) utilizing "whatever it takes", wraparound-like, intensive, community-based mental health services and supports to a focal population of individuals with mental illness. The program is founded on a strength-based, solution-focused, culturally competent, client/family model to help individuals accomplish wellness, recovery, and resiliency in their lives so they may remain in their community. Target populations include:

  1. Children and Youth, 0-17 years old, with one or more of the following characteristics:

  - "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
  - Foster Youth with multiple placements.
  - Risk of out-of-home placement.
  - In juvenile justice system.

  2. Transitional Age Youth (TAY), 16-21 years old, that have one or more of the following characteristics:

  - "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
  - Co-Occurring substance abuse issues.
  - Foster Youth with multiple placements or aging out/have aged out.
  - Recently diagnosed with a mental illness.

3. Adults, 18-59 years old, that have one or more of the following characteristics:

- At risk for involuntary institutionalization.
- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Co-Occurring substance abuse issues.
- Homeless or at risk of becoming homeless.

4. Older Adults, ages 60+, that have one or more of the following characteristics:

- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Homebound – unserved.
- Homeless or at risk of becoming homeless.
- Co-Occurring substance abuse issues.
- Presenting with mental issues at their primary care provider's office.

Workforce, Education, and Training (WET) priority populations:

- The County chose to address the following priority populations in its plan, based on its targets to grow a multicultural workforce (Appendix 08):
  1. Behavioral Health clinicians and support staff
  2. Community Based Organizations serving mental health clients
  3. Bilingual and culturally diverse clinicians
  4. Clinicians specializing in co-occurring disorders
  5. Undergraduate and Graduate students seeking a career in Behavioral Health
  6. Mental Health clients seeking education and/or a career in the field of Behavioral Health
  7. Criminal justice personnel who intervene with the behavioral health population.
  8. Clients, family members, reentry and current students interested in working in the behavioral health field.

Prevention and Early Intervention (PEI) priority populations:

- The County chose to address all six of the PEI priority populations in its plan:
  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

1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

Stakeholders in the PEI Planning Process were charged with review and analysis of the priority populations and community's desires, as expressed though data collection, focus groups, work groups, and surveys. The stakeholders then determined the key community needed to respond and narrowed priority populations to targeted groups. From there, the stakeholders reviewed the strategies that were appropriate for the needs and populations as well as matched community recommendations (592 viable PEI strategies were submitted). They then began combining ideas that would ultimately lead to final programs and projects.

The Planning Team formulated criteria to prioritize options, (such as the balance between prevention and early intervention programming: serve a few groups more in depth rather than many groups "lightly") and adopted guiding practices that would be universal to the all the PEI projects. These guiding practices included cooperative and coordinated services, easy access, utilizing existing strategies before starting something new, maximizing existing natural relationships, serving whole family units rather than just the "problem" individual, and varying services to be culturally aware and appropriate (these were themes from the community at large).

To gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. Each group then addressed the specific nature and needs of the PEI priority populations within each age cohort. Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, target groups and strategies that are most realistic, feasible and best use of PEI funds. Their recommendations were brought to the full PEI Community Planning Team to develop the projects included in the final PEI plan.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI's priority/targeted populations).

A. A significantly dominant disparity in San Luis Obispo County, which cuts across all the Medi-Cal, CSS, WET, and PEI's priority/targeted populations, is the under-representation of the Latino/Latinx/Hispanic community. This imbalance in service access is made even more dramatic considering the relatively high proportions of this community experiencing poverty coupled with the health and access problems that are part of such experience. The Latino/Latinx/Hispanic community represents 22.60% of the total county population of

283,111 but they represent about 36% of the poverty population receiving services. To further compound ethnic and cultural barriers, a high percentage of the prevalent unrepresented Latino/Latinx/Hispanic population in our county reside in the rural areas (communities with populations less than 3000 and/or are located 15-30 miles from services), thus exacerbating access, transportation, and information distribution difficulties.

Medi-Cal and CSS Populations

Within the overarching Latino/Latinx/Hispanic service imbalance, the disparity between the percentage of Youth and Transition Age Youth receiving services is underrepresented, compared to their numbers in the poverty population. A very telling disproportionate service pattern exists, with approximately 20% of services going to Latino/Latinx/Hispanic while representing about 31% of the eligible population. In a similar fashion, when reviewing the unserved population, Latino/Latinx/Hispanic Youth and Transition Age Youth represent the highest combined percentages of unserved individuals among the youth and transition age groups.

It is estimated that among older adults and adults, Latino/Latinx/Hispanic again represent a relatively low percentage of those served compared to their percentage of both in the poverty level population (48%), which includes all Latino/Latinx/Hispanic from different origins. Acculturation and assimilation processes impact all Latino/Latinx/Hispanic in different degrees, but the experience ultimately brings in even more cultural and linguistic barriers and therefore presents a greater access disparity based on this potential imbalance in cultural and linguistic barriers.

In 2004, SLOBHD conducted a study to assess the characteristics which influence the local Latino/Latinx/Hispanic population's underutilization of Mental Health Services. The survey was administered to 200 Spanish speaking low-income Latino/Latinx/Hispanic residents. All 200 surveys were completed by those who were Spanish literate and illiterate. The results showed that the following variables affected utilization of mental health services:

- Latino/Latinx/Hispanic did not feel comfortable accessing services in a government building. They perceive the government as an authoritarian entity and were intimidated by it;
- Some of the Latino/Latinx/Hispanic members who had attempted to receive services from the County Behavioral Health Department reported that the experience was confusing and involved telling personal information to various persons prior to being assigned a therapist. Some reported that after sharing personal information they were told that their problem was not serious enough to qualify for services;
- Latino/Latinx/Hispanic members reported difficulty trusting someone who was not of their own culture and were concerned they would not be understand because of the differences in life experiences, and

- Latino/Latinx/Hispanic members preferred someone who spoke Spanish rather than having an interpreter. They found the interpreter interfered with the flow of information.

On a much smaller scale, Asian/Pacific Islanders maintain a service disparity across age and gender groups. It is most pronounced with Transition Age Youth. More examination and study of this inequity is needed to determine strategies to better address reducing this disparity.

Workforce, Education, and Training

- **Behavioral Health clinicians and support staff**: There is a need for additional bilingual/bicultural staff in all classifications, especially in the threshold language of Spanish, but it is difficult to recruit these staff members based on community capacity, cost of living, and factors such as limited local schooling for professionals. Psychiatrists and Registered Nurses that work at the Psychiatric Health Facility (PHF), for example, are very hard to recruit. The County faces competition for salary equity from institutions such as the Atascadero State (Psychiatric) Hospital and the California Men's Colony, a state prison; both of which pay much higher wages for qualified staff.
- **Community Based Organizations serving mental health clients**: The County's WET Plan addresses the need for the development of Community Based Organizations (CBOs) who serve mental health clients. The county has tremendous CBOs providing support, education, wellness, and recovery services, yet there is still a disparity for those organizations that do not have the capacity or cultural competence to appropriately serve those clients who, for one reason or another, need services outside of what County Behavioral Health can provide.
- **Bilingual and culturally diverse clinicians**: Those staff and clinicians who are bilingual and culturally diverse are often placed in demanding positions to handle larger clinical caseloads while also serving as outreach workers. This places an increased demand on keeping these positions filled.
- **Clinicians specializing in co-occurring disorders**: It is a priority to have appropriately trained and skilled therapists and clinicians who serve clients presenting both mental illness diagnoses and addiction issues. Like many other California counties have done so in several years, SLOBHD has sought to integrate mental health and alcohol and drug services. Disparities which reduce these clinicians' ability to serve include the challenge of having to navigate difficult confidentiality issues, medicinal ethics, and a lack of professional education and development.
- **Undergraduate and Graduate students seeking a career in Behavioral Health**: Local colleges, including California Polytechnic State University, San Luis Obispo (Cal Poly) offer limited psychology and counseling programs. College admissions for native Spanish-speakers in California are traditionally low (Atkinson, 2003). Locally, there is a small pool of graduate students looking for work; however, the pay for license-track trainees is minimal at best.

- **Mental Health clients seeking education and/or a career in the field of Behavioral Health**: Consumers seeking education which would prepare them for work in the mental health field are faced with several barriers in San Luis Obispo County. These include the cost of college education, impacted schools which only take highly competitive academic applicants and recruitment efforts which rarely target those with mental illness. Of course, the weakened job market in California has also impacted the availability of career positions, making the recruitment even more competitive. Mental health consumers face the stigma of professionals, among others, working alongside peer counselors.
- **Criminal justice personnel who intervene with the mental health population**: The target population of criminal justice personnel who intervene with the mental health population includes those first-responders who have intensive interactions with the mentally ill and their families. Training in mental health issues and cultural competency is often limited by resources and scheduling pressures for other training which may have a more salient impact on communities.
- **Clients, family members, reentry and current students interested in working in the mental health field**: This is an issue the SLOBHD continues to work on. The County has supported several programs which develop consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers. In the past decade, the County has increased contractual and grant programs which require peer and family member employment. In 2018, the Department adopted new job classifications which allow lived experience to be equitable to work and educational backgrounds. This allows the County to employ consumer staff in regular benefited positions versus relying on practices including volunteers, stipends, and personal service contracts.

Prevention and Early Intervention:

- **Trauma Exposed Individuals**: Disparities include reduced access by those who may avoid seeking services for the psycho-social effects of the traumas they have experienced.
- **Individuals Experiencing Onset of Serious Psychiatric Illness**: Disparities include reduced access by those unlikely to seek services from traditional mental health services due to stigma, or lack of understanding of their illness.
- **Children and Youth in Stressed Families**: Disparities include lack of services and reduced access due to stigma and inability to engage parents and caregivers in providing access.
- **Children and Youth at Risk for School Failure**: Disparities include lack of services and reduced access due to stigma, and inability to engage school systems in increasing access to services.
- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement**: Disparities include lack of services and reduced access due to stigma, and fear of further juvenile system involvement.

- **Underserved Cultural Populations**: Disparities include lack of services and reduced access due to stigma, language barriers, lack of culturally sensitive locations and hours, and limited understanding of other systems which may support access (i.e. schools which cannot communicate with monolingual parents).

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:
   II. Medi-Cal population
   III. 200% of poverty population
   IV. MHSA/CSS population
   V. PEI priority population(s) selected by the county, from the six PEI priority populations

The following section outlines SLOBHD's strategies and objectives which guide its approach to culturally competent activities. Programs described here range in scope from clinic-based therapeutic services to community partnerships, to public education and engagement.

A. The strategies identified in the County's CSS, WET, and PEI plans are described here to provide a comprehensive demonstration of how San Luis Obispo County is addressing disparities in service throughout its system of care.

Community Services and Supports (CSS)

The County originally established a partnership with a local psychologist to conduct research to determine best practice approaches to overcoming disparities with Latino/Latinx/Hispanic clients. The resulting paper, "Servicios Sicológicos Para Latinos: A Latino Outreach Program: Addressing Barriers to Mental Health Service" (Appendix 09) outlined the county's local data, described in the previous Criterion, and outlined the services which continue to anchor the CSS strategies in San Luis Obispo County.

Latino Outreach Program (LOP) offers culturally appropriate psychotherapy services to monolingual, low-income Spanish speakers, and their bilingual children. The model for LOP is based on the findings of research and the findings of the County study conducted in 2004. The program is in the process of re-establishing itself to address the current local, state, and national climate to support the specific needs of this population.

The client's access to services is conducted in a manner that minimizes unnecessary interaction, but directly connecting with their provider. The clients access services from either community referrals (e.g. Family Resource Centers, schools, etc.), or directly through the central access service – which now has bilingual, bicultural staff available at all times. This "managed care" team assigns the client to the therapist that conducts the intake and provides therapy. This method of accessing services addresses the barrier described in Criterion 3, Section IIA, which speaks to the difficulty of telling the personal story to various persons prior to receiving treatment, and is respectful of the findings of Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, (2001) and Chung (1990) that indicate clients get lost when trying to navigate through the bureaucracy of the agencies that provide mental health services.

All LOP therapists are bicultural and bilingual. The program is currently experiencing a deficit due to the constrains placed by the COVID-19 pandemic and uncertainty in employment. The SLOBHD has launched a robust strategy to target potential candidates in the county and in nearby areas by employing direct outreach, social media, and reaching out to Spanish-speaking areas to spread the word. An entire list of current staff can be found in Appendix 10. The ethnicity of the therapists and their cultural backgrounds addresses the concerns stated in Criterion 3, Section IIA. By being Spanish speaking Latinos/Latinas, the therapists can increase the probability of retaining the client because as noted by Lehman, E.W., Harrison-Ross, P. & Seigal, K. (1982), there is a decrease in dropout rates when there is an ethnic and language match between the mental health professional and an ethnic minority client. By having therapists with experiences both as immigrants and as first-generation U.S. citizens, staff can share world views and connect with the Latino client's cultural perspectives and experiences.

In 2011, the SLOBHD launched an Innovation (MHSA) project to test improving mental health access for veterans and active military. "Operation Coastal Care" tested a unique community collaboration providing a licensed mental health therapist to be embedded with local "surf" recreation/rehabilitation programs for veterans and other high-risk individuals, which has proven to be a great success. Now called the *Veterans Outreach Program*, the County offers monthly outdoor activities, group experiences, and community service for local veterans and their family members. At each event, the participants are introduced to the County's veteran-focused clinician and are offered an opportunity to meet in a relaxed and supportive environment. Veterans seeking further counseling or treatment are provided a safe introduction to services, and often make their first appointments while at the event. The outreach event is funded, now, as part of the Prevention & Early Intervention plan. The clinician is funded with CSS, and now also provides services to the County's Veterans Treatment Court. During the COVID-19 impact, service provision was accommodated to ensure safety of each and all clients and their loved ones, and allowed the staff to expand services via virtual alternatives.

Workforce Education and Training (WET)

The County's original WET plan addressed the disparities of recruitment, training, and education of qualified individuals who provide services. The County spent its WET funding over a ten-year period. Some original WET programs are now being funded with CSS funding. The County concluded programming associated with the following strategies:

- **Workforce Education and Training Coordinator and Intern:** This strategy reassigned a Mental Health Therapist to 20 hours per week as the WET Coordinator in December of 2008. A part-time WET intern was hired in the second year to assist in the planning and implementation of the WET blueprint. These positions coordinated the implementation of educational and training strategies identified in the County, performing tasks such as conducting assessments of county staff, contract providers, consumers, youth, and family members' training needs; assisting in the development and implementation of a strategic training plan for SLOBHD; and participating both at a state and regional level to ensure coordination of training opportunities.
- **All Workforce Training in Co-Occurring Disorders:** WET stakeholders expressed extensive interest in promoting system-wide competencies in co-occurring disorders. Based on this interest, the County provided workforce training in treating individuals with co-occurring mental health and substance disorders in a culturally competent manner to staff and volunteers of the County and contracting CBOs, and to consumers and family members.
- **Psychosocial Rehabilitation Certification Program:** This strategy addressed the identified shortages in occupations, skills sets, and individuals with unique cultural and linguistic competence at SLOBHD and community organizations providing services in the public mental health system.
- **Scholarships:** This strategy addressed shortages and diversity needs in the mental health workforce, and increased consumer and family member participation in the workplace by offering stipends and incentives to those individuals interested in pursuing education in delivering mental health care in the county.

Going forward, the current MHSA plan includes the following original WET strategies, funded with CSS dollars:

- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** The County works with Transitions Mental Health Association (TMHA), a community-based organization, and their "Peer Advisory/Advocacy Team" (PAAT), to educate the community about mental health, wellness, and recovery. Members of the peer advisory team are consumers and family members that sit on local boards and commissions, provide training and outreach, and co-facilitate recovery groups with SLOBHD staff.
- **E-Learning:** Per a contract with Relias Learning, SLOBHD has developed, delivered, and managed educational opportunities and distance learning for staff, consumers/family members, and community-based organizations. Funding has been used to access an extensive course catalog and to customize courses to meet the specific, diverse needs of our community. Trainings are wellness, recovery, and resiliency oriented. All employees, including consumer and family members, have

access to trainings. The DEI Committee, formerly known as the Cultural Competence Committee, makes recommendations for training curriculum and processes for accessing training.

- **Law Enforcement, First Responders and Crisis Intervention Training (CIT) Description:** This strategy trains law enforcement officers to handle crisis situations involving individuals with serious mental illness. This is conducted in collaboration with the Sheriff's Department and Local Police Departments touching on subjects of law enforcement, adult and youth mental health, and Cultural Competence.
- **Bilingual Internship Program:** This strategy provides funding to support three part-time Bilingual students to gain experience and knowledge working in the public mental health system within a recovery approach.
- **Consumers, family members, reentry and current students interested in working in the mental health field**: This is an issue the SLOBHD has worked for many years. The County has supported several programs which develop consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers. In the past decade the County has increased contractual and grant programs which require peer and family member employment. In 2018, the Department adopted new job classifications which allow lived experience to be equitable to work and educational backgrounds. This allows the County to employ consumer staff in regular benefited positions versus relying on practices including volunteers, stipends, and personal service contracts.

Prevention and Early Intervention

The County's PEI plan addresses those disparities outlined in the previous section by first seeking to address stigma on a countywide, public basis. The Stigma Reduction campaign includes mass media approaches to public education as well as targeted outreach to the high-risk, underserved populations described in Criterion 3 Section I. Second, access is a foundational component of all PEI services including increased exposure of wellness messaging and early intervention services on campuses, in parent training forums, and with risk populations including seniors and TAY. Hours and availability of short, brief intervention counseling services has been expanded as well. Finally, the County's cultural competence in providing PEI services is a major key in its strategies. All programs must increase both provider capacities to engage people in culturally appropriate services, and provide the public with warm, welcoming services which reduce those disparities linked to cultural competency gaps.

B. This section identifies further strategies per each targeted area examined in Criterion 2.

II. Medi-Cal Strategies

- The Latino Outreach Program (LOP) can provide services to those who meet medical necessity and those who have a diagnosis outside the realm of medical necessity such as substance abuse, marital problems, and parent child relational problems. The LOP

reduces the barrier stated in Criterion 3, Section IA which highlights that SLOBHD cannot provide psychotherapy to people who do not meet the criteria for medical necessity. LOP is in the unique position that regardless of the diagnosis, cases can be opened under Medical Necessity or under CSS therefore no one is turned away based on a diagnosis.

- Other strategies have included the addition of bilingual therapists in the SLOBHD to expand services for those who do meet medical necessity.

III. 200% of Poverty Strategies

- LOP is embedded in the community to increase access for those unable to meet the economic need for transportation in the vast county. Psychotherapy is offered in Paso Robles, San Luis Obispo, Oceano, Arroyo Grande, and Nipomo at eight community sites (Appendix 9). Due to the pandemic an expansion of telehealth and digital literacy was implemented as part of service provision.
- This strategy allows the program to break through the barrier stated in Criterion 3, Section IIA which addresses the discomfort of receiving psychotherapy in a government agency. The community-based model also is consistent with the findings of Cheung's (1990), and Kiselica &Robinson (2001), which stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings".

IV. Community Services and Supports (CSS) Strategies

- **Full-Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults, and older adults. The County has launched FSPs focused on homeless populations, and another on individuals with judicial and criminal-justice history. All services are provided in English and Spanish.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life, feel better and be more satisfied with their lives. Support includes vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support programs; outreach to unserved seniors; and expand services for persons with co-occurring substance abuse. This includes an Adolescent Co-Occurring Disorder program, launched in 2017.
- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility. With the inclusion of the crisis stabilization unit, services have expanded, and they are all offered in English and Spanish.
- **Latino Outreach & Services** program reaches unserved and underserved limited-English speakers and provide community-based, culturally appropriate treatment and support.

- The **Behavioral Health Treatment Court** offers support to adults who are mentally ill, on probation and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA.
- **The Veterans Outreach and Veterans Treatment Court** therapeutic services invite local service people and their families to access care and referral in a stigma-free, culturally competent settings.
- **School-Based Mental Health Services** for students offers intense, daily contact to address serious emotional disturbances.

V. Prevention and Early Intervention (PEI)

- **Trauma Exposed Individuals**: Strategies include increased engagement with schools, seniors, and high-risk cultural populations (incl. Latinos/Latinx/Hispanic, homeless, veterans, LGBTQ) to educate those at higher risk for depression and the trauma caused by transitions, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. One example is the creation and now expansion of Student Assistance Program to all middle schools in the county. These teams include a counselor specialized in risk assessment and trauma, along with a "Family Advocate" who meets with students and their families to build community linkage to needed resources, such as food, employment, and academic tutoring.
- **Individuals Experiencing Onset of Serious Psychiatric Illness**: Strategies include increased access to care on school campuses and in community centers where high risk populations (as mentioned above) will have more immediate responses from professional care and supports. Stigma reduction communitywide, including the "SLOtheStigma" media campaign, will increase knowledge and selective seeking-out of care. In its first six months, the website www.slothestigma.org attracted over 8500 unique visitors, 96% of whom indicated they would use the resources found on the website.
- **Children and Youth in Stressed Families**: Strategies include parenting education for both universal and selective populations to reduce stress; as well as increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency skills. One rewarding strategy has been the coordination of all county parent education offerings into an online family resource center website, www.sloparents.org. Available in Spanish, the website materials lead parents to targeted training, coaching, and education which deal with reducing stress in families and improving health outcomes.
- **Children and Youth at Risk for School Failure**: Strategies include increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency

skills through the Student Assistance Program now in all middle schools in the county.

- **Underserved Cultural Populations**: Strategies include increased engagement with high-risk cultural populations (incl. Latinos/Latinx/Hispanic, those experiencing homelessness, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. Programs such as the Latino Outreach Program, the Veterans Outreach, the LGBTQ Needs Assessment, and the SLO ACCEPTance Project provide services and enhance staff knowledge and skills to best engage these communities by addressing their specific needs.

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

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. **Note:** New strategies must be related to the analysis completed in Criterion 2.

B. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

In preparing the CCPR the County's goal is to provide intended historical information and new initiatives and strategies put in place to address the requirements of the Cultural Competence Plan.

A. Since the development of CSS, the County has focused much of its approach to disparities through strategies brought forth in the MHSA process. Some of the strategies that have been developed outside of the Medi-Cal, CSS, WET, and PEI approaches include:

- **Co-Occurring Disorders**: With training initiated through the WET plan, the County has embarked on developing a program of integrated service which will allow individuals with dual diagnoses of mental illness and substance addiction to access integrated treatment. In 2015-2016 the SLOBHD incorporated all forensic programs under a co-occurring system of care. This integration of mental health and substance use disorder services provided clients with singular treatment plans and singular access points.
- **Innovation**: The County continues to expand knowledge and services utilizing Innovation (MHSA) component funds. San Luis Obispo County's stakeholder process has yielded several research-type projects that address cultural competency and assess the efficacy of new practices. As written earlier, the original Veterans Outreach program was designed as an Innovation project. Current projects are designed to

support the LGBTQ+ population, children, youth, and a system change regarding potential and imminent threats at educational settings.

- **Forensic Services**: The development of the Justice Division was designed to provide services for all behavioral health clients with a history in the justice system. The MHSA Stakeholder group approved funding in fiscal year 2019-2020 and expanded their Behavioral Health Treatment Court and their Forensic Re-entry Programs.

B. SLOBHD has identified several strategies and programs that are working well, and lessons learned through the process of the County's development of strategies intended to reduce disparities in the target populations of Medi-Cal, CSS, WET, and PEI.

The Latino Outreach Program, the major strategy addressing disparities in the Medi-Cal and CSS populations, continues to be a successful model for reducing the disparities in access for Latino/Latinx/Hispanic and Spanish-speaking clients.

Workforce Education and Training (WET)

Examples of successes and lessons learned with WET include the following:

- The original WET planning did not include funding or development of a training room which could be equipped with computers and technology training aids. The SLOBHD used Capital Facilities and Technology opportunities to develop such a resource.
- The development of the Electronic Learning initiative was a morale boost for staff and created many opportunities for staff to build capacity and for the Department to enhance its services by expanding cultural competence and privacy training for all employees and community providers.
- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. The Department has increased data collection in all programs, including its training offerings.

Prevention and Early Intervention

After its first decade of implementation, the County's PEI plan has yielded several areas of success. Examples of successes and lessons learned with PEI include the following:

- Foremost are the County's PEI projects which sought to reduce and eliminate stigma. The "SLOtheStigma" campaign launched in the winter of 2009-2010 made a major impact on the community. Over 150,000 media impressions were made in its first year, and the www.SlotheStigma.org website demonstrated its capacity to drive individuals to needed mental health services and information. The campaign used traditional media (i.e. billboards, television, print, and web) to show its centerpiece, a documentary short on local people living with and recovering from mental illness. The debut of the documentary also launched a community tradition, the "Journey of Hope" forum which continues to draw large audiences every year. The program has

featured nationally renowned speakers who have addressed the role of mental health and stigma in communities, veteran culture, law enforcement, schools, and families.

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities (Criterion 3, Section I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

The county shall include the following in the CCPR:

A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

C. Identify county technical assistance needs.

The County has worked to develop a system of planning and monitoring of the strategies to reduce mental health disparities, including establishing objectives and monitoring outcomes.

A. The strategies identified in the County's CSS, WET, and PEI plans described here provide a comprehensive demonstration of how the County of San Luis Obispo is addressing disparities in service throughout its system of care.

Community Services and Supports (CSS)

- **Full-Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults, and older adults. The County has launched FSPs focused on homeless populations, and for judicial and criminal-justice history. All services are designed to reduce homelessness, jail, and inpatient hospitalization, and increase employment and school success. All programs are currently in operation.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life. Support includes vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support

programs; outreach to unserved seniors; and expanded services for persons with co-occurring substance abuse. This includes an Adolescent Co-Occurring Disorder program, launched in 2017. All services are designed to engage consumers in wellness and recovery and increase employment and school success.

- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility. In the last year, the County has opened its first crisis stabilization unit. All services are designed to reduce jail and inpatient hospitalization, reduce suicide, and move people from crisis to care.
- **Latino Outreach & Services** program reaches unserved and underserved limited-English speakers to provide community-based, culturally appropriate treatment and support. All services are designed to increase access to care, provide culture-affirming care, and increase satisfaction.
- The **Behavioral Health Treatment Court** offers support to adults who are mentally ill, on probation, and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA. All services are designed to reduce jail and inpatient hospitalization and move people from justice system involvement to recovery.
- **The Veterans Outreach and Veterans Treatment Court** therapeutic services invite local service people and their families to access care and referral in a stigma-free, culturally competent setting. All services are designed to increase access to care, provide culture-affirming care, and increase satisfaction.
- **School-Based Mental Health Services** for students offers intense, daily contact to address drug and alcohol and mental health disturbances. All services are designed to reduce crises and increase school success.

Workforce Education and Training (WET)

- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** This strategy has been in place since 2009 and will continue to be monitored by PAAT activities and enrollment of consumers in education programs.
- **E-Learning** was launched in 2011 and is monitored annually to ensure staff and community partners are receiving current information on issues of culture, wellness, and recovery.
- **Law Enforcement, First Responders and Crisis Intervention Training (CIT) Description:** This strategy was implemented as part of WET in 2009 and continues in partnership with the County's Sheriff Department.
- **Integrating Cultural Competence in the Public Mental Health System:** This strategy is monitored with objectives described in Criterion 5.

- **Bilingual Internship Program:** This strategy has been successful in engaging bilingual license-track interns to work within the mental health system. This is monitored by the MHSA team and SLOBHD management on a quarterly basis.

Prevention and Early Intervention

- **The Stigma Reduction Campaign** was implemented in the fall of 2009. This project is reported monthly and quarterly, as well as having site visits conducted by SLOBHD with providers to assess successes and needs.
- **Access Strategies** are embedded in each of the PEI projects. These strategies began in 2009 and are monitored by regular reporting and SLOBHD contract monitoring, including site visits and tests. Hours and availability of short, brief intervention counseling services are being tracked by rosters and client satisfaction.
- **Cultural competence in providing PEI** is tracked in all programs including provider training events and evaluations, quarterly site visits, and client satisfaction rates.
- **Trauma Exposed Individuals and Children and Youth at Risk for School Failure**: Some strategies include the Student Assistance Program teams now at all middle schools. This program is part of the County's extensive PEI evaluation, which includes regular tracking and reporting of pre-posts, student outcomes, and overall community impacts over time. This evaluation takes place every three years.
- **Children and Youth in Stressed Families** strategies include parenting education for both all and specific populations to reduce stress and increase family communication outcomes. This adult-based program was implemented in fall of 2009 and the provider reports quarterly to the SLOBHD.
- **Underserved Cultural Populations**: The above-detailed LOP and Veterans Outreach programs were embedded in the PEI plan to increase engagement with high-risk cultural populations (incl. Latinos/Latinx/Hispanic, those experiencing homelessness, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. All programs are tracked and reported quarterly and annually.

Medi-Cal & 200% of Poverty Strategies

- The Latino/Latinx/Hispanic Outreach Program (LOP), as described above, is also a strategy delivered to decrease disparities amongst Medi-Cal eligible consumers. The strategy is measured quarterly by reports of service, client outcomes, and client satisfaction. A copy of the LOP Client Survey is available in this document (Appendix 11).

New Strategies from Section IV

- All strategies described in Section IV, are currently operational. Tracking and monitoring includes provider quarterly reports, site visits, pre and posttests, and client surveys.

B. The County currently has various levels of mechanisms in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. For instance, the PEI Plan and its projects are monitored by site visits, quarterly evaluative reports, and annual data analyses and reporting. Programs within the CSS Plan also collect data at many points along the intervention providing quarterly and annual reporting. Mental Health Service programs collect basic data, which the County then reports as part of EQRO and other audit functions. The County is working to construct outcome measurement systems which will better document the experience of consumers and track the effects of service interventions.

The key strategy the County uses to monitor the reduction or elimination of disparities is a quarterly data review by the DEI Committee. This review is then reported to the SLOBHD quality Support Team (QST) division. The reduction of disparities is monitored by analyzing penetration rates, service documentation, and measures such as client satisfaction. The Latino Outreach Program regularly assesses its impact on consumers and their families by measuring satisfaction and effects of treatment.

C. SLOBHD has identified the need for technical assistance in evaluation, with the desire for better collection, analyses, and reporting. Currently, the Department does not employ a data analyst or statistician. Some program leaders have evaluation experience and skills which are often used in grant and report analyses and report writing. However, these responsibilities are often limited to the availability of time. The PEI and Innovation programs were launched with an evaluative end in mind, and therefore much data is being collected and reported. The CSS and other Mental Health Services programs have had less evaluative design, so technical assistance in this area would be beneficial.

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

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

The county shall include the following in the CCPR:

A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary;

C. Organizational chart; and

D. Committee membership roster listing member affiliation if any.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 4:

13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee addressing issues, participating in decision-making, practices, and evidence of its engagement.

To meet the County Behavioral Health Department's commitment to developing a system of care that serves an increasing, evolving, and diverse population, a Cultural Competence Committee was formed in 1996 and continues to operate to this day. The Committee consists of staff members from various programs of the Department, as well as contract agencies and community stakeholders. The Committee addresses cultural issues affecting the entire behaviorall health system. The committee members represent diverse cultural backgrounds and other special interests.

A. The SLOBH Diversity, Equity and Inclusion Committee, formerly known as the Cultural Competence Committee, is dedicated to assuring that The County of San Luis Obispo

Behavioral Health Department becomes a culturally competent health system which integrates the concept of diversity, equity, and inclusion into the organizational identity and operations. The committee creates agency-wide awareness of the issues relevant to culture diversity, sets up trainings, and provides recommendations.

The Committee operates as an entity of the County of San Luis Obispo Behavioral Health Department. The Chairperson is appointed by, and reports to, The County Behavioral Health Director. The Committee members are the decision-making body and represent a diverse range of cultural, ethnic, racial, and geographic regions of the county. Additionally, the Committee advises and serves as a resource group to County Behavioral Health Staff, the Performance Quality Improvement (PQI) team, and affiliated agencies.

Meetings are held quarterly. Visitors are welcomed to attend committee meetings and provide input. Beginning January 2022, the SLO BHD DEI Committee will begin a process of reassessment and rebranding. Currently, the goals of the committee include:

- To ensure that County Behavioral Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity;
- To provide recommendations that will increase service delivery to culturally diverse clients;
- To provide recommendations that address the need of continued training on diversity, equity, and inclusion topics;
- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients;
- To provide recommendations that address the recruitment and retention of bilingual providers;
- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos/Latinx/Hispanics, Native Americans, transitional-aged youth and older adults;
- To provide County Behavioral Health employees with the topics and information discussed at the SLO BHD DEI Committee;
- To provide and sponsor trainings focused on expanding and enhancing cultural and linguistic knowledge;
- To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee; and
- To foster a strong network among community agencies that will facilitate an integrated delivery of services.

B. As outlined in the formerly known Cultural Competence Committee guidelines (Appendix 12), the Committee consists of members from County Behavioral Health, affiliated agencies, network providers, and clients. Anyone interested in serving on the Committee shall state their interest to serve by informing a Committee member. A simple majority is required for the election of Committee members. A vacancy exists when a member misses four

consecutive Committee meetings without prior notification to the Chairperson or when a member tenders their resignation verbally or in writing to the Chairperson.

No meetings shall be held in a facility that prohibits the admittance of any person based on culture, ethnic background, religious beliefs, sex, sexual orientation, or of various emotional/physical abilities. The Chairperson convenes the meetings, and the Committee members develop the agenda. The Committee will strive to make decisions by consensus considering resources. A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by a quorum. A quorum is defined as 50% of the Committee. A motion may be made and seconded by any of the Committee members. Motions require a simple majority to be recommended as action items or task assignments.

C. The Organizational Chart which demonstrates the relationship of the Committee, and the Behavioral Health Department is in Appendix 13.

D. Please see Appendix 14 for the most recent DEI Committee Roster and affiliations.

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;
2. Provides reports to Quality Assurance/Quality Improvement Program in the county;
3. Participates in overall planning and implementation of services at the county;
4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;
5. Participates in and reviews county MHSA planning process;
6. Participates in and reviews county MHSA stakeholder process;
7. Participates in and reviews county MHSA plans for all MHSA components;
8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
9. Participates in revised CCPR (2010) development.

A. The following information provides evidence of policies, procedures, and practices that demonstrate that the DEI committee's activities include those listed in Criterion 3, Sec. II:

- ***Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county:***
    - As per the DEI Committee guidelines - Article II: The Purpose of the Committee, Section 1 (Appendix 12): *The Committee is dedicated to assuring that San Luis Obispo County Behavioral Health Services becomes a culturally competent health system which integrates the concept of cultural, racial and ethnic diversity into the fabric of its operation. The committee will create agency-wide awareness of the issues relevant to cultural diversity.*
    - Goals of the DEI Committee (Appendix 12) include:
        - To ensure that County Behavioral Health embraces and implements the behaviors, attitudes, values, and policies of cultural diversity.
        - To provide recommendations that will increase service delivery to culturally diverse clients.
        - To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos/Latinx/Hispanics, American Indians, transition age youth and older adults.
        - To provide and sponsor trainings focused on expanding and enhancing cultural and linguistic knowledge.

- ***Provides reports to Quality Assurance/Quality Improvement Program in the county:***
    - Goals of the DEI Committee (Appendix 12) include "To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients." This is done by having the CCC Chairperson provide quarterly information and briefs to both the County's Performance and Quality Improvement (PQI) and Quality Management (QMC) committees.

- ***Participates in overall planning and implementation of services at the county:***
    - Goals of the DEI Committee (Appendix 12) include:
        - To ensure that County Behavioral Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
        - To provide recommendations that will increase service delivery to culturally diverse clients.
        - To provide County Behavioral Health employees with the topics and information discussed at the DEI Committee.

- ***Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Behavioral Health Director:***
    - As per the DEI Committee guidelines - Article II: The Purpose of the Committee, Section 2 (Appendix 12): "*The Committee is committed to meeting the goals set forth in this document and will provide recommendations to the County Mental Health Director on issues pertinent to the achievement these goals*."

- ***Participates in and reviews county MHSA planning process***:

- Nestor Veloz-Passalacqua, M.P.P., the Chairperson of the DEI Committee has extensive knowledge of MHSA. Current members of the Committee have participated and are part of the Mental Health Advisory Committee, which continues to meet every other month to assess all components.

- ***Participates in and reviews county MHSA stakeholder process:***
  - The DEI Committee members have been active members of MHSA stakeholder planning for each component – CSS, PEI, WET, and Innovation. Cultural competence issues were at the forefront of MHSA planning and have been discussed and processed at each level of planning. Committee members have assured that each MHSA stakeholder process included focus groups and feedback sessions that were held in Spanish or were provided in settings accessible and comfortable for diverse populations.
  - The CCC Chairperson is responsible for representing the DEI Committee in reviewing the MHSA stakeholder process.

- ***Participates in and reviews county MHSA plans for all MHSA components***:
  - The chairperson of the DEI Committee is a staff member of the MAC and is responsible for reviewing the MHSA plans for all components. Other members of the Committee, including the Behavioral Health Director, Anne Robin, LMFT, also participate in this oversight.

- ***Participates in and reviews client developed programs (wellness, recovery, and peer support programs)***:
  - The Committee produces a quarterly newsletter (Appendix 4) which addresses issues related to wellness and recovery – and is made available to organizations in the community dedicated to peer support programs.
  - The Committee is proud to have a member of the Peer Advisory and Advocacy Team (PAAT) which is coordinated by TMHA, one of the County's MHSA partners, to join the committee. PAAT members are residents, and most have received mental health services in this county. Members enjoy volunteering, whether at community events, on advisory groups and boards, and within the behavioral health system. Some are also in paid positions within TMHA.

- ***Participates in revised CCPR development:***
  - The DEI Committee chairperson launched the CCPR preparation sessions and remained the lead in preparing the CCPR. The Chairperson has provided content, oversight, and review of each section of the document, while the SLOBHD staff and direction from Committee members representing County staff have taken lead roles in preparing the material included herein.

B. Provide evidence that the Cultural Competence Committee participates in the above review process

B. The following documents, included in the Appendix, demonstrate evidence of the formerly known Cultural Competency Committee's (CCC) participation in the activities listed in the CCPR:

- **Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county**:
  - The Chair of the DEI Committee is responsible for providing a variety of services, including training of Behavioral Health Services staff in relation to cultural competency issues. This includes cultural competence under Crisis Intervention Training (Appendix 15). In this role, the chair shall provide oversight of programs and services by participating in the quarterly Performance Quality Improvement (PQI)/Quality Management team.

- **Provides reports to Quality Assurance/Quality Improvement Program in the county**:
  - An agenda for the QST/Quality Management team is included in this document (Appendix 16). The group receives reports from the CCC quarterly.

- **Participates in overall planning and implementation of services at the County**:
  - As identified in formerly known CCC agendas and minutes included herein (Appendices 17 and 18), the County Behavioral Health Director, Anne Robin, LMFT, participates as a member of the Committee and provides monthly reports and discussions of County programs and services.
  -
- **Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director**:
  - As explained above, the formerly known CCC agendas and minutes included herein (Appendices 17 and 18) along with the latest QST agenda (Appendix 16) demonstrate the interaction and reporting transmittal between the committee and the County Behavioral Health Director, Anne Robin, LMFT.

- **Participates in and reviews county MHSA planning process**:
  - The Cultural Competence Chairperson and some members are part of the MHSA Advisory Committee (MAC) and take part in all discussions regarding MHSA planning and major decision making. Included in the Appendix are FY 2020-2021 meeting minutes (Appendix 18) for reference. Since the DEI Program Manager just started an increased involvement is expected.

- **Participates in and reviews county MHSA stakeholder process**:
  - Historically, in 2008, Dr. Ortiz, along with other members of the formerly known CCC, including the previous Ethnic Services Manager were active members of the MHSA PEI stakeholder process (Appendix 19). These duties will be completed by the DEI Program Manager.

- **Participates in and reviews county MHSA plans for all MHSA components**:
  - The Chairperson of the DEI Committee and members are part of the MAC stakeholder group and take part in reviewing each of the county's MHSA plans and reports as documented in Appendix 20.

- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs):**
  - The formerly known CCC does not currently have a formal objective to review client-developed programs but seeks to increase its engagement with peer advocates and other recovery programs in future years.

- **Participates in revised CCPR (2010) development**:
  - The chairperson and the membership of the formerly known CCC have been integral to the development of this Cultural Competence Plan.

C. Annual Report of the Cultural Competence Committee's activities including:

1. Detailed discussion of the goals and objectives of the committee.
   a. Were the goals and objectives met?
   - If yes, explain why the county considers them successful.
   - If no, what are the next steps?
2. Reviews and recommendations to county programs and services;
3. Goals of cultural competence plans;
4. Human resources report;
5. County organizational assessment;
6. Training plans; and
7. Other county activities, as necessary.

C. The Annual Report of the Committee is included in the following section. A report to the SLOBHD from the Committee is also included herein (Appendix 21).

1. The goals and objectives of the Committee, as outlined above, are listed here with details regarding their successes or next steps:

- To ensure that County Behavioral Health embraces and implements the strategies, attitudes, values and policies of cultural diversity.
  - The Committee has met in person for several years and now has adapted to virtual meeting to accommodate concerns and meet the required COVID-19 protocols.
  - The Committee was able to obtain an Administrative Assistant to take the Committee minutes and format them for the Committee.
  - The Committee has increased membership from various sectors of SLOBHD, as well as representation from the community.

- To provide recommendations that will increase service delivery to culturally diverse clients.
  - The Committee has been active in MHSA stakeholder processes, including the Innovation workgroups to keep cultural competence issues at the forefront of service delivery discussions.

- To provide recommendations that address the need of continued training on cultural diversity topics.
  - The Committee is active in training collaborations countywide, including providing input to the SLOBHD three-year training plan. In recent years the Committee has also informed the WET planning process as well as providing training as outlined in the next Criterion.

- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
  - The Committee produces a quarterly newsletter on cultural issues affecting behavioral health systems and providers. This material is part of the Committee's work to reduce barriers that affect sensitive and competent delivery of service to culturally diverse clients.

- To provide recommendations that address the recruitment and retention of bilingual providers.
  - The Committee, through its involvement in SLOBHD and MHSA workgroups, has provided strong recommendations for workforce improvements, demonstrated by addressing and incorporating information relevant to hiring practices that include a diverse lens.

- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latino/Latinx/Hispanic population, Native Americans, and transition age youth, and older adults.
  - The Latino Outreach Program, which has aided a 30% increase in Latino clients since 2006, falls within the Committee's response.

- To provide County Behavioral Health employees with the topics and information discussed at the DEI Committee, formerly known as Cultural Competence Committee.
  - Minutes from the Cultural Competence Committee (example, Appendix 17) are made available to all SLOBHD employees.
  - The Committee's newsletter is produced quarterly and sent to each SLOBHD staff member and behavioral health partners in the community.

- To forge alliances with other community agencies and committees who support the mission and goals of the Committee.

    - The Committee prides itself on its collaborative spirit and diverse membership and reflects the vast array of service providers and consumers served by the behavioral health system.
    - The Committee has worked within the WET plan to engage other organizations through training collaboratives.
    - In reporting to the County's PQI team, the Committee is also able to engage providers outside of the SLOBHD system.

- To foster a strong network among community agencies that will facilitate an integrated delivery of services.
    - The Committee prides itself on its collaborative spirit and diverse membership and reflects the vast array of service providers and consumers served by the behavioral health system.

2. The Committee's Annual Report does not currently contain reviews and recommendations to county programs and services. This process is done through Committee meetings (staffed by SLOBHD leadership) and via reports to PQI.

3. As the committee continues to expand, the Committee will update their goals and objective next calendar year.

4. The SLOBHD provides the Committee with its Human Resources information as requested. At this time the Committee does not review the SLOBHD's entire personnel portfolio, but has focused, in recent years, on the increase of bilingual staffing. This is demonstrated by the roster of bilingual staff included in the Appendix 22.

5. The Committee does not review the SLOBHD's organizational structure for its Annual Report. A copy of the organization chart outlining the Committee's relationship to the Behavioral Health Department is included herein (Appendix 13).

7. The Annual Report (Appendix 21) features information on activities and efforts made by the CCC during fiscal year 19-20.

CRITERION 5
COUNTY MENTAL HEALTH SYSTEM
CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR:

A. The county shall develop a three-year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.
2. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.
3. How cultural competence has been embedded into all trainings.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 5:

4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee activities.

The County of San Luis Obispo Behavioral Health Department (SLOBHD) is committed to providing training and supports which build cultural competence across the entire health system. Staff and stakeholders, including contractual partner providers, are provided with training that meets the goals of the Committee, which are outlined in the previous Criterion, and include the goal "to provide recommendations that address the need of continued training on cultural diversity topics."

A. SLOBHD, in building upon the strengths of its MHSA Workforce Education and Training (WET) Plan, is focused on developing meaningful training opportunities. Beginning next calendar year, a training plan will be developed in partnership with stakeholders and contractual partner providers. A majority of the training is provided by the Department, with community partners offering many opportunities for staff to engage in learning cultural competence strategies outside of the Department. These trainings will be coordinated through the Committee and internal training staff.

1. The projected number of County staff that will require training is roughly 370 individuals. The projected number of direct services contractual staff is 150 individuals. These numbers

were originally identified in the 2009 Workforce Education and Training Plan with current internal updates provided by the divisions within the Behavioral Health Department.

2. SLOBHD, as per its WET training plan, has taken the following steps to provide required cultural competence training to reach a 100% of the staff over the training period (2018-2021):

- SLOBHD will liaison with established training partners including local and online Colleges and University and Continuing Education Unit (CEU) providers. These partnerships increase the diversity of training opportunities, as well as increasing the capacity for training larger numbers of staff over time.
- Provide training through an electronic-learning initiative. SLOBHD is now offering training via an "e-learning" company which will provide core competency and cultural competency training menu which staff and contract partner staff can access at their convenience. This type of expansion will build capacity amongst all staff and increase training access and delivery to reduce barriers for staff who have limited hours or assignments which preclude attending training events.
- Throughout the year, additional training needs will be identified through surveys, focus groups, and community outreach. It will also cover the cost of refresher courses for interpreters; specialized training focused on the County's various ethnic populations and attendance at State-wide Cultural Competence trainings.

3. The following section will detail the training events held for SLOBHD staff. Cultural Competence is a key component of each training opportunity and at the core of service delivery. Through its membership in the Southern Counties Regional Partnership (WET), SLOBHD will have the opportunity to work with Dr. Jonathan Martinez, Ph.D., a Professor of Psychology at Cal State Northridge, who has been assisting in the development of a cultural competence assessment that will be used countywide with mental health providers. SLOBHD believes this strategy will result in further integration of cultural competence models into the training policies and practices of the County. Due to the COVID-19 pandemic, the SLOBHD continued to offer trainings via virtual means and will continue to partner with providers to ensure a continuity of learning opportunities are present. At the beginning of the 2022 calendar year, the DEI Committee will strategically work with agency partners to conduct cultural competence assessments in each of the partner agencies to assess and carefully develop practices that are specific to each agency with the goal to enhance and strengthen diversity, equity, and inclusion practices in various segments. This initiative will help the committee has a broader understanding of the state of cultural competence within each organization, but also of the entire health care system. This study will serve each partner organization to either allocate funds, design practices and initiatives, and assign specific staff to help improve employee environment and service delivery.

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function (If available, include if they are clients and/or family members):

1. Administration/Management;
2. Direct Services, Counties;
3. Direct Services, Contractors;
4. Support Services;
5. Community Members/General Public;
6. Community Event;
7. Interpreters; and
8. Mental Health Board and Commissions; and
9. Community-based Organizations/Agency Board of Directors

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. Mental Health Interpreter Training
7. Training staff in the use of mental health interpreters
8. Training in the Use of Interpreters in the Mental Health Setting

The following table (Table 6) provides detail on the cultural competence trainings attended by staff for FY 2018-2021. The Department currently tracks registration for every single attendee based on their professional role and the organization they are coming from. As the committee welcomes and pushes for family and clients to be part of the training, it is common for each of these training workshops and events to be attended by several members of the consumer and recovery community. The committee has made efforts to ensure family members and consumers continue to attend trainings as we continue to develop a strong relationship with PAAT and other consumer-based organizations.

See **Table 6** below for a description of all training workshops, forums, and events that speak directly to section A and B of the current criterion.

Table 12 – Behavioral Health Training Calendar	
2018-2021 Fiscal Year	
Training Title:	Trans 101
Presenter(s)	Dr. Jay Bettergarcia and Dr. Stacy Hutton

Description:	The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy sessions. Attendees will be taught about the subtleties in language and perspective that make interactions with trans people truly affirming		
# Of Attendees	54	Date of Training:	3/18/2018
Hours/Credits:	4	# Of CEU Certificates	24
Training Title:	LGBTQ Awareness, Sensitivity and Competency		
Presenter(s)	Poshi Walker, MSW		
Description:	This highly interactive training leads participants through the foundational steps of LGBTQ cultural competence, while creating a learning environment that is safe, fun, and comfortable for attendees who may have varying degrees of knowledge or comfort with this subject matter. This training gives staff members a better understanding of sexual orientation and gender identity, addresses myths and negative stereotypes about LGBTQ individuals, and helps develop core competencies towards reducing LGBTQ mental health disparities.		
# Of Attendees	8	Date of Training:	6/18/2018
Hours/Credits:	4.5	# Of CEU Certificates	5
Training Title:	Trans 101		
Presenter(s)	Dr. Jay Bettergarcia and Dr. Stacy Hutton		
Description:	The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy sessions. Attendees will be taught about the subtleties in language and perspective that make interactions with trans people truly affirming		
# Of Attendees	55	Date of Training:	7/10/2018
Hours/Credits:	4	# Of CEU Certificates	17
Training Title:	Out for Mental Health Ally Training		
Presenter(s)	Shannon L. Dunlap, MSW and Jeremy T. Goldbach, PhD, LMSW		
Description:	This interactive training provides a basic framework of understanding LGBTQ youth and the unique challenges they often face. This training is designed to create dialogue regarding what it means to be an adult ally for LGBTQ youth by informing participants about terminology used in the LGBTQ community, the process of "coming out" as an LGBTQ person and a discussion of the challenges faced by LGBTQ youth in their homes, schools, and communities. Through activities, participants are encouraged to explore biases, build knowledge and understanding, enhance self-efficacy, and develop empathy. In addition to providing this framework, the Ally Training offers specific action items to improve the environment for LGBTQ youth.		
# Of Attendees	11	Date of Training:	8/24/2018
Hours/Credits:	2	# Of CEU Certificates	3
Training Title:	How to Support LGBTQ Youth		

Presenter(s)	Shannon Dunlap, MSW and Jeremy Goldbach, PhD, LMSW		
Description:	This interactive training provides an overview of suicide among LGBTQ youth and the different environmental stressors that contribute to their heightened risk for suicide. This training combines research, case studies, best practice recommendations and practical steps for reducing the risk of suicide and promoting resilience in all young people regardless of their sexual orientation or gender identity		
# Of Attendees	5	Date of Training:	8/24/18
Hours/Credits:	2	# Of CEU Certificates	2
Training Title:	Enhance Cultural Humility		
Presenter(s)	Jonathan I. Martinez, PhD.		
Description:	Cultural diversity and the rising emphasis on evidence-based practice within community based mental health settings have sparked dialogues regarding cultural competence among mental health professionals. Given the complexity of multiculturalism, we have a responsibility to recognize the value and diversity of our clients. Moreover, it is beneficial to understand cultural competency as a process rather than an end product. From this perspective, competency involves more than gaining or practicing scientific knowledge; it also includes our ongoing attitudes and unconscious thought process toward both our clients and ourselves. We must enter work with diverse families with cultural humility, acknowledging that we are always in the process of learning and growing. This talk has a central aim to enhance the implementation of cultural humility values and skills into daily work with diverse families in community-based settings		
# Of Attendees	41	Date of Training:	6/20/2019
Hours/Credits:	2	# Of CEU Certificates	19
Training Title:	Cultural Competence Toward a Culturally- Informed Behavioral Health Practice		
Presenter(s)	Leola Macmillan		
Description:	Toward A Culturally Informed Behavioral Health Practice is a workshop aimed at helping all behavioral health employees better serve an increasingly diverse client population. The workshop will be divided into modules that help participants: ● Understand key terms such as intersectionality, structural inequality, and cultural proficiency ● Understand the connection between these terms and a more inclusive behavioral health practice ● Reframe equity, diversity, and inclusion within the context of behavioral health ● Recognize Health Care Disparities among Marginalized and Underserved Populations Upon completion of the course, participants will be better informed and better equipped to serve culturally diverse populations		
# Of Attendees	294	Date of Training:	8/16/2019 8/23/2019 2/7/2020 2/28/2020
Hours/Credits:	6	# Of CEU Certificates	101
Training Title:	Enhancing Cultural Humility in Working with Diverse Families		
Presenter(s)	Jonathan I. Martinez, PhD.		
Description:	Cultural diversity and the rising emphasis on evidence-based practice within community based mental health settings have sparked dialogues regarding		

	cultural competence among mental health professionals. Given the complexity of multiculturalism, we have a responsibility to recognize the value and diversity of our clients. Moreover, it is beneficial to understand cultural competency as a process rather than an end product. From this perspective, competency involves more than gaining or practicing scientific knowledge; it also includes our ongoing attitudes and unconscious thought process toward both our clients and ourselves. We must enter work with diverse families with cultural humility, acknowledging that we are always in the process of learning and growing. This talk has a central aim to enhance the implementation of cultural humility values and skills into daily work with diverse families in community-based settings		
# Of Attendees	70	Date of Training:	8/20/2019
Hours/Credits:	2	# Of CEU Certificates	23
Training Title:	SLO ACCEPTance 101		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	24	Date of Training:	10/4/2019
Hours/Credits:	24	# Of CEU Certificates	12
Training Title:	SLO ACCEPTance 201		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Hanssmann, Morrison, & Russian, 2008; Israel, Willging, & Ley, 2016; Lelutiu-Weinberger & Pachankis, 2017; McElfish, Long, Rowland, Moore, Wilmoth, & Ayers, 2017; Owen-Pugh, & Baines, 2014; Pepping, Lyons, & Morris, 2018; Rutherford, McIntyre, Daley, & Ross, 2012)		
# Of Attendees	21	Date of Training:	2/7/2020
Hours/Credits:	21	# Of CEU Certificates	12
Training Title:	Trans 101		
Presenter(s)	Dr. Jay Bettergarcia and Dr. Stacy Hutton		
Description:	The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy		

	sessions. Attendees will be taught about the subtleties in language and perspective that make interactions with trans people truly affirming		
# Of Attendees	57	Date of Training:	3/12/2020
Hours/Credits:	13	# Of CEU Certificates	4
Training Title:	Bridges Out of Poverty		
Presenter(s)	Jodi Pfarr		
Description:	Bridges Out of Poverty workshop provides both the social service provider and the community member key lessons in dealing with individuals from poverty. Topics include increasing awareness of the differences in economic cultures and how those differences affect opportunities for success. This workshop is based on the book Bridges Out of Poverty: Strategies for Professionals and Communities, a collaboration between Ruby K. Payne, Phillip DeVol, and Terie Dreussi Smith. Phil's experience includes developing school based, substance abuse prevention, intervention and student assistance programs, and Terie is an experienced educator and prevention coordinator. This workshop is designed for audiences of employers, community organizations, law enforcement, counselors, health care and social service providers.		
# Of Attendees	19	Date of Training:	4/30/2020
Hours/Credits:	4.5	# Of CEU Certificates	10
Training Title:	SLO ACCEPTance 301		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	24	Date of Training:	5/1/2020
Hours/Credits:	24	# Of CEU Certificates	12
Training Title:	Intro to Substance Use Disorder for LGBTQ		
Presenter(s)	UCLA- Grant Hovik, MA,		
Description:	This half-day training is intended for any provider in contact with LGBT individuals, including MH and SUD clinicians, HIV providers, State, Local and County governments employees, Primary care providers, public health practitioners, Prevention specialists, Community based organizations, School teachers and counselors. The training includes an introduction to key terms and concepts (such as gender identity and sexual orientation), treatment considerations for clinical work, and addressing the specific needs of lesbian, gay, bisexual, and transgender individuals.		
# Of Attendees	20	Date of Training:	5/19/2020
Hours/Credits:	3	# Of CEU Certificates	Unknown; provided by UCLA
Training Title:	Challenging Client Situations with Cultural Humility		
Presenter(s)	Grant Hovik, MA,		

Description:	Substance use disorders are pervasive and chronic conditions that can impact the lives of any person regardless of ethnicity, race, culture, religious preference, sexuality, gender or any other individual or group factor. Learning how to approach everyone who asks us for help with humility and a willingness to accept those individual differences is crucial to provide effective treatment for successful outcomes. This training will help participants define cultural humility and begin to raise awareness of cultural factors that can have an impact on treatment retention and outcomes. Using the most current data and incorporating real world clinical examples, the training will demonstrate the importance of incorporating cultural humility into practice		
# Of Attendees	10	Date of Training:	6/1/2020
Hours/Credits:	3	# Of CEU Certificates	Unknown; provided by UCLA
Training Title:	SLOACCEPTance 101		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	26	Date of Training:	10/2/2020
Hours/Credits:	8	# Of CEU Certificates	16
Training Title:	SLOACCEPTance 201		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	14	Date of Training:	12/4/2020
Hours/Credits:	8	# Of CEU Certificates	13
Training Title:	SLOACCEPTance 301		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming		

	services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	26	Date of Training:	2/5/2021
Hours/Credits:	8	# Of CEU Certificates	17
Training Title:	SLOACCEPTance 401		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	18	Date of Training:	4/9/2021
Hours/Credits:	8	# Of CEU Certificates	14
Training Title:	SLOACCEPTance 501		
Presenter(s)	Theodore Burnes, PhD., LPCC, M.S.Ed. and Benjamin Geilhufe, LPCC		
Description:	The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules		
# Of Attendees	22	Date of Training:	5/21/2021
Hours/Credits:	8	# Of CEU Certificates	13

Total # Trainings	**20**	**Total # Attendees**	**819**
Total # of Hours	**157**	**Total # of CEU Certificates**	**317**

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

C. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;
2. Results of pre/posttests (Counties are encouraged to have a pre/posttest for all trainings);
3. Summary report of evaluations; and

4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

Cultural Competence trainings are a core element of staff development and the SLOBHD is committed to relevant and effective learning opportunities for all staff and community partners. This section will outline the most recent training conducted by the Department.

