



SANTA BARBARA COUNTY  
DEPARTMENT OF  
**Behavioral Wellness**  
A System of Care and Recovery

Office of Health Equity and Diversity

# Cultural Competence Plan

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## COVER SHEET

**An original, three copies, and a compact disc  
of this report (saved in PDF [preferred]  
or Microsoft Word 1997-2003 format)  
due July 28, 2016 to:**

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## **Executive Summary**

The Santa Barbara County Department of Behavioral Wellness is committed to involving consumers, family members and individuals from diverse ethnic and cultural groups in developing, implementing and monitoring programs and services. Stakeholders from diverse communities are involved in various forums, including the Cultural Competency and Diversity Action Team (CCDAT), the Consumer and Family Member Advisory Committee, the Latino Advisory Committee, the Behavioral Wellness Commission, Peer Recovery Learning Centers and human resource panels.

An analysis of the population of Santa Barbara County identified the threshold language as Spanish. The Department's commitment to providing culturally competent services is embedded through a wide range of policies and procedures, including telephone access, human resources training and recruitment, bilingual allowances, cultural competence training, interpretation, signage and other areas documented in the plan.

A key strategy to advance the Department's commitment to providing culturally competent services are a series of trainings that will focus on ethnically and culturally diverse communities, including, but not limited to: Oaxaqueno/Indigenous Mexicans, Native American, LGBTQ, African American, Filipino, Latino and the military. Another major strategy for hiring and maintaining a diverse workforce is the requirement that the Department and contractors provide sufficient Spanish-speaking bilingual/bicultural staff to meet the needs to the clients, which may vary by county region.

Through the Community Services and Supports (CSS), Workforce Education and Training (WET), and the Prevention and Early Intervention (PEI) components, the Mental Health Services Act (MHSA) supports a number of targeted initiatives for outreach, education, linkage and assistance to underserved ethnic and cultural populations. Under this revised Cultural Competence Plan, efforts will be maximized as a new Ethnic Services and Diversity Manager assumes authority for department-wide cultural competence programs and activities.

## CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

### **I. County Mental Health System commitment to cultural competence**

#### **The county shall include the following in the CCPR:**

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

The Department of Behavioral Wellness (hereafter referred to as “the Department”) is committed to involving consumers and family members (including individuals who reflect the diverse populations in Santa Barbara County) in developing, implementing, and monitoring of the Department’s programs and services. The Department ensures participation of consumers and family members who reflect cultural diversity on panels, committees, and in stakeholder groups, whose work impacts current and future programs and services.

Consumers and family members participate in hiring panels for the Department staff members who have a direct impact on clients. To increase the involvement and comfort level of consumers and family members participating in the hiring panels, the Human Resource Department provides an information session/briefing prior to the interviews.

Consumer and family members are represented on the Cultural Competency and Diversity Action Team (CCDAT), the Behavioral Wellness Commission, the Consumer and Family Member Advisory Committee (CFMAC). For CFMAC, eleven positions are designated for consumers and eleven for family members, with a commitment to include Spanish-speaking communities. Transportation, stipends, and simultaneous interpretation are provided.

The Behavioral Wellness Commission currently has one member who is bilingual and bicultural. The Latino Advisory Committee (LAC) was established eleven years ago in an effort to ensure that all MHSA programs fulfilled the requirement of serving the unserved and underserved communities. The LAC focuses on services for Latinos and Spanish speakers. Members of the LAC include the Department’s clinicians and non-clinician staff, members of the legal system, social services, and other community-minded organizations. Approximately ten members regularly attend the monthly meetings held in a central location. The meetings are usually conducted in Spanish to increase the participation of monolingual Spanish speaking consumers and family members.

The LAC is one example of the Department’s dedication to service the county’s diverse community. Moreover, the Department strives to hire and maintain a workforce that is diverse and representative of the population. Currently, 39% of Department staff members are bilingual/bicultural. The compliance of this requirement is and will continue to be monitored on a quarterly basis with a department-wide survey conducted annually.

*Criterion 1: Commitment to Cultural Competence*

In addition to the current reporting requirements, the Department's guidelines will be enhanced to require that all County and CBO programs report:

- Number of bilingual/bicultural staff by position;
- Number and ethnicity of clients served;
- Clients' preferred language;
- Language in which the service was provided; and
- When interpretation services were provided, and who provided them, such as another clinician, a non-clinician staff person, or the language line, etc.

All requests for Spanish interpretation at public meetings such as the Behavioral Wellness Commission, the Consumer Family Advisory Committee Meeting, and all stakeholder meetings will be accommodated with advance notice.

The Department is committed to providing culturally competent services. Trainings will focus on the disabled, elderly, Oaxaqueno, Native American, LGBTQ, African American, and various other marginally-/under-/un-served communities. Through the Prevention and Early Intervention Community Health Education Project (CHEP), new initiatives will be made to teach community members from diverse cultures about accessing social services, learning to advocate for systemic change and advocacy for consumers, family members, and underserved groups.

With the Cultural and Linguistic Competency Policy (Exhibit 61), the Department formally established recognition of the importance of culturally-adapted care. It is the policy of the Department to provide culturally- and linguistically-adapted supports, services and treatments that respond effectively to the diverse needs of all individuals. The Department recognizes that providing high-quality, conscientious, and equitable care requires cultural and linguistic adaptations that reflect the individual's race, ethnic and national heritage; primary or preferred language; age; physical or mental status, including mobility and developmental disabilities; spirituality or religious affiliation; veteran status; and gender identity and sexual orientation.

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

- B. Copies of the following documents that ensures the commitment to cultural and linguistic competence services is reflected throughout the entire system.
  - 1. Mission Statement;
  - 2. Statement 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.

**1. Mission Statement:**

The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

**2. Statement of Philosophy:**

The Department is oriented toward supporting and promoting recovery for clients and problem solving for communities. It is the Department's role to help individuals identify what brings purpose, meaning, and quality into their lives, and to identify personal goals for living, learning, working, and social relationships.

The Department is invested in building upon the assets available within communities to support the well-being of individuals and families, including address environmental conditions that exacerbate individual, family, and neighborhood mental health, alcohol and other drug related problems. As clients of the Department recover, their identity as a service recipient becomes less central, and they become more engaged in community life in a positive role (i.e. volunteer, employee, neighbor, artist, author, student, parent, sibling, son/daughter, friend, advocate, member of a faith community, etc).

The Department's service system is strengthened by partnerships with community-based organizations, other county and state departments, network providers, and schools and colleges. Many of the clients are served by multiple agencies/departments and it is important that they be well-coordinated and accessible to clients and families. The Department believes that teams are the best way to provide high quality services to persons and communities impacted by mental illness and substance use. Through the structure of team-based care, all team members strive to help individuals recover, achieve wellness, and reach their personal goals.

**3. The Strategic Plan:**

The Mental Health Services Act (MHSA) requires meeting the needs of un-served and underserved cultural groups and providing culturally competent services. Behavioral Wellness needs to

*Criterion 1: Commitment to Cultural Competence*

increase attention to gender, faith, veterans, and physical disabilities. Therefore, it is the strategy of the Department to establish a Cultural Competence Plan focused on system-wide implementation of cultural competency initiatives and standards, and to provide updated trainings that create awareness on local issues and national diversity trends.

In order to achieve this, the following Key Components from the Department's 2016-2018 Strategic Plan will be adhered to:

- Departmental cultural competency trainings will be incorporated into Relias.
- Increased ability of clinical staff to work with consumers from diverse populations.
- The Organized Delivery System (ODS) plan's programs/services will be culturally competent.
- Quarterly bilingual/bicultural staffing level reports will be presented to the Leadership Team.
- Acknowledge and celebrate cultural holidays.
- Increased access to services for clients with limited English proficiency.
- Services to identified culturally discrete groups will represent prevalence of mental illness/substance use in that subset.
- Implementation of 2-tier bilingual allowance policy.
- Distribution of Cultural Competence Plan and Reducing Disparities progress reports.

#### 4. Policies and Procedures:

Through a number of policies and procedures, the Department targets and addresses various cultural and linguistic competency areas. While some are focused exclusively on the rights of clients to all diverse backgrounds, other policies may embed information related to accessibility of services, information and supports through cultural and language adaptations. Below is a listing of several policies with a summary of the policy function and/or specific language from the policy related to cultural competency. All policies are available as exhibits in the Cultural Competence Plan and on the Department’s website via this link:

<http://countyofsb.org/behavioral-wellness/policies>.

(Exhibit #). Policy Name	Cultural Competency Relevance
1. <b>Accessing a Welcoming and Integrated System of Care</b>	Defines the Department's position on access to mental health and alcohol/drug services and its commitment to cultural competence.
2. <b>Cultural and Linguistic Competency</b>	Department’s commitment to cultural and linguistic competency system-wide, including the endorsement of the National CLAS standards, the participation of the Cultural Competency and Diversity Action Team (CCDAT), and the adoption of the Cultural Competence Plan.
3. <b>Beneficiary Rights</b>	Ensures that beneficiary rights are clearly communicated to the beneficiaries, which includes ensuring that oral interpretation services are accessible in ALL non-English languages.
4. <b>Adult Homeless Care, Coordination &amp; Outreach</b>	Defines the Department's policy to reach out persistently and respectfully, and to provide care coordination services to homeless individuals who suffer from mental illness.
5. <b>Beneficiary Problem Resolution Process</b>	To ensure that beneficiaries are treated and served in a respectful, culturally and linguistic manner by detailing how beneficiaries with problems or grievances are handled and resolved.
6. <b>Care of Transgender Patients</b>	Details the Department's policy with caring for transgender patients admitted to the Psychiatric Health Facility (PHF), including guidelines on pronoun usage, room assignments, access to restrooms, and the disclosure of the patient’s transgender status.
7. <b>Client Problem Resolution Process</b>	Details how beneficiary grievances are handled and resolved, including doing so in a respectful, culturally and linguistic sensitive manner.

Criterion 1: Commitment to Cultural Competence

(Exhibit #). Policy Name	Cultural Competency Relevance
<p><b>8. Consumer Information Checklist</b></p>	<p>It is the policy of the Department that consumers will be provided with culturally and linguistically appropriate services by ensuring that they will be provided with adequate written and verbal information regarding the Department's services and their rights as a client.</p>
<p><b>9. Mental Health Plan - Beneficiary Information</b></p>	<p>States that the Department will ensure that beneficiaries are provided with information regarding the Department's interpretive services. Information on access to specialty mental health services will be readily available in English and Spanish and interpreted in other languages as needed.</p>
<p><b>10. Mental Health Plan - Provider List</b></p>	<p>States that a current list of all providers will be organized by region and will identify any cultural and/or linguistic specialties.</p>
<p><b>11. Mental Health Plan - Visually and Hearing Impaired and Beneficiaries with Limited Reading Ability</b></p>	<p>Ensures the Department will provide appropriate interpretive services and written materials to beneficiaries with special visual, hearing and linguistic needs.</p>
<p><b>12. Non-English Speaking Beneficiaries</b></p>	<p>Ensures access to care and culturally competent service delivery for non-English-speaking beneficiaries.</p>
<p><b>13. Patients' Rights Advocacy</b></p>	<p>Addresses Department adherence to all laws and regulations relating to the provision of patient rights advocacy, including ensuring that agreements are in a language the client understands.</p>
<p><b>14. Provider Relations</b></p>	<p>States that the Santa Barbara County MHP monitors provider satisfaction, documentation standards, as well as provider selection and retention. There are annual reviews with regards to the types of providers required to meet the cultural and linguistic needs of beneficiaries.</p>
<p><b>15. Service Triage: Routine Conditions</b></p>	<p>States that beneficiaries may contact the Access Team through a toll-free, 24/7 telephone line, with multi-linguistic capabilities. Also states that the beneficiary is able to choose from culture specific and other preference providers.</p>
<p><b>16. Mandatory Trainings</b></p>	<p>Lists Cultural Competence and Client/Family Culture as required trainings completed annually by all staff.</p>

## **5. Human Resource Training and Recruitment Policies:**

Policy at the County and Department level address equality and diversity in recruitment, hiring and training practices.

### **County of Santa Barbara – Americans with Disabilities Act Policy (Exhibit 17):**

If you have a protected disability as defined under the Americans with Disabilities Act (ADA), our organization is required to provide you with reasonable accommodations for these purposes:

1. To ensure you can apply for employment; and
2. To enable a qualified individual with a disability to perform essential job functions.

In the employment process, reasonable accommodation is any modification or adjustment to the employment process that makes it possible for you to apply for employment. In job performance, reasonable accommodation is any modification or adjustment to the job, the work environment, or the way things are usually done that makes it possible for a qualified person with a disability to perform a job.

If you believe that such an accommodation is needed, please tell your interviewer. You may indicate the type of accommodation you feel would be effective. For certain types of accommodations to permit you to apply for employment (such as providing a reader or interpreter), we will need reasonable advance notice.

By law, we are not permitted to ask you if you need an accommodation or have a protected disability. Also, we cannot discuss reasonable accommodations to perform essential job functions until after you have received a conditional offer of employment.

Accommodations must be made only when they do not pose an undue hardship for the employer. It is up to the employer to decide which accommodation will be made. We will consider your suggestions concerning the accommodations which will be most effective. However, we reserve the right (as the ADA permits us to do) to choose the accommodation which we believe will best serve both your needs and the organization's needs.

### **County of Santa Barbara – Non-Discrimination Policy (Exhibit 18):**

The County Code, Chapter 27, Article II, Section 27-30, states that no employee of the County “...shall be discriminated against in violation of any applicable state or Federal law, rule or regulation which may now or hereafter specifically prohibit discrimination on such grounds as race, creed, color, political affiliation, physical handicap when otherwise qualified, veterans status, age, marital status, cancer-related medical condition or sexual orientation.”

