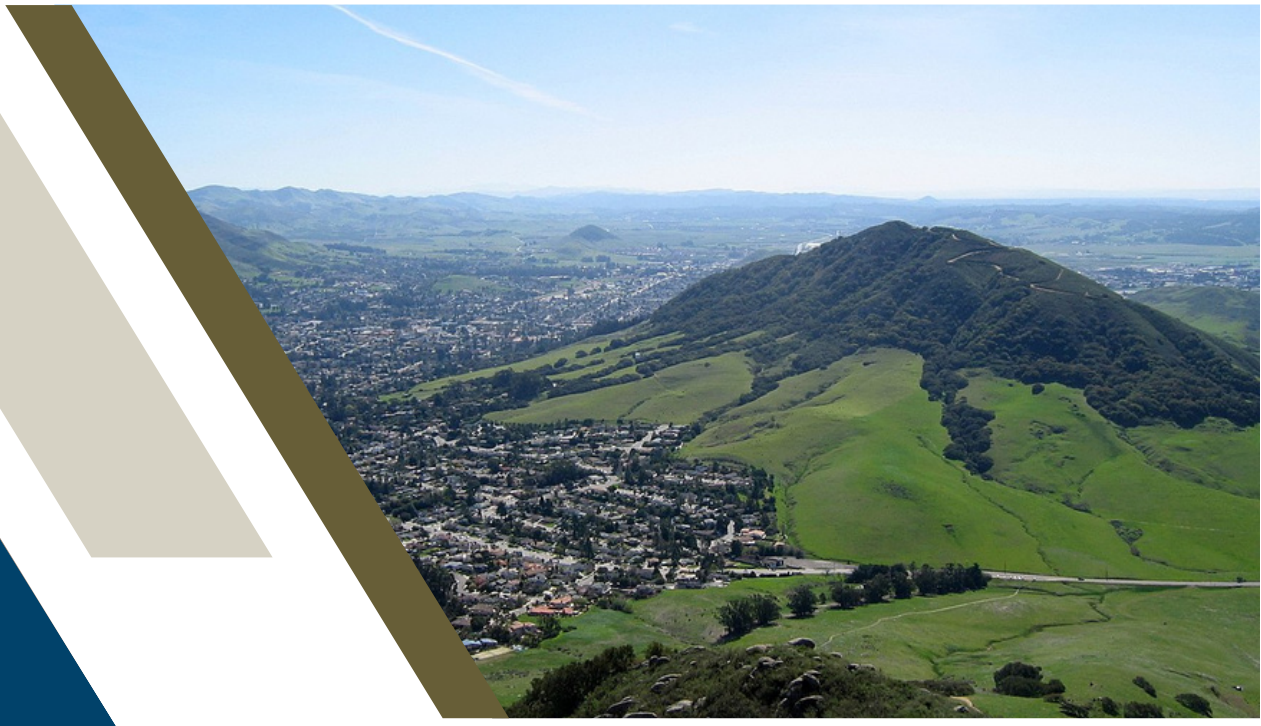
2023 CULTURAL COMPETENCE PLAN

COUNTY OF SAN LUIS OBISPO

BEHAVORIAL HEALTH DEPARTMENT



COUNTY of SAN LUIS OBISPO

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Introduction

The County of San Luis Obispo Behavioral Health Department (SLOBHD) has a longstanding and strong commitment to justice, equity, diversity, and inclusion. SLOBHD is committed to developing a system that strives for cultural awareness, humility, and competence, which is embedded at all levels of the organization.

To accomplish this goal, the Diversity, Equity, and Inclusion (DEI) Committee, formerly known as Cultural Competence Committee, which was formed in 1996, leads and provides recommendation to the Behavioral Health Department. Members of the DEI committee assess, implement, and monitor policies and practices to ensure effective and inclusive services are provided in various cross-cultural interactions. The committee members, representing diverse cultural backgrounds with special interests, provide input and insight to write this report.

This report has been designed to provide a snapshot of the Behavioral Health Department's strategies and efforts toward becoming a more inclusive and culturally attentive organization. This report provides an inclusive look at the entire behavioral health system, including Drug Medi-Cal Organized Delivery System (DMC-ODS) and Mental Health (MH).

Acknowledgements

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Cultural Competence – Diversity, Equity & Inclusion

As part of the continued efforts to solidify diversity, equity, and inclusion practices within the behavioral health system, the department's approaches to integrating services speak to cohesive strategies within the mental health and the drug and alcohol systems to best support all communities seeking services. The addition of new and relevant language within the behavioral health system has been important to showcase strengths and focus attention on internal practices, while highlighting areas for improvement.

The DEI Committee continues to provide feedback and support to the Behavioral Health Leadership team to improve services and programming. The Committee aims to create and support a culturally inclusive and competent organization that continually assesses organizational diversity; invests in building capacity for cultural competency and inclusion, practices strategic planning that incorporates community culture and diversity, implements prevention strategies using culture and diversity as a resource, and evaluates cultural competence practices within the system (SAMHSA, Center for the Application of Prevention Technologies). The need to provide services to all individuals from many diverse cultures and socioeconomic backgrounds that are culturally and linguistically appropriate, diverse, and inclusive is first and foremost the purpose of the department. While efforts are built to increase diversity and inclusion practices in the workforce, the department faces

challenges from local diverse candidate pools and retention strategies for current employees. This Plan is part of the Department's efforts to remain accountable to current strategies and to enhance access by embracing innovative approaches rooted in a justice, equity, diversity, and inclusion lenses from organizational governance to service provision.

Key Objectives and Recommendations

By using the Department of Health Care Services Cultural Competence Plan requirements as a starting point and the lessons learned from the social and political climate within the county and the state, SLOBHD aims to develop integrative strategies based on a DEI lens that is meaningful and can impact the way staff interact with the community, and the how services continue to be more inclusive and affirmative to the current realities experienced by various community members.

The following key objectives have been developed and monitored for the next four years:

Goal	Objective	Action
The SLOBHD will complete and begin implementation of a Diversity, Equity & Inclusion Proposal that is adaptable and will serve as the foundation for culture change and affirmative service provision.	Organizational Culture shift developed and driven under the leadership of the Department and the Diversity, Equity & Inclusion Committee. Efforts include careful development of a clear identity statement (purpose, vision, and core values).	DEI Proposal has been developed. HR suggested including Public Health as a partner and making the proposal an agency-wide proposal. The proposal is going to be sent to HA executive leadership for review and is currently under revision by the recently hired DEI Program Manager.
	Address hiring and retention practices for Black, Indigenous, and People of Color (BIPOC) candidates and staff members.	A comprehensive audit list has been created and will be presented to HR for review and potential testing implementation.
	DEI Committee will broaden the approach to cultural affirmative trainings to improve the behavioral health system's capacity to serve various populations including specific trainings	A comprehensive Inclusion & Belonging survey has been completed and the data is being used to develop a DEI training plan for the next two upcoming years.

	focused on LGBTQIA+ individuals, veterans, consumers, and family members.	
Revise the BH DEI Committee Bylaws and review membership to ensure that we meet the requirements. Include key collaborative partners that will ensure a rich and engaging experience within the committee.	Develop a policy that requires the committee to meet specific community membership to enhance the diversity of the Committee, which serves to improve cultural competence principles across the department's programs and services.	For future development and implementation in the upcoming fiscal year.
The BH DEI Committee will develop a review process for policies and procedures to ensure it meets specific standards for diversity, equity, and inclusion.	Establish BH DEI Committee's review process of SLOBHD programs and services within an inclusion lens.	For future development and implementation in the upcoming fiscal years.
Develop a stronger social media presence with culturally-and historically based information applying a BH lens to instruct and raise awareness in the community.	Partner with the BH Public Information Officer to streamline processes for media outreach and important calendar events that highlight diversity.	For future development in current fiscal year.

Culturally and Linguistically Appropriate Services (CLAS) Standards Reference Page

Criterion 1: Commitment to Cultural Competence

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.

Criterion 2: Updated Assessment of Service Needs

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 includes new data collection reporting and strategies identified, determined, and adopted for the year.

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Behavioral Health Disparities

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.

Criterion 4: Client/Family Member/Community Committee: Integration of the Committee Within the County Behavioral Health System

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.

Criterion 5: County Behavioral Health System Culturally Competent Training Activities

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.

Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Diverse Staff

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.

Criterion 7: County Behavioral Health System Language Capacity

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.

Criterion 8: County Behavioral Health System Adaptation of Services

The following CLAS Standards align with Criterion 8:

11) 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.

Culturally and Linguistically Appropriate Services (CLAS) Standards Reference Document

Criterion 1

Commitment to Cultural Competence

I. County Behavioral 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 Behavioral Health System.

The County of San Luis Obispo Behavioral Health Department (SLOBHD) has developed various Cultural Competence Plans, the most recent in 2022. The plan has also received Annual Updates that highlight the work of the department in ensuring services and programs meet linguistically and culturally appropriate standards. The 2023 Cultural Competence Plan Update will continue to provide a foundation for policies, procedures, and practices to reflect the department's aim to enhance diversity, equity, and inclusion practices within the entire behavioral health system.

SLOBHD has revised their purpose statement, which serves as a banner for all official public records. The purpose statement mentions the following (Appendix 01):

> *To serve all individuals in the 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.*

Regarding employment practices, all county employees, including candidates for employment, are provided the following statement by the County Administrative Office 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 Disability Act in hiring and retaining employees.*

Within the Mental Health Services Act (MHSA), the General Treatment Considerations (Appendix 02), includes the County's required process to incorporate clients' unique experiences and cultures into treatment and engagement:

> *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.*

In order to create a culturally inclusive and consistent workforce, the department has focused resources and efforts in training activities with the goal to enhance knowledge and applicable skills of diversity, equity, and inclusion. The Department's use and strategic development under the MHSA components has allowed the implementation of training plans with the goal to increase capacity in the system and improve service provision. Likewise, the development of the Diversity, Equity, & Inclusion (DEI) Proposal, which is in draft format and still being reviewed, first and foremost highlights the Department's unwavering commitment to transforming the behavioral system from governance practices to communication. The goal of the DEI Proposal is to create a framework for the next five years and to begin aligning programs, services, policies, and procedures with transformative objectives impacting the entire behavioral health system (Appendix 3).

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 all on-site compliance and audit review, the State will examine documents which demonstrate the Department's commitment to justice, equity, diversity, and inclusion strategies that support cultural competency practices embedded in the entire system, including the following:

- The draft of the County Behavioral Health Department's Purpose Statement, which is also listed in the annual budget documents.
- Previous Cultural Competence Plans, including all Annual Updates to the Cultural Competence Plans.
- Policy and Procedure Manual, including the DEI Committee Bylaws redone in 2022, meeting agendas and minutes, and newsletters.
- Human Resources policies and accompanying documents that support ways to incorporate DEI practices to best recruit, hire, and retain diverse staff and candidates, including the Civil Service Commission Rules & Ordinances, Guidelines, and Policy Against Discriminatory Harassment (Appendix 4 & Appendix 5).
- Specialized reports focused on key stakeholders and population needs, such as the LGBTQIA+ Workgroup Report.
- Contracts outlining culturally competent service requirements, and other documents that support and enhance staff and providers' development.

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

The CCPR shall be completed by the County Behavioral 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 behavioral 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 behavioral health planning processes and services development.

All Cultural Competence Plans and Annual Updates have been completed by the Diversity, Equity, & Inclusion Program Manager, in collaboration with staff from the Behavioral Health Department and the recently renamed DEI Committee. The nature of the plan and the Department's partnerships with community providers and stakeholders allows for development of a robust plan focused on collaborative activities and efforts to train and support staff and to enhance culturally and linguistically appropriate services for all clients.