C. This section will provide cultural competence training information.

1. All trainings in recent years were identified and developed through key stakeholder input. Our 2017 Internal Cultural Competence Survey identified the current tentative training priority (Appendix 23) which include Trans-Training 101, Challenges/Values of Different Cultures, LGBTQ and Gender Identity Training, Poverty and Youth Training, and others. The Internal Cultural Competence Survey employed the document "Building Bridges: Tools for Developing an Organization's Cultural Competence" by La Frontera Center to measure all Behavioral Health staffs' level of competence regarding populations which have disparities in access and treatment. The results indicated a need for further training in the areas related to different cultures, LGBTQ members, and older adults. Trainings that focused on Co-occurring Disorders were identified through a Workforce Education and Training needs assessment and the SLOBHD Co-Occurring Taskforce. San Luis Obispo County is continuing to further integrate its Drug and Alcohol Services with its Mental Health Services divisions to better serve the needs of co-occurring population.

2. The Behavioral Health Department will be implementing material and language from the California Brief Multicultural Competence Scale (CBMCC) as part of our evaluation process for every training sponsored by the SLOBHD. We plan to develop a retrospective pre/post-test to better gauge the level of competency on a regular basis. The County will continue to develop strategies to evaluate the level of staff competence through pre and post testing over the next years. The County will access technical assistance in developing standardized measures for pre and post testing of clinical skills.

3. Overall, the clinical trainings provided by the SLBHD in the past year were well received. The trainings were evaluated using an evaluation form that participants could complete through the SurveyMonkey.com online service. Surveys were made available to participants one day after completing the training to receive Continuing Education Units (CEU). The training evaluation form is designed for post measurement asking demographic information in regard to professional status/licenses held, work location, reasons for choosing the training, rating of the overall value of the training, and three concepts learned from the training. At the current time, the training evaluation form does not measure a level of information or skills learned.

The highest rated training was "Trans Training 101" by Dr. Jay Bettergarcia and Dr. Stacy Hutton. Over 55 individuals registered and 34 completed the training evaluation form. 81% (17 attendees) rated the training "excellent," 19% (4) rated the training "good". Concepts that participants learned included the impact of personal stories, understanding identity videos and images, the importance of vocabulary and providing agency to the client, affirmation, gender identity, and local referral resources. Examples of training evaluation reports are included in the Appendix 24.

4. At this time, the County is not currently monitoring the advancement of staff skills learned in trainings. The County will be developing strategies to monitor staff skill by utilizing follow up trainings, post-test, surveys, and employee evaluations.

5. The County will follow the Education and Training Policy (Currently under revision in draft form, Appendix 25) for the entire Behavioral Health Department, will identify the methodology/protocol that supports competency-based trainings, mandatory trainings, and orientation trainings and follows the guidelines put forth in each Mental Health Services Act plan. This policy will assist employees, contracted employees, and volunteers to meet training and licensing requirements and to ensure our workforces ability to provide quality of care and culturally and linguistically competent services to the community. SLOBHD is currently using "e-learning" to allow each staff and community provider access to competency and mandatory trainings using personal computers. SLOBHD has contracted with Relias Learning to offer this service. This web-based system includes an interface with the County's human resources management software, and it has the capacity to track individual staff learning.

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

The county shall include the following in the CCPR:

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:
   - Culture-specific expressions of distress (e.g., nervios);
   - Explanatory models and treatment pathways (e.g., indigenous healers);
   - Relationship between client and mental health provider from a cultural perspective;
   - Trauma;
   - Economic impact;
   - Housing;
   - Diagnosis/labeling;
   - Medication;
   - Hospitalization;

- Societal/familial/personal;
- Discrimination/stigma;
- Effects of culturally and linguistically incompetent services;
- Involuntary treatment;
- Wellness;
- Recovery; and
- Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.

A. The following workshop descriptions provide evidence of a variety of cultural competence trainings provided for the county's behavioral health system.

LGBTQ Awareness, Sensitivity and Competency: This highly interactive training leads participants through the foundational steps of LGBTQ cultural competence, while creating a learning environment that is safe, fun, and comfortable for attendees who may have varying degrees of knowledge or comfort with this subject matter. This training gives staff members a better understanding of sexual orientation and gender identity, addresses myths and negative stereotypes about LGBTQ individuals, and helps develop core competencies towards reducing LGBTQ mental health disparities.

Out for Mental Health Ally Training: This interactive training provides a basic framework of understanding LGBTQ youth and the unique challenges they often face. This training is designed to create dialogue regarding what it means to be an adult ally for LGBTQ youth by informing participants about terminology used in the LGBTQ community, the process of "coming out" as an LGBTQ person and a discussion of the challenges faced by LGBTQ youth in their homes, schools, and communities. Through activities, participants are encouraged to explore biases, build knowledge and understanding, enhance self-efficacy, and develop empathy. In addition to providing this framework, the Ally Training offers specific action items to improve the environment for LGBTQ youth.

Intro to Substance Use Disorders for LGBTQ: This half-day training is intended for any provider in contact with LGBT individuals, including MH and SUD clinicians, HIV providers, State, Local and County governments employees, Primary care providers, public health practitioners, Prevention specialists, Community based organizations, School teachers and counselors. The training includes an introduction to key terms and concepts (such as gender identity and sexual orientation), treatment considerations for clinical work, and addressing the specific needs of lesbian, gay, bisexual, and transgender individuals.

Trans-Training 101: The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy sessions. Attendees will be taught about the

subtleties in language and perspective that make interactions with trans people truly affirming.

SLO ACCEPTance: The SLO ACCEPTance Project is an innovative approach to training mental health professionals to provide affirming services for local Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ) community members via two 9-month intensive training programs. These programs draw upon over two decades of quantitative and qualitative research highlighting the dearth of providers with knowledge, awareness, and skills to provide LGBTQ-affirming services. This 101 training will provide the foundation for the remaining training modules

Enhancing Cultural Humility in Working with Diverse Families: Cultural diversity and the rising emphasis on evidence-based practice within community based mental health settings have sparked dialogues regarding cultural competence among mental health professionals. Given the complexity of multiculturalism, we have a responsibility to recognize the value and diversity of our clients. Moreover, it is beneficial to understand cultural competency as a process rather than an end product. From this perspective, competency involves more than gaining or practicing scientific knowledge; it also includes our ongoing attitudes and unconscious thought process toward both our clients. We must enter work with diverse families with cultural humility, acknowledging that we are always in the process of learning and growing. This talk has a central aim to enhance the implementation of cultural humility values and skills into daily work with diverse families in community-based settings

Toward a Culturally Informed Behavioral Health Practice: Toward A Culturally Informed Behavioral Health Practice is a workshop aimed at helping all behavioral health employees better serve an increasingly diverse client population. The workshop will be divided into modules that help participants: ● Understand key terms such as intersectionality, structural inequality, and cultural proficiency ● Understand the connection between these terms and a more inclusive behavioral health practice ● Reframe equity, diversity, and inclusion within the context of behavioral health ● Recognize Health Care Disparities among Marginalized and Underserved Populations Upon completion of the course, participants will be better informed and better equipped to serve culturally diverse populations

Table 7

Table 7 – Tentative Behavioral Health Training Calendar	
2021-2022 & 2022-2023 Fiscal Years	
Training Title:	Suicide Prevention Summit
Presenter(s)	Kelechi Ubozoh, Dr. Ashley Hart, Dr. Kelly Posner, Ellen Eggert, Stan Collins, and Meghan Boaz Alvarez.
Description:	Workshop Session 1: This workshop explores the unique insights offered by a suicide attempt survivor and share with providers how to connect and provide

	effective support in a time of crisis, with the goal of providing intervention at the least restrictive level. Workshop Session 2: Sharing experience across the lifespan, this panel discussion explores the mental health needs of men, barriers to help seeking behaviors, and ways to outreach effectively to men who may need support. Workshop Session 3: The Columbia Lighthouse Project team provides training on the proper use, scoring, efficacy in clinical settings, and interpretation of the Columbia Suicide Risk Assessment Scale. Workshop Session 4 (Option 1): This workshop defines collaborative safety planning and explores the need for structured follow up, connecting the use of the Columbia-Suicide Severity Rating Scale to indicators for implementation of safety planning and follow up. Workshop Session 4 (Option 2): This workshop will present multiple ways to create safe messaging and social media postings related to suicide and suicide prevention work. Workshop Session 5: This session will explore various experiences and voices of lived experience of mental health crises and share insights into non-traditional ways to support and intervene effectively with individuals at risk. Systems collaboration and effectively utilizing natural supports in intervention work will be included.		
# Of Attendees	450 (estimated)	Date of Training:	TBD
Hours/Credits:	6	# Of CEU Certificates	200 (estimated)

Training Title:	Law & Ethics		
Presenter(s)	Linda Garrett, JD		
Description:	This course is a review of new legislation effecting healthcare providers and their patients including new rules affecting licensure and training, access to records, gender issues, mandated reporters, drug prescribing and involuntary treatment. Information will cover 42 CFR Part 2 substance use disorder confidentiality regulations and HIPAA and State law privacy and confidentiality issues, consent and non-consent as well as a review of relevant topics in the news and how individual free speech may trigger ethical concerns related to dual relationships and boundary issues		
# Of Attendees	180 (estimated)	Date of Training:	TBD
Hours/Credits:	6	# Of CEU Certificates	180 (estimated)

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

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

The county shall include the following in the CCPR:

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 6:

3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

SLOBHD is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations.

A. The Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component can be found in Appendix 08.

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

B. Tables and analysis included in the WET Plan's workforce assessment demonstrate full-time staff-to-client ratios by race and ethnicity. An overall shortfall was indicated in the mental health workforce regarding meeting the prevalence needs within San Luis Obispo County. The County and its providers continue to face difficulty in recruiting and retaining a multicultural workforce, and with the impact of the COVID-19 pandemic, other staff have felt the need to leave the entire health care systems. The county and its partners work in collaboration to close the gap and provide culturally and linguistically appropriate programs to consumers.

The Plan's assessment also revealed a continued need for additional bilingual/bicultural staff in all classifications, especially in the county's threshold language of Spanish. As described in other sections of this document, these practitioners are difficult to recruit and retain.

C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

C. The County of San Luis Obispo never received cultural consultant technical assistance as part of any review of the WET Plan submission to the State. However, the County has taken the initiative to build cultural competence capacity activities, funded through statewide WET initiatives. This has included attending underserved population conferences produced as part of the Southern California Regional (WET) Partnership. The Partnership has also sponsored training for County staff (and its contracted partners) on culturally appropriate service provision, as well as workforce development tools for high school students, clinical supervision training, and a job search website.

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

D. The targets that have been reached based on past ten years of programming include:

- Bilingual clinical interns have been hired and placed in the county regionally.
- Over 75 scholarships were awarded to individuals working in the mental health field or wanting to seek employment in the field.
- Provided hundreds of hours of training reaching out to thousands of individuals.
- The Transitions Mental Health Association Peer Advisory and Advocacy Team is meeting weekly and provides stigma reduction education and peer counseling throughout the community.
- Crisis Intervention Training has been provided to hundreds of law enforcement personnel.
- The formerly known Cultural Competence Committee has provided several trainings to support competence in the behavioral health field. Additional trainings have been provided to meet licensing and state regulations.

E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

E. Several lessons were learned in implementing county WET planning, including:

- WET funding for a training room equipped with computers and technology training aids was not originally conceived or proposed in the planning process; consequently, Behavioral Health created a designated computer training room.
- The development of the Electronic Learning initiative has been a morale boost for staff and has created many opportunities for staff to build capacity and for the Department to enhance its services. The SLOBHD created policy and procedures so that the product is used to an effective purpose.
- “Action 5” of the WET plan, Integrating Cultural Competence, has been adapted to provide stakeholders with better monitoring of funds. A need was identified to assure

stakeholders that funds were being used efficiently, for instance training or hiring staff that were already proficient in Spanish or bicultural instead of trying to train a staff member to learn Spanish.

- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. This has included the ongoing identification of other needs as mentioned in this document, including expanding services for veterans and the LGBTQ community. This Committee has been successful in guiding training decisions and developing core competencies.

F. Identify County technical assistance needs.

F. The County has identified the need for further technical assistance in the arena of data collection, evaluation, and statistical reporting to further improve SLOBHD's ability to analyze the efficacy of its cultural competence. The County has developed standardized measures to evaluate learning outcomes and best practices in providing training. It would be useful to view standardized models of pre and posttests to evaluate levels of learning in best practices and cultural competence.

CRITERION 7
COUNTY MENTAL HEALTH SYSTEM
LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.
2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.
3. Total annual dedicated resources for interpreter services.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 7:

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

This section meets the requirement of inclusion of Drug Medi-Cal Organized Delivery System (DMC-ODS) SUD service regarding Cultural Competence Committee trainings for administrative, management, and staff providing SMHS and providers

The County of San Luis Obispo has made significant strides in improving services to Spanish-speaking clients over the past years, but the impact of the COVID-19 pandemic on the Latino/Latinx/Hispanic population demonstrated that continued outreach and support is needed to engage this community. By increasing the bilingual workforce and the number of bicultural staff, the SLOBHD hopes to reduce barriers and increasing access.

A. SLOBHD has committed resources and developed strategies in each of its MHSA plans to grow bilingual staff capacity. In 2005, during the planning process for the first MHSA plan (CSS), a study was done to determine the need for increased staff capacity which would better serve the Latino population in the county. Clearly the most underserved population in need throughout the county, Spanish-speakers were often unable to access services due

to limited language proficiency on the part of County and community providers. Since that initial MHSA plan, it has been the SLOBHD's goal to increase bilingual staff. MHSA plans and funding have not only increased the County's staffing of therapists but have increased positions and hours for Spanish-speaking psychiatrists, medication managers, drug and alcohol specialists, and clerical staff as well.

Another strategy that has emerged from these MHSA discussions and studies is the need to increase the exposure of position postings. Currently, SLOBHD management staff in collaboration with the BHD Public Information Officer, the DEI Program Manager and the County's Human Resources Department are engaging in strategies to expand recruitment range throughout the county and in neighboring localities to reach to a larger pool of potential candidates. Positions have also been advertised through presentations to local cultural organizations, such as the Latino Outreach Council and the department hopes to work with the local "Somos" magazine.

1. The County's Workforce Education and Training (WET) Plan has specific planks on which to build bilingual staff capacity to address threshold language needs. The **Bilingual Internship Program** strategy provides funding to support three part-time bilingual students to gain experience and knowledge working in the public behavioral health system within a recovery approach. The Intern Program Supervisor tracks the number of interns obtaining employment with the County and with local community-based organizations; and will begin to develop strategies for retaining interns in the behavioral health field. Currently, due to the strain placed on the health care system due to the COVID-19 pandemic, these three positions are currently vacant.

2. Because cultural competence is a key component of each MHSA plan and its projects, language and cultural appropriateness has expanded throughout the mental health system.

- SLOBHD, partly due to the CSS strategy which created the Latino Outreach Program (LOP), has increased to a total of five (6) LOP bilingual and bicultural staff over the last two years.
- Other CSS programs, including the supports provided by community partner agencies, have increased overall community bilingual capacity. Programs like TMHA's peer recovery programs are now available in Spanish.
- Several PEI programs are being implemented in Spanish as well and support the inclusion of culturally appropriate language services provided by staff and contracted providers. For instance, the SLOtheStigma campaign and subsequent public presentations are available in Spanish; the school-based wellness programs feature bilingual and bicultural "Family Advocates;" and all parent education programs and coaches are offered in Spanish as well.

3. The total annual amount of dedicated resources for interpreter services is $50,245. This is funded by the MHSA Workforce, Education, and Training component.

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

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices in place 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. 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.
4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

SLOBHD is committed to providing services to persons having Limited English Proficiency (LEP) by using interpreter services, translated forms, and help lines, which are linguistically capable and accessible to those with impairments.

A. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 26): "Mental Health Services is committed to providing multi-lingual and culturally appropriate services to the diverse populations in the County including Telecommunication Device for the Deaf (TDD) and California Relay Services (CRS)."

1. A 24-hour phone line with statewide toll-free access (800-838-1381) that has linguistic capability, including TD, is available for all individuals. We utilize AT&T Language Line for LEP callers and California Relay Services for hearing impaired callers. We utilize bilingual staff for initial contacts when available.

2. SLOBHD has expanded its use of technology to further improve access. The Department is currently using Anazasi or Cerner as the Electronic Health Record System, and Relias E-Learning to improve training outcomes, and NeoGov for their employment services including professional development. With the inclusion of telehealth, the Department will accommodate and implement ways to move forward with new technology, service delivery, and access.

3. The Language Line protocol consists of the following steps:

1. Caller requests services in another language.
2. Staff member answering the phone identifies the language and, if Spanish, reads instructions to client in Spanish to hold while the staff member contacts an interpreter.
3. Staff member calls AT&T language Line at 800-523-1786 and asks for an interpreter.
4. Staff Member informs caller through the interpreter in caller's language that interpretation services are free of charge and then ascertains caller's needs through the interpreter. If applicable, services are scheduled with a provider who speaks the caller's language. Language and cultural requests are documented on the Service Request form.

As described in Appendix 26 the Department's language line policy consists of the following standards:

1. Interventions in alternative languages are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care database.

2. Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.

3. Interventions in alternative, culturally competent approaches are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care data base.

4. Each clinic site has the capacity to provide services in the County's primary threshold language upon request (i.e., Spanish).

5. All new employees are given information on the use of the AT&T Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure.

6. Linguistic translation and interpretation services are provided in a confidential manner. As a general policy, family members will not be relied upon as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.

7. When culturally appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.

8. If there is a need for services not currently available, the following progression of referral is followed:

a. From Therapist or receptionist to Program Supervisor.
b. Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.

4. All new employees are given a brochure on the use of the Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure. Additionally, The After-Hours Crisis Worker on the Psychiatric Health Facility (PHF) is currently training all PHF staff in the use of the Language Line.

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

B. SLOBHD clients are informed in writing in their primary language, of their rights to language assistance services. Clients are informed of the right to free interpretation services via the Language Line and an option available on the Service Request (Appendix 27). This information is also posted in the Lobby of each SLOBHD center (Appendix 28).

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

1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

C. According to SLOBHD's Bilingual Certification Policy (Appendix 29) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Behavioral Health Services." This is exhibited in the following procedures and practices.

1. Staff at SLOBHD routinely make accommodations to persons who have LEP, getting help for consumers and family members who need bilingual staff or interpreter services.

The Department also has staff certified in American Sign Language (ASL). Knowledge of those language and interpretation skills possessed by all members of the organization has increased the Department's capacity to meet the needs of a diverse population.

Lessons have also been learned regarding the Language Line. The tool can sometimes be difficult to use, and it is difficult to ask personal-but-necessary screening questions over the phone with an interpreter. Positively, it allows SLOBHD staff to rapidly do the screening needed to enroll clients.

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

D. The greatest challenge in establishing services to persons who have Limited English Proficiency (LEP) using interpreter services is the difficulty the County has with hiring and retaining bilingual and/or bicultural staff. Several factors play into this challenge. First, the well-established lack of Latino/Latinx/Hispanics (and other language-capable) health and social service professionals (Institute of Medicine, 2004) is a major roadblock to staffing which accurately reflects the needs in the state. Secondly, the cost-of-living index in the County is higher than the California and U.S. averages, making recruitment of out-of-town professionals difficult – along with the challenge of maintaining a culturally diverse workforce in an expensive market. Advertisements for therapists and other providers who are bilingual get limited responses. Finally, the County faces competition for staff recruitment and salary equity from institutions such as the Atascadero State Hospital and the California Men's Colony, a state prison; both of which pay much higher wages for qualified staff. These issues are at the core of the County's WET Plan which seeks to improve both intra-county development of diverse providers as well as improve the County's current cultural and linguistic capacities.

E. Identify County technical assistance needs.

E. San Luis Obispo County Behavioral Health would be interested in any developments which may increase the County ability to provide services to persons who have Limited English Proficiency (LEP) using appropriate technology. The Department does not have staff capacity to develop computer or telecommunication solutions to this issue but would welcome technical assistance to increase the County's capacity and organizational change in targeting outreach and services with technological solutions.

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

Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

The county shall include the following in the CCPR:

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

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

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).

SLOBHD is committed to providing bilingual staff and/or interpreters for the threshold languages at all points of contact. Documents which demonstrate this commitment of practice are described in this section.

A. The flyer displayed in each Behavioral Health center countywide (Appendix 28) demonstrates SLOBHD's availability of interpreter and/or bilingual staff availability for the languages spoken by community. Signs in Spanish and English indicating the availability of free translation services and help with paperwork are posted in the lobby/reception area of each County Behavioral Health Services center.

B. The standard Service Request (Appendix 27) demonstrates that SLOBHD's interpretation services are offered and provided to clients and the response to the offer is recorded. Once interpretation services are offered, the offer/response is documented on the Service Request. Additionally, Care Plans, Master Service Plans, and Progress Notes each document whether interpretation services were utilized. These forms are available for review upon State site visit.

C. The included list of bilingual staff (Appendix 22), as well as the County client services brochure (Appendix 30) demonstrates that SLOBHD provides contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

D. According to SLOBHD's Bilingual Certification Policy (Appendix 29) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Behavioral Health Services." The following procedures are in place to monitor and certify bilingual staffing:

Procedure:

1. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).

2. The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members, at least one of whom is a native speaker of the threshold languages in the county.

3. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a total of 100. The checklist will include, but not be limited to:

a. Fluency, the ability to communicate with ease, both verbally and non-verbally.

b. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.

c. Grammar, appropriate use of tense and grammar.

d. Cultural considerations related to potential client.

4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.

5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

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

The county shall include the following in the CCPR:

A. Policies, procedures, and practices the county uses 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.

According to SLOBHD's Services for Provider List Availability Policy (Appendix 31), "Mental Health Services provides clients with a list of specialty internal health providers upon first receiving mental health services, upon request, and on an annual basis." The Culturally Competent, Multi-Lingual Services Policy (Appendix 26) adds important procedures which assure clients receive the services they seek.

A. These policies outline the procedures for providing clients with updated lists of service providers who are equipped to handle specialty needs – including culturally and linguistically appropriate services. SLOBHD is prepared to make ASL translation available upon request by way of a contract with Independent Living Resource Center (805-963-0595). Interpretation services are free to all Behavioral Health clients.

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.

B. The following procedure, from the Services for Provider List Availability Policy (Appendix 31), outlines how clients who do not meet the threshold language criteria are assisted to secure, or linked to culturally and linguistically appropriate services.

Procedure

1. Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations, and telephone numbers of current contracted providers in the beneficiary's service areas by category.

2. Each service site has a list of service providers available and will provide this list to any applicant upon request.
3. Upon completion of an application for services at the time of the first specialty mental health service, the applicant is offered a list of service providers.
4. The offer of this list is confirmed by the therapist or support staff checking the box labeled "list of service providers available to applicant" on the application form.
5. The list of providers is available at any time upon request at all service sites and offered on an annual basis. The annual offer of the list is recorded on the Application for Services.

The Culturally Competent, Multi-Lingual Services Policy (Appendix 26), adds the following procedures which assure clients get the culturally and linguistically specific services they seek:

- *Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.*
- *When culturally appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.*
- *If there is a need for services not currently available, the following progression of referral is followed:*
    a. From Therapist or receptionist to Program Supervisor.
    b. Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) 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.

C. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 26), the following procedures are in place to assure the Department complies with Title VI of the Civil Rights Act of 1964, including the above-mentioned requirements: attune

- *Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.*
- *Linguistic translation and interpretation services are provided in a confidential manner. As a general policy family members will not be relied on as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.*
- *When culturally appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.*

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

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

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

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

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

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

E. Mechanism for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

A. Examples of culturally and linguistically appropriate written information for threshold languages include the following:

Member service handbook or brochure:

1. The County provides Media-Cal beneficiaries with a Beneficiary Handbook (Appendix 32) and other informing materials at the time of admission into the system, annually thereafter, and at any time upon request. The Beneficiary Rights & Informing policy specifies that these materials are available in Spanish and for disabled clients. (Appendix 33).
2. An example of general correspondence template is included herein (Appendix 34).

3. Beneficiary problem, resolution, grievance, and fair hearing materials are included in the Beneficiary Handbook and the Department's Grievance Process materials (Appendix 35).
4. The Latino Outreach Program has created a satisfaction survey used for both Medi-Cal beneficiaries and community clients. This questionnaire is included (Appendix 11).
5. The Department's Informed Consent for Medication form is included (Appendix 36).
6. The Department's Confidentiality and Release of Information form is included (Appendix 37).
7. Service orientation for clients includes information about specialty services, including the Latino Outreach Program. The brochure provided for consumers and the community is included (Appendix 38)
8. SLOBHD makes several publications and mental health education materials available to the public and the clients visiting each of its centers. An example of materials is included in the Lobby Materials Checklist (Appendix 39).
9. The Lobby Materials Checklist, Drug & Alcohol and Mental Health Diagrams (Appendix 39) and Distribution of Translated Materials (Appendix 40) provide further evidence of appropriately distributed and utilized translated materials.

B. The County requires staff to accurately document clinical findings/reports communicated in the clients' preferred language. Bilingual staff are required to document key findings and reports for clients using their preferred language within the Master Service Plan (Appendix 27). Elements of the plan which are written in both English and Spanish include desired goals, target symptoms and functions, and objectives. This material is reviewed with the clients.

C. As referenced above, the Latino Outreach Program utilizes a consumer satisfaction survey translated in the threshold language of Spanish (Appendix 11).

D. As per the County's "Readability of Medi-Cal Informing Materials" Policy (Appendix 41), The Behavioral Health Department through the Behavioral Health Board periodically involves clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level. The Patients' Rights Advocate periodically meets face to face with a representative sample of beneficiaries and guides a process for reviewing the Handbook for readability. The process for readability in translated document will be explored further by the DEI committee over the next two years.

CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

A. List and describe the county's/agency's client-driven/operated recovery and wellness programs.

1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.
2. Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The following CLAS Standards align with Criterion 8:

12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

SLOBHD is committed to providing opportunities which enhance client-driven recovery and wellness programs (Appendix 42). The County has established critical partnerships with community-based recovery and wellness programs to expand the capacity of the behavioral health system to provide culturally and linguistically appropriate recovery services.

A. SLOBHD's primary community partner for providing client-driven and operated recovery and wellness programs is Transitions Mental Health Association (TMHA). This established non-profit organization is focused on reducing the stigma of mental illnesses, maximizing personal potential, and providing innovative mental health services to individuals and families in need. TMHA offers a full spectrum of programs in both San Luis Obispo and Northern Santa Barbara Counties. TMHA includes the National Alliance on Mental Illness (NAMI) as one of its partners in providing culturally appropriate recovery services, and internally, they have established their own Cultural Competence Committee.

TMHA operates 34 programs at over 35 locations that reach over 2,000 people and 1,500 families in the San Luis Obispo county. The emphasis of TMHA's many services is to teach vital independent living skills and build a framework for community re-entry through personal empowerment and hands on experience. With the County, TMHA provides housing, employment, case management and life-skills support to mentally ill adults, at-risk youth, and homeless adults.

TMHA also participates in multi-agency collaboration that provides 24/7 support services where and when they are needed. Staff teams are fully integrated to give everyone a range of choices and help them decide on a recovery process. Services include psychiatric care, housing assistance, substance abuse recovery, medication management, health and financial education, employment, and social support options.

SLOBHD's **Full-Service Partnership** (FSP) is an MHSA program conducted in partnership with TMHA for adult clients, Wilshire Community Services for older clients, and Family Care Network for Transitional Aged Youth clients. FSP provides 24/7 intensive community-based wrap around services to help people in recovery live independently. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's and their loved ones needs and to empower everyone to attain their highest level of independence possible.

SLOBHD also provides recovery services via its **Behavioral Health Treatment Court** (BHTC), which operates as an FSP for adults, ages 18 to 60, with a serious and persistent mental illness, are on probation, and who have had mental health treatment as part of their probation orders. These individuals have been previously underserved or inappropriately served because of a lack of effective engagement or in meeting their needs. They often have a co-occurring disorder, experience homelessness, and have had multiple incarcerations through the criminal justice system.

The County provides funding (via contractual agreements) for TMHA's various recovery and wellness programs, and the two organizations work closely to move clients, families, and supports fluidly between County and community services. TMHA provides the following client-driven/operated recovery and wellness programs:

In Our Own Voice is a NAMI-developed presentation format that equips individuals with mental illness to share their stories with others. This multi-media, interactive, public education program is intended for all audiences, including family members, health providers, law enforcement, faith communities, community or civic organizations, and other groups.

Stamp Out Stigma (SOS) is a client-driven advocacy and educational outreach program designed to make positive changes in the public perception of mental illness and inform the community about the personal, economic, and socio-political challenges faced by people living with mental illness. SOS presentations consist of 1-6 presenters who share personal experiences of living with mental illness, relating their own experiences of stigma and how they have worked to change the negative societal perceptions. **SLOtheStigma** is a PEI-developed partnership project between the County and TMHA consisting of a documentary and public media campaign utilizing this consumer-led stigma-reduction model.

The Peer Advisory Advocacy Team (PAAT) was created to give consumers the opportunity to participate in committees and workgroups at SLOBHD and other local mental health organizations to enhance the behavioral health system, educate the community, and reduce stigma.

TMHA offers **Peer Support Groups** run by and for people with mental illness. The groups provide peer-to-peer interaction, the sharing of stories, education, and a sense of community. Currently groups are run in Arroyo Grande, San Luis Obispo, and Atascadero. **Peer-to-Peer** is a formatted peer support group for any person with serious mental illness who is interested in establishing and maintaining wellness. This nine-week course (two hours per week) developed by NAMI uses a combination of lecture, interactive exercises, and structured group processes to explore recovery. Peer Support Groups are held at TMHA's Wellness Centers.

1. The County has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences. As described throughout this Criterion section and subsequent Appendices, the County has policies and practices in place (including those with its community partners) to provide language support along with alternatives which meet a minimum standard of cultural competence.

Examples of community programs which offer alternative supports while meeting specific cultural and diversity needs are also based at TMHA:

Short Term Therapeutic Treatment Program (STRTP) is a residential treatment program serving young people who cannot cope with their present living situation and need a different living structure to recover and become stable.

Transitional Housing for Individuals Experiencing Homelessness serves different able adult residents who are currently or at risk of experiencing homelessness. The goal for all program residents is successful independent living within 24 months. At completion of the program, residents may be eligible for Section 8 housing assistance.

Full-Service Partnership (FSP) Intensive Residential Program is funded by the Mental Health Services Act (MHSA) and provides 24/7 intensive community-based wrap around services to help people in recovery live independently. Residents are referred to the program through SLOBHD and occupy a variety of community housing and apartment rentals throughout San Luis Obispo, Atascadero, and Arroyo Grande.

As described in Criterion Four, it is the intent of the DEI Committee, formerly known as the Cultural Competence Committee, to continue to develop monitoring strategies and programming options which increase the County's capacity to meet the needs of the diverse citizenry – including the LGBTQ community, veterans, and underserved ethnic populations.

2. Of the programs listed in the above section, all strive to meet the needs of participants including racially, ethnically, culturally, and linguistically specific services. Some examples of this effort include:

- SLOtheStigma: Both the documentary film and its website (www.slothestigma.org) are accessible in Spanish. This is critical as the website also serves as an MHSA directory of services including all the county's support and provider contacts.
- TMHA's Peer Support Groups include specific groups for LGBTQ, older adults, youth, and other diverse populations.
- All FSP and BHTC services are provided in Spanish, and other cultural needs are met by the one-on-one support and case management of these specialized programs.

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally appropriate, non-traditional mental health provider.

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

Currently, the County does not have a uniform listing of available alternatives and options of cultural/linguistic services that can be provided to clients upon request. To begin addressing this need, SLOBHD promotes the use of interpretation services for our threshold language population and has streamlined a process to set appointments for Promotores to assist clients as needed, which increases access to services. Additionally, the Drug & Alcohol Services is currently in a final phase to provide recommendations on their LGBTQIA+ Study to enhance their services. Their executive summary can be found in Appendix 43. SLOBHD's current efforts are designed to provide us with information on how the recommended alternative services in the community can meet and improve the County's standards of service.

A. The primary resource provided to clients is the SLOBHD Mental Health and Drug & Alcohol Services brochure in English and Spanish (Appendix 30). This lists all local programs and services known to meet the behavioral health and wellness needs of clients. The Provider List includes language and cultural services as well as any other alternative supports available. This list is available to all SLOBHD clients.

The primary culture-specific program provided by SLOBHD is the **Servicios Sicológicos Para Latinos: A Latino Outreach Program (LOP)** described in Criterion 3, Part III, which offers culturally appropriate psychotherapy services to monolingual, low-income Spanish speakers and their bilingual children.

SLOBHD staff individually offer clients alternatives and options that accommodate individual preferences or cultural and linguistic preferences, provided by community-based, culturally appropriate, non-traditional mental health providers. Examples include:

- The Human Services and Support Groups Directory published by Hotline/211 (local crisis prevention/intervention phone services, although the publication is no longer in print).
- Contact information for LGBTQ+ resources including PFLAG (Parents & Friends of Lesbians and Gays) www.pflagcentralcoastchapter.net; GALA and Diversity Center www.ccgala.org; Tranz Central Coast http://tranzcentralcoast.web.officelive.com, R.A.C.E Matters SLO https://www.racemattersslo.org/welcome, among others.
- Spiritual resources including all faith-based services found in local directories, drumming circles found in the New Times (popular alternative weekly newspaper), and Salinan Tribe of San Luis Obispo (http://salinantribe.com/)
- Drug and alcohol recovery resources including lists and schedules of all local 12-Step (AA, NA, Al-Anon, etc.) which are available at each SLOBHD site; Christian-based 12-step groups, such as Celebrate Recovery at ABC Church in Atascadero, and specific neighborhood recovery centers such as North County Connection - (Alano club, 12-step & general info.) http://www.northcountyconnection.com/meetings.html.

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.

B. The Behavioral Health Department informs clients of the availability of the above-mentioned listings primarily via the Beneficiary Handbook and the Provider List Policy of Behavioral Health Clinics and Contract Providers (Appendix 301) and the Member Services Brochure which will include all alternatives and options described in the previous section.

The Beneficiary Handbook is given to Medi-Cal beneficiaries at their intake assessment and subsequently annually thereafter. SLOBHD Policy 4.20 (Appendix 33) outlines the Beneficiary Handbook protocol, which includes the engagement of clients regarding linguistic and cultural treatment options, as described in the Provider List. The Provider List Policy (Appendix 31) states that "Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations, and telephone numbers of current contracted providers in the beneficiaries' service areas by category."

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. *(Outreach requirements as per Section 1810.310, 1A and 2B, Title 9)* (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.)

C. The Behavioral Health Department conducts several practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. These practices include internal policies which mandate staff to provide information regarding available services under consolidation of specialty mental health services, as described in the previous section. The Behavioral Health Department informs clients of the availability of the above-mentioned listings primarily via the Beneficiary Handbook and the Provider List of Behavioral Health Provider List Availability Policy (Appendix 32 and 31 respectively).

Therapeutic Behavioral Services (TBS) are a specialty mental health service for children and youth under age 21 receiving EPSDT mental health services who are placed in or are being considered for Rate Classification Level 12 or higher; **or** have received psychiatric hospitalization in the past 24 months; **or** are being considered for psychiatric hospitalization. SLOBHD held forums (Appendix 44) to educate the public and providers as to how these services are engaged. Materials for these forums were distributed in English and Spanish.

Other efforts include outreach services, including those of the **Latino Outreach Program** (LOP). As described in Criterion 3, LOP engages the Latino and monolingual community during the year so that Medi-Cal beneficiaries (including those yet to engage the system) are made aware of the cultural and linguistic capacities of the mental health system locally.

County partners, such as Transitions Mental Health Association (TMHA) and Family Care Network, Inc. (FCNI) utilize professional websites which disseminate information regarding specialty mental health services. FCNI's website provides information regarding its provision of **TBS** (|Family Care Network (fcni.org)). TMHA's website (Supported Employment | Transitions Mental Health Association (t-mha.org)) outlines services including their **Supported Employment Program** (SEP), which provides on-going job support services necessary for individuals with mental illnesses to choose, receive, and keep competitive employment while working in jobs and environments they prefer and with the level of professional support they desire.

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas;
2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and
3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

D. The County continually examines the factors which affect access to its services and develops plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services.

1. The SLOBHD maintains a Provider List of Behavioral Health Clinics and services available to all the community (Appendix 30). This document is available to clients and the public, and includes information about provider services, operating hours, and location including access points near public transportation. Each County facility offers the public current and relevant public transportation, informational brochures, and schedules. Some providers have contracted services with local transportation companies, outside of the scope of County services.

2. The SLOBHD clinics and offices are ADA compliant and accessible to all. The Department maintains a Provider List of Behavioral Health Clinics which includes information about provider services, language capacity, and ADA access. Department and provider sites aim to be warm, comfortable, and inviting to individuals of diverse cultural backgrounds.

3. SLOBHD has been a leader in developing collaborative and integrated services for several years. Systems Affirming Family Empowerment (SAFE) is the County's foundational integrated services system and continues to offer community members access to integral social and health services in warm, neighborhood settings.

The SAFE Children's System of Care has been evolving since the original Healthy Start Programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) Children's System of Care grant helped establish initial funding for Multiagency Collocated Integrated Children's Systems of Care. The SAFE Program was designed to facilitate the development of a client-family-driven coordinated treatment planning and implementation system that is strengths driven; community based and demonstrates culturally competent service delivery. The program is made up of a Hub of Service centrally located in the South County. Radiating out from the center are three additional Family Resource Centers (FRCs) that reflect the structure and values inherent in Children's System of Care. Each of the FRCs has bilingual resource specialists and access to bilingual therapists. Agency participants in the SAFE SOC are Education, Department of Social Services, Probation, Mental Health, and

other appropriate entities that may be invited to participate when the family believes they are beneficial to the process. The outcomes of the program have been excellent as evidenced by continued reductions in group home placements, reduced hospitalizations, decreased arrests and improved school attendance and performance.

The County's Behavioral Health Services and Office of Education have a long history of collaborative programming for Seriously Emotionally Disturbed (SED) children. Mental Health has a contract with many school districts to provide Behavioral Health services in classes for children designated as SED. The County continues to provide AB3632, Individual Education Plan (IEP) driven services for children that qualify throughout the SELPA. Collocation allows for coordinated treatment planning. As a Children's System of Care County, the values of family inclusion, strength, and needs-driven services provided in the community by culturally competent trained staff permeates the entire system.

Stigma reduction is an outcome that is accomplished by having services available in the community where consumers live, provided by people that are visible and known to the community. SAFE has provided linkage and services that go beyond traditional therapy. FRCs provide linkage to multiple resources such as food, job opportunities, parenting classes, recreational opportunities, and linkage to unique services and supports that families identify. The access to bilingual staff has helped reduce the stigma and has made coming to the FRCs safe and comfortable for the diverse population in the South County.

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

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.

San Luis Obispo County Behavioral Health has developed strong partnerships with community providers who deliver quality services to the public. SLOBHD requires each community partner receiving funding from the County to demonstrate cultural competence and participate in the development of services which meet the needs of the community's diverse population.

A. Each of the County's MHSA plans has outlined the critical link between community provision of service and the need to improve cultural competence throughout the mental health system. As described in previous sections of this document, the original CSS plan for the County created the Latino Outreach Program (LOP), which focused the County's attention on improving services for monolingual and bicultural individuals who made up the county's most significant disparity. This service is provided by a community organization which has a

unique capacity to provide quality behavioral health services in both a linguistic and culturally competent manner.

The County's Prevention and Early Intervention plan also outlined specific cultural competence principles within each work plan project. Each of the PEI work plans contained the directive that "Each PEI provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation, and innovation." This was followed through by requiring each applicant for PEI contracts to provide the following information as part of the Request for Funding Applications process:

> ***Cultural Competence:*** *Describe your organization's cultural competence in program approach, staffing and organization governance.*
>
> *A. Describe how services proposed will meet the requirements of cultural competence set forth the County's PEI plan.*

Subsequently, contract language for those receiving funding includes the following in the Special Conditions section, Exhibit E (Appendix 45):

> ***Compliance with County Cultural Competence Plan.***
> *Consistent with County Cultural Competence Plan and 42 C.F.R. section 438.206(c)(2), Contractors shall make services available in a manner consistent with Culturally and Linguistically Appropriate Service (CLAS) national standards. Contractor shall provide services that meet the cultural, ethnic, and linguistic backgrounds of clients, including but not limited to, access to services in the appropriate language and/or reflecting the appropriate culture or ethnic group. Contractor shall adopt effective measures to enforce compliance with this standard by its employees, subcontractors, and agents.*
> *Within ninety (90) calendar days of hire, and annually thereafter, Contractor, its employees, subcontractors, and agents shall read the latest edition of the Cultural Competence Employee Information Pamphlet and complete related training provided by the Health Agency or other cultural competence training determined by Contractor.*
> *Contractor shall maintain records providing signatures (either actual or electronic) from each employee, subcontractor and agent stating that they completed annual cultural competence training. Records shall specify the training topic, provider or vendor, hours of training, and date completed. Relias Learning or equivalent E-learning records are sufficient to comply with this requirement.*

B. Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

B. In 2009, all Mental Health Services staff were asked to participate in the California Brief Multicultural Competence Scale (Appendix 46). This survey was sent to all staff via email, and

returned surveys were kept confidential. This survey assessed staff comfort and proficiency with handling issues of cultural competence.

As part of the County's Behavioral Health Department efforts to ensure cultural competence, the committee, in collaboration with Cal Poly, conducted a Cultural Competence Study and Survey in fall of 2017. Results from the study allowed the Committee to concentrate efforts in developing a training list that addresses the employees' experience and needs to better engage our community (Appendix 23).

C. 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.

C. The following paragraph from SLOBHD policy 11.07, Grievance Process (Appendix 35), details how the complaints, grievances, and appeals are reviewed and analyzed.

> "Issues identified as a result of the complaint resolution or Appeal process are presented to the MHP's Performance and Quality Improvement/Quality Management Committee (PQI/QM), as needed and, on a quarterly basis, in summary form. The PQI/QM Committee forwards identified issues to the Behavioral Health Administrator or another appropriate body within the MHP for implementation of needed system changes."

There is not currently any comparison analysis between the general beneficiary population and ethnic beneficiaries with regards to client grievance and complaint data, except the availability of bilingual and multicultural staff addressing the need of the client. SLOBHD's intent is to fully address any grievance by any individual with the utmost care to their identity and experience in the behavioral health care system. The Department, through the Patient Rights Advocate, maintain a complaint/appeal list of all individuals and their preferred language as part of their grievance. Due to upcoming changes to the electronic health record system, future data will be able to discern in granular elements various social and demographic factors. It is essential to mention that a client may choose not to identify their ethnicity or any other personal identifier, and in this case, no actual comparison could be established.

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MISSION STATEMENT

To serve all individuals in our community affected by mental illness and/or substance abuse through culturally inclusive, diverse, strength-based programs centered around clients and families to improve emotional and physical health, safety, recovery, and overall quality of life.

SERVICE PROGRAMS

Behavioral Health has a total expenditure level of $0 and a total staffing level of 0.00 FTE to provide the following services:

Outreach and Education

To engage and enhance knowledge and skills of all individuals in our community through advocacy, education, and awareness practices to recognize early signs of mental illness and addiction, reduce stigma and discrimination, prevent suicide and crisis, and increase access to services.

Total Expenditures: $
Total Staffing (FTE):

Prevention

To engage underserved individuals in our community impacted by the earliest onset of mental illness and substance abuse through increasing access to services and programs and diverse and inclusive initiatives to protect and promote emotional and physical health.

Total Expenditures: $
Total Staffing (FTE):

Early Intervention

To engage individuals in our community to precent and reduce the duration of untreated mental illness and substance use from becoming severe through culturally inclusive and diverse services focused on screening, education, brief intervention, and individual and group counseling to promote and encourage individuals to live fulfilling and productive lives.

Total Expenditures: $
Total Staffing (FTE):

Appendix 01

DRAFT

Treatment

A Behavioral Health interdisciplinary team provides a range of specialty mental health services and substance use disorder services including; individual, family, and group therapy; rehabilitation services; intensive home based services; case management; intensive care coordination and psychiatric services and medications support for adults and children.

Total Expenditures: $
Total Staffing (FTE):

Residential

Residential Services in Behavioral Health includes a range of locked facilities supporting individuals with mental illness to local residential housing supports for individuals receiving specialty mental health services or substance use treatment.

Total Expenditures: $
Total Staffing (FTE):

DRAFT

Appendix 01

Mental Health Service's primary goal is to provide the least restrictive treatment and rehabilitation strategies to help the clients with chronic mental illness maintain the highest possible quality of life. For clients with more quickly remediable disturbances, the Department's basic emphasis is on brief, crisis-oriented treatment. Maximum use of Recovery groups and time-limited Family and Collateral therapy is encouraged.

Client's unique cultural needs and strengths must be a primary factor in treatment formulation and ongoing care. The Recovery Model, based on optimism, wellness and client empowerment, should be used as a guiding principle for treatment.

Mental Health Services understands that clients have the right to be treated with respect and with consideration for their privacy and dignity. They have the right to receive information on alternative treatment options and choose to refuse treatment if they wish.

Continuity of care for clients is important organizational goal. Within the Mental Health system, this means retaining the same therapist or psychiatrist for a client whenever possible, as well as ensuring a seamless transition of services and transmission of information between programs and clinic sites when clients are transferred. Client's requests for change in Therapist or Psychiatrist will be given fair and open consideration according to the process outlined in standardized Mental Health policies and procedures. If the change in provider is due to a contract termination, reasonable efforts will be made to notify the beneficiary in writing.

When individuals, who have received definitive evaluations and treatment in any of the direct services, are referred to other agencies or facilities, a positive referral should be made, with a clear understanding as to whether responsibility for care is transferred. Treatment summaries and other pertinent information should be promptly disclosed following client's written authorization, whenever needed.

In support of the primary goal of least restrictive treatment measures, every effort should be made to avoid the long-term placement or hospitalization of clients, especially children at risk of placement. This includes minimizing the placement of clients in Institutes of Mental Disorder (IMD), State Hospitals, and Out-of-County facilities by striving to keep them in the community whenever it is therapeutically indicated. Alternatives to inpatient hospitalization should be used whenever possible. Maximum use of community resources and caretakers should be made.

Appendix 02

Appendix 02

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 2/27/2009
Revision dates: 2/27/2009

Workforce Training Education Plan
Action #5 – Title: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff:

Description:

While cultural competence is embedded in all actions of the WET Plan, this action focuses on specific technical assistance and trainings necessary to achieve Cultural and Linguistic Competency within the public mental health system. We will be coordinating the BHS Cultural Competence Committee comprised of direct care staff from Behavioral Health Services, Drug and Alcohol Services, Gay and Lesbian Alliance (GALA,) Community Based Organizations, consumer and family members. This committee will create the cultural competency plan and develop recommendation for a year-round training plan. As this training program is completed, additional training needs will be identified and supported. Also covered will be the cost of a refresher course for interpreters, specialized training focused on the County's various ethnic populations, and attendance at State-wide Cultural Competence trainings.

The purpose of cultural training is to develop understanding, skills and strategies to assist in embedding cultural competence into the MHSA implementation process and to support cultural competence integration in San Luis Obispo County. Our hope is that the training will provide the tools and skills necessary to increase the County's capacity for the delivery of culturally relevant services, ultimately resulting in better outcomes for the County's culturally diverse clients.

The California Brief Multi-Cultural Competence Scale (CBMCS) and Training Program will be an integral component of the training curriculum for staff. The CBMCS is designed to measure and improve the self-reported multicultural competence of mental health service providers. Training will focus on the disparities identified in the planning process and work with administration and programs to apply the strategies created in the Community Services and Support (CSS) plans. Trainings will also include continued culturally focused discussions with community-based organizations, community agencies, community leaders, clients and family members for their perspectives on the cultural aspects of the organization's MHSA and cultural competence plan. Trainings will consult with the Multi-Cultural Services Development Center of the California Institute for Mental Health (CiMH.).

Also embedded in this action is the intent to increase the number of staff able to provide services in Spanish or are able to communicate in basic conversational Spanish. This will be accomplished by contracting with San Luis Coastal Adult School to provide a High Intensity Spanish Language training program. The program has a linguistic culture component with an emphasis on workplace communication.

Appendix 03

Additional specific medical and psychiatric terminology would be covered during the course. Also, the Cultural Competency Committee will work to identify consumers, family members, and/or behavioral health staff who are bilingual and looking to further advance professionally in the mental health field. These identified bilingual individuals will be eligible for grants, stipends, or internships.

Objectives:

1. Utilize the CBMCS Self-Assessment Tool to determine a baseline for San Luis Obispo staff and its contractors in the summer of 2009.

Appendix 03


APRIL - JUNE 2021
CULTURAL COMPETENCE NEWSLETTER
COUNTY of SAN LUIS OBISPO
County of San Luis Obispo - Health Agency

Appendix 04


"Our ability to reach unity in diversity will be the beauty and the test of our civilization."
- Mahatma Ghandi
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Appendix 04

Cultural Competence Committee

Members:

Amanda Corcoran, L.C.S.W. Behavioral Health Clinician II, Drug & Alcohol Services
Amber Trigueros, L.M.F.T. Behavioral Health Clinician
Anne Robin, L.M.F.T. Behavioral Health Administrator
Annika Michetti, Behavioral Health Program Supervisor, Drug & Alcohol Services
Barry Johnson, TMHA Division Director, Education and Advocacy
Bonita Thomas, PAAT Member, Peer Advisory and Advocacy Team
Claudia Lopez, L.M.F.T. Patient Rights Advocate
Gabriel Granados, Behavioral Health Specialist II
Jay Bettergarcia, Ph.D., Professor & Director of QCARES
Jill Rietjens, L.M.F.T. Behavioral Health Division Manager, Ethnic Services Manager Co-Chair
Joe Madsen, TMHA Division Director, Housing Programs and Forensic Services Director
Katherine Soule, Ph.D., Director UC Cooperative Extension & Youth, Families, & Communities
Kiana Shelton, L.C.S.W. Behavioral Health Clinician, Ethnic Services Manager Co-Chair
Lashelle Burch, Licensed Clinician Social Worker, Atascadero State Hospital
Laura Zarate, Secretary II Behavioral Health
Leticia Palafox, Behavioral Health Specialist I, Latino Outreach Program
Lilia Rangel-Reyes, Tri-Counties Regional
Marcy Paric, Ph.D., Behavioral Health Board Vice Chair
Maria Ordunez-Lara, L.M.F.T. Licensed Advanced Alcohol & Drug Counselor
Maria Troy, R.N., B.S., M.P.A. Promotores
Marne Anna Trevisano, Ed.D, Ph.D., Psychologist
Michelle Call, Executive Director Gala Pride and Diversity Center
Nasseem Rouhani, Health Education Specialist, Public Health Department
Nestor Veloz-Passalacqua, M.P.P. Whole Person Care Program Manager
Tabitha Castillo, Administrative Assistance, Veterans Service Office
Tania Resendiz, Behavioral Health Clinician II, Drug & Alcohol Services

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Appendix 04


Cultural Competence
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Appendix 04

Addressing Racial and Ethnic Health Disparities in Adult Obesity and Encouraging Physical Activity

CDC | cdc.gov

Every person should be able to reach his or her full health potential. I'm proud of the work we do in CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) to support Americans' journey to good health—especially among people most vulnerable to chronic disease. We protect the health of Americans at every stage of life by encouraging regular physical activity and good nutrition, helping to prevent obesity in children and adults, and addressing barriers to treating obesity in children.

Obesity is a serious health problem and the prevalence of obesity continues to increase among adults in the United States. We know that obesity is common, serious, and costly. This epidemic is putting a strain on American families, affecting individuals' overall health, health care costs, productivity, and military readiness. We also know that obesity affects some groups more than others. To be successful, we must reduce racial and ethnic disparities in obesity.

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https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

Appendix 04

Here I'm going to discuss the costs of obesity and how it is disproportionally affecting some racial and ethnic groups more than others. I'm also going to talk about physical activity as one of the strategies we promote to address obesity. Finally, I'll share how CDC's Racial and Ethnic Approaches to Community Health (REACH) program, State Physical Activity and Nutrition Program (SPAN), and High Obesity Program (HOP) are working with communities to improve physical activity access, among other strategies, to help people most at risk for chronic disease.

Costs of Obesity

Obesity is a problem for both children and adults in the United States. Nearly 1 in 5 young people aged 2 to 19 years have obesity. These children are at risk for type 2 diabetes, asthma, depression, and low self-esteem. The risk of adult obesity is also increased for individuals who had obesity as children.