**Department of Behavioral Wellness – Code of Conduct: Diversity and Equal Opportunity (Exhibit 19):**

The Department actively promotes diversity in its workforce at all levels of the organization. Our Department is committed to providing an inclusive work environment where everyone is treated with fairness, dignity, and respect. We will make ourselves accountable to one another for the manner in which we treat one another and for the manner in which people around us are treated. Santa Barbara County Department of Behavioral Wellness is an equal opportunity workforce, and no one shall discriminate against any individual with regard to age, ancestry, race, color, religion, sex, national origin, marital status, physical or mental disability, economic status, appearance, medical condition, or sexual orientation with respect to any offer, or term or condition, of employment. The Department makes reasonable accommodations to the individual needs of qualified individuals with disabilities.

**Department of Behavioral Wellness – Mandatory Training Policy:**

It is the policy of the Santa Barbara County Mental Health Plan (SBC MHP) to comply with all relevant state and federal laws, regulations, contracts, and guidelines with regard to trainings. It is also the policy of the SBC MHP to provide further trainings to promote compliance with laws, regulations, contracts, guidelines, and department Policies and Procedures.

Code of Conduct is a training which describes and discusses the MHP Compliance Plan and MHP Code of Conduct, for the purpose of informing staff of relevant legal and ethical issues and encouraging compliance with legal and ethical standards.

It is the policy of the SBC MHP to require two (2) annual Cultural Competence trainings to be completed each year by staff members. One (1) of the trainings will be online through the Relias web portal; whereas one (1) of the trainings must be an in-person spotlight training focusing on one (1) or more specific cultures. The spotlight training requirement can be satisfied if the employee attends an equivalent training put on by a Community Based Organization (CBO).

**6. Contract Requirements (Exhibit 20):**

Providers entering into contract with the Department to provide Specialty Mental Health Services must meet certain cultural and linguistic service requirements and submit reports periodically. Below are excerpts from the Mental Health Statement of Work template that highlight areas specific to culture and language:

- C. **Staffing.** Contractor shall submit quarterly staffing reports to County. These reports shall be on a form acceptable to, or provided by, County and shall report actual staff hours worked by position and shall include the employees' names, licensure status, bilingual Spanish capabilities, budgeted monthly salary, actual salary, hire date, and, if applicable, termination date. The reports shall be received by County no later than 25 calendar days following the end of the quarter being reported.

**D. Programmatic.**

5. Contractors receiving MHSA-funding shall track and report the following to County in Contractor's Quarterly Programmatic Report per MHSA requirements, in not entered into the County's Management Information System (MIS).
  - a. Client age;
  - b. Client zip code;
  - c. Number of types of services, groups, or other services provided;
  - d. Number of clients served in which language (English/Spanish/Other);
  - e. Number of groups offered in which language (English/Spanish/Other).

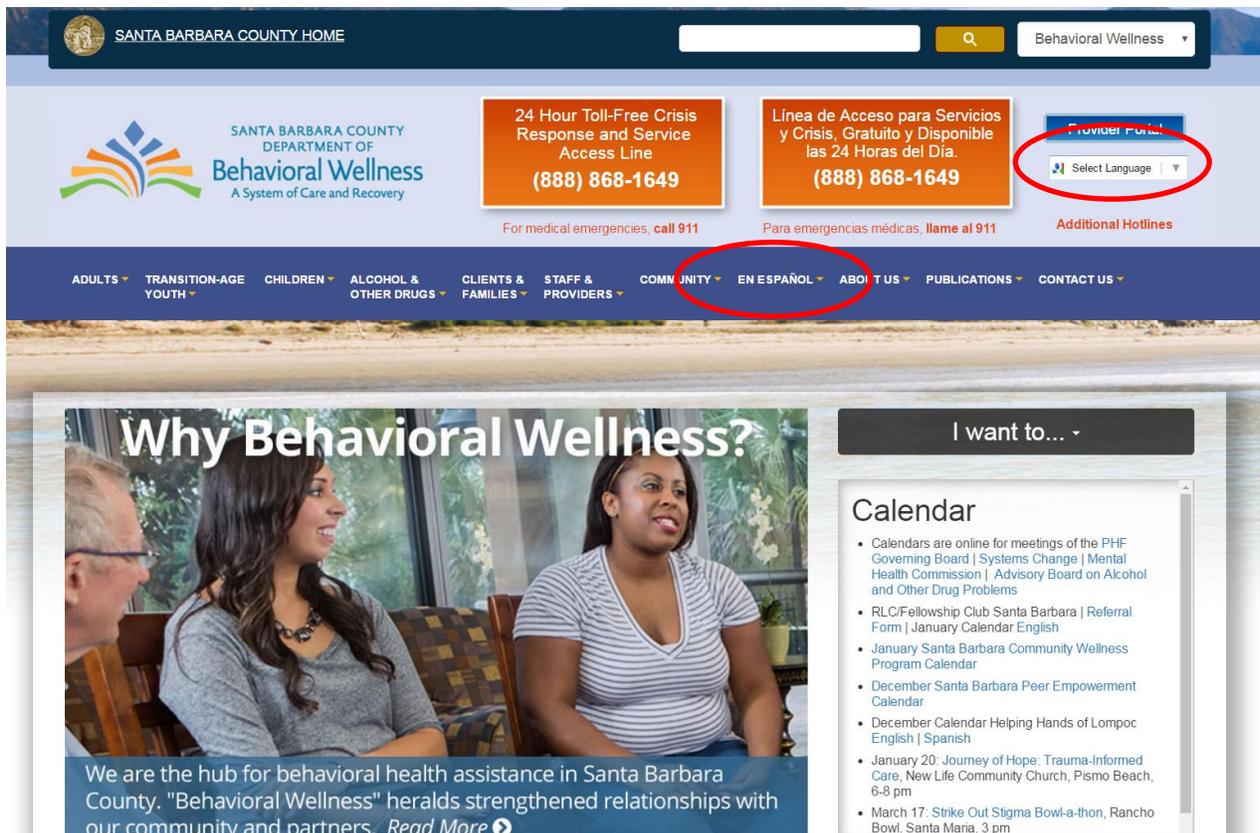
**10. Cultural Competence**

- A. Contractor shall report on its capacity to provide culturally competent services to culturally diverse clients and their families upon request from County, including:
  1. The number of culturally diverse clients receiving Program services;
  2. Efforts aimed at providing culturally competent services such as training provided to staff, changes or adaptations to service protocol, community education/outreach, etc.
- B. At all times, the Contractor's Program(s) shall be staffed with personnel who can communicate in the client preferred language, or Contractor shall provide interpretation services;
- C. Contractor shall maintain Spanish bilingual capacity with the goal of filling 40% of direct service positions with bilingual staff in County's second threshold language, Spanish.
- D. Contractor shall provide staff with regular training on cultural competence, sensitivity and the cultures within the community.
- E. Contractor shall provide services that consider the culture of mental illness, as well as the ethnic and cultural diversity of clients and families served; materials provided to the public must also be printed in Spanish (second threshold language).
- F. Services and programs offered in English must also be made available in Spanish, if clients identify Spanish as their preferred language, as specified in section B above.
- G. As applicable, a measurable and documented effort must be made to conduct outreach to and to serve the underserved and the non-served communities of Santa Barbara County.

## 7. Relevant Culturally Competent and Threshold Translated Documents:

Spanish is Santa Barbara County's sole threshold language. The majority of Department brochures, flyers and forms have been translated into Spanish by a contracted nationally-certified translator. Translated materials include information related to available services, mental health/substance use conditions, beneficiary rights, satisfaction surveys, grievances, informed consent, release of information and privacy practices. The Medical Records Administrator, Privacy Officer and Ethnic Services and Diversity Manager work collaboratively to identify and process documents requiring translation. Documents are available by request at all Department and contracted providers sites and can also be located and downloaded from the Behavioral Wellness website.

The Department's website features a Spanish-language section visible on the homepage titled "En Español" ("In Spanish") that explains how to obtain services, what programs are available and frequently asked questions. Visitors can also select to have the entire website translated to Spanish with a Google translate widget located on the upper right-hand corner of the homepage. Below is a screenshot of the homepage with the Spanish-language section and Google translate widget circled in red:



The following is a selection of documents translated in Spanish. All are available for review in the Exhibits section:

Criterion 1: Commitment to Cultural Competence

General	Quality Care Management
21. Welcome to the Department of Behavioral Wellness	42. Medi-Cal Beneficiary Booklet
22. Behavioral Health Services in Santa Barbara County	43. Mental Health Plan Services
23. Access Flyer	44. Provider Directory
24. Access Cards	<b>Patients' Rights</b>
25. Guide to Medical Services	<b>Booklets on Patients' Rights:</b>
26. Satisfaction Surveys	45. Patients' Rights Flyer
27. Beneficiary Brochure	46. Patients' Rights Brochure
28. State Fair Hearings	47. Advance Directives for Medical and/or Psychiatric Healthcare
29. Guide for Latinos and Their Families	<b>Mental Health &amp; Alcohol and Drugs</b>
30. HIPAA: Notice of Privacy Practices	48. General Information About Mental Illness
31. Compliance Hotline Flyer	49. Schizophrenia Information
<b>Adult Services</b>	50. PTSD Information
32. Santa Barbara Adult Services Information	51. Mood Disorders in Adults: Depression & Bipolar Disorder
33. Carpinteria Outreach flyer	Suicide Awareness & Prevention Resources
34. Santa Maria Adult Services	Brochures & Fact Sheets on Alcohol-Related Topics
35. Mental Health Services for Adults	
36. Anxiety Disorders in Adults	<b>Forms</b>
<b>Children and Transition-Age Youth Services</b>	52. Mental Health Appeal Forms
37. Children's Services Countywide	53. Mental Health Change of Clinician Form
38. Children's Services Santa Maria	54. Consent Forms
39. Children's Services Lompoc	55. Mental Health Grievance Form
40. Children's Services Santa Barbara	56. ADP Grievance Form
41. Children and Youth Crisis Line (SAFTY) Brochure	57. ROI – Consent for Release of Patient Information or Records
	58. Request for a Second Opinion
<b>Online Only</b>	
About the Department of Behavioral Wellness	
AOD Services	
<b>Video:</b> Access to Behavioral Health Services in SBC (In Mixteco)	
<b>Video:</b> Mental Health: A guide for Latinos and Their Families	
10 Educational Brochures about ADHD, Bipolar Disorder, Teen Depression, Suicide, and other topics	
Booklets for Parents and Teens about Drug Abuse	

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

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

**The county shall include the following in the CCPR:**

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

**Outreach and Engagement**

Community outreach, engagement, and involvement efforts are discussed, planned and driven by the Culture Competency and Diversity Action Team (CCDAT). Meetings are held the 2nd Friday of each month from 9:30-11:00 AM and can be attended from Santa Barbara, Lompoc and Santa Maria with the assistance of video conferencing equipment. The CCDAT is chaired by Yaneris Muñiz, Ethnic Services and Diversity Manager, and supported by Evan Kudler, Department Business Specialist, Enrique Bautista, Patients' Rights Advocate/Outreach and Engagement Specialist, and Kathleen Chiarappa, Administrative Office Professional. The mission of the CCDAT is to advocate for culturally competent services, conduct outreach and engagement to underserved, unserved, and inappropriately served individuals, and reduce mental health disparities for racially, ethnically, and culturally diverse communities. Meetings are open to all department staff, community based organizations (CBOs), community partners, families and consumers.

For Fiscal Year (FY) 2016-2017, the CCDAT made a commitment to intensify outreach and engagement efforts through various methods, including public presentations, community events and informal "meet-and-greets" held in neighborhoods, worksites and churches. Collaboration with La Casa de La Raza, Pacific Pride Foundation, The United Domestic Workers (UDW), Sierra Madre Head Start Program, NAACP/New Hope Missionary Baptist Church, Santa Maria High School and Santa Maria Sanchez Elementary School helped generate a "Top 10" list of communities and groups in need for outreach. Coordination of outreach and engagement events is ongoing and evolves based on the participation of CCDAT members and requests received from the community.

### *Criterion 1: Commitment to Cultural Competence*

Below is an overview of outreach and engagement efforts precipitated by the CCDAT. However, the Department recognizes that engagement and outreach happens daily through the work of Department and contracted provider staff, and these efforts can be difficult to capture formally and quantify. Engaging hard-to-reach segments of the community is central to the Department's organizational culture and done so at every available opportunity.

#### Sierra Madre Head Start Program – October 27<sup>th</sup>, 2016

Behavioral Wellness invited to present information on anxiety, stress and depression to parents and Head Start staff. Information given to 15 people in English and Spanish by Kay Kizer-Waldo (Patients' Rights Advocate) and Enrique Bautista.

#### United Domestic Worker's (UDW) union event in Santa Maria – November 5<sup>th</sup>, 2016

Behavioral Wellness invited to provide a PowerPoint presentation on access to services. Information given to over 150 attendees in English and Spanish by Yaneris Muñiz and Enrique Bautista.

#### NAACP/New Hope Missionary Baptist Church – Outreach Ministry – November 12<sup>th</sup>, 2016

Homeless outreach event that offered showers, new clothing and a hot lunch in Santa Maria. Behavioral Wellness invited to provide information on services and assist in outreach efforts in English and Spanish.