SLOBHD has identified that behavioral health services can often be perceived as out of reach for various diverse communities in the county. Strategies to address access to services include outreach activities that support embedding SLOBHD staff in key access

priority points, such as in educational settings, partner providers' locations, and streamlining referral processes. Another strategy includes ensuring a stronger presence in community social and advocacy events with non-profit organizations, supporting local groups and specialized centers that provide support to various diverse populations, such as the GALA Pride & Diversity Center, Race Matters SLO, The Diversity Coalition of SLO, The City of SLO Police Department Police Advisory Committee (PAC), The SLO Legal Assistance Foundation (SLOLAF), 40 Prado Shelter, El Camino Homeless Organization (ECHO), and the Housing Authority of SLO (HASLO) among others.

Latinx/Latino/Hispanic & Mixteco Speaking Communities: The largest ethnic group is the Latino/Latinx/Hispanic community and the threshold language in the county is Spanish. The Latino/Latinx/Hispanic community constitute about 24% of the entire county population according to the U.S. Census Bureau, but only represent about 22% of penetration rates for behavioral health services. Cultural barriers in accessing services as well as availability have become critical challenges for service provision. Additionally, an increase of Mixteco-speakers in the northern and southern region of the county have propelled the Department to expand linguistically appropriate information in partnership with the Public Health Department, including the provision of services in Mixteco by ensuring Mixteco is offered by the local Promotores group. The effects of the Covid-19 pandemic on this community, including the Mixteco-speaking community, have negatively impacted engagement. Besides maintaining and expanding partnerships with the Latino/Latinx/Hispanic community through social justice forums and presentations, consumers and family members through the MHSA Stakeholder group, and the DEI Committee, the Department is in the process to re-design the Latino Outreach Program to match the needs of the community with a more inclusive lens and the Department has hired a Bilingual and Bicultural Public Information Officer solely dedicated to providing and engaging the Spanish-speaking community throughout the entire county with culturally and linguistically appropriate messaging about behavioral health services and helping the community navigate the system.

Older Adult Community: Another special interest group and community is the older adult population. Individuals aged 60 and above represent about 29% of the entire population of the county. Under the MHSA Stakeholder meeting and planning processes, stronger partnerships for outreach and services have been built with Wilshire Community Services and their partners. Special focus on suicide prevention and other prevention and early intervention activities have been implemented with senior care organizations and older adult consumers who are part of the stakeholder processes, including the expansion to include older adult Full-Service Partnerships (FSP) through MHSA funding.

Individuals Experiencing Homelessness: A deep commitment of the Department is to address the needs of all individuals who are experiencing homelessness. Understanding that an intersectional lens must be applied in service provision for individuals experiencing

homelessness, a comprehensive and fluid approach is needed to best engage and provide services to this population. Continued efforts have been implemented with local shelters and furthering support for the expansion of infrastructure to distribute information in several points of access in the county, including the new El Camino Homeless Organization (ECHO) shelter in Paso Robles where outreach services have been provided, and a deeper partnership has been established to support families and children. Additionally, the DEI Program Manager reviewed and provided feedback for the most recent San Luis Obispo Countywide Plan to Address Homelessness 2022-2027 to ensure careful consideration and vision in addressing intersectional experiences in homelessness were being implemented. The plan can be accessed in the following link.

Veterans and Armed Forces: Another key community and population of focus is the veteran and armed forces community. Veterans are often at high risk for suicide and depression, and they have distinct cultural needs and barriers to accessing services. Under the Department's strategies, local veterans and veterans' groups are engaged to receive services but also in the design and development of MHSA-funded programs and services that meet this particular community's needs. The continued and expanded efforts of the MHSA-funded Veterans Outreach Program (VOP) offering case management, social engagement, and clinical services are integral to continue to serve this population. Additionally, the clients are referred to local veterans' services and navigation of services are offered to support clients and their families in accessing other behavioral health services, such as the Veterans Treatment Court program.

LGBTQIA+ Community: The Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Asexual (LGBTQIA+) community presents a widely intersectional experience and age groups from children to transitional aged youth, adults, and older adults. From 2018 with the LGBTQ Mental Health Needs Assessment to the current BH LGBTQIA+ Workgroup Report, the Department has continued to implement practices to ensure outreach, engagement, and service provision meets affirmative standards of care. Larger efforts to ensure messaging and public information meets inclusive standards have been operationalized throughout the entire department to reach the community, including messaging in Spanish. Other services include the First Episode Psychosis (FEP) program designed to embed a clinician at higher educational settings and college-based housing to provide immediate contact and support. The Department continues to expand training opportunities to ensure staff receive inclusive and affirmative training, including other policy practices such as the development of the first Transgender Policy (Appendix 6) to meet appropriate standards of care in the Psychiatric Health Facility (PHF).

Children and Youth

In each of the communities and populations discussed above, children and youth are impacted. Understanding the cultural aspects within each of the groups and their behavioral health needs is key to strategizing best practices to outreach and engage them

in receiving and staying informed. County services and programs address families, children, and youth by helping them navigate and build skills to successfully engage in school, work, and various community settings. Youth and families are met in schools, churches, coffee shops, community centers, and in response to COVID-19, strategies for engagement were implemented virtually ensuring to meet safe, brave, welcoming, culturally, and linguistically appropriate services. Likewise, youth and their families take part in the MHSA Stakeholder meetings and planning processes, therefore impacting the manner in which services and programs are designed to ensure they meet cultural and linguistic standards.

B. 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 behavioral health boards and commissions, and community organizations in the behavioral health system's planning process for services.

A key factor impacting how services and programs are designed and delivered is dependent on the collaboration and partnerships established between the Department and local partner providers, organizations, families, clients, and social justice agencies targeting disenfranchised communities. The long-standing partnerships focus on strengthening efforts to ensure clients move within the behavioral health system seamlessly while addressing their specific cultural needs from a diversity, equity, and inclusion lens. While the Department partners with other County agencies, such as Probation, Social Services, Public Health, and the Veterans Services Office, clients and their loved ones and other interest groups drive engagement and provide feedback on programs and service provision.

The County's Behavioral Health Board provides directions and recommendations to the Department with the aim of meeting mandates as outlined in the Welfare and Institutions Code 5604.2. The board reviews and evaluates the community's behavioral health needs, services, facilities, and special programs, while advising the governing body (Board of Supervisors) and the Behavioral Health Director regarding any aspect of the local behavioral health system. Likewise, the Board is representative of the community receiving services, including behavioral health providers, professionals from the County Office of Education, law enforcement agencies, local recovery and wellness organizations, community organizations, social justice non-profits, representatives from diverse interest groups, and members from the local NAMI chapter. The Board's bylaws require that "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."

While seeking diversity in leadership is important, the Board has experienced some challenges in recruiting and retaining bilingual and bicultural members. Ongoing recruitment efforts are focused on promoting diversity reflecting a more inclusive and culturally responsive approach. The Board continues to seek strategies to increase exposure to diverse populations and individuals who provide a richer perspective to the Board.

Under the MHSA process, the stakeholder group aims to create an atmosphere built on diversity, equity, and innovative approaches to address mental health needs. Each of the County's required stakeholder meetings have included clients, family members, and professionals as well as community members representing the ethnic and linguistic diversity of the County. This approach has helped in identifying and designing specific programs and services targeting specific populations.

The Diversity, Equity, & Inclusion Committee, formerly known as the Cultural Competence Committee, is comprised of staff, partner providers, and behavioral health clients. The Committee seeks to provide the local behavioral health system with guidance and oversight to assure policies and procedures are in place to improve DEI efforts. The group meets six times a year and reviews agency processes, forms, and programs to provide input toward increasing capacity to deliver services which reduce disparities. The committee produces circulars every quarter in both English and Spanish (Appendix 7 & Appendix 8) for staff and providers to disseminate and features key cultural and linguistic information that expands knowledge on the importance of access to services.

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 Department's strategy to address the shortage of qualified candidates, including the impact of the Covid-19 pandemic in overall workforce recruiting, has led to expand outreach capacities consistent with and supportive of the purpose, vision, goals, and objectives of the Department, which also align with the MHSA Workforce, Education, and Training (WET) component. As part of continued efforts, the Department partners with community organizations, clients and their loved ones, and diverse cultural groups to best target and address ways in which recruitment and retention of staff takes place.

With the addition of the Workforce, Education, & Training (WET) Coordinator, the Departments continues to consider the workforce development needs of the behavioral health system to create strategies and educational programs that meet the needs of the community and support best human resource practices. The WET Coordinator is the liaison to the Southern Counties Regional Partnership (SCRP) Collaborative. These meetings help

identify state and regional trends in workforce challenges and needs in the system, needs of clients and their loved ones, identification of inequities linked to diverse communities and populations receiving behavioral health services, as well as introduction to trainers and educational opportunities for each WET Coordinator to bring to their respective counties. Additionally, workshops and webinars sponsored by the California Institute of Behavioral Health Solutions (CIBHS) and the County Behavioral Health Directors Association (CBHDA) provide opportunities for collaboration and additional technical support.

In July of 2023 the DEI Program Manager sent out a comprehensive Inclusion & Belonging survey (Appendix 9) to collect workforce information with two main purposes. First to capture information on workforce challenges, barriers, and employment environment as it relates to DEI practices for staff to perform their assigned duties. Secondly, capturing data on essential training information to best develop a cohesive plan to ensure behavioral health staff is provided with the skills and knowledge needed to provide essential services. The implementation and completion of the survey are helping the Department for the very first time understand the makeup of the workforce and to identify the additional human resource strategies needed to offer support to current staff, as well as, develop an inclusion & belonging training series.

Continued partnership is essential to best understand and capture the local workforce challenges that the behavioral health system is experiencing. Focus groups, interviews, and information sessions held with Community Based Organizations (CBOs), the Behavioral Health Board (BHB), and the leadership team from the Latino Outreach Program (LOP), as well as social justice community organizations provide ideas and recommendations concerning workforce development throughout the process, including from recruitment, hiring, retention, and promotion practices.

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

In reviewing documents and strategies that highlight the success around community outreach and engagement, staff skill development, and improvements in the behavioral health system, the Department recognizes barriers and challenges that need further attention to ensure DEI practices are fully embedded in operation, governance, and service delivery.

The DEI Committee understands the importance of shaping and designing areas of impact in the behavioral health field. This is the reason that diverse leadership with a strong behavioral health experience can help shape and respond to the needs of the community. By expanding diversity in leadership and in overall representation in the committee, the committee is also aligning with the Committee's purpose, vision, and values. The

committee is also dedicated to expanding the role of clients and their loved ones in the Committee's activities.

Another lesson learned is that ever-changing communities and populations need a different approach for outreach and engagement. This translates into best practices through communication plans. For example, in partnership with the Behavioral Health Public Information Officer, social media campaigns and key informational posts and stories engage children and youth with the goal of emphasizing prevention activities. This has proven to be effective to help reach out to remote and rural areas, and where continued partnerships with school districts and wellness centers provide support. Likewise, all social media posts are translated to the threshold language to ensure support and a diverse population of clients are reached. In designing and creating behavioral health posts, clear attention is paid to the cultural and historical components of specific communities and populations in order to highlight the importance of substance use prevention and treatment and mental health access in a manner that is respectful to cultural norms and language, and affirmative to service provision.

Other proven lessons include partnering with the local higher educational institutions to acquire diverse and innovative practices, research, and language use to support clients and their loved ones in navigating the behavioral health system by understanding cultural barriers and best building cultural support and rapport. Likewise, the use of online evaluation tools to assess training has proved useful. Online surveys have had higher rates of return than previous hard copy methods, and administrative staff have employed this tool in the development of pre- and post-testing to further assess skill development and retention of knowledge. Finally, another key lesson is to maintain fluidity in DEI practices within the organization while allowing key partnerships and innovative ideas to take place. This includes continued support from the leadership team in implementing new practices and to maintain communication with staff on the importance of becoming a behavioral health transformative institution meeting all individuals needs in a culturally affirmative environment.

E. Identify county technical assistance needs

The most pressing component where technical assistance is requested is for the State to release the newly approved Cultural Competence Plan Requirements template and to provide technical assistance to counties as the document is being produced. As this component is still under review by the Department of Health Care Services, it is also encouraged to receive technical assistance in the form of core competency policy development samples to provide counties with clear understanding and expectations when providing services and how policies and procedures shelter and ensure counties' behavioral health system become more diverse, inclusive, and equitable in-service provision.