Nearly 4 in 10 adults in the United States have obesity. Adults with obesity often have multiple-organ system complications from the condition and are more at risk for heart disease, stroke, type 2 diabetes, and 13 types of cancers. Obesity costs the US health care system approximately $147 billion a year. Adult obesity decreases productivity and increases the risk of workplace injuries. The cost of obesity-related absenteeism is between $3.4 billion and $6.4 billion each year. Obesity in young adults limits the eligibility for many to serve in our military. About 1 in 4 young adults is too heavy to serve.

Disparities

CDC plays a key role in tracking data on obesity burden and the racial and ethnic disparities within the obesity burden. Using self-reported data from the Behavioral Risk Factor Surveillance System (BRFSS), we have published state obesity maps since 1999. For the past 4 years, we published more detailed state and territorial maps to show self-reported adult obesity by race/ethnicity to bring awareness to the disparities in obesity.

The racial and ethnic maps for 2015–2017 show where obesity is more burdensome for particular populations. Overall, 31 states and the District of Columbia had an obesity prevalence of 35% or higher among non-Hispanic black adults; 8 states (Arizona, Illinois, Kansas, Michigan, North Dakota, Oklahoma, South Dakota, and Texas) had an obesity prevalence of 35% or higher among Hispanic adults; and only 1 state (West Virginia) had an obesity prevalence of 35% or higher among non-Hispanic white adults.

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https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

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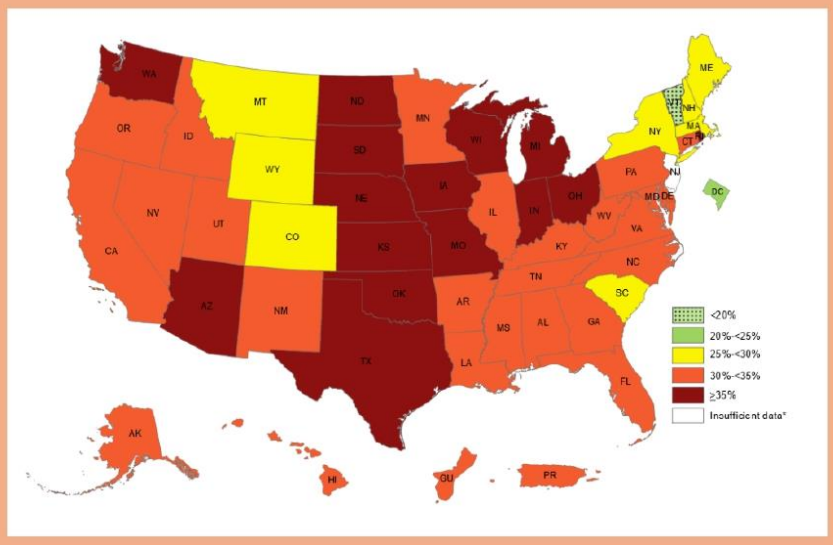
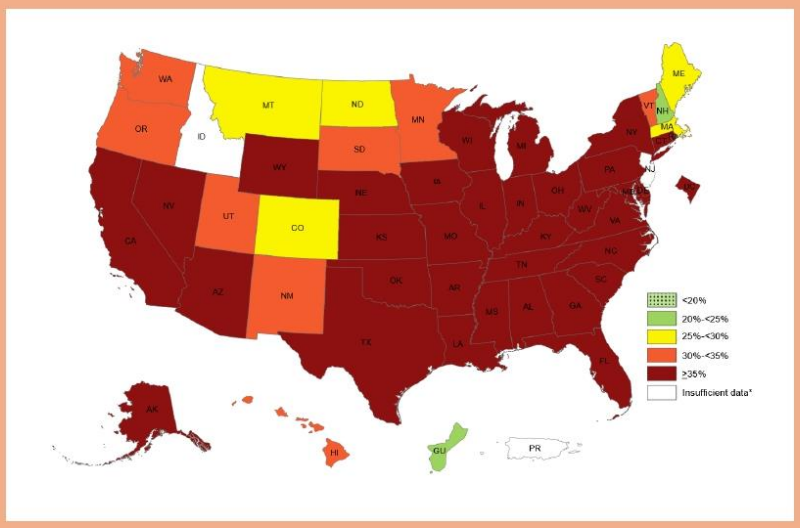
Prevalence of Self-Reported Obesity Among Hispanic Adults by State (2017)



Prevalence of Self-Reported Obesity Among Black Adults by State (2017)



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https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

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Encouraging Physical Activity to Manage and Prevent Obesity

There is no single or simple solution to the obesity problem our nation faces. We do know there are proven strategies to help turn this around if we work together and across sectors. In the spirit of the 2019 National Minority Health Month's Active & Healthy theme, I would like to talk about one strategy—increasing physical activity. Physical activity, when combined with a healthy diet, can help people prevent unhealthy weight gain and help them lose weight.

However, physical activity has many other benefits beyond helping with weight management. Physical activity promotes health by reducing the risk of chronic diseases and other conditions that are often more common and more severe among racial and ethnic minority groups. Physical activity also fosters normal growth and development in children, improves mental health, and can make people feel better, function better, and sleep better. The Physical Activity Guidelines for Americans outlines the amounts and types of physical activity needed to maintain or improve overall health and reduce the risk of chronic disease.

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https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

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One way communities can help residents be active is to create easy and safe options for physical activity. Since 1999, CDC's Racial and Ethnic Approaches to Community Health (REACH) program has demonstrated that through community participation, locally-based and culturally-tailored efforts can be effective. REACH communities address chronic diseases for specific racial and ethnic groups in urban, rural, and tribal communities with high disease burden. They implement community planning and transportation plans that support safe and accessible physical activity by connecting sidewalks, paths, bike routes, and public transit with homes, early care and education settings, schools, and parks and recreation centers.

CDC's State Physical Activity and Nutrition Program (SPAN) and High Obesity Program (HOP) also focus on improving racial and ethnic health disparities and include strategies to increase physical activity. Through SPAN, CDC funds statewide initiatives to implement evidence-based strategies at state and local levels to improve nutrition and physical activity. CDC's HOP funds 15 land grant universities to work with community extension services to increase access to healthier foods and safe and accessible places for physical activity in counties that have more than 40% of adults with obesity.

Together, we can help states and communities to improve physical activity access and to reduce obesity rates for all Americans.

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https://blogs.cdc.gov/healthequity/2019/04/24/addressing-racial-and-ethnic-health-disparities-in-adult-obesity-and-encouraging-physical-activity-this-national-minority-health-month/

Appendix 04

Mental illness in children: Know the signs

Mayo Clinic | mayoclinic.org

Children can develop the same mental health conditions as adults, but their symptoms may be different. Know what to watch for and how you can help.

Mental illness in children can be hard for parents to identify. As a result, many children who could benefit from treatment don't get the help they need. Understand how to recognize warning signs of mental illness in children and how you can help your child.

What is a mental illness?

Mental health is the overall wellness of how you think, regulate your feelings and behave. A mental illness, or mental health disorder, is defined as patterns or changes in thinking, feeling or behaving that cause distress or disrupt a person's ability to function.

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https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

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Mental health disorders in children are generally defined as delays or disruptions in developing age-appropriate thinking, behaviors, social skills or regulation of emotions. These problems are distressing to children and disrupt their ability to function well at home, in school or in other social situations.

Barriers to treating childhood mental health disorders

It can be difficult to understand mental health disorders in children because normal childhood development is a process that involves change. Additionally, the symptoms of a disorder may differ depending on a child's age, and children may not be able to explain how they feel or why they are behaving a certain way.

Concerns about the stigma associated with mental illness, the use of medications, and the cost or logistical challenges of treatment might also prevent parents from seeking care for a child who has a suspected mental illness.

Common disorders among children

Mental health disorders in children — or developmental disorders that are addressed by mental health professionals — may include the following:

- **Anxiety disorders.** Anxiety disorders in children are persistent fears, worries or anxiety that disrupt their ability to participate in play, school or typical age-appropriate social situations. Diagnoses include social anxiety, generalized anxiety and obsessive-compulsive disorders.
- **Attention-deficit/hyperactivity disorder (ADHD).** Compared with most children of the same age, children with ADHD have difficulty with attention, impulsive behaviors, hyperactivity or some combination of these problems.
- **Autism spectrum disorder (ASD).** Autism spectrum disorder is a neurological condition that appears in early childhood — usually before age 3. Although the severity of ASD varies, a child with this disorder has difficulty communicating and interacting with others.
- **Eating disorders.** Eating disorders are defined as a preoccupation with an ideal body type, disordered thinking about weight and weight loss, and unsafe eating and dieting habits. Eating disorders — such as anorexia nervosa, bulimia nervosa and binge-eating disorder — can result in emotional and social dysfunction and life-threatening physical complications.

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https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

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- **Depression and other mood disorders.** Depression is persistent feelings of sadness and loss of interest that disrupt a child's ability to function in school and interact with others. Bipolar disorder results in extreme mood swings between depression and extreme emotional or behavioral highs that may be unguarded, risky or unsafe.
- **Post-traumatic stress disorder (PTSD).** PTSD is prolonged emotional distress, anxiety, distressing memories, nightmares and disruptive behaviors in response to violence, abuse, injury or other traumatic events.
- **Schizophrenia.** Schizophrenia is a disorder in perceptions and thoughts that cause a person to lose touch with reality (psychosis). Most often appearing in the late teens through the 20s, schizophrenia results in hallucinations, delusions, and disordered thinking and behaviors.

What are the warning signs of mental illness in children?

Warning signs that your child may have a mental health disorder include:

- Persistent sadness — two or more weeks
- Withdrawing from or avoiding social interactions
- Hurting oneself or talking about hurting oneself
- Talking about death or suicide
- Outbursts or extreme irritability
- Out-of-control behavior that can be harmful
- Drastic changes in mood, behavior or personality
- Changes in eating habits
- Loss of weight
- Difficulty sleeping
- Frequent headaches or stomachaches
- Difficulty concentrating
- Changes in academic performance
- Avoiding or missing school

What should I do if I suspect my child has a mental health condition?

If you're concerned about your child's mental health, consult your child's doctor. Describe the behaviors that concern you. Talk to your child's teacher, close friends, relatives or other caregivers to see if they've noticed changes in your child's behavior. Share this information with your child's doctor.

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https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

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How do health care professionals diagnose mental illness in children?

Mental health conditions in children are diagnosed and treated based on signs and symptoms and how the condition affects a child's daily life. To make a diagnosis, your child's doctor might recommend that your child be evaluated by a specialist, such as a psychiatrist, psychologist, clinical social worker, psychiatric nurse or other mental health care professional. The evaluation might include:

- Complete medical exam
- Medical history
- History of physical or emotional trauma
- Family history of physical and mental health
- Review of symptoms and general concerns with parents
- Timeline of child's developmental progress
- Academic history
- Interview with parents
- Conversations with and observations of the child
- Standardized assessments and questionnaires for child and parents

The Diagnostic and Statistical Manual of Mental Disorders (DSM), a guide published by the American Psychiatric Association, provides criteria for making a diagnosis based on the nature, duration and impact of signs and symptoms. Another commonly used diagnostic guideline is the International Classification of Diseases (ICD) from the World Health Organization.

Diagnosing mental illness in children can take time because young children may have trouble understanding or expressing their feelings, and normal development varies. The doctor may change or refine a diagnosis over time.

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https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

Appendix 04

How is mental illness in children treated?

Common treatment options for children who have mental health conditions include:

- **Psychotherapy.** Psychotherapy, also known as talk therapy or behavior therapy, is a way to address mental health concerns by talking with a psychologist or other mental health professional. With young children, psychotherapy may include play time or games, as well as talk about what happens while playing. During psychotherapy, children and adolescents learn how to talk about thoughts and feelings, how to respond to them, and how to learn new behaviors and coping skills.
- **Medication.** Your child's doctor or mental health professional may recommend a medication — such as a stimulant, antidepressant, anti-anxiety medication, antipsychotic or mood stabilizer — as part of the treatment plan. The doctor will explain risks, side effects and benefits of drug treatments.

How can I help my child cope with mental illness?

You will play an important role in supporting your child's treatment plan. To care for yourself and your child:

- Learn about the illness.
- Consider family counseling that treats all members as partners in the treatment plan.
- Ask your child's mental health professional for advice on how to respond to your child and handle difficult behavior.
- Enroll in parent training programs, particularly those designed for parents of children with a mental illness.
- Explore stress management techniques to help you respond calmly.
- Seek ways to relax and have fun with your child.
- Praise your child's strengths and abilities.
- Work with your child's school to secure necessary support.

Learn more:

www.cdc.gov/childrensmentalhealth/index.html

www.nimh.nih.gov/health/publications/children-and-mental-health

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https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

Appendix 04

How To Make Friends With Someone Who Has Autism

CBC | cbc.ca

For many people, autism is mysterious and frightening. "We are afraid because we don't know how to react, so we tend just to avoid," said Dr. Grace Iarocci, a Psychology Professor with Simon Fraser University Autism and Developmental Disorders Lab. But social isolation only makes the problem worse.

Autism affects the way a person's brain and body work. Someone with the disorder might have trouble speaking, make strange sounds or not talk at all. Some may flap their hands, spin in circles or sit and avoid looking at others. Each person with Autism Spectrum Disorder (ASD) is unique, and the disorder manifests in complex ways. They're also intelligent, passionate people who value friendship.

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https://www.cbc.ca/cbcdocspov/features/how-to-make-friends-with-someone-who-has-autism

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These tips can help you connect with individuals who have ASD:

- **Try to connect.** Social isolation is a big risk for people with ASD. Avoidance makes that worse.
- **Keep an open mind.** Just because a person struggles to connect does not mean they do not want to. Some people with autism are very social and desire friendships just like everyone else.
- **Set aside fears.** Remember that ASD does not automatically make a person aggressive. Meltdowns can happen, but they're often about being overwhelmed. If your ASD acquaintance is visibly agitated, merely give them space and time to calm themselves.
- **Forget social norms and conventions.** Repetitive behaviours, such as hand flapping or noises, are coping mechanisms — nothing to be concerned about. Remember that eye contact may be difficult for an ASD person. Many ASD people use their body — not words — to communicate. Try not to stare when they do unusual things.
- **Look for creative ways to connect.** Ask a caregiver for best practice advice for individuals. Speak at a reasonable pace and volume, and use short sentences. Some children connect with touch, music or animals. Think non-verbal, perhaps pictures or flash-cards. Don't expect an immediate response; it may take time.
- **Be aware of sensitivities.** Some people with autism are hypersensitive to sounds, smells or certain physical sensations. Some are exactly the opposite. Ask a caregiver for advice about making the environment comfortable for the person with ASD.
- **Let people practice.** Reach out and help ASD people practice social interaction. Every child and young adult needs to practice social interaction.
- **Foster awareness.** Remember your reaction to a person with ASD becomes part of how they see themselves and how others see them.
- **Advocate** for more respect and behavioural training supports. Sound the alarm about the lack of services for people, especially once they hit age 18. Take an active stand against bullying and abuse.
- **Be inclusive.** Keep in mind that ASD is complex. Focus on more than just a "cure." Think acceptance and inclusion. Says Iarocci: "It's not the kind of thing you can fix. You need to be understanding. People with ASD just do things differently."

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Appendix 04

When Your Loved One Has Borderline Personality Disorder

PSYCOM | psycom.net

Personality disorders are a unique category in the world of mental illness. While someone with depression or anxiety may feel that they are experiencing symptoms that are different from their normal state, people with personality disorders often fail to realize that their emotions and reactions depart from the typical human experience. People with borderline personality disorder (BPD) struggle to understand how wives, husbands, friends, and other family members experience their intense reactions, mood swings, and risky behavior.

Needless to say, if you have a loved one with BPD, life can be fraught with crises and conflict. You might feel like you're being held hostage, worrying that your family member will injure themselves if you don't appease them. You may wonder whether you should let them borrow money again or answer the dozens of voicemails they left on your phone.

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https://www.psycom.net/personality-disorders/bpd-and-relationships/

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Dealing with borderline personality disorder requires skills for deescalating crises and fostering independence in your loved one. With the right tools and community strategies, it is possible to help your loved one towards recovery.

Signs and Symptoms

Only a doctor or mental health professional can officially provide an official diagnosis of a personality disorder, but there are several key symptoms you can observe that might indicate a person has BPD. These include:

- Intense fear of rejection, separation, or abandonment
- Rapid changes between thinking someone is perfect to believing they are evil
- Risky behaviors including unsafe sex, gambling, drug use, or accumulating credit card debt
- Threats of suicide or self-harm
- Difficulty empathizing with other people
- Mood swings from euphoria to intense shame or self-criticism
- Frequently losing one's temper

Origins and Treatments

Like many other mental illnesses, researchers don't fully understand the origins of the disorder. Some studies suggest that there is a genetic component, meaning the disorder can be hereditary. Hostile family environments, childhood abuse, and neglect, and separation from caregivers can also increase the risk. Some research indicates BPD can emerge when parts of the brain that help regulate emotions and aggressive impulses are not functioning well.

Psychotherapy, otherwise known as talk therapy, can be incredibly valuable for treating BPD. In addition to learning about the signs and symptoms of the disorder, individuals can gain skills for managing difficult emotions, developing and maintaining relationships, reducing impulsive decision-making, and improving daily functioning. The most common typed of psychotherapy used to treat BPD is known as dialectical behavior therapy, or DBT. The therapy helps people change unhealthy patterns of behavior by becoming more mindful about the emotions and reactions they are experiencing at the moment. To date, there are no drugs approved by the FDA that have been specifically created to treat personality disorders. However, some people find that medications can help reduce anxiety or impulsivity in individuals. These might include antidepressants, mood stabilizers, and antipsychotic medications. If an individual with BPD experiences intense symptoms, such as self-injury or physically harming others, they may be in need of inpatient treatment at a hospital or other residential program.

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How should I structure the home environment?

People with BPD benefit from a home environment that is calm and relaxed. All involved family members (including a boyfriend or girlfriend) should know not to discuss important issues when the individual is in crisis mode. Stop to take a breath yourself when they do become emotionally reactive. It's also important to not center all discussions around the disorder and setbacks. Conversely, it's important not to place too much emphasis or praise on progress, or an individual may begin to self-sabotage. People with BPD should have opportunities to talk about their interests and thoughts about the news, family events, and other leisure activities. Take the time to laugh at a funny joke or eat dinner together several times a week. The less an individual feels like his or her mental illness is under the spotlight, the more opportunity they have to explore other aspects of themselves.

How can I communicate effectively during a crisis?

When a loved one becomes reactive, they may become to insult you or make unfair accusations. The natural response is to become defensive and to match the level of reactivity. You have to remind yourself that an individual with BPD struggles to place themselves in a different person's perspective. They struggle to gauge what is a minor issue and what is a full-blown catastrophe. They interpret your defensiveness as not being valued.

Instead, when they become reactive, take the time to listen without pointing out the flaws in their argument. Try not to take it personally. If the person does point out something you could improve or have done wrong, acknowledge their point, apologize, and suggest a way you can improve on the matter in the future. If the individual feels like they're being heard, the crisis is less likely to escalate. However, if the conflict rises to the level where an individual is throwing a full-on tantrum or threatening you, it's best to walk away and resume the conversation when they are calmer.

What if they threaten to hurt themselves?

A crisis is escalating if a person with BPD begins to threaten to harm themselves. Sometimes self-harm signs may be less overt, such as scratching the skin, eating less, coloring or shaving off hair, or isolating themselves from others. These actions represent the person's inability to express their emotions verbally. Recognizing early signs can help prevent an emotional crisis from becoming more serious or requiring medical or psychiatric attention.

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How can I communicate effectively during a crisis?

Be aware that you don't put the idea into someone's head by asking about self-harm or suicide. Instead, you invite the individual to talk about their emotions and allow yourself to gauge whether professional assistance is necessary. All threats of suicide should be taken seriously. Even if the behavior is attention-seeking, it can result in serious harm or even death. However, that doesn't mean you have to call 911 every time an individual speaks about hurting themselves. This sends the message that they have an enormous amount of power over all arguments. Instead, ask your family member what they would feel most comfortable doing when they threaten injury. They might want to speak with their therapist, call a hotline, or walk with you into an emergency room. Allowing them some amount of agency in deescalating a crisis can help calm out of control emotions.

What other strategies can reduce conflict?

Listening and reflecting can be the most effective strategy in communicating with someone with BPD. Though you might disagree with every word that is spoken, listening is not the same as agreeing. It is simply acknowledging a person's emotions and perspective. Ask open-ended questions that encourage them to share, such as "What happened today that caused you to feel this way?" or "Tell me about how your week is going."

Statements of reflection and summarizing can also help an individual feel heard. For example, if your son shares that he thinks you value his sister more than him, you can say, "You feel that we don't love you as much as your sister." The temptation to argue and point out their bias will be present, but just remind yourself that reflecting is not agreeing. This type of communication is not about winning an argument or being right. It's about helping your family member feel heard and de-escalating conflict.

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What can I do when I feel overwhelmed?

Because a family member with BPD may not be able to provide the empathy and self-awareness necessary for a relationship, it's vital to have other supports in your life. Carve out time to spend with friends and engage in leisure activities. If you need to talk about the experience of living with someone with a mental illness, support groups, mental health professionals, religious leaders, and your doctor can be excellent resources. You also should consider how to involve other family members in the care and support of someone with BPD. No single person should be responsible for communicating calmly and responding to crisis situations. The more people who know effective strategies for responding to the individual, the less often crises will erupt.

Will they ever completely recover?

Unlike a physical illness, recovery has a different meaning when it comes to mental health. Recovery does not imply the total elimination of symptoms, the lack of need for medication or therapy, and functioning comparable to persons without the disorder. Recovery from Borderline personality disorder looks like fewer threats of self-harm, reduction of frequency of emotional outbursts, and a decrease in the intensity of reactivity. Relapse may occur, but crises will resolve quickly and you will feel more prepared to handle the situation. In turn, your loved one will feel encouraged to take small but steady steps towards a fuller and healthier life.

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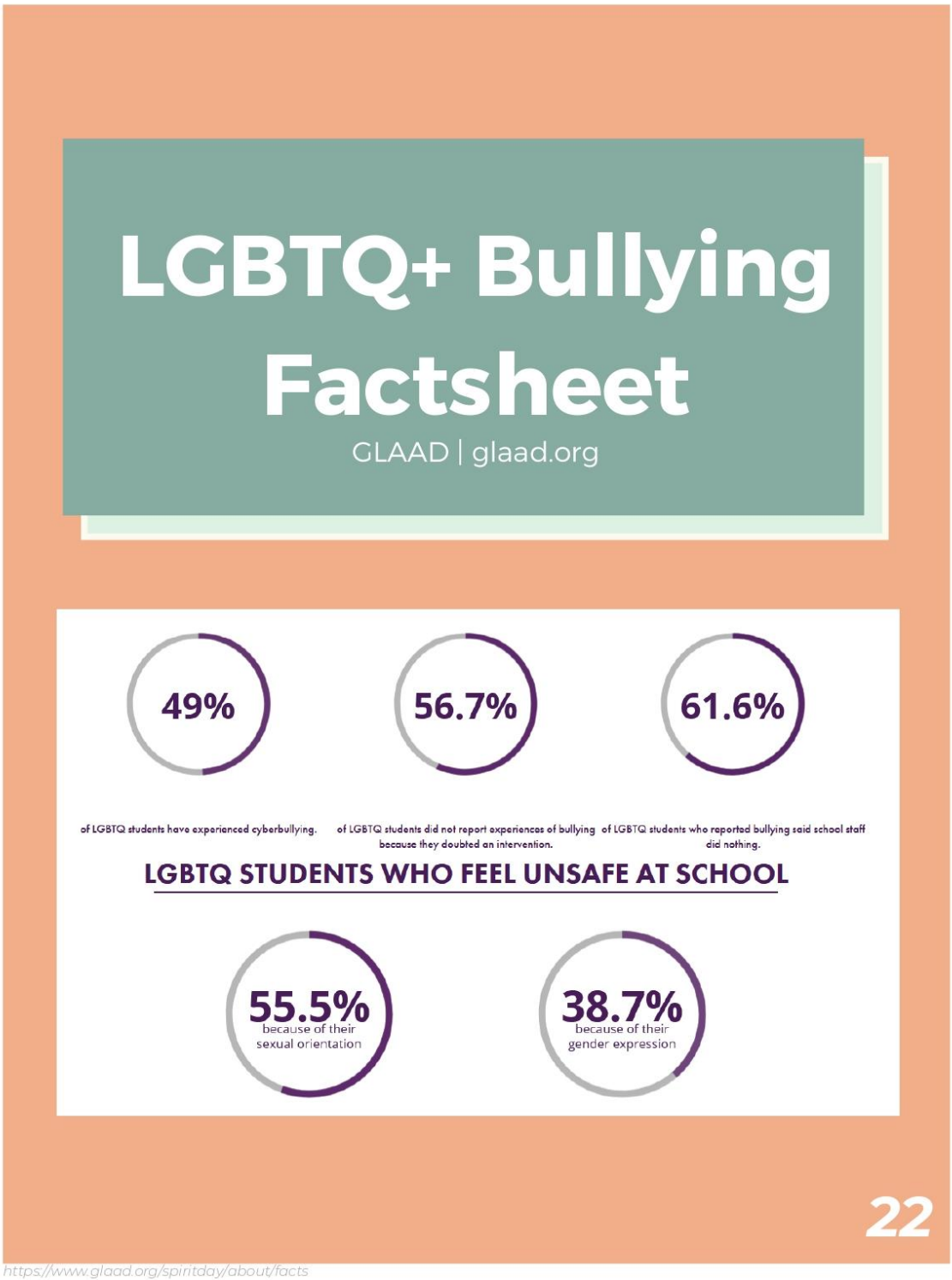

https://www.glaad.org/spiritday/about/facts

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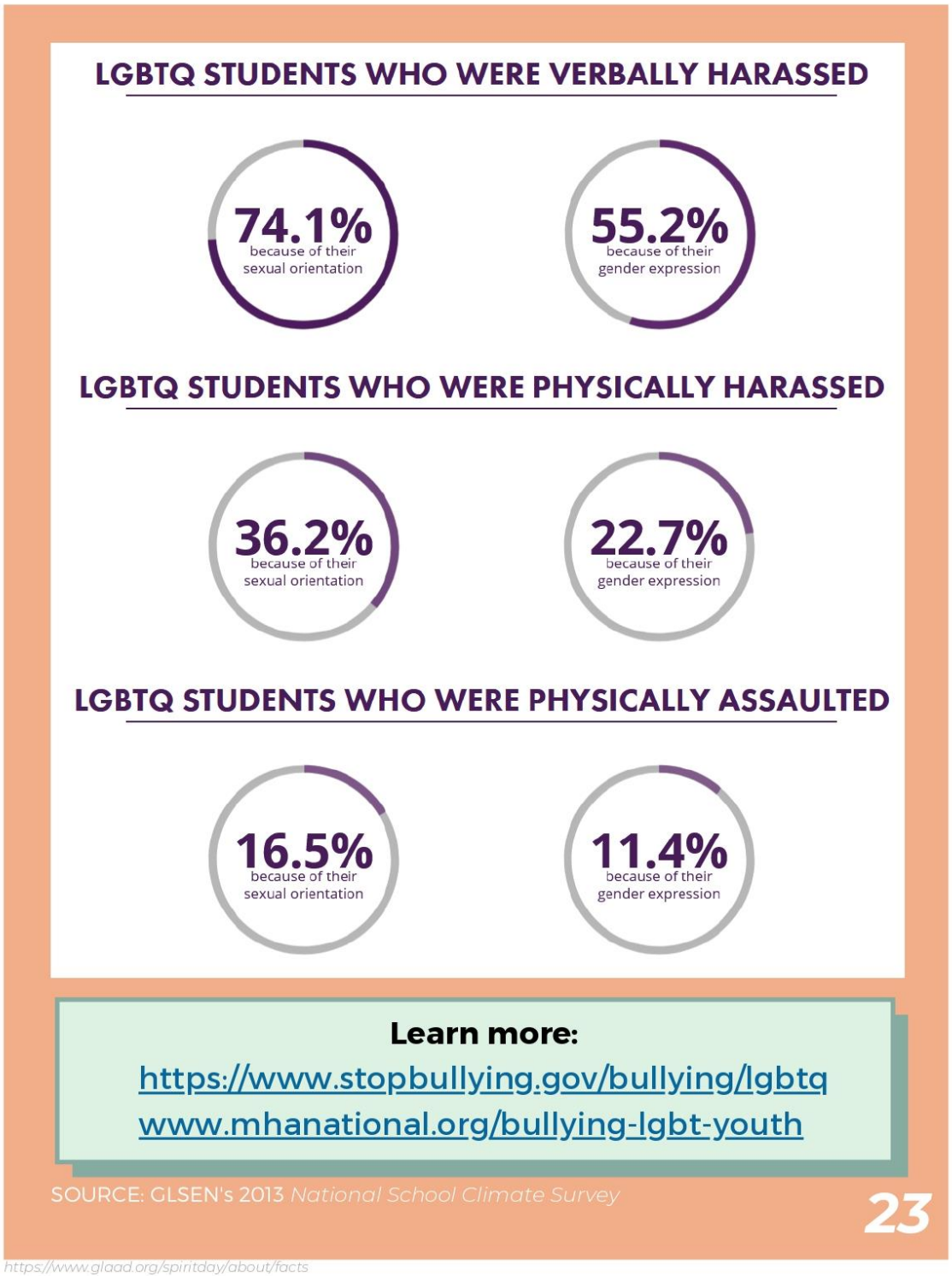

https://www.glaad.org/spiritday/about/facts

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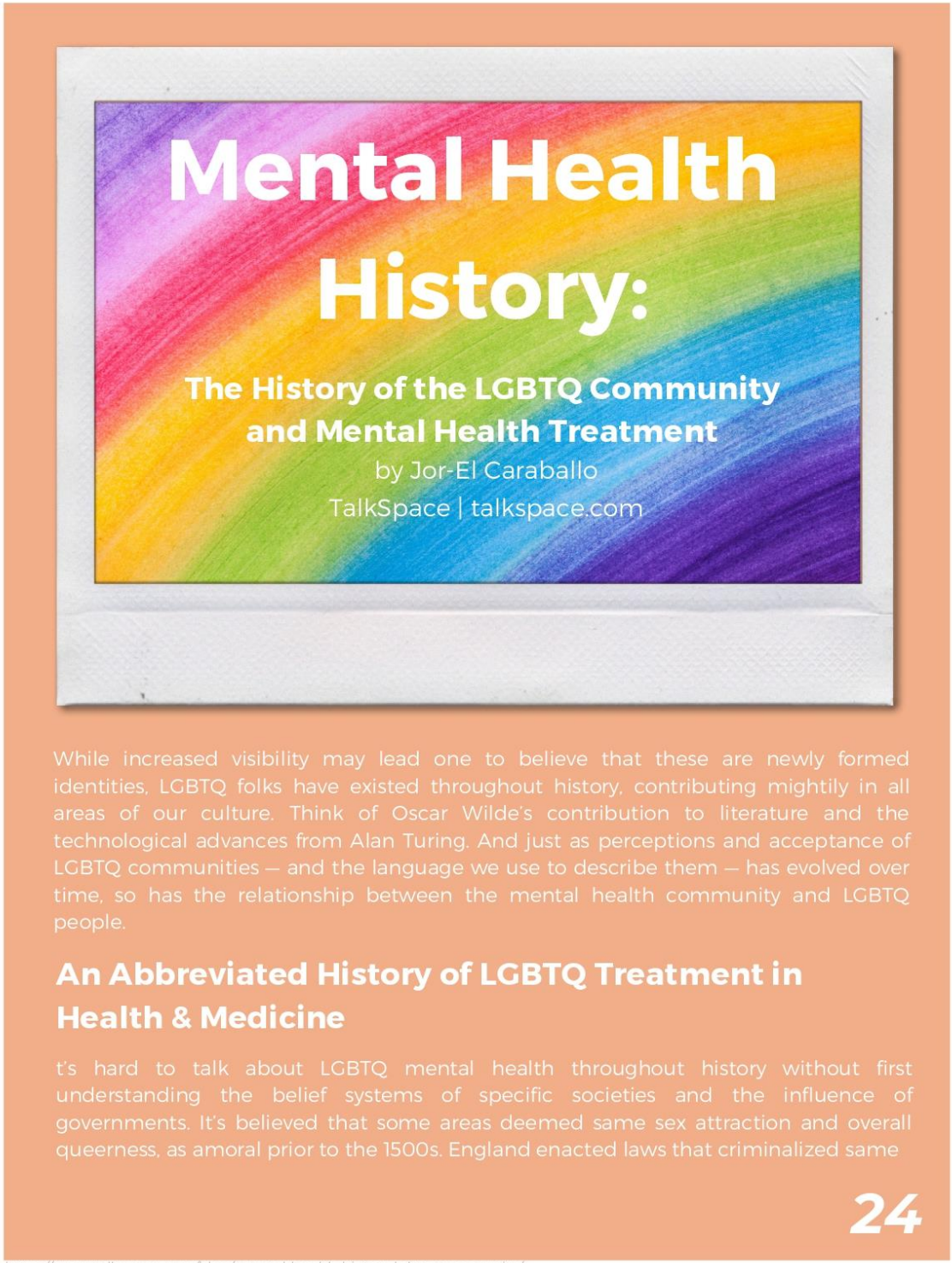

https://www.talkspace.com/blog/mental-health-history-lgbtq-community/

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sex acts and any other sexual behavior that wasn't for the sole purpose reproduction — called "crimes against nature." These sanctions were often passed down from criminal courts or religious entities. The sanctions led to the beginning of religious influence in legislatures, which impacted how the healthcare system viewed the LGBTQ community. Similar laws were brought to the thirteen colonies as the United States was formed.

How LGBTQ identity came to be designated as a mental illness

Depending on who you ask, the motivation for considering LGBTQ identities mental illnesses in the early days of psychology was either intentionally punitive or questionably benevolent. However, there were also those who believed that homosexuality (or overall queerness) was a disorder that could be effectively treated (altered) and therefore queer folks shouldn't be punished for such "crimes against nature." Even if the treatment was in good faith (often times it wasn't), the major problem was that treatment wasn't effective, was most often non-consensual, and resulted in large swaths of the community being traumatized.

Conversion therapy changed the LGBTQ community's relationship with medicine

The medical and psychiatric fields haven't had the best relationship with the LGBTQ community over time, to say the least. The history of this abuse, for the most part, began with a practice that is still in operation today called conversion therapy. Historically many gay or queer folks were subjected to medical experiments designed to help them acclimate to more normative gender and sexual identities. Gay men and lesbians were "treated" so that they would be more attracted to the opposite sex. People with divergent gender identities were tortured into changing their dress and mannerisms to fit into "polite society." Many suffered at the hands of these treatments. The research tells us that those exposed to conversion therapy at the hands of their parents (studies only done on minors at this point) contributes to higher rates of depression, suicide risk and less overall positive outcomes in life.

Effects of these treatments contribute to the LGBTQ community's ongoing fear of medical providers, even more prevalent in people of color and those of lower social classes. As a therapist, it's not uncommon for clients to come to me sharing their negative experiences with doctors or other therapists who weren't affirming of their identities.

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Removing homosexuality's "disorder" designation

An LGBTQ-affirming perspective became more mainstream in the late 1960s and 1970s. During this time, activists and professionals in the field sought to remove homosexuality as a disorder in the widely used Diagnostic and Statistical Manual of Mental Disorders (DSM). These efforts led to homosexuality being removed in the book's second edition in 1973. The removal helped create a more accepting field, yet there are many who still believe that sexual orientation can be changed. A contentious legislative debate also still rages, with more states banning conversion therapy for minors due to limited effectiveness versus a high likelihood of harm.

Ongoing Conversations about Gender

Currently, the field of psychology is still contending with the diagnosis of Gender Dysphoria, which is relatively common among people who may identify as transgender, gender non-conforming, or genderqueer. The World Health Organization has recently removed Gender Dysphoria from their list of mental disorders, as they believe the diagnosis reinforces cultural stigma. The condition remains as "gender incongruence," a different diagnostic code now featured in the ICD's reproductive health section, to ensure that individuals with this experience will still receive life-saving treatments. The conversation about gender dysphoria will no doubt continue in the psychological community as well, with focus on making sure clients have access to care that can be both affirming and accessible.

Current Issues & The Path Forward

Due to issues around family, societal acceptance, and discrimination we see higher rates of mental health conditions, substance abuse, and suicide among those who identify as LGBTQ. LGBTQ+ identified adults are more than twice as likely than heterosexual adults to experience a mental health condition. This means a higher risk of suicidal ideation. This is particularly true for queer people of color, especially black and latinx trans-women. As of June 2019, nine black trans-women have been killed across the United States. As you can imagine, the threat of ongoing violence negatively impacts the mental health and safety of trans-women of color and other queer folks worldwide. That's not to mention that hate crimes have been on the rise over the past several years. Queer folks of color — who live at the intersections of race, class, and sexuality or gender difference — are particularly vulnerable. The constant threat of violence, combined with legally sanctioned discrimination in housing and employment makes the daily lives of LGBTQ folks more difficult. One of the best things that we can do to positively impact the mental health of the LGBTQ community is to become allies in the fight for safety and well-being for all LGBTQ folks, but especially queer people of color. Social acceptance of often marginalized communities can be a beacon of hope, signaling a better and safer future for all.

https://www.talkspace.com/blog/mental-health-history-lgbtq-community/

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Dates to Remember
April
Alcohol Awareness Month
National Autism Awareness Month
Stress Awareness Month
Sexual Assault Awareness and Prevention Month
National Counseling Awareness Month
National Minority Health Month
World Autism Awareness Day (Apr. 2)
National Alcohol Screening Day (Apr. 7)
National Stress Awareness Day (Apr. 18)
Day of Silence (Apr. 24)
May
Mental Health Month
Borderline Personality Disorder Awareness Month
National Mental Health Counseling Week (May 6-12)
National Prevention Week (May 11-17)
World Maternal Mental Health Day (May 6)
National Children's Mental Health Awareness Day (May 9)
June
LGBTQ Pride Month
PTSD Awareness Day (Jun. 7)
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Resources

DRUG & ALCOHOL SERVICES

SAN LUIS OBISPO ADULT
2180 Johnson Ave.,
San Luis Obispo, CA 93401
805-781-4275

SAN LUIS OBISPO YOUTH
277 South St., Suite T,
San Luis Obispo, 93401
805-781-4754

PASO ROBLES YOUTH AND ADULT
1763 Ramada Drive
Paso Robles, CA 93446
805-226-3200

ATASCADERO YOUTH AND ADULT
5575 Hospital Drive
Atascadero, CA 93422
805-461-6080

PREVENTION & OUTREACH
277 South St.,
San Luis Obispo, CA 93401
805-781-4754

MENTAL HEALTH SERVICES

SAN LUIS OBISPO YOUTH 0-5 MARTHA'S PLACE CHILDREN'S ASSESSMENT CENTER
2925 McMillan Avenue
San Luis Obispo, CA 93401
805-781-4948

SAN LUIS OBISPO YOUTH
1989 Vicente Avenue
San Luis Obispo, 93401
805-781-4179

SAN LUIS OBISPO ADULT
2178 Johnson Avenue
Paso Robles, CA 93446
805-781-4700

SAN LUIS OBISPO PSYCHIATRIC HEALTH FACILITY
2178 Johnson Avenue
San Luis Obispo, CA 93401
805-781-4711

ARROYO GRANDE YOUTH
345 S. Halcyon,
Arroyo Grande, CA 93420
805-473-7060

ARROYO GRANDE ADULT
1350 East Grand Avenue
Arroyo Grande, CA 93420
805-474-2154

ATASCADERO YOUTH AND ADULT
5575 Hospital Drive
Atascadero, CA 93422
805-461-6060

SERVICES AFFIRMING FAMILY EMPOWERMENT (SAFE)
1086 Grand Avenue
Arroyo Grande, CA 93420
805-474-2105

RESOURCES IN THE COMMUNITY

TRANSITIONS-MENTAL HEALTH ASSOCIATION
784 High St.,
San Luis Obispo, CA 93401
805-540-6500

COMMUNITY ACTION PARTNERSHIP OF SAN LUIS OBISPO (CAPSLO)
1030 Southwood Dr.,
San Luis Obispo, 93401
805-544-4355

THE LINK FAMILY RESOURCE CENTER
6500 Morro Rd. #A
Atascadero, CA 93422
805-466-5404

CENTER FOR FAMILY STRENGTHENING (CFS)
3480 Higuera St., Suite 100
San Luis Obispo, CA 93401
805-543-6216

STAND STRONG NOW
51 Zaca Lane, Suite 150
San Luis Obispo, CA 93401
805-781-6400

WILSHIRE COMMUNITY SERVICES
285 South St., Suite J
San Luis Obispo, CA 93401
805-547-7025

COMMUNITY COUNSELING CENTER
1129 Marsh St.,
San Luis Obispo, CA 93401
805-543-7969

FAMILY CARE NETWORK
1255 Kendall Rd.,
San Luis Obispo, CA 93401
805-781-3535

RESPECT, INSPIRE, SUPPORT, EMPOWER (RISE)
LGBTQ Healthy Relationship Support Group
805-226-6791

ACCESS SUPPORT NETWORK (ASN)
1320 Nipomo St.,
San Luis Obispo, CA 93401
805-781-3660

GAY AND LESBIAN ALLIANCE (GALA) OF THE CENTRAL COAST
805-541-4252

TRANZ-CENTRAL COAST
SLO & North County Support Groups
805-242-3821

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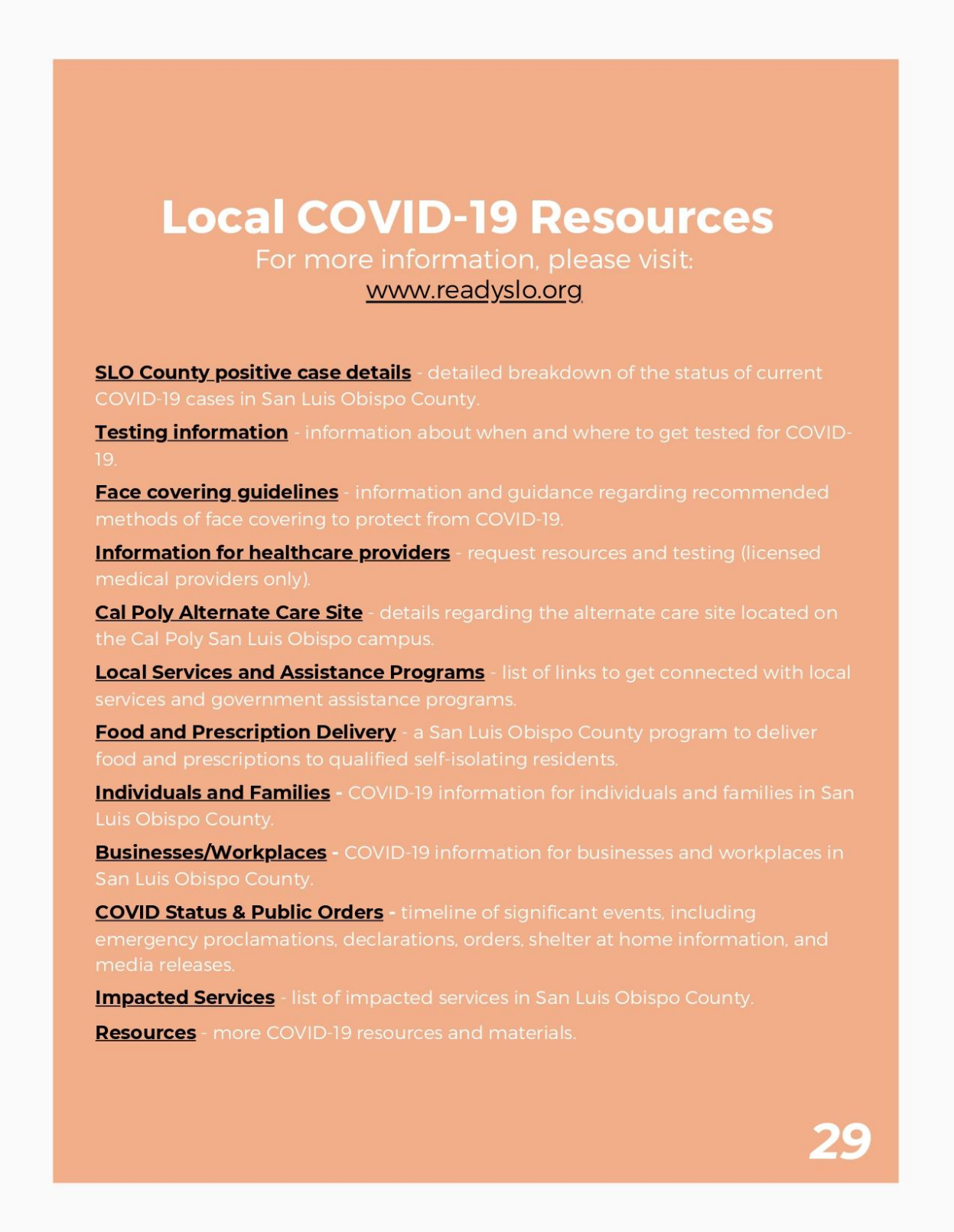
Local COVID-19 Resources
For more information, please visit:
www.readyslo.org
SLO County positive case details - detailed breakdown of the status of current COVID-19 cases in San Luis Obispo County.
Testing information - information about when and where to get tested for COVID-19.
Face covering guidelines - information and guidance regarding recommended methods of face covering to protect from COVID-19.
Information for healthcare providers - request resources and testing (licensed medical providers only).
Cal Poly Alternate Care Site - details regarding the alternate care site located on the Cal Poly San Luis Obispo campus.
Local Services and Assistance Programs - list of links to get connected with local services and government assistance programs.
Food and Prescription Delivery - a San Luis Obispo County program to deliver food and prescriptions to qualified self-isolating residents.
Individuals and Families - COVID-19 information for individuals and families in San Luis Obispo County.
Businesses/Workplaces - COVID-19 information for businesses and workplaces in San Luis Obispo County.
COVID Status & Public Orders - timeline of significant events, including emergency proclamations, declarations, orders, shelter at home information, and media releases.
Impacted Services - list of impacted services in San Luis Obispo County.
Resources - more COVID-19 resources and materials.
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Useful Tips for Assisting Individuals with Hearing Loss

In an effort to keep people with hearing loss safe when visiting a medical facility and when everyone is wearing a mask, we have the following suggestions.

- Be patient
- Speak slowly and clearly, be prepared to repeat
- Enunciate
- Don't drop your voice at the end of a sentence
- Allow patients to bring someone to interpret, if possible
- Use a whiteboard
- Written instructions are always helpful
- Masks with a clear view of your mouth can be ordered from https://safenclear.com/product/communicator-box/

If you would like more information on supporting individuals with hearing loss, please refer to these resources:

https://www.nad.org/wp-content/uploads/2020/03/COVID-19-Hospital-Communications-Access-1.pdf

https://www.nad.org/covid19-communication-medical-access-for-deaf-hard-of-hearing/

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Appendix 04


Cultural Competence Committee
COUNTY of SAN LUIS OBISPO
County of San Luis Obispo Health Agency

Appendix 04

Diversity, Equity & Inclusion Manager Areas of Responsibility
FY 2020-2021

The Diversity, Equity & Inclusion Program Manager (DEIPM), which is known as Cultural Competence Coordinator or Ethnic Services Manager in other counties, promotes and monitors quality and equitable care as it relates to diversity, equity, and inclusion regarding racial, ethnic and cultural populations served by both county-operated and contracted behavioral health programs.

County DEIPMs are key members of the executive leadership team with a sustained and meaningful role in helping shape the county service delivery system in a way that advances health equity and cultural responsiveness. The Behavioral Health Director recognizes the essential role and function within the organization and allocates sufficient time and resources for the performance of job responsibilities and duties.

The importance of the CC/ESM position necessitates individuals with a level of expertise and professionalism that leads to results – better services and outcomes for diverse racial, ethnic and cultural populations experiencing health disparities. One approach to achieving this level of expertise and professionalism is to build on the strengths of existing staff members, address barriers and enhance their capacity to be effective.

The recommended qualifications include the following:

- Professional education (meeting county manager level requirements) in relevant fields like sociology, psychology, public health, public policy, ethnic studies, and healthcare administration
- Training and/or experience in areas pertaining to equity, community engagement and program and staff management
- A proven track record of demonstrating understanding and application of cultural humility, awareness and competence
- Knowledge of best practices for tracking and addressing disparities
- Demonstrated capacity to interact with individuals from various diverse communities with respect and commitment
- Demonstrated understanding of the impact of differing world views on the experience of mental health and substance use disorders, help-seeking behaviors and the conceptualization of what is appropriate care
- Demonstrated understanding of key drivers of system change and an ability to effectuate organizational change
- Demonstrated ability to effectively identify and collaborate with diverse community-focused service and civic organizations including faith communities, youth and senior organizations, business owners and social service providers

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The scope of duties varies by county due to size and available resources. Some DEIPMs have multiple overlapping job responsibilities and may need the support of other staff members who take shared ownership of these responsibilities.

In all counties, the DEIPM is an essential resource for helping the county to meet a growing number of local, state and federal cultural competence requirements. DEIPMs regularly review service utilization data, actively participate in local behavioral health planning and projects that respond to the needs of the county's diverse racial, ethnic and cultural populations, and review and comment on numerous major state policy and legislative proposals that would impact those populations.

Since counties are increasingly being held accountable for performance, DEIPMs offer more to the county than just being the designated person to complete any paperwork relating to cultural competence. Counties should designate the following responsibilities to the DEIPM and designated staff members (in small counties these duties are often divided among administrative team members; in large counties, they may be shared among a team led by the DEIPM):

- Participating as an official member of the local behavioral health management/leadership team that makes programs and procedural policy recommendations to the Behavioral Health Director
- Participating and providing advice in planning, policy, compliance and evaluation components of the county system of care and making recommendations to county Directors that assure access to services or ethnically and culturally diverse groups
- Promoting the development of responsive behavioral health services that will meet the diverse needs of the county's racial, cultural and ethnic populations. This includes, but is not limited to, reviewing local proposals to augment or decrease services to the local community, participating organizational units within and outside the local behavioral health department
- Participating in the development and implementation of local policies and procedures that would potentially impact services for racially, ethnically and culturally diverse consumers
- Reviewing and providing feedback to the county Director on materials generated at the State and local levels, including but not limited to, proposed legislation, State plans, policies and other documents
- Monitoring of county and service contractors to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations
- Identification of local and regional cultural behavioral health need of ethnic and culturally diverse populations as they impact county systems of care and making recommendations to local Behavioral Health Directors, CBHDA and the State Department of Health Care Services.

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- Working with the county's Quality Improvement team, tracking penetration and retention rates and outcome data for racially, ethnically and culturally diverse populations, and developing strategies to eliminate disparities
- Participating in the cultivation and maintenance of relationships with cultural, racial, ethnic community leaders and cultural-specific community organizations to promote an array of behavioral health programs and activities that are specific to underserved populations
- Maintaining an active advocacy, consultative and supportive relationships with consumer and family organizations, local planning boards, advisory groups and task forces, the State and other behavioral health advocates
- Working with the county's Human Resources office to help ensure that the workforce is ethnically, culturally and linguistically diverse. Assisting the Equal Employment Opportunity Office to ensure the recruitment, retention and upward mobility of staff
- Assisting in the development of system-wide training that addresses enhancement of workforce development and addressing the training necessary to improve quality of care for all communities and reduce behavioral health disparities
- Lead responsibility for the development and implementation of cultural competence planning within the organization
- Attending trainings that inform, educate and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the behavioral health system
- Attending meetings as required by the position including, but not limited to, CBHDA CCESJC, Full Association and other committee meetings, regionaL regular meetings, various State meetings, meetings convened by various advisory bodies and other meetings as appropriate
- Establishing and continuing operation of a Bilingual Certification Committee (BCC); the BCC shall be comprised of the DEIPM and two bilingual staff members, at least two of whom is a native speaker of the threshold languages within the county
- Developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification
- Developing an evaluation checklist that includes: fluency, the ability to communicate with ease (verbally and non-verbally,) depth of vocabulary including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language question, grammar, and cultural considerations related to a potential client
- Conducting the certification process of a candidate with the BCC

Appendix 05

Medical Necessity

California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

"The beneficiary must meet criteria outlined in (1,) (2) and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
   - (A) Pervasive Developmental Disorders, except Autistic Disorders
   - (B) Disruptive Behavior and Attention Deficit Disorders
   - (C) Feeding and Eating Disorders of Infancy and Early Childhood
   - (D) Elimination Disorders
   - (E) Other Disorders of Infancy, Childhood, or Adolescence
   - (F) Schizophrenia and Other Psychotic Disorders
   - (G) Mood Disorders
   - (H) Anxiety Disorders
   - (I) Somatoform Disorders
   - (J) Factitious Disorders
   - (K) Dissociative Disorders
   - (L) Paraphilia
   - (M) Gender Identity Disorder
   - (N) Eating Disorder
   - (O) Impulse Control Disorders Not Elsewhere Classified
   - (P) Adjustment Disorders
   - (Q) Personality Disorders, excluding Antisocial Personality Disorder
   - (R) Medication-Induced Movement Disorders related to other included diagnoses

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
   - (A) A significant impairment in an important area of life functioning.
   - (B) A probability of significant deterioration in an important area of life functioning.
   - (C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:
   - (A) The focus of the proposed intervention is to address the condition identified in (2) above.

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(B) The expectation is that the proposed intervention will:
    i. Significantly diminish the impairment, or
    ii. Prevent significant deterioration in an important area of like functioning, or
    iii. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
(C) The condition would not be responsive to physical health care-based treatment."

Section 18310.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age

(a) "For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3,) medical necessity criteria for specialty mental health services covered by this chapter shall be met when all of the following exist:
    (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1,)
    (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
    (3) The requirements of Title 2, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met."

Appendix 06

CSS Work Plan	CSS Sub Plan	Program	Program Description
1. FSP Child/Youth	1	Children and Youth Full Service Partnership (FSP)	The Children and Youth Full Service Partnership program serves children and youth ages 0-15 of all races and ethnicities with severe emotional disturbance or serious mental illnesses. Behavioral Health partners with Family Care Network to provide a wide array of culturally and linguistically appropriate services. All services are family driven and may include: individual and family therapy; rehabilitation services focusing on activities for daily living, social skill development, case management; crisis services; and medication supports.
2. FSP TAY	2	Transitional Aged Youth (TAY) Full Service Partnership (and Housing)	The Transitional Age Youth Full Service Partnership program serves youth between the ages of 16-25 of all races and ethnicities. Young adults served include those with serious emotional disturbances/serious mental illness and a chronic history of psychiatric hospitalizations; law enforcement involvement; co-occurring disorders. Behavioral Health and Family Care Network collaborate to provide wrap-like services and includes 24/7 crisis availability, intensive case management, housing, employment linkages and supports, independent living skill development and specialized services for those with a co-occurring disorder.
3. FSP Adult	3	Adult Full Service Partnership	The Adult Full Service Partnership team is a community and wellness approach to engage persons at risk and targets adults 26-59 years of age with serious mental illness. The participants are usually unserved, inappropriately served or underserved and are at risk of institutional care because their needs are difficult to meet using traditional methods. They may be frequent users of hospital or emergency room services, involved with the justice system or suffering with a co-occurring substance abuse disorder. Behavioral Health partners with Transitions Mental Health Association to provide a full range of services including assessment, individualized treatment planning, case management, integrated co-occurring treatment, medication supports, housing, and integrated vocational services to enable individuals to remain in the community, and live full, productive, self-directed lives.