### **Solicitation of Diverse Input to Local Mental Health Planning**

- Stakeholder announcements inviting community members to participate in MHSA stakeholder planning meetings are routinely translated into Spanish.
- Behavior Wellness staff members are routinely made available to provide simultaneous interpretation upon request at any Department-sponsored community meeting such as the Behavioral Wellness Commission, the Consumer and Family Member Advisory Committee meetings and other events. Behavioral Wellness staff is available to interpretation for events sponsored by CBOs that provide mental health services or for advocacy groups. Interpretation equipment is also available on loan to CBOs and other organizations.

### **Involvement Efforts with Identified Racial, Ethnic, Cultural, and Linguistic Communities**

- With a grant awarded by the Office of Statewide Health Planning and Development (OSHPD), the Department launched new support groups led by department-trained consumer and family mental health peers (promotoras). Support groups are led by five promotoras who reflect the cultural, ethnic and socioeconomic background of the community in which they work. Group topics include identifying and understanding mental health symptoms, developing coping skills, and linkage to community supports and services. Groups are held weekly in Carpinteria, Goleta and Guadalupe and three times a week in Santa Barbara. As of October 2016, over 250 group meetings have been held. The advocacy for a sustainable strategy to continue the operations of promotoras groups was developed through the guidance of the CCDAT.

*Criterion 1: Commitment to Cultural Competence*

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

Behavioral Wellness is committed to better engaging and serving unserved and underserved communities. Spanish is the only threshold language of Santa Barbara County. As a result, Behavioral Wellness has incorporated ethnic specific groups in order to better serve the diverse community.

- In Southern Santa Barbara County, El Nuevo Amanecer is a Latino/Spanish support group for consumers and family members struggling with mental illness and/or alcohol and drug use. The support group meets twice a month. The group also has active members who provide advocacy and outreach to and for the Spanish-speaking community.
- Santa Maria based Latino Spanish support group offers consumers and family members a forum to discuss their struggles while building community and decreasing the stigma associated with mental illness. The group meets on a monthly basis and is held in a community setting. The group has spearheaded advocacy activities to draw awareness to the needs of monolingual Spanish speaking community members.
- The Department is collaborating with Marian Medical Center in Santa Maria to assist in developing job descriptions and training curriculum for promotoras providing services for mothers with postpartum mental health disorders.
- The Latino Advisory Committee (LAC) includes staff from the department of Behavioral Wellness, CBOs and representatives which include members from the judicial and social service sectors. The Director of Behavioral Wellness is highly supportive of the Committee and supports the attendance of Behavioral Wellness managers and line staff participating in the monthly meetings.
- Members of the Consumer and Family Member Advisory Committee (CFMAC) are consumers and family members who provide input on the development, implementation, and review of Behavioral Wellness programs. Spanish interpretation services are always available for the monthly meetings. There are several Latinos that are currently voting members. All members are eligible to receive a stipend and mileage reimbursement for their attendance.
- Key MHSA planning documents and feedback forms are translated into Spanish and posted to the Behavioral Wellness web site. All documents in English or Spanish are made available via US Postal Service at no charge upon request.
- The involvement of the underserved communities was critical in the development of two key aspects of the PEI Plan. The Promotora program and the Community Health Clinics programs were created to respond to the feedback from the Spanish speaking/Latino, Oaxaqueno, LGBTQ, Native American, and Transition Age Youth (TAY) communities. The Promotora program is providing liaisons dedicated to helping underserved individuals gain access to services and knowledge about mental health conditions. The Community Health Clinics have Spanish-speaking representatives dedicated to helping Spanish-speaking

*Criterion 1: Commitment to Cultural Competence*

individuals access affordable mental health services in a neighborhood setting in both North and South Santa Barbara County.

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.

Information sharing and training are key instruments in developing and advancing the skills and abilities of community organizations and partners. All contracted providers and partners are invited to attend cultural competence trainings, space permitting. Future trainings currently in development will place a “spotlight” on local communities that are traditionally underserved and misunderstood, including the Mixtec/indigenous migrants living and working in Santa Maria, and transgender youth and adults. Trainings will be held throughout the county and/or in a central county location, such as Buellton, to encourage attendance, or online to promote access to as many learners as possible.

Presently and in the past year, several opportunities were made available online through the Relias Learning platform, as part of the Cultural Competency and Diversity Action Team, and in-person through select events and trainings:

Crisis Intervention Training (CIT) with discussion on Assisted Outpatient Treatment (AOT)

During the month of November 2016, Pam Fisher, Ph.D., Deputy Director of Clinical Operations, attended seven (7) Crisis Intervention Trainings (CIT) to inform law enforcement officers of the upcoming implementation of Assisted Outpatient Treatment (AOT). AOT is a new program beginning Jan 1, 2017 that allows for up to 180 days of involuntary outpatient mental health treatment for adults that suffer from a mental illness and are unlikely to survive safely in the community without supervision, based on a clinical determination. Referrals to the program require that the person(s) must have a history of non-compliance with treatment that has either resulted in multiple hospitalizations, prison or jail within the last 36 months or resulted on one or more acts, attempts or threats of serious violent behavior towards themselves or others in the past 48 months.

As law enforcement officers are eligible to refer to this program it was imperative that they were aware of the program and criteria for referral. Approximately 245 law enforcement officers were trained.

Contract Requirements for Latino Community

The Recovery Learning Center charters require contractors to include monolingual and bilingual consumers and family members as advisory boards members. CBOs are required to provide services and groups in Spanish. Unlike the traditional consumer and family member advocacy efforts, the Latino consumer and family members advocated for planning sessions and charters that reflected the familial cultural values which call for consumers and family members both be included in all aspects of the RLC planning and service provision components.

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

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As the Department has become acquainted and continues to develop rapport with the many providers and partners in Santa Barbara County, it's becoming apparent that many outreach and engagement efforts are occurring constantly, sometimes in silos. Pooling and leveraging the various efforts will have a greater overall impact in reaching and educating the community on mental health resources available. Collaborating together on strategies or simply joining an already-planned event can benefit the community as well as strengthen partnerships.

E. Identify county technical assistance needs.

The Department and community partners need assistance on researching and developing new, innovative ways to reach isolated communities. Small ethnic groups – including Mixtec, Pilipino and Chinese – are becoming more visible in the community and are in need of mental health services. Currently, there are little to no ethnicity-specific support systems available to these groups.

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

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

**The county shall include the following in the CCPR:**

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

In June 2016, Alice Gleghorn, Ph.D., Director of the Department of Behavioral Wellness, appointed Yaneris Muñiz as Ethnic Services and Diversity Manager for the Department. Ms. Muñiz concurrently serves as Policy and Project Development Coordinator through the Department's Office of Quality Care and Strategy Management (OQSM). Ms. Muñiz's responsibilities include research, development and implementation of the Department's Cultural Competence Plan as well as chairing and coordinating the Cultural Competency and Diversity Action Team (CCDAT). Ms. Muñiz is bilingual in Spanish and a second generation Cuban-American raised in southeast Los Angeles. Her exposure and experience to mental health disparities in the Latino community makes her uniquely qualified to lead in this role.

As Ethnic Services and Diversity Manager, Ms. Muñiz advocates and takes a leadership role in the development and implementation of policies, programs, practices and services that address the

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cultural and linguistic needs of all communities in Santa Barbara County and has direct access to Dr. Gleghorn to discuss issues impacting mental health issues related to racial, ethnic, cultural, and linguistic populations within the county.

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

The Ethnic Services and Diversity Manager will plan, implement, monitor, and evaluate the Department’s cultural and linguistic healthcare and outreach services and programs. Ms. Muniz’s duties will include:

- Develop and manage the implementation of the Cultural Competence Plan, including a training and education program.
- Facilitate and coordinate the development and on-going management of the cultural competence committee (the CCDAT).
- Develop programs to assess the cultural competency of staff.
- Develop a minimum core curriculum standard for annual diversity trainings.
- Identify the behavioral health care needs of ethnically and culturally diverse populations as they impact county systems of care, make recommendations to management, and coordinate and promote quality and equitable care.
- Maintain an ongoing relationship with community organizations, planning agencies, and the community at large.
- Visit and assess Behavioral Wellness contract agency facilities and make recommendations about facility changes and location in accordance with the needs of diverse population.
- Plan, organize, provide and document outreach and engagement activities and efforts.
- Develop, manage, and document process for monitoring access responsiveness and provide corrective feedback regarding all underserved cultural populations.
- Develop and implement translation and interpretation services.
- Gather data on penetration and retention rates, and based on identified disparities; make recommendations to Quality Improvement Committee (QIC), Department leadership, and the Department’s director.
- Update the Cultural Competence Plan annually.
- Other duties to ensure services in the mental health system of care are culturally, linguistically and ethnically competent.

**IV. Identify budget resources targeted for culturally competent activities**

**The county shall include the following in the CCPR:**

*Criterion 1: Commitment to Cultural Competence*

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

The amount of funding provided for cultural competency related services and activities is immeasurable. Culturally competent service funding is embedded in all programs, services, personnel salaries and benefits, training, etc. Certain activities, such as interpreter and translation services and contracts with service providers such La Casa de la Raza, Pacific Pride Foundation and the Independent Living Resource Center are examples of services and supports budgeted that address cultural competency needs.

A more exact calculation and allocation break-down will be presented in the annual update.

**Criterion 1 Exhibits:**

1. Accessing a Welcoming and Integrated System of Care Policy
2. Cultural and Linguistic Competency Policy
3. Beneficiary Rights Policy
4. Adult Homeless Care, Coordination & Outreach Policy
5. Beneficiary Problem Resolution Process Policy
6. Care of Transgender Patients Policy
7. Client Problem Resolution Process Policy
8. Consumer Information Checklist Policy
9. Mental Health Plan - Beneficiary Information Policy
10. Mental Health Plan - Provider List Policy
11. Mental Health Plan - Visually and Hearing Impaired and Beneficiaries with Limited Reading Ability Policy
12. Non-English Speaking Beneficiaries Policy
13. Patients' Rights Advocacy Policy
14. Provider Relations Policy
15. Service Triage: Routine Conditions Policy
16. Mandatory Trainings Policy
17. ADA Policies
18. Non-Discrimination Policy
19. Department Diversity and Equal Opportunity Policy
20. MH – Statement of Work
21. Welcome to the Department of Behavioral Wellness
22. Behavioral Health Services in Santa Barbara County
23. Access Flyer
24. Access Cards
25. Guide to Medical Services
26. Satisfaction Surveys
27. Beneficiary Brochure
28. State Fair Hearings
29. Guide for Latinos and Their Families
30. HIPAA: Notice of Privacy Practices

*Criterion 1: Commitment to Cultural Competence*

31. Compliance Hotline Flyer
32. Santa Barbara Adult Services Information
33. Carpinteria Outreach flyer
34. Santa Maria Adult Services
35. Mental Health Services for Adults
36. Anxiety Disorders in Adults
37. Children's Services Countywide
38. Children's Services Santa Maria
39. Children's Services Lompoc
40. Children's Services Santa Barbara
41. Children and Youth Crisis Line (SAFTY) Brochure
42. Medi-Cal Beneficiary Booklet
43. Mental Health Plan Services
44. Provider Directory
45. Patients' Rights Flyer
46. Patients' Rights Brochure
47. Advance Directives for Medical and/or Psychiatric Healthcare
48. General Information About Mental Illness
49. Schizophrenia Information
50. PTSD Information
51. Mood Disorders in Adults: Depression & Bipolar Disorder
52. Mental Health Appeal Forms
53. Mental Health Change of Clinician Form
54. Consent Forms
55. Mental Health Grievance Form
56. ADP Grievance Form
57. ROI – Consent for Release of Patient Information or Records
58. Request for a Second Opinion

## CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS

<b>I.</b>	<p><b>General Population</b></p> <p><b>The county shall include the following in the CCPR:</b></p> <p>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).</p>
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### Selected Data for Santa Barbara County, California (U.S. Census Bureau)

Please note: The U.S. Census does not recognize “Hispanic/Latino” as an ethnicity or race. “Hispanic/Latinos” may be of any race. Consequently, the sum of “Persons of Hispanic or Latino origin” and all the recognized racial designations does not add up precisely to 100%. This is due to a small number of “Hispanics/Latinos” who did not designate themselves as “White” may be double counted in a racial designation such as “Black persons”, “Persons Reporting Two or More Races,” etc.