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

The CC/ESM will report to, and/or have direct access to, the Behavioral Health Director regarding concerns impacting behavioral 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 Behavioral Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate behavioral 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 FY 2020-2021, the MHSA Advisory Committee approved the addition of the Diversity, Equity, & Inclusion Program Manager for the Behavioral Health Department, which was previously known as the Cultural Competence Coordinator/Ethnic Services Manager (CCC/Ethnic Services Manager). In July 2008, Dr. Karen Baylor, the Behavioral Health Director, assigned Nancy Mancha-Whitcomb, LMFT as the CC/ESM. In April 2017, Anne Robin, the new Behavioral Health Director, assigned Nestor Veloz-Passalacqua, MPP, & MLS. as the new CCC/ESM, and now Diversity, Equity, & Inclusion Manager. In July 2023, Anne Robin, the Behavioral Health Administrator hired Matthew Pennon, EMPP as the Diversity, Equity, and Inclusion Program Manager and then assigned Matthew Pennon, EMPP as the new CCC/ESM.

In his capacity, the DEI Program Manager is the liaison for state audit and program reviews, as well as the representative for ESM meetings for the Southern County Regional Partnership (SCRP) and is responsible for disseminating information to all behavioral health clinics and providing support and recommendations to behavioral health providers. The DEI Program Manager chairs the DEI Committee and, in collaboration with Annika Michetti (Drug & Alcohol DEI Co-chair), Jill Rietjens (Mental Health DEI Co-Chair), and Kianah Corey (DEI Student Intern), provide larger direction for policy and procedures review, training, and information processing. Likewise, the DEI Program Manager is an active member of the MHSA Advisory Committee and other local groups/committees impacting services for various diverse groups.

The Behavioral Health Administrator recognizes the role and function of the current DEI Program Manager within the organization by allocating sufficient time for the performance of the job responsibilities and duties. Additionally, the Administrator promotes the staff influence in policy and program change by considering and following recommendations for change in human resource practices, linguistically and culturally specific services, and all other related areas.

B. The responsibilities of the designated DEI Program Manager include:

- 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 outreach 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.
- Take lead responsibility for the development and implementation of cultural competence planning within the organization.
- Participate and advise on planning, policy, compliance, and evaluation components of the county system of care, and make recommendations to the County Director or management team that assure access to services for ethnically and culturally diverse groups.
- Track penetration and retention rates of racially and ethnically diverse populations and develop strategies to eliminate disparities.
- Maintain 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.
- Assist 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.
- Attend 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 is currently updating the policy for certifying staff. The policy is still consistent in ensuring all certified staff meet the following standards:

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 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 10.

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 behavioral health disparities;
3. Outreach to racial and ethnic county-identified target populations;
4. Culturally appropriate behavioral health services; and
5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers

The Department is committed to providing necessary fiscal resources to support diversity, equity, and inclusion activities in the entire behavioral health department.
Below are the activities included in FY 2021-2022 Actual Budget for SLOBHD:

Table 1. FY 2021 – 2022 DEI – Cultural Competence Budget

2021-2022 Funding for Diversity, Equity, & Inclusion – Cultural Competence		
Item	**FY 2021-2022**	**FY 2022-2023**
MHSA-funded Diversity, Equity, & Inclusion Program Manager – Cultural Competence	$80,728	$119,798
Explanation: The DEI Program Manager position is funded through MHSA and Medi-Cal.		
MHSA-funded Latino Outreach Program (LOP) 7.00 FTE permanent positions.	$625,617	$900,915
Explanation: Increase in expense due to Minimum Wage /COLA increases in FY 2022-23 plus 8.00 FTEs were filled out of 9.00 FTE's under Latino Outreach Program.		
WET-funded DEI-Cultural Competence trainings	$25,000	$0
Explanation: offered the Behavioral Health Interpretation Trainings in May and June 2022, but the invoice was paid in FY 2022-2023, therefore this will be counted for FY 2022-2023.		
WET-funded Clinical Bilingual Internship to work in three separate clinics.	$6,328	$19,381
Explanation: Slight increase of bilingual internship to support staff.		
SLOBHD one-time funding to support Promotores Behavioral Health Interpreters with maintenance cost for electronic equipment and internet access	$0	$0
Explanation: One-time expense in FY 2020-21		
SLOBHD appropriation bilingual differential pay which includes coverage for the mental health core budget and MHSA.	$121,848	$55,704
Explanation: Includes expenses covered by release of MHSA Prudent Reserves funds.		
SLOBHD Crisis Intervention Training under MHSA WET Programming	$66,658	$2,354
Explanation: Last FY included a CIT Vehicle for $57,409 funded by the release of MHSA Prudent Reserves funds.		
MHSA WET-funded Promotores Behavioral Health Interpretation Services Contract	$37,454	$86,324
Explanation: 4% increase in contract per fiscal year. This approach helps with providers and ensures continuity of services while addressing changes in the county.		
MHSA WET-funded Peer Advisory and Advocacy Team (PAAT)	$26,265	$36,995
Explanation: continued support through MHSA funding is critical to outreach clients and their loved ones, by increasing the funding for PAAT, additional interventions and practices are implemented.		
MHSA CSS & PEI-funded Veterans Outreach Program (VOP)	$400,212	$452,177
Explanation: Due to the pandemic certain activities were impacted in frequency, but clinical services and contact with the clients and their loved ones were maintained.		

Language Line Interpretation Services funded by County General Fund Support and Realignment	$21,879	$17,724
Explanation: A decrease in usage on interpretation services has been recorded using Language Line services. It is expected these services will increase now that a more streamline process is being implemented to ensure less wait time and easier contact processing.		
Total Funding	**$1,411,989**	**$1,691,371**
Explanation: Part of the aim of the DEI – Cultural Competence practices is to increase funding in areas that support service provision, training opportunities, and operational interventions that enhance a DEI lens embedded in the department.		

Criterion 2

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).

Table 2. County's General Population Summary

TOTAL POPULATION 282,424	100%
Gender	
Female	**49.83%**
Male	**50.58%**
Age	
0-14 years	**13.65%**
15-24 years	**18.66%**
25-59 years	**38.52%**
60 years and up	**29.16%**
Race/Ethnicity	
Black/African American	**1.63%**
Asian/Pacific Islander	**3.68%**
White/Caucasian	**70.23%**
Latino/x/Hispanic	**23.19%**
Native American	**1.12%**
Other/Unknown	**0.15%**
Language	
English	**83.0%**
Spanish	**12.5%**
Other	**4.5%**

Data Source: U.S. Department of Commerce, Census Bureau & the CensusReporter.org

The table above represents the most updated and recent demographic population captured in the U.S. Census Bureau data. What is notable about the data is that White/Caucasian, which do not include the category "White alone, not Hispanic or Latino," represents about 70% of the entire population. In previous reports, White/Caucasian alone represents about 89%. While it is important to distinguish racial groups within ethnic populations, we provide a more accurate representation of racial diversity in ethnic populations in the data presented. Similarly, the percentage of Latino/Latinx/Hispanic decreased from previous reports from about 24% to 23%. The third largest ethnic group is the Asian/Pacific Islander ethnic group with about 4%, followed by Black/African American at 1.63% and then Native American with an increase from previous years from 0.83% to 1.12%.

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.

The following table breaks down the entire Behavioral Health Services (Drug & Alcohol and Mental Health) Medi-Cal population served:

Table 3.

	Medi-Cal Beneficiaries		Medi-Cal Clients		Penetration Rate
	68,002	100%	6,120	100%	9.00%
Gender					
Female	32,181	47.32%	2,802	45.78%	8.71%
Male	35,821	52.68%	3,318	54.22%	9.26%
Age					
0-11 years	14,766	21.71%	504	8.24%	3.41%
12-21 years	13,455	19.79%	932	15.23%	6.93%
22-44 years	21,506	31.63%	2,190	35.78%	10.18%

45+ years	18,275	26.87%	1,288	21.05%	7.05%
Ethnicity					
African American	688	1.01%	180	2.94%	26.16%
Asian/Pacific Islander	526	0.77%	103	1.68%	19.58%
White/Caucasian	25,373	37.31%	4,143	67.70%	16.33%
Latino/x/Hispanic	19,127	28.13%	1,235	20.18%	6.46%
Native American	298	0.44%	124	2.03%	4.16%
Other/Unknown	21,990	32.34%	377	6.16%	1.71%
Language					
English	54,359	79.94%	4,678	76.44%	8.61%
Spanish	12,958	19.06%	303	4.95%	2.34%
Other	685	1.01%	26	0.42%	3.80%

The information listed above summarizes data by gender, age, race/ethnicity, and language categories. The current electronic health record is limited in providing more comprehensive data, the Quality Support Division staff has been able to assist in the extraction of the most defined and accurate data of unduplicated clients served by the Department. Additional data was collected from the California Health and Human Services Open Data Portal. While the information is provided, margin of errors or other difficulties have been tried to be accounted for as to try and avoid errors in reporting. Based on the information on Table 3., White/Caucasian served clients constitute the largest population receiving services. While penetration rate for Black, Asian, and Native Americans are quite high, a cautionary analysis is recommended based in understanding that there is still a lower number of Medi-Cal beneficiaries under those three racial/ethnic groups in the entire County. Therefore, a higher number of clients served compared to the number of beneficiaries may not necessarily reflect equity in service provision, but a demographic reality of limited diversity. Additionally, the Latino/Latinx/Hispanic group constituting about 30% of Medi-Cal beneficiaries, only about 6% of them are part of service provision. Identifying these disparities have helped the Department identify appropriate interventions for the Latino/Latinx/Hispanic population to increase outreach, service delivery and retention.

The following two tables break down the data by services provided in Mental Health and Drug & Alcohol Services:

Table 4. Mental Health Services Medi-Cal Indicators

	Medi-Cal Beneficiaries		Medi-Cal Clients		Penetration Rate
	68,002	100%	3,339	100%	4.91%
Gender					
Female	32,181	47.32%	1,732	51.87%	5.38%

Male	35,821	52.68%	1,607	48.13%	4.49%
Age					
0-11 years	14,766	21.71%	504	15.09%	3.41%
12-21 years	13,455	19.79%	787	23.57%	5.85%
22-44 years	21,506	31.63%	1,185	35.49%	5.51%
45+ years	18,275	26.87%	939	28.12%	5.14%
Race/Ethnicity					
African American	688	1.01%	99	2.96%	14.39%
Asian/Pacific Islander	526	0.77%	75	2.25%	14.26%
White/Caucasian	25,373	37.31%	2,122	63.55%	8.36%
Latino/x/Hispanic	19,127	28.13%	734	21.98%	3.84%
Native American	298	0.44%	72	2.16%	24.16%
Other/Unknown	21,990	32.34%	223	6.68%	1.01%
Language					
English	54,359	79.94%	3,213	96.23%	5.91%
Spanish	12,958	19.06%	275	8.24%	2.12%
Other	685	1.01%	2	0.06%	0.29%

Under provisions of Mental Health, most services are provided to males ranging between the ages of 16-24. White/Caucasian clients, representing about 15% of Medi-Cal clients account for about 9% of services received. As stated above, cautionary analysis is presented for the Black/African American and Native American racial/ethnic groups. The higher penetration rates compare to the population the groups represent do not signify equity in service provision. Instead, it provides a picture of limited diversity in the county demographics.