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	3	Adult Full Service Partnership: Homeless Outreach Team	The team focuses on outreach to unserved, difficult-to-reach homeless population, and seeks to engage clients in health care, mental health treatment, and housing. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence.
	3	Adult Full Service Partnership: AOT	The Adults in Assisted Outpatient Treatment includes AOT outreach and treatment services provided by a FSP team comprised of TMHA staff. SLOBHD staff provide assessment, program support and coordination with the court. The services offered to AOT clients include co-occurring treatment to address both mental health and substance use disorder needs, rehabilitation services to assist clients in learning and utilizing skills to improve self-care, social support system, and health, and intensive case management to support clients in accessing housing, financial, vocational, health care, and social support services, including voluntary mental health services.
	3	FSP AOT Intensive Residential Housing	This program provides supported housing with Intensive Residential Case Management services for adults with mental illness and operates in conjunction with Adult Assisted Outpatient Full Service Partnership Team services. Intensive Residential Services consists of independent living with external supports and includes evening and weekend (40 hours/week) case management coverage
	3	FSP Adult Intensive Residential Housing	This program provides supported housing with Intensive Residential Case Management services for adults with mental illness and operates in conjunction with FSP program services. Intensive Residential Services consists of independent living with external supports and includes evening and weekend (40 hours/week) case management coverage
	3	FSP Adult Intensive Residential Case Management Services	Program provides intensive residential management services to the 33 bed FSP Adult Intensive Residential Housing Program and 8 units at the Nipomo Street Studios. This program provides intensive case management services to assist the clients in developing problem solving skills related to

			daily living, housing, managing chronic symptoms of illness, decreasing psychiatric hospitalizations and employment. Case management activities also include assisting residents with cooking, cleaning, conflict resolution, budgeting, socialization and community integration
	3	FSP Homeless Housing Component	FSP Homeless Housing Component shall provide stable, supportive housing for individuals participating in the FSP program dedicated to homeless individuals. TMHA operates a 4-bed housing program in the city of San Luis Obispo for clients in the Homeless FSP program.
4. FSP Older Adult	4	Older Adult Full Service Partnership	The goal of the Older Adult Full Service Partnership team is to offer intensive, individualized interventions to older adults ages 60+ to ensure that participants remain in the least restrictive setting possible. Behavioral Health partners with Wilshire to provide client driven services to Older Adults who are at risk of inappropriate or premature out-of-home placement due to a serious mental illness and, in many instances, co-occurring medical conditions that impact their ability to remain in home/community environments.
Housing	Housing	Nelson St Studios	Studios were constructed and continue to be administered by Transitions Mental Health Association. Studios were constructed and continue to be administered by Transitions Mental Health Association. These five studio units are in South San Luis Obispo County adjacent to a peer-lead wellness center. The studio apartments provide stable and affordable housing with supports to assist low and very low-income clients in promoting whole life wellness. Crisis services are available as needed.
		Nipomo St Studios	Studios were constructed and continue to be administered by Transitions Mental Health Association. This MHSA housing project provides 8 units to serve adults who are homeless or at risk of homelessness and have a diagnosis of severe mental illness, consistent with the CSS Plan and the MHSA definition of target population. Those with co-occurring disorders are also considered for residency in a unit.

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5. Client and Family Wellness	5.1	Client & Family Partners Adult Family Advocates and Youth Family Partners (TMHA)	Conducted in partnership with Transitions Mental Health Association (TMHA), Adult Family Advocates and Youth Family Partners is a liaison with family members, care givers, consumers, local NAMI groups, and other service providers in San Luis Obispo County. This program provides support, education, information and referral, and community outreach for families of adults with psychiatric disabilities and children in care. Assist in orientation of new families entering the mental health system and develop programs that strengthen parent to parent support.
	5.2	Dual Diagnosis	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Located in every adult outpatient clinic, caseload reduction therapists and co-occurring specialists facilitate a “no wrong door” approach and ensure that every participant receives appropriate services regardless of how they enter the system.
	5.3	Family Education Program	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Trained family members provide education and support and orientation class that provides information regarding services available in our community including housing and supported employment, promoting self-care and help with navigating through the mental health system.
	5.4	Service Enhancement Team	Conducted in partnership with Transitions Mental Health Association (TMHA), Behavioral health navigators will help clients, their families, loved ones, and caregivers navigate through the first steps of receiving services, help assess needs, and engage services for basic necessities within the clinic setting.
	5.4	Martha's Place SET	Behavioral health navigators will help clients, their families, loved ones, and caregivers navigate through the first steps of receiving services, help assess needs, and engage services for basic necessities within the clinic setting. This clinician is housed at Martha's Place.

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	5.5	Peer Support & Education Peer to Peer Program (TMHA)	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA provide peer mentoring, peer and family educational and support groups focused on wellness, recovery and resilience. Peer to Peer and Family to Family education coursed are delivered throughout the County
	5.6	Supportive Employment and Vocational Training	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA partners with Department of Rehabilitation to provide employment readiness classes, on the job training, and job placement.
	5.6	Growing Grounds Retail	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. TMHA provides vocational training, support and direct work experience in their retail outlet store. The program offers job coaching, assessment, vocational support and work experience.
	5.7	Integrated Case Management	These integrated access therapists allow clinic staff to spend more time with outpatient clients, providing more resources and referrals, groups, system navigation, and wellness activities within the traditional structure of mental health services.
	5.7	Integrated Case Management: Martha's Place	This integrated access therapist allows clinic staff to spend more time with outpatient clients, providing more resources and referrals, groups, system navigation, and wellness activities within the traditional structure of mental health services. The position will continue to serve the community, to increase access and triage those clients with needs outside of the child's assessment center.
	5	Wellness Centers	Conducted in partnership with Transitions Mental Health Association (TMHA), Client and Family Wellness and Supports provides an array of services designed to facilitate and support wellness, recovery, and resiliency. Peer driven wellness centers offer support groups, socialization activities and sponsored educational activities in comfortable, welcoming settings throughout the county.

6. Latino Outreach Program	6	Latino Outreach and Engagement (LOP: Therapy Services)	Bilingual and bicultural therapists to provide culturally appropriate treatment services offered in both community and clinic settings. The target population is the unserved and underserved Latino community, particularly those in identified pockets of poverty in the north and south county areas and rural residents.
7. Enhanced Crisis and Aftercare	7.1	Mental Health Evaluation Team (MHET) & Crisis Response Team (CRT)	The Enhanced Crisis Response and Aftercare work plan features the Mobile Crisis team, and the new clinic-based Crisis Resolution Team (**funded as part of an SB 82 grant**), to increase the county's capacity to meet the needs of individuals requiring specialized, critical intervention and aftercare. The goal and objectives of the work plan include the aim to increase access to emergency care, prevent further exacerbation of mental illness, and be available to all county residents, across all age, ethnic and language groups. Additional to this work plan is a Crisis Mental Health Therapist assigned to coordinate efforts between emergency rooms, law enforcement, jails, the local Hotline, and inpatient psychiatric health facility.
	7.2	Crisis Stabilization Unit (CSU)	The Crisis Stabilization is a 23 hr. stay unit that is in place for crisis intervention, assessment, evaluation, collateral, medication support services, therapy, peer support, etc. to avoids unnecessary hospitalization and incarceration while improving wellness for individuals with mental health disorders and their families.
8. School and Family Empowerment	8.1	Community Schools	Behavioral Health and the San Luis Obispo County Office of Education have partnered with the community schools in the county to provide mental health services to seriously emotionally disturbed youth, engaging these youths and their families in services that enable them to stay in school. A separate team concentrates on students within the county's largest school district (Lucia Mar Unified) in the diverse, southern region of the county. This team provides an intense-but-brief engagement, focusing on family, school, and socialization outcomes.
	8.2	Family Empowerment (SAFE)	Behavioral Health and the San Luis Obispo County Office of Education have partnered with the community schools in the county to provide mental health services to seriously emotionally disturbed youth, engaging these youths and their families in services that enable them to stay in school. A

			separate team concentrates on students within the county's largest school district (Lucia Mar Unified) in the diverse, southern region of the county. This team provides an intense-but-brief engagement, focusing on family, school, and socialization outcomes.
9. Froensic Mental Health Services	9.1	Behavioral Health Treatment Court (BHTC)	The BHTC team serves adults, ages 18 and older, with a serious and persistent mental illness, who are on formal probation for a minimum of two years, and who have had chronic use of mental health treatment observed as a factor in their legal difficulties. BHTC clients volunteer for the program forming a contractual agreement as part of their probation orders. These individuals have been previously underserved or inappropriately served because of lack of effective identification by all systems, may be newly diagnosed, or may have been missed upon discharge from jail or Atascadero State Hospital. BHTC clients, in many cases, have little insight or understanding about having a mental illness or how enhanced collaborative services could meet their needs.
	9.2	Forensic Re-Entry Services (FRS)	A Forensic Re-entry Services (FRS) team, comprised of community-provided Personal Services Specialists (PSS) provides a "reach-in" strategy in the County Jail, adding capacity for providing aftercare needs for persons exiting from incarceration. The Forensic PSS is provided in partnership with TMHA and is responsible for providing a "bridge" for individuals leaving the jail in the form of assessment and referral to all appropriate health and community services and supports in addition to short-term case management during this transition.
	9.3a	Veterans Treatment Court (VTC)	Behavioral Health has a Mental Health Therapist located in the Veterans Services Office to serve veterans referred directly from the and those participating in the Veterans Treatment Court. The placement of the Therapist on-site at the VSO provides a culturally competent environment for veterans and their families to seek support and engage in behavioral health services.
	9.3b	Veterans Program	Behavioral Health has a Mental Health Therapist that provides individual, couple, family and group treatment services to veterans and their families during participation in the veterans' outreach program as well as monitors progress with other treatment providers.

	9.4	Forensic Coordination Therapist (FCT)	The FCT, in partnership with a Sheriff's Deputy assigned to the team, assists law enforcement with difficult, mental illness-related cases. The team works closely with all local law enforcement and court personnel in training and case management issues to reduce crisis.
	9.5	Community Action Team (CAT)	A behavioral health care professional shall be embedded within a municipal police department to respond directly to individuals experiencing behavioral health crises who are or in need of outreach and engagement. The behavioral health professional (CAT Community Liaison) shall work closely with highly trained officers establishing a new behavioral health unit within the SLO police department (SLOPD) focused on homeless, transient, and other high-risk individuals.

Appendix 07

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	0	0	0							
Case Manager/Service Coordinator	2.0	0	4.0							
Employment Services Staff	0	0	0							
Housing Services Staff	0	0	0							
Consumer Support Staff	1.0	0	2.0							
Family Member Support Staff	0	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	1.0	0	2.0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ↓						
Sub-total, A (County)	**4.0**	**0**	**8.0**	**3.0**	**1.0**	**0**	**0**	**0**	**0**	**4.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	60.4	1.0	120.8							
Case Manager/Service Coordinator	29.5	0	59.0							
Employment Services Staff	5.5	0	11.0							
Housing Services Staff	19.3	1	38.6							
Consumer Support Staff	16.0	0	32.0							
Family Member Support Staff	6.0	1.0	12.0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	22.0	1.0	44.0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ↓						
Sub-total, A (All Other)	**158.7**	**4.0**	**317.4**	**115**	**31.7**	**7**	**2**	**1**	**2**	**158.7**
Total, A (County & All Other):	**162.7**	**4.0**	**325.4**	**118**	**32.7**	**7**	**2**	**1**	**2**	**162.7**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	10.0	1.0	20.0							
Psychiatrist, child/adolescent	1.0	1.0	2.0							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	4.0	1.0	8.0							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	34.0	0	68.0							
Licensed Clinical Psychologist	3.0	0	6.0							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	11.0	1.0	22.0							
MSW, registered intern (or waivered)	2.0	1.0	4.0							
Marriage and Family Therapist (MFT)	35.0	0	70.0							
MFT registered intern (or waivered)	12.0	0	24.0							
Other *Licensed* MH Staff (direct service)	1.0	0	2.0	(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ↓						
Sub-total, B (County)	**113.0**	**5.0**	**226**	**86**	**7**	**1**	**2**	**0**	**2**	**98**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	0	0	0							
Psychiatrist, child/adolescent	0	0	0							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	0	0	0							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	5.5	0	0							
Licensed Clinical Psychologist	3.0	0	6							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	2.5	0	4							
MSW, registered intern (or waivered)	2.0	0	0							
Marriage and Family Therapist (MFT)	18.4	0	22							
MFT registered intern (or waivered)	12.8	0	2	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ↓						
Other *Licensed* MH Staff (direct service)	0	0	0							
Sub-total, B (All Other)	**44.2**	**3.0**	**88.2**	**38.2**	**4.5**	**1.5**	**0**	**0**	**0**	**44.2**
Total, B (County & All Other):	**157.2**	**8.0**	**314.2**	**124.2**	**11.5**	**2.5**	**2.0**	**0**	**2.0**	**142.2**

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EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	1.0	0	2.0							
Registered Nurse	8.0	1.0	16.0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ↓						
Sub-total, C (County)	**9.0**	**1.0**	**18.0**	**9.0**	**0**	**0**	**0**	**0**	**0**	**9.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0	0	0							
Registered Nurse	1.5	1.0	3.0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0	(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ↓						
Sub-total, C (All Other)	**1.5**	**1.0**	**3.0**	**1.5**	**0**	**0**	**0**	**0**	**0**	**1.5**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor	7.0	0	14.0							
Supervising psychiatrist (or other physician)	1.0	0	2.0							
Licensed supervising clinician	7.0	0	14.0							
Other managers and supervisors	2.0	1	4.0	(Managerial and Supervisory; Sub-Totals Only) ↓						
Sub-total, D (County)	**17.0**	**1**	**34.0**	**15.0**	**1.0**	**0**	**0**	**0**	**1.0**	**17.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	11.0	1.0	14.0							
Supervising psychiatrist (or other physician)	0.5	1.0	1.0							
Licensed supervising clinician	7.5	1.0	4.0							
Other managers and supervisors	22.0	2.0	14.0	(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Sub-total, D (All Other)	**41.0**	**5.0**	**33.0**	**40.5**	**0**	**0**	**0**	**0**	**.5**	**41.0**
Total, D (County & All Other):	**58.0**	**6.0**	**67.0**	**55.5**	**1.0**	**0**	**0**	**0**	**1.5**	**58.0**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	**3.0**	**0**	**6.0**							
Education, training, research	**1.0**	**1.0**	**2.0**							
Clerical, secretary, administrative assistants	**28.0**	**0**	**56.0**							
Other support staff (non-direct services)	**11.0**	**0**	**22.0**	(Support Staff; Sub-Totals Only) ↓						
Sub-total, E (County)	**43.0**	**1.0**	**86.0**	**37.0**	**6.0**	**0**	**0**	**0**	**0**	**43.0**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	**10.5**	**0**	**4.0**							
Education, training, research	**4.0**	**0**	**2.0**							
Clerical, secretary, administrative assistants	**13.8**	**0**	**4.0**							
Other support staff (non-direct services)	**8.8**	**0**	**1.0**	(Support Staff; Sub-Totals and Total Only) ↓						
Sub-total, E (All Other)	**37.2**	**0**	**11.0**	**30.4**	**6.0**	**0**	**0.8**	**0**	**0**	**37.2**
Total, E (County & All Other):	**80.1**	**1.0**	**97.0**	**67.4**	**12**	**0**	**0.8**	**0**	**0**	**80.2**

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EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

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

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).....**	**186.0**	**8.0**	**372.0**	**150.**	**15.0**	**1.0**	**2.0**	**0**	**3.0**	**171.0**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) .....**	**282.5**	**13**	**452.6**	**225. 6**	**42.2**	**8.5**	**2.8**	**1.0**	**2.5**	**282.5**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**468.5**	**21**	**824.6**	**375. 6**	**57.2**	**9.5**	**4.8**	**1.0**	**5.5**	**453.5**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**3382**	**684**	**131**	**50**	**49**	**113**	**4409**
G. TOTAL % PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**77.%**	**16%**	**3.0%**	**1.0%**	**1.0%**	**2.0%**	**100%**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff.....	7.0	0	7.0
Family Member Support Staff	6.0	1.0	6.0
Other *Unlicensed* MH Direct Service Staff.....	4.0	0	0
Sub-Total, A:	**17.0**	**1.0**	**13**
B. *Licensed* Mental Health Staff (direct service).....	**16.2**	**0**	**0**
C. Other Health Care Staff (direct service)	**0**	**0**	**0**
D. Managerial and Supervisory.....	**10.5**	**1.0**	**2.0**
E. Support Staff (non-direct services).....	**25.3**	**0**	**0**
GRAND TOTAL (A+B+C+D+E)	**69.0**	**2.0**	**15.0**

III. LANGUAGE PROFICIENCY

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

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. __ SPANISH_____	Direct Service Staff __44.0___ Others __10.0__	Direct Service Staff __88.0__ Others __20.0__	Direct Service Staff _132.0__ Others _30.0____
2. __VIETNAMESE_____	Direct Service Staff __0___ Others __0__	Direct Service Staff __2.0___ Others __1.0__	Direct Service Staff _2.0____ Others _1.0____
3. __CANTONESE_____	Direct Service Staff __0_ Others __0___	Direct Service Staff __1.0__ Others __1.0__	Direct Service Staff _1.0____ Others _1.0____
4. __ HMONG_____	Direct Service Staff _ 1.0___ Others __0___	Direct Service Staff __1.0___ Others __0___	Direct Service Staff _1.0____ Others _0____
5. __ _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

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EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Methodology: The projections of estimated need for staff were based on a comparison of the overall prevalence of mental illness in San Luis Obispo County with the proportion of that prevalent need currently being met by existing providers. In general, San Luis Obispo County needs to increase its current providers by three times the current level. This Needs Assessment attempted to capture the current workforce within the San Luis Obispo County Public Mental Health Service System. Accurate data was obtained from the San Luis Obispo County Human Resources data system (from FY2007-08) and directly from each Community Based Organization (CBO). Language proficiency data was obtained by survey of staff or from current, existing human resources data. Data was obtained from Behavioral Health Services (BHS) and all of its organizational and network providers including those organizations serving diverse unserved, underserved and inappropriately served communities. San Luis Obispo County conducted a Workforce Needs Assessment Survey of all BHS Staff and all Network Providers in December of 2008. Through vigorous follow up, San Luis Obispo County was able to achieve a 100% response rate. The information was analyzed to prepare these remarks.

A. Shortages by occupational category:

- There is a need for additional bilingual/bicultural staff in all classifications, especially in our threshold language of Spanish, which we have found to be hard to recruit.
- Psychiatrist and Registered Nurses that work at the Psychiatric Health Facility (PHF) are very hard to recruit.
- Other employers in the county, such as the State University, California Men's Colony and Atascadero State Hospital pays higher wages draws on the limited resources of the mental health workforce.
- Most of our positions are impacted greatly by the county's cost of living that limits the qualified pool of applicants.
- There is a small pool of graduate students looking for work, however the pay is minimal.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

- The table below displays FTE-to-client ratios by race and ethnicity for total and direct service staff. There is an overall shortfall in the mental health workforce in regards to meeting the prevalence needs within San Luis Obispo County. The county and its providers have indicated that it only provides services to 33% of the consumers who need mental health services.
- As indicated in the chart below, direct service providers for the County of San Luis Obispo do not represent target population in race/ethnicity and there is a specific shortage in bilingual staff.
- Contract providers and Behavioral Health Services need to hire more bilingual Spanish speaking employees as indicated below.
- It has been very difficult to find, hire, and train bilingual therapists skilled at working with individuals, families, and children.

	Number of Consumers who Identify as:	Direct Service Staff		Total Staff	
		Who Identify as	Ratio	Who Identify as	Ratio
White/Caucasian	3382 (77%)	108	31:1	280	12:1
Hispanic/Latino	684 (16%)	9	76:1	48	14:1
African-American	131 (3%)	2.5	52:1	9.5	14:1
Asian/Pacific Islander	50 (1%)	2	25:1	4	12:1
Native American	49 (1%)	0	0:1	1	49:1
Multi/Other	113 (2%)	2	56:1	5	23:1

C. Positions designated for individuals with consumer and/or family member experience:

- There is a significant shortfall in the mental health workforce in regard to the employment of consumer and family staff throughout the system though some CBO contractors have been more successful than others in recruiting consumer staff.
- There is a need to employ consumer staff in regular benefited positions vs. relying on volunteers, stipends, personal service contracts, ect.
- We need a significant increase in bilingual Spanish-speaking direct service consumer and family member staff in order to meet service demands.

D. Language proficiency:

- There is a great demand for bilingual (English/Spanish) clinicians.
- There is a strong need to improve the training and recruitment of language proficient and bicultural individuals.
- There is a need for bilingual (English/Spanish) consumer and family member staff.

E. Other, miscellaneous:

The geographic size and rural location of San Luis Obispo County makes the provision of services to all those in need of mental health services a challenge. For those individuals that do enter the mental health field, they seek higher paying positions with the State Hospital, Men's Colony Prison, or Cal Poly State University. Due to a high cost of living, it is particularly challenging to recruit professional staff into relocating to this area.

Appendix 08

Servicios Psicologicos Para Latinos
A Latino Outreach Program: Addressing Barriers to Mental Health Service

Silvia Ortiz, PhD

The demographic and epidemiological data shows a significant increase in ethnic minorities in the United States. Estimates of the population shifts in California indicate that ethnic minorities will constitute significant pluralities, with the Latino population being the most represented group. With this demographic shift comes an increasing awareness in the mental health community that psychological services need to be responsive to the ethnic minority population. Research, task forces, and committees are tackling the complex issues associated with providing psychological services that are appropriate for ethnic and culturally diverse populations.

In 1988, the APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations. In July 1991 the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse populations were published (American Psychological Association, 1993). In 1989, the Council for Children with Behavioral Disorders (CCBD) established the Committee on Ethnic and Multicultural Concerns (Bullock, 1999). In January1999, at the first Multicultural Conference coordinated by the American Psychological Association, the importance of developing cultural competence in mental health services was emphasized.

In February 2010, The California Department of Mental Health (DMH) issued the statewide Cultural Competence Plan Requirements (CCPR) which set new standards for achieving cultural and linguistic competence. In accordance with California Code of Regulations, Title 9, Section 1810.401, each county must develop and submit a Cultural Competence Plan that adheres to the CCPR (2010) by July 2010. The CCPR emphasizes the need to provide culturally and linguistically competent services within the mental health system to the racial, ethnic, and cultural communities which represent California's diversity.

Since 1988, a growing body of research is emerging that help guide the practitioners as they provide therapy to ethnic minorities. The research indicates that the underutilization of mental health services by ethnic minorities is not a reflection of fewer emotional problems, less severe emotional conditions or lack of awareness of these conditions. Minority individuals do recognize the need for services but contextual barriers such as difficulties with language, communication style, and discrepant cultural beliefs affect the utilization of mental health services (Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, 2001).

Cheung (1990) conceptualizes the barriers in terms of institutional, cultural, language and economic. Studies on institutional barriers indicate that minority clients report that they "feel stupid and embarrassed" because they do not fit in with the culture of the agency or understand the procedures of the agency. Other studies indicate that the "red tape' or multiple steps before a person receives the actual help contributes to drop out rates. These studies

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explain that clients who are distraught, depressed, and anxious and cannot read or speak the language just give up trying to navigate through the bureaucracy of the agencies that provide mental health services (Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, 2001)..

Even though theories and research provide some guidelines, many of the concepts such as culturally sensitive and culturally appropriate, are very difficult to implement. In their research with Latinos, Casa, Pavelski, Furlong & Zanglis (2001) note the importance of offering services that fit the paradigm of the culture. Since most theories have been developed based on the European culture, which is foreign and difficult for many Latinos to understand, adjusting the paradigm is critical. How to adjust the paradigm or enter into the Latino's world view remains vaguely undefined. The easiest approach is to belong to that world view and share the same values. It has been noted that there is an increase in the use of services and a decrease in dropout rates when there is an ethnic and language match between mental health professional and ethnic minority client (Lehman, E.W., Harrison-Ross, P. & Seigal, K.1982). Given the lack of bicultural/ bilingual mental health professionals, we are faced with the task of finding the way to provide mental health services within a less than ideal situation.

As a bilingual/bicultural Latina psychologist who has provided services to Latinos for about 25 years, I have noted many variables that affect utilization of mental health services as well as retention of clients. These variables are aspects of the Latino culture that need to become part of the therapeutic process.

One variable is that the low acculturated Latinos many not understand how a mental health professional can help. They tend to use family, friends, comadres, priests, and curanderos to help with emotional problems. Somehow we need to fit into this cluster of helpers. A way of fitting in is to be part of the network and work within the network. Lesley & Bestman (1984) and Kiselica &Robinson (2001) stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings". They note that some of these settings can be schools, churches, community centers, and local agencies. I have noticed that in addition to leaving the office, it is helpful to become part of the community by attending community events and becoming acquainted with the members of the community. This enables the mental health professionals to network with potential clients and other respected members of the community.

Another important factor is to have a deep understanding of the context of relationships within the Latino culture. Relationships have a hieratical system, an intense bond of trust that should not be broken, implicit and explicit respect, a strong spiritual connection to God and nature, and a very strong connection to family.

Within the Latino culture trust is critical. Sandoval and La Roza (1986) refer to this as personalism and describe it as a need to relate in personal terms and to trust people. They suspect it could be rooted in the strong family ties that are characteristic of this culture. Personalism provides strong feelings of attachment and commitment to family, friends, and others. It places great

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emphasis on interactions with people, which can make life meaningful or empty. In this paradigm people are judged according to their behaviors with their family and friends and not just on public or professional performance. As professionals it is important we extend ourselves in ways that foster interpersonal trust. This comes with knowledge of the cultural values, empathy, practice and exposure to the Latino culture.

Respect is important in the Latino culture. One needs to show respect and be worthy of receiving respect. It is shown in the way one carries oneself, speaks, looks at other, the words that are used, the way one addresses hierarchy, the ability to follow through with ones word, the ability to ask before assuming, the ability to have knowledge without arrogance, the relationships one has with one's own family and the community. The process of gaining respect can be an overwhelming burden. But again, it grows slowly, and is an essential component of the therapeutic process. Many times respect and trust grow simultaneously. At times, respect and trust can be given to a person by the position they hold in the community or through affiliation with a person of respect in the community.

An understanding of the family system and the ability to respect that system is very important. It is a hierarchical close net system based on machismo. Each member has a place in the family and each holds some form of power. The concept of power in the Latino culture differs from that of the majority culture. It is understood as "su position" or "ones position". Every member from the eldest to the youngest has a position. Men and women hold different positions. Providing therapy within the context of the Latino family system can be difficult when the system has been injured through domestic violence, child abuse, sexual abused, and/or substance/alcohol abuse.

The Latino culture is highly spiritual. The spiritual world impacts many aspects of life which at times can only be cured through spirituality. Destiny or "el destine" is closely connected to the spiritual world. Many clients utilize corianders, rely on priests, go on religious missions and use prayer to help deal with emotional problems. As professionals, it is important to have the ability to place one's own religious beliefs aside and work within the spiritual context of the Latino cultural. This culture is highly spiritual and it is an integral part of most clients' sense of self. Being able to therapeutically navigate through the spiritual world is an important role of the bicultural therapist.

The last variable I'll mention which affects the utilization of mental health services, especially those affiliated with the majority culture is the history of racism and oppression. For many Latinos this has become part of their identity. Current issues with the immigration system have given a rise to overt forms of racism. Many Latino clients report feeling the anger, hatred and not being wanted in this country. Although many mental health providers many abhor the oppression and racism that explicitly and implicitly occurred in the past and still exists, they have the burden of gradually proving this to each potential Latino client. Depending on the client's acculturation process and personal history, this may be fairly easy to do or almost impossible.

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In 2004, San Luis Obispo County Behavioral Health Services conducted a study to assess the characteristic which influence Latino's underutilization of Mental Health Services. The survey was administered to 200 Spanish speaking low income Latinos who resided in the County. All 200 surveys were completed by those who were Spanish literate and illiterate. The results showed that the following variables affect utilization of mental health services: (a) Latinos did not feel comfortable access services in a government building. They perceive the government as an authoritarian entity and were intimidated by it; (b) Some of the Latinos who had attempted to receive services from The County Behavioral Health Department reported that the experience was confusing and involved telling personal information to various persons prior to being assigned a therapist. Some reported that after sharing personal information they were told that their problem was not serious enough to qualify for services; (c) Latinos reported difficulty trusting someone who was not from their own culture and were concerned they would not be understood because of the differences in life experiences; and (d) Latinos preferred someone who spoke Spanish rather than having an interpreter. They found the interpreter to interfere with the flow of information.

The results of this survey are supported by the previously conducted research. In June of 2006, San Luis Obispo County Behavioral Health Services Via the Mental Health Service Act (MHSA) and Prevention Early Intervention (PEI) provided funding to a program that offers culturally appropriate psychotherapy services to the monolingual low income Spanish speakers and their bilingual children. The program is Servicios Psicologicos Para Latinos: A Latino Outreach Program (LOP) (appendix A, B, C, D). The model for LOP is based on the findings of previous research and the finding of the 2204 SLO County study. The program has been successful in establishing a community base model that provides psychotherapy, medication evaluation, psychotherapy groups, parenting groups for parents whose child is a ward of the court, substance abuse groups, and workshops (table 5 for workshops) to the Spanish speaking community and their bilingual children.

With the utilization of MHSA and PEI funding the program is able to provide services to those who meet medical necessity and those who have a diagnosis outside the realm of medical necessity such as substance abuse, marital problems, parent child relational problems, acculturation issues. The combined funding provides LOP the ability to remove the barrier stated in variable (a) which highlights That County Behavioral Health Services cannot provide psychotherapy to people who do not meet the criteria for medical necessity. LOP is in the unique position that regardless of the diagnosis, cases can be opened under Medical Necessity or under Community Services and no one is turned away based on a diagnosis.

LOP is embed in the community. All workshops, groups, and trainings are provided in community sites. Psychotherapy is offered in Paso Robles, San Luis Obispo, Oceano, Arroyo Grande, and Nipomo at eight community sites (appendix E). The clients who receive services from LOP are able to access therapists, workshops and groups in a familiar community site in their own neighborhood.

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This allows the program to break through the barrier stated in variable (a) which addresses the discomfort of receiving psychotherapy in a government agency. The community based model also is consistent with the findings of Cheung's (1990), Lesley & Bestman (1984) and Kiselica &Robinson (2001), which stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings".

The client's access to services is conducted in a manner that minimizes telling the personal story to multiple persons and navigating through a bureaucracy. The clients are referred to the director of LOP, Silvia Ortiz, Ph.D. who directly assigns the client to the therapist that conducts the intake and the therapy. This method of accessing services addresses variable (b) which speaks to the difficulty of telling the personal story to various persons prior to receiving treatment and is respectful of the findings of Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, 2001 and Cheung (1990) that indicate clients get lost when they try to navigate through the bureaucracy of the agencies that provide mental health services.

LOP has been fortunate in the hiring process. All therapists are bicultural and bilingual. The director of the program and two of the therapists are immigrants from Colombia and Mexico, respectively. The other two therapists are first generation in the United States (appendix F). The ethnicity of the therapist and their cultural backgrounds address the concerns stated in variable (c), and (d). By being Spanish speaking Latinos/Latinas the therapists can increases the probability of retaining the client because as noted by Lehman, E.W., Harrison-Ross, P. & Seigal, K. (1982) there is a decrease in dropout rates when there is an ethnic and language match between mental health professional and ethnic minority client. This match, as indicated by Casa, Pavelski, Furlong & Zanglis (2001) also facilitates the ability to share world views and enables the therapist to enter the Latino client's paradigm.

Even though the therapist are bicultural and bilingual, the concept of adjusting theories that have been developed on the European culture to the paradigm of the Latino's world view remains vaguely undefined and can be very difficult to implement . Group supervision and individual supervision is conducted in Spanish on a weekly basis to provide a venue for monitoring the delivery of culturally appropriate therapy. The concepts of family, curanderos, spirituality, immigration, acculturation, respect, trust, and working within the Latino paradigm are addressed in supervision. The integration of therapeutic theories and interventions into the Latino worldview is examined in supervision in the hope that the therapists remain true to a culturally sensitive model.

In an effort to educate the community about LOP and to form a stronger partnership with the community, on October 25th 2008 LOP and The County Behavioral Health Department invited specific community members to an event which featured a power point presentation along with dinner, dancing and the opportunity to network (appendix F). It was sponsored via funding from a grant from the Board of Supervisors, The Latino Outreach Council, and MHSA. The event offered a venue for professionals and staff who represent community agencies in SLO county to network and learn about LOP. It drew a group of

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approximately 95 persons who represent The Board of Supervisors, the County Behavioral Health Department, The Department of Probation, Latino Outreach Council, Latino Outreach Program, Cal Poly University, Cuesta College, Drug and Alcohol Services, Services, Affirming Family Empowerment, Transitions Mental Health, Vision Unida, Family Care Network, Gay Lesbian and Transgender Alliance, SAFE, and the Public Schools.

This event along with the network system provides the venue for educating the community about LOP. Information on LOP is disseminated via media, workshops, presentations and visits to numerous locations in the community (appendix G). Due to the tremendous amount of requests for LOP services the program has been able to grow from 1 therapist to 3.5 therapist. The statistics reflect the number of persons who have received services in 2008-current (appendix H, I). Client referrals to the program occur through community programs, schools, churches, and the network system. Unfortunately, the program always has a wait list for services and at times referrals have been closed because the wait list is too long. The success of the referral system is a direct reflection of the people and community agencies working together to form a wonderful network that enables the clients to reach LOP directly.

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Servicios Sicológicos Para Latinos
A Latino Outreach Program
Staff

NAME	E-MAIL	PHONE NUMBER
Yvette Arias	yarias@co.slo.ca.us	805-781-4700
Marisol Mariscal	mmariscal@co.slo.ca.us	805-474-7471
Jessica Ramos	jeramos@co.slo.ca.us	805-503-9345
Susana Franco	sfranco@co.slo.ca.us	805-781-4342
Ana Sobalvarro de Garcia	asobalvarrodegarcia@co.slo.ca.us	805-781-4960
Vacant Position	n/a	n/a

Appendix 10

LATINO OUTREACH PROGRAM

	Refuse to answer survey

Age Group

□ 0-15 y/o	□ 16-25 y/o	□ 26-59 y/o	□ 60+ y/o

Race

□ American Indian/Alaska Native	□ Asian	□ Black/African American	□ Hispanic/Latino
□ Native Hawaiian/Pacific Islander	□ White	□ More than 1 race	□ Decline to Answer

Ethnicity

□ Caribbean	□ Central American	□ Mexican/Mexican American/Chicanx	□ Puerto Rican
□ South American	□ African	□ Asian Indian/South Asian	□ Cambodian
□ Chinese	□ Eastern European	□ European	□ Filipino
□ Japanese	□ Korean	□ Middle Eastern	□ Vietnamese
□ More than 1 ethnicity	□ Decline to Answer	□ Other:	

Country of Origin: **Primary Language:**

Sex: Please share what sex you were assigned at birth.

□ Male □ Female

Gender: Please select the option that best describes you.

□ Male	□ Female	□ Transgender	□ Genderqueer/fluid
□ Questioning	□ Another gender identity		

Sexual Orientation: Please select the option that best describes you.

□ Gay/Lesbian	□ Heterosexual/ Straight	□ Bisexual	□ Questioning
□ Queer	□ Another Sexual Orientation identity		

Disabilities

□ Difficulty seeing	□ Difficulty hearing	□ Learning/developmental	□ Physical mobility
□ Chronic health	□ None	□ Decline to answer	□ Other

Appendix 11

PLEASE RATE YOUR OVERALL EXPERIENCE WITH THE SERVICES PROVIDED:

Statements	Prefer Not to Answer	N/A	Strongly Disagree	Disagree Slight	Neutral	Agree	Strongly Agree
The therapy was sensitive to the Latino culture and language.		0	1	2	3	4	5
Therapy helped me understand and resolve my mental health needs.		0	1	2	3	4	5
Therapy helped me gain internal strength and feeling better about life.		0	1	2	3	4	5
I have learned coping skills		0	1	2	3	4	5
I am now familiar with mental health resources.		0	1	2	3	4	5
My resilience and positive outlook in life has improved.		0	1	2	3	4	5
Therapy has helped me improve when I feel nervous, anxious, or scared.		0	1	2	3	4	5
Therapy has improved my sleep quality.		0	1	2	3	4	5

Appendix 11

PROGRAMA DE BIENESTAR PARA LATINOS

	Prefiero no contestar encuesta

Grupo de Edad

□ 0-15 años □ 16-25 años □ 26-59 años □ 60+ años

Raza

□ Indio Americano / Nativo de Alaska □ Asiático □ Negro/Afroamericano □ Hispano/Latino

□ Nativo de Hawai / Isleño del Pacífico □ Blanco □ Más de un raza □ Prefiero no Contestar

Etnicidad

□ Caribeño □ Centroamericano □ Mexicano/Mexicano americano/Chicanx □ Puertorriqueño

□ Sudamericano □ Africano □ Asiatico Hindú / Sur Asiático □ Camboyano

□ Chino □ Europeo Oriental □ Europeo □ Filipino

□ Japonés □ Coreano □ Medio Este □ Vietnamita

□ Más de un grupo étnico □ Prefiero No Contestar □ Otro:

País de Origen: **Idioma Principal**

Sexo Por favor seleccione que sexo fue asignado en su ficha ó certificado de nacimiento

□ Masculino □ Femenino

Género Por favor seleccione el género que mejor lo describa

□ Masculino □ Femenino □ Transgénero □ Genderqueer /fluido

□ Cuestionando □ Otra identidad de género

Orientación Sexual Por favor seleccione la orientación sexual que mejor lo describa

□ Gay/Lesbiana □ Heterosexual □ Bisexual □ Cuestionando

□ Queer □ Otra identidad sexual

Disabilidades

□ Dificultad para ver □ Dificultad para escuchar □ Aprendizaje y Desarrollo □ Mobilidad Física

□ Salud crónica □ Ninguna □ Negar a contestar □ Otro

Appendix 11

POR FAVOR CALIFIQUE SU EXPERIENCIA CON LOS SERVICIOS PROPORCIONADOS:

Declaraciones	Prefiero No Contestar	N/A	Totalmente en Desacuerdo	En desacuerdo	Neutral	De Acuerdo	Totalmente deacuerdo
La terapia proporcionada abarca la cultura y el idioma latino.		0	1	2	3	4	5
La terapia proporcionada ayuda a entender y resolver mis necesidades de salud mental.		0	1	2	3	4	5
Los terapia proporcionada me ayuda a obtener fortaleza interna y me siento mejor acerca de la vida.		0	1	2	3	4	5
He aprendido formas que me ayudan a calmarme y sentirme mejor.		0	1	2	3	4	5
Ahora estoy mas familiarizado con los recursos de salud mental.		0	1	2	3	4	5
Mi capacidad de recuperación y mi actitud positiva en la vida han mejorado.		0	1	2	3	4	5
El terapia proporcionada me ha ayudado a mejorar cuando me siento nervioso, ansioso, ó asustado.		0	1	2	3	4	5
El terapia proporcionada ha mejorado mi calidad al dormir.		0	1	2	3	4	5

Appendix 11

Diversity, Equity & Inclusion Committee Bylaws

Mission

The County of San Luis Obispo Behavioral Health Department (SLOBHD) is committed to Cultural Competence through promoting respect and understanding of diverse cultures, ethnic, social, and linguistic groups, and individuals. To achieve that commitment, SLOBHD is devoted to developing, enhancing, and maintaining a high performing workforce that provides meaningful service access and improves outcomes for all clients. We deliver culturally, and linguistically responsive services and our workforce reflects the diversity of the communities we serve. SLOBHD staff and administration ensures Cultural Competence is integrated into the overall organizational culture and ongoing business practices.

Goals

1. To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity;
2. To provide recommendations that will increase service delivery to culturally diverse clients;
3. To provide recommendations that address the need of continues training on cultural diversity topics;
4. To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients;
5. To provide recommendations that address the recruitment and retention of bilingual providers;
6. To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, American Indians, transition age youth and older adults;
7. To provide County Mental Health employees with the topics and information discussed among the Cultural Competence Committee;
8. To provide and sponsor trainings focused on expanding and enhancing cultural and linguistic knowledge;
9. To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee; and
10. To foster a strong network among community agencies that will facilitate an integrated delivery of services.

Committee Guidelines

Article I: Name of Committee

Section 1: The Committee is known as the Cultural Competence Committee. The committee operates under the department of San Luis Obispo County Behavioral Health Services.

Appendix 12

Article II: Purpose of the Committee

Section 1: The Committee is dedicated to assuring that San Luis Obispo County Behavioral Health Services becomes a culturally competent health system which integrate the concept of cultural, racial and ethnic diversity into the fabric of its operation. The committee will create agency-wide awareness of the issues relevant to cultural diversity.

Section 2: The Committee is committed to meeting the goals set forth in this document and will provide recommendations to the County Behavioral Health Director on issues pertinent to the achievement of these goals.

Article III: Structure of the Committee

Section 1: The Committee operates as an entity of the County of San Luis Obispo Behavioral Health Department.

Section 2: The County Behavioral Health Director appoints the Chairperson.

Section 3: The Chairperson reports to the County Behavioral Health Director.

Section 4: The Committee members are the decision-making body of the Committee. The members are elected by the Committee and represent a diverse range of cultural, ethnic, racial and geographic regions of the country.

Section 5: The Committee will advise and serve as a resource group to the County Behavioral Health Director, the County Behavioral Health Training Committee, County Behavioral Health staff, and affiliated agencies.

Section 6: General membership is not a requirement for involvement in the Committee. Visitors are welcome to attend Committee meetings and provide input.

Article IV: General Membership

Section 1: The Committee consists of approximately ten (10) members from County Behavioral Health, affiliated agencies, network providers, consumers, and community advocates. The members of the Committee represent a range of cultural and ethnic backgrounds.

Section 2: The Chairperson is part of the Committee.

Section 3: Anyone interested in serving on the Committee shall state his/her interest to serve by informing a current Committee member.

Section 4: A simple majority vote is required for the election of Committee members.

Section 5: A vacancy exists when a Committee member misses four consecutive Committee meetings without prior notification to the Chairperson or any other member. A vacancy also exists when a Committee member tenders his/her resignation verbally or in writing to the Chairperson.

Appendix 12

Section 6: When a vacancy exists, the Committee shall nominate individuals to serve on the Committee.

Article V: Meetings

Section 1: No meetings shall be held in a facility that prohibits the admittance of any person based on their culture, ethnic background, religious beliefs, sex, sexual orientation, or emotional/physical disabilities.
Section 2: Meetings will convene the second Monday on a quarterly basis, with a minimum of four meetings in one fiscal year.
Section 3: The Chairperson convenes the meetings.
Section 4: The Committee members develop the agenda for the meetings.
Section 5: The Committee will strive to make decisions by consensus.
Section 6: A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by a quorum to be recommended to the County Behavioral Health Director.
Section 7: A quorum is defined as 50 percent of the Committee.
Section 8: A motion may be made and seconded by any of the Committee members.
Section 9: Motions require a simple majority to be recommended as action items or task assignments.

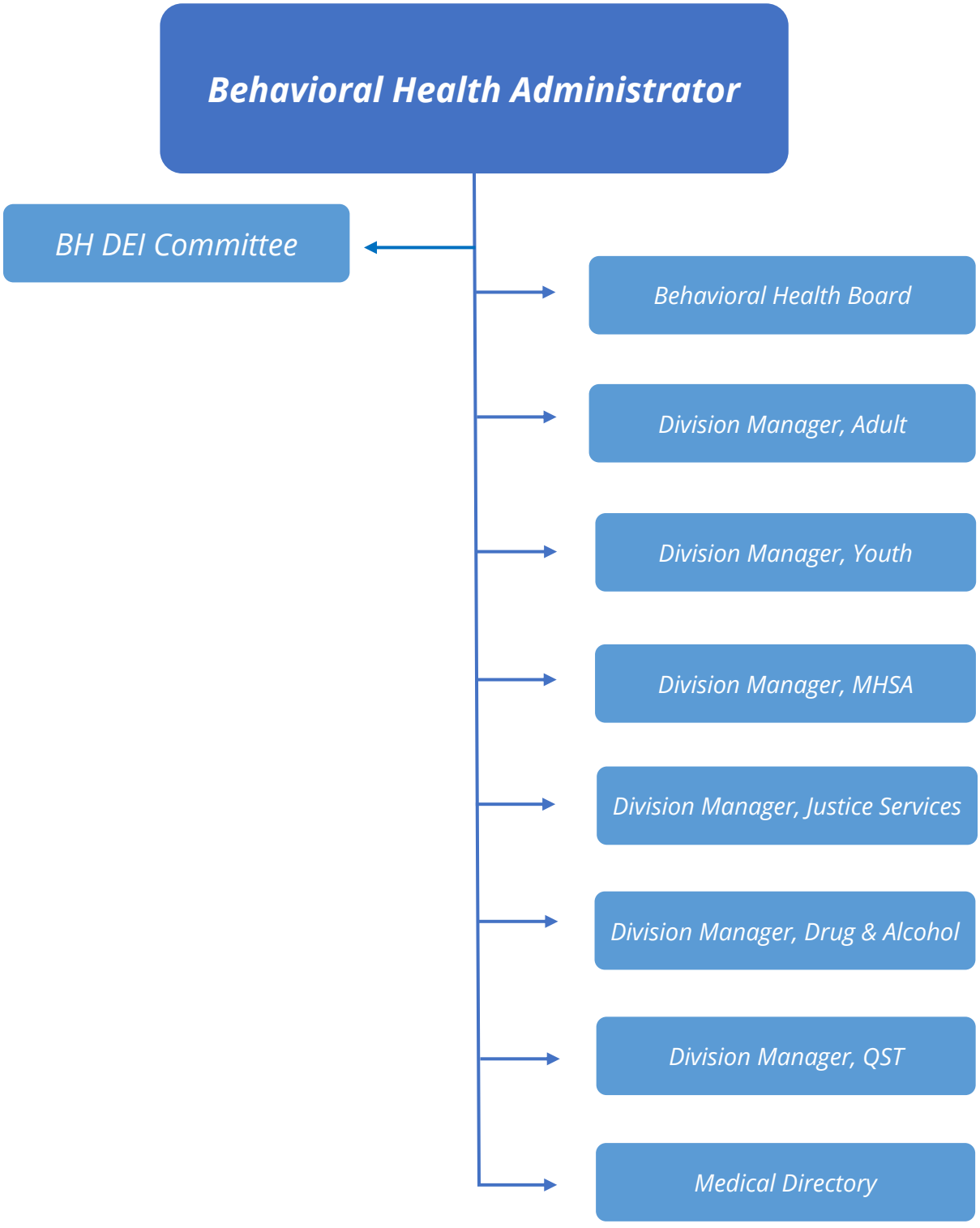
Article VI: Amendments

Section 1: These Bylaws may only be amended or repealed, and new bylaws adopted by the affirmative vote of a majority of a quorum of the Board.

Approved by the Director of Behavioral Health: _____

Date: _____

Appendix 12

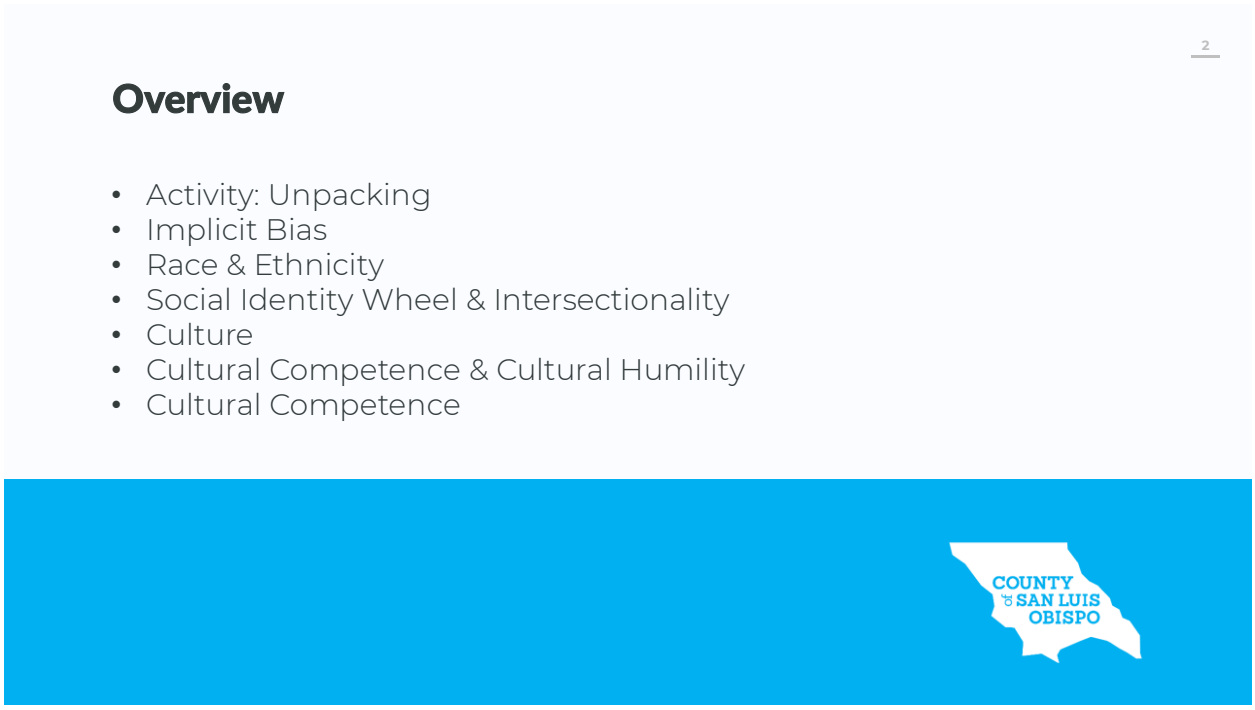

Behavioral Health Administrator
BH DEI Committee
Behavioral Health Board
Division Manager, Adult
Division Manager, Youth
Division Manager, MHSA
Division Manager, Justice Services
Division Manager, Drug & Alcohol
Division Manager, QST
Medical Directory

Appendix 13

2020-2021 Cultural Competence Committee - Roster		
Name	**Title**	**Agency**
Nestor Veloz-Passalacqua, M.P.P.	Diversity, Equity & Inclusion Manager	Behavioral Health Department
Anne Robin, L.M.F.T.	Behavioral Health Administrator	Behavioral Health Department
Joe Madsen	Division Director	Transitions-Mental Health Association
Claudia Lopez, L.C.S.W.	Patient Rights Advocate	Behavioral Health Department
Michelle Call	Executive Director	The GALA & Diversity Center
Tabitha Castillo	Administrative Assistant	Veterans Services Office
Jill Rietjens	Program Supervisor, Youth Services	Behavioral Health Department
Bonita Thomas	PAAT Member	Peer Advisory & Advocacy Team - TMHA
Marne Travisano, Ph.D.	Licensed Psychologist Private Practice	Private Practice – Community Member
Amber Trigueros, M.A., L.M.F.T.	Mental Health Therapist III	Behavioral Health Department
Mikaela Weidman	Cal Poly Student	California Polytechnic State University SLO
Jay Bettergarcia, Ph.D.	Assistant Professor	California Polytechnic State University SLO
Kiana Shelton	Mental Health Therapist IV	Behavioral Health Department
Laura Zarate	Secretary I	Behavioral Health Department
Gabriel Granados	Case Manager (Veteran Services)	Behavioral Health Department
Lilia Rangel-Reyes	Multicultural Specialist	Tri-Counties Regional Center
Barry Johnson	Division Director	Transitions-Mental Health Association
Katherine Soule	Director	UC Coop. Ext. Youth, Families, & Comm.
Annika Michetti	Program Supervisor	Drug & Alcohol Services
Maria Ordunez-Lara	Counselor	Family Care Network
Leticia Palafox	B.H. Clinician	Drug & Alcohol Services
Marcella Paric	Peer	Community Member
Tanya Resendiz	B.H. Clinician	Behavioral Health Department
Maria Oliveros	B.H. Specialist	Drug & Alcohol Services

Appendix 14


County of San Luis Obispo | Behavioral Health Department
Cultural Competence Committee
Nestor VelozPassalacqua, M.P.P.
Ethnic Services Manager & Cultural Competence Coordinator
COUNTY OF SAN LUIS OBISPO


2
Overview
• Activity: Unpacking
• Implicit Bias
• Race & Ethnicity
• Social Identity Wheel & Intersectionality
• Culture
• Cultural Competence & Cultural Humility
• Cultural Competence
COUNTY OF SAN LUIS OBISPO

Appendix 15

3

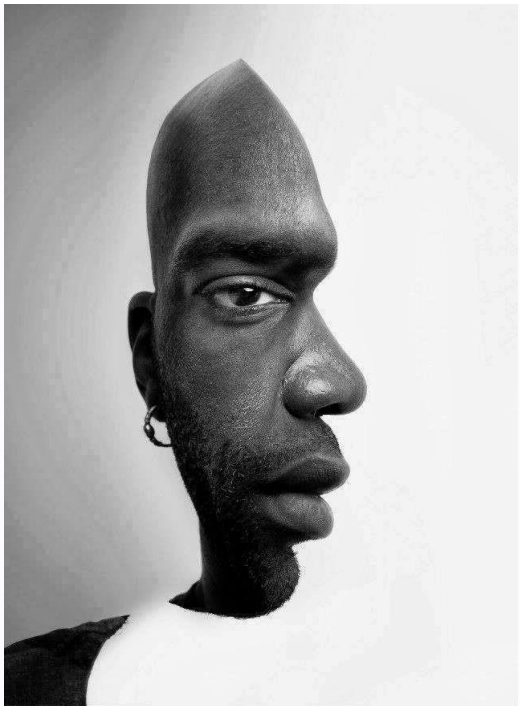
Unpacking

- Recognize Biases/Perceptions
- Becoming Aware
- Actionable Changes

COUNTY OF SAN LUIS OBISPO

4

What do we see?



Appendix 15

5

What face did you see in the previous slide?

Perceptions

Unconscious Responses

Learned attitudes/behaviors

COUNTY OF SAN LUIS OBISPO

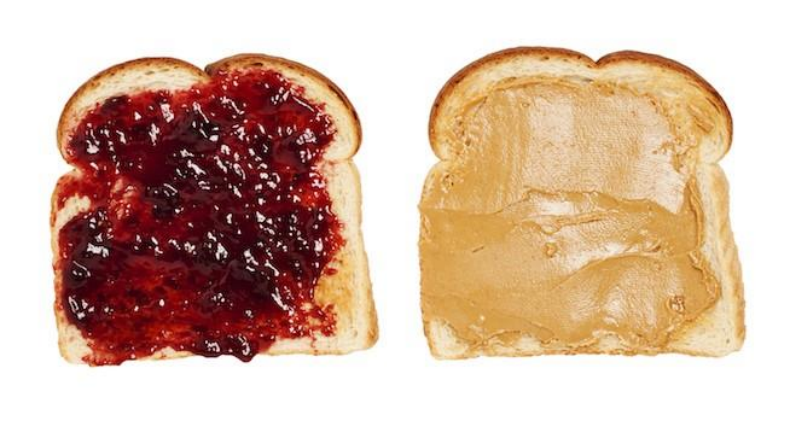
6

Car accident

Appendix 15

7

Implicit Bias



8

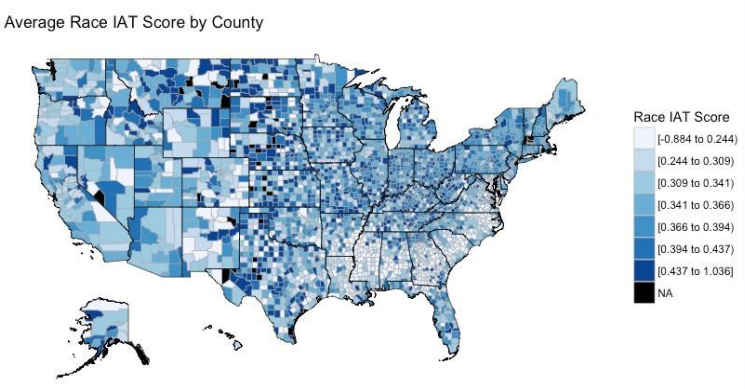
What is implicit bias?