	Santa Barbara County	California
<b>Footnotes</b>		
<b>(a) Includes person reporting only one race.</b>		
<b>(b) Hispanics may be of any race, so also are included in applicable race categories.</b>		
Population estimates, July 1, 2015	444,769	39,144,818
Population, percent change - April 1, 2010 (estimates base) to July 1, 2015	4.9%	5.1%
Population estimates base, April 1, 2010	423,939	37,254,503
Persons under 5 years, percent, July 1, 2015	6.5%	6.4%
Persons under 18 years, percent, July 1, 2015	22.4%	23.3%
Persons 65 years and over, percent, July 1, 2015	14.3%	13.3%
Female persons, percent, July 1, 2015	49.9%	50.3%
Black or African American alone, percent, July 1, 2015 <b>(a)</b>	2.4%	6.5%
American Indian and Alaska Native alone, percent, July 1, 2015 <b>(a)</b>	2.2%	1.7%
Asian alone, percent, July 1, 2015 <b>(a)</b>	5.8%	14.7%

Criterion 2: Updated Assessment of Service Needs

	Santa Barbara County	California
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2015 <b>(a)</b>	0.2%	0.5%
Two or More Races, percent, July 1, 2015	3.6%	3.8%
Hispanic or Latino, percent, July 1, 2015 <b>(b)</b>	44.8%	38.8%
White alone, not Hispanic or Latino, percent, July 1, 2015	45.4%	38.0%
Foreign born persons, percent, 2010-2014	23.2%	27.0%
Living in same house 1 year ago, percent of persons age 1 year+, 2010-2014	79.1%	84.6%
Language other than English spoken at home, percent of persons age 5 years+, 2010-2014	39.6%	43.8%
High school graduate or higher, percent of persons age 25 years+, 2010-2014	79.3%	81.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2010-2014	31.4%	31.0%
With a disability, under age 65 years, percent, 2010-2014	6.2%	6.7%
Persons without health insurance, under age 65 years, percent	15.5%	9.7%
Households, 2010-2014	142,028	12,617,280
Persons per household, 2010-2014	2.9%	3.0%
Median household income (in 2014 dollars), 2010-2014	63,409	61,489
Per capita income in past 12 months (in 2014 dollars), 2010-2014	30,526	29,906
Persons in poverty, percent	17.4%	15.3%

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

**The county shall include the following in the CCPR:**

I. 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).

The following data is from the Department’s ShareCare system. Due to an error in underreporting of Hispanic eligible counts, EQRO data does not accurately represent penetration and utilization

Criterion 2: Updated Assessment of Service Needs

data. In 2016, the Department’s Director, Dr. Gleghorn, and Behavioral Wellness noticed a significant shift in the way ethnicity data was reported for Santa Barbara County beginning between 2008 and 2009, resulting in lower numbers of Hispanics/Latinos reported as eligible for Medi-Cal. This data is obtained from the Department of Social Services (DSS) eligibility files. The Director of DSS was contacted and an extensive review was performed.

The primary problem stems from new racial and ethnic reporting requirements for the CalFresh Program. CalWIN was changed to support the data collection requirements. Because the new racial categories were limited to just five choices that did not include Hispanics/Latinos, and the CalWIN system utilizes the racial category to send an individual's ethnicity data to the MEDS automation system, individuals were identified only with these racial categories, resulting in the significant change in the Hispanic/Latino eligible count.

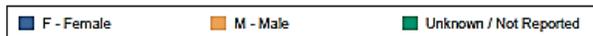
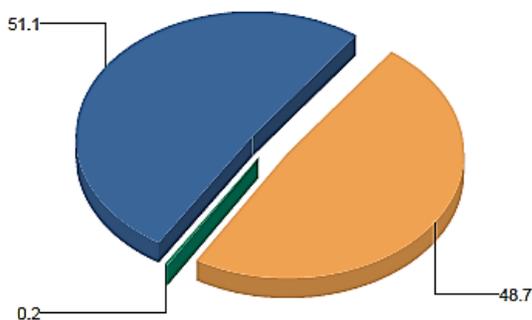
**Medi-Cal Utilization by Gender (left) and Age (right), Calendar Year 2015**

		Total
<b>Gender</b>	<b>Unique Clients</b>	<b>7,144</b>
	<b>% Unique Clients</b>	<b>100.00%</b>
F - Female	Unique Clients	3,653
	% Unique Clients	51.13 %
M - Male	Unique Clients	3,476
	% Unique Clients	48.66%
Unknown / Not Reported	Unique Clients	15
	% Unique Clients	0.21%

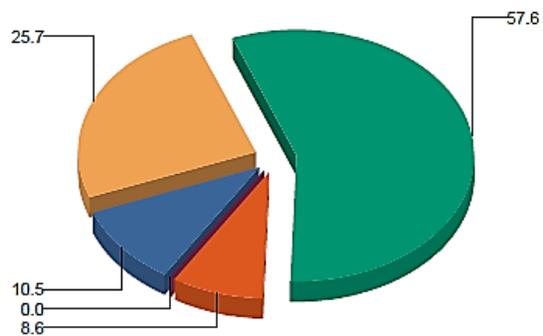
  

		Total
<b>Age at Service</b>	<b>Unique Clients</b>	<b>7,144</b>
	<b>% Unique Clients</b>	<b>100.00%</b>
Age 0 - 5	Unique Clients	748
	% Unique Clients	10.47%
Age 6 - 17	Unique Clients	1,839
	% Unique Clients	25.74%
Age 18 - 59	Unique Clients	4,117
	% Unique Clients	57.63%
Age 60 +	Unique Clients	612
	% Unique Clients	8.57%
Not Provided	Unique Clients	1
	% Unique Clients	0.01%

Percentage of Distinct Clients - Gender



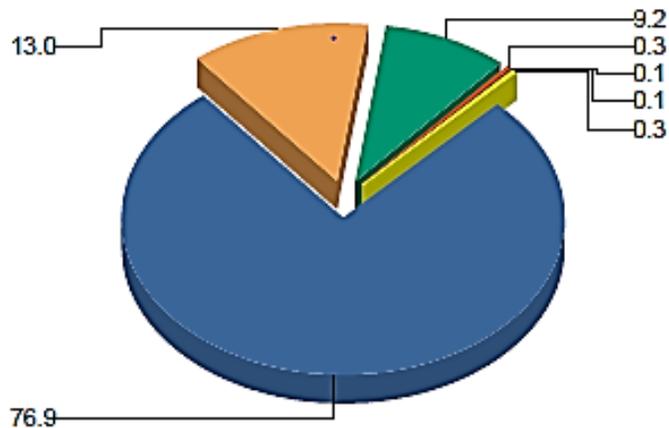
Percentage of Distinct Clients - Age Group



**Medi-Cal Utilization by Language, Calendar Year 2015**

		Total
<b>Language</b>	<b>Unique Clients</b>	<b>7,144</b>
	<b>% Unique Clients</b>	<b>100.00%</b>
English	Unique Clients	5,497
	% Unique Clients	76.95%
Spanish	Unique Clients	930
	% Unique Clients	13.02%
Unknown / Not Reported	Unique Clients	660
	% Unique Clients	9.24%
Cantonese	Unique Clients	24
	% Unique Clients	0.34%
Mixtec	Unique Clients	5
	% Unique Clients	0.07%
Thai	Unique Clients	5
	% Unique Clients	0.07%
American Sign Language	Unique Clients	4
	% Unique Clients	0.06%
Tagalog	Unique Clients	4
	% Unique Clients	0.06%
Other Non-English	Unique Clients	15
	% Unique Clients	0.21%

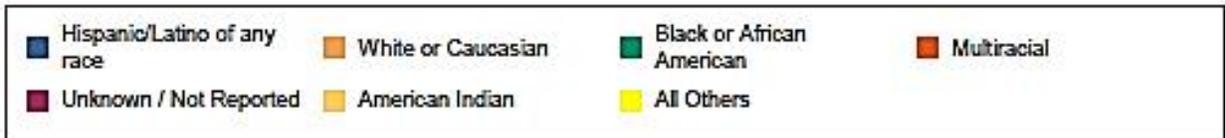
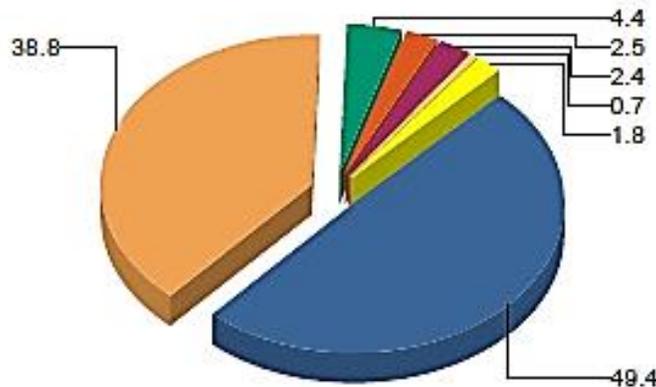
**Percentage of Distinct Clients - Language**  
( Top 6 groups - includes ties)



**Medi-Cal Utilization by Ethnicity, Calendar Year 2015**

		Total		
<b>Ethnicity</b>	<b>Unique Clients</b>	<b>7,144</b>	Korean	Unique Clients % Unique Clients
	<b>% Unique Clients</b>	<b>100.00%</b>		
Hispanic/Latino of any race	Unique Clients	3,529	Japanese	Unique Clients % Unique Clients
	% Unique Clients	49.40%		
White or Caucasian	Unique Clients	2,773	Vietnamese	Unique Clients % Unique Clients
	% Unique Clients	38.82%		
Black or African American	Unique Clients	313	Chinese	Unique Clients % Unique Clients
	% Unique Clients	4.38%		
Multiracial	Unique Clients	181	Alaskan Native	Unique Clients % Unique Clients
	% Unique Clients	2.53%		
Unknown/Not Reported	Unique Clients	171	Other Pacific Islander	Unique Clients % Unique Clients
	% Unique Clients	2.39%		
American Indian	Unique Clients	48	Cambodian	Unique Clients % Unique Clients
	% Unique Clients	0.67%		
Filipino	Unique Clients	42	Laotian	Unique Clients % Unique Clients
	% Unique Clients	0.59%		
Other Asian	Unique Clients	29	Guamanian	Unique Clients % Unique Clients
	% Unique Clients	0.41%		
Other	Unique Clients	11	Hmong	Unique Clients % Unique Clients
	% Unique Clients	0.15%		
			Native Hawaiian	Unique Clients % Unique Clients

**Percentage of Distinct Clients - Ethnicity**  
( Top 6 groups - includes ties)



**Medi-Cal Claim Data by Ethnicity, Calendar Year 2015**

		Total	Claimed				Unclaimed
			Total	Approved	Denied	Open	
<b>Ethnicity</b>	<b>Unique Clients</b>	<b>7,144</b>	<b>6,355</b>	<b>6,150</b>	<b>750</b>	<b>269</b>	<b>6,150</b>
	<b>% Unique Clients</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>
Hispanic/Latino of any race	Unique Clients	3,529	3,068	2,946	335	82	3,083
	% Unique Clients	49.40%	48.28%	47.90%	44.67%	30.48%	50.13%
White or Caucasian	Unique Clients	2,773	2,537	2,480	336	167	2,384
	% Unique Clients	38.82%	39.92%	40.33%	44.80%	62.08%	38.76%
Black or African American	Unique Clients	313	286	282	28	9	264
	% Unique Clients	4.38%	4.50%	4.59%	3.73%	3.35%	4.29%
Multiracial	Unique Clients	181	170	168	14	2	149
	% Unique Clients	2.53%	2.68%	2.73%	1.87%	0.74%	2.42%
Unknown / Not Reported	Unique Clients	171	136	119	22	2	117
	% Unique Clients	2.39%	2.14%	1.93%	2.93%	0.74%	1.90%
American Indian	Unique Clients	48	44	44	3	1	40
	% Unique Clients	0.67%	0.69%	0.72%	0.40%	0.37%	0.65%
Filipino	Unique Clients	42	40	39	5	1	35
	% Unique Clients	0.59%	0.63%	0.63%	0.67%	0.37%	0.57%
Other Asian	Unique Clients	29	24	23	1	2	26
	% Unique Clients	0.41%	0.38%	0.37%	0.13%	0.74%	0.42%
Other	Unique Clients	11	9	9	0	0	10
	% Unique Clients	0.15%	0.14%	0.15%	0.00%	0.00%	0.16%
Korean	Unique Clients	10	9	9	1	0	10
	% Unique Clients	0.14%	0.14%	0.15%	0.13%	0.00%	0.16%
Japanese	Unique Clients	9	9	9	0	1	7
	% Unique Clients	0.13%	0.14%	0.15%	0.00%	0.37%	0.11%
Vietnamese	Unique Clients	7	7	7	2	1	7
	% Unique Clients	0.10%	0.11%	0.11%	0.27%	0.37%	0.11%
Chinese	Unique Clients	6	5	4	2	0	5
	% Unique Clients	0.08%	0.08%	0.06%	0.27%	0.00%	0.08%
Alaskan Native	Unique Clients	4	4	4	0	0	4
	% Unique Clients	0.06%	0.06%	0.06%	0.00%	0.00%	0.07%
Other Pacific Islander	Unique Clients	4	3	3	0	0	3
	% Unique Clients	0.06%	0.05%	0.05%	0.00%	0.00%	0.05%
Cambodian	Unique Clients	2	2	2	0	0	1
	% Unique Clients	0.03%	0.03%	0.03%	0.00%	0.00%	0.02%
Laotian	Unique Clients	2	1	1	1	1	2
	% Unique Clients	0.03%	0.02%	0.02%	0.02%	0.02%	0.03%
Guamanian	Unique Clients	1	0	0	0	0	1
	% Unique Clients	0.01%	0.00%	0.00%	0.00%	0.00%	0.02%
Hmong	Unique Clients	1	1	1	0	0	1
	% Unique Clients	0.01%	0.02%	0.02%	0.00%	0.00%	0.02%
Native Hawaiian	Unique Clients	1	0	0	0	0	1
	% Unique Clients	0.01%	0.00%	0.00%	0.00%	0.00%	0.02%

**Medi-Cal Claim Data by Gender, Calendar Year 2015**

		Total	Claimed				Unclaimed
			Total	Approved	Denied	Open	
<b>Gender</b>	<b>Unique Clients</b>	<b>7,144</b>	<b>6,355</b>	<b>6,150</b>	<b>750</b>	<b>269</b>	<b>6,150</b>
	<b>% Unique Clients</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>
F - Female	<b>Unique Clients</b>	<b>3,653</b>	<b>3,282</b>	6,167	397	133	<b>3,130</b>
	<b>% Unique Clients</b>	<b>51.13%</b>	<b>51.64%</b>	51.50%	52.93%	49.44%	<b>50.89%</b>
M - Male	<b>Unique Clients</b>	<b>3,476</b>	<b>3,061</b>	2,978	344	136	<b>3,009</b>
	<b>% Unique Clients</b>	<b>48.66%</b>	<b>48.17%</b>	48.42%	45.87%	50.56%	<b>48.93%</b>
Unknown / Not Reported	<b>Unique Clients</b>	<b>15</b>	<b>12</b>	5	9	0	<b>11</b>
	<b>% Unique Clients</b>	<b>0.21%</b>	<b>0.19%</b>	0.08%	1.20%	0.00%	<b>0.18%</b>