Table 5. Drug & Alcohol Services Medi-Cal Indicators

	Medi-Cal Beneficiaries		Medi-Cal Clients		Penetration Rate
	68,002	100%	2,781	100%	4.09%
Gender					
Female	32,181	47.32%	1,070	38.48%	3.32%
Male	35,821	52.68%	1,711	61.52%	4.78%
Age					
0-11 years	14,766	21.71%	0	0%	0%
12-21 years	13,455	19.79%	145	5.21%	1.08%
22-44 years	21,506	31.63%	1,005	36.14%	4.67%
45+ years	18,275	26.87%	349	12.55%	1.91%
Race/Ethnicity					
African American	688	1.01%	81	2.91%	11.77%

Asian/Pacific Islander	526	0.77%	28	1.01%	5.32%
White/Caucasian	25,373	37.31%	2,021	72.67%	7.97%
Latino/x/Hispanic	19,127	28.13%	501	18.02%	2.62%
Native American	298	0.44%	52	1.87%	17.45%
Other/Unknown	21,990	32.34%	154	5.54%	0.70%
Language					
English	54,359	79.94%	1,465	52.68%	2.70%
Spanish	12,958	19.06%	28	1.01%	0.22%
Other	685	1.01%	24	0.86%	3.50%

As reviewed in the analysis conducted for Mental Health Services; Drug & Alcohol Services show that males seek services more than females, showing a penetration rate of 2.59%. Adults ages 25-59 are seeking at a greater rate Drug & Alcohol service as well. White/Caucasian clients have a 3.69% penetration rate of services, while Black/African American and Native American represent 7.42% and 8.76% respectively, representing a disproportionate rate of penetration. As described above, this could be due to a lower number of Medi-Cal Beneficiaries within those populations, but a relatively low-to-medium Medi-Cal client served. As pointed above, this also represents the lack of higher diversity in the entire population overall.

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 provides information on the data on population under the 200% federal poverty line. This population is calculated by identifying the 200% FPL population minus the current Medi-Cal beneficiaries. The data on the total population under the 200% FPL was in the U.S. Census Bureau for the Fiscal Year June 30, 2021- June 30, 2022. The Medi-Cal Eligible data was located at California Health & Human Services Open Data Portal and corresponded to the same fiscal year. Upon further analysis, there were discrepancies in the State website between the total number of Medi-Cal Beneficiaries compared to several categories (race/ethnicity, sex, age, language) of the Population under 200% of FPL. To remediate and lessen marginal errors in the analysis, mean values for each category were

obtained from the available data and counted against the State reported Medi-Cal beneficiaries values. Although such formulation was instituted to avoid greater marginal errors, by the nature of the reported data, we anticipate some minor errors, but in general terms it represents the most accurate representation.

Table 6. Calculation for the Population under 200% FPL (minus Medi-Cal Eligible Beneficiaries)

Population under 200% of Federal Poverty Line:	72,086
Medi-Cal Eligible Beneficiaries:	68,002
Population under 200% FPL minus Medi-Cal Eligible Beneficiaries:	4,084

Table 7. Population under 200% FPL minus Medi-Cal Eligible Beneficiaries

	Population Under 200% FPL*		Medi-Cal Beneficiaries		Medi-Cal Clients Served	
	72,086	100%	68,002	100%	6,120	100%
Gender						
Female	35,773	49.62%	32,181	47.32%	2,802	45.78%
Male	36,313	50.37%	35,821	52.68%	3,318	54.22%
Age						
0-11 years	11,454	15.89%	14,766	21.71%	504	8.24%
12-21 years	11,882	16.48%	13,455	19.79%	932	15.23%
22-44 years	28,008	38.85%	21,506	31.63%	2,190	35.78%
45+ years	20,742	28.77%	18,275	26.87%	1,288	21.05%
Race/Ethnicity						
African American	875	1.23%	688	1.01%	180	2.94%
Asian/Pacific Islander	2,590	3.61%	526	0.77%	103	1.68%
White/Caucasian	50,412	69.95%	25,373	37.31%	4,143	67.70%
Latino/x/Hispanic	17,115	23.76%	19,127	28.13%	1,235	20.18%
Native American	586	0.83%	298	0.44%	124	2.03%
Other/Unknown	508	0.72%	21,990	32.34%	377	6.16%
Language						
English	60,768	84.3%	54,359	79.94%	4,678	76.44%
Spanish	8,002	11.1%	12,958	19.06%	303	4.95%
Other	3,316	4.6%	685	1.01%	26	0.42%

* The State of California has not updated data since 2016, as such we are limited in the data that we can provide.
**Includes variable margin of errors due to available data from ch@Khs.ca.gov data.

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.

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 original plan. The current PEI Programming includes all required MHSA Subcategories that also align with

services provided to the six (6) PEI priority populations. This includes the following MHSA PEI Program categories and programs.

PEI Program Categories	PEI Program	Priority Population
Prevention		
	Positive Development	Mainly children ages 2-6, from all backgrounds, cultures, and experiences.
	In-Home Parent Educator	All families at elevated risk with children 0-18 years of age from all backgrounds, cultures, and experiences.
	Family Education, Training, and Support	Mainly parents/caregivers either families experiencing homelessness, fathers, teen parents, isolated families in rural areas, and parents in recovery from all backgrounds, cultures, and experiences.
	Middle School Comprehensive Program	At-risk middle school youth and families from all backgrounds, cultures, and experiences.
Early Intervention		
	Community Based Therapeutic Services	Individuals and families who are underinsured, at-risk, and needs of early intervention services from all backgrounds, cultures, and experiences.
	Integrated Community Wellness	All families, individuals, youth needing mental health and suicide prevention from all backgrounds, cultures, and experiences.
Increasing Recognition of Early Signs of Mental Illness		
	Older Adults Mental Health Initiative	Older adults at risk and experiencing isolation, their loved ones and support networks from all backgrounds, cultures, and experiences.
Access and Linkage to Treatment		
	Veterans Outreach Program	Veterans and their families (children, youth, TAY, adults, and

		older adults from all backgrounds, cultures, and experiences)
Stigma and Discrimination Reduction		
	Social Marketing Strategy – Community Outreach & Engagement	All communities and populations, including LGBTQIA+ communities, Peers, clients and their loved ones, Native American communities, Veterans, Children and Youth and other diverse groups)
	College Wellness Program	Transitional-Aged Youth and Adults in college settings from all backgrounds, cultures, and experiences.
Suicide Prevention		
	Suicide Prevention Coordination	All communities and populations, including LGBTQIA+ communities, Peers, clients and their loved ones, Native American communities, Veterans, Children and Youth and other diverse groups)

B. Interested parties and community members who are part of the PEI Planning Process reviewed and analyzed the various communities and populations whose behavioral health needs were reported as part of surveys, focus and work groups. During the initial and comprehensive planning process, priority services were aligned with targeted populations. This resulted in three population areas of emphasis, Children and Youth, TAY and Adult, and Older Adult. By focusing on each community and the intersection of experience within each group, the planning process developed long-lasting programs focused on strengthening such groups' well-being. This resulted in applicable, client-centered, and adaptable to social changes of the communities/populations receiving services.

Criterion 3

Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Behavioral 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).

Through the MHSA Planning Process, the Department has collected data and interested parties' input to identify unserved and underserved communities and populations throughout the entire county.

A. The following section identifies the target populations fully explaining disparities within the above selected populations.

Medi-Cal Population

SLOBHD describes and aligns "Medical Necessity" (Appendix 11) within the California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity for MHP Reimbursement of Specialty Mental Health Services. Along the same lines, the department aligns with the Drug Medi-Cal Organized Delivery System (DMC ODS) model meeting service provision for substance use disorder treatment services. Likewise, with the implementation of California Advancing & Innovating Medi-Cal (CalAIM), and the development of integrative models taking place in mid-2023 by the local Managed Health Care Plan (CenCal), the Medi-Cal population will receive system of care that will be reflective of careful client consideration and experience.

While SLOBHD aligns services and follows through with State and Federal practices, there is still a barrier for those who do not meet required eligibility under Medi-Cal to access

primary services from the department. Further legislative action could help expand Medi-Cal population eligibility and therefore ability to access services.

Community Services and Supports (CSS) Full-Service Partnership Population

The Full-Service Partnership (FSP) Program (Appendix 11) provides several services utilizing "whatever it takes," wraparound-like, intensive, community-based mental health services and supports to specific age-group populations facing mental illness. FSP is grounded on strength-based, solution-centered, culturally, and linguistically affirmative approaches, client and family oriented, recovery, and resiliency. Target populations include:

1. **Children and Youth:** 0-15 years old, with one or more of the following characteristics:
    1) "High utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
    2) Foster youth with multiple placements
    3) Risk of out-of-home placement
    4) In juvenile justice system
2. **Transitional Age Youth (TAY),** 16-25 years old, that have one or more of the following characteristics:
    1) "High utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
    2) Co-occurring substance abuse issues
    3) Foster youth with multiple placements or aging out/have aged out
    4) Recently diagnosed with a mental illness
3. **Adults**, 26-59 years old, that have one or more of the following characteristics:
    1) At risk for involuntary institutionalization
    2) "High utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
    3) Co-occurring substance issues
    4) Homeless or at-risk of becoming homeless
4. **Older Adults**, ages 60+, that have one or more of the following characteristics:
    1) "High utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
    2) Homebound – unserved
    3) Homeless or at-risk of becoming homeless
    4) Co-occurring substance abuse issues
    5) Presenting with mental issues at their primary care provider's office

Workforce, Education, and Training (WET) Population

Priority populations identified in the original plan are still relevant today. With the impact of the COVID-19 pandemic, there is a growing importance in recognizing priority populations and identifying key strategies for current retention, promotion, and innovative practices to recruit and hire staff.

1) Behavioral Health clinicians and support staff
2) Bilingual and bicultural staff across all positions from direct service staff to management and leadership
3) Clinicians with co-occurring specializations
4) Clients, family members, reentry clients with experience in the Behavioral Health field and are ready to be part of the workforce
5) Diverse staff from all different backgrounds and populations, including expanding recruiting pools from LGBTQIA+, Veterans, Disability, Ethnic and Racial, and Linguistic populations
6) Community Based Organizations serving mental health and drug and alcohol clients
7) Undergraduate and graduate students seeking a career in Behavioral Health
8) Mental Health clients seeking education/career in Behavioral Health
9) Expand diverse criminal justice personnel that best support diverse populations

Prevention & Early Intervention (PEI) Population

The PEI Committee addressed all PEI priority population in the original plan, and it continues the same:

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).

The PEI Planning Process led the review and analysis of the priority populations' needs. The outcome of such a process led to a defined and narrowed targeted group application of services and programs. With a total of 592 PEI strategies submitted, the PEI Committee began combining and formalizing the plans.

Along the process, the PEI Community Planning Team created prioritization criteria for all required programming categories and adopted guiding principles that apply universally to all PEI programs. The guiding principles focus on cooperation, coordination, accessibility, use

of current strategies, maximizing current networks/relationships, family-focus service provision, and diversity in culturally and linguistically appropriate services.

To gain more community feedback in development of the PEI plan, three age-specific workgroups were created. Children/Youth, Adults, and Older Adults. Each group addressed the specific needs of each population. Each workgroup utilized data, conducted additional research, and developed strategies and ideas that best met the PEI criteria and funding requirements. The recommendations were then brought up to the PEI Community Planning Team that ultimately used the information and data to develop the final Prevention and Early Intervention 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).

Currently, based on penetration rates and Medi-Cal beneficiary data, the most significant population experiencing disparities is the Latino/Latinx/Hispanic community. The lack of access to services is made even more relevant when this community represents about 24% of the total county population but represents about 28% of the poverty population. To further understand the county makeup and experience of the Latino/Latinx/Hispanic population is the fact that they reside in rural areas that thus exacerbate access, transportation, outreach, and engagement to services.

Medi-Cal and CSS Populations

CenCal Health, the local Managed Health Provider, has provided Medi-Cal coverage in San Luis Obispo County since 2008. CenCal Health recognizes the importance of offering services that addresses the health education, quality of services, and health needs of its members. According to the population needs assessment, in San Luis Obispo County, about 80% of members speak English and 19% speak Spanish. Accompanying this analysis is the fact that individuals in the Latino/Latinx/Hispanic community receive considerably less services while representing about 23% of the population. Additionally, Latino/Latinx/Hispanic youth and transitional-aged youth represent the highest combined percentages of unserved individuals among youth. Cultural, language, geographical, and generational barriers are elements that still contribute to access to services. Constant education and outreach at all middle schools and partnerships with the local colleges are crucial in addressing the needs of this population.