Implicit bias is the thought process that refers to stereotypes that affect our attitudes, understanding, actions, and decisions in an unconscious manner.

Our biases are activated involuntarily and without our awareness or intentional control.

Biases happen at:

- Thinking (stereotypes)
- Feelings (prejudice)
- Behavior (discrimination)



Race Implicit Association Test (IAT) – the blue scale illustrate relative differences across counties: lighter blues indicate less pro-White bias.

Appendix 15

Race

Category of people who share certain inherited physical characteristics, such as skin color, facial features, and stature. – Race is a social construct/category

Ethnicity

Refers to the shared social, cultural, and historical experiences, stemming from common national or regional backgrounds that make subgroups of a population different from one another.

Source: Sociology: Understanding & Changing the Social World, 2016

Statistics

POPULATION: 284,010 (2018)

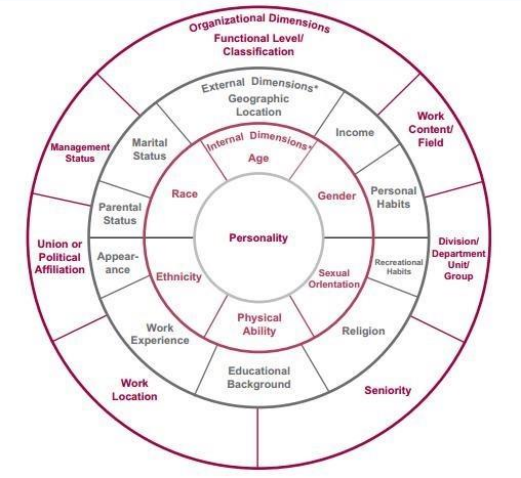
Race & Ethnicity

White 88%
Black/African American 2%
American Indian and Alaska Native 1.4%
Asian 4.0%
Native Hawaiian/Pacific Islander 0.2%
Two or More Races 3.5%
White Alone (not Hispanic/Latino) 68.8%

Hispanic/Latino 22.6%

10

Social Identity Wheel



Intersectionality

Appendix 15

Culture

"Meanings, values, and behavioral norms that are learned and transmitted in society and within social groups."

Source: Guarnaccia, 2006

Culture Influences

- How people communicate and manifest their symptoms
- Their style of coping
- Their willingness to seek treatment
- Their expectations of law enforcements
- Their family and community support

Source: Culture, Race, and Ethnicity; A supplement to Mental Health: A report of the Surgeon General, 2001

Appendix 15

Cultural Competence

- Integration process of skills and cultural knowledge about individuals and groups of people into specific workplace policies, programs, and behaviors for the purposes of increasing quality of workplace interactions and service delivery.
- Is the ability to interact effectively and appropriate with people of different cultures.
- Is the ability of systems to provide care to individuals with diverse values, beliefs, behaviors, backgrounds, including tailoring delivery to meet individuals' social, cultural, and linguistic needs.

Cultural Humility

- Cultural humility is about accepting our limitations. Those who practice cultural humility work to increase self-awareness of their own biases and perceptions and engage in a life-long self-reflection process about how to put these aside and learn from clients.

Source: Hohman, Cultural Humility: A Lifelong Practice, 2013.

Appendix 15

Cultural Competence

- Cultural competence provides a framework for assessing and understanding each client and family's unique rules, roles, habits, activities, and beliefs in the context of their cultural, linguistic, and ethnic identity.

Cultural Competence

- Become aware of the diversity of the populations with which the system is working.
- Acknowledge variations in acceptable behaviors, beliefs and values in accessing and treating a person's mental health or problems.
- The knowledge, skills, and attitudes to work within consumers' and their families' values and reality conditions.
- BECOME AWARE OF THE STEREOTYPES (BIASES/PERCEPTIONS) YOU CARRY, AND MAKE AN EFFORT TO SET THEM ASIDE WHEN INTERACTING WITH PEOPLE OF OTHER CULTURAL/ETHNIC/RACIAL GROUPS.

Appendix 15

- Know about diversity
- Acknowledge variations
- Enhance skills and attitudes
- Become aware of own stereotypes

Mental Health & Culture

STRATEGY #1
Become familiar with the culture(s) of the people you serve

STRATEGY #2
Become familiar with how you are perceived by the people you serve

Cultural Competence Committee

THANK YOU

Nestor VelozPassalacqua, M.P.P.
Ethnic Services Manager & Cultural Competence Coordinator

COUNTY of SAN LUIS OBISPO

Appendix 15

San Luis Obispo County Health Agency

MH Quality Support Team/Quality Management
November 04, 2021
10:00am - 11:30am

MH	X
PHF	

1. **Welcome and introductions, review, and approval minutes of July 2021**

2. **Follow-Up Old Business:**
   a. Psychiatric Services Updates – Daisy Ilano
      - ❖ Outpatient licensed medical staff training
   b. Temporary Therapist floaters to help reduce caseloads for all sites.

3. **New Items or Updates**
   a. EQRO

4. **Statistics:**
   a. MH Outpatient (Q1 21/22) Statistics:
      i. Access Timeliness Metrics – Adults, Youths, Spanish
      ii. Appointments seen w/in standards – Adults, Youths, Spanish
      iii. Scheduled/Walk-in Attendance appointment types
      iv. CSU Discharge reasons
      v. TBS/IHBS Trends
      vi. Risk Management – Incident Reports
      vii. Morbidity and Mortality Committee Report (Dr. Ilano)

5. **Committee Briefings**
   a. Managed Care
   b. M&M (will review in data presentation).

6. **Consumer/Family Advocate**

7. **Round table:**

8. **Next Meeting:** December 09, 2021 – PHF QST

Appendix 16

AGENDA
Cultural Competence Committee Meeting
ZOOM Meeting
July 13, 2020
Time: 9 am – 10 am

I. Welcome

II. Introduction

a. Member Updates: Adare Toral from DAS

III. Leadership Updates

a. Cultural Competence Newsletter: https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee/Newsletters.aspx
b. New Cultural Competence Plan Template
c. Chatting with Behavioral Health Videos:
    i. https://www.youtube.com/playlist?list=PL-zLcAasfhzvsqbxc-wCSUgftnFDc-gOk
    ii. Instagram: @slobehavioralhealth (https://www.instagram.com/slobehavioralhealth/?hl=en)
    iii. Facebook: @slobehavioralhealth (https://www.facebook.com/slobehavioralhealth/)
d. Anti-Discrimination Statement: https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee.aspx
e. Senate Concurrent Resolution (SCR) No.92

IV. New Business

a. Cultural Competence Training:
    i. Community Inclusion for all SLOBHD staff
    ii. Supporting Adults in the Grieving Process for staff primarily serving adults, and
    iii. Bullying: Strategies for Prevention and Intervention for those serving primarily youth.
b. Use of the term BIPOC: https://www.canva.com/design/DAEBVG11MC4/3Au4UPeSCj7ulQQHCTa5Rw/view?utm_content=DAEBVG11MC4&utm_campaign=designshare&utm_medium=link&utm_source=sharebutton

Appendix 17

c. BIPOC SLOBHD Staff Meeting
d. Video SLOBHD Staff Project
e. 10-Year Plan w/ Dr. Martinez
f. Southern Counties Regional Partnership (SCRP)
g. Cultural Competence Logo: https://www.canva.com/design/DAD-4N-Y0QU/qcPIG6zYX2P6RAOnnPBCxQ/view?utm_content=DAD-4N-Y0QU&utm_campaign=designshare&utm_medium=link&utm_source=sharebutton
h. NeoGov: Learn Courses on Diversity:
    i. As Simple As Respect: Diversity, Respect, and Inclusion in the Workplace Series (1-8);
    ii. Inclusion Insights: Stereotypes;
    iii. Anti-Bias Policing: Part 1 & 2; and
    iv. Understanding Geographic Identity & Biases

V. Announcements

a. 2nd quarter newsletter under development

VI. Next Meeting

a. October 12th 2020 – 9:00am – 10:00am

Appendix 17

AGENDA
Cultural Competence Committee Meeting
ZOOM Meeting
October 19, 2020
Time: 9 am – 10 am

I. Welcome

II. Introduction
a. Updates from members

III. Leadership Updates
a. Cultural Competence Newsletter
b. New Cultural Competence Plan Template
c. Chatting with Behavioral Health Videos:
    i. https://www.youtube.com/playlist?list=PL-zLcAasfhzvsqbxc-wCSUgftnFDc-gOk
    ii. Instagram: @slobehavioralhealth (https://www.instagram.com/slobehavioralhealth/?hl=en)
    iii. Facebook: @slobehavioralhealth (https://www.facebook.com/slobehavioralhealth/)
d. Senate Concurrent Resolution (SCR) No.92

IV. New Business
a. Cultural Competence Training:
    i. Community Inclusion for all SLOBHD staff
    ii. Supporting Adults in the Grieving Process for staff primarily serving adults, and
    iii. Bullying: Strategies for Prevention and Intervention for those serving primarily youth.
b. Cultural Awareness Conversation Series
c. Upcoming Holidays and Decorations
d. CCC Chair Transition
e. External Quality Review Organization (EQRO) meeting

V. Announcements
a. 3rd quarter newsletter under development

VI. Next Meeting
a. January 11th 2021, 9:00am – 10:00am

Appendix 17

AGENDA
Cultural Competence Committee Meeting
ZOOM Meeting
January 11, 2021
Time: 9 am – 10 am

I. Welcome

II. Introduction
a. Updates from members

III. Leadership Updates
a. Cultural Competence Newsletter
b. New Cultural Competence Plan Template – Update
c. External Quality Review Organization (EQRO) – Update
d. Upcoming Holidays and Decorations – Policy Guidelines Provided to BH Admin

IV. New Business
a. Cultural Competence Training:
    i. Community Inclusion for all SLOBHD staff
    ii. Supporting Adults in the Grieving Process for staff primarily serving adults, and
    iii. Bullying: Strategies for Prevention and Intervention for those serving primarily youth.
b. Cultural Awareness Conversation Series – 10/28 Update
c. CCC Chair Transition – Kiana Shelton & Jill Rietjens as new Chairs

V. Announcements
a. 3rd quarter newsletter

VI. Next Meeting
a. April 12, 2021, 9:00am – 10:00am

Appendix 17

AGENDA
Cultural Competence Committee Meeting
ZOOM Meeting
April 26,2021
Time: 9 am – 10 am

I. Welcome

II. Introduction
a. Updates from members
b. New member – Maria Olivares

III. Leadership Updates
a. Cultural Competence Newsletter
b. New Cultural Competence Plan Template – Update

IV. New Business
a. Cultural Competence Training:
    i. Community Inclusion for all SLOBHD staff
    ii. Supporting Adults in the Grieving Process for staff primarily serving adults, and
    iii. Bullying: Strategies for Prevention and Intervention for those serving primarily youth.
b. Cultural Awareness Conversation Series – next month?

V. Announcements
a. 4th quarter newsletter

VI. Next Meeting
a. July 12, 2021, 9:00am – 10:00am

Appendix 17

San Luis Obispo County
Cultural Competence Meeting
July 13, 2020
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Joe Madsen, Division Director, TMHA
Kianna Shelton, BH Clinician II
Jill Rietjens, Program Supervisor, Youth Services
Laura Zarate, Secretary I
Amber Trigueros, M.A., LMFT, M.H. Therapist III
Leticia Palafox
Tania Resendiz
Gabriel Granados
Tabitha Castillo
Maria Ordunez Lara
Michelle Call

Members Absent:
Bonita Thomas, PAAT
Maria Troy, Promotores
Barry Johnson, Division Director TMHA
Marcella Paric, PAAT, BHB
Katherine Soule, UC Cooperative Extension & Youth, Families, & Communities
Dr. Jay Bettergarcia, Cal Poly
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Lilia Rangel-Reyes, Tri-Counties Regional
Lashelle Burch
Amanda Corcoran
Barry Johnson
Annika Michetti
Lilia Rangel-Reyes
Nasseem Rouhani
Katherine Soule
Adare Toral
Claudia Lopez

Appendix 18

Topic	Discussion	Recommendations/ Actions
Introductions: Leadership Updates: New Business:	Welcome and Round-table introductions. a) Member Updates: Adare Toral from Drug and Alcohol Services will be joining us. a) Cultural Competence Newsletter: There is a new template and Newsletter that went out last month. If you have an article related to artistry, poetry or anything that shows cultural awareness, please send to Nestor. Here is the link for our current Newsletter: https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee/Newsletters.aspx b) New Cultural Competence Plan Template – Great news! New template is coming from the State. State now will be looking at qualitative and quantitative data and want to make sure Counties are working with their Quality Support Team and keeping data on all populations we are serving which. Nestor will give feedback on the Template hoping they explain the requirements for each criterion. c) Chatting with Behavioral Health Videos: i. https://www.youtube.com/playlist?list=PL-zLcAasfhzvsqbxc-wCSUgftnFDc-gOk ii. Instagram: @slobehavioralhealth (https://www.instagram.com/slobehavioralhealth/?hl=en) iii. Facebook: @slobehavioralhealth iv. (https://www.facebook.com/slobehavioralhealth/) Videos have been recorded by Carolyn Johnson, Kiana Shelton and Tania Resendiz. Great job ladies! Nestor has followed up with Jill and the LOP group trying to identify how best to engage with the Latino Community and recording these videos in Spanish. The goal is to record a video once per week. a) Anti-Discrimination Statement: https://www.slocounty.ca.gov/Departments/Health-	Welcome Adare! Please send any feedback on Newsletter to Nestor.

Topic	Discussion	Recommendations/ Actions
	Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee.aspx b) Senate Concurrent Resolution (SCR) No.92: Hoping to pass this resolution to denounce racism as a National Health Crisis in our State.	
	a) Cultural Competence Training for FY 2020-21: i. Community Inclusion for all SLOBHD staff ii. Supporting Adults in the Grieving Process for staff primarily serving adults, and iii. Bullying: Strategies for Prevention and Intervention for those serving primarily youth. There are due by June 30th 2021 in Relias.	Please take a look at this term in English and in Spanish and forward feedback to Nestor.
	b) Use of the term BIPOC: https://www.canva.com/design/DAEBVG11MC4/3Au4UPeSCj7ulQQHCTa5Rw/view?utm_content=DAEBVG11MC4&utm_campaign=designshare&utm_medium=link&utm_source=sharebutton Did the research if this term is appropriate. Instead of using the term "minorities" or "marginalized" we will start to use the term Black Indigenous People Of Color. It is a more inclusive word. We are still working on translating properly this term in Spanish- it is difficult because it does not translate directly.	Will talk to HR and will start thinking about this project. More information to come.
	c) BIPOC SLOBHD Staff Meeting: Met with Anne Robin who suggested opening the discussion by having a meeting regularly (once we are able to after COVID) to be facilitated possibly by the Cultural Competence Committee to see how staff feel supported.	
	d) Video SLOBHD Staff Project: Adult staff Clinician brought up the conversation – can we share our own experience/story? Marcy Paric has volunteered herself to lead this project. Looking for volunteers. If it is cleared by HR and you are interested,	Please look at our Cultural Competence Logo and provide feedback to Nestor

Topic	Discussion	Recommendations/ Actions
<u>Announcements:</u> <u>Next Meeting:</u>	please contact Nestor or Marcy Paric. Email to come out soon. e) 10-Year Plan with Dr. Martinez: Still under development. Got held back due to COVID-19. Moving forward on this. f) Southern Counties Regional Partnership (SCRP): We are extending our MOU. This means more trainings until 2026 between Behavioral Health and partners in our Community. g) Cultural Competence Logo: https://www.canva.com/design/DAD-4N-Y0QU/qcPIG6zYX2P6RAOnnPBCxQ/view?utm_content=DAD-4N-Y0QU&utm_campaign=designshare&utm_medium=link&utm_source=sharebutton Take a look at these logos. We would like to start using this logo in our next Newsletter. h) NeoGov: Learn Courses on Diversity: i. As Simple As Respect: Diversity, Respect, and Inclusion in the Workplace Series (1-8); ii. Inclusion Insights: Stereotypes. iii. Anti-Bias Policing: Part 1&2; and iv. Understanding Geographic Identity & Biases These are some of our available courses for staff. If you have taken this or if you will, please share with our group if you recommend them. a) Second quarter newsletter under development. a) Next Meeting: October 12, 9-10am	ASAP if you would like.

Appendix 18

San Luis Obispo County
Cultural Competence Meeting
October 19, 2020
10:00 a.m. – 11:00 a.m.

Members Present: Chair: Nestor Veloz-Passalacqua
Kianna Shelton, BH Clinician II
Jill Rietjens, Program Supervisor, Youth Services
Laura Zarate, Secretary I
Amber Trigueros, M.A., LMFT, M.H. Therapist III
Leticia Palafox
Tania Resendiz
Mikey, CalPoly
Tabitha Castillo
Maria Ordunez Lara
Michelle Call
Barry Johnson, Division Director TMHA
Annika Michetti
Claudia Lopez,BH PRA
Maria Troy, Promotores

Members Absent:

Bonita Thomas, PAAT
Gabriel Granados
Joe Madsen, Division Director, TMHA
Marcella Paric, PAAT, BHB
Katherine Soule, UC Cooperative Extension & Youth, Families, & Communities
Dr. Jay Bettergarcia, Cal Poly
Marne Trevisano, PhD, Licensed Psychologist, Private Practice AT.
Lilia Rangel-Reyes, Tri-Counties Regional
Lashelle Burch
Amanda Corcoran
Lilia Rangel-Reyes
Nasseem Rouhani
Katherine Soule
Adare Toral

Appendix 18

Topic	Discussion	Recommendations/ Actions
Introductions:	Welcome and Round-table introductions. b) Member Updates: Mikey will now join us representing CalPoly.	Welcome Mikey!
Leadership Updates:	d) Cultural Competence Newsletter: Working on Draft Newsletter. If you have any suggestions or feedback, please contact Nestor. e) New Cultural Competence Plan Template –New template is coming from the State. No information has been released from State. Latest Plan was in 2018 and before that was in 2010. We have all data from trainings and population served ready to complete the report. We are on stand-by. f) Chatting with Behavioral Health Videos: v. https://www.youtube.com/playlist?list=PL-zLcAasfhzvsqbxc-wCSUgftnFDc-gOk vi. Instagram: @slobehavioralhealth (https://www.instagram.com/slobehavioralhealth/?hl=en) vii. Facebook: @slobehavioralhealth viii. (https://www.facebook.com/slobehavioralhealth/) Videos have been recorded by Carolyn Johnson, Kiana Shelton and Tania Resendiz. Great job ladies! Nestor has followed up with Jill and the LOP group trying to identify how best to engage with the Latino Community and recording these videos in Spanish. The goal is to record a video once per week. g) Senate Concurrent Resolution (SCR) No.92: Hoping to pass this resolution to denounce racism as a National Health Crisis in our State. We would be able to work with Public Health on equity. We wont know until after the election.	Please send any feedback on Newsletter to Nestor. Will keep you posted on Resolution outcome.
New Business:	Anti-Discrimination Statement: https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee.aspx i) Cultural Competence Training for FY 2020-21:	

Topic	Discussion	Recommendations/ Actions
Next Meeting:	iv. Community Inclusion for all SLOBHD staff v. Supporting Adults in the Grieving Process for staff primarily serving adults, and vi. Bullying: Strategies for Prevention and Intervention for those serving primarily youth. These are due by June 30th 2021 in Relias. j) Cultural Awareness Conversation Series- Got green light from HR. 3-part series via Zoom. An opportunity for staff to First series is called: All Ears. Will be an open discussion/brainstorming in a safe place. Geared for front staff to share information on what is like to work for the Health Agency ie. Areas for improvement etc. Second part is called: Unpacking Compartmalization – geared for our people of color (BIPOC) staff to share unique experiences, concerns and allow people to share their voice. Third is called: This is me. Geared for our LGBTQ staff to feel inclusive. The Agency does care to what you have to say. HR and upper management agreed to this project. Next available dates are in October, November and one in December. More information to come. k) Holidays and Decorations- Administrators are trying to understand what is best and are asking the Cultural Competence Committee. Should each office decorate with Christian believes, very neutral "happy holidays" or nothing at all? We might send out a Survey Monkey. We want to identify the staff preference. We need to be inclusive but at the same time follow policy. We will be looking at gift receiving as well. l) CCC Chair Transition- Nestor is now working for Public Health and not Behavioral Health. This will be possibly Nestor's last meeting as chair of CCC meeting. m) External Quality Review Organization (EQRO) meeting- Nestor will be present for these EQRO meetings to answer questions on Cultural Competence. These will take place once per year. Next Meeting- b) January 11th 2021, 9:00am – 10:00am	Staff: Please complete trainings by June 30, 2021. Nestor and Kianna to send out Zoom meeting information. Will be reviewing Policy on Holiday Decorations. We will miss you Nestor!

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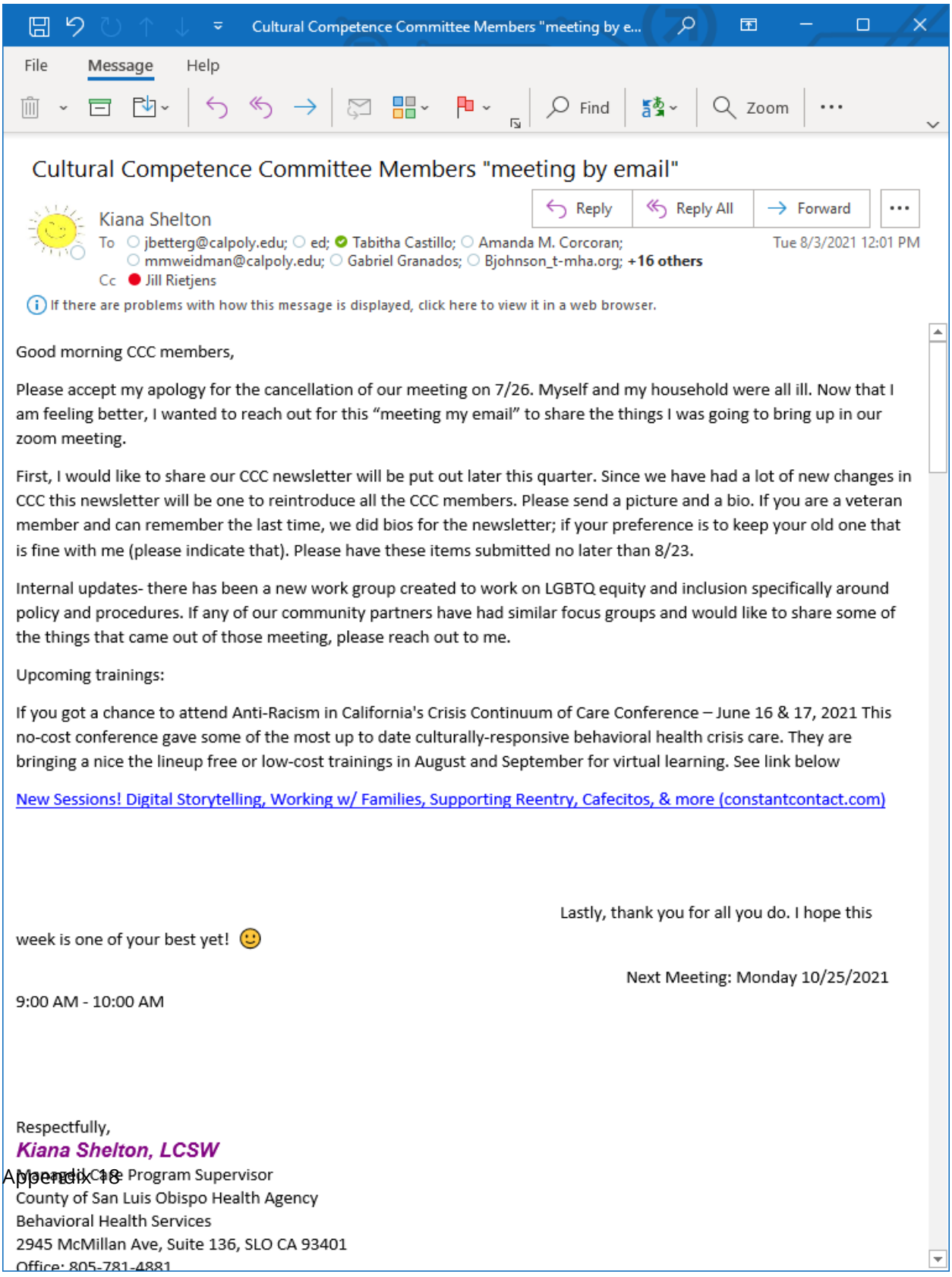

Appendix 18

Appendix 18

MHSA Stakeholder Meeting
Wednesday July 29, 2020
4:00pm-5:30pm
Live via Zoom

Meeting Minutes

1. Frank Warren welcomed the stakeholder group at 4:00 pm. All participants introduced themselves and Frank presented the goals for the meeting. Frank also reviewed the Stakeholder Process, format, and rules for the meeting (e.g. consensus voting, no rules of order, etc.)
2. **COVID-19 Update:**
    a. Anne Robin, Behavioral Health Administrator
    Anne stated the Department and Its partners have transitioned well to all the changes that have occurred in the past few months. Anne appreciates everyone's flexibility and that clients and staff are staying safe. The appointments have been timely with a decrease in no shows. All groups have been well attended and is grateful with everyone's patience. She thanked Caroline Johnson for all her work in communicating mental health tips in both English and Spanish. She also praised Kim Mott and Frank Warren for supporting county employee's mental health.
3. **CSS Update:** Kristin Ventresca, CSS Coordinator
    a. Kristin gave an overview of all nine Workplans and states all are doing well. With the focus on increases in the next year with added funding to all five FSP programs.
    b. Dylan Hunt from Family Care Network stated the increased funding for a full-time employee has increased availability to engage with most parents giving them increased confidence.
    c. Meghan Boaz-Alvarez from TMHA spoke about the full time increase to the Medication Manager position, this has brought the Full-Service Partnership caseload from 35 clients to 45. This has made a significant difference in providing a higher level of medical care and will help with more complex medical issues. Also, the increase in mentor time to 40 hour/week will provide more client contact.
    d. Mariam Vargas gave an update on the new Homeless Outreach Full-Service Partnership Team.
    e. Traci Autry from Wilshire states they appreciate the funding and have hired a Psychiatrist and a part time Medication Manager.
4. **PEI Update:** Nestor Veloz-Passalacqua, PEI Coordinator
    a. Nestor states all programs are doing well and have been working closely with providers for data collection for the MHSA report coming next year.
    b. Lisa Fraser and Erica Ruvalcaba from Promotores stated the clinics have higher requests for interpretation. They have recruited a clinician who speaks Spanish and Mixteco. There is a need for additional funding to provide technology, laptops, cellphones for the Clinicians.

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c. Veterans Outreach has increased events and client services. Gabe Granados moved to a Full time Behavioral Health Specialist functioning as a case Manager.

5. **Innovation Update:** Nestor Veloz-Passalacqua, Innovation Coordinator
   a. Dr. Battle, Cal Poly Evaluator spoke on his Innovation evaluation findings for current and past projects. He stated all Innovation projects seemed to be successful and adaptable. Report will be made available at the time the Annual Update is released.
6. **Wet Update:** Caroline Johnson, Trainings and Communications Coordinator.
   a. Caroline gave an update on communications and trainings.
7. **Fiscal Update:** Jalpa Shinglot, Fiscal Department Administrator
   a. Jalpa gave an update on the current fiscal status. She stated the FY 19-20 numbers will be finalized at the next Stakeholder Meeting.
8. **Old Business:**
   a. 40 Prado. The grant for a Clinician was funded until June 2020. To sustain the position, they would need $142,000, a survey will be sent to the Stakeholders.
   b. Wellness Centers. Request for new funds, the overall cost to keep the San Luis Obispo and Arroyo Grande centers open would be $472,528. The MHSA funding could come from $391,715 funding set aside for Martha's Place that is not being used and $80,813 in additional CSS funds. A survey will be sent to the Stakeholders.
9. **New Business:**
   a. CFS Promotores Request. The request from the Prudent Reserve is $13,525 this is a one-time request for Telehealth equipment and for Spanish interpretation services in the Behavioral Health Department countywide.
10. **Updates:**
    a. CSU Admission Process. The requirements to get admitted into the CSU have changed, there will be new walk-in procedures that could start September 1, 2020. They are working with Dr. Ilano and the PHF unit on these procedures. The CSU will go from 4 beds to 8.
    b. MHSSA Grant. This will go to the board for approval in a few weeks and the Middle Schools are excited to have the additional staff.
    c. Suicide Prevention Grant. We did not get the Grant.
11. **Next Meetings:**
    a. MAC: 9/30/2020
12. **Meeting adjourned** at 5:45pm
13. **Attendees:** Dawn Anderson, Traci Autry, Katy Bertrand, Elissa Feld, Lisa Fraser, Barry Johnson, Jack Kretovics, Pam Kretovics, Meghan Boaz-Alvarez, Jill Bolster-White, Danijela Dornan, Amanda Getten, Dylan Hunt, Raven Lopez, Joni McCoy, Joe Madsen, Christina Menghrajani, Christine Pirruccello, Rebecca Redman, David Riester, Anne Robin, Jalpa Shinglot, Bonita Thomas, Morgan Torell, Nestor Veloz-Passalacqua, Kristin Ventresca, Clint Weirick, Jessica Yates, Pam Zweifel, Robert Rogers, Michelle Madgett, Hilary Lawson, Lisa Peterson, Lexie Signore, Martin Battle, Caroline Johnson, Trista Ochoa, Erica Ruvalcaba, Julie Turney, Elizabeth Lowham, Sandy Farley, Christy Mulkerin, Heather Bagwell-Jones

Appendix 19

MHSA Stakeholder Meeting
Wednesday September 30, 2020
4:00pm-5:30pm
Live via Zoom

Meeting Minutes

1. Frank Warren welcomed the stakeholder group at 4:00 pm. All participants introduced themselves and Frank presented the goals for the meeting. Frank also reviewed the Stakeholder Process, format, and rules for the meeting (e.g. consensus voting, no rules of order, etc.)
2. **COVID-19 Update:**
    a. The Stakeholders were given the Behavioral Health COVID-19 resource page link: www.slocounty.ca.gov/BHCovid19
3. **CSS Update:** Kristin Ventresca, CSS Coordinator
    a. Kristin gave an overview of all nine Workplans and states all are doing well. She went on to state more detailed information will be included in the Annual Update next month.
    b. CSU Update: Sandy Farley

    The Crisis Stabilization Unit (CSU) now has walk-in hours M-F, this includes anyone that comes in voluntarily and when evaluated is deemed appropriate can stay with the same admission criteria. For those persons on a hold they must still go to French Hospital to be medically cleared before they can be admitted. The CSU can also now clear clients to be admitted to the Psychiatric Health Facility (PHF).
    c. Behavioral Health Treatment Court: The case manager position was formerly held by Transitions Mental Health (TMHA) and will now be a County Behavioral Health Specialist position.
4. **PEI Update:** Nestor Veloz-Passalacqua, PEI Coordinator
    a. Nestor states all programs are doing well and have been working closely with providers for data collection for the MHSA report coming next year.
    b. The contract with Cuesta College for the program, Successful Launch has ended.
    c. There are no pending Evaluations for the PEI Programs.
5. **Innovation Update:** Nestor Veloz-Passalacqua, Innovation Coordinator
    a. The Innovation Evaluation Report for fiscal year 16-20 projects is complete. The current fiscal year 20-24 projects are in review with the office of Oversight and Accountability Commission.
    b. The current Innovation projects for FY 18-22, SLO ACCEPTance, 3-by-3 and FY 19-23, Holistic Adolescent Health, B-HARP were all approved last March and are all active.
    c. Nestor also informed the Stakeholders he has taken a new position, Program Manager for the Whole Person Care program with the County in the Public Health Division.
6. **Wet Update:** Caroline Johnson, Trainings and Communications Coordinator.

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a. Caroline spoke on the upcoming social media content which includes: Chatting with Behavioral Health, Mental Illness Awareness week, World Mental Health Day, and Halloween-End the Stigma.
b. The Suicide Prevention Drive thru was held today and handed out 48 resource bags.
c. The COVID-19 Resource page is a great success.
d. Innovation projects-SLO ACCEPTance and B-HARP trainings are both going well.

7. **Fiscal Update:** Jalpa Shinglot, Fiscal Department Administrator
   a. Jalpa gave an update on the current fiscal status. The fund balance is currently $19,707,158 and the Prudent Reserve fund balance is $2,774,412.
   b. Frank Warren stated there will be significant changes to the work plans in the next two years, due to COVID-19 and the County is looking for savings wherever possible.
8. **Old Business:**
   a. The Promotores equipment request of $13,525 from Prudent Reserve funding was approved through a Stakeholder email vote.
9. **New Business:**
   a. OSHPD funded training: this would require the County to spend $74,102 of our Prudent Reserve funds that would be matched for grant funded programs for a total of $150,000. We have Prudent Reserve funds that need to be spent by 2022. This would be a one-time payment good for the next 5 years.
   b. 40 Prado-CAPSLO: This request for $207,500 from the Prudent Reserve would help build a facility that is focused on residential treatment and medication assistance.
   c. An email will be sent to all Stakeholders to vote on both proposals.
10. **Updates:**
    a. MHSSA-Middle school grant, the positions are almost fully staffed.
    b. The Annual Update will be ready for the 30-day review on October 15, it then goes to the Behavioral Health Board on October 21 and then out for public review on November 18.
    c. Frank spoke to the Stakeholders about Nestor Veloz-Passalaqua and his accomplishments during his time here at Behavioral Health. Several Stakeholders gave their appreciation as well.
    d. There will be a Zoom meeting on October 8 with Frank Warren and Kristin Ventresa on the position that Nestor is leaving.
11. **Next Meetings:**
    January 2021
12. **Meeting adjourned** at 5:35pm
13. **Attendees:** Barry Johnson, Clint Weirick, Caroline Johnson, Joe Madsen, Nestor Veloz-Passalacqua, Joni McCoy, Sandy Farley, Frank Warren, Morgan Torell, Kristin Ventresca, Rebecca Redman, Lisa Fraser, Jalpa Shinglot, David Riester, Bonita Thomas, Mark Woelfle, Mark Lamore, Cynthia Barnette, Grace McIntosh, Anna Boyd-Bucy, Christina Menghrajani, Jenilee Sneed, Joseph Kurtzman, Jessie Yates, James Slater, Cami Slater, Nicole Bennett, Amanda Getten, Dylan Hunt, Tonya Leonard, Katie Berchand, Daniella Garcia, Raven, Lopez, Pam Zweifel, Christy Mulkerin, Jenny Luciano, Anne Robin

Appendix 19

MHSA Stakeholder Meeting
Wednesday January 27, 2021
3:30pm-5:00pm
Live via Zoom

Meeting Minutes

14. Frank Warren welcomed the stakeholder group at 3:30 pm. All participants introduced themselves and Frank presented the goals for the meeting. Frank also reviewed the Stakeholder Process, format, and rules for the meeting (e.g., consensus voting, no rules of order, etc.) Frank introduced Tim Siler, the new Innovation and PEI Coordinator.
15. **COVID-19 Update:**
    a. The Stakeholders were given the Behavioral Health COVID-19 resource page link: www.slocounty.ca.gov/BHCovid19
    b. Anne Robin, Behavioral Health Director, gave a brief update on the new vaccination site at Cuesta College and encouraged anyone who would like to help to volunteer at the site.
16. **CSS Update:** Kristin Ventresca, CSS Coordinator
    a. Kristin gave an overview of all nine Workplans and states all are doing well. She went on to state more detailed information is included in the Annual Update.
    b. LOP Update: Tania Resendiz
    Tania is a Behavioral Health Clinician working for the Latino Outreach Program (LOP). This program serves both children and adults. Tania shared some positive stories and went on to say she loves working with the Latino community and feels the program is a success.
    c. FSP Update: Christina Menghrajani
    Christina gave an update on the Full-Service Partnership (FSP). She states all clients are being seen by Telehealth or face to face, and there has been no interruption in services due to COVID-19. The program works closely with MHET, CSU and Hospitals to help those in need gain access to services. Christina also stated all FSP caseloads are full.
17. **PEI Update:** Frank Warren, MHSA Coordinator
    a. Frank stated that although there is no current growth in the program, all programs are doing well, fully operating and are active.
    b. The PEI programs are currently funded, with no new funds coming in.

18. **Innovation Update:** Frank Warren, MHSA Coordinator
    a. The Innovation Evaluation Report for fiscal year 16-20 projects is complete. The current fiscal year 20-24 projects are in review with the office of Oversight and Accountability Commission.
    b. The current Innovation projects for FY 18-22, SLO ACCEPTance, 3-by-3 and FY 19-23, Holistic Adolescent Health, B-HARP were all approved last March and are all active.

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19. **Fiscal Update:** Jalpa Shinglot, Fiscal Department Administrator
    a. Jalpa gave an update on the current fiscal status, she stated that although MHSA funding will not be hit as hard as expected we could see an impact due to COVID-19 in the coming 22/23 Fiscal Year. The fund balance is currently $17,414.102 and the Prudent Reserve fund balance is $2,774,412.
    b. PEI has no additional funding available currently.
2. **New Business:**
    a. A proposal was brought to the Stakeholders, that would use $509.536 of the MHSA Trust Fund for Assessment Coordinators in the Co-Occurring Disorders program. This funding would bridge the gap left by the nearly 1-million-dollar budget cut to the General Fund. If approved the Co-Occurring program would become, for 2 fiscal years, through June 30, 2022, an MHSA program. A bill, AB-2265, was passed that would allow the Co-Occurring program to use MHSA dollars.
    b. An email will be sent to all Stakeholders to vote on this proposal.
3. **Updates:**
    a. 40 Prado, this project will require additional funding of 10,000, this will bring the total to $217,000.
    b. MHSSA (middle school) Grant is going well, with positive feedback from the schools.
    c. CHFFA Youth Grant, will be submitted on Friday, with a good chance of approval.
    d. The Annual Update was approved by the Board of Supervisors and sent to the Oversight and Accountability Commission (OAC), who were impressed with the report especially our Innovation and PEI evaluations.
4. **Next Meetings:**
    March 31, 2021
    May 26, 2021
5. **Meeting adjourned** at 5:05pm
6. **Attendees:**

Barry Johnson, Clint Weirick, Joe Madsen, Joni McCoy, Frank Warren, Morgan Torell, Kristin Ventresca, Rebecca Redman, Lisa Fraser, Jalpa Shinglot, David Riester, Mark Lamore, Cynthia Barnett, Anna Boyd-Bucy, Christina Menghrajani, Jenilee Sneed, Jessie Yates, Amanda Getten, Dylan Hunt, Raven Lopez, Pam Zweifel, Jenny Luciano, Anne Robin, Dawn Marie Anderson, Tim Siler, Tania Resendiz, Carrie Collins, Jenny Luciano, John Gillespi, Danijela Dornan, Jeff Smith, Jill Bolster-White, Cathy Manning, Star Graber, Trista Ochoa

Appendix 19

MHSA Stakeholder Meeting
Wednesday March 31, 2021
3:30pm-5:00pm
Live via Zoom

Meeting Minutes

1. Frank Warren welcomed the stakeholder group at 3:30 pm. All participants introduced themselves and Frank presented the goals for the meeting. Frank also reviewed the Stakeholder Process, format, and rules for the meeting (e.g., consensus voting, no rules of order, etc.). He discussed what services MHSA provides for the county.
2. **Department Update:** Anne Robin, Behavioral Health Administrator
    a. Anne discussed the emphasis for the County to keep people housed and spoke about various projects.
    b. Anne gave an update on the Covid-19 response, she stated the County is now giving vaccinations to people 30 and above and looking to develop target outreach pop-up clinics.
    c. The County is looking forward to more in-person treatment services and will be doing more hiring to make sure we have sufficient staffing to meet the demand for services.
3. **CSS Update:** Kristin Ventresca, CSS Coordinator, Program Manager
    a. Kristin gave an overview of all nine Workplans and states all are doing well. She went on to state we are working on providing more face-to-face services.
    b. CSU Update: Kristin discussed the new walk-in hours and information for the Crisis Stabilization Unit (CSU). It is posted on the County website.
    c. FSP Update: Christina Menghrajani, Behavioral Health Program Supervisor
    Christina gave an update on the Full-Service Partnership (FSP) Program. She states all clients are being seen by Telehealth or face to face, and there has been no interruption in services due to COVID-19. The program works closely with MHET, CSU and Hospitals to help those in need gain access to services. Christina also stated all FSP caseloads are full.
4. **PEI Update:** Tim Siler, Administrative Services Officer
    a. Suicide Prevention Plan is available for public comment/review until April 21st.
    b. Middle school programs are going strong, twelve schools have counselors and Friday Night Live has been active all year with different online activities.
    c. Behavioral Health Navigators are doing amazing things and Tim went on to discuss some success stories.
    d. All other programs have been moving along with either safe in-person, drive thru, virtual meetings, or virtual outreach events.
5. **Innovation Update:** Tim Siler, Administrative Services officer
    a. The Innovation Plan Draft is available for Public Comment/Review until April 21st. The Plan includes Behavioral Health Education & Engagement Team (BHEET) and SoulWomb.
    b. The current Innovation projects for FY 18-22 are SLO ACCEPTance: Cal Poly, and 3X3: First 5.

c. The current Innovation projects for FY 19-23 are Holistic Adolescent Health: CAPSLO, and Behavioral Health Assessment & Response Project (BHARP).
d. Sarah Montes Reinhart, Program Administrator for 3X3 Discussed how the Innovation project uses three methods, Health Educator, Parent/Guardian, and Childcare Provider to assess the child through developmental and emotional screenings, this helps identify children that may need services. The Ages and Stages Questionnaire (ASQ) is used to better understand the child's growth and development.

6. **Wet Update:** Frank Warren, Behavioral Health, Division Manager
   a. Frank introduced Renee Draga from TMHA to talk about the Peer Advisory and Advocacy Team (PAAT). Renee discussed using Listening Sessions to bolster interagency collaboration as well as looking at Intersectionality Framework. She went on to talk about positive feedback and experiences with the program. Renee listed some priorities for advocacy, including, housing and substance use and abuse, services expansion of adolescent and transitional aged youth and older adult and family services.
   b. Renee informed the meeting participants of the two-day summit put on by PAAT, this event will focus on consumer-identified goals through panel discussions, forums, and workshops.
7. **Fiscal Update:** Jalpa Shinglot, MHSA Accountant
   a. The fund balance as of March 29, 2021 (excluding Prudent Reserve) is $20,921,255 with the Prudent Reserve Fund balance of $2,774,412.
   b. CSS: Although the Full-Service Partnership should have the majority of CSS funding (51%) it currently has 45% for FY 20/21.
   c. PEI: No additional funding currently.
8. **Old Business:**
   a. The Trust Fund for Assessment Coordinators AB2265 was approved for a total of $509,536.
9. **New Business:**
   a. PMAD: proposed moving PMAD out of PEI and into CSS and then funded with money from Work Education Training (WET) Program. The money to come from the Prudent Reserve Fund ($55,000) and put into CSS. There will be further explanation and a request for funding at the next MHSA Meeting in May.
   b. In May we will present to the Stakeholders a request for Prudent Reserve Funds to be used for a Diversity, Equity, Inclusion Coordinator. This position will be MHSA funded with Medi-Cal reimbursement.
10. **Updates:**
    a. CHFFA Grant, the County got the grant, which will fund the current Youth Triage Team for an additional 5 years.
    b. VTC Grant will be submitted next week.
    c. COLA, there is a 2% COLA increase up for internal review, with a policy recommendation in May.
    d. Joni McCoy, MHSA Accountant, has accepted a position with County Libraries.
11. **Next Meetings:**
    May 26, 2021; July 28, 2021

Meeting adjourned at 5:15pm

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12. **Attendees:**

Barry Johnson, Clint Weirick, Joe Madsen, Joni McCoy, Frank Warren, Kristin Ventresca, Rebecca Redman, Lisa Fraser, Jalpa Shinglot, David Riester, Cynthia Barnett, Anna Boyd-Bucy, Christina Menghrajani, Jessie Yates, Dylan Hunt, Pam Zweifel, Jenny Luciano, Anne Robin, Dawn Marie Anderson, Tim Siler, Carrie Collins, Jenny Luciano, John Gillespi, Danijela Dornan, Trista Ochoa, Mark Woelfe, Renee Draga, Tonya Leonard, Michelle Call, Andrea Wagner, Mike Bosenberry, Sarah Montes Reinhart, Sandra Miscovich

Appendix 19

MHSA Stakeholder Meeting
Wednesday May 26, 2021
3:30pm-5:00pm
Live via Zoom

Meeting Minutes

1. Frank Warren welcomed the stakeholder group at 3:30 pm. All participants introduced themselves and Frank presented the goals for the meeting. Frank also reviewed the Stakeholder Process, format, and rules for the meeting (e.g., consensus voting, no rules of order, etc.).
2. **Department Update:** Anne Robin, Behavioral Health Administrator
    a. Anne spoke about the Behavioral department recruiting for various positions.
    b. Frank Warren gave an update on the County's Covid-19 response. He stated the County is moving away from the large Vaccination sites and, asked if any of our partners would consider hosting small vaccination pods. He also stated that most local pharmacies are giving the Covid Vaccinations.
    c. Frank also told the Stakeholders that on June 15 the states tier system will be coming to an end and he is looking forward to in-person meetings and suggested a hybrid type meeting until that time.
3. **CSS Update:** Kristin Ventresca, CSS Coordinator, Program Manager
    a. Kristin gave an overview of all the CSS workplans and stated that all are doing well. She also stated the current FSP teams are at full capacity.
4. **PEI Update:** Tim Siler, Administrative Services Officer
    a. The Suicide Prevention Strategic Plan was approved by the Board of Supervisors.
    b. Veteran's Outreach Program (VOP) - Gabriel Granados, VOP Coordinator
    The Veteran's Outreach Program started nine years ago as an Innovation Project. During the Covid emergency the program has hosted a variety of online events such as, trivia and game nights, Netflix watch party, paint by Zoom and cooking as well as nutrition classes and Veteran's Voices Art Exhibit. All the materials needed were provided by the program and dropped off for the participants. These events are also a way to introduce the Veteran's Outreach Therapist, Breanne Salmon, who also participates in the events. They will be hosting Kayaking in Morro Bay for a limited number of participants as their first in-person event in June.
5. **Innovation Update:** Tim Siler, Administrative Services officer
    a. The Newest Innovation Plans, Behavioral Health Education & Engagement Team (BHEET) and SoulWomb have completed public review and are currently with the MHSA Oversight and Accountability Commission waiting for approval.
    b. Tim stated he spoke to Dr. James Holifield about the H-Harp Innovation Project and is hoping to have him present to the group at the next Stakeholder meeting.
    c. Holistic Adolescent Health Project, Charley Newel, CAPSLO
    This program offers comprehensive team health coaching in mental health and other related areas. They are using virtual implementation and are looking forward to resuming in person coaching.

6. **Fiscal Update:** Jalpa Shinglot, MHSA Accountant
    a. The fund balance as of May 14, 2021 (excluding Prudent Reserve) is $18,354,473 with the Prudent Reserve Fund balance of $2,774,412.
    b. CSS: Although the Full-Service Partnership should have the majority of CSS funding (51%) it currently has 45% for FY 20/21.
    c. PEI: No additional funding currently.
7. **New Business:**
    a. The Stakeholders were presented a request for a decision on funding a full time Diversity, Equity, Inclusion Coordinator. The state requires the county to have an Ethnic Services Manager, which we would title Diversity, Equity, Inclusion Coordinator. This would be a full-time position, equal to a program manager and would fall under our quality Division. The ask is to fund this position with a one-time funding of up to $65,000 from the Prudent Reserve. The Stakeholders will be emailed the decision form for review.
    b. The Stakeholders were presented with a request for a decision on funding for the Perinatal Mood and Anxiety Disorder Program. This funding would sustain the Public Health Dept. PMAD Program for one year, while future funding can be procured. The ask is for one-time funding of $50,000 from the Prudent Reserve. The Stakeholders will be emailed the decision form for review.
8. **Updates:**
    a. CHFFA Grant, the grant was approved for one year.
    b. VTC Grant, waiting to hear if approved, if approved it will be housed at South Street location.
    c. 2% COLA calculation, working on policy and timeline.
9. **Next Meetings:**
    July 28, 2021; Sept. 29, 2021

Meeting adjourned at 5:10pm

10. **Attendees:**

Barry Johnson, Frank Warren, Kristin Ventresca, Rebecca Redman, Lisa Fraser, Jalpa Shinglot, Cynthia Barnett, Christina Menghrajani, Jessie Yates, Dylan Hunt, Pam Zweifel, Jenny Luciano, Anne Robin, Tim Siler, John Gillespi, Danijela Dornan, Mark Woelfe, Mike Bosenberry, Gabe Granados, Brenda Serna, Kimberly Umana Alvarado, Jeff Smith, Charley Newel, Morgan Torell, Nestor Veloz-Passalacqua, Jenna Miller, Joseph Kurtzman, Amanda Getten, Bonita Thomas, Jenilee Sneed, Raven Lopez

Appendix 19

PEI COMMUNITY PROGRAM PLANNING PROCESS
County: San Luis Obispo (SLO County) **Date: November 17, 2008**

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

The San Luis Obispo County Behavioral Health Department Administrator, Karen Baylor, Ph.D., MFT in conjunction with Nancy Mancha-Whitcomb, Mental Health Services Act Division Manager, had the overall responsibility for ensuring that the Community Program Planning Process was carried out as required by statute.

Ms. Mancha-Whitcomb was responsible for participating in statewide discussions and ensuring that DMH Notices and communications were followed, and that a compliant, feasible proposed PEI plan was submitted to DMH for approval.

A County Mental Health Services Accountant II, Lisa Anderson, is dedicated to MHSA and had the overall fiscal responsibility during the planning process.

Frank Warren, Program Supervisor within Drug and Alcohol Services, was the lead for writing the plan document, and will work with the MHSA Oversight and Accountably Commission to obtain approval of the plan. Mr. Warren will be responsible for PEI program implementation.

A 34-member Community Planning Team of diverse public and private stakeholders was responsible for guiding the planning process, analyzing community input, and selecting projects in accordance with community priorities. That membership is described further in Section 1c below.

An independent planning consultant, Dale Magee, was contracted to design and manage the planning process resulting in project selection and assist Mr. Warren in writing the plan document. Ms. Magee was also responsible for the 2005 CSS Community Program Planning Process.

b. Coordination and management of the Community Program Planning Process

From January through October 2008, the planning consultant coordinated and managed all components necessary to conduct a comprehensive community input and program planning process, including: the recruitment and coordination of the Community Planning Team and age specific workgroups; a publicity campaign; develop and distribute surveys, create-

informational materials; conduct focus groups and stakeholder interviews; synthesize and analyze input data; create data reports; identify community priorities; research program options and details, and facilitate the Planning Team's project selection process.

A mental health therapist experienced in community partnerships and integrated systems of care was dedicated half time from February through June 2008, to assist with outreach and input efforts, especially to reach underserved rural communities, age groups, and cultural populations.

From March through May 2008, the bilingual/bicultural psychologist who directs the CSS Latino Services Program and chairs County Mental Health's Cultural Competency Committee conducted extensive

outreach to low-acculturated Latino communities and other Latino groups, and conducted focus groups, interviews and PEI presentations. She also served an advisory role to the planning consultant.

An internal SLOBHD work team met at least monthly beginning September 2007 to review the PEI Guidelines, formulate the overall planning process, refine survey and input instruments, track the state and local planning process, and develop program and projects details. Those members included:

• Karen Baylor, Ph.D, MFT Behavioral Health Administrator
• Nancy Mancha-Whitcomb, MHSA Division Manager (joined January 2008)
• Frank Warren, Drug and Alcohol Services (DAS) Program Supervisor
• Lisa Anderson, MHSA Accountant
• Rhea Liiamaa, Systems Affirming Family Empowerment (SAFE) Coordinator (January - June 2008)
• Brad Sunseri, Youth Services Division Manager (September - December 2007)
• Janet Amanzio, Adult Services Division Manager (September - December 2007)
• Dale Magee, planning consultant

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The comprehensive Community Program Planning Process began in August 2007 and consisted of four phases:

1. "Plan to Plan." August 2007 through January 2008.
2. Community Outreach and Input. February through April 2008.
3. Data Analysis; Priorities and Strategy Identification. May through August 2008.

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4. Project Selection and Design. August 2008 through October 2008.

More than 3,000 individuals were involved in the Community Program Planning Process throughout the phases. Stakeholders were involved from the beginning and will continue once PEI projects are operating.

Phase I: Plan to Plan (August 2007 - January 2008)

This phase was for educating the work team on the PEI guidelines and DMH's approach, for strategy development for the community input process, and to gather resources to ensure a successful Community Program Planning Process. This was primarily an internal effort yet key stakeholders provided valuable input and guidance.

The existing MHSA CSS Community Planning Team, whose membership includes most of the representatives required for the PEI planning process, was consulted in December 2007 to provide recommendations on outreach strategies and stakeholder groups to include during the forthcoming PEI community input process. More than 25 people, including consumers, family members and Latino community representatives, contributed.

Recruitment for the PEI Community Planning Team began during this phase. Both "required" and "recommended" stakeholders were enlisted.

The 34-member PEI Community Planning Team first convened in January 2008 for a PEI component orientation and training. The Planning Team represents most of the required and recommended PEI groups, and serves as the oversight body for the Community Program Planning Process, and ensured a comprehensive and inclusive input process and that the resulting proposed PEI Plan reflected the spirit of the community's wishes.

The **Community Planning Team** membership includes representatives from the following groups (some members represent more than one group):

• Individuals with mental illness (at least 4)
• Consumers (at least 2)
• Family members (at least 7)
• Family Advocates
• Behavioral Health Department Administrator
• California Polytechnic University (Cal Poly), Counseling Services
• Community Members at Large

Appendix 20

County of San Luis Obispo Behavioral Health Department
Cultural Competence Plan
Annual Update – December 2020

Summary

The County of San Luis Obispo Behavioral Health Department (SLOBHD), which includes divisions providing mental health and substance use disorder services, is committed to developing a system of care which serves an increasing, changing and diverse population in the county. The system must strive to ensure cultural competence at all levels of the organization. A Cultural Competence Plan is at the heart of the efforts to develop and maintain effective providers of health care for diverse communities.

The 2020 Cultural Competence Plan provides guidelines to help the Behavioral Health Department become a more culturally competent organization and to ensure that diverse populations in the county receive mental health and substance use services that are culturally appropriate throughout the behavioral health system. The Plan serves as a roadmap led by both the Cultural Competence Committee and the Department's Management Team.