**Medi-Cal Claim Data by Age, Calendar Year 2015**

		Total	Claimed				Unclaimed
			Total	Approved	Denied	Open	
<b>Age at Service</b>	<b>Unique Clients</b>	<b>7,144</b>	<b>6,355</b>	<b>6,150</b>	<b>750</b>	<b>269</b>	<b>6,150</b>
	<b>% Unique Clients</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>
Age 18 - 59	<b>Unique Clients</b>	<b>4,117</b>	<b>3,762</b>	3,631	519	189	<b>3,483</b>
	<b>% Unique Clients</b>	<b>57.63%</b>	<b>59.20%</b>	59.04%	69.20%	70.26%	<b>56.63%</b>
Age 6 - 17	<b>Unique Clients</b>	<b>1,839</b>	<b>1,635</b>	1,582	129	12	<b>1585</b>
	<b>% Unique Clients</b>	<b>25.74%</b>	<b>25.73%</b>	25.72%	17.20%	4.46%	<b>25.77%</b>
Age 0 - 5	<b>Unique Clients</b>	<b>748</b>	<b>523</b>	517	15	3	<b>694</b>
	<b>% Unique Clients</b>	<b>10.47%</b>	<b>8.23%</b>	8.41%	2.00%	1.12%	<b>11.28%</b>
Age 60 +	<b>Unique Clients</b>	<b>612</b>	<b>575</b>	554	94	65	<b>518</b>
	<b>% Unique Clients</b>	<b>8.57%</b>	<b>9.05%</b>	9.01%	12.53%	24.16%	<b>8.42%</b>
Not Provided	<b>Unique Clients</b>	<b>1</b>	<b>0</b>	0	0	0	<b>1</b>
	<b>% Unique Clients</b>	<b>0.01%</b>	<b>0.00%</b>	0.00%	0.00%	0.00%	<b>0.02%</b>

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

According to census data, Santa Barbara County is 2.4% Black and 44.8% Latino. Based off of the Department’s ShareCare Medi-Cal Utilization rates by ethnicity, 4.38% of clients served are of Black or African American ethnic background and 49.40% of clients served are of Hispanic/Latino ethnic background. Compared to the county’s ethnic demographics, it appears that the Department, with regards to Medi-Cal eligible individuals, is providing care to a percentage of minority population that is in line with or surpasses the county’s demographic makeup.

However, based on the analysis contained in the Racial and Ethnic Disparities (R.E.D.) Mental Health Report published by the University of California, Santa Barbara, “African American and Latino/a youth [within the juvenile justice system] were overrepresented in Behavioral Wellness admissions.” Whereas 1.3% of the youth population in Santa Barbara County in 2015 was African American, 2.9% of African American youth in the juvenile justice system were admitted to Behavioral Wellness programs, almost three (3) times the rate compared to white youth. Alongside this, 72.6% of youth admissions in Behavioral Wellness were Latino/a youth, when only 61.7% of

the youth in Santa Barbara County are Latino/a. This overrepresentation, however, may be expected, given that there are racial and ethnic disproportionalities in the Medi-Cal eligible population in Santa Barbara County, White youth were expected to be underrepresented relative to many other racial and ethnic groups.

**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).

Based on current data estimations and data availability, Santa Barbara County has 156,037 individuals below the 200% of poverty line as of August 2015. Also, 124,519 of individuals below the 200% of poverty line are Medi-Cal eligible, whereas, 31,518 individuals below the 200% of poverty line are not Medi-Cal eligible.

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

The Department is in need of an alternative way to collect and catalogue poverty level, Medi-Cal and non-Medi-Cal client utilization, and other data sets more accurately and consistently. Santa Barbara County has not seen a noticeable shift in the diversity of its population. Therefore, the analysis of disparities that follows is based off of historical findings as the Department expects the percentages to be similar to previous findings.

**Race/Ethnicity:** Historically, Santa Barbara County has served approximately 33%, or 1/3<sup>rd</sup>, of the white population being below the 200% of poverty level, whereas the Department’s non-Medi-Cal clients have been approximately 50% white. Of the non-Medi-Cal clients below the 200% of poverty level served by the Department, Hispanics have historically comprised around 20% of those served.

**Language:** The data available with regards to the primary language of the population served by the Department does not represent the needs of the clients. The data does not reflect what the Department knows to be true; being that the Department serves a large proportion of clients whose primary/preferred language is Spanish. Future focus to improve the Department’s data collection will be done through staff training and by conducting reviews of the Department’s current data collection systems.

**Age:** The most recent data available for the ages of individuals living below the 200% of poverty level is not currently available or accessible by the Department. Historically, the largest portion

*Criterion 2: Updated Assessment of Service Needs*

of non-Medi-Cal clients living below the 200% of poverty level served by the Department have been aged 16-59, approximately 80-90%. As the population has not aged significantly in the time between historical estimates and analysis, it is safe to say that the distribution should remain approximately the same, with a possibility for fewer individuals in the 16-59 age range and more individuals in the 60+ age range.

**Gender:** Historically, there has not been a large discrepancy between the percentage of females served versus the percentage of males served; it has hovered around 50% for either male or female (+/- 2%). The Department expects this lack of discrepancy to remain consistent with its current population served.

**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).

The Department has not conducted a CSS population assessment since 2005. Despite relatively little change in population size and demographics over the past twelve years, using data and analysis from this assessment may not accurately represent present issues, including mental health disparities. Plans to produce a new population assessment in 2017 have been established.

**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 PEI planning process resulted in stakeholders identifying all six populations as priorities:

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

B. Describe the process and rationale used by the county in selecting their PEI priority population(s).

Research conducted during both the CSS and PEI planning processes identified disparities within target populations. For example, access to services between Caucasians and Latinos was identified to be a major disparity within target populations. A number of the PEI projects and strategies formulated to reach underserved segments of the Latino community are as follows:

- Mental health programs were strengthened in community health clinics;
- Settings that reduce stigma and geographical barriers for access by Latinos countywide;
- New TAY mental health teams for detection and early intervention will focus on underserved youth in both north and South County;
- Early childhood mental health programs will target underserved Latino children countywide;
- A school-based program in South County will provide prevention and early intervention services to children and youth who have been underserved; and
- Community health educators from Latino communities will provide outreach, education and linkages to underserved members of the Latino community.

The community health education component of PEI will also target additional underserved cultural groups, including, but not limited to, Latinos, Native Americans, Oaxacans and LGBT.

The PEI planning process was conducted in five phases in order to identify the target populations (further details provided in Criterion 3).

## **CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES**

- I. Identified unserved/underserved target populations (with disparities):**
- A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).
    - 1. Describe the process and rationale the county used to identify and target the population(s) with disparities.

Prevention and Early Intervention (PEI) stakeholder forums were held in March, 2009 in each major population center in Santa Barbara County (Santa Maria, Lompoc and Santa Barbara). Stakeholders were briefed on MHSA guidelines and research conducted by the University of California, Santa Barbara. Stakeholders broke into workgroups by age of the target populations (children, TAY, adults and older adults). After a discussion they were asked to prioritize priority populations. A series of focus groups were also held targeting specific populations (Latino, TAY, LGBTQ, etc.) known from past planning processes (CSS, WET) to be under-represented in conventional stakeholder processes such as community forums.

Community interest focused on providing prevention and early intervention services for school-age children at risk for failure, children and youth with involvement or at risk of involvement with CWS, young adults in crisis, adults in the criminal justice system, older adults who are isolated and/or experiencing a serious mental health condition and underserved cultural populations of all ages.

The PEI planning process was conducted in five phases in order to identify the target populations.

**Phase One: Research conducted by the University of California, Santa Barbara (UCSB).** To obtain a solid research foundation from which to build the PEI planning process, a team of researchers with the UCSB Gevirtz Graduate School of Education compiled comprehensive information regarding mental health risk factors and prevalence (including national, state and local data). The data was then presented at all PEI planning meetings.

**Phase Two: Regional Stakeholder Forums.** In March 2009, three community forums, one in each of the County's major population centers (Santa Maria, Lompoc and Santa Barbara), offered stakeholders a background about MHSA and PEI guidelines, a summary of the research findings by UCSB, and participation in one of four workgroups based on the four age groups (children, TAY, Adults and Older Adults) that prioritized community mental health needs and priority populations.

Two means of informing stakeholders about the PEI Community Forums were used. First, the Department announced the forums at a number of major stakeholder groups, including the

CFMAC, the Latino Advisory Committee (LAC), the Santa Barbara County Mental Health Commission (MHC) and Latino consumer and family member support groups in North and South County. Second, to ensure widespread coverage, emails were sent to 275 individuals or representatives of various organizations throughout the County reflecting the following key PEI constituencies and all age groups:

- Alcohol and Drug Treatment
- Community Centers
- Individuals with a serious mental illness
- Education
- Employment
- Faith-Based
- Family Members of individuals with a serious mental illness
- Homeless Activists
- Law Enforcement
- Mental Health
- Physical Health
- Social Services
- Underserved Communities

**Phase Three: Focus Groups and Key Informant Interviews.** The third phase of the stakeholder planning process was designed to ensure diversity and representation of underserved and unserved communities with an emphasis on individuals and groups who were unlikely to participate in regional meetings and other conventional stakeholder forums. Consisting of 38 individuals, the focus groups and key informant interviews addressed the concerns of the following under-represented groups:

- Transition-age youth;
- Native Americans;
- Latino/Spanish-speaking individuals;
- Members of the Oaxacan community;
- Members of the LGBT community;
- Victims of Crime.

**Phase Four:** During the three regional stakeholder forums, attendees discussed and ranked PEI priority populations and community mental health needs. An online survey solicited further

stakeholder input, including suggested programs and interventions. The survey was based on the priorities, recommendations and information gathered from the interviews, focus groups and regional forums. Approximately 700 stakeholders were invited to complete the survey, which was also available in hard copy and in Spanish upon request. Hard copies of the survey and postage-paid return envelopes were distributed at a meeting of the countywide CFMAC. 138 responses were received.

**Phase Five:** After synthesizing the multiple and diverse sources of stakeholder input previously described, a draft plan was developed and feedback was solicited and integrated into the final approved 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).

The Oaxaqueno/indigenous community is an invisible community with unmet needs. There are approximately 25,000 indigenous Mexicans in Santa Barbara County, and the Department employs one staff person that is trilingual, speaking Mixtec, English, and Spanish. The need for more trilingual staff is necessary in order to provide minimal mental health services to the Oaxaqueno/indigenous community.

The LGBTQ population was not assessed in the CSS plan. Suicide risk for Transition Age Youth and Adults was a key concern for the LGBTQ population, and the Department had not previously recognized this group as an underserved group. As a result, the PEI plan has remedied the oversight by designating one community mental health worker be designated specifically to serve the LGBTQ population.

### **III. Identified strategies/objectives/actions/timelines**

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

#### CSS:

- Use natural healing practices and ceremonies as recognized by enrollees, their families and communities.
- Develop an advisory body consisting primarily of clients and family members to provide advice and feedback on program functioning and development; include representatives from culturally and ethnically diverse and underserved communities.
- Promote community engagement by providing educational forums and developing natural community settings to be welcoming to people in recovery, including outreach to ethnically and culturally diverse communities.
- Provide cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities that proactively reach children who may have emotional and/or behavioral disorders and provide easy and immediate access to mental health services when needed.
- Deploy integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments that are strength-based and focused on engagement of the transition- age youth and provide gender and culture-specific assessments as in the DSM-IV-R cultural formulation.
- Hire staff consistent with racial/ethnic composition of clients and emphasizing cultural competence including bilingual staff.
- Promote the inclusion of representatives of diverse ethnic and cultural communities in the planning and management of peer-run Recovery Learning Centers in each region of the County.

#### WET:

- The WET plan identifies key strategies which includes the incorporation of cultural competence and language capacity in the workforce.
- Develop an Internship Program designed to: 1) afford interested consumers and family members an opportunity to participate in the consumer/family training program; 2) provide supervision and training in Spanish; 3) develop training opportunities for Oaxacan/indigenous and Native American communities.
- Develop a strategy to increase the workforce of direct service staff persons who are bilingual/bicultural to serve Spanish speaking communities.
- Increase the capacity of law enforcement to better manage crisis situations with individuals experiencing severe mental illness by providing Crisis Intervention Training which

includes components including cultural competence for different ethnic groups as well as the consumer and family culture.

PEI:

- Conduct outreach and education; community engagement, case management and linkages and cultural wellness practices for persons at risk of serious mental illness and their families in the Latino, Oaxacan, LGBT and Native American communities countywide.
- Offer prevention and early intervention services in community health clinics throughout the County that will maximize access for culturally and ethnically underserved communities, including the Latino community, by reducing the barriers of transportation and stigma.
- Provide in-home support, health and development screening, parent education and skills training, infant parent psychotherapy, advocacy, resources and referrals, postpartum support groups and further outreach.
- Focus on providing prevention and early intervention services to children and transition-age youth from underserved cultural and ethnic communities.
- Provide crisis services to school-based support and early detection and intervention teams for TAY. The population served countywide is underserved at risk children and TAY whose ages range from 15-25.