Trauma either by acculturation or assimilation, as well as navigation of a foreign health care system, contribute to lack of access and disengagement for Latino/Latinx/Hispanic populations in various degrees, therefore presenting a greater access disparity, particularly for groups within the Latino/Latinx/Hispanic population that identify as immigrants. Also, use of government-based services is not considered culturally appropriate due to potential public charge challenges, impacting the wellbeing of the entire family unit.

The previous 2004 Latino/Latinx/Hispanic study revealed a few key variables, specifically for mental health services:

- Accessing services in government settings is uncomfortable, as government is perceived as authoritarian and intimidating.
- Receiving services can create confusion and involve disclosing personal information to various individuals before assignment of a therapist. Some reported that after disclosing information, they were advised they did not meet medical eligibility for services.
- Cultural trust and knowledge were aspects of concern that deterred full engagement in services.
- Knowledge of the Spanish language and the cultures of Spanish-speaking countries are essential for service provision. Interpretation is relevant and of utmost importance for the flow of information and rapport development.

While recognizing major challenges in addressing disparities for the Latino/Latinx/Hispanic population, the Department has strategized by expanding recruitment practices that are more inclusive of the threshold language in service provision and in various leadership roles throughout the entire behavioral health department. This is accomplished by recruiting, hiring, and promoting bilingual and bicultural staff into decision-making roles and ensuring service-oriented positions meet the proper culturally and linguistically standards of the county as well as State and Federal requirements. The inclusion of case managers under the Latino Outreach Program will allow for better service provision in the three larger areas of the county addressing the needs in the Northern, SLO, and Southern-regions, and meeting such population where they are located.

Under Medi-Cal, other populations encountering less access to services include the Asian and Pacific Islander population, who across age and gender groups access services a less rates. This is mainly more pronounced in youth and transitional aged youth. With the social and cultural negative impact of Covid-19, access and social support for this population was a focus of attention as the Department aimed to create a safe and inclusive space to engage with this community. Continued engagement and further review is needed to determine what other cultural aspects need to be strategized and implemented to address access and continue to provide cultural support in service provision.

Workforce, Education, and Training

Behavioral Health clinicians and support staff: there is a need for bilingual/bicultural staff in all service-oriented positions, especially in the threshold language of Spanish. Due to cost of living, limited schooling in the community, capacity, and diverse pools, the Department continues to struggle in this area.

Community Based Organizations: while SLOBHD has strong partnerships with local and regional non-profit organizations, there are still organizations that do not have the capacity or are still in the process of developing policies and practices to provide more culturally appropriate and affirmative care to various populations/communities. Expanding and searching for a variety of potential partners is critical to ensure services are provided.

Diverse clinicians and staff: staff and clinicians who provide services and have specialized lived cultural experiences are critical to continuing to expand services and creating a welcoming atmosphere. Bilingual and cultural staff are one of the key points on disparity in the entire SLOBHD workforce, which places an increasing demand on keeping current employees and open positions available for recruitment.

Clinicians with co-occurring disorders specialization: while the Department has increased in hiring staff with co-occurring disorders experience, skilled therapists and clinicians who are able to navigate both systems and provide culturally appropriate engagement and diagnosis on addiction issues, is critical. As an integrated system, SLOBHD has sought to reduce disparities by creating a comprehensive system based on collaboration and integrative knowledge to best serve clients and their needs.

Undergraduate and graduate students seeking a career in Behavioral Health: SLOBHD has experienced a decrease in partnership and collaboration with the local college due to impacts from the pandemic and changes in students' career interests in the behavioral health field. Likewise, Cal Poly faces a challenge in recruiting and admitting diverse students with different experiences, therefore decreasing the pool of candidates the Department can target. This explains the larger systemic issues associated with the local educational system. With the WET Coordinator and the new Clinical Coordinator, an established relationship has begun forming with the local colleges to attract potential students/candidates.

Need for expansion on behavioral health justice personnel: SLOBHD's response to address the need of justice-involved population has dedicated funding and programming to increase staffing. Training staff in both systems has resulted partially in a challenge, but the staffing has slowly been increasing and in collaboration with the Drug & Alcohol Services and Mental Health, an integrated approach to service provision has been created to best target the co-occurring needs of clients.

Clients, family members, and re-entry: the Department has moved slowly in recognizing hiring practices that welcome lived experiences as key professional factors for employment. Since some or most of the contracted CBOs have programs employing clients and their loved ones, the Department has increased contractual and grant programs which require peer and family member employment, therefore shifting the make up in the entire local behavioral health system.

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

This section outlines SLOBHD's strategies and objectives for each of the targeted populations. 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 SLOBHD addresses disparities:

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 12) outlined the county's local data, described in the previous Criterion, and outlined the services which continue to anchor the CSS strategies.

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 constraints 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 13. The ethnicity of the therapists and their cultural backgrounds addresses the concerns stated in Criterion 3, Section IIA. By being Spanish speaking Latinos/Latinas/Latinx, or now referred to as well as Latine, the therapists can increase the probability of retaining when there is an ethnic and language match between the behavioral health professional and the 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 client's cultural perspectives and experiences. To begin addressing the needs at an earlier phase, the new LOP Supervisor designed and acquired MHSA funding to hire bilingual and bicultural Case Managers, one in each key region. One in North County, one is the San Luis Obispo City region, and one in the South County region.

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:** The Department now has an Outreach & Training Coordinator, who is also the WET Coordinator for the Department. The WET Coordinator is assigned a group of staff ranging from suicide prevention staff, public information, college-based behavioral health services, opioid prevention services, and training coordination. Embedding the Coordinator within various aspects and strategies of the Department, is designed to reach a larger approach by identifying training needs and providing support to the community. Additionally, the Coordinator leads 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.
- **Workforce Training in Co-Occurring Disorders:** co-occurring disorder trainings and information are a key strategy to expand best service provision. Based on this, the Department continues to strategize 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.
- **Clinical Training Supervisor:** This new strategy is designed to address the clinical training needs and expand skills and knowledge for the entire behavioral health clinical staff. In collaboration with the WET Coordinator and the DEI Program Manager, the Clinical Training Supervisor is currently defining plans in addressing workforce needs.
- **Scholarships and Repayment Programs:** This strategy addressed shortages and diversity needs in the behavioral 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 behavioral health care in the county. Likewise, the WET Coordinator is the liaison at the State and Regional Levels where loan repayment plans have been instituted to support current staff with repayment and grant options as they are part of the field.

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 consumers and family members, have access to trainings. The DEI Committee makes recommendations for training curriculum and processes for accessing training. Recently a new expanded and more detailed DEI-Cultural Competence Training has been implemented starting in the 2022 fiscal year.
- **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**: The County has supported several programs developed for consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers. In the past decade the Department 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. Additional support is being provided in defining and implementing the State's initiative about Peer Certification Program and embedding lived experience at a larger reach in the entire behavioral health field.

Prevention and Early Intervention

The County's PEI plan addresses 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) provides services to those who meet access criteria and those who have a diagnosis outside of access criteria such as substance abuse, marital problems, cultural trauma, 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 access. LOP is in the unique position that regardless of the diagnosis, cases can be opened under criteria access or under CSS, therefore no one is turned away based on a diagnosis. Case Managers have been hired in three main areas of the county, the North County Region, The City of SLO, and the South County Region. This allows for expansion and navigation of services within the entire county to best serve clients where their needs are present.
- Other strategies have included the addition of bilingual therapists in the SLOBHD to expand services for those who do meet access criteria. From administrative assistants at the very first contact to bilingual/bicultural staff embedded in various programs. The Department aims to increase such bilingual services in collaboration with the HR Department.

III. 200% of Poverty Strategies

- Most, if not all the 200% poverty population, receive Medi-Cal or Private Insurance services due to the Affordable Care Act and the expansion on Medi-Cal. The population that mainly represents the 200% Federal Poverty Level are non-English speaking communities, including the Latino/Latinx/Hispanic populations. To address these needs, the LOP is embedded in the community to increase access and decrease barriers, primarily transportation within the county. Psychotherapy and Case Management is offered to all LOP clients in welcoming and community settings that are culturally comforting and reassuring, and with the impact of the pandemic, other modes of service expansion include telehealth and digital literacy. Alongside this strategy, contract expansion with the local Promotores group was implemented to address behavioral health needs, particularly in the Drug & Alcohol field.
- 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 support 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 inclusion of Case Managers in the three (3) key specific regions allows for best outreach 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. Latino/Latinx/Hispanic communities, individuals experiencing homelessness, veterans, LGBTQIA+) 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, this includes the new North County Health Campus in Paso Robles, which is an integrated facility offering public health and behavioral health services under one roof, and with easy access for all north county communities. Stigma reduction communitywide, including the original "SLOtheStigma" media campaign, which helped increase knowledge and capacity for mental health access. 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 led 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. Likewise, the new North County Health Campus offers services for children 0-5 and youth from 6-25 years of age, and within a culturally and linguistically appropriate setting.
- **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:

B. 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.

C. 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 community planning 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. Other projects are designed to support the LGBTQIA+ population, children, youth, and a system change regarding potential and imminent threats at educational settings. This also includes the incorporation of non-western perspective into treatment services to allow a more integrative and comprehensive approach to wellbeing.
- **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.
- The Department continues to build upon previous success and offer current staff scholarships and programs to help pay for their education as they are part of the behavioral health workforce.

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 behavioral 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 Department 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 in a culturally and linguistically appropriate approach.

Enhanced Crisis Response and Aftercare has increased the number of mobile responders and added follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility. With the Department's crisis stabilization unit, more clients are able to be seen and stabilized first and then referred and opened to a case. 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, case management, and support. All services are designed to increase access to care, provide culture-affirming care, and increase satisfaction in system navigation.

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 culturally affirming care, and increase satisfaction.

School-Based Mental Health Services offers intense, daily contact to address drug and alcohol and mental health issues for students. 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. PAAT members serve as an advisory team to the department and seek to align key strategies that support implementation around a client-focused approach.

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 Behavioral 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 behavioral 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 youth- and adult-based program was implemented in fall of 2009 and the provider reports quarterly to the SLOBHD.

Underserved Cultural Populations, such as those detailed above for 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 14).

New Strategies from Section IV
All strategies described in Section IV, are currently operational. Tracking and monitoring include 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. With the implementation of the new Electronic Health Care Record in July of this year, the Department is hoping to expand the ways reporting is created to ensure a more comprehensive picture and description of the services provided.

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

Client/Family Member/Community Committee: Integration of the Committee Within the County Behavioral 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.

The Diversity, Equity, and Inclusion (DEI) Committee, previously known as the Cultural Competence Committee, was formed in 1996, and continues to operate to this day. The DEI Committee consists of behavioral health staff, partner providers, clients, and their loved ones, interested parties/groups from different cultural and linguistic backgrounds, and diverse interests. The Committee addresses various cultural components and issues impacting the entire behavioral health system.

A. The Committee is dedicated to providing guidance to the SLOBHD Leadership team to make the Department a more diverse, inclusive, and equitable organization. The Committee creates agency-wide awareness and strategies about relevant issues around diversity, equity, and inclusion, and application in practices and policies. The Committee operates as part of the Department and the DEI Program Manager is appointed as the Chair and reports directly to the Behavioral Health Administrator. The Committee members are the decision-making body and represent a diverse range of cultural, ethnic, racial, and geographic regions within the County.