The Cultural Competence Committee, formed in 1996, consisting of staff members from the various divisions and programs of the Behavioral Health Department as well as community partners, continues to assess, implement, and monitor policies and practices which ensure effective services are provided in cross-cultural situations. The committee members, representing diverse cultural backgrounds and other special interests, have provided input and insight in order to make the Plan an active document which will inform the County's mental health system for years to come.

La Frontera Inc., a mental health organization based in Arizona, developed a cultural competence self-assessment tool titled "Building Bridges", which the Department and its Cultural Competence Committee continues to use. In this assessment manual, culture is defined as follows: "The term culture is used in a broad inclusive sense. It includes race, ethnicity, gender, sexual orientation, primary language, spiritual life, age, and physical condition. Culture is also a multifaceted concept. It incorporates cultural objects such as music, art and clothing; ways of living such as kinship patterns, communication styles and family roles; as well as beliefs or values such as religion, attitudes towards time and views of the natural world." With this definition as a starting point, the committee hosts a series of discussions to define and operationalize the concept of cultural competence for the mental health system.

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As the Department continues to seek methods to engage staff and community providers with modern, effective cultural competence training and practices, a commitment to organizational growth is a Department value. According to the Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies, culturally competent organizations are ones which:

- ***Continually assesses organizational diversity****: Organizations should conduct a regular assessment of its members' experiences working with diverse communities and focus populations. It also regularly assesses the range of values, beliefs, knowledge, and experiences within the organization that would allow for working with focus communities.*
- ***Invests in building capacity for cultural competency and inclusion****: Organizations should have policies, procedures, and resources in place that make ongoing development of cultural competence and inclusion possible. It must also be willing to commit the resources necessary to build or strengthen relationships with groups and communities. Including representatives of the focus population within the organization's ranks is especially useful.*
- ***Practices strategic planning that incorporates community culture and diversity****: Organizations are urged to collaborate with other community groups. Its members are also encouraged to develop supportive relationships with other community groups. When these steps are taken, the organization is seen as a partner by other groups and their members.*
- ***Implements prevention strategies using culture and diversity as a resource****: Community members and organizations must have an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to ensure they are accessible to and attuned to their community or focus population.*
- ***Evaluates the incorporation of cultural competence****: Community members must have a forum to provide both formal and informal feedback on the impact of all interventions.*

The Cultural Competence Plan is part of the Department's efforts to remain a culturally competent, responsive, and supportive community organization.

Key Objectives and Annual Results

In response to the Department of Health Care Services CCP requirement, the SLOBHD has developed a comprehensive Plan and has chosen to include key objectives to monitor.

- The SLOBHD will complete the revision and adopt the Cultural Competence Training Policy which includes requirements for staff development in cultural competence and demonstrated improvements in service to diverse clients.
    - In 2019-2020, the Department continued the use of the Relias E-Learning system to provide core competency training and education for all staff, as well as community partners, consumers, and family members.

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- The Department provided access to 500 providers, consumers, and family members with a total of over 2,000 completed hours in fiscal year 2019-2020.
- In 2019-2020, the Cultural Competence Committee selected training courses on Relias Learning for Behavioral Health staff focused on multicultural care and issues of abuse. The assigned curriculum included the completion of two courses:
    - Working with People Experiencing Homelessness (assigned to all staff)
    - Suicide and Depression in Older Adults (assigned to adult-based staff)
    - Developmental Concerns, Childhood to Adolescence (assigned to youth-based staff)
- Staff course completion was 85%, with 365 (out of 384) direct service employees (including temporary and volunteer staff) completing the curriculum.

- The Cultural Competence Committee (CCC) will increase cultural competence training for mental health and drug and alcohol system providers by two activities per year.
    - Strategies to accomplish this objective include networking with community partners who can provide quality training for mental health and drug and alcohol system provider professionals.
        - The CCC brought an important perspective to local providers in April, 2020 – "Bridges Out of Poverty" provided key lessons in dealing with individuals from poverty. Topics included increasing awareness of the differences in economic cultures and how those differences affect opportunities for success. This workshop was based on the book Bridges Out of Poverty: Strategies for Professionals and Communities, and was presented by Jodi Pfarr, an author focused on community training.
            - All attendees surveyed (n = 14) reported the ability to develop a mental model of generational poverty and explore the impact of poverty on those served by the organization and understand the six poverty registers of language, discourse patterns, and cognitive issues.
        - In partnership with the regional WET collaborative – Southern California Regional Partnership – the CCC (also in August, 2019) presented "Enhancing Cultural Humility in Working With Diverse Families in Community Based Mental Health Settings." The training was presented by Jonathan Martinez, PhD., of California State University, and was attended by 96 local providers.
            - All participants reported the ability to understand culture, cultural humility, race/ethnicity, and diversity. And, 87% (36/41 surveyed) reported gaining the knowledge to implement culturally-responsive, evidence-based strategies to enhance cultural humility values in daily practice.

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- The County and its CCC will also broaden the approach to cultural competence training to include activities which improve the mental health and the drug and alcohol system's capacity to serve cultural populations (e.g. LGBTQ, Veterans, consumers and family members).
  - In August 2019 and February 2020, the CCC hosted a powerful training focused on implicit bias, systemic racism, and racial inequities in behavioral health. "Cultural Competence: Toward a Culturally-Informed Behavioral Health Practice " was presented by Dr. Leola Dublin Macmillan and associates to the entire Behavioral Health Department over three weeks, with a follow-up session to enroll all staff. Nearly four hundred staff were engaged by Dr. Macmillan on issues of structural inequality, implicit bias, cultural relevance, and dismantling oppression within the behavioral health continuum of care.
    - Participants reported (83%, 110/131 surveyed) a greater understanding of the intersection of social justice and behavioral health, and how those terms relate to behavioral health. Participants also gained (85%, 111/131) knowledge of health care disparities in marginalized and underserved communities and how those disparities are salient issues for behavioral health practitioners.
  - The last training held prior to shelter at home orders, due to COVID-19, was a 'Trans Training 101" presented by Dr. Jay Bettergarcia (Cal Poly) and Stacy Hutton, on March 12, 2020. The purpose of the workshop (which had 75 attendees) was to enhance the ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics was presented in an informative and accessible manner. Attendees engaged in experiential activities, watched video clips, and observed mock therapy sessions. All attendees surveyed (21) reported better understanding of subtleties in language and perspective that make interactions with trans people truly affirming.

- The CCC will increase membership of staff from the Drug and Alcohol Division by two or more members annually over the next two years.
  - This objective is critical to enhance the diversity of the Committee which serves to improve cultural competence principles across the SLOBHD's programs and services. This specific goal was accomplished as a total of five (5) qualified staff members from across the Department's divisions joined the committee.
  - The strategies to meet this objective include working with the County's Prevention and Early Intervention (PEI) programs which have built relationships and partnerships with organizations serving cultural populations often underserved in the mental health and drug and alcohol system, along with expanded services with the Latino and Latinx population. These include Asian/Pacific Islanders, LGBTQ, veterans, older adults, TAY, and consumers.

Appendix 21

        - During FY 2019-2020, the CCC participated in the release of the findings of the LGBTQ+ Mental Health Needs Assessment which attempted to best identify the needs of the community. The research will help the County identify gaps and needs for training to develop a culturally competent system and workforce. The results became available in June 2019 with local presentations to the Behavioral Health Board and the MHSA Advisory Committee and PEI Stakeholder groups in November. The results are meant to influence and develop strategic practices to ensure services and programs needed for the LGBTQ+ community are addressed.

- The CCC, as part of its mission to "ensure that cultural diversity is incorporated into all levels of the Behavioral Health Department," will begin the development of practices to best process review and recommendation related to culturally competent factors and services in the mental health system.
    - This objective will need to include an expansion of the CCC's review process for documents and translation services aimed at the Spanish-speaking community; staffing recruitment and recommendations, and presentations made to various Department programs currently not represented in the CCC. Strategies to meet this objective include establishing CCC practices to provide feedback and advice to all SLOBHD programs and services that serve diverse clients to assure cultural competence policies and procedures are in place. These elements have begun implementation as the CCC is in the process of reviewing a specific policy for the Latino Outreach Program regarding clients' cultural gift appreciation.
        - The most critical advance in this objective was the need for the Cultural Competence Committee to monitor and assist the Department in meeting the cultural and linguistic challenges of the COVID-19 shelter orders. The CCC worked with the Department and its providers to ensure telehealth options were made available, staff had access to outreach vulnerable cultural populations, and all public communication by the Department reflected appropriate cultural competence.
            - Members of the CCC provided over 300 hours of public health translation services for the County during the first six months of COVID-19 operations.

The Cultural Competence Committee

The Cultural Competence Committee is dedicated to assure that the County of San Luis Obispo Behavioral Health Department becomes a culturally competent health system which integrates the concept of cultural, racial, and ethnic diversity into the fabric of its operation and organization. The committee creates agency-wide awareness of the issues relevant to cultural diversity and provides recommendations to the County Behavioral Health Administrator on issues pertinent to the achievement of these goals.

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The Committee members are the decision-making body and represent a diverse range of cultural, ethnic, racial and geographic regions of the county. The Committee advises and serves as a resource group to the Behavioral Health Director, County Health Agency Staff, Quality Support Team (QST), and affiliated agencies. Meetings are held quarterly. Visitors are welcome to attend committee meetings and provide input.

The goals of the Committee are:

- To ensure that County Behavioral Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
- To provide recommendations that will increase service delivery to culturally diverse clients.
- To provide recommendations which address the need of continued training on cultural diversity topics.
- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
- To provide recommendations which address the recruitment and retention of bilingual providers.
- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, Native Americans, and transition age youth, and older adults.
- To provide County Behavioral Health employees with the topics and information discussed at the Cultural Competence Committee.
- To provide and sponsor trainings focused on expanding and enhancing cultural and linguistic knowledge;
- To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee.
- To foster a strong network among community agencies that will facilitate an integrated delivery of services.

Cultural Competence Newsletters

The Committee produces quarterly newsletters focused on cultural topics in relation to mental health issues. In 2019-2020, the CCC released a total of four newsletters, along with information on local resources and articles highlighting various topics related to the mental health field.

Cultural Competence Training

- Journey of Hope is a community forum presented in partnership with Transitions Mental Health Association. In February, 2019 the featured keynote speaker was comedian Adam Grabowski. An acclaimed performer and leader of the #sayitanyway campaign, Adam spoke about his depression and anxiety, empowering others to talk about their own mental health experiences, at two separate events. This was the first time hosting multiple Journey of Hope events (one in the south and one in north county) to engage diverse audiences.

- Relias "E-Learning": The Department provided access to 500 providers, consumers, and family members with a total of over 2,000 completed hours in fiscal year 2019-2020.
    - In 2019-2020, the Cultural Competence Committee selected training courses on Relias Learning for Behavioral Health staff focused on multicultural care and issues of abuse. The assigned curriculum included the completion of two courses:
        - Working with People Experiencing Homelessness (assigned to all staff)
        - Suicide and Depression in Older Adults (assigned to adult-based staff)
        - Developmental Concerns, Childhood to Adolescence (assigned to youth-based staff)
    - Staff course completion was 85%, with 365 (out of 384) direct service employees (including temporary and volunteer staff) completing the curriculum.

- Using a Trauma-Informed Lens: This training is designed to support a shift in thinking, perception, and behavior. Looking through a Trauma Informed Lens means being sensitive to the impact of trauma on others and yourself, understanding and utilizing tools to support self and others in regulating during times of stress; as well as identifying and supporting the system change needed to reduce re-traumatization. Continuing our efforts toward a Trauma Informed SLO County will enhance resilience, increase connection and support stability within our community.

- Trans-Training 101: The purpose of this workshop is to enhance the attendee's ability to work in an effective and affirming manner with transgender clients across the lifespan. A broad overview of trans-related terms and topics will be presented in an informative and accessible manner. Attendees will have the opportunity to engage in experiential activities, watch video clips, and observe mock therapy sessions. Attendees will be taught about the subtleties in language and perspective that make interactions with trans people truly affirming.

- Promotores Collaborative: The Cultural Competence work plan includes cultural competence-based workforce development and training. The funds are used with stakeholder approval to offer translation and interpretation services for the Latino Outreach Program (LOP) clients across the county. The Promotores Collaborative goal is to develop a sustainable, diverse, and comprehensive culture that promotes equal access to community resources and services among all members of the Latino community in the County of San Luis Obispo.

Appendix 21

2019-2020 Cultural Competence Committee - Roster		
Name	**Title**	**Agency**
Nestor Veloz-Passalacqua, M.P.P.	Ethnic Services Manager	Behavioral Health Department
Anne Robin, L.M.F.T.	Behavioral Health Administrator	Behavioral Health Department
Joe Madsen	Division Director	Transitions-Mental Health Association
Desiree Troxell,	Quality Support Team	Behavioral Health Department
Jill Rietjens	Division Manager, Youth Services	Behavioral Health Department
Bonita Thomas	PAAT Member	Peer Advisory & Advocacy Team
Marne Travisano, Ph.D.	Licensed Psychologist Private Practice	Private Practice – Community Member
Amber Trigueros, M.A., L.M.F.T.	Mental Health Therapist III	Behavioral Health Department
Jay Bettergarcia, Ph.D.	Assistant Professor	Cal Poly San Luis Obispo
Kiana Shelton	Mental Health Therapist IV	Behavioral Health Department
Laura Zarate	Secretary I	Behavioral Health Department
John Aparicio	Outreach Coordinator	Veteran Services Office
Lilia Rangel-Reyes	Multicultural Specialist	Tri-Counties Regional Center
Leola Dublin MacMillan, Ph.D.	Assistant Professor	Cal Poly San Luis Obispo
Katherine E. Soule	Director	UC Coop. Extension & Youth, Families.
Barry Johnson	Division Director	Transitions-Mental Health Association
Maria Mickens, L.M.F.T.	Social Worker	Family Care Network
Gabriel Granados	Behavioral Health Specialist II	Behavioral Health Department
Maria Troy, R.N., B.S.,M.P.A.	Promotores Interpreter	Promotores
Marcy Paric, Ph.D.	Behavioral Health Board Member	Behavioral Health Board
Maegan Cain	HR Personnel Technician	Behavioral Health Department
Michelle Call	Executive Director	Gay and Lesbian Alliance
Nasseem Rouhani	Health Education Specialist	Public Health Department
Leticia Palafox	Behavioral Health Specialist I	Drug & Alcohol Division
Tania Resendiz	Behavioral Health Clinician II	Drug & Alcohol Division
Annika Michetti	Program Supervisor	Drug & Alcohol Division
Claudia Lopez	Patient's Rights Advocate	Behavioral Health Department
Adare Toral	Behavioral Health Clinician II	Drug & Alcohol Division

Finally, in late 2019, the CCC helped the Department produce the following “We Welcome” signage for each of its public offices:

Appendix 21

Bilingual Staff

First Name	Last Name	Position
Corinne	Yozamp	Health Information Tech II
Maria	Oliveros	B.H. Specialist I
Yesenia	Mora	B.H. Clinician II
Connie	Velasquez	Administrative Asst III
Conrad	Mendoza	B.H. Clinician III
Ricardo	Lopez	B.H. Specialist II
Melissa	Soto	B.H. Specialist II
Allison	Sommers	B.H. Clinician III
Gloria	Lopez	B.H. Specialist I
Abril	Delgado	Administrative Asst III
Humberto	Cantu	B.H. Clinician II
Gricel	Mendoza	B.H. Clinician III
Angelica	Ruvalcaba	Administrative Asst III
Mayra	Lopez	B.H. Clinician II
Claudia	Lopez	B.H. Clinician III
Jakelyn	Llamas Meza	B.H. Clinician II
Irma	Real	Health Information Tech II
Alexandra	Hernandez	B.H. Clinician III
Leticia	Palafox	B.H. Clinician I
Jessica	Ramos	B.H. Clinician II
Angie	Acosta	B.H. Specialist II
Susana	Franco	B.H. Clinician II
Jacqueline	Rivera	Administrative Asst III
Elizabeth	Sanchez	B.H. Clinician II
Perla	Sanchez Ramos	Administrative Asst III
Rita	Jordison	Health Information Tech II
Elba	Vasquez	B.H. Worker II
Fatima	Ponce Alvarez	Health Information Tech I
Terresa	Sanchez	Administrative Asst III
Maria	Aquino-Anda	B.H. Specialist II-Limited Term
Diana	Martin	Administrative Asst III
Alexis	Gibson	B.H. Clinician II
Alisson	Rivas Lua	Administrative Asst III
Christina	Garcia	B.H. Specialist II
Vanessa	Corona	B.H. Specialist II

Appendix 22

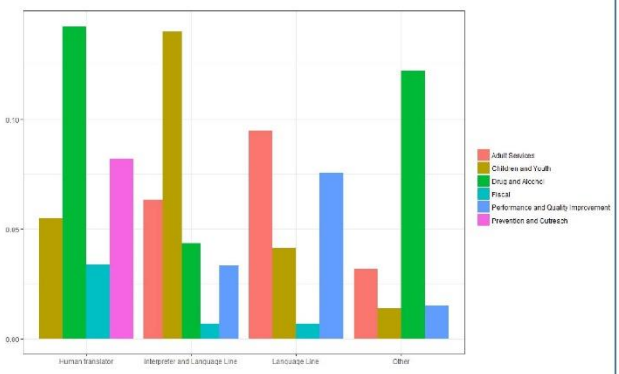
Research Questions

1. Does the staff's level of comfortability/understanding of cultural competence with their clients differ by the division in which they work? By their gender? By their race?
2. How does the staff of the Behavioral Health Department feel about connecting with different cultural groups?
3. How does the staff feel about their division serving its targeted populations?
4. How does the staff feel about cultural competency trainings preparing them for their job? What topics would they like to see in future trainings?
5. Overall, how does the staff of the Behavioral Health Department feel about their level of cultural competency?

Ex) Grouping together Similar Answers

How would you address a situation where a client speaks a language other than your own?

Coded Responses	Number in this category	Percent
Human translator	24	31%
Interpreter and Language Line	22	29%
Language Line	15	22%
Other	10	18%



Broken Down

Agreement Scale

Disagree | Somewhat Disagree | Somewhat Agree | Agree

- Agree
- Somewhat Agree

→ Agree

- Somewhat Disagree
- Disagree
- Neutral / Don't Know

→ Do Not Agree

Frequency Scale

Never | Seldom | Sometimes | Often | Always

Question: "Which race do you primarily identify with?"

Response	Number of People	Percent
White	54	73.6%
Latino	12	17.6%
Other	6	8.8%

→ Hispanic/Latinx | White | Other

Division	Sample Size	Population Size	# of respondents
Fiscal	7	15	7
Prevention and Outreach	13	27	8
Performance and Quality Improvement	16	45	9
Adult Services	24	67	13
Child and Youth	23	73	18
Drug and Alcohol	27	109	16
			71

Response Rate = 64%

Cooperation Rate = 100%

Appendix 23

Of all the trainings you have received, which topic(s) did you find most relevant to your work?

Coded Responses	Number in this category	Percent
Issues of Mental Health, Access and/or Attitudes	12	18%
Issues of culture, race and/or language barriers	19	25%
Issues pertaining to gender and orientation	6	9%
Issues relating to trauma, poverty and/or substance abuse	6	8%
N/A or No Answer	12	16%
None	5	8%
Other (answers which strongly overlapped or themes not contained in other categories)	11	13%

Identify the subgroup(s) you believe are inadequately served by your division.

Coded Responses	Number in this category	Percent
Impoverished	3	6%
LGBTQ+	4	9%
Latinos and the spanish speaking community	18	39%
Mentally ill and/or Homeless population	9	23%
Non-Latino ethnic groups	6	10%
Other	5	10%

Future Trainings - Simplified

We went through the comments on the question: “Are there any subjects in particular that you would like to see
in a future training?” and tallied similar response and identified similar themes which are presented below. Near
the end of the appendix are the unedited comments for reference.
The results mainly speak for themselves, there were many topics that received some support (2-5 respondents), 2
that received a noticeable amount (6-9), and 2 that had a large amount of support.
Large:

- Challenges/Values of Different Cultures - 18
- Gender Identity - 10

Moderate:

- Poverty/Gang/Youth Training - 7
- Mental Health - 6

Some:

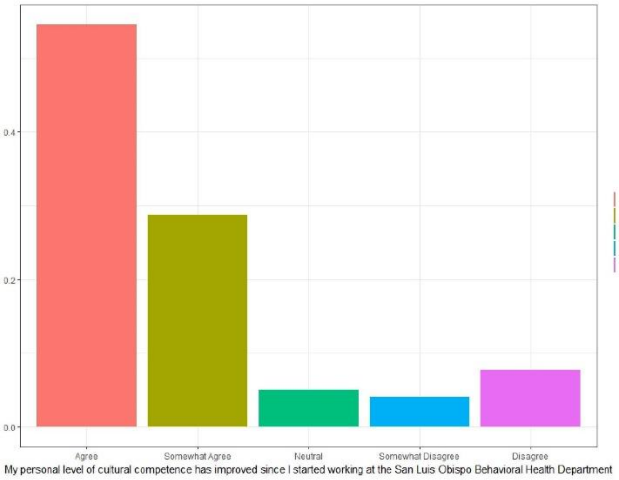
- LGBT Sensitivity - 5
- How to Reach Minorities - 5
- More Trainings (in general) - 4
- Dealing with Language Barriers - 3
- Co-worker Relationships - 2
- Working with Homeless - 2
- Substance Abuse - 2
- Women Treatment - 2
- Older Populations - 2

Appendix 23

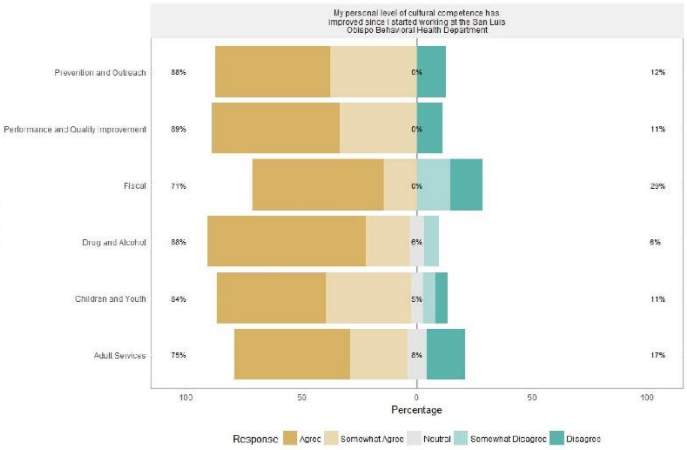
Example Analysis for Each Question

"My personal level of cultural competence has improved since I started working at the San Luis Obispo Behavioral Health Department"

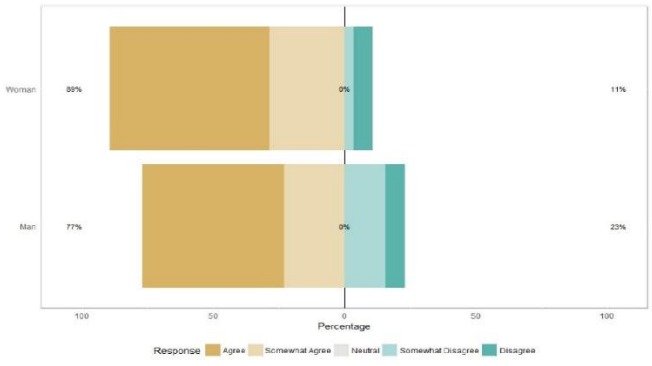
OVERALL



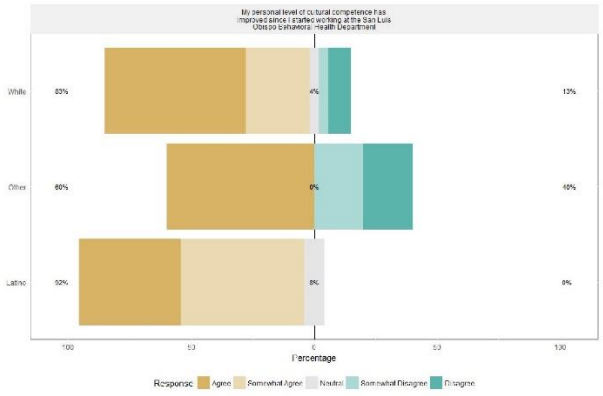
BY DEPARTMENT



BY GENDER



BY RACE



Appendix 23

Q1 Please complete for certificate

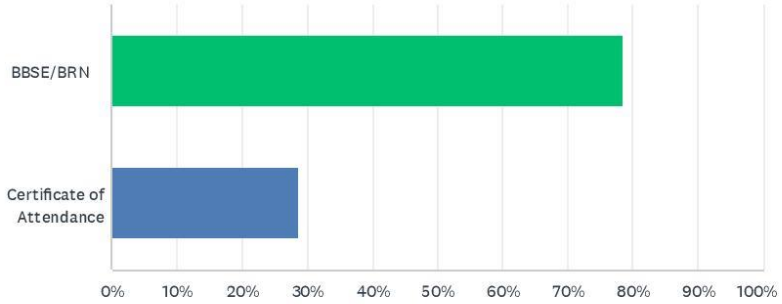
Answered: 14 Skipped: 0

ANSWER CHOICES	RESPONSES	
Last name, First	100.00%	14
Organization	100.00%	14
Address	0.00%	0
Address 2	0.00%	0
City/Town	0.00%	0
State/Province	0.00%	0
ZIP/Postal Code	0.00%	0
Country	0.00%	0
Email Address	100.00%	14
Phone Number	100.00%	14

Appendix 24

Q2 Please choose which certificate you need:

Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
BBSE/BRN	78.57%	11
Certificate of Attendance	28.57%	4
Total Respondents: 14		

Appendix 24

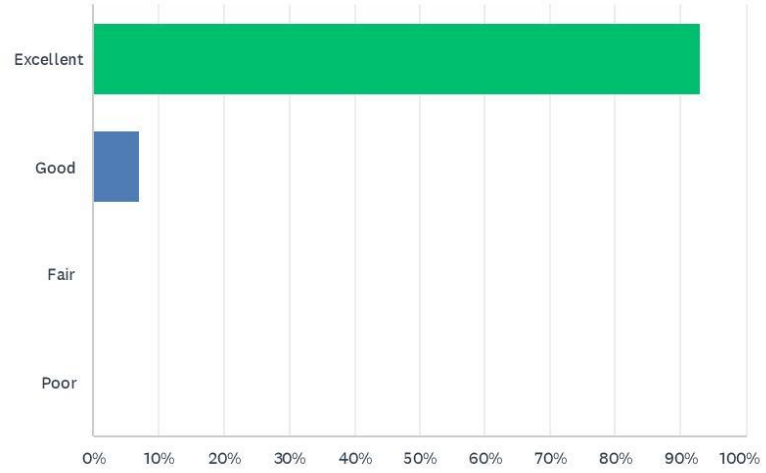
Q3 Enter your license number below (license number is required to issue a CEU certificate, make sure to enter information correctly, if you don't have a license number, please enter N/A):

Answered: 14 Skipped: 0

Appendix 24

Q4 Please rate your overall experience of this training?

Answered: 14 Skipped: 0

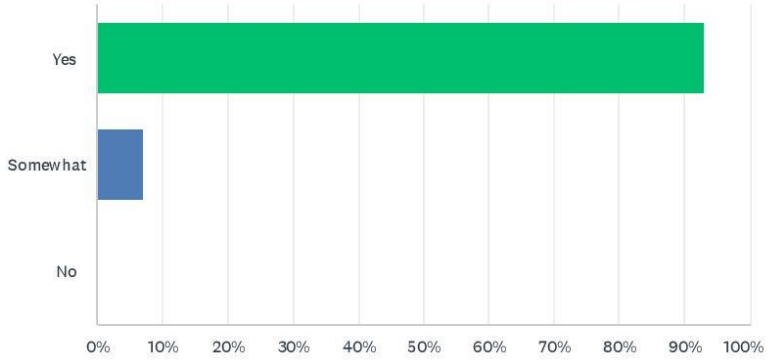


ANSWER CHOICES	RESPONSES	
Excellent	92.86%	13
Good	7.14%	1
Fair	0.00%	0
Poor	0.00%	0
TOTAL		14

Appendix 24

Q5 Did the training meet your expectations?

Answered: 14 Skipped: 0

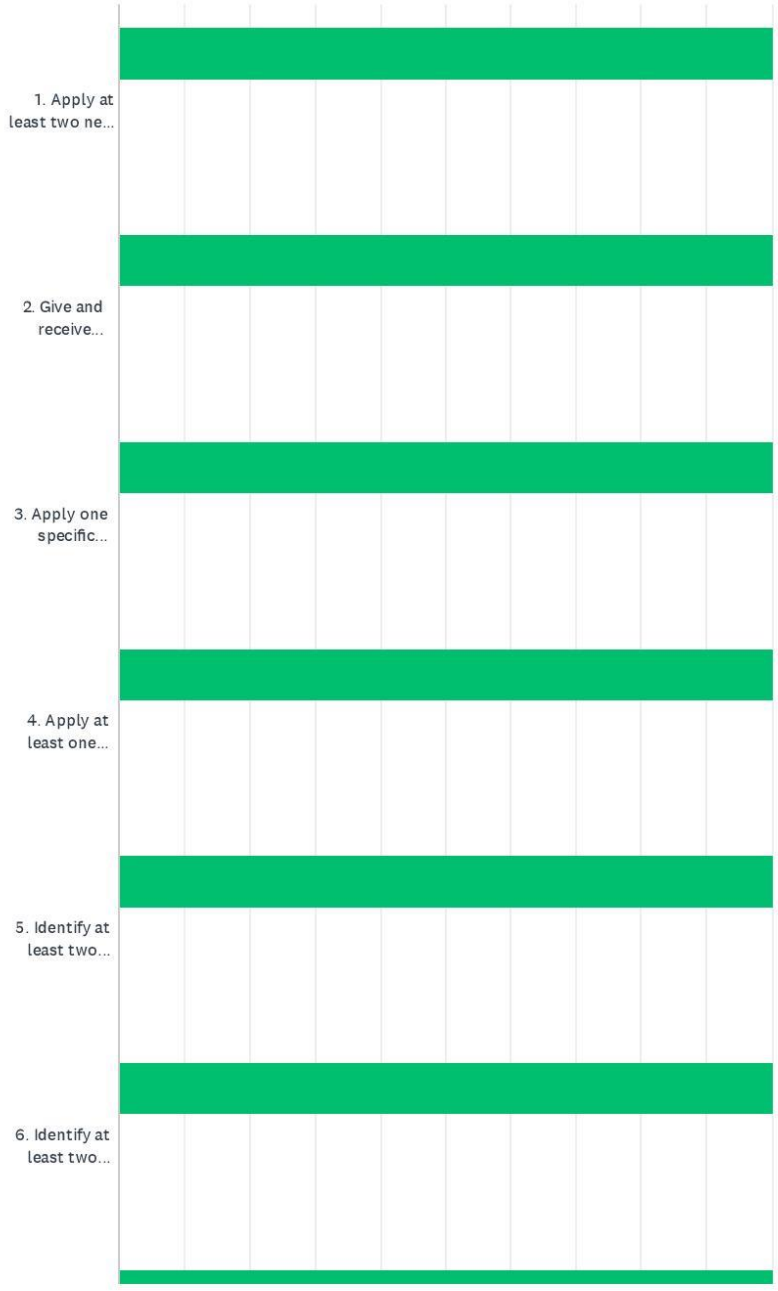


ANSWER CHOICES	RESPONSES	
Yes	92.86%	13
Somewhat	7.14%	1
No	0.00%	0
TOTAL		14

Appendix 24

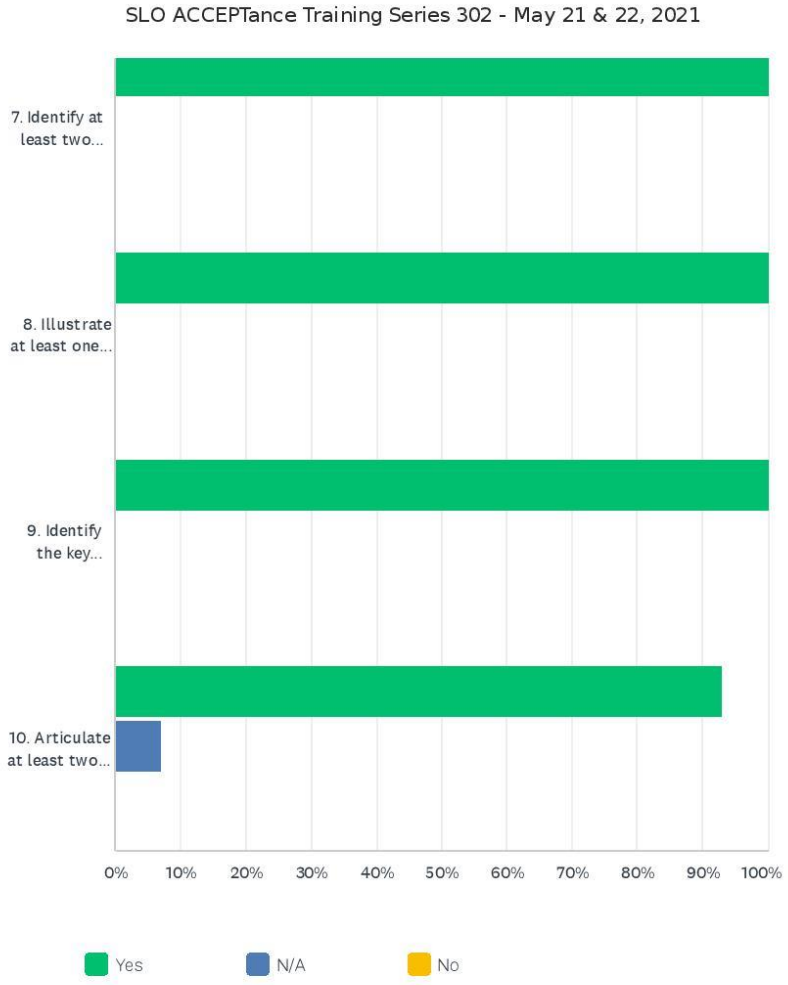
Q6 Learning goals and objectives:

Answered: 14 Skipped: 0



6 / 16

Appendix 24


SLO ACCEPTance Training Series 302 - May 21 & 22, 2021
7. Identify at least two...
8. Illustrate at least one...
9. Identify the key...
10. Articulate at least two...
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes
N/A
No

Appendix 24

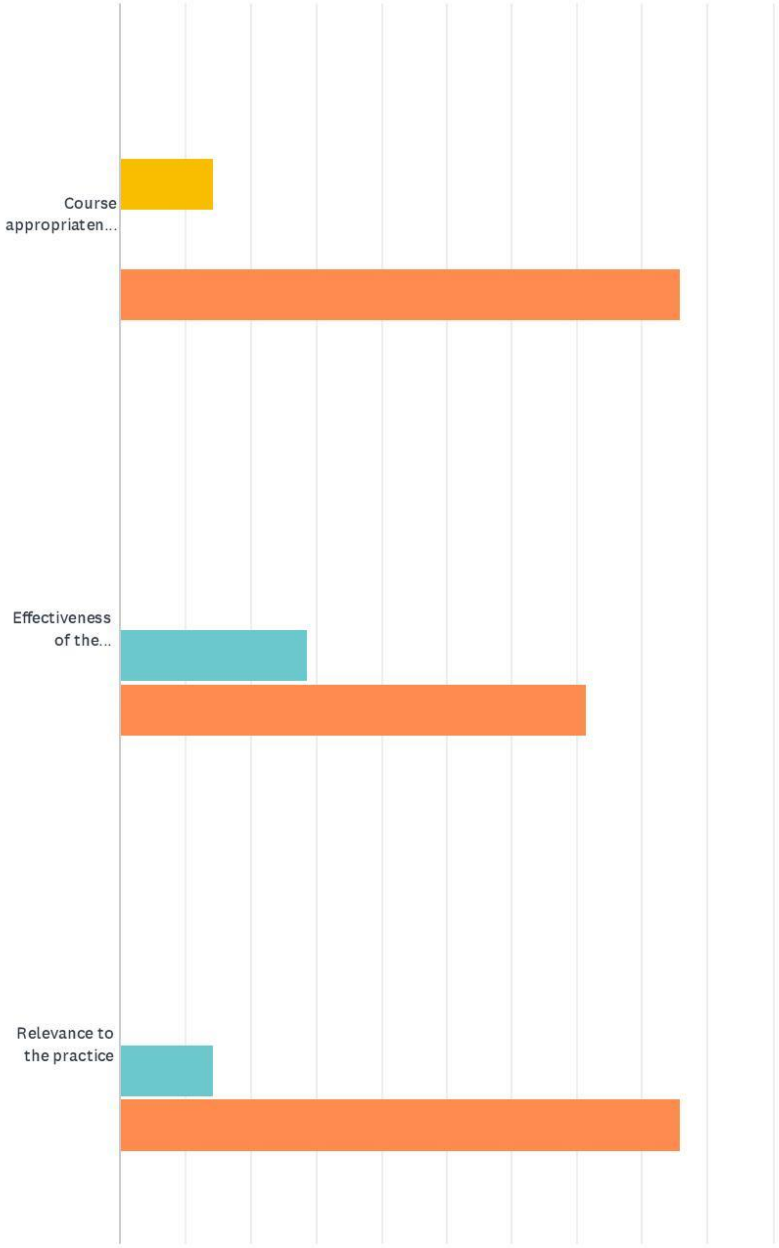
SLO ACCEPTance Training Series 302 - May 21 & 22, 2021

	YES	N/A	NO	TOTAL	WEIGHTED AVERAGE
1. Apply at least two new clinical skills implementing affirming interventions when addressing internalized oppressions with LGBTQ clients.	100.00% 14	0.00% 0	0.00% 0	14	0.00
2. Give and receive feedback on clinical skills so as to assist in strengthening attendees' own therapeutic practice.	100.00% 14	0.00% 0	0.00% 0	14	0.00
3. Apply one specific affirmative-focused clinical skills with LGBTQ-identified youth consumers of mental health in their local community.	100.00% 14	0.00% 0	0.00% 0	14	0.00
4. Apply at least one affirmative theory with LGBTQ-identified youth consumers of mental health in their local community.	100.00% 14	0.00% 0	0.00% 0	14	0.00
5. Identify at least two specific needs of local consumers who have utilized LGBTQ Mental Health Services.	100.00% 14	0.00% 0	0.00% 0	14	0.00
6. Identify at least two examples of discrimination faced by trans/gender diverse youth	100.00% 14	0.00% 0	0.00% 0	14	0.00
7. Identify at least two specific clinical methods of supporting caregivers of trans/gender diverse youth	100.00% 14	0.00% 0	0.00% 0	14	0.00
8. Illustrate at least one specific unmet need of LGBTQ-identified consumers of mental health in their local community.	100.00% 14	0.00% 0	0.00% 0	14	0.00
9. Identify the key determinant to overall mental health wellness for LGBT youth (caregiver acceptance and support).	100.00% 14	0.00% 0	0.00% 0	14	0.00
10. Articulate at least two goals for further professional development (to be explored after the ending of the SLOAcceptance training).	92.86% 13	7.14% 1	0.00% 0	14	0.00

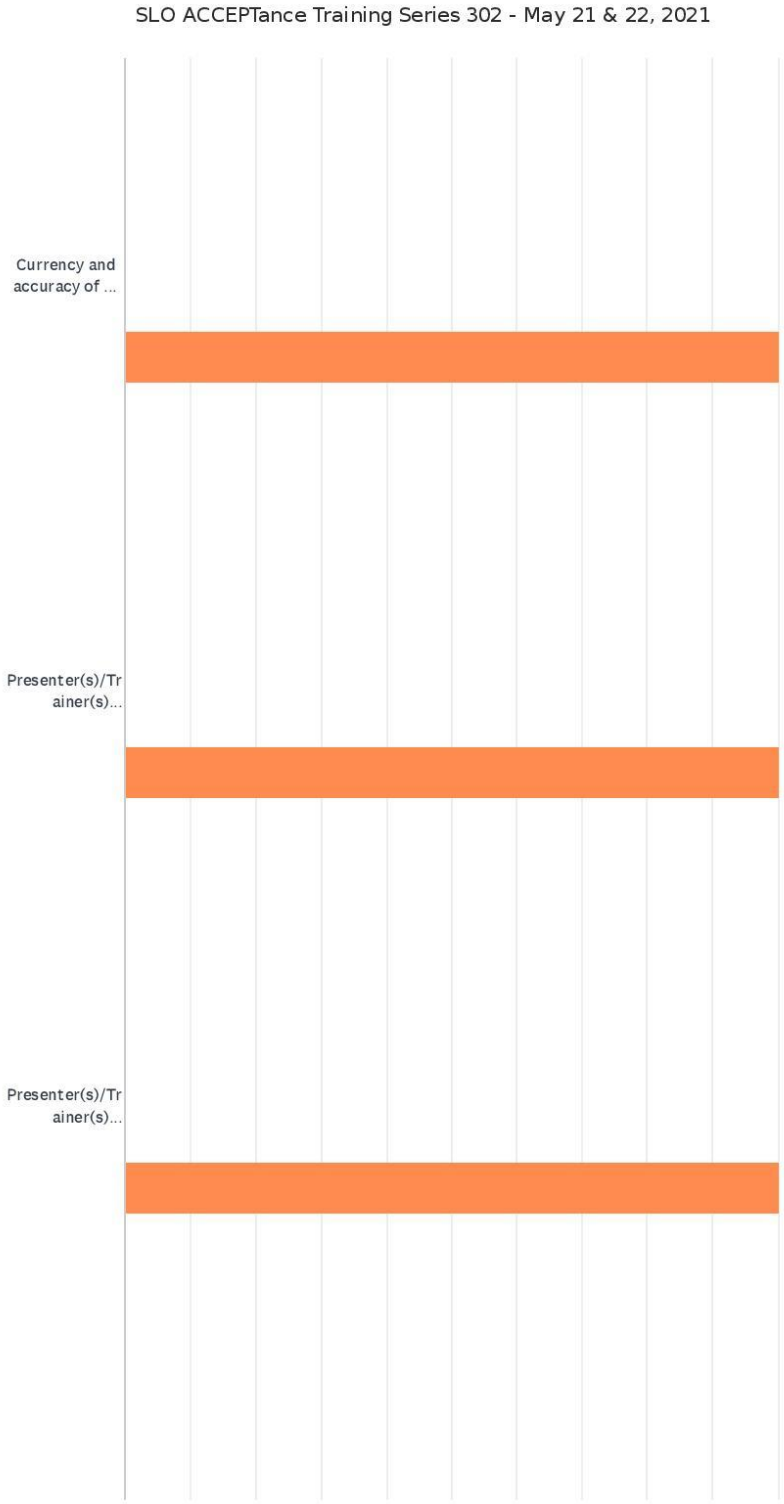
Appendix 24

Q7 Rate, on a scale of 1 to 5 with 1 being "Needs Improvement" and 5 being "Excellent", the following areas:

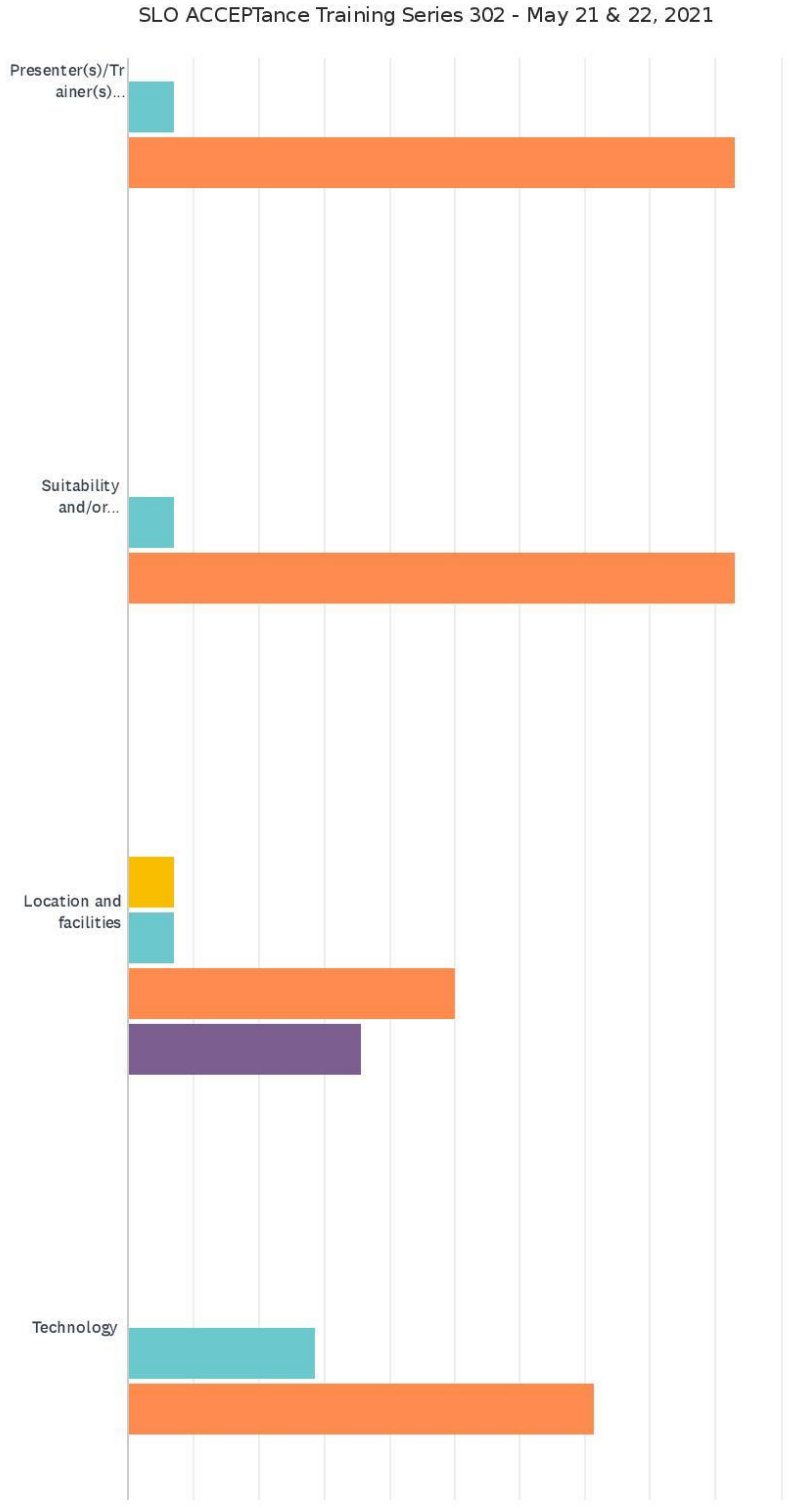
Answered: 14 Skipped: 0



Appendix 24

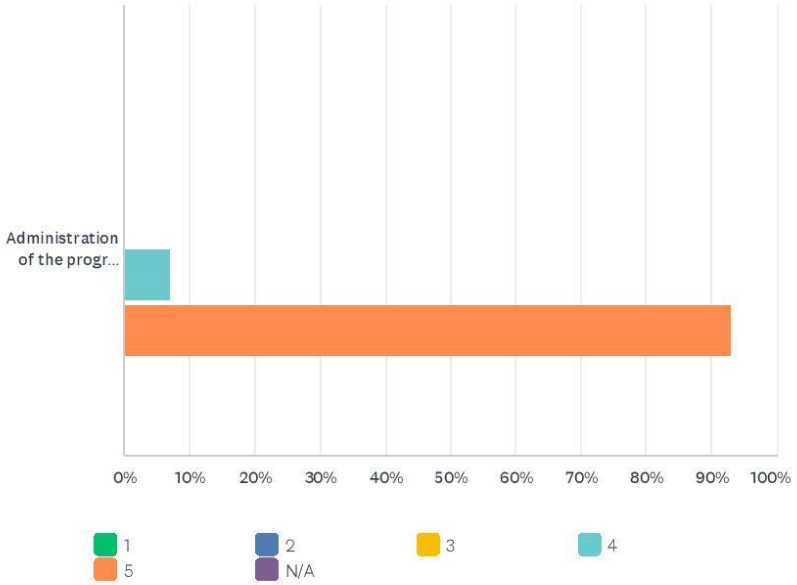

SLO ACCEPTance Training Series 302 - May 21 & 22, 2021
Currency and accuracy of ...
Presenter(s)/Trainer(s)...
Presenter(s)/Trainer(s)...
10 / 16

Appendix 24


SLO ACCEPTance Training Series 302 - May 21 & 22, 2021
Presenter(s)/Trainer(s)...
Suitability and/or...
Location and facilities
Technology
11 / 16

Appendix 24

SLO ACCEPTance Training Series 302 - May 21 & 22, 2021



	1	2	3	4	5	N/A	TOTAL	WEIGHTED AVERAGE
Course appropriateness to participants' education, experience, and licensure level	0.00% 0	0.00% 0	14.29% 2	0.00% 0	85.71% 12	0.00% 0	14	4.71
Effectiveness of the presentation, including use of experiential or active learning	0.00% 0	0.00% 0	0.00% 0	28.57% 4	71.43% 10	0.00% 0	14	4.71
Relevance to the practice	0.00% 0	0.00% 0	0.00% 0	14.29% 2	85.71% 12	0.00% 0	14	4.86
Currency and accuracy of the information	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 14	0.00% 0	14	5.00
Presenter(s)/Trainer(s) knowledge of the subject matter and clarity of delivery	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 14	0.00% 0	14	5.00
Presenter(s)/Trainer(s) responsiveness to participants	0.00% 0	0.00% 0	0.00% 0	0.00% 0	100.00% 14	0.00% 0	14	5.00
Presenter(s)/Trainer(s) ability to utilize course-appropriate technology to support participant learning	0.00% 0	0.00% 0	0.00% 0	7.14% 1	92.86% 13	0.00% 0	14	4.93
Suitability and/or usefulness of instructional materials	0.00% 0	0.00% 0	0.00% 0	7.14% 1	92.86% 13	0.00% 0	14	4.93
Location and facilities	0.00% 0	0.00% 0	7.14% 1	7.14% 1	50.00% 7	35.71% 5	14	3.00
Technology	0.00% 0	0.00% 0	0.00% 0	28.57% 4	71.43% 10	0.00% 0	14	4.71
Administration of the program (overall course organization)	0.00% 0	0.00% 0	0.00% 0	7.14% 1	92.86% 13	0.00% 0	14	4.93

Appendix 24

Q8 What was the most useful part of the training? Please describe below.

Answered: 14 Skipped: 0

Appendix 24

Q9 What was the least useful part of the training? Please describe below.

Answered: 14 Skipped: 0

Appendix 24

Q10 Do you have any suggestions to improve training? Please describe below.

Answered: 14 Skipped: 0

Appendix 24

Q11 Please identify two concepts, ideas, tools you will take away from this training.

Answered: 14 Skipped: 0

ANSWER CHOICES	RESPONSES	
1.	100.00%	14
2.	100.00%	14

Appendix 24

Policy:
It is the policy of the Behavioral Health Department to provide education and training to employees, contracted employees, and volunteers that is in accordance with State requirements and Departments goals.

Purpose:
To assist employees, contracted employees and volunteers to meet training and licensing requirements and to ensure our workforces ability to provide quality of care and culturally and linguistically competent services to the community.

Definitions:

Competency Based Training:
Trainings/classes within a group of trainings/classes deemed a "competency", for a specific job classification to be completed in order to meet the Department's training requirements and or attain job related knowledge.

Mandatory Training:
Training required by BH, the supervisor or training necessary to maintain licensing and certification requirements for job classifications or job related duties.

Orientation Training:
Training provided by the Department during a new employee's orientation process.

Training Types:
Training may be delivered by any of the following sources:

* Online/Web – Essential Learning (E-Learning)
* County – BH or another County department
* Private – Contracted consultant or organization

Mental Health Services Act:
As part of the Mental Health Services Act (MHSA) Workforce Education and Training Component, the Departments education and training program is dedicated to:

* Maintaining a curriculum to train and retrain staff to provide services that are in accordance with provision under Act
* Establishing partnerships among the behavioral health system and educational system to expand outreach to multicultural communities
* Increasing the diversity of the behavioral health workforce to reduce the stigma associated with mental illness, co-occurring illness, and addiction
* Promoting the use of web-based technologies and distance learning techniques.
* Promoting the inclusion of behavioral health consumers and family members' viewpoints and experiences in the training and education program.
* Promoting the inclusion of the cultural competency in the training and education programs.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, MFT, Date 08/2010

Revision dates:

DRAFT

Appendix 25

Cultural Competence:
As defined by the California Code of Regulations (CCR) Title 9 § 3200, 100, cultural competence means incorporating and working to achieve the items listed below, into all aspects of policy-making, program design, administration and service delivery.

Goals of cultural competence:

* Equal access to services
* Treatment interventions and outreach
* Reduction of disparities in services
* Understanding of the diverse belief system concerning behavioral illness
* Understanding the impact of historical bias, racism, and other discriminations have on behavioral health.
* Improvement of services and support unique to individuals racial/ethnic, cultural and linguistic populations.
* Development and implementation of strategies to promote equal opportunities for administrators, service providers and others involved in service delivery who share the diverse racial/ethnic and linguistic characteristics of individuals being served

Cultural Competency Training:
In accordance with the Cultural Competency Plan, it is required that all new employees attend the mandatory cultural competency training that the Department offers. In addition, administrative and management employees, as well as direct service providers are required to attend more extensive cultural competency trainings.

On a continuous basis, all BH employees are required to take cultural competency training annually.

Continuing Education (CE) Credit Training:
The Department will offer several training opportunities to obtain CE credits to meet licensing and certification requirements as needed.

Other Trainings:
Trainings related to the Departments rules, regulations, goals, as well competency based trainings, and those required under CCR, Title 9 §1922, will also be offered through the Department.

References:

* California Code of Regulations, Title 9, Division 1, Chapter 11 §1810.410, Chapter 12, § 1922, and Chapter 14, §3200.100
* Behavioral Health Department, (2010) Cultural Competency Plan
* Welfare and Institution Code, Division 5, Chapter 4 §5820 - §5822

Approved by Behavioral Health Administrator: Karen Baylor, PhD, MFT, Date 08/2010

Revision dates:

DRAFT

Appendix 25

2.00 Culturally Competent, Multi-lingual Services

I. PURPOSE

To describe the way we provide multilingual and culturally appropriate services to the diverse populations in the County, as detailed in the Cultural Competence Plan

II. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) continues to develop a system of care that serves an increasing, changing, and diverse population in the County. SLOBHD will follow the guidelines in the Cultural Competence Plan to become a more culturally competent organization and to ensure that each person receives Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) that are culturally and linguistically appropriate.

SLOBHD will value diversity, reduce disparities, and will not discriminate against or deny admission or services to any person based on age, ethnicity, marital status, medical condition, national origin, physical or mental disability, pregnancy, race, religion, sex, sexual orientation, gender expression or identity, socio-economic status, literacy level, or any other legally protected status.

III. REFERENCE

- Code of Federal Regulations, Title 45, Part 80
- Code of Federal Regulations, Title 42, §438.6(f)(1), §438.10, §438.100, §438.206
- Welfare & Institutions Code §5600.2(g)
- California Code of Regulations, Title 9, §1810.410
- California Code of Regulations, Title 9, §3200.100, §3200.210, §3320
- Mental Health Plan Contract with DHCS
- Drug Medi-Cal Organized Delivery System contract with DHCS
- SLOBHD Cultural Competence Plan and Updates
- SLO Health Agency Non-discrimination and Language Access Plan

IV. PROCEDURE

A. Language Needs/Informing:

1. Upon initial contact to request services, individuals are informed in a language they understand that they have a right to free language assistance. An offer of free interpretation services is documented on the BH Service Request form and on the Demographic form.