- A. 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

## **II. Medi-Cal population**

- Outreach to the Spanish speaking community has been identified as a priority of the Department. It has been recognized that more bilingual/bicultural staff are required in the areas where there is a larger Spanish speaking community base, such as Guadalupe and Santa Maria.
- The indigent population is in need of services despite the lack of Medi-cal eligibility. The Department has made a commitment to serve the neediest of the indigent population via MHSA programs.

## **III. 200% of poverty population**

- Serve 20% more Latinos in Spanish by December 2018.
- Increase bilingual/bicultural staffing levels in the entire system of care by 2018.
- Require reporting be 100% complete, to include ethnicity and language preferred.
- Review services and programs on a quarterly basis to ensure that they are culturally competent and that the number of bilingual/bicultural staff hired is consistent the projected targets.
- Monitor the number of bilingual/bicultural clients served by bilingual/bicultural staff to ensure appropriate utilization.
- Review services for each age group and assess cultural competence for each program.
- Track ethnicity, primary language spoken, and language in which their service was received.

## **IV. MHSA/CSS population**

- Ten programs were developed as a result of the CSS stakeholder process to maximize cost-effectiveness and quality of services; one program was eliminated and two were expanded.
- The LGTBQ, Oaxaqueno and Native American populations were not considerably represented during the CSS planning stages. During the PEI research and planning process, these communities were represented and programs developed to serve them.

**V. PEI priority population(s) selected by the county, from the six PEI priority populations**

- All priority populations were identified during the PEI stakeholder process as being important. Populations identified as being unserved and underserved included the Native American, Oaxaqueno and LGBTQ communities.
- The community health educator (Promotora) project will place individuals in the Oaxacan, Latino, LGBT and Native American communities to provide, outreach, support and referrals to programs and services to enhance resiliency, decrease stigma, and connect the identified underserved populations to community services.
- Within each local community clinic mental health representatives will provide the new PEI program that strengthens preventive mental health services in community clinics countywide is designed to increase access to underserved communities by offering services in convenient, non-stigmatizing locations.

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

- A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI.

Improved tracking of the language in which the service was provided will contribute to a greater understanding of whether the bilingual/bicultural staffing requirements are having the result of providing services in a cultural and linguistically competent manner. Revising the training plan to include the identified unserved and underserved communities such as the Oaxaquenos, LGBTQ, Disabled, etc., will increase understanding and skills to address the needs of these populations.

**V. Planning and monitoring of identified strategies/objectives/actions/ timelines to reduce mental health disparities**

- 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.).

- Enhance services to Latinos by increasing bilingual/bicultural staffing requirements throughout the mental health system by December 2018.
- Establish a measurement tool to assess programs and services' cultural competence by June 2017.
- Establish target that 50% of clients whose preferred language is not English are served only by bilingual/bicultural staff instead of via interpretation services by December 2018.

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

- Ensure 100% reporting by Behavioral Wellness programs and contract agencies by December 2018.
- Enhance IT capability to track ethnicity, language preferred, language service was provided, if interpretation services were used and if they were by another clinician, non-clinician, friend, or language line. IT capability will be completed by December 2018.
- Analyze and report outcomes with an emphasis on the requirements for the Cultural Competence Plan to the Department's Administration, Behavioral Wellness Commission, Consumer and Family Advisory Committee, Latino Advisory Committee, and the Cultural Competency and Diversity Action Team on a quarterly basis beginning in January 2016.

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.

- The Department monitors compliance via quarterly reports which are required of all community based organizations.
- Oversight committees, which include the Consumer and Family Member Advisory Board, the Behavioral Wellness Commission, the Quality Improvement Committee, the Latino Advisory Committee, and the Cultural Competency and Diversity Action Team will review all outcome reports, the reviews of which will be reported by the Department on a quarterly basis.
- The Department expects to have 100% reporting compliance by December 2018 that will include data on ethnicity of clients, served, language of services, etc.

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

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

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

The Cultural Competency and Diversity Action Team (CCDAT) has been developed and is committed to staff development in the areas of cultural competence, consumer recovery and best practice approaches to support recovery and resiliency, in order to promote the inclusion and representation of underserved/unserved communities. The main goals of the CCDAT are to advocate for culturally competent services; conduct outreach to underserved, unserved, and inappropriately served communities; and reduce mental health disparities for racially, ethnically, and culturally diverse communities. To ensure accountability for the provision of such care and services, the CCDAT is prepared to work with all relevant parties to develop and implement empirically sound and culturally appropriate policies, procedures and practices.

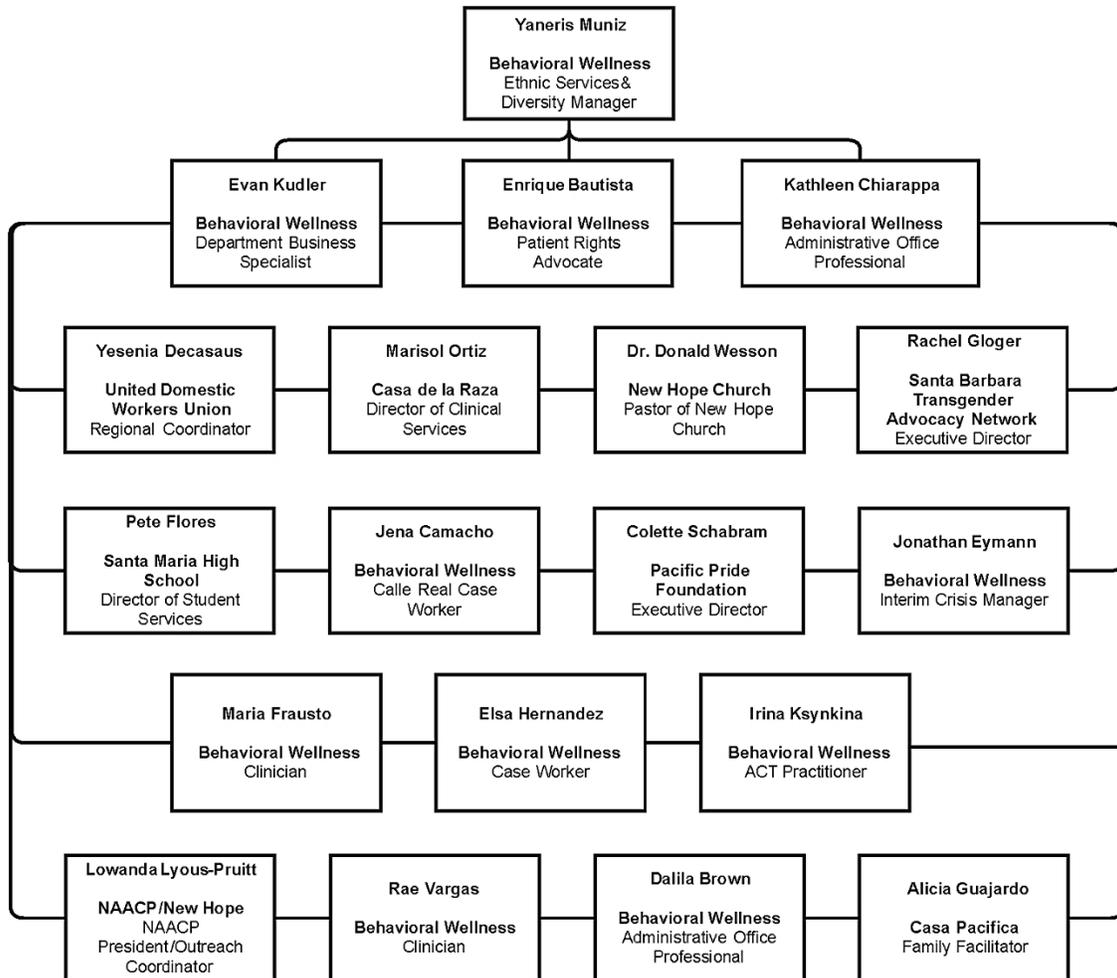
- B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and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

The CCDAT thrives on the inclusivity and the collective partnership of Department staff, providers, community partners, advisory groups, consumers and family. All meetings are open to the public and widely publicized in multiple mediums, including mass distribution emails, the Director's monthly report and online on the Department's website. Additionally, the Ethnic Service and Diversity Manager actively recruits individuals throughout the county to create a diverse network of representatives within the CCDAT. The Department's policy, "Cultural and Linguistic Competency", formally establishes and recognizes the CCDAT as an essential component to service planning and delivery.

C. Organizational chart.

Cultural Competency and Diversity Action Team

Organization Chart



**D. Committee membership roster listing member affiliation if any.**

**CULTURAL COMPETENCY AND DIVERSITY ACTION TEAM CONTACT LIST**

Rev. 12.12.16 EB

Name	Title	Company	Phone	E-Mail
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Enrique Bautista	Patient Rights Advocate/Outreach and Engagement Specialist	Santa Barbara County Department of Behavioral Wellness	805-451-7211	enbautista@co.santa-barbara.ca.us
Jena Camacho	Calle Real Case Worker	Santa Barbara County Department of Behavioral Wellness	805-681-4747	jcamacho@co.santa-barbara.ca.us
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Elsa Hernandez	Case Worker	Santa Barbara County Department of Behavioral Wellness		ehernandez@co.santa-barbara.ca.us

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

Name	Title	Company	Phone	E-Mail
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Lowanda Lyons-Pruitt	President NAACP/Outreach coordinator	NAACP/New Hope Church	805-448-7869	lyonspruitt@msn.com
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Dr. Donald Wesson	Pastor Of New Hope Church	New Hope Church		
Evan Kudler	Department Business Specialist	Santa Barbara County Department of Behavioral Wellness		
Rachel Gloger	Executive Director	Santa Barbara Transgender Advocacy Network		transyouthsb@gmail.com
Dalila Brown	AOP 2-Admin	Santa Barbara County Department of Behavioral Wellness		dabrown@co.santa-barbara.ca.us
Jonathan Eymann	Interim Crisis Manager	Santa Barbara County Department of Behavioral Wellness	805-681-5314	jeymann@co.santa-barbara.ca.us
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## Resource Contact List

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<b>Matt Pennon</b>	Resource Family Recruiter and Trainer	Our County Our Kids	805-698-2703	<a href="mailto:M.Pennon@OurCountyOurKids.org">M.Pennon@OurCountyOurKids.org</a>
<b>Elena Richardson</b>	Director of Grantmaking	The Fund for Santa Barbara	805-962-9164 Ext. 101	<a href="mailto:erichard@fundofsantabarbara.org">erichard@fundofsantabarbara.org</a>
<b>Gemma Garcia</b>	North County Program Associate	The Fund for Santa Barbara	805-922-1707 Ext. 201	<a href="mailto:gemma@fundforsantabarbara.org">gemma@fundforsantabarbara.org</a>
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<b>Dorothy Jackson</b>	Family Support Services	Family Recourse Center	805-742-2943	<a href="http://www.fsacares.org">www.fsacares.org</a>
<b>Mattie Gadsby</b>	CAC Sierra Madre Head Start Center Supervisor	Community Action Commission of Santa Barbara/Head Start Program	805-349-9707	<a href="http://www.headstartprogram.us">www.headstartprogram.us</a>
<b>Lorraine Neenan</b>	Program Director	Community Action Commission of Santa Barbara/Head Start Program	805-964-8857	<a href="http://www.headstartprogram.us">www.headstartprogram.us</a>
<b>Lisa Rosemarie Ray</b>	CEO/President	Children's Resource Network of the Central Coast	805-709-8673	<a href="http://www.childrensresourcenetwork.org">www.childrensresourcenetwork.org</a>
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<b>Lawanda Lyons-Pruitt</b>	Hospitality Chair, Outreach Coordinator	New Hope MB Church	805-448-7869	<a href="mailto:lyonspruitt@msn.com">lyonspruitt@msn.com</a>
<b>Alicia Guajardo</b>	Wraparound Family Facilitator	Casa Pacifica, Centers for Children & Families	805-975-9491	<a href="mailto:aguajardo@casapacifica.org">aguajardo@casapacifica.org</a>
<b>Victoria Wolf</b>	Program Coordinator	LAGS Recovery Centers	805-332-4568	<a href="mailto:VWolf@lagsrecovery.com">VWolf@lagsrecovery.com</a>

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

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

The Cultural Competency and Diversity Action Team (CCDAT) exists to ensure that the Department fully embraces and implements the behaviors, attitudes and values that define cultural diversity. As per the CCDAT Charter, "the major goals of [the CCDAT] are to advocate for culturally competent services, outreach to underserved/unserved/inappropriately served communities and reducing mental health disparities for racially, ethnically, and culturally diverse communities. To ensure accountability for the provision and maintenance of such care and services, the action team is prepared to work with all relevant parties to develop and implement empirically sound and culturally appropriate evaluation instruments and procedures."

Additionally, the Department's "Cultural and Linguistic Competency" policy establishes the CCDAT as a key advisory group that participates in the overall planning, implementation and delivery of services. This may include submission of recommendations to management- and executive-level staff, transmission of concerns to Leadership and the Director, and stakeholder participation in the Mental Health Services Act (MHSA) planning process.

Beginning in 2017, a CCDAT summary report will be provided quarterly at the Department's Quality Improvement Committee (QIC).

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

Evidence is not available at this time. Future annual updates will include agenda and meetings minutes demonstrating integration of cultural competence throughout the system.

C. Annual Report of the Cultural Competence Committee's Activities.

An Annual Report for 2016 is not available at this time. A 2017 report will be developed that details progress towards goals and objectives, reviews and recommendations to programs and Directors, and a summary of hiring/retention, outreach/engagement and training initiatives.

## **CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES**

- I. The county system shall require all staff and stakeholders to receive annual cultural competence training.**
- A. The county shall develop a three year training plan for required cultural competence training that includes the following:
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.