The Committee meets every other month with a total of six (6) meetings in one fiscal year and visitors are welcome to attend. The current goals of the committee include:

1) To ensure that County Behavioral Health embraces and implements practices, attitudes, values, and policies that support diversity in cultural identity, gender identity and expression, sexuality, language, abilities, veteran status, and spiritual affiliation.
2) To provide policy and practice recommendations that will help increase service delivery to individuals of various cultures, linguistic identities, gender identities and expressions, sexualities, abilities, veteran statuses, and spiritual affiliations.
3) To identify and facilitate the removal of barriers that affect sensitive and competent delivery of services to individuals of various cultures, linguistic identities, gender identities and expressions, sexualities, abilities, veteran statuses, and spiritual affiliations.
4) To provide recommendations that will address the policies and practices of recruiting, hiring, and retaining individuals of various cultures, linguistic identities, gender identities and expressions, sexualities, abilities, veteran statuses, and spiritual affiliations.
5) To provide recommendations that increase utilization patterns of the unserved and underserved populations.
6) To provide County Behavioral Health employees with the topics and information discussed among the DEI Committee to further diversity, equity, and inclusion processes and strategies.
7) To provide and sponsor training opportunities for new and current staff focused on expanding and enhancing diversity, equity, and inclusion knowledge and practices.
8) To forge alliances with other community agencies and committees who support the purpose and purpose, vision, and goals of the DEI Committee.
9) To foster a strong network among community agencies that will facilitate an integrated delivery of services.

B. The DEI Committee's Bylaws (Appendix 15) provides details on the composition of the committee, which include staff from SLOBHD, partner agencies, network providers, interest social groups, clients, and their loved ones, as well as individuals with lived experience. Individuals interested in being part of the Committee are presented to the Committee and approved by a simple majority. A vacancy exists when a member misses four consecutive meetings without prior notification to the Chairperson or when a member tenders their resignation verbally or in writing.

To ensure proper access, all meetings are held at facilities that allow easy access based on different abilities and/or held through virtual means to ensure greater participation and to address the impact of the pandemic. Likewise, all meetings will be held where all individuals with different experiences, identities, and backgrounds are supported and celebrated. The Chairperson convenes the meetings and the DEI Student Intern, Kianah Corey, in partnership with the members, develops the agenda. A quorum is required to approve policies and procedures. All policies 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 (Appendix 16) demonstrates the relationship of the Committee and the Behavioral Health Administrator.

D. Please see Appendix 17 for the most updated DEI Committee membership and affiliations.

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Behavioral 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 Behavioral 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 activities include those listed in Criterion 3, Sec. II of the CCPR:

- ***Reviews of all services/programs/cultural competence plans with respect to cultural***

competence issues at the county

- As per the Committee guidelines - Article II: The Purpose of the Committee, Section 1 (Appendix 18): *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 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 increase utilization patterns of the unserved and underserved populations.
  - To provide and sponsor trainings opportunities for new and current staff focused on expanding and enhancing diversity, equity, and inclusion knowledge and practices.

- ***Provides reports to Quality Assurance/Quality Improvement Program in the county***
  - Goals of the Committee include "To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to various culturally, linguistically, gender identity and expression, sexuality, abilities, veteran status, and spiritual affiliation individuals." This is done by having the DEI 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 Committee include:
    - To ensure that County Behavioral Health embraces and implements the practices, attitudes, values, and policies that support cultural, gender identity and expression, sexuality, language, abilities, veteran status, and spiritual affiliation diversity.
    - To provide recommendations that will increase utilization patterns of the unserved and underserved populations.
    - To provide County Behavioral Health employees with the topics and information discussed among the DEI Committee to further diversity, equity, and inclusion processes and strategies.

- ***Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Behavioral Health Director***
  - As per the Committee guidelines - Article II: The Purpose of the Committee,

Section 2: "The Committee is dedicated to assuring that the County of San Luis Obispo County Behavioral Health Department becomes a culturally aware and competent behavioral health system which integrates the concept of diversity, equity, and inclusion into the fabric of its operation. The committee will create agency-wide awareness of the issues relevant to cultural, linguistic, gender identity and expression, sexuality, abilities, veteran status, and spiritual affiliation diversity, equity and justice for all individuals, and inclusion of various experiences in decision-making processes with the goal of impacting service provision.

- ***Participates in and reviews county MHSA planning process***
    - Matthew Pennon, EMPP, the Chairperson of the Committee is a member of the MHSA Community Planning process. Current members of the Committee have participated and are part of the Mental Health Advisory Committee. The MAC meets every other month to review MHSA components, programs, and to guide planning.

- ***Participates in and reviews county MHSA stakeholder process***
    - The Committee members have been active members of MHSA Community Planning Process for each component – CSS, PEI, WET, and Innovation. DEI - Cultural Competence issues were at the forefront of MHSA planning (including disparities, priority populations, and outreach to consumers and family members) and have been discussed and processed at each level of planning. Committee members have assured that each MHSA planning process included focus groups and feedback sessions that were held in Spanish or were provided in settings that were accessible and comfortable for diverse populations.
    - The Committee's Chairperson is responsible for representing the DEI Committee in reviewing the MHSA Community Planning Process.

- ***Participates in and reviews county MHSA plans for all MHSA components***
    - Matthew Pennon, EMPP as a member of the MAC, is responsible for representing the DEI Committee in reviewing the MHSA plans for all components. Other members of the Committee, including the Behavioral Health Administrator, Star Graber PhD, LMFT, also participate in this oversight.

- ***Participates in and reviews client developed programs (wellness, recovery, and peer support programs)***
    - The Committee produces four (4) circulars which addresses issues related to diversity, equity, inclusion, and belonging 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 premier MHSA partners, to join the Committee. PAAT members are residents, and most have received behavioral 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 (2021) development***
    - Nestor Veloz-Passalacqua, M.P.P., M.L.S., the former DEI Program Manager and Chairperson of the Committee, launched the CCPR preparation sessions and remained on the ad-hoc workgroup charged with preparing the CCPR. Mr. Veloz-Passalacqua 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.

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 Committee's 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 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 19). In their role as Chairperson of the DEI Committee Matthew Pennon also provides reviews of programs and services by participating in the quarterly Performance Quality Improvement (PQI)/Quality Management team (see next).

- **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 20). The group receives reports from the CCC quarterly.

- **Participates in overall planning and implementation of services at the County**
    - As identified in DEI Committee agendas and minutes included herein (Appendix 21

and Appendix 22), the County Behavioral Health Director, Star Graber, PhD, 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 DEI Committee's agendas and minutes included herein (Appendices 21 and 22) along with QST agendas (Appendix 20) demonstrate the interaction and reporting transmittal between the Committee and the County Behavioral Health Administrator, Star Graber, PhD, LMFT.

- **Participates in and reviews county MHSA planning process**
  - The Committee's 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 the agenda and minutes (Appendix 23 and Appendix 24) demonstrating this involvement.

- **Participates in and reviews county MHSA stakeholder process**
  - In 2008, Dr. Ortiz, along with other members of the Committee, including the Ethnic Services Manager (Nancy Mancha-Whitcomb) were active members of the MHSA community planning process, an example of which is demonstrated in the appendix (Appendix 25).

- **Participates in and reviews county MHSA plans for all MHSA components**
  - The Chairperson of the Committee and members are part of the MAC stakeholder group and take part in reviewing each of the county's MHSA plans and reports.
- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs)**
  - The Committee does not currently have a formal project 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 Committee 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.
2. Were the goals and objectives met?
   - If yes, explain why the county considers them successful.
   - If no, what are the next steps?

3. Reviews and recommendations to county programs and services;
4. Goals of cultural competence plans;
5. Human resources report;
6. County organizational assessment;
7. Training plans; and
8. Other county activities, as necessary.

C. The last Annual Report of the DEI – CC Committee is in Appendix 26. The following section goes over the last Cultural Competence Plan goal and objectives:

1. The goals and objectives of the Committee from the previous Pan include the following:
    - The SLOBHD will complete a Diversity, Equity & Inclusion Organization Plan 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 (purpose, vision, and core values) that will become part of internal operations. This goal is under development and waiting for approval from the leadership team.
        - Work in collaboration with Human Resources to address hiring and retention practices for 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 inclusive practices. This is an ongoing process that continues to be implemented with changes in the way in which job postings are delivered and presented to the community.
        - 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+ individuals, veterans, consumers, and family members. This is an ongoing goal that continues to be met as part of interventions that support the staff's increasing knowledge and skills.
        - 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. A comprehensive survey has been completed and the Department has begun assessing and analyzing the information to best shape and design new interventions and ideas to address the needs of the various served communities.

- Revise the BH DEI Committee Bylaws and review membership to ensure that we meet the requirements and extend impact by incorporating key collaborative partners 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 consumer/family member. This goal has not been met this year and we are looking to update our membership of the committee in the next fiscal year.

- 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. This is an ongoing goal. The Committee and the Chairperson are the leads on this strategy.

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 Cultural Competence Plan included updated goals in this plan to reflect the current activities held to accomplish the committee's goals.

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 and will continue to focus on this goal.

5. The Committee reviews and provides recommendations to the Department's Leadership team to best integrate a diverse structure in operations and service delivery through assessments, surveys, and hiring interventions.

6. The Committee Chairperson, in collaboration with the WET Coordinator and the Clinical Supervisor Training Coordinator is in the first steps of developing a comprehensive approach to meet the training needs of the staff, including DEI-lens trainings, clinical trainings, and continuing education trainings. Development and implementation will take place in FY 2024-2025.

7. The last Annual Report (Appendix 26) included features information on activities and efforts made by the CCC during fiscal year 17-18.

Criterion 5

County Behavioral 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.

A. Through the MHSA Workforce, Education, and Training (WET) plan, the Department has recently developed meaningful training sessions and opportunities for the staff and partner providers. Most recently, under direction of the DEI Program Manager, a new DEI – Cultural Competency Training has been implemented, which also offers continuing education units (CEUs) for clinical staff. For the current fiscal year and next fiscal year, the DEI Program Manager, in collaboration with the WET Coordinator and the Clinical Coordinator, are in the process of developing a series of new training designated to meet the needs of the staff and supported by the Committee.

1. Using Relias Learning, it is projected that the number of County staff trained is roughly 400. Direct service staff is about 150. The number of individuals increases once service providers staff is also included.

2. SLOBHD has taken steps to provide required training to reach 100% of the staff over the current training period:

- SLOBHD will partner with the local college and the university to increase diversity and training opportunities, as well as increasing the capacity to train a larger number of staff over time.
- Provide training through an electronic learning initiative. Through the use of Relias Learning, the Department provides core competency training modules on an annual basis, which is a required for all staff, including direct, management, and clerical staff.

- Throughout the year, additional training needs are identified through collaboration with the WET Coordinator and the Clinical Supervisor Coordinator. Additional information will be collected through surveys, focus, groups, and conversational/listening sessions with staff.

3. For the last year, the previous DEI Manager has designed and slowly implemented a series of interventions through the development of the DEI Proposal. The Proposal has been designed to embed cultural competence into all trainings in order to address the needs of the staff and the entire local behavioral health community. Additionally, through the membership with the Southern Counties Regional Partnership (SCRP), the department has partnered up with Dr. Johnatan Martinez, PhD to ensure key trainings and all other trainings have a diversity, equity, and inclusion lens. While impacted by the COVID-19 Pandemic, the Department continued to provide trainings virtually to maintain the learning momentum. Another intervention is a series of assessments that can help best understand the level of cultural knowledge and skill of the staff, then helping address the needs of the staff.

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

The following table provides in detail cultural competency trainings attended by staff in FY 2022-2023. The Department currently tracks registration for every single attendee based on professional role and organization they are coming from. Constant communication with partner providers is key to increasing the number of clients and their loved ones that attend trainings. The following table provides a description of all workshops, forums, trainings, events as required in section A & B of the current criterion.