Appendix 26

2. Informing materials, including the Beneficiary Handbook, Notice of Privacy Practices, Consent for Treatment and other relevant documents are available in English and Spanish (SLOBHD's threshold language). Large print (72-point font) and audio CD versions of the Beneficiary Handbook are also available. See Policy 4.20, Information Process for Beneficiaries, for more detail.

3. When SLOBHD staff translate written materials into Spanish, every effort is made to provide review by two bilingual staff members to ensure that the translation is clear and culturally appropriate. See the SLO Health Agency Non-discrimination and Language Access Plan for additional detail.

B. Language Capacity:

1. SLOBHD is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations so that beneficiaries are provided with culture-specific and linguistically appropriate services. Our goal is to provide services by, in order of preference:

   - Bilingual/bicultural providers
   - Bilingual providers
   - Bilingual/bicultural interpreters
   - Language Line Solutions

2. SLOBHD will make key hiring and contracting decisions to grow our language capacity in all geographic regions of SLO County.

3. Particular emphasis will be placed on making sure that key points of contact, such as Central Access and SLOBHD afterhours 24/7 Access Line contractor employ staff who are bilingual (English and Spanish).

4. Language Line Solutions will be used to ensure oral interpretation capacity in Spanish if a more preferred option is not available.

5. Language Line Solutions will be used to accommodate consumers who speak non-threshold languages. Information and training in the use of the Language Line Solutions will be provided for all staff.

6. A specialized MHSA program, (Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP)) will offer culturally appropriate psychotherapy services to monolingual, low-income Spanish speakers and their bilingual children. LOP staff will be bilingual/bicultural.

7. Each clinic site will have the capacity to provide services in Spanish using bilingual staff.

Appendix 26

V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
10/1/2015	All	Reformatted and expanded
3/15/2018	All	Added references to the SLO Health Agency Non-discrimination and Language Access Plan
Prior Approval dates:		
02/27/2009		

		3/15/18
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 26

UR Status/Annual Dates ☐ **Annual Review** ☐ **Six Month Review**

Reporting Unit: ________ Start Date: ______/______/______ Provider: ______________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: ________ Start Date: ______/______/______ Provider: ______________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: ________ Start Date: ______/______/______ Provider: ______________________

Target Symptom / Functional Impairment:

Interventions:

Frequency / Duration:

Objectives:
1. Date Objectives Met: ____/______/______
2. Date Objectives Met: ____/______/______
3. Date Objectives Met: ____/______/______

Reporting Unit: ________ Start Date: ______/______/______ Provider: ______________________

Target Symptom / Functional Impairment:

Appendix 27

Interventions:
Frequency / Duration:
Objectives: 1. Date Objectives Met: ___/___/___ 2. Date Objectives Met: ___/___/___ 3. Date Objectives Met: ___/___/___

Authorization Date: From: ___/___/___ To: ___/___/___

Client Signature: _____ Date: ___/___/___

Parent / Guardian Signature: _____ Date: ___/___/___

___/___/___ _____ ___/___/___

Lead Coordinator / Therapist Date Co-Signature (When Required) Date

___/___/___

Program Supervisor/Approval/Authorization Date

Interpretation Service Utilized in (Language) _____ ☐ Yes ☐ No Culture Specific Service Utilized (Culture) _____ ☐ Yes ☐ No

		SERVICE PLAN

CLIENT NAME CLIENT NUMBER Cd651

Service Plan Rev 10//07

Appendix 27

Dear Consumers,
Informational materials are available in alternative formats. Please ask the receptionist for assistance.

Estimados Consumidores,
Los materiales informativos estan disponibles in otros formatos. Solicite ayuda a la recepcionista.

Appendix 28

Dear Consumers,
Free language assistance services are available upon request. Please ask the receptionist or any staff person for assistance.

Estimados Consumidores,
Los servicios gratuitos de asistencia para diferentes idiomas están disponibles. Por favor solicite asistencia a la recepcionista o a cualquier otro miembro del personal.

Appendix 28

Free language assistance available upon request.

La asistencia gratuita en diferentes idiomas está disponibile a pedido.

Appendix 28

Policy

Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services.

Procedure:

1. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).

2. The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members at least one of whom is a native speaker of the threshold languages in the county.

3. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a total of 100. The checklist will include, but not be limited to:

    a. Fluency, the ability to communicate with ease, verbally and non-verbally.
    b. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.
    c. Grammar, appropriate use of tense and grammar.
    d. Cultural considerations related to potential client.

4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.

5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

Approved by Behavioral Health Administrator Karen Baylor, Ph.D., LMFT Date: 02/27/2009
Revision dates: 02/27/2009

Appendix 29

6. Following the departure of the candidate the BCC members separately score their evaluation of the candidate's performance. The evaluators' score is then averaged. A passing score will be 60 or greater. The candidate is notified by a memo issued from the committee as to the outcome of the evaluation, with copy given to Mental Health Human Resources.

7. A candidate who has failed to be certified may appeal to the Bilingual Certification Committee and request to be retested by two other committee members who will repeat the process.

Approved by Behavioral Health Administrator Karen Baylor, Ph.D., LMFT Date: 02/27/2009
Revision dates: 02/27/2009

Appendix 29

Servicios de Drogas & Alcohol

Evaluación / Evaluación
Los servicios de tratamiento comienzan con una evaluación seguida de una evaluación. Esto nos ayuda a determinar el programa correcto y el nivel de atención según sus necesidades. Tratamiento Ambulatorio Ambulatorio e Intensivo disponible.

Tratamiento / recuperación en curso
Una vez que se haya determinado su programa apropiado, trabajaremos con usted a través de varios servicios de asesoramiento para ayudarlo en su recuperación.

- **Tratamiento individual**
  Trabajaremos con usted individualmente para ayudarlo a encontrar formas de enfrentar y crecer.
- **Tratamiento grupal**
  Ofrecemos grupos para ayudarlo a aprender sobre su uso de sustancias y formas de recuperación.
- **Gestión de retiros**
  Brindamos asistencia médica y evaluación de medicamentos para reducir y manejar los síntomas de abstinencia de los trastornos por consumo de sustancias de opiáceos, alcohol y metanfetaminas.
- **Gestión de casos**
  Podemos ayudarlo a trabajar con agencias locales para obtener los servicios que necesita, como Tratamiento residencial o Residencia de recuperación.
- **Trastornos coocurrentes Tratamiento**
  Ofrecemos servicios especializados para personas con un trastorno de salud mental y uso de sustancias.
- **Prevención, intervención temprana y alcance**

Recursos Importantes y Números de teléfono

SLO Hotline/Línea Directa: (800) 783-0607

Admin. Del Dept. de Salud Mental:
(805) 781-4719

Defensor de los Derechos de los Pacientes:
(805) 781-4738

Otros Servicios en la Communidad

AEGIS Centro de Tratamiento: (805) 461-5212

Consejería de Cal Poly: (805) 756-2511

Community Counseling Center: (805) 543-7969

Grupo Holman: (800) 321-2843

Hospice/Hospicio: (805) 544-2266

Transitions Mental Health Association (TMHA): (805) 540-6500

Veterans Affairs: (805) 543-1233

Victim/Witness/Testigo/Víctima: (805) 781-5821

Wilshire Health & Community: (805) 547-7025

Servicios para Niños/Familia

Child Development Resource Center:
(805) 544-0801

Family Care Network, Inc.: (805) 781-3535

Kinship Center: (805) 434-2449

Tri-Counties Regional Center (805) 543-2833

Asistencia Financiera/Vivienda

Dept. of Social Services: (805) 781-1600

Community Action Partnership of
San Luis Obispo (CAPSLO): (805) 544-4355

Servicios de Salud

Community Health Centers (CHC): (805) 269-1500

Long Term Care Ombudsman: (805) 785-0132

Public Health Department: (805) 781-5500

Información General

National Alliance on Mental Illness (NAMI): (805) 236-1007

COUNTY of SAN LUIS OBISPO

AGENCIA DE SALUD

Departamento de Salud Mental

www.slobehavioralhealth.org

Estamos aquí para ayudarlo!

Para servicios de salud mental ó de drogas y alcohol,

Por favor llame:

(800) 838-1381

June, 2018

Servicios de Salud Mental

Evaluación
Los servicios para pacientes ambulatorios comienzan con una evaluación que nos ayuda a comprender sus necesidades, fortalezas y objetivos. Hablaremos sobre los servicios que pueden ayudarlo mejor y es posible que proporcionemos referencias a otras agencias.

Tratemiento/recuperación en curso:
Trabajaremos con usted para encontrar los servicios adecuados para ayudarlo en su recuperación. Por ejemplo, los servicios pueden incluir, pero no están limitados a:

- **Terapia individual**
  Podemos trabajar con usted individualmente para ayudarlo a encontrar maneras de sobrellevar y crecer.
- **Rehabilitación grupal**
  Ofrecemos grupos para ayudarlo a aprender sobre su enfermedad y formas de recuperación.
- **Manejo de medicamentos**
  Incluye una reunión con un psiquiatra para analizar si los medicamentos lo ayudarán.
- **Gestión de casos**
  Podemos ayudarlo a trabajar con agencias locales para obtener los servicios que necesita.
- **Trastornos coocurrentes Tratamiento**
  Ofrecemos servicios especializados para personas con un trastorno de salud mental y uso de sustancias.
- **Evaluación de crisis y respuesta**
- **Prevención, intervención temprana y alcance**

Llame 1-800-838-1381

Servicios de Salud Mental

PARA CONTACTO DE SERVICIO:

Servicio de Salud Mental
Servicios de Atención &
24/7 Servicios de Crisis
(800) 838-1381

Sitio Web:
www.slomentalhealth.org

Defensor de los Derechos de los Pacientes
(805) 781-4738

Servicios para Adultos y Jóvenes

- Servicios ambulatorios para adultos y jóvenes
- Servicios de tratamiento concurrenteServicios para pacientes internados
- Programas forenses
- Manejo de medicamentos
- Servicios de evaluación de salud mental
- Servicios de terapia

Prevención y Alcance

- Alcance de Veteranos
- Consejería de intervención temprana
- Alcance y educación

Servicios de Drogas & Alcohol

PARA CONTACTO DE SERVICIO:

Servicios de Drogas & Alcohol
(800) 838-1381

Sitio Web:
www.slodas.org

Conducir Bajo los Programs de Influencia
(805) 781-4746

- Servicios de tratamiento para adultos
- Tribunal de drogas para adultos (ADC)
- Tribunal de Tratamiento de Salud Conductual (BHTC)
- Tribunal concurrente (ATCC)
- Tribunal de Tratamiento Familiar (FTC
- Tratamiento ambulatorio
- Tratamiento de mujeres y niños de grupo extendido ambulatorio perinatal (POEG)
- Desvío previo al juicio (DPT)
- Programa Prop 36

Prevención y Alcance

- Asesoramiento de apoyo estudiantil
- Friday Night Live
- Tratamiento de uso de sustancias juveniles

Si está experimentando una emergencia, llame al 911
24/7 SLO Hotline/Línea Directa: (805) 783-0607
Si habla español, tiene a su disposición servicios gratuitos de asistencia linguística.

Encuentre una Clínica cerca a usted:

Arroyo Grande Mental Health (Adultos)
1350 E. Grand Ave , Arroyo Grande, CA 93420
(805) 474-2154

Arroyo Grande Mental Health (Menores)
354 S. Halcyon , Arroyo Grande, CA 93420
(805) 473-7060

Atascadero Drug & Alcohol (Adultos y Menores)
3556 El Camino Real , Atascadero, CA 93422
(805) 461-6080

Atascadero Mental Health (Adultos y Menores)
5575 Hospital Drive , Atascadero, CA 93422
(805) 461-6060

Grover Beach Drug & Alcohol (Adultos y Menores)
1523 Longbranch Avenue , Grover Beach, CA 93433
(805) 473-7080

Paso Robles Drug & Alcohol (Adultos y Menores)
1763 Ramada Dr. , Paso Robles, CA 93446
(805) 226-3200

San Luis Obispo Drug & Alcohol (Adultos)
2180 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4275

San Luis Obispo Drug & Alcohol (Menores)
277 South St., Ste. T , San Luis Obispo, CA 93401
(805) 781-4754

San Luis Obispo Mental Health (Adultos)
2178 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4700

San Luis Obispo Mental Health (Menores)
1989 Vicente , San Luis Obispo, CA 93405
(805) 781-4179

San Luis Obispo Mental Health (Niños 0-5)
Martha's Place Children's Center
2925 McMillan Ave, Ste. 108, San Luis Obispo, CA 93401
(805) 781-4948

San Luis Obispo Prevention & Outreach
277 South St., Ste. T , San Luis Obispo, CA 93401
(805) 781-4754

San Luis Obispo Psychiatric Health Facility
2178 Johnson Ave , San Luis Obispo, CA 93401
(805) 781-4711

Services Affirming Family Empowerment (SAFE)
1086 Grand Ave., Arroyo Grande, CA 93420
(805) 474-2105

La Agencia de Salud comple con las leyes federales de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, sexo ó cualquier otra clase protegida.

4.24 Provider List Availability

I. PURPOSE

To describe the contents of and beneficiary access to the Provider List

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will maintain and make available a list of providers that will enable beneficiaries to make decisions about services. SLOBHD will update the Provider Lists monthly and within 30 days of any changes to the list or more often as needed to reflect the services available to beneficiaries.

III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.360, 1810.110, 1810.235
- Code of Federal Regulations, Title 42, §438.10
- MHP Contract, Exhibit A, Attachment 1, Section 7
- SLOBHD Policy 4.20 Beneficiary Rights and Informing Practices
- SLOBHD Policy 4.03 Change of Provider Request
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals

IV. PROCEDURE

A. Availability:

1. The Provider List will be:
   a. Given to each beneficiary at the beginning of services
   b. Available at any time upon request at all service sites or by contacting Central Access at 800-838-1381
   c. Included in the Client Information Centers in all clinic sites
   d. Available electronically on the SLOBHD website

B. Documentation

1. Beneficiaries will confirm receipt of the Provider List by signature in the Consent For Treatment
2. SLOBHD clinical staff will check the box labeled “Provider List Given” on the Assessment Progress Note

C. Content

1. The Provider List will:
   a. Be written in English and Spanish

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b. Contain the following elements:

i. Category or categories of services available from each provider
ii. Names, locations, and telephone numbers of current contracted providers by category
iii. Options for services in languages other than English and services that are designed to address cultural differences

c. Detailed provider specialty information will be available to beneficiaries by request from Managed Care Staff and electronically on the SLOBHD website

D. Network Provider availability:

1. Managed Care staff will contact Network Providers to determine availability to provide services in a timely manner

2. Beneficiaries will be informed in person which beneficiaries are accepting new clients upon referral

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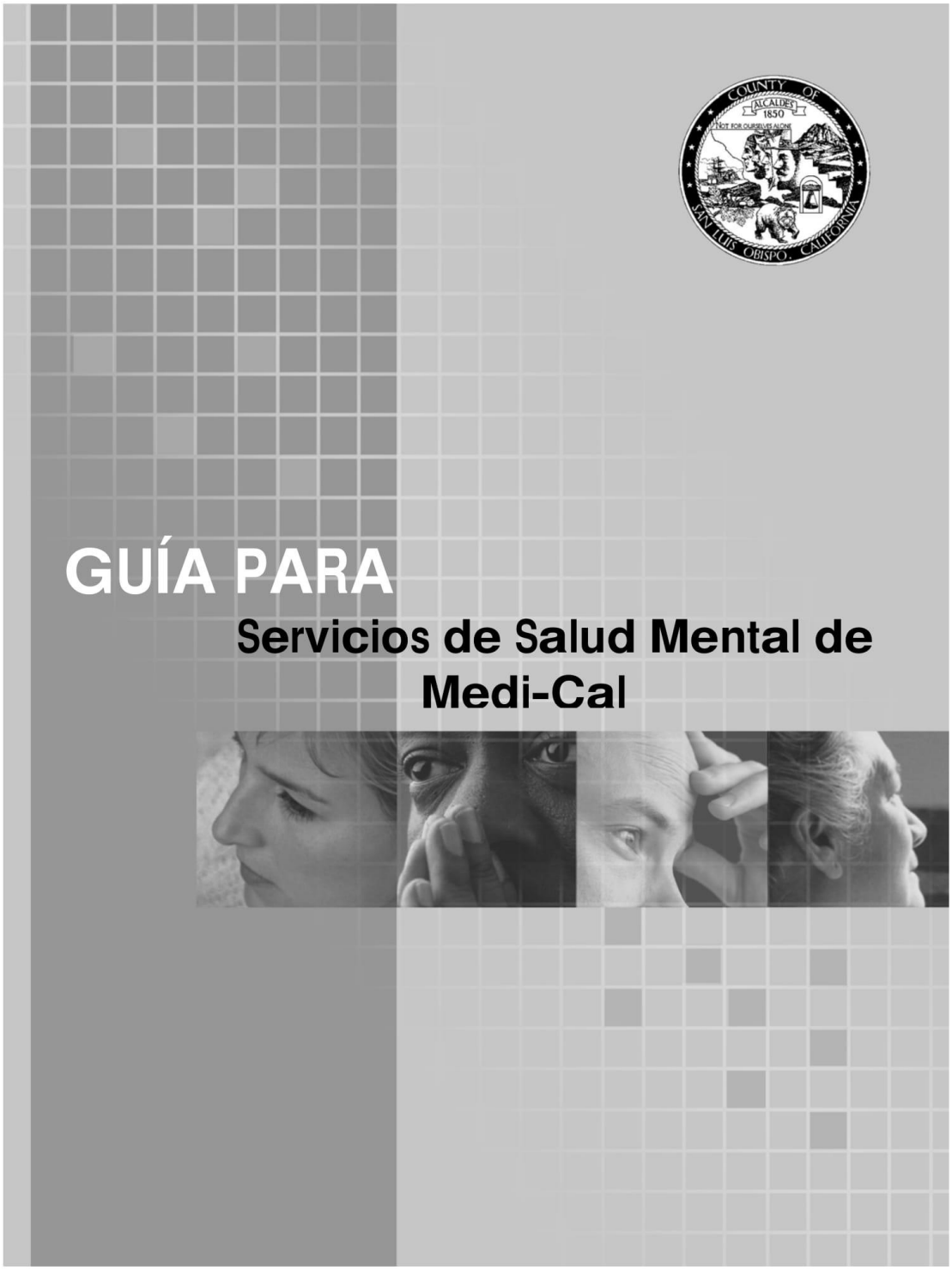
V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
11/01/2015	All	Added Purpose, reformatted
08/17/2017	All	Formatting
Prior Approval dates:		
05/30/2010		

Signature on file		*08/29/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 31



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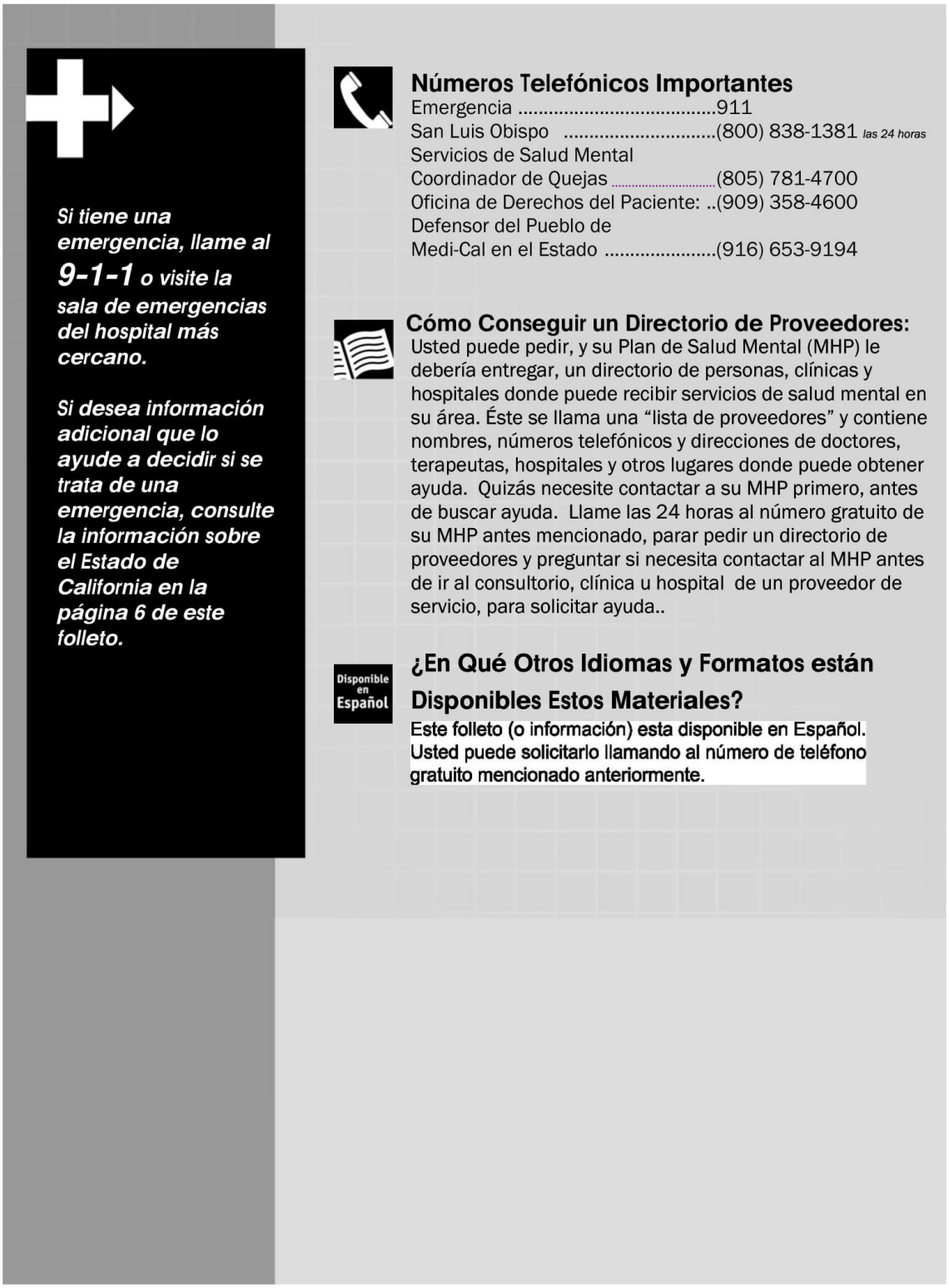
Si tiene una emergencia, llame al 9-1-1 o visite la sala de emergencias del hospital más cercano.
Si desea información adicional que lo ayude a decidir si se trata de una emergencia, consulte la información sobre el Estado de California en la página 6 de este folleto.
Números Telefónicos Importantes
Emergencia 911
San Luis Obispo .....(800) 838-1381 las 24 horas
Servicios de Salud Mental
Coordinador de Quejas .....(805) 781-4700
Oficina de Derechos del Paciente: ..(909) 358-4600
Defensor del Pueblo de
Medi-Cal en el Estado .....(916) 653-9194
Cómo Conseguir un Directorio de Proveedores:
Usted puede pedir, y su Plan de Salud Mental (MHP) le debería entregar, un directorio de personas, clínicas y hospitales donde puede recibir servicios de salud mental en su área. Éste se llama una "lista de proveedores" y contiene nombres, números telefónicos y direcciones de doctores, terapeutas, hospitales y otros lugares donde puede obtener ayuda. Quizás necesite contactar a su MHP primero, antes de buscar ayuda. Llame las 24 horas al número gratuito de su MHP antes mencionado, parar pedir un directorio de proveedores y preguntar si necesita contactar al MHP antes de ir al consultorio, clínica u hospital de un proveedor de servicio, para solicitar ayuda..
Disponible en Español
¿En Qué Otros Idiomas y Formatos están Disponibles Estos Materiales?
Este folleto (o información) esta disponible en Español. Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

Appendix 32

GUIDE TO
Medi-Cal Mental Health Services

Appendix 32

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

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

Important Telephone Numbers

Emergency 911

San Luis Obispo .....(800) 838-1381 *24-hours*
Mental Health Services
Grievence Coordinator..... (805) 781-4700
State Patient's Rights Office .....(909) 358-4600
Medi-Cal State Ombudsman .....(800) 896-4042
.....(916) 653-9194

How to Get a Provider List:

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

Disponible en Español

In What Other Languages And Formats Are These Materials Available?

Este folleto (o información) esta disponible en Español. Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

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4.20 Beneficiary Rights and Informing Process

I. PURPOSE

To describe beneficiary rights and beneficiary informing practices

II. POLICY

- County of San Luis Obispo Behavioral Health Department (SLOBHD) will comply with all Federal and State laws that pertain to beneficiary rights, and will ensure that all staff and providers take those rights into account when furnishing services.
- SLOBHD will ensure that each beneficiary is informed, in a language and format that the beneficiary can understand, of available services and the benefits, requirements and protections (rights) afforded to them.
- SLOBHD will ensure written materials are produced in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and for those who have auditory limitations.
- SLOBHD will ensure that written materials are readily accessible on the SLOBHD website, which is compliant with Web Content Accessibility Guidelines (WCAG) 2.0 guidelines in a machine readable and printable format.
- SLOBHD will ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights will not adversely affect treatment.

III. REFERENCE

- California Code of Regulations, Title 9, § 1810.360
- Code of Federal Regulations, Title 42, §§ 438.10 and 438.100
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 04-05
- SLOBHD Policy 2.00 Culturally Competent, Multilingual Services
- SLOBHD Policy 4.00 Patient's Rights Advocate
- SLOBHD Policy 4.03 Change of Provider
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 4.09 Fair Hearing Process
- SLOBHD Policy 4.23 Advanced Medical Directives
- SLOBHD Policy 4.24 Provider List Availability

IV. PROCEDURE

A. SLOBHD will inform beneficiaries of their rights, protections and processes in the following ways:

1. The Beneficiary Handbooks, *Guide to Mental Health Services and Guide to Substance Use Disorders Services*, will contain detailed information about rights, protections and access. It will be available in English and Spanish in regular, large print (minimum 18 point font) and audio versions.

   i. The handbook will be:

   - Given to each beneficiary at the beginning of services and upon request thereafter
   - Available at all sites and by request through the 24/7 Central Access line at: 800-838-1381 within 5 business days
   - Posted in the lobby at each site
   - Available on the SLOBHD website

   ii. The handbook content will comply with contract requirements for informing beneficiaries about their rights

2. Client Information Centers at each site will make information readily available to both beneficiaries and staff, in English and Spanish. Beneficiaries will be able to obtain, complete and return a Consumer Request Form without having to make a verbal or written request to anyone. Client Information Centers will contain:

   i. "What are my Rights?" poster
   ii. Crisis Services poster
   iii. Provider List
   iv. Notice of Privacy Practices
   v. Notification that:
   - Alternative formats are available
   - Free language assistance is available
   - Assistance with forms is available

   vi. Consumer Request Form, which will describe problem solving processes, and:
   - Instructions
   - Patient's Rights Advocate contact information
   - Postage paid/addressed envelopes

   vii. Consumer Request Drop Box (locked)

3. Informing materials regarding Advance Medical Directives will be given to each adult consumer at the beginning of services.

4. The Consent for Treatment form will be explained to, signed by and given to each beneficiary at the start of treatment. It will further describe rights, responsibilities and payment processes.

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5. The Notice of Privacy Practices will explain the manner in which SLOBHD will maintain and use the beneficiary's medical record. An acknowledgement of receipt will be signed by each beneficiary.
6. Beneficiaries will also be inform of rights and benefits verbally by:
   i. Clinical and administrative staff
   ii. Patients' Rights Advocate (PRA)
7. The PRA will make informing materials, including the handbook titled, "Rights for Individuals in Mental Health Facilities" available to consumers.
8. The Patient's Rights Advocate will regularly train staff regarding beneficiary rights, including how to assist a beneficiary with completing the Consumer Request Form.

B. Documentation of Informing:

1. Distribution of the Beneficiary Handbooks and Provider lists will be documented by:
   - Client signature on the Behavioral Health Consent for Treatment form indicating receipt
   - Clinician attestation on the Assessment Progress Note
2. Right to Change Providers/limits on freedom of choice will be documented by clinician attestation on the Assessment Progress Note
3. Beneficiary signature on Consent for Treatment and Acknowledgement of Notice of Privacy Practices will be maintained in the medical record.

I. Definition

1. Each beneficiary has the right to:
   - Be treated with personal respect, dignity and with respect for privacy
   - Receive information on available treatment options and alternatives
   - Have treatment options resented in an understandable manner
   - Obtain services in a language of choice, without cost for interpretation services
   - Participate in decisions regarding care, including the right to refuse treatment
   - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
   - Request and receive a copy of his/her medical records
   - Request that medical records be amended or corrected
   - Receive appropriate, available and accessible services
   - Access other community services regardless of participation in treatment
   - Access other government supported services and providers regardless of participation in treatment
   - Request a change of provider

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- Access the problem resolution processes, including the Grievance, Appeal, Expedited Appeal and Fair Hearing processes, without fear of any punitive action as a result

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V. REVISION HISTORY

Revision Date:	Section(s) Revised:	Details of Revision:
11/18/2015	All	Added purpose, reformatted, added F
08/17/2017	All	Reformatted, New CRF Language
01/02/2018	All	Reformatting
Prior Approval dates:		
02/27/2009, 08/08/2011, 1/20/2012		

Signature on file		*08/29/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 33

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
Michael Hill, *Health Agency Director*
Anne Robin, LMFT *Behavioral Health Director*

December 23, 2021

Client name, last name
Address
San Luis Obispo, CA

RE: (if minor name here)

Estimado Cliente:

Esta carta es respecto a sus servicios de psicoterapia:

Sus Servicios de psicoterapia han sido arreglados para usted con el siguiente consejero:
Network Provider Name, Office Address, and phone number

Por favor pongase en contacto con el consejero para hacer una cita para sus servicios.

Gracias,

Fatima Ponce
Health Information Technician I
Managed Care

CONFIDENTIAL PATIENT INFORMATION – NOT TO BE FORWARDED
This information has been disclosed to you from records that are **confidential** and protected by **state confidentiality law** that protects mental health records (See California Welfare and Institutions Code Section 5328). Information subject to release in accordance with Federal Privacy Act of 1974 (Public Law 93-597). This information has been disclosed to you from records protected by **Federal confidentiality rules** (42 CFR, Part 2, Section 2.32). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Total pages included: _____

The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class

County of San Luis Obispo Health Agency
2180 Johnson Avenue | San Luis Obispo, CA 93401 | (P) 805-781-4719 | (F) 805-781-1273
slobehavioralhealth.org | slocounty.ca.gov

Appendix 34

4.07 Beneficiary Grievances, Appeals & Expedited Appeals

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes.

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBHD's performance of its duties.

The Appeals and Expedited Appeals processes will ensure that beneficiaries have consistent and timely means to respond to any adverse benefit determination taken by SLOBHD. The Grievance process will ensure that beneficiaries have a consistent and timely means to resolve all other concerns about the care they receive at SLOBHD.

SLOBHD will ensure that all Medi-Cal beneficiaries are well informed about the appeals process.

SLOBHD will process Grievances, Appeals and Expedited Appeals within the periods established by law.

III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.200, 1810.375, 1810.203.5, 1810.216.2,1850.205 – 1850.208
- Code of Federal Regulations, Title 42, §§ 438.400 – 438.424, 438.3(h)
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMC-ODS Waiver Contract
- DMH Letter 05-03

IV. PROCEDURE

A. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to clients at the beginning of services and upon request thereafter. See *Beneficiary Rights and Informing Processes* for detail regarding availability of materials in alternative formats and electronic form on the SLOBHD website.

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2. The Beneficiary Handbooks, *Guide to Mental Health Services and Guide to Substance Use Disorder Services* contain detailed information about the processes and will be available at all certified sites, through the 24/7 Central Access line at: 800-838-1381, and posted on the SLOBHD website in a machine readable and downloadable format.
3. SLOBHD will post Client Information Centers at each certified site, which will contain notices explaining grievance, appeal, and expedited appeal processes to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

B. General Provisions

1. A beneficiary may authorize another person to act on the beneficiary's behalf, including the Behavioral Health care provider in an appeal or expedited appeal. The beneficiary's legal representative may use the grievance/appeal/expedited appeal processes on the beneficiary's behalf.
2. All grievances/appeals/expedited appeals will be directed to the Patients' Rights Advocate (PRA) for logging and assistance.
3. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive adverse benefit determination for filing a grievance/appeal/expedited appeal
4. All grievances/appeals/expedited appeals will be resolved in a confidential manner that respects the rights and dignity of the beneficiary.
5. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

C. Filing a Grievance/Appeal/Expedited Appeal

1. Appeals and expedited appeals must be filed within 60 days of the Notice of Adverse Benefit Determination (NOABD) that is being appealed.
2. Grievances can be filed orally or in writing at any time.
3. Appeals will be initially filed orally or in writing. An oral appeal must be followed up by a written, signed appeal.
4. Expedited appeals will be filed orally without requiring that the request be followed by a written appeal.
5. The Consumer Request Form will be available for written submission of grievances/appeals/expedited appeals.

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6. The PRA will, at the beneficiary's request, assist with these filing processes. Assistance will include, but not be limited to, help writing the grievance/appeal/expedited appeal on a Consumer Request Form, interpreter services, including ASL and TTY/TTD.
7. The date of the initial oral or written submission starts the disposition timeline.

8. If SLOBHD denies a beneficiary's request for expedited appeal resolution, the PRA will:

    a. Resolve the issue as a standard appeal
    b. Make reasonable efforts to promptly notify the beneficiary and/or representative of the denial of the request for an expedited appeal
    c. Provide written notice within two calendar days of the date of the denial

D. Grievance/Appeal Log and Confirmation of Receipt

1. The PRA will record each grievance/appeal/expedited appeal in a Grievance/Appeal Log within one working day of receipt. The log will contain all of the following:

    - Name of the beneficiary
    - A general description of the reason for the appeal or grievance
    - The date received
    - The date of each review or, if applicable, review meeting
    - Resolution at each level of the appeal or grievance, if applicable
    - Date of resolution at each level, if applicable
    - Persons responsible for resolution
    - Final resolution
    - Date the written decision is sent to the beneficiary

2. The PRA will report de-identified data to DHCS from the log on an annual basis that summarizes beneficiary grievances, appeals and expedited appeals. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas and by disposition.

3. The PRA will retain the log and records for a period of no less than 10 years.

4. The PRA will send written confirmation to the beneficiary within one working day of the receipt of the grievance/appeal/expedited appeal. The written notice of the resolution must include the following:

    a. The results of the resolution process and the date it was completed
    b. For appeals not resolved wholly in favor of the enrollees—
        I. Have the right to request a State fair hearing, and how to do so

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II. Have the right to request and receive benefits while the hearing is pending, and how to make the request
III. Know that the beneficiary, may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds SLOBHD's Notice of Adverse Benefit Determination (NOABD).

E. Timelines for Resolution

Resolution	Resolution and Notification Timeline
Grievance	90 calendar days
Appeal	30 calendar days
Expedited Appeal	72 hours

1. If the grievance/appeal/expedited appeal is not resolved in the allotted timeframe, the PRA will notify the beneficiary and issue a NOABD.
2. Timeframes may be extended by up to 14 calendar days if the beneficiary requests an extension or if SLOBHD determines that there is a need for additional information and that the delay is in the beneficiary's interest.
3. If SLOBHD extends the timeframes, the PRA shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing within (2) two calendar days. The notice must include the reason the decision to extend the timeframe was made and information of the right to file a grievance if he or she disagrees with that decision.

F. Review process

1. SLOBHD will allow the beneficiary and/or representative to examine, before and during the appeal process, the beneficiary's medical records, any other documents or records and any new or additional evidence considered, relied upon or generated by SLOBHD in connection with the appeal.
2. In an appeal or expedited appeal, SLOBHD will provide the beneficiary with a reasonable opportunity to present evidence in person or in writing and make legal and factual arguments.
3. SLOBHD will utilize staff who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
4. If an appeal or expedited appeal is about a clinical issue, SLOBHD will utilize staff with appropriate clinical expertise to review and make decisions on the appeal.
5. SLOBHD must take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
6. SLOBHD must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for

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the appeal) and must be confirmed in writing, unless the beneficiary or the provider requests expedited resolution.

7. SLOBHD must provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. SLOBHD must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals.
8. SLOBHD must provide the beneficiary and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by SLOBHD in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

G. Notification of Resolution

1. The PRA will notify providers involved in the grievance/appeal/expedited appeal of the final disposition of the process.

2. The PRA will notify the beneficiary and/or his or her representative of the resolution of the grievance or appeal in writing. The notice will contain:

    I. The results of the appeal resolution process
    II. The date that the appeal decision was made
    III. If an appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing after the appeal process has been exhausted

3. In addition to written notification following an expedited appeal, the PRA will make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

H. SLOBHD will promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

I. Aid Paid Pending

1. SLOBHD will provide “aid paid pending” (APP) services during the resolution of an appeal or expedited appeal to beneficiaries who have filed a timely appeal (10 days from the date the Notice Of Adverse Benefit Determination (NOABD) was mailed or 10 days from the date the NOABD was personally given to the beneficiary).

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2. The beneficiary must either have an existing service authorization, which has not lapsed, and the service is being terminated, reduced, or denied for renewal by SLOBHD.
3. This adverse benefit determination will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal is otherwise withdrawn or closed, whichever is earliest.
4. APP services will be provided at no cost to the beneficiary.

V. Definitions:

a. **Adverse benefit determination**:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by SLOBHD
- A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals

b. **Appeal**

- A review by **SLOBHD** of an adverse benefit determination when requested by a beneficiary or provider.
- A request by a beneficiary or a beneficiary's representative for review of an adverse benefit determination.
- A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for Specialty Mental Health Services (SMHS) and/or Substance Use Disorder Services (SUDS).
- A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a SMHS or SUDS when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs, whether or not SLOBHD has established a timeliness standard for the delivery of service.

c. **Expedited Appeal:** The accelerated resolution of an appeal when SLOBHD determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

d. **Grievance:** A beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an adverse benefit determination. Grievances

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may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by SLOBHD to make an authorization decision.

VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	Purpose All	Added Purpose Combined Policies 4.02, 4.07, 4.08, 4.10
08/15/2017	All	Updated with CFR 42 language and timeliness
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2015		

Signature on file		*08/24/2017*
Approved by:	Anne Robin, LMFT, Behavioral Health Administrator	Date

Appendix 35

SAN LUIS OBISPO COUNTY
MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535

PLEASE READ THIS FORM CAREFULLY. IF YOU HAVE PROBLEMS READING IT, ASK TO HAVE IT READ TO YOU.

Dr. _____ has met with me and we talked about the following items.

1) We discussed my illness or condition for which my doctor is recommending medication.

2) The doctor told me of medications, and other reasonable alternatives, if any, which are known to be of help in treating problems such as mine.

3) The doctor also informed me why such medications are important or necessary in the treatment of my illness or condition and discussed with me the likelihood of my improving or not improving without such medication(s). I understand the medication will be from the group that follows:

MEDICATIONS AND DOSAGE/RANGE

Neuroleptic/
Major Tranquilizer_____

_____

Mood Stabilizer _____

_____

Antidepressant _____

_____

Hypnotics/
Antianxiety_____

_____

Stimulants_____

_____

Other _____

_____

We also discussed:

a) the type, frequency, and amount of each medication, as well as the method (by mouth, injection, etc.), and how long I will need to take them.

b) the side effects of these medications which commonly occur and ones which may particularly affect me.

I understand that I have the right to accept, to refuse, or to discontinue medication(s) ordered for me by telling my physician or a member of the treatment staff at any time.

I understand that if I have any further questions or want to know more about my medications I can ask for further information.

I HAVE READ THIS FORM, I UNDERSTAND IT, AND I CONSENT TO TAKE THE MEDICATION(S) PRESCRIBED BY THE DOCTOR. I HAVE RECEIVED EDUCATIONAL MATERIAL(S) WHICH DISCUSSES THE ABOVE MEDICATIONS AND POSSIBLE SIDE EFFECTS.

Patient's Signature:_____ / /
Date

Physician's Signature:_____ / /
Date

CLIENT NAME:_____ **RECORD NUMBER:**_____

Original: Client Record
Copy: Client

12/99 CD-601

MEDICATION CONSENT FORM

Appendix 36

SAN LUIS OBISPO COUNTY
MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535

PHOTOCOPY FOR CLIENT

POR FAVOR, LEA ESTE DOCUMENTO CUIDADOSAMENTE. SI TIENE ALGUNA DIFICULTAD PARA LEER LO, PIDA QUE ALGUIEN LE AYUDE.

El Doctor _____ me ha comunicado personalmente lo siguiente:

1) Hemos hablado de mi condición o enfermedad por lo cual el me ha recomendado medicamento(s).

2) El doctor me ha explicado acerca de los medicamentos y otras alternativas razonables conocídas, si las hay, efectivas en el tratamiento de problemas como el mío.

3) También el doctor me ha informado acerca de la importancia o necesidad de este(os) medicamentos en el tratamiento de mi enfermedad o condición. Además, el doctor me explicó acerca de las posibilidades de mejorar, o no mejorar, sin tomar este(os) medicamentos. Yo entiendo que los medicamentos serán de las siguientes categorias:

MEDICAMENTOS Y SU DOSIS/AMPLITUD

Neurolépticos/
Tranquilizante Mayor _____
_____

Hipnóticos/
Anti-Ansiedad _____
_____

Estabilizante de Humor _____
_____

Estimulantes _____
_____

Anti-Depresivo _____
_____

Otro _____
_____

Nosotros también placticamos de lo siguiente:

a) el típo, la frecuencia, y la cantidad de cada medicamento y el método de tomarlo (por la boca, por inyección) y por cuanto tiempo necesitaré tomarlo(s).

b) las contraindicaciones de este(os) medicamento(s) que son comunes, y los que me pueden afectar a mí en particular.

En cualquier momento, retengo el derecho de aceptar, rechazar, o descontinuar este(os) medicamento(s) ordenados para mi solamente con decirle a mi médico o uno de los trabajadores de tratamiento.

Yo entiendo que si tengo más preguntas o quiero saber más acerca de mis medicamentos, puedo pedir más información.

DESPUES DE HABER LEIDO Y ENTENDIDO ESTE DOCUMENTO, DOY MI CONSENTIMIENTO PARA TOMAR EL (LOS) MEDICAMENTO(S) QUE HAN SIDO RECETADOS POR EL DOCTOR. TAMBIEN HE RECIBIDO MATERIALES EDUCATIVOS QUE INFORMAN SOBRE LOS MEDICAMIENTOS MENCIONADOS Y LOS EFECTOS NEGATIVOS POSIBLES DE ELLOS.

Firma del paciente: _____ *Fecha*: _____

Firma del doctor: _____ *Fecha:* _____

CLIENT NAME:_____ **RECORD NUMBER:**_____

07-97 ***CD-601 Spanish/la***

CONSENTIMIENTO PARA TOMAR MEDICAMENTOS
MEDICATION CONSENT FORM

Appendix 36

San Luis Obispo County Behavioral Health Services
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535

Phone: (805) 781-4700
Fax: (805) 781-4271

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Last Name	First	Middle	AKA:
Street Number/Name	City	State	Zip Code
Home Telephone: ( )	DOB:	Last four digits of SSN#: XXX – XX - _____	

San Luis Obispo County Behavioral Health Services is authorized to:

☐ Receive/Obtain information from **AND/OR** ☐ Release information to:

Contact Person Name/Organization:

Street Address:

City/State/Zip Code

Telephone: ( ) Fax:( )

_____ **I authorize the use and/or disclosure of the entire behavioral health record.**
(Initials)

OR*

I only authorize the use and/or disclosure of the following (initial):

_____ Mental Health Diagnosis/Diagnostic Information
_____ Initial Evaluation/Assessment
_____ Psychiatric Evaluation
_____ Medication History _____ Discharge Summary _____ Transfer Summary
_____ Labs _____ Nursing Assessment _____ Treatment Summary
_____ Other: _____
_____

*Psychotherapy notes require a separate authorization

I additionally specifically authorize the use and/or disclosure of the following health information (initial):

_____ Alcohol and/or Drug Abuse Treatment Program
_____ HIV/AIDS Testing, Diagnosis and/or Treatment

PURPOSE: I authorize San Luis Obispo County Behavioral Health Services to use or disclose my health information, during the term of this authorization for the following specific purpose:

☐ Evaluation ☐ Treatment Planning/Course/Delivery
☐ Other (Specify): _____
_____

Client Name:_____ **Record Number:**_____

Appendix 37

I understand the following about this authorization:

- I can revoke this authorization in writing. Requests to revoke authorizations must be made in writing at the Medical Records Office where this form originated. For additional information see our Notice of Privacy Practices. Revocation is effective upon receipt, except to the extent that others have previously acted in reliance upon this authorization
- Treatment cannot be denied to you if you refuse to sign this authorization. However, outside agencies, that require protected health information to provide various services to, or for, you may not be able to do so.
- If the recipient of this information is subject to California or federal confidentiality laws, it is possible that it may be redisclosed.
- This authorization includes written, electronic, and/or verbal disclosure.
- I have a right to receive and I will be offered a copy of this authorization. _____ _____
  Please Initial Received Offered copy
- A copy of this authorization is as valid as an original.

I may contact San Luis Obispo County Behavioral Health Services Privacy Officer by mail at:
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, or by calling (805) 781-4700.

TERM: This authorization will remain in effect from the date of this authorization until the _____ day of _____, 20 _____ .

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize San Luis Obispo County Behavioral Health Services to use and/or disclose my health information in the manner described above.

Client Signature : _____ Date:_____

A minor client's signature (12-17) is required in order to release information concerning care for mental health conditions and/or alcohol drug abuse issues.

Signature of Parent/Guardian/Conservator and Authorized Representative and Description of Authority**

_____ Date:_____

**(with copy of court papers/letters of conservatorship)

Signature of Staff:_____ Date: _____
(MD, PhD, LCSW, LMFT)

Client Name:_____ Record Number:_____

Appendix 37

San Luis Obispo County Mental Health
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535

Teléfono: (805) 781-4700
Fax: (805) 781-4271

AUTORIZACIÓN PARA USAR Y/O REVELAR INFORMACIÓN SANITARIA PROTEGIDA
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Apellido	Primer nombre	Segundo nombre	También conocido como:

Calle/Número	Ciudad	Estado	Código postal

Teléfono particular: ( )	Fecha nac.:	Últimos cuatro dígitos del Nro. de seguro social: XXX – XX - _____ _____ ____ ____

El servicio de salud conductual del condado de San Luis Obispo está autorizado a:
☐ Recibir / Obtener información de **Y/O** ☐ Brindar información a:

Nombre de la persona/organización de contacto:

Domicilio:

Ciudad/Estado/Código postal

Teléfono: ( ) Fax:( )

_____ **Autorizo el uso y/o la publicación de <u>toda</u> la historia clínica conductual.**
(Firmas)

<u>O*</u>

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):
_____ Diagnóstico de enfermedad mental/Información del diagnóstico
_____ Evaluación inicial/Diagnóstico
_____ Evaluación psiquiátrica
_____ Historial de medicación _____ Resumen del alta médica _____ Resumen para transferencia
_____ Laboratorio _____ Evaluación de las enfermeras _____ Resumen del tratamiento
_____ Otros: _____
_____

*Las anotaciones de psicoterapia requieren una autorización por separado.

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):
_____ Programa de tratamiento para el abuso de alcohol /drogas
_____ Pruebas para VIH, su diagnóstico y/o tratamiento

<u>PROPÓSITO:</u> Autorizo al Servicio de salud conductual del condado de San Luis Obispo a usar y publicar información sobre mi salud durante el término de esta autorización para los siguientes propósitos específicos:
☐ Evaluación ☐ Planificación del tratamiento/Curso/Entrega
☐ Otro (especificar) _____
_____

Client Name: _____ **Client Number:** _____

Appendix 37

Entiendo lo siguiente acerca de esta autorización:

- Puedo revocar esta autorización por escrito. Las solicitudes para revocar autorizaciones pueden hacerse por escrito en la oficina de registros médicos donde se emitió este formulario. Para más información, vea nuestra notificación sobre prácticas de privacidad. La revocación tiene vigencia a partir de su recepción, excepto en la medida en que otros hayan actuado en base a la autorización.
- No se le pueden negar tratamientos sobre la base de haberse negado a firmar esta autorización. Sin embargo, es probable que agencias externas, que requieran información protegida de salud para brindarle varios servicios, no estén en condiciones de brindarle el tratamiento.
- Si quien recibe esta información está sujeto a las leyes de California o a las federales de confidencialidad, es posible que la pueda volver a publicar.
- Esta autorización incluye la revelación por escrito, en forma electrónica y/o oral.
- Tengo derecho a recibir y se me debe ofrecer una copia de esta autorización. _____ _____
  Firme Recibido Copia ofrecida
- La copia de esta autorización es tan válida como el original.

Puedo ponerme en contacto con la oficina de privacidad del Servicio de salud conductual del condado de San Luis Obispo por correo escribiendo a:
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, o llamando por teléfono al (805) 781-4700.

PLAZO: La presente autorización tendrá vigencia a partir de la fecha de la presente autorización hasta el _____ día de _____ de 20 _____ .

He leído y entiendo los términos de la presente Autorización y he tenido la oportunidad de hacer preguntas acerca del uso y/o la publicación de información relativa a mi salud. Por medio de mi firma, que aparece más abajo, en forma voluntaria y con conocimiento, autorizo por la presente al Servicio de salud conductual del condado de San Luis Obispo a usar y/ o revelar la información sobre mi salud en la forma descripta más arriba.

Firma del paciente: _____ Fecha:_____

En caso de un paciente menor de edad (12-17 años), se requiere su firma para revelar información relativa a su estado de salud mental y/o temas relacionados con el abuso de drogas y alcohol.

Firma del padre/tutor/protector, representante autorizado y descripción de autoridad**

_____ Fecha:_____

**(con copia de documentos del tribunal/documentos de tutela o curaduría)

Signature of Staff
Firma del personal:_____ Fecha(Date): _____
(Doctor en medicina, PhD., asistente social clínico matriculado, terapeuta familiar matriculado)
(MD, PhD, LCSW, LMFT)

Client Name: _____ **Client Number:** _____

Appendix 37

Services

- Increase access to other community services / Acceso a otros servicios comunitarios.
- Services available at clinics, schools, and community resource centers / Los servicios están disponibles en clínicas, escuelas, y centros de recursos comunitarios.
- Services will help you improve your coping and social skills / Los servicios te ayudarán a mejorar tus habilidades sociales y para enfrontar problemas.

Mental Health Services Act
Ley de Servicios de Salud Mental

The services provide culturally competent behavioral health services.
Funding for this program is provided by Community Services and Supports, and Prevention and Early Intervention.

Los servicios proveen servicios de salud conductal culturalmente competentes.
El financiamiento para éste programa es propocionado por Servicios Comunitarios y Apoyos, y Prevención e Intervención Temprana.

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY

WELLNESS · RECOVERY · RESILIENCE

Latino Outreach Program

COUNTY OF
SAN LUIS OBISPO
BEHAVIORAL HEALTH
DEPARTMENT

EMOTIONAL
WELLNESS SERVICES FOR
THE LATINO COMMUNITY

SERVICIOS DE BIENESTAR
EMOCIONAL PARA LA
COMUNIDAD LATINA

TELEPHONE
TELÉFONO
1-800-838-1381

We can help you if you are experiencing / Le podemos ayudar si esta experimentado:

1. Emotions and behaviors which you cannot understand / Emociones y comportamientos que no puedes entender.

2. Anger that you cannot control / Cólera que no puedes controlar.

3. Uncontrollable crying and prolonged periods of sadness / Llanto incontrolable y períodos prolongados de tristeza.

4. Excessive worry / Preocupación excesiva.

5. Painful and fearful memories / Recuerdos que traen dolor y temor.

6. Irrational thoughts / Pensamientos irracionales.

7. Decreased functioning at school, work, or home / Disminución del funcionamiento en la escuela, el trabajo, ó el hogar.

8. Suicidal and/or self-harm thoughts / Pensamientos suicidas.

9. Great difficulty adjusting to and coping with the American culture / Dificultad para adaptarse a la cultura Americana.

Services Offered

- Therapy for children, youth, adults, and families offered by bilingual and bicultural therapists.

Servicios Ofrecidos

- Terapia para niños, jóvenes, adultos, y familias ofrecidos por terapeutas bilingües y biculturales.

Information About the Services / Información Acerca de los Servicios

- Services are offered to Latinos who are low income and to those covered by MediCal. / Los servicios son ofrecidos a los Latinos que tengan poco ingreso y a aquellos que sean cubiertos por MediCal.

- Services are provided by bilingual and bicultural counselors. / Los servicios son proporcionados por terapeutas bilingües y biculturales.

LOBBY CHECKLIST

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH LOBBIES:
North County MH Clinic/Atascadero, Kinship Center, SLO Adult MH Clinic (CON REP), SLO Youth Services, MHSA, Martha's Place, Family Care Network, Juvenile Services Center, Transitions Mental Health Admin Office, South County Clinic/Arroyo Grande, SAFE Family Resource Center - South County

LOCATION: _____ AUDIT DATE: _____

___ Consumer Request Form ENGLISH, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)

___ Consumer Request Form SPANISH, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)

___ GUIDE TO Medi-Cal Mental Health Services, ENGLISH booklet
(Beneficiary Handbook)

___ GUIDE TO Medi-Cal Mental Health Services, SPANISH booklet
(Beneficiary Handbook)

___ Notice of Privacy Practices (May 10, 2010) ENGLISH (HIPAA)

___ Notice of Privacy Practices (10/1/2009) SPANISH (HIPAA)

___ Medi-Cal Ombudsman Services (tri-fold brochure), ENGLISH

___ Medi-Cal Ombudsman Services (tri-fold brochure), SPANISH

___ SIGN (font 48): "Dear Consumers, Informational materials are available in alternative formats. Please ask the receptionist for assistance."

___ SIGN (font 48): "Dear Consumers, Free language assistance services are available upon request. Please ask the receptionist for assistance."

___ SIGN (font 48): "Estimado Consumidores, Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda."

___ SIGN (font 48): "Si usted busca servicion de salud mentales y necesita ayuda en espanol por favor de informarle a la recepcionista. Gracias."

Appendix 39

___ SIGN (font 72): "Free language assistance available upon request."

___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO ENGLISH

___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO SPANISH

Appendix 39
___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided.) On M-Drive, each Program Supervisor has access/copy.

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH FACILITIES:
PSYCHIATRIC HEALTH FACILITY (PHF), SLO COUNTY MENTAL HEALTH; YOUTH TREATMENT PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA); SOCIALIZATION PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA); AMERICAN CARE HOME, ATASCADERO

LOCATION: _____ AUDIT DATE: _____

___ MENTAL HEALTH PATIENTS RIGHTS poster (CA Dept. M Health, 1999)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. HANDBOOK ENGLISH: (CA Dept. of Mental Health)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. HANDBOOK/MANUAL SPANISH: (CA Dept. of M. Health)

___ Consumer Request Form ENGLISH, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ Consumer Request Form SPANISH, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ GUIDE TO Medi-Cal Mental Health Services ENGLISH booklet
(Beneficiary Handbook)

___ GUIDE TO Medi-Cal Mental Health Services SPANISH booklet
(Beneficiary Handbook)

___ Notice of Privacy Practices (May 10, 2010) ENGLISH

___ Notice of Privacy Practices (10/1/2009) SPANISH

Appendix 39

___ Medi-Cal Ombudsman Services (tri-fold brochure) ENGLISH

___ Medi-Cal Ombudsman Services (tri-fold brochure) SPANISH

___ SIGN (font 48): "Dear Consumers, Informational materials are available in alternative formats. Please ask the receptionist for assistance."