The Department projects that approximately 432 Behavioral Wellness staff will need to be trained based on 2016 staffing levels.

All required trainings will be offered online via the Relias Learning platform. With Relias, the Department can assign, track and report trainings quickly and efficiently. Cultural competency trainings are announced annually in February via email with reminders sent periodically. Department staff must complete required cultural competency trainings by June 30 of every year. Noncompliance reports are generated and sent to the respective supervisor/manager to follow-up. The Department's Ethnic Services and Diversity Manager and Chief of Compliance assist with ensuring completion of all trainings. In those cases in which trainings are not completed by the deadline, staff may be barred from continuing work/services until all trainings are complete.

All training curricula within this plan address cultural competence issues. This includes information and examples regarding consumer and family culture and other cultural groups such as Native American, members of the military, Latino, Oaxaqueno, and LGBTQ. Some trainings may focus specifically on working with individuals whose native language is not English; this may include Spanish speakers, Mixtec speakers, etc.

<b>Three-Year Schedule of Cultural Competence Trainings</b>			
<b>Cultural Competence Training Schedule 2016</b>			
<b>1st Quarter 2016 Jan-Feb-Mar</b>	<b>2nd Quarter 2016 Apr-May-Jun</b>	<b>3rd Quarter 2016 Jul-Aug-Sep</b>	<b>4th Quarter 2016 Oct-Nov-Dec</b>
Interpreter Training (3-day training)	Cultural Competency Training(Online)		UCSB TransYouth Training
Interpreter Provider Training (How to use interpreters)	Consumer/Family Culture Training (Online)		Mixteco Training
<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>
New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)
Tours of the Clinics	Tours of the Clinics	Tours of the Clinics	Tours of the Clinics
Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library
<b>Cultural Competence Training Schedule 2017</b>			
<b>1st Quarter 2017 Jan-Feb-Mar</b>	<b>2nd Quarter 2017 Apr-May-Jun</b>	<b>3rd Quarter 2017 Jul-Aug-Sep</b>	<b>4th Quarter 2017 Oct-Nov-Dec</b>
Mixteco Training (Online)	Cultural Diversity Training (Online)	Care of Transgender Clients Training (Buellton)	Spotlight Training (Overview of Local Communities: Local ethnicities, LGBTQ+, etc.)
Antioch University Santa Barbara Symposium on latino Mental Health, Education, and Engagement (Jan. 14, Feb. 25, Mar. 18)	Antioch University Santa Barbara Symposium on latino Mental Health, Education, and Engagement (Apr. 22, Jun. 10)		
Interpreter Training (3-day training)	Mental Health Consumer/Family Culture Training (Online)		
Interpreter Provider Training (How to use interpreters)	Spotlight Training (Overview of Local Communities: Local ethnicities, LGBTQ+, etc.)		
<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>
Consumer Culture Recovery Stories Live Training	Consumer Culture Recovery Stories Live Training	Consumer Culture Recovery Stories Live Training	Consumer Culture Recovery Stories Live Training
New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)
Implicit Bias Training	Implicit Bias Training	Implicit Bias Training	Implicit Bias Training
Tours of the Clinics	Tours of the Clinics	Tours of the Clinics	Tours of the Clinics
Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library

<b>Cultural Competence Training Schedule 2018</b>			
<b>1st Quarter 2018 Jan-Feb-Mar</b>	<b>2nd Quarter 2018 Apr-May-Jun</b>	<b>3rd Quarter 2018 Jul-Aug-Sep</b>	<b>4th Quarter 2018 Oct-Nov-Dec</b>
Recovery Stories	Cultural Diversity Training (Online)		Spotlight Training (Overview of Local Communities: Local ethnicities, LGBTQ+, etc.)
Spotlight Training (Overview of Local Communities: Local ethnicities, LGBTQ+, etc.)	Mental Health Consumer/Family Culture Training (Online)		
<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>	<b>Ongoing:</b>
New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)	New Hire Orientation (Monthly)
Implicit Bias Training	Implicit Bias Training	Implicit Bias Training	Implicit Bias Training
Tours of the Clinics	Tours of the Clinics	Tours of the Clinics	Tours of the Clinics
Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library	Online Cultural Competency Trainings Library

**II. Annual cultural competence trainings**

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

<b>Cultural Competence Trainings 2016</b>							
<b>Training Event</b>	<b>Description of Training</b>	<b>How long and often</b>	<b>Attendance by Function</b>	<b>No. of Attendees</b>	<b>Total</b>	<b>Date of Training</b>	<b>Name of Presenter</b>
<b>Interpreter and Provider Training</b>	To help interpreters see themselves as critical members of a professional team that requires their understanding of clinical issues while maintaining	Training is a 3-day intensive training from 8:30am-4:30pm	Direct Service contractors B-Well Staff	7 10	17	03/29/16-04/01/16	<b>Lidia Gamulin and Rachel Guerrero</b>
<b>Cultural Diversity Training</b>	To train and help staff on understanding; cultural diversity, common issues in cultural diversity, common issues in cultural diversity and cultural competence	Training is annually and its 1hr 25min.	B-Well Staff	1760	1760	Training has to be complete before the end of June of each year.	<b>Relias E-Learning</b>
<b>Mixtec Culture and Perspectives on Mental Health Training</b>	Mixtec culture, language, and family dynamics. Will also address domestic violence, migration trauma, mental health, alcohol abuse and prevention.	This is a 2 hour training	B-Well Staff	52	52	11/16/16	<b>MICOP Genevieve Flores-Haro, Dr. Carlos Jimenez, Arcenio J. Lopez,</b>

**III. Relevance and effectiveness of all cultural competence trainings**

- A. Training report on the relevance and effectiveness of all cultural competence trainings.
1. Rationale and need for the trainings. Describe how the training is relevant in addressing identified disparities.

Cultural competence trainings are an excellent tool for building awareness, which, in turn, is a necessary step in reducing ethnic and cultural disparities. All key players in the public mental health system, including administrators, county and contracted staff, community leaders and clients need to be educated about the needs, beliefs and strengths of culturally and ethnically underserved communities. As awareness is heightened, individuals become more supportive of efforts to increase inclusion. For example:

- The training about Mixtec Culture and Perspective on Mental Health Training highlighted how this non-Spanish- speaking group is culturally and linguistically isolated even from the larger Latino community. Language and cultural barriers require unique outreach strategies for the Oaxacan community unprecedented in Santa Barbara County. The lack of a written language presents additional challenges and relies heavily on audio/visual media methods of communication (i.e. radio, video, TV).
- Client and family culture trainings have vividly illustrated the challenges faced by consumers and their families. As clients and family members tell their stories, often with great passion and emotion, this humanizes mental health and makes a positive impact on the mental health and law enforcement professionals who attend the trainings.
- Our Spotlight Training is going to focus on our community diversities. We will provide more information helping the community understand and educating staff on certain diversities from our communities. We will be focusing in Mixtec Culture, LGBT and the diversity and cultural changes our communities are having.

No group or profession has a monopoly on the best practices to achieve wellness and recovery. Every underserved cultural and ethnic group has a lot to offer to the wider community and to the system of care. With a robust schedule of cultural competence trainings addressing the LGBT, Latino and Native American communities, client and family member culture and other issues, Behavioral Wellness is committed to continue to build awareness and share ideas across cultures. This will enrich the mental health service delivery system and ensure greater access for underserved individuals.

2. Results of pre-/post-tests.

Majority of the Cultural Competency Diversity Training tests that were taken in 2016 scored 92% or higher, passing is 80% or greater.

3. Summary report of evaluations.

Currently, we are switching our cultural competency diversity training from E-learning to Relias. Relias has evaluations at the end of trainings that we will be collecting at the end of 2017 in order to have a summary ready for the next Cultural Competence Plan. For our Interpreter Training, a majority of staff felt that the course objectives supported the course description and that it was good quality overall. They commented specifically on the trainers' enthusiasm and their style of training.

4. Current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.

Behavioral Wellness does not currently monitor staff skills developed in training or the application of those skills in the field. The Cultural Competency and Diversity Action Team (CCDAT) will discuss strategies on how to monitor advancing staff skills learned in trainings during 2017.

5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

The Department does not currently have a methodology for following up and ensuring that trained staff members are using their acquired skills. The Cultural Competency and Diversity Action Team (CCDAT) will discuss strategies on ensuring that staff is utilizing skills over time.

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

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

In FY 2015-2016, Behavioral Wellness Staff were assigned the Mental Health Consumer and Family Culture online training electives through the Department's eLearning Training platform. Staff completed these trainings with a 99.96% compliance rate. Within the eLearning system, staff are able to choose between six (6) different electives that satisfy their Client Culture training requirement. Three (3) of the offered trainings focus on individual consumer's experiences with mental health and accessing services within the public mental health system, whereas three (3) of the offered trainings focus on clients and their families experiences with mental health and accessing services within the public mental health system. Trainings are done through various cultural lenses so that staff are able to understand and witness the different experiences with mental health and accessing services within the public mental health system faced by the Department's clients and their families.

*Criterion 5: Culturally Competent Training Activities*

For FY 2016 – 2017, the Department’s Systems Training Coordinator, Talia Lozipone, in collaboration with the Department’s Consumer Empowerment Manager, Tina Wooton, will develop a new Mental Health Consumer Culture training to offer to the Department’s staff. The training will be called “Mental Health Consumer Culture: Recovery Stories”. The training will consist of:

- Introduction video which discusses why it is important for staff to learn about the various experiences of the populations served with mental illness and what “recovery” means. This portion of the training will feature video interviews of peers and clients within the mental health system.
- Instructions for Part 1 of the Training
  - Part 1 of the training is to include videos of four (4) clients’ individual experiences and stories with mental illness with associated quizzes to ensure trainees are learning and understanding.
- Instructions for Part 2 of the Training
  - Part 2 of the training is to consist of a flyer from SAMHSA which defines recovery and provides the trainees with principles of recovery with an associated quiz to ensure that trainees are learning and understanding the essential material.

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:  
H. Family focused treatment;  
I. Navigating multiple agency services; and  
J. Resiliency.

Please see Criterion 5, Section II “Cultural Competence Trainings 2016” Table.

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

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

The Department is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations. There is a significant shortfall in the mental health workforce in regard to the employment of consumer and family staff throughout the system, though some CBO contractors have been more successful than others in recruiting consumer staff. Additionally, the Department is focused on ensuring the availability of adequate bilingual Spanish-speaking staff in key regions of the County with larger Latino consumer numbers. Recruitment and retention challenges are impacted by Santa Barbara County's high cost of living.

- A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.
- B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data

The MHSA workforce assessment was last completed by the Department in 2009. Data may not correctly reflect the current workforce as a number of new positions were established in recent years to respond to increasing demand.

- 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.

Not applicable. No technical assistance was used.

*Criterion 6: County's Commitment to Growing a Multicultural Workforce*

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

Limited targets have been developed through the WET Plan to grow a multicultural workforce because the focus was mainly on consumer/family member entry level peer training opportunities.

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

Rolling out the WET plan is a complex, multidimensional task that focuses on developing an internship program to provide consumers and family members an opportunity to participate in newly developed peer training, to address shortages in the mental health field and to build skills for entry or re-entry into the workforce.

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

The Department needs technical assistance in conducting a workforce assessment as an assessment has not been conducted since 2009. However, a department-wide language survey is conducted annually to determine how many staff within the Department that are bilingual/bicultural. Survey results will be compared with client demographic data to calculate workforce needs.

## CRITERION 7: LANGUAGE CAPACITY

### I. Increase bilingual workforce capacity

- A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.
  - 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.

### WET Plan and MHSA Updates

Tina Wooton, the Department's Workforce Education and Training (WET) Manager, is responsible for overseeing all aspects of the WET component of MHSA and developing long-term workforce plans to ensure that shortages in critical areas are met. Currently, 39% of the Department's direct care staff are bilingual; 35% are bilingual in Spanish. Bilingual/bicultural staffing is a mandatory reporting element for CBOs and is tracked quarterly to ensure compliance with contract requirements.

Additionally, the Department's Human Resources Division has been involved as a critical participant in the implementation of MHSA programs and is playing a key role in developing a bilingual/bicultural workforce to meet the needs of the target population.

On the Santa Barbara County job's website, all Behavioral Wellness job postings encourage bilingual/bicultural individuals to apply in addition to advertising the availability of a bilingual allowance. For those candidates who indicate on the employment application that he/she is bilingual in Spanish, management and leadership staff ask interview questions in Spanish to identify the candidate's general level of fluency. At hire, bilingual employees are encouraged to complete a bilingual fluency exam offered by Language Line. Successful completion of fluency testing qualifies employees for a bilingual allowance (currently \$57.69 per pay period). Employees are tested through an oral interview conducted entirely in the tested language. All testing is completed and rated by professional, certified evaluators and all tests have been validated by external experts or a psychometrician. As of this report, over half of the Department's bilingual staff receives a bilingual allowance every pay period. Efforts are underway to encourage remaining bilingual staff to complete a fluency exam.

### Dedicated Resources for Interpreter Services

The National Latino Behavioral Health Association (NLBHA), in partnership with the South California Regional Partnership (SCRIP), provided Santa Barbara County a 3-day Mental Health Interpreter Training and 1-day Provider Training in March 2016. Trainings were open to all

department and community based organization (CBO) staff. The 3-day training series focused on the role of the interpreter within the therapeutic relationship, common clinical diagnosis and mental health terms, developing technical interpretation skills, and boundaries and limitations. The 1-day Provider training educated staff on how to appropriately and effectively utilize interpreter services. 17 Department and CBO staff completed the Interpreter Training and received a certificate of completion and nine employees participated in the Provider Training.