Behavioral Health Training Calendar			
2022-2023 Fiscal Year			
Training Title:	Suicide Prevention Summit		
Presenter(s)	Sally Spencer-Thomas, Psy.D., MNM, Meghan Boaz-Alvarez, Sara Mann, MPH, Renay Bradley, PhD., Darcy Massey, LCSW, Brenda DeMonge, LMFT, Kevin Berthia, Kevin Briggs		
Description:	This full day of workshops will include voices of lived experience sharing what they found helpful in times of crisis. In addition, helpers and mental health professionals will cover strategies for helping those at risk of suicide. Sharing her own story of suicide loss and experience as a mental health professional, Dr. Spencer Thomas will discuss barriers to help seeking behaviors in men, how providers can engage men in mental health treatment, and wellness strategies for maintaining protective factors. First responders and veterans service experts will identify their strategies for supporting one another, maintaining wellness and connection, and helpful resources that can be accessed while one is waiting to be connected to professional help. The California Department of Public Health will provide an update on strategies and progress in statewide suicide prevention efforts. Individuals with lived experience as receivers of mental health services will identify effective actions on the part of providers seeking to support individuals in crisis. Retired Highway Patrol Officer Kevin Briggs and Suicide Attempt Survivor Kevin Berthia will share their helper and person at risk experience and highlight the effectiveness of listening in moments of suicidal crisis.		
# Of Attendees	4142	Date of Training:	9/30/22
Hours/Credits:	6	# Of CEU Certificates	54
Training Title:	Behavioral Health Interpreter Training		
Presenter(s)	MAXINE HENRY, MSW, MBA		
Description:	The need to communicate effectively and convey information in a manner that is easily understood by Limited English Proficient (LEP) clients in any clinical situation in which behavioral health services are provided is critical. The number of LEP clients far exceeds the available number of bilingual, bi-cultural		

	behavioral health professionals. Properly trained Interpreters can fill a critical role in improving the quality of care to clients whose first language is not English, ensuring accurate and complete communication to minimize risk and maximize appropriate care.		
# Of Attendees	46	Date of Training:	5/17/22-5/20/22 and 6/21/22-6/24/22
Hours/Credits:	14	# Of CEU Certificates	27
Training Title:	Trauma Informed De-escalation, Grounding, and Safety Planning		
Presenter(s)	Gabriella Grant		
Description:	Designed to teach clinical professionals active skills to work effectively with trauma-exposed clients, this webinar training asks attendees to examine de-escalation, safety planning and grounding as key safety skills for any clinical professional working in publicly funded systems. Attendees will be able to use scaling to measure danger levels and use sensory awareness/grounding practices to detach from overwhelming emotions, as well as learning about safety planning and using the Anytime Safe Action Plan worksheet.		
# Of Attendees	261	Date of Training:	11/08/2022
Hours/Credits:	1.5	# Of CEU Certificates	72
Training Title:	Seeking Safety – Introductory Session		
Presenter(s)	Gabriella Grant		
Description:	Designed to teach clinical professionals active skills to work effectively with trauma-exposed clients, this webinar training asks attendees to examine de-escalation, safety planning and grounding as key safety skills for any clinical professional working in publicly funded systems. Attendees will be able to use scaling to measure danger levels and use sensory awareness/grounding practices to detach from overwhelming emotions, as well as learning about safety planning and using the Anytime Safe Action Plan worksheet.		
# Of Attendees	261	Date of Training:	11/08/2022
Hours/Credits:	1.5	# Of CEU Certificates	72
Training Title:	Suicide Prevention & Intervention		
Presenter(s)	Deborah Silveria PhD		
Description:	In this workshop participants will learn techniques and obtain tools for assessing suicidal risk among consumers, with cultural awareness, humility, and sensitivity. They will learn crisis intervention techniques that allow them to practice to the standard of care. Evidence based therapies for working with suicidal clients will be discussed and self-care for clinicians to protect them from burnout with this population will also be discussed.		
# Of Attendees	25	Date of Training:	10/06/23
Hours/Credits:	6	# Of CEU Certificates	n/a

Training Title:	Supporting and Affirming LGBTQIA+ Clients		
Presenter(s)	Serrin Ruggles		
Description:	The Cal Poly Wellness Center and San Luis Obispo Behavioral Health have identified ensuring LGBTQIA+ affirming clinical practice as a priority for staff training. Specifically, office staff, clinicians, and other healthcare providers need practical information and strategies to help them engage with and support LGBTQIA+ clients.		
# Of Attendees	35 (estimated)	Date of Training:	4/05/2023
Hours/Credits:	2	# Of CEU Certificates	25 (estimated)
Training Title:	Beyond Pronouns: Advancing Training for Supporting Gender Diverse Clients		
Presenter(s)	Stacy Hutton, PhD and Jay N. Bettergarcia, PhD		
Description:	Participants will learn essential clinical considerations for working with gender diverse clients. The presenters will discuss the nuances of gender identity exploration and how to use active listening and reflections to help clients explore their gender. Participants will also learn about the differences in social and medical transition options and how to support clients by writing letters for gender-affirming medical care. Clinical strategies for working with children, teens, and families will be covered. In addition, there will be an emphasis on considering intersectional identities for gender diverse individuals who experience other areas of marginalization.		
# Of Attendees	95	Date of Training:	05/09/2023 & 05/16/2023
Hours/Credits:	3	# Of CEU Certificates	41
Training Title:	Creativity and Healing		
Presenter(s)	Marshall Lyles, LPC-S, LLMFT-S, RPT-S		
Description:	Humans deserve to feel the benefit from the depth of their inherent creative potential, but this often goes largely unexplored. In this workshop, participants will hear an overview of expressive therapy approaches and the relational neuroscience involved in creative exploration. Through hands on healing, this training hopes to inspire ways to layer intermodal expressive work and conceptualize dynamic methods of facilitating the process of created works.		
# Of Attendees	39	Date of Training:	10/04/2023
Hours/Credits:	6	# Of CEU Certificates	22
Training Title:	The Neurobiology of Trauma: An Update on the Science of Trauma		
Presenter(s)	Gabby Grant		
Description:	Neurobiology shows that traumatic events affect the brain at the time of the event and over the lifespan. Once the neurobiology of trauma is understood, through a user-friendly approach, staff and agencies can better understand client reactions, better understand how to minimize re-traumatization and triggering interaction, and know how to use neurobiology to create safety and connection.		
# Of Attendees	218	Date of Training:	1/24/2023 & 1/25/2023
Hours/Credits:	3	# Of CEU Certificates	50
Training Title:	Trauma and Homelessness: Trends and Realities		
Presenter(s)	Gabby Grant		

Description:	Homelessness is both caused by trauma and is a symptom of trauma. By focusing shelter or program rules on safety, empowerment, and addressing unsafe behavior in a compassionate manner, agencies working on addressing homelessness in their communities can improve client outcomes, create safer shelters, and reduce staff burnout.		
# Of Attendees	91	Date of Training:	3/7/23
Hours/Credits:	1.5	# Of CEU Certificates	50

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

A. 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.

DEI-Cultural Competence trainings are a core element of staff development, and the Department is committed to effective learning opportunities for all staff and community partners.

1. All trainings in recent years were identified and developed through key community planning processes. Our 2017 Internal Cultural Competence Survey identified the current tentative training priority (Appendix 27) 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. The Department 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. SLOBHD has consistently measured the level of knowledge and skill earned through trainings. The tests help 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.

3. Though impacted by the COVID-19 Pandemic, clinical trainings are still a priority to address the needs of the staff and to help with retention. With the Clinical Training Coordinator, new strategies to target open conversations on issues of diversity, equity, and inclusion will be designed through direct feedback from online surveys sent to staff. Similarly, online surveys on trainings are made available to participants one day after completing the training to receive Continuing Education Units (CEU). The training evaluation form is designed for post-training measurement asking demographic information regarding 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.

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 28 for the entire Behavioral Health Department, will identify the methodology/protocol that supports competency-based trainings, mandatory trainings, and orientation trainings, and will follow the guidelines put forth. This policy will assist employees, contracted employees, and volunteers in meeting training and licensing requirements and ensuring our workforce's ability to provide quality 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 behavioral 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 behavioral 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 behavioral health client, including the experience of having a mental illness and of the behavioral health system.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency

A. The following trainings or workshops provide evidence of a variety of cultural competence trainings:

LGBTQIA+ Awareness, Sensitivity, and Competency: This highly interactive training leads participants through the foundational steps of LGBTQIA+ affirmative and culturally competent training, while creating a learning environment that is safe, 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 and expression, addresses myths and negative stereotypes about

LGBTQIA+ individuals, and helps develop core competencies towards reducing LGBTQIA+ behavioral 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 LGBTQIA+ youth by informing participants about terminology used in the LGBTQIA+ community, the process of "coming out" as an LGBTQIA+ person and a discussion of the challenges faced LGBTQIA+ 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 LGBTQIA+ youth.

Intro to Substance Use Disorders for LGBTQIA+: This half-day training is intended for any provider in contact with LGBTQIA+ 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, and school teachers and counselors. The training includes an introduction to key terms and concepts (such as gender identity, expression, 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 are 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 are presented with information about the subtleties in language and perspective that make interactions with trans people 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 behavioral health settings has sparked dialogue 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 is divided into modules that help participants: 1) understand key terms such as intersectionality, structural inequality, and cultural proficiency; 2) understand the connection between these terms and a more inclusive behavioral health practice; 3) reframe equity, diversity, and inclusion within the context of behavioral health; and 4) 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.

Criterion 6

County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Diverse 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.

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

A. The Mental Health Services (MHSA) workforce assessment submitted to the Department of Health Care Services (DHCS) for the Workforce, Education, & Training (WET) component can be found in Appendix 29.

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 Department 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 depart from the entire health care system. The Department and its partners work in collaboration to close the gap and provide culturally and linguistically appropriate programs to clients and their loved ones.

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 San Luis Obispo Behavioral Health Department never received cultural consultant technical assistance as part of any review of the WET Plan submission. However, the County has taken the initiative to build cultural competence capacity activities, funded through statewide WET initiatives. This has included attending conferences focused on addressing the behavioral health needs of diverse populations sponsored by the Southern Counties Regional Partnership (SCRP). The partnership has also sponsored training opportunities for County staff (and its contracted partners) on diversity, equity, and inclusion service provision practices, as well as workforce development tools for high school students, and clinical supervision trainings.

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

D. The Department has not developed or implemented another WET Plan since the last plan. The DEI Program Manager has recommended for the WET Coordinator engage in the implementation of the WET Assessment for future reporting. Based on the past ten years of programming, the targets reached include:

- Bilingual clinical interns have been hired and placed in several clinics regionally.
- Over 75 scholarships were awarded to individuals working in the mental health field or wanting to seek employment in the field.
- The Transitions-Mental Health Association (TMHA) Peer Advisory and Advocacy Team (PAAT) meets weekly and provides stigma reduction education and peer counseling throughout the community.
- Crisis intervention training (CIT) has been provided to hundreds of law enforcement personnel.
- The DEI Committee has provided and sponsored several trainings to support competence in the behavioral health field. Additional trainings have been scheduled to support and meet licensure requirements for staff.

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, therefore the Department created a designated computer training room.
The development and implementation of the Electronic Learning initiative has created many opportunities for staff to build capacity and for the Department to enhance its services. The SLOBHD creates 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 community and interested parties with better monitoring of funds. For instance, training and hiring practices are intended to ensure diversity is embedded in the organization. Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. This includes the ongoing identification of needs, including affirmative service provision for the LGBTQIA+ and Veteran community. The DEI Committee has been successful in guiding training decisions and developing core competencies.

F. Identify County technical assistance needs.

F. The SLOBHD has identified the need for further technical assistance in the area of data collection, evaluation, and statistical reporting to further improve the Department's ability to analyze the effectiveness of its DEI practices. The Department 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 post-tests to evaluate levels of knowledge and applicable skills.

Criterion 7

County Behavioral 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.

The SLOBHD has made significant progress in improving services to Spanish-speaking clients over the past years. Although the Covid-19 pandemic had truly impacted the bilingual and bicultural workforce, particularly in retention and recruitment, the Department had continued outreach to increase the pool of bilingual candidates and support a diverse workforce. By increasing the bilingual and bicultural workforce, SLOBHD hopes to reduce barriers and increase access.

A. The SLOBHD has committed resources and implemented interventions in its MHSA Plans to increase bilingual staff capacity. Based on the needs of the community, the most underserved population in the county is the Spanish-speaking community due to limited language proficiency. For the last years, MHSA Plans have not only increased in funding and staffing, but also in Spanish-speaking providers such as medication managers, case managers, behavioral health specialists, clinicians, and administrative and clerical staff, as well as leadership.