___ SIGN (font 48): "Dear Consumers, Free language assistance services are available upon request. Please ask the receptionist for assistance."

___ SIGN (font 48): "Estimado Consumidores, Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda."

Appendix 39

___ SIGN (font 48): "Si usted busca servicion de salud mentales y necesita ayuda en espanol por favor de informarle a la recepcionista. Gracias."

___ SIGN (font 72): "Free language assistance available upon request."

___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided.) This document is on the SLO County M-Drive

DAS
SLO County Health Agency Client Information Center
Centro de Información para Cliente

Behavioral Health Patients' Rights Poster
English
(Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) *Ask PRA*

Behavioral Health Patients' Rights Poster
Spanish
(Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) *Ask PRA*

Guide to Medi-Cal Mental Health Services Handbook
English and Spanish
(Located on the slocounty.ca.gov website-Behavioral Health section)
Request hard copy from PRA

Drug Medi-Cal Organized Delivery System Handbook
English and Spanish
(Located on the slocounty.ca.gov website-Behavioral Health section)
Request hard copy from PRA

Language Assistance
(Located on the slocounty.ca.gov website-Behavioral Health section)

Emergency Phone List
Specific to site
(Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials\Emergency Services Clinic List) *Ask PRA*

Code of Conduct
(Request from PRA)

Notice of Privacy Practices
(Request from PRA)

SUDS Provider List
English
Spanish
(Located on the slocounty.ca.gov website-Behavioral Health section)

Mental Health Provider Directory
English
&
Spanish
(Located on the slocounty.ca.gov website-Behavioral Health section)

Complaint / Appeal Information **Información de Quejas / Apelaciones**

Consumer Request Instructions English
(Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) *Ask PRA*

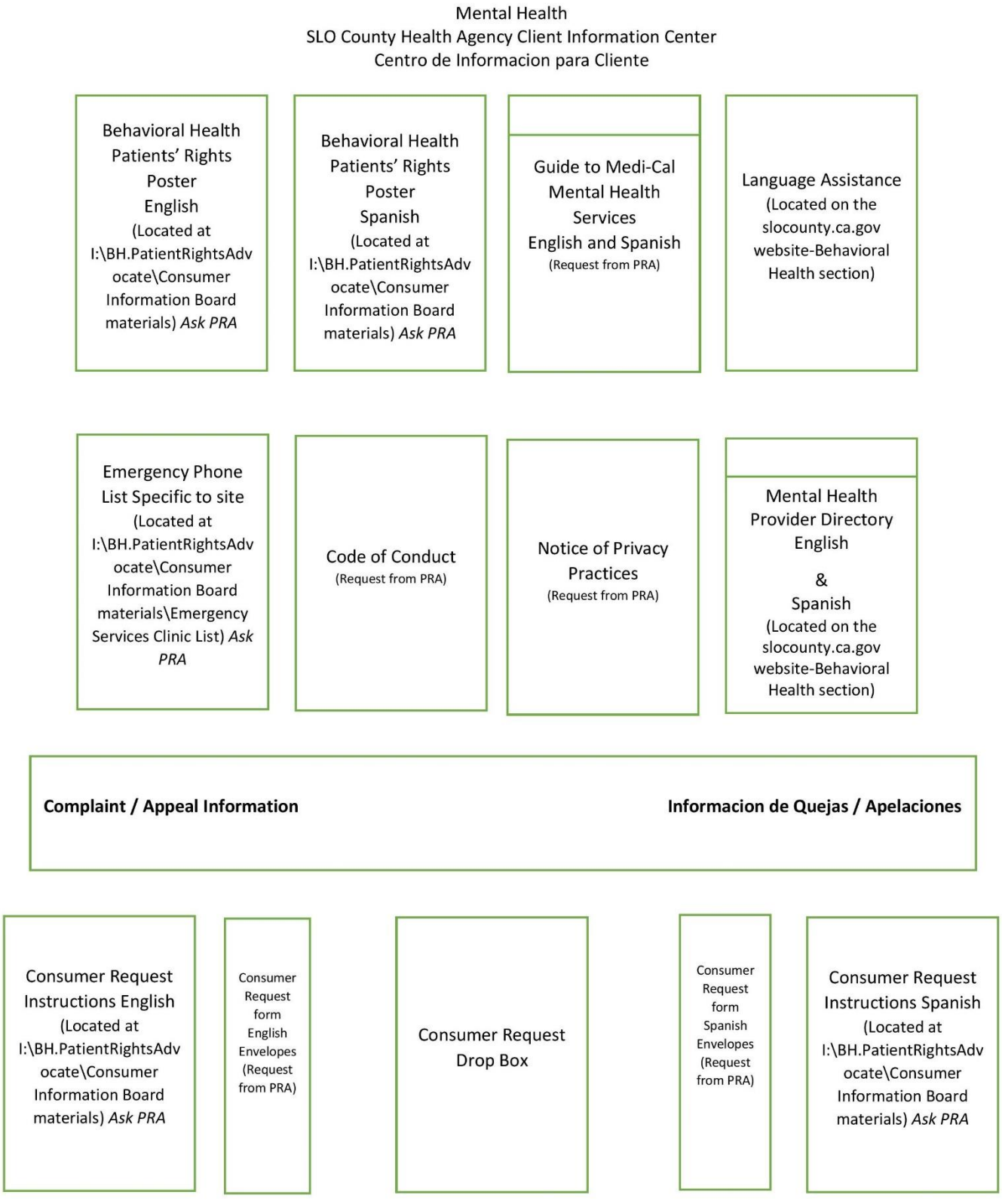
Consumer Request form English
slocounty.ca.gov website-Behavioral Health section
Envelopes (Request from PRA)

Consumer Request Drop Box

Consumer Request form Spanish
slocounty.ca.gov website-Behavioral Health section
Envelopes (Request from PRA)

Consumer Request Instructions Spanish
(Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) *Ask PRA*

Appendix 39


Mental Health
SLO County Health Agency Client Information Center
Centro de Informacion para Cliente
Behavioral Health Patients' Rights Poster English (Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) Ask PRA
Behavioral Health Patients' Rights Poster Spanish (Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) Ask PRA
Guide to Medi-Cal Mental Health Services English and Spanish (Request from PRA)
Language Assistance (Located on the slocounty.ca.gov website-Behavioral Health section)
Emergency Phone List Specific to site (Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials\Emergency Services Clinic List) Ask PRA
Code of Conduct (Request from PRA)
Notice of Privacy Practices (Request from PRA)
Mental Health Provider Directory English & Spanish (Located on the slocounty.ca.gov website-Behavioral Health section)
Complaint / Appeal Information
Informacion de Quejas / Apelaciones
Consumer Request Instructions English (Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) Ask PRA
Consumer Request form English Envelopes (Request from PRA)
Consumer Request Drop Box
Consumer Request form Spanish Envelopes (Request from PRA)
Consumer Request Instructions Spanish (Located at I:\BH.PatientRightsAdvocate\Consumer Information Board materials) Ask PRA

Appendix 39

Policy
Bilingual materials are distributed to all treatment sites.

Procedure

1. Behavioral Health Services maintains a list of bilingual material including, but not limited to:
    a. Outpatient medical records material on the list called Bilingual Forms
    b. Patient's Rights poster as contained in the medical records Forms Managed Care file
    c. Medi-Cal Beneficiary Member Handbook
    d. County of San Luis Obispo Health Agency Grievance Form
    e. Department of Behavioral Health Medi-Cal Ombudsman Services Brochure
    f. Consumer Satisfaction Survey

2. Bilingual materials are distributed on an as-needed basis by the Central Medical Records to sites.

3. Program Supervisors and Contract Provider Supervisors designate a contact employee for the inventory and distribution of bilingual materials at each service site.

4. The designated contact person replenishes the displayed bilingual materials from Patient's Rights Advocate and Medical Records.

Appendix 40

Policy
San Luis Obispo Behavioral Health Services periodically involved clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level.

Reference:
CFR, Title 42, Section 438.10(d)(1)(i)
CCR, Title 9, Chapter 11, Section 1810.110(a)

Procedure

1. The standardized review protocol is followed to assess the readability of the Beneficiary Handbook as well as other informing handouts.

2. The Patients' Rights Advocate periodically meets face-to-face with a representative sample of beneficiaries and follows these steps:

    a. The presenter introduces the process to a group of clients using wording such as the following: "We need your assistance in reviewing our Beneficiary Handbook and other informing materials. If you wish to participate you may do so voluntarily. You are not required to participate in this focus group. Each client of mental health should receive a Beneficiary Handbook when he or she signs up for services and at the time of the review of their client care plan. We want to ensure that the handbook is understandable to our clients. Clients also receive other informing materials, and we would like to know whether or not these materials are easy to understand."

    b. The presenter distributes the handbook and materials to the clients and reads selected portions out loud as clients follow along by reading their own copy.

    c. The presenter queries for questions or comments and records all responses.

    d. The presenter offers a summary of the client responses to the Performance and Quality Improvement/Quality Management Committee.

3. Tests of readability must happen with each significant revision of the Beneficiary Handbook or the informing materials.

Appendix 41

Policy:
The Mental Health Services Act (MHSA) of County of San Luis Obispo establishes Peer support and family education support services and expand these services to meet the needs and preferences of clients and/or family members.

Reference
Title 9, Chapter 14, Section 3610(b)

Procedure
A. Transitions Mental Health Association (T-MHA) is the leading local Community-Based Organization (CBO) responsible for consumer based activities in San Luis Obispo County. MHSA funds the following consumer-based activities run by T-MHA which aims at providing a forum for advocacy, education, promotion of Wellness and Recovery, and striving to eliminate stigma:

1. **Supportive employment and vocational training** is provided through employment readiness classes and job placement.

2. **Client and family-run support**, mentoring and educational groups is conducted through the following programs overseen by a community-based organization.

3. **Peer to Peer** is a 9-week experiential education course on recovery that is free to any person with a mental illness. It is taught by a team of 3 to 4 peer teachers who are experienced at living well with mental illness.

4. **Family to Family** is a 12-week educational course for families of individuals with severe mental illness. It provides up to date information on the diseases, causes and treatments, as well as coping tools for family members who are also caregivers. A team of 2 family members teach the class.

5. The **Peers Empowering Peers** (PEP) Center is a consumer driven Wellness Center in the northern region of the county. Support groups and socialization activities as well as NAMI –sponsored educational activities are conducted here.

6. **Client & Family Partners act as advocates**, to provide day-to-day, hands on assistance, link people to resources, provide support and help to "navigate the system." This strategy will also include a flexible fund that can be utilized for individual and family needs such as uncovered health care, food, short-term housing, transportation, education, and support services.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 05/30/2009
Review dates: 05/30/2009

Appendix 42

7. **Peer Advisory/Advocacy Team** (PAAT), Advocates and educates the community about mental health and recovery. Goals include: Eliminate the stigma attached to mental illness. Advocate and educate the mental health system about the valuable workforce contributions to be made by the individuals it serves. Educate individuals served and family members about their rights and responsibilities in the mental health system. Provide support to peer employees and other leaders of the peer movement to ensure that they have the tools they need to achieve and maintain success and job satisfaction. Promote the concept of wellness versus illness and focus attention on personal responsibility and a balanced life, grounded in wholeness.

B. Evidence that the County, in collaboration with T-MHA, has established ongoing peer support and family education support services, as well as expanded these services will be provided in the form of:

i. Announcements and flyers of the aforementioned programs.
ii. Agendas and sign-in sheets
iii. Brochures and newsletters
iv. Meeting minutes
v. Curricula or similar documents that reflect that peer support services and family education support services are available or offered.
vi. Records of statistics for required DMH reports will also be available.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 05/30/2009
Review dates: 05/30/2009

Appendix 42

Rationale for Focusing on the Needs of the LGBTQIA+ Community

Formation of the LGBTQIA+ Workgroup came in response to several related efforts in San Luis Obispo County that, though launched independently over the last few years, are closely related in focus and direction of recommended next steps. Below is a list of those that the LBGTQIA+ Workgroup have learned about during the last several months:

- San Luis Obispo County LGBTQ+ Mental Health Needs Assessment (2019);
- SLO ACCEPTance Mental Health Provider Development Project (2019 – 2021);
- The LGBTQ+ Mental Health Equity Task Force of SLO County, publishing their Strategic Plan following a two-year grant-funded community-based effort (2022);
- Newly filled position of Program Manager for Diversity, Equity & Inclusion; and
- San Luis Obispo County Health Agency Strategic Plan for Diversity, Equity & Inclusion (anticipated for January 2022).

The LGBTQIA+ Workgroup has now added this report as part of the broader effort to bring into focus opportunities for the Health Agency to improve its practices so as to better serve members of the LGBTQIA+ community in all of its programs.

QCARES (Queer Community Action, Research, Education & Support) conducted the 2019 mental health community needs assessment.[1] Their report identified elevated mental health risks faced by individuals who identify as members of the LGBTQIA+ community. According to the needs assessment report "the findings suggest that there are several barriers to seeking mental health support services for LGBTQ+ people in SLO County, including several that were specific to finding or accessing an LGBTQ+ affirming or competent provider." The 2019 Mental Health (MH) needs assessment study collected data that provided a snapshot of the issues faced by clients who are members of the LGBTQIA+ community, including:

Appendix 43

[1] https://www.queercares.com/lgbtq-needs-assessment-1

DRAFT

- Not knowing how to find an LGBTQ+ competent provider (68%);
- Having no LGBTQ+ knowledgeable mental health services in their neighborhood (60%);
- Experiencing "moderate to high levels of psychological distress (87%)" often presenting as "severe symptoms of depression and anxiety"; and
- Linking this distress, "at least in part, to their gender or sexual orientation (74%)." [2]

Recommendations in the 2019 MH community needs assessment targeted improving "mental health and wellness of LGBTQ+ communities across San Luis Obispo County."

The findings of the 2019 MH community needs assessment may be applicable to discussion of both Drug & Alcohol Services programs as well as mental health services. As part of current practice, some mental health and substance use treatment providers have recognized an overlap between substance use disorder treatment and mental health treatment, noting that the same clients are often seen in both service locations. Indeed, Drug & Alcohol Services clinics have implemented co-occurring treatment options for clients for a few years at the time of this writing. Given the linkage between mental health/wellness and recovery from substance use disorders, the LGBTQIA+ Workgroup members regard the 2019 mental health needs assessment findings as important context and rationale for recommending program improvements at the Health Agency to better serve members of the LGBTQIA+ community.

Workgroups as a Planning Tool for Program Development

Within the Drug & Alcohol Services (DAS) Division of Behavioral Health of the San Luis Obispo County Health Agency, staff-led workgroups have periodically been assigned specific assignments to assist the management team in program development planning. Workgroups comprised of front-line staff have functioned as part of the planning processes

[2] https://www.queercares.com/lgbtq-needs-assessment-1

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to provide programmatic perspective, information, insights, and recommendations related to specific topic areas.

In March 2021, a staff-led workgroup was convened to address issues and concerns related to treatment services for members of the LGBTQIA+ community. This move followed information brought to the Division Managers that specifically identified unmet needs of this community. Ms. Amanda Getten, LMFT, Quality Support Team Division Manager for Behavioral Health for San Luis Obispo County, provided information to the Management Team after she attended an annual Substance Use Disorders conference where she learned about several initiatives designed to address the specialized treatment needs of those who identify as part of LGBTQIA+ communities (personal communication, November 23, 2021). Discussion at leadership meetings eventually led to formation of the LGBTQIA+ workgroup to further explore ways in which SLO County Health Agency programs might become more responsive to the needs of this community of clients, Health Agency staff and community organization partners.

Focus and Faces of the LGBTQIA+ Workgroup

Drug & Alcohol Services (DAS) Division Manager Dr. Star Graber confirmed the purpose of the workgroup as "providing guidance to ensure a welcoming, inclusive and responsive environment for all clients attending services at all of the clinics" (personal communication May 19, 2021). This guidance was expected to take the form of prioritized recommendations to be presented to the Health Agency's Division Managers for their consideration. Following review of the recommendations, Division Managers' role would entail giving direction about implementation of these, with a potential ongoing role for the LGBTQIA+ Workgroup to provide technical assistance and oversight for this process.

Over its course, the LGBTQIA+ Workgroup membership included frontline staff in clinical roles (representing both drug and alcohol treatment and mental health treatment in adult and youth clinics), administrative support roles, the Medication Assisted Treatment (MAT) program, as well as testing services.

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The LGBTQIA+ workgroup convened on March 26, 2021 with 6 attending, and 3 additional people unable to attend that meeting. Reconvened in June 2021, the workgroup roster had a dozen members; however, not all these individuals were able to sustain participation.[3] Between the end of March 2020 and mid-June 2020, there was a brief hiatus during which the workgroup transitioned to a new facilitator and was reactivated. In early June 2021, workgroup members unanimously agreed to an effort to recruit additional members from across all the Divisions in Behavioral Health. Dr. Star Graber carried this recruitment forward, and Division Managers invited staff members to join the LGBTQIA+ workgroup. As of August 2021, twelve workgroup members were listed on the roster. Since that time, seven LGBTQIA+ Workgroup members have actively worked together to formulate the recommendations described in this report.

Even though LGBTQIA+ Workgroup membership fluctuated over the course of this brief span of time, cohesion of purpose and vision was sustained. Each person who participated for any length of time in the LGBTQIA+ Workgroup contributed their ideas, passion, and professional as well as personal commitment to the effort to articulate recommendations to strengthen a welcoming and inclusive Health Agency environment. The LGBTQIA+ Workgroup developed a group "voice" that held over time. There was consensus among workgroup members to advocate for the recommendations described in this report.

Why LGBTQIA?

The LGBTQIA+ Workgroup discussed its name and concluded that it was important to use updated terminology to identify itself. "The language used to talk about LGBTIQ people is constantly evolving. Terms that were forgotten or unused, even terms that at some point were deemed derogatory, have been reclaimed and have entered into common parlance today. In a move towards inclusivity, the older, shorter acronym – LGBT – has been expanded." https://outrightinternational.org/content/acronyms

[3] Attrition in the workgroup membership reflected changes in professional roles in the agency, resignations due to need for better work/family balance, workload pressures, lack of time set aside to effectively participate, and other challenges.

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Identification of Focus Areas for Workgroup Exploration

Beginning with the initial meeting, the LGBTQIA+ Workgroup identified several areas for continued exploration (personal communication with Ms. Getten, November 23, 2021). These were:

A. Adding welcoming signage and LGBTQIA resource information in all clinic lobbies;

B. Creating staff training to highlight LGBTQIA+ affirming communication and interactions;

C. Reviewing procedures and protocols to accommodate trauma-informed care principles in the testing area; and

D. Investigating additional community connections (e.g., QCARES, Access Support Network, GALA, and others) to cultivate opportunities for support groups, education, and more.

Summary of Recommendations

LGBTQIA+ Workgroup members reached consensus on three areas as recommendations to the Division Managers. These are listed below, in priority order:

I. Environmental Enhancements

II. Ongoing Staff Development

III. Structural Alignment in Policies, Procedures and Practices

The workgroup considered these three to be interconnected. The LGBTQIA+ Workgroup thought that each area represented significant opportunities to strengthen welcoming and inclusive environments throughout the Health Agency. The Workgroup viewed these recommendations as key elements in a sequenced set of efforts, on a continuum from "most easily achieved" to "more complicated to achieve" over time. Improvements in each of these areas take into consideration the broader community connected to the Health Agency: clients, staff, community partners and other stakeholders.

Highlights for each of the three recommendations are provided below.

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Priority I Highlights: Environmental Enhancements

- Analyze elements of the facility's physical appearance: what is *seen* can be aligned with better practices for inclusion (welcoming signage and other visual signals);[4]
- Attend to auditory congruence: ensure that what is *said* aligns with better practices for inclusion (personal pronoun awareness[5]; awareness of gender-bias, gender-affirming awareness); and
- Observe interactional cues: cultivate social competence in intercultural/diverse interactions; promote awareness of and conscious refraining from enacting micro-aggressions;[6] and focus on the impact of behavior even when unintentional harm is done.

Priority II Highlights: Ongoing Staff Development

- Provide ongoing staff development to support implementation, encourage updating ideas based on current thinking in a rapidly-evolving, fluid societal space, to promote appropriate behavior change;
- Emphasize *ongoing* focus for institutional and individual change;
- Clarify expected behavior change and plan specifically to reinforce better practices;
- Utilize demonstrated best practices in adult training and development;
- Maintain focus on interactional dynamics reflective of intercultural awareness and positive responsiveness to diversity;
- Arrange for quarterly focus on current issues, with reminders to keep the conversation going through tools, conversation starters, articles or other engagement tools (such as staff meetings or other no-cost options);

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[4]"Provide a welcoming environment." Online information from the American Medical Association. https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice

[5] "Gender Pronouns." Online information from the Lesbian, Gay, Bisexual, Transgender, Queer Plus (LGBTQ+) Resource Center, University of Wisconsin Milwaukee. https://uwm.edu/lgbtrc/support/gender-pronouns/

[6] Microaggression is defined as a "comment or action that subtly and often unconsciously or unintentionally expressed a prejudiced attitude towards a member of a marginalized group." https://www.merriam-webster.com/dictionary/microaggression

- Designate a person at each clinic to communicate to all staff to keep the topic alive on an ongoing basis (person is responsible to be the "driver" in each clinic setting);
- Consider adoption of corrective feedback[7] as a training tool;
- Plan for and support integrated implementation of concepts and skills; and
- Ensure Human Resources department involvement in all aspects of training from onboarding to evaluation and promotion.

Priority III Highlights: Structural Alignment in Policies, Procedures and Practices

- Review Health Agency policies to ensure these include language related to values, mission, and goals reflecting alignment with principles of a welcoming and inclusive environment;
- Review Health Agency procedures to ensure alignment with values, mission, and goals;
- Investigate and adopt standards of care (practices) informed by client-centered practices that align with LGBTQIA+ community needs;[8]
- Review and ensure that management practices include guidance in utilizing corrective feedback (as well as other interventions and strategies) to improve consistency in establishing and maintaining a welcoming and inclusive environment for clients, staff and others;
- Align efforts with those of the office of the Program Manager for Diversity, Equity and Inclusion, as well as emerging community efforts (e.g., SLO County LGBTQ+ Mental Health Equity Task Force) to integrate and coordinate strategic development initiatives.

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[7] "Corrective feedback is a frequent practice in the field of learning and achievement. It typically involves a Learner receiving either formal or informal feedback on his or her understanding or performance on various tasks by an agent such as teacher, employer or peer(s)." https://en.wikipedia.org/wiki/Corrective_feedback

[8] For example, see Guidelines for Care of Lesbian, Gay, Bisexual,, and Transgender Patients. https://npin.cdc.gov/publication/guidelines-care-lesbian-gay-bisexual-and-transgender-patients

COUNTY OF SAN LUIS OBISPO BEHAVIORAL HEALTH DEPARTMENT

You are cordially invited to
Participate in a discussion about
Therapeutic Behavioral Services (TBS)
In San Luis Obispo

Who: County of San Luis Obispo Mental Health; Public defenders; CASA; Family Court Judge; San Lis Obispo Probation; San Luis Obispo Child Welfare Services; Foster Family Agencies, TMHA; Mr. Baily; CAPSLO; Child Development Center; County Office of Education; SELPA.

Who is eligible for TBS under the Emily Q settlement?
Children and youth under age 21 receiving EPSDT mental health services who:

1. Are placed in or are being considered for RCL 12 or higher; or
2. Have received psychiatric hospitalization in the past 24 months; or
3. Are being considered for psychiatric hospitalization.

Agenda topics:
Introduction – Welcome and Purpose of the Meeting
TBS Overview
TBS A Case Presentation
Discussion regarding the following questions:

1. Are the children and youth in your county wo are Emily Q class members and who benefit for TBS, getting TBS?
2. Are the children and youth who get TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in your county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in your county?
5. What are the other issues or concerns do you have?

When: October 30, 2009 from 10-12 noon
Where: San Luis Obispo County Library
Why: Assure that TBS services are accessible to those that need

RSVP – Patty Ford, LMFT at pford@co.slo.ca.us | 805.781.4209

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EXHIBIT A
CONTRACT FOR BEHAVIORAL HEALTH SERVICES
SPECIAL CONDITIONS

1. **Compliance with Health Care Laws.** Contractor agrees to abide by all applicable local, state and federal laws, rules, regulations, guidelines, and directives for the provision of services hereunder, including without limitation, the applicable provisions of the Civil Code, the Welfare and Institutions Code, the Health and Safety Code, the Family Code, the California Code of Regulations, the Code of Federal Regulations ("C.F.R."), Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), and the Health Insurance Portability and Accountability Act ("HIPAA"). This obligation includes, without limitation, meeting delivery of service requirements, guaranteeing all client's rights provisions are satisfied, and maintaining the confidentiality of patient records.
2. **No Discrimination In Level Of Services.** As a condition for reimbursement, Contractor shall provide to and ensure that clients served under this Contract receive the same level of services as provided to all other clients served regardless of medical or medication status or other source of funding, or in any other respect on the basis of race, color, gender, gender identity, gender expression, religion, marital status, national origin, age, sexual orientation, disability, or on any other basis.
3. **Nondiscrimination.**
   a. Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified disabled persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86 dated May 4, 1977.
   b. Contractor shall comply with the provisions of the Americans with Disabilities Act (ADA) of 1990, the Fair Employment and Housing Act (Government Code § 12900 et seq.) and the applicable regulation promulgated thereunder. (California Code of Regulations, Title 2, § 7285 et seq.) Contractor shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.
   c. Contractor shall comply with all state and federal nondiscrimination laws and regulations, and shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, access to programs or activities, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, gender identity, gender expression, religion, marital status, national origin, age, sexual orientation, disability, or on any other basis.
4. **Quality Assurance.** Contractor agrees to conduct quality assurance and program review that meets all requirements of the DHCS, and provide the outcome(s) to County on a quarterly basis. Contractor agrees to cooperate fully with program monitoring or other protocols that may be established by County to promote high standards of mental health care to clients at economical costs.

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5. **Compliance Certification.**
   a. Contractor shall certify in writing on an annual basis that it has credentialed staff that comply with DHCS requirements including, but not limited to, the following elements of this Contract:
      1) Exhibit D.26.: Conflict of Interest
      2) Exhibit E.6.: Screening for:
         i. Inspector Generals' Excluded Provider List and Medi-Cal List of Excluded Providers
         ii. Social Security Death Master File
         iii. System for Awards Management (SAM) List
         iv. National Provider Identifier (NPI)/National Plan and Provider Enumeration System (NPPES) List
         v. National Practitioner Data Bank (NPDB) List
      3) Exhibit E.7.: Compliance Plan
      4) Exhibit E.8.: Cultural Competence Plan
      5) Exhibit E.9.: Health Information Privacy and Security Policy and Training Program
      6) Exhibit E.11.: Disclosures - Conviction of Crimes / Ownership Interest of Greater than 5%
      7) Exhibit E.12.: Drug Free Workplace
      8) Exhibit E.19.b.: Licensing Restrictions
   b. Contractor shall sign the Contractor Certification form in conjunction with signing this Contract. The Contractor Certification form has been approved by the Health Agency Director and will be either provided with this Contract or can be found at: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx
6. **Screening of Inspector Generals' Excluded Provider List, Medi-Cal List of Excluded Providers, Social Security Death Master File, SAM List, NPI/NPPES, and NPDB List.**
   a. Consistent with the requirements of 42 C.F.R. section 455.436, Contractor must confirm the identity and determine the exclusion status of all providers (employees and network providers), any subcontractor(s), any person with an ownership or control interest, and/or any person who is an agent or managing employee of the Mental Health and Drug Medi-Cal Organized Delivery Service (DMC-ODS) Plans through periodic checks of federal and state databases.
   b. Inspector Generals' Excluded Provider List and Medi-Cal List of Excluded Providers: At the time of securing a new employee or service provider, Contractor shall conduct, or cause to be conducted, a screening and provide documentation to County certifying that its new employee or service provider is not listed on the Excluded Provider List of the Office of the Inspector General or the Medi-Cal List of Excluded Providers. On a monthly basis, Contractor shall conduct or cause to be conducted a screening of all employees, subcontractors or agents assuring that neither Contractor nor any of its employees, subcontractors or agents are listed on the Excluded Provider

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List of the Office of the Inspector General or the Medi-Cal List of Excluded Providers.

c. Social Security Death Master File: Pursuant to 42 C.F.R. section 438.602(b), Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R Part 455, subparts B and E.

d. System for Awards Management (SAM) List: At the time of securing a new employee or service provider, Contractor shall conduct or cause to be conducted a screening and provide documentation to County certifying that its new employee or service provider is not listed on the SAM Excluded Provider List. On a monthly basis, Contractor shall conduct or cause to be conducted a screening of all employees, subcontractors or agents assuring that neither Contractor nor any of its employees, subcontractors or agents are listed on the SAM Excluded Provider List.

e. NPI/NPPES List:
   1) Contractor shall certify that all employees, subcontractors, and agents who are required to have an NPI number have been checked monthly against the NPPES provider list on a monthly basis. Contractor will verify that NPI number and taxonomy number have not changed, and, if so, that the discrepancy has been corrected.
   2) If Contractor finds that any of the above persons or providers is/are excluded, it must promptly notify County and take action consistent with 42 C.F.R. section 438.610(c). Contractor shall not certify or pay any such person or provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

f. NPDB List: At the time of securing a new employee or service provider, Contractor shall conduct or cause to be conducted a screening and provide documentation to County certifying that its new employee or service provider is not listed on the NPDB List. Periodically, Contractor shall conduct or cause to be conducted a screening of all employees, subcontractors or agents assuring that neither Contractor nor any of its employees, subcontractors or agents are listed on the NPDB List.

7. **Compliance Plan.**

a. Contractor shall, at a minimum, adopt and comply with all provisions of the latest version of the Health Agency Compliance Plan and Code of Conduct–Contractor and Network Provider Version ("Compliance Plan"). Contractor may adopt and comply with an alternate Compliance Plan and Code of Conduct if granted written approval by the Health Agency Compliance Officer. Contractor shall adopt effective measures to enforce compliance with the Compliance Plan by its employees, subcontractors and agents.

b. Within thirty (30) calendar days of hire, and annually thereafter, Contractor, its employees, contractors and agents shall read the latest edition of the Health Agency Compliance Plan and Code of Ethics and complete related training provided by Contractor or the Health Agency.

c. Contractor shall maintain records providing signatures (either actual or electronic) from each employee, subcontractor and agent stating that they read the Compliance

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Plan, completed the related training and agree to abide by its contents. Relias Learning or equivalent E-learning records are sufficient to comply with this requirement.

d. The Compliance Plan and related training (YouTube video) may be found here: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx

8. **Compliance with County Cultural Competence Plan.**

a. Consistent with County Cultural Competence Plan and 42 C.F.R. section 438.206(c)(2), Contractors shall make services available in a manner consistent with Culturally and Linguistically Appropriate Service (CLAS) national standards. Contractor shall provide services that meet the cultural, ethnic and linguistic backgrounds of clients, including but not limited to, access to services in the appropriate language and/or reflecting the appropriate culture or ethnic group. Contractor shall adopt effective measures to enforce compliance with this standard by its employees, subcontractors and agents.

b. Within ninety (90) calendar days of hire, and annually thereafter, Contractor, its employees, subcontractors and agents shall read the latest edition of the Cultural Competence Employee Information Pamphlet and complete related training provided by the Health Agency or other cultural competence training determined by Contractor.

c. Contractor shall maintain records providing signatures (either actual or electronic) from each employee, subcontractor and agent stating that they completed annual cultural competence training. Records shall specify the training topic, provider or vendor, hours of training, and date completed. Relias Learning or equivalent E-learning records are sufficient to comply with this requirement.

d. The Cultural Competence Plan may be found here: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx

9. **Health Information Privacy and Security Policy and Training Program.**

a. Contractor shall provide health information privacy and security training to all employees as required by Title 22 of the California Code of Regulations, the Health Information Portability and Accountability Act of 1996 ("HIPAA"), the California Medical Information Act ("CMIA"), and as required by County.

b. Within fifteen (15) calendar days of hire, and annually thereafter, Contractor, its employees, subcontractors, and agents shall read the latest edition of the Confidentiality Agreement and HIPAA Primer for Contractor Use, and complete related training provided by the Health Agency. Contractor may adopt and comply with an alternate Confidentiality Agreement, HIPAA Policy, and related training if granted written approval by the Health Agency Compliance Officer.

c. Contractor shall maintain records providing signatures (either actual or electronic) from each employee, subcontractor and agent stating that they read the Health Information Privacy and Security Policy, completed the related training and agree to

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abide by its contents. Relias Learning or equivalent E-learning records are sufficient to comply with this requirement.

d. The Health Information Privacy and Security Policy and Procedure may be found here: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx

e. The Confidentiality Agreement and HIPAA Primer for Contractor Use may be found here: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx

10. **Confidentiality.** Contractor shall abide by all applicable local, state and federal laws, rules, regulations, guidelines, and directives regarding the confidentiality and security of patient information, including without limitation, Welfare and Institutions Code sections 14100 et seq. and 5328 et seq.; 42 C.F.R. section 431.300 et seq.; 42 C.F.R. Part 2; California Medical Information Act ("CMIA"); the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, including but not limited to 45 C.F.R. Parts 142, 160, 162 and 164; and the provisions of Exhibit F of this Contract (the Business Associate Agreement). Any conflict between the terms and conditions of this Contract and Exhibit F shall be read so that the more legally stringent terms and obligations of this Contractor shall control and be given effect. Contractor shall not disclose any client/patient identifying information, except as otherwise authorized by law.

11. **Disclosures.** Pursuant to 42 C.F.R. sections 455.104 and 455.106, Contractor shall submit the disclosures described in this section regarding Contractor's ownership and control and convictions of crimes. Contractor must submit new or updated disclosures to the Health Agency prior to entering into or renewing this Contract. Contractor shall submit an updated disclosure to the Health Agency within thirty-five (35) calendar days of any change of ownership, conviction of crime by a Contractor employee, or upon request of the Health Agency. Disclosures as provided herein:

a. For disclosure of five percent (5%) or More Ownership Interest, Contractor shall provide in writing the following:
   1) The name and address of any person (individual or corporation or other entity) with an ownership or control interest in Contractor/network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
   2) Date of birth and social security number (in the case of an individual);
   3) Other tax identification number, in the case of a corporation or other entity that uses a tax identification number for tax purposes;
   4) Whether the person (individual or corporation or other entity) with an ownership or control interest in Contractor/network provider is related to another person with ownership or control interest in the same or any other network provider of the Health Agency as a spouse, parent, child, or sibling; or whether the person

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(individual or corporation or other entity) with an ownership or control interest in any subcontractor in which the managed care entity has a five percent (5%) or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

5) The name of any other disclosing entity in which Contractor or subcontracting network provider has an ownership or control interest; and
6) The name, address, date of birth, and social security number of any managing employee of the managed care entity.

b. For disclosure of Conviction of Crime(s), Contractor shall provide in writing the following:
   1) The identity of any person who is a managing employee of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)
   2) The identity of any person who is an agent of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)
   3) Contractor shall supply the written disclosures to County before entering into this Contract and at any time upon County's request.
   4) Network providers should submit the same disclosures to County regarding the network providers' criminal convictions. Network providers shall supply the disclosures before entering into this Contract and at any time upon the Health Agency's request.

12. **Drug Free Workplace.** Contractor shall abide by all applicable local, state and federal laws, rules, regulations, guidelines, and directives regarding the Federal Drug-Free Workplace Act of 1988, Section 5151 et seq. of Subtitle D of Title V of United States Public Law 100-690 (100th Congress). Contractor shall certify that none of its employees, contractors, or agents use drugs or alcohol in a manner that would affect their ability to perform any functions required by this Contract.
13. **Record keeping and reporting of services.**
   a. Contractor shall keep complete and accurate records for each client treated pursuant to this Contract, which shall include, but not be limited to, diagnostic and evaluation studies, treatment plans, medication log, progress notes, program compliance, outcome measurement and records of services provided in sufficient detail to permit an evaluation of services, including timely access to such services, without prior notice. Such records shall comply with all applicable federal, state, and County record maintenance requirements.
   b. Contractor shall submit informational reports as required by County on forms provided by or acceptable to County with respect to Contractor's program, major incidents, and fiscal activities of the program.
   c. Contractor shall collect and provide County with all data and information County deems necessary for County to satisfy state reporting requirements, which shall include, without limitation, Medi-Cal Cost reports in accordance with Welfare and Institutions Code sections 5651(a)(3), 5664, and 5705(a), and guidelines established by DHCS. Said information shall be due no later than ninety (90) days after close of

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fiscal year of each year, unless a written extension is approved by County. Contractor shall provide such information in accordance with the requirements of the Short-Doyle/Medi-Cal Cost Reporting System Manual, applicable state manuals and/or training materials, and other written guidelines that may be provided by County to Contractor.

d. Contractor shall retain records of services rendered under the Medi-Cal program or any other health care program administered by DHCS for a minimum of ten (10) years from the final date of the contract period between County and Contractor, from the date of completion of any audit, or from the date the service was rendered, whichever is later in accordance with Welfare and Institutions Code section 14124.1.
e. If applicable, Contractor shall ensure insurance information is verified for every client at each service and record the current insurance information in County's EHR.

14. **State Audits.** Pursuant to California Code of Regulations, Title 9, section 1810.380, Contractor shall be subject to state oversight, including site visits, monitoring of data reports and claims processing, and reviews of program and fiscal operations to verify that medically necessary services are provided in compliance with said code and the contract between the state and County. If Contractor is determined to be out of compliance with state or federal laws and/or regulations, the state may require actions of County to rectify any out of compliance issue, which may include financial implications. Contractor agrees to be held responsible for their portion of any action the state may impose on County.
15. **Equipment.** Contractor shall furnish all personnel, supplies, equipment, telephone, furniture, utilities, and quarters necessary for the performance of services pursuant to this Contract with the exception of:
    a. All required Behavioral Health forms; and
    b. County may at its option and at County's sole discretion, elect to provide certain equipment which shall remain County property and be returned to County upon earlier demand by or in no event later than the termination of this Contract. Contractor may at its option use County provided equipment for non-County clients as long as the equipment in any given instance is not for the sole use of non-County clients.
16. **Other Employment.** Contractor shall retain the right to provide services at another facility or to operate a separate private practice, subject, however, to the following prohibitions:
    a. No such private practice shall be conducted or solicited on County premises or from County-referred clients.
    b. Such other employment shall not conflict with the duties, or the time periods within which to perform those duties, described in this Contract.
    c. The insurance coverage provided by County or by Contractor for the benefit of County herein is in no way applicable to or diminished by any other employment or services not expressly set forth in this Contract.
17. **State Department of Health Care Services Contract.** Contractor agrees that this Contract shall be governed by and construed in accordance with the laws, regulations

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and contractual obligations of County under its agreement with the DHCS to provide specialty mental health services to Medi-Cal beneficiaries of San Luis Obispo County. (Medi-Cal Specialty Mental Health Services, Welfare and Institutions Code § 5775.)

18. **Use of Information Provided by the Social Security Administration.** Contractor shall comply with all conditions required under the Social Security Administration agreement with the DHCS available at: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Quality-Support/Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx
19. **Placement Authority, if applicable.** County shall have sole and exclusive right to screen and approve or disapprove clients prior to placement in Contractor's facility. Approval must be obtained in writing by client's case manager or designee prior to placement under this Contract.
20. **License Information.**
    a. Contractor agrees that all facilities and staff including, but not limited to, all professional and paraprofessional staff used to provide services will maintain throughout the term of this Contract, such qualifications, licenses, registrations, certifications, and/or permits as are required by state or local law.
        1) Contractor shall assure that licensed staff are enrolled in the Medi-Cal Provider Application and Verification of Enrollment (PAVE) and Medi-Cal Rx portals, in accordance with current DHCS guidance and requirements available at: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx and https://medi-calrx.dhcs.ca.gov/home/
        2) Contractor shall provide County a written list of all licensed/registered/waivered or certified persons who may be providing services under this Contract. The list shall include the name, title, professional degree, license number, and NPI number.
    b. Licensing Restrictions.
        1) Contractor certifies that none of its subcontractors or agents has ever had a professional license, registration or certification revoked, limited, restricted, suspended, placed on probation/conditional status, or had other disciplinary action taken against them by a licensing or certification board. Contractor staff must also attest to the above.
        2) Contractor certifies that none of its subcontractors or agents have ever had professional privileges or membership revoked, cancelled or denied. Contractor staff must also attest to the above.
        3) Contractor certifies that any of its subcontractors or agents who have ever been convicted of a felony have reported the circumstances of the conviction to Contractor and Contractor has determined that the conviction will not affect the individual's ability to perform any of the contracted functions. Contractor staff must also attest to the above.
21. **Professional Licensing Waiver Requirements.** When Contractor employs or contracts with a provider who is licensed in another state, Contractor shall obtain a

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Professional Licensing Waiver from DHCS pursuant to Department of Mental Health ("DMH") Letter No 02-09 prior to allowing the provider to perform services pursuant to this Contract. The Professional Licensing Waiver shall remain in effect until such time as the provider is registered with the appropriate California licensing board.

22. **Gifts.** Gifts may not be charged to this Contract, whether to Contractor staff or anyone else. However, incentive items for youth clients used in a clinical behavioral modification program are allowed with clinical documentation and compliance with established County procedures.
23. **Violations and Deviations.**
    a. If County discovers any practice, procedure, or policy of Contractor which deviates from the requirements of this Contract, violates federal or state law, threatens the success of the program conducted pursuant to this Contract, jeopardizes the fiscal integrity of such program, or compromises the health or safety of recipients of service, County may require corrective action, withhold payment in whole or in part, or terminate this Contract immediately. If County notifies Contractor that corrective action is required, Contractor shall promptly initiate and correct any and all discrepancies, violations or deficiencies to the satisfaction of County within thirty (30) days, unless County notifies Contractor that it is necessary to make corrections at an earlier date in order to protect the health and safety of recipients of service. If Contractor is an in-patient facility, Contractor shall submit its patient admissions and length of stay requests for utilization review through existing hospital systems or professional standards review organizations.
    b. Contractor shall notify County immediately by telephone should Contractor or its agents be investigated for, charged with, or convicted of a health care related offense. In addition, Contractor shall promptly submit to County a written report including: (1) the names and addresses of the Contractor's employees and/or agents who are being investigated, charged, or convicted; (2) the time and location of the incident; (3) the names of County employees, if any, involved with the incident; and (4) a detailed description of the incident.
    c. During the pendency of any such proceedings, Contractor shall keep County fully informed about the status of such proceedings and shall consult with County prior to taking any action which will directly impact County. This Contract may be terminated immediately by County upon the actual exclusion, debarment, loss of licensure, or conviction of Contractor or its agents of a health care offense. Contractor shall indemnify, defend, and hold harmless County for any loss or damage resulting from the conviction, debarment, or exclusion of Contractor or its agents.
24. **Reports of Death, Injury, Damage, or Abuse.**
    a. Reports of Death, Injury, or Damage. If death, serious personal injury, or substantial property damage occur in connection with the performance of this Contract and involving County's clients, Contractor shall immediately notify County's Behavioral Health Administrator by telephone. In addition, Contractor shall promptly submit to County a written report including: (1) the name and address of the injured/deceased person; (2) the time and location of the incident; (3) the names and addresses of

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Contractor's employees and/or agents who were involved with the incident; (4) the names of County employees, if any, involved with the incident; and (5) a detailed description of the incident.

b. Child Abuse Reporting. Contractor shall ensure that all known or suspected instances of child abuse or neglect are promptly reported to proper authorities as required by the Child Abuse and Neglect Reporting Act, Penal Code section 11164 et seq. Contractor shall require that all of its employees, consultants, and agents performing services under this Contract, who are mandated reporters under the Act, sign statements indicating that they know of and will comply with the Act's reporting requirements.

c. Child Death Review. Contractor may disclose confidential mental health information to a County interagency child death review team that is investigating a child's death as per, Penal Code section 11174.32, the Interagency Child Death Review.

d. Elder Abuse Reporting. Contractor shall ensure that all known or suspected instances of abuse or neglect of elderly people sixty-five (65) years of age or older and dependent adults age eighteen (18) years of age or older are promptly reported to proper authorities as required by the Elder Abuse and Dependent Adult Protection Act. (Welfare and Institutions Code § 15600 et seq.)

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Contractor shall require that all its employees, consultants, and agents performing services under this Contract, who are mandated reporters under the Act, sign statements indicating that they know of and will comply with the Act's reporting requirements.

25. **Trafficking Victims Protection Act of 2000.**

a. Contractor shall comply with Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000 (22 U.S.C. § 7104(g)) as amended by 22 U.S.C. section 7102. For full text, see: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim

b. Contractor, Contractor's employees, and subcontractors shall not:
   1) Engage in severe forms of trafficking in persons during the period of time that this Contract is in effect.
   2) Procure a commercial sex act during the period of time that this Contract is in effect.
   3) Use forced labor in the performance of the award or sub-awards under this Contract.

c. Contractor shall:
   1) Immediately notify County's Behavioral Health Administrator, by telephone, in the event they receive any information from any source alleging a violation of a prohibition in section 25.a. of this Exhibit.
   2) Include the requirements of this section in any subcontract awarded under this Contract.

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d. Violation of any of these provisions is cause for immediate termination of this Contract.

26. **Disclosure of Unusual Incidents.** Contractor shall notify County's Behavioral Health Administrator, by telephone, of the violation of any provision of this Contract within twenty-four (24) hours of obtaining reasonable cause to believe such a violation occurred. Notice of such violation shall be confirmed by delivering to County's Behavioral Health Administrator, within seventy-two (72) hours of obtaining a reasonable cause to believe that such violation occurred, a written notice which shall describe the violation in detail. Contractor shall comply with state law and County's policies and requirements concerning the reporting of unusual occurrences and incidents.

27. **Standard for Security Configurations, if applicable.**
    a. Contractors accessing County's EHRs system shall abide by and implement the standard Security Configurations below. Contractor shall configure its computers with the applicable United States Government Configuration Baseline ("USGCB") and ensure that its computers have and maintain the latest operating system patch level and anti-virus software level.
    b. Contractor shall ensure IT applications operated on behalf of County are fully functional and operate correctly on systems configured in accordance with the above configuration requirements. Contractor shall test applicable product versions with all relevant and current updates and patches installed. Contractor shall ensure currently supported versions of information technology products meet the latest USGCB major version and subsequent major versions.
    c. Contractor shall ensure IT applications designed for end users run in the standard user context without requiring elevated administrative privileges.
    d. Contractor shall ensure hardware and software installation, operation, maintenance, update, and patching will not alter the configuration settings or requirements specified above.
    e. Contractor shall ensure that its subcontractors (at all tiers) which perform work under this Contract comply with the requirements contained in this section.
    f. Contractor shall ensure that computers which store Protected Health Information ("PHI") and/or Personally Identifiable Information ("PII") locally have hard drive encryption installed and enabled.
    g. For those Contractors accessing County's EHRs system, County shall not provide Contractor with computer hardware support in connection with the performance of this Contract. County shall provide Contractor with necessary EHRs software support in connection with the performance of this Contract. County and Contractor shall be aware of and exclusively responsible for all legal implications of County providing Contractor with any computer support in connection with the performance of this Contract.

28. **Charitable Choice.**
    a. Contractor shall not use any money provided under this Contract for any inherently religious activities such as worship, sectarian instruction, and proselytization. In

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regard to rendering assistance, Contractor shall not discriminate against an individual on the basis of religion, a religious belief, or refusal to actively participate in a religious practice. If an individual objects to the religious character of a program, Contractor shall provide a secular alternative at no unreasonable inconvenience or expense to the individual or County.

b. Contractor shall comply with 42 C.F.R. Part 54.

c. Contractor shall submit documentation annually showing the total number of referrals necessitated by religious objection to other alternative substance use disorder activities. This information must be submitted to County by September 1st of each year, including the September 1st after the termination of this Contract. The annual submission shall contain all substantive information required by County and be formatted in a manner prescribed by DHCS.

29. **No Unlawful Use or Unlawful Use Messages Regarding Drugs.** Contractor agrees that information produced through funds allocated under this Contract, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol. (Health and Safety Code §§ 11999-1199.3.) Contractor agrees that it shall enforce, and shall require its agents, including subcontractors, to enforce these requirements.

30. **Restriction on Distribution of Sterile Needles.** Contractor agrees that no Substance Abuse Prevention and Treatment ("SAPT") Block Grant funds made available through this Contract shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

31. **Network Adequacy Standards (applicable only to contractors located within San Luis Obispo County).** Contractor agrees to provide information required by the Network Adequacy Standards, as directed by the Medicaid Managed Care and Children's Health Insurance Program Managed Care Final Rule. Contractor shall provide the following, if applicable:

a. Staff list, updated monthly, including, but not limited to the following items, or as required per DHCS, a copy of the following for each staff member:
   1) Credentials including copy of license, registration, certification, NPI, Taxonomy, etc.;
   2) California driver's license;
   3) Language capacity, including American Sign Language;
   4) Work location address and/or geographic coverage area if providing services in the community or mobile services;
   5) Cultural competence training received;
   6) Specialties practiced;
   7) Evidenced Based Practices utilized;
   8) Number of years' experience in the field;

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9) Date of hire or Contract start date; and
10) Date and confirmation of negative tuberculosis test.

b. Contractor and staff shall comply with DHCS Provider Enrollment requirements, which may include registering clinical staff in each DHCS database and/or providing County with all necessary provider data to allow enrollment in DHCS databases and County's Provider Directory.
c. Work locations that are ADA compliant, including full street address and zip code.
d. List of client complaints about lack of timely access, if any, updated monthly, for each site, submitted to County's Patients' Rights Advocate.
e. Ability to ensure clients timely access at each site and/or provider, indicated by:
   1) Client screening and/or triage wait time;
   2) Availability of same or next day services; and
   3) Appointment wait time must be timely from client request to offered first service;
f. Ability to provide evidence of timely access to County in a form and format approved by County in order to comply with DHCS reporting requirements;
   1) Timely to be defined as:
      i. Within forty-eight (48) hours of client request for crisis services;
      ii. Within ninety-six (96) hours of client request for urgent services;
      iii. Within ten (10) business days of client request for routine services;
      iv. Within fifteen (15) business days of client request for psychiatry; and
      v. Within three (3) business days of client request for opioid treatment program ("OTP").
g. Ability to ensure that offered hours of operation are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee For Service, if the provider serves only Medicaid enrollees.
h. Client time and distance to County behavioral health services facilities shall be no longer than listed below and applies to clinics and individual offices:
   1) Outpatient mental health services = forty-five (45) miles or seventy-five (75) minutes' drive;
   2) Outpatient substance use disorder = sixty (60) miles or ninety (90) minutes' drive; and
   3) Drug Medi-Cal Organized Delivery System (DMC-ODS), or OTP services = forty-five (45) miles or seventy-five (75) minutes' drive.
i. Number of staff and subcontractors in County service area of each drive time/zone.

32. **Managed Care Final Rule.** Contractor shall comply with Managed Care Final Rule and County policy, if applicable, to provide timely access to services and abide by accessibility standards as per the Managed Care Final Rule. (Mental Health Parity and Addiction Equity Act of 2008, MHPAEA.) County reserves the right to adjust this policy if the state changes the rule.
33. **California Values Act.** Contractor, acting as a provider of mental health and wellness services to County clients, shall comply with Government Code sections 7284.2 and 7284.8, Cooperation with Immigration Authorities. Contractor shall ensure effective policing, to protect the safety, well-being, and constitutional rights of clients served by

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Contractor by limiting assistance with immigration enforcement to the fullest extent possible consistent with federal and state law, while assuring Contractor services remain safe and accessible to all California residents, regardless of immigration status. For full text, see: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=7284.2.&lawCode=GOV

34. **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances.** None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act. (21 U.S.C. § 812.)
35. **Debarment and Suspension.**
    a. Contractor shall not subcontract with any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 C.F.R. Part 180 that implement Executive Orders 12549 (3 C.F.R. Part 1986, Comp. p. 189) and 12689 (3 C.F.R. Part 1989, p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority.
    b. Executive Order 12549. Contractor shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 C.F.R. Part 1001.
36. **MHSA Contract Publicity Language, if applicable.**
    a. County requires public acknowledgment of the organizations, programs, and projects it supports, as outlined in Provider Publicity Guidelines.
    b. Contractor shall issue a press release announcing Contract award within 30 days of executed Contract.
        1) Press release shall acknowledge County Behavioral Health Department and the Mental Health Services Act (MHSA).
        2) Press release shall use the following standard language: Funding for this program is/was provided by the County of San Luis Obispo Behavioral Health Department, through the Mental Health Services Act.
    c. Include County logo on print and digital materials promoting MHSA-funded programs and activities; consult the Provider Publicity Guidelines for specifics.
        1) If space allows on design, Contractor shall also include the standard language stated above in section 36.b.2).
        2) The Behavioral Health Department will supply providers with County logo artwork. The logo must be produced as a unit without alteration.
        3) County Seal is for Board of Supervisors business only and shall not be used on materials related to this MHSA-funded program or activity.
    d. Contractor shall send all MHSA Contract-related activity press releases, media advisories and general publicity materials to County at slobehavioralhealth@co.slo.ca.us.

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1) Contractor shall submit all materials fourteen (14) days prior to Contract-related activities.

37. **Byrd Anti-Lobbying Amendment (31 U.S.C. § 1352).** Contractor certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. section 1352. Contractor shall also disclose to County any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.
38. **Information Access for Individuals with Limited English Proficiency.** Contractor shall comply with all applicable provisions of the Dymally-Alatorre Bilingual Services Act (Government Code §§ 7290-7299.8) regarding access to materials that explain services available to the public as well as providing language interpretation services.

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Print Form

California Brief Multicultural Competence Scale

Below is a list of statements dealing with multicultural issues within a mental health context.

Please indicate the degree to which you agree with each statement choosing from the drop down list.

1.	I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1.	1 Strongly Disagree
2.	I am aware of how my own values might affect my client.	2.	1 Strongly Disagree
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	3.	1 Strongly Disagree
4.	I am aware of institutional barriers that affect the client.	4.	1 Strongly Disagree
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	5.	1 Strongly Disagree
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	6.	1 Strongly Disagree
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	7.	1 Strongly Disagree
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	8.	1 Strongly Disagree
9.	My communication skills are appropriate for my clients.	9.	1 Strongly Disagree
10.	I am aware that being born a White person in this society carries with it certain advantages.	10.	1 Strongly Disagree
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	11.	1 Strongly Disagree
12.	I have an excellent ability to critique multicultural research.	12.	1 Strongly Disagree
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	13.	1 Strongly Disagree
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	14.	1 Strongly Disagree
15.	I can discuss, within a group, the differences among ethnic groups socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	15.	1 Strongly Disagree
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	16.	1 Strongly Disagree
17.	I can discuss research regarding mental health issues and culturally different populations.	17.	1 Strongly Disagree
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	18.	1 Strongly Disagree
19.	I am knowledgeable of acculturation models for various ethnic minority groups.	19.	1 Strongly Disagree
20.	I have an excellent ability to assess, accurately, the mental health needs of women.	20.	1 Strongly Disagree
21.	I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	21.	1 Strongly Disagree

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (In Press, 2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. Measurement and Evaluation in Counseling and Development, 37, 3.

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