In addition to these in-house resources, the Department contracts with Language Line and Ortiz-Schneider Translation and Interpretation for interpreter services. Language Line services are available over the phone 24/7 in over 240 languages from a pool of 8,000 professional interpreters. Ortiz-Schneider Translation and Interpretation is a local company based in Santa Barbara and provides in-person interpreters in a variety of languages common to the area, including Spanish, Mixteco and other indigenous Mexican languages, and Tagalog.

The total annual amount of dedicated resources for contracted interpreter services is \$49,000.

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

- 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 Services, 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.

The Department has policies and procedures in place and implemented for a 24-hour access phone line (also known as the "Access Line") that is available to all individuals, including those that require linguistic accommodations and TDD/TTY/California Relay Service for the hearing impaired. These policies include:

- 24/7 Toll-Free Telephone Access (Policy #1)
- Mental Health Plan – Visually and Hearing Impaired and Beneficiaries with Limited Reading Ability (Policy #5)
- Accessing a Welcoming and Integrated System of Care and Recovery (Policy AQS-2.000)

Interpretation equipment is available for meetings and other events as needed. With the centralization of the Access Line within the Quality Care Management (QCM) division, an Access Screener training was developed addressing language access and how to use the Language Line (EXHIBIT 27). The Access Screener resource packet also includes a call script, Language Line procedures, and instructions on how to make a three-way conference call. The Ethnic Services and Diversity Manager provides training on Language Line usage as needed.

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

Throughout clinics and programs, signs are posted in reception areas and consultation rooms informing clients of language assistance services. All signage is available in English and Spanish. For other languages, a Language ID Poster (EXHIBIT 28) is displayed in the lobby or at reception desk. Instructions in the top 20 common languages state: "Point to your language. An interpreter will be called. The interpreter is provided at no cost to you." This signage can easily assist a client in self-identifying his/her language by simply pointing.

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

At first contact, the Department collects demographic information from the client, including primary/preferred language. This information may be documented on the Pre-consumer Access form used by Access Line Screeners (EXHIBIT 29) or within ShareCare during the client's intake/assessment.

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

Providing appropriate accommodation can be highly complex. Santa Barbara County is rich in cultural diversity, and with that richness comes a variety of language needs. The most complicating factor is the various dialects for any given cultural/linguistic preference. The Department has learned that it is not sufficient to simply have bilingual capacity in Santa Barbara County's threshold language. The Department has had to understand the variety of dialects and attempt to meet the challenge of ensuring interpretation of materials and translation can accommodate those dialects as needed. Additionally, the Department has learned that it takes a great deal of human and financial resource to meet the bilingual needs of a community such as Santa Barbara County.

The primary challenges faced by the Department have been in finding alternatives to the Language Line and in having fully certified interpreter services available due to resource and financial limitations. However, over the past 3-5 years the Department has focused efforts on recruiting and hiring bilingual/bicultural staff in key positions who can communicate to clients in their primary language. Additionally, steps have been taken to ensure that all clinical staff members remain

aware of the availability of the Language Line as a resource and that they use it whenever necessary. The Department has practices in place to ensure that beneficiary material is consistently available and easily accessed in both English and Spanish at all service sites.

Another challenge had been providing interpretation at various stakeholder meetings and processes. MHSA funds were utilized to purchase interpretation equipment in order to provide non-intrusive interpretation and improve stakeholder and consumer participation in meetings, trainings and other processes.

The Department is investigating upgrading the Language Line use from telephone only to video conferencing. In order to do so, the Department would require the installation of a sufficient number of webcams to ensure that the video conferencing for interpretation services is of acceptable quality. The Department must speak with a consultant to develop and plan an effort of this scale. The Department must also research how to incentivize interpreters and bring more diverse resources into the system.

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

- A. Evidence of availability 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 the counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

Beneficiary Rights and Responsibility material is posted and available in English and Spanish in all Behavioral Wellness clinics, provider organizations, and service areas. Additionally, bulletins regarding the availability of interpreter services and Language Line are posted throughout clinic and program sites. During the intake process, clients are asked to identify their language preference, which is then documented in the client file.

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

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

To be developed.

- 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.

To be developed.

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

To be developed.

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

- A. Culturally and linguistically appropriate written information for threshold languages.

The Department has met this criterion by offering standard beneficiary information in English and Spanish. At entry to services and annually, clients are provided with information in English and Spanish services offered to them (**EXHIBITS 10, 11, & 18**), general welcome and correspondence (**EXHIBIT 21**), new client orientation (**EXHIBIT 26**), beneficiary rights (**EXHIBIT 1**), problem resolution processes and forms (**EXHIBITS 4, 6, 9, and 15**), release of information form (**EXHIBIT 16**), informed consent for medication form (**EXHIBIT 19**), discharge criteria and process (**EXHIBIT 3**), compliance hotline (**EXHIBIT 8**), informative mental health materials (**EXHIBITS 7, 12, 14, and 17**), state fair hearings (**EXHIBIT 20**) and privacy practices and advance directives (**EXHIBITS 5 & 13**). Availability of materials in waiting rooms is also monitored for all the Department clinic sites and community based organizations in the provider network. The Department monitors the distribution and availability of these materials through Patient's Rights Advocates checking clinics and service areas whenever they are at said clinics and service areas.

*Criterion 7: Language Capacity*

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

The Department's assessment form includes a section for this documentation (**EXHIBIT 2**).

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

The Consumer Perception Survey (**EXHIBITS 22, 23, 24, & 25**) conducted by the Department is available in the Spanish and other languages, including Tagalog, Vietnamese and Hmong. As summary reports become available, the Department will analyze the outcomes and make recommended improvements.

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

This criterion has not been met. The Department intends to research the best or most efficient method to determine accuracy. Resource availability will determine progress.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).

This criterion has not been met. The Department intends to research the best or most efficient method to determine accuracy. Resource availability will determine progress.

**Exhibits for Criterion 7:**

1. Beneficiary Brochure Mental Health Plan Services (English & Spanish)
2. Cultural Competency Questionnaire
3. Discharge Process
4. ADP Grievance Form (English & Spanish)
5. Advance Directives Form (English & Spanish)
6. Appeal Form (English & Spanish)
7. CARES Facts (English & Spanish)
8. Compliance Hotline (English & Spanish)
9. Mental Health Plan Grievance Form (English & Spanish)
10. Medi-Cal Mental Health Services (English & Spanish)
11. Mental Health Plan Services (English & Spanish)
12. Mental Illness Information (English & Spanish)
13. Privacy Practices (English & Spanish)
14. PTSD Information (English & Spanish)

*Criterion 7: Language Capacity*

15. Request for Second Opinion Form (English & Spanish)
16. Release of Information (ROI) Form (English & Spanish)
17. Schizophrenia Information (English & Spanish)
18. Services for Mental Health (English & Spanish)
19. Informed consent for Medications (English & Spanish)
20. State Fair Hearing (English & Spanish)
21. Welcome to Behavioral Wellness (English & Spanish)
22. Customer Satisfaction Survey – ADULT (English & Spanish)
23. Customer Satisfaction Survey – OLDER ADULT (English & Spanish)
24. Customer Satisfaction Survey – YOUTH (English & Spanish)
25. Customer Satisfaction Survey – FAMILY (English & Spanish)
26. New Client Orientation - Welcoming PowerPoint (English & Spanish)
27. Language Line Flowchart
28. Language Line Poster – Top 20 Common Languages
29. Pre-consumer Access Form

## CRITERION 8: ADAPTATION OF SERVICES

### I. Client driven/operated recovery and wellness programs

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

Partners in Hope is a MHSA CSS program that promotes wellness and recovery through peer support activities in Santa Barbara County. The Partners in Hope Program is a peer-run program providing peer support services to consumers and family members, with the integration of three (3) Peer Recovery Specialists and three (3) Family Advocates with Transitions Mental Health Association (TMH) and the Mental Health Association (MHA). Recovery Learning Communities are located in Santa Maria, Lompoc and Santa Barbara are centers where consumers and family members can get information and resources for care and services in Santa Barbara County and learn more about self-help wellness recovery approach to their own treatment.

Partners in Hope has integrated Peer Recovery Specialists and can promote and model recovery from his or her personal experience, as well as from training in respected curriculums on best practices for mental health recovery. The Department has hired one (1) bilingual/bicultural staff member and has now made it a requirement to have at least one (1) bilingual/bicultural staff member in the Santa Maria Peer Specialist position since the majority of the population is Latino. Peer Recovery Specialists and Family Advocates conduct groups in all three (3) regions of the County. In addition, Partners in Hope has two (2) Peer Recovery Specialists that have AOD experience and conduct groups as well.

### II. Responsiveness of mental health services

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

The Department offers a variety of referral options to meet the cultural needs of consumers. Referrals are done via the ACCESS Team when appropriate for culturally and linguistically appropriate services (i.e.: Spanish speaking network providers, LGBTQ resources, peer counseling, support groups and various natural and community supports). Clinics and contractors refer or offer culturally sensitive services, as well as research evidenced-based culture-specific programs to ensure availability of the most appropriate services within available resources.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

The Department partakes in a variety of outreach and engagement activities to inform the community of the availability of services. Presentations on the availability of services and access to care are frequently provided in community forums such as community centers, schools, churches and during weekend events, such as the Day of the Farm Worker held annually in Santa Maria. Additionally, the Department disseminates written materials that advertise how to obtain services in Santa Barbara County and the availability of the Access Line in English and Spanish (**EXHIBIT 1, 2, 3**).

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.

1. Location, transportation, hours of operation, or other relevant areas.

The Santa Maria Adult/Children Clinic is located on Foster Road in Santa Maria. Peer Recovery Specialists provide rides to and from the clinic for groups if clients schedule with the Peer Recover Specialists beforehand. The local bus transportation system stops at Foster Road and is connected throughout the city.

In Santa Barbara, the Recovery Learning Center (RLC) operates from a central downtown location accessible by multiple modes of transportation, including the local bus transportation system with a stop immediately in front the RLC. The CARES walk-in clinic is also located in located in downtown Santa Barbara.

Lompoc clinics are centralized within the town as it is a geographically small area, making navigation and transportation quick and efficient. The Adult and Outpatient Clinics, Assertive Community Treatment (ACT) program and the RLC are all located on or near the main thoroughfare in Lompoc.

All RLC programs operate during weekdays with varying hours:

- Santa Barbara RLC – 10:00 am to 4:00 pm Mondays, Wednesdays and Thursdays, and 10:00 am to 7:00 pm on Tuesdays.
- Santa Maria RLC – 9:00 am to 5:00 pm Tuesday, Wednesday, Friday, and 11:00 am to 5:00 pm on Thursday.
- Lompoc RLC – 10:00 am to 4:00 pm Mondays, Wednesdays and Thursdays, and 10:00 am to 7:00 pm on Tuesdays.

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

The County follows regulations for facilities to be American's with Disability Act (ADA) compliant and contractors are required to do the same.

Clinic and provider sites are warm, comfortable and inviting to diverse cultural backgrounds. As part of an ongoing System's Change effort, several Department clinics engaged in a lobby redesign project to promote welcoming environments. Clinic teams updated wall colors, furniture and art, including photos and drawings that reflected diverse cultural backgrounds.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and/or partnerships.

The Department's Santa Barbara programs are centralized on a main campus along with Public Health and Social Services that is safe, accessible and well-lit. The Sheriff's Department and the County Jail are in the near vicinity, offering a quick response (usually 3-5 minutes) to requests for assistance. Other programs, such the Recovery Learning Center, are located in community centers in the heart of downtown Santa Barbara.

In Lompoc, the majority of program sites are community based along the main thoroughfare (Ocean Rd.) and is surrounded by shops, restaurants and neighborhoods.

The Santa Maria Adult/Children Outpatient clinic is located on Foster Rd with several other county entities, including a Sheriff's substation and the Food Bank of Santa Barbara County.

### **III. Quality of Care: Contract Providers**

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

During the provider selection process, the Department accounts of the provider's ability to provide cultural competent mental health services. Within the Mental Health Services Statement of Work boilerplate (**EXHIBIT 4**) are several cultural competence requirements, including adherence to reporting requirements on ethnicity, race and language of clients served and staff training completion.

**IV. Quality Assurance**

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

The Department does not currently conduct these activities. The Cultural Competency and Diversity Action Team will develop and incorporate surveys and/or other relevant data gathering techniques in 2017. These surveys will address topics such as:

1. Staff sensitivity to consumer's cultural/ethnic background, separated by age group and/or gender;
2. The convenience of the location of the Department's services; and
3. The convenience of the times that services are offered.

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.

The Department does not currently conduct activities with regards to staff satisfaction measurement. The Cultural Competence and Diversity Action Team will develop and incorporate surveys and assessment measures in 2017 in order to gauge the levels of staff's satisfaction concerning:

1. Staff experience;
2. Staff opinion regarding the Department's level of cultural diversity within the workforce; and
3. Staff views with regards to the Department's current levels of culturally and linguistically competent services.

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

The Department's Quality Improvement Committee (QIC) analyzes data quarterly to assess and address trends and patterns. However, the Department does not currently compare the general beneficiary population with ethnic beneficiaries. Beginning in 2017, the Ethnic Services and

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Diversity Manager will become a standing member of QIC and will collaborate with the Quality Care Management (QCM) division to generate comparison rates.

**Exhibits for Criterion 8:**

1. Behavioral Health Services in Santa Barbara County (English & Spanish)
2. Access Flyer (English & Spanish)
3. Access Cards (English & Spanish)
4. Mental Health Statement of Work – Cultural Competence Excerpt