Another strategy is the translation of service-oriented positions/job postings to best target and reach out to a larger pool of diverse candidates. Under collaboration with the BHD Public Information Specialist, the DEI Program Manager, and the Human Resources team, strategies to expand recruitment include expanding the range throughout the county and in neighboring localities to reach a more diverse pool. Likewise, open positions have been advertised through presentations to local cultural organizations, partner providers, and in social media in Spanish and English.

1. The County's WET Plan addressed areas to increase bilingual capacity by building the Bilingual Internship Program on three clinics in the three regional areas to offer services. This strategy provides funding to support three part-time bilingual students to gain experience and knowledge working in the behavioral health system. 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 diversity, equity, and inclusion are key components of each MHSA plan and its projects and local design, appropriate cultural, affirmative, linguistic interventions have been embedded in the entirety of the behavioral health system.

- The MHSA Community Services and Support (CSS) Component Latino Outreach Program has hired case managers to provide more culturally appropriate care and support to the Spanish-speaking community.
- 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 that support the inclusion of culturally and linguistically 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 interpretation services increased to $86,324. This is funded by MHSA and Mental Health funding.

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 person having Limited English Proficiency (LEP) by using interpretation services, translated forms, and language lines, which are culturally and linguistically appropriate and accessible to all individuals seeking those services.

A. The Culturally Competent Multilingual Services Policy (Appendix 30) states that "mental health services is committed to providing multilingual 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 TDD, 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 SmartCare 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:
   a) Caller either calls the Drug and Alcohol line or the Mental Health Line.
   b) Staff identifies the required language. If Spanish is the required language, staff is prompted to push a key, otherwise they wait for a prompt to select another language
   c) Staff member is directly connected to the interpreter.

This new process has been recently implemented in FY2022-2023 which will help reduce the wait time for clients to be connected to services and for staff to complete the process ensuring services are provided on a timely manner and culturally responsive to the needs of the clients. Additionally, the DEI Program Manager has been working with the Language

Line to identify promotional material that has been distributed to staff along with an online training to provide support to staff as the new process is implemented.
As described in Appendix 30, 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 to receptionist to Program Supervisor
b. Program Supervisor will facilitate language access through Central Access Language Line Services.

4. All new employees are presented with Language Line promotional materials that describe how to engage with the services. Clients are informed of the right to free interpretation services via the Language Line and an option available on the Service Request (Appendix 31).

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 31). This information is also posted in the Lobby of each SLOBHD center (Appendix 32).

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 the draft of SLOBHD's Bilingual Certification Policy (Appendix 33) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Health Agency Services." This is exhibited in the following procedures and practices.

1. Staff at SLOBHD routinely provide accommodations to people 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/Hispanic (and other language-capable) health and social service professionals is present in the county and in adjacent areas and is also challenging due to with competition from other providers. 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 original 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. The Behavioral Health Department 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).

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

A. Signage on the client bulletin board, such as the Language Access Information Posting (Appendix 32) demonstrates the Department's availability of interpretation services for clients accessing services. Signs in Spanish and English indicating availability of free interpretation services and assistance completing paperwork is made available and posted in the lobby/reception are of each clinic.

B. The Service Request Form (Appendix 31) which is completed at the first access contact point, demonstrate that SLOBHD's interpretation services are provided to clients and the response to the offer is recorded. Subsequent 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 35), as well as the County client services brochure (Appendix 34) in English and Spanish demonstrate that SLOBHD aims to meet the linguistic and cultural needs of the various populations we serve.

D. According to the new draft of the Bilingual Certification Policy (Appendix 33) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Health Agency Services." The following procedures are in place to monitor and certify bilingual staffing:

Procedure

A. *The Diversity, Equity, and Inclusion (DEI) Manager shall be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC), who proctors the certification examination.*
B. *The BCC is comprised of the DEI Manager and two or three bilingual and/or bicultural staff members whom at least two of them is a native speaker of the threshold languages in the county.*
C. *The BCC is responsible for developing a minimum of four 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:*
Fluency: the ability to communicate with ease, verbally and non-verbally.

Vocabulary: the ability to understand and communicate complex health agency information, concepts, and
Grammar: appropriate use of grammatical rules and tense.
Cultural knowledge and nuance related to the potential client seeking services or information.

D. *The certification process is conducted by two committee members, one of whom is the committee's identified native speaker.*
E. *The entire certification process could take approximately 30 – 60 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks they may wish to make for clarification.*
F. *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 70 or greater. The candidate is notified via e-mail by the DEI Manager, as well as their supervisor or hiring manager of the outcome of the evaluation, with copy given to Human Resources Department.*
G. *The BCC determines and assesses the language (grammar, reading, writing, and speaking) skills, knowledge, and application of the language for interpretation and translation purposes. The employee's hiring, supervisor, or division manager shall recommend compensation at one of the two differential levels based on staff role and expectation for using the non-English language.*
    High differential shall be approved when bilingual skills are a primary element of the staff member's job and are used as a regular and routine part of the job. Operationally, the high differential means that the staff member is regularly called upon to use the non-English language at least 50% of a normal workweek.
    Low differential shall be approved when non-English language skills are used on a frequent but intermittent basis i.e., when the staff member is regularly called upon to use the non-English language less than 50% of a normal workweek.
H. *A candidate who has failed to be certified may appeal to the BCC via e-mail and request to be retested by other committee members who will repeat the process.*

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the behavioral 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 behavioral 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 36), "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 30) 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 interpretation 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 36), outlines how clients who do not meet the threshold language criteria are assisted to secure, or be linked to culturally and linguistically appropriate services:

Procedure

1. Upon initial contact with the Managed Care System, 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 behavioral 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 provides available to applicant" on the application form.
5. The list of providers is available at any time upon request 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, Multilingual Services Policy (Appendix 30), 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 Supervisors;
    b) Program Supervisor will facilitate language access through Central Access or the 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, Multilingual Services Policy (Appendix 30), 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:

- *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 service are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services are 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. Behavioral 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 Medi-Cal beneficiaries with a Beneficiary Handbook for Mental Health (Appendix 37) and Drug Medi-Cal Organized Delivery System (DMC-ODS) (Appendix 38). Upon intake, this and other information materials are provided. The Beneficiary Rights & Informing Policy specifies that these materials are available in Spanish and in different formats to meet the needs of all clients (Appendix 39).
2. An example of the general correspondence template is included in Appendix 40.

3. Beneficiary problem, resolution, grievance, and fair hearing materials are included in the Beneficiary Handbook and the Department's Grievance Process materials (Appendix 41).
4. The Latino Outreach Program has created a satisfaction survey used for both Medi-Cal beneficiaries and community clients. This questionnaire is included in Appendix 14.
5. The Department's Informed Consent for Medication form is included in Appendix 42.
6. The Department's Confidentiality and Release of Information form is included in Appendix 43.
7. Service orientation for clients includes information about specialty services including the Latino Outreach Program. The brochure provided for clients and the community is included in Appendix 44.
8. SLOBHD makes several publications and behavioral health education materials available to the public and the clients visiting each clinic. An example of material in included in the Lobby Materials Checklist (Appendix 45).
9. The Lobby Materials Checklist, Drug & Alcohol and Mental Health Diagrams, and the Distribution of Translated Materials (Appendix 46) provide further evidence of appropriately distributed and utilized translated materials.

B. The SLOBHD requires staff to accurately document clinical findings/reports communicated in the client's preferred language. Bilingual staff are required to document key findings and reports for clients using their preferred language within the Service Request form (Appendix 31). Elements of the plan which are written in both English and Spanish include goals, symptoms and objectives. This material is reviewed with the clients.

C. As referenced above, the Latino Outreach Program utilized a consumer satisfaction survey translated in the threshold language of Spanish (Appendix 14).

D. As per the County's Readability of Medi-Cal Informing Materials Policy (Appendix 47), the SLOBHD though 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. The process for readability in translated documents is reviewed by the Translation Committee on a continuous basis.

Criterion 8

County Behavioral 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.

The SLOBHD is committed to providing opportunities which enhance client-driven recovery and wellness programs (Appendix 48). The Department 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 illness, 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 DEI Committee.

TMHA operates 34 programs at over 35 locations that reach over 2,000 people and 1,500 families in 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. TMHA provides housing, employment, case management and life-skills support to mentally ill adults, at-risk youth, and adults experiencing homelessness.

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 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 lectures, interactive exercises, and structured group processes to explore recovery. Peer Support Groups are held at TMHA's Wellness Centers.

1. The Department has alternatives and options available within the above programs that accommodate individual preference and racial, ethnic, cultural, and linguistic 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 include:

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 to continue to develop monitoring strategies and programming options which increase the County's capacity to meet the needs of the diverse communities – 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 behavioral 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 behavioral 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 Department has now developed a list of culturally and linguistically appropriate services for diverse clients. This list can be found on the DEI – Cultural Competence Website (BIPOC Affirming Services - County of San Luis Obispo, LGBTQIA+ Affirming Resources - County of San Luis Obispo (ca.gov), Recursos y Servicios en Español - County of San Luis Obispo (ca.gov)). Additionally, 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 LGBTQIA+ Workgroup has released recommendations, which have slowly been under implementation (Appendix 49). 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 34). 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.

The Department offers 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 SLOBHD informs clients of the availability of the above-mentioned listings primarily via de Beneficiary Handbook, the Provider List Policy of Behavioral Health Clinics and Contract Providers, and the Member Services Brochure which 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. The Beneficiary Rights and Informing Policy (Appendix 39) 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 36) states that "Upon initial contact with 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 behavioral 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 behavioral 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 behavioral health services, etc.)

C. The Behavioral Health Department conducts several practices to inform all Medi-Cal beneficiaries of available 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.

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.

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.

Another program is the **Perinatal Outpatient Extended Group** (POEG) which offers individuals the opportunity to receive substance use treatment along with their children ages birth to five years. This provides parents and caregivers with more supervised time to spend with their child, while they are supported during the recovery to strengthen healthy relationships. Additionally, the **Children Affected by Drugs & Alcohol** (CADA) program provides support to the parents and children while they are in treatment and work to adopt healthy lifestyles in recover. An integrative approach to services includes the collaboration of social workers, treatment staff, and ancillary community support that help family reunification while offering a cadre of engaging topics such as nutrition, decision making and goal setting, facts about alcohol and drugs, healthy communication, feelings and anger management, and safe and healthy boundary setting.

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 Department 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. 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 clinic 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 offers 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 behavioral health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with behavioral health providers.

The Department has developed strong partnerships with community providers who deliver quality services to the public. The 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 diversity, equity, and inclusion throughout the behavioral 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.

The Department's Prevention & Early Intervention Division also provides specific DEI and cultural competence interventions in the services it provides. Each of the PEI programs contain the directive that "Each PEI provider will be required to meet the Department's requirements for cultural competence, accessibility, evaluation, and innovation." This was followed through by requiring each applicant for PEI contractors to provide the following information as part of their request for funding:

> ***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 50):

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.

IV. Quality Assurance

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

The County shall include the following in the CCPR:

A. List if applicable, any outcome measures, identification, and description of any culturally relevant consumer outcome measures used by the County.

A. The SLOBHD participates in Treatment Perception Surveys (TPS) for both Mental Health and Drug & Alcohol Services. The most recent surveys come from the September 2021 Survey Period. The surveys are compiled and prepared by the University of California, Los Angeles. The most recent survey results indicate that about 89% of mental health clients are satisfied with the services, about 82% are satisfied with the location where services are provided, and about 85% are satisfied with the time spent for clinical appointments. Likewise, Drug & Alcohol Services reported a 91.9% of agreement of appropriate cultural sensitivity when receiving services by staff, 91.5% reported treatment with respect, and 93.2% agreed that they understood communication between service staff and client.

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 Behavioral Health Services staff we asked to participate in the California Brief Multicultural Competence Scale (Appendix 51). This survey was sent to all staff via email, and returned surveys were kept confidential. This survey assesses 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 27).

C. Grievances and Complaints: Provide a description of how the county behavioral 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 41), 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, maintains 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.