



# Culturally and Linguistically Appropriate Services

2020-21 UPDATE



COVER SHEET

Document Revision Date: December 2020

Submit update to: [MCBHD.CCPR@dhcs.ca.gov](mailto:MCBHD.CCPR@dhcs.ca.gov)

Name of County: **County of Santa Cruz**

Name of County Behavioral Health Director: **Erik Riera**

Name of Contact: **Cybele Lolley**

Contact's Title: **Quality Improvement Director**

Contact's Unit/Division: **Quality Improvement, Behavioral Health**

**1400 Emeline Ave., Bldg. K**

**Santa Cruz, CA 95060**

Contact's Telephone: **831-454-4671**

Contact's Email: [cybele.lolley@santacruzcounty.us](mailto:cybele.lolley@santacruzcounty.us)

## Table of Contents

Introduction

Criterion #1: Commitment to Culturally and Linguistically Appropriate Services (CLAS)

Criterion #2: Updated Assessment of Service Needs

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

Criterion #4: Client-Family Member Committee- Integration of the Committee within the Mental Health System

Criterion #5: CLAS Training Activities

Criterion #6: Counties Commitment to Growing a Multi-Cultural Workforce- Hiring and Retaining Culturally and Linguistically Competent Staff

Criterion #7: Language Capacity

Criterion #8: Adaption of Services

CLAS Feedback Form

The Table of Contents reflects the Checklist of the Cultural Competence Plan Requirements (2010)

## INTRODUCTION

The County of Santa Cruz Health Service Agency's integrated Behavioral Health Services Division and its community-based providers seek to continuously improve the delivery of a broad range of behavioral health services including prevention and early intervention and mental health and/or substance use disorders treatment, which are based in cultural humility, are culturally responsive and appropriate for the communities that make up Santa Cruz County. Santa Cruz County Behavioral Health Services (BHS) comprises of the Mental Health Plan (MHP) for Specialty Mental Health Services, Serious Emotional Disturbance and the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot initiated in January 2018. The DMC-ODS pilot aims to demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system healthcare costs.

The State of California requires each County Mental Health and Drug Medi-Cal system to have a Cultural Competence Plan. This 2020 Cultural Compliance Plan is an update to earlier plans developed by Santa Cruz County Behavioral Health Services and shall focus on the eight criterions of the State's proposed Cultural Competence Plan Requirement (CCPR).

BHS developed a Cultural Awareness Mission Statement which demonstrates the values of our division. It states:

Our goal of Santa Cruz County Behavioral Health Services is to support our consumers, youth, and family members with culturally appropriate resources, encouragement, tools and skills so they may achieve the quality of life they desire.

As an agency we challenge ourselves to develop ever-greater cultural awareness and sensitivity to acknowledge and embrace individual differences, including language, beliefs, values, attitudes, healing practices, sexual orientation, gender, physical and mental abilities.

We endeavor to build on existing strengths, develop new skills and maximize the opportunity for recovery and optimal health of our community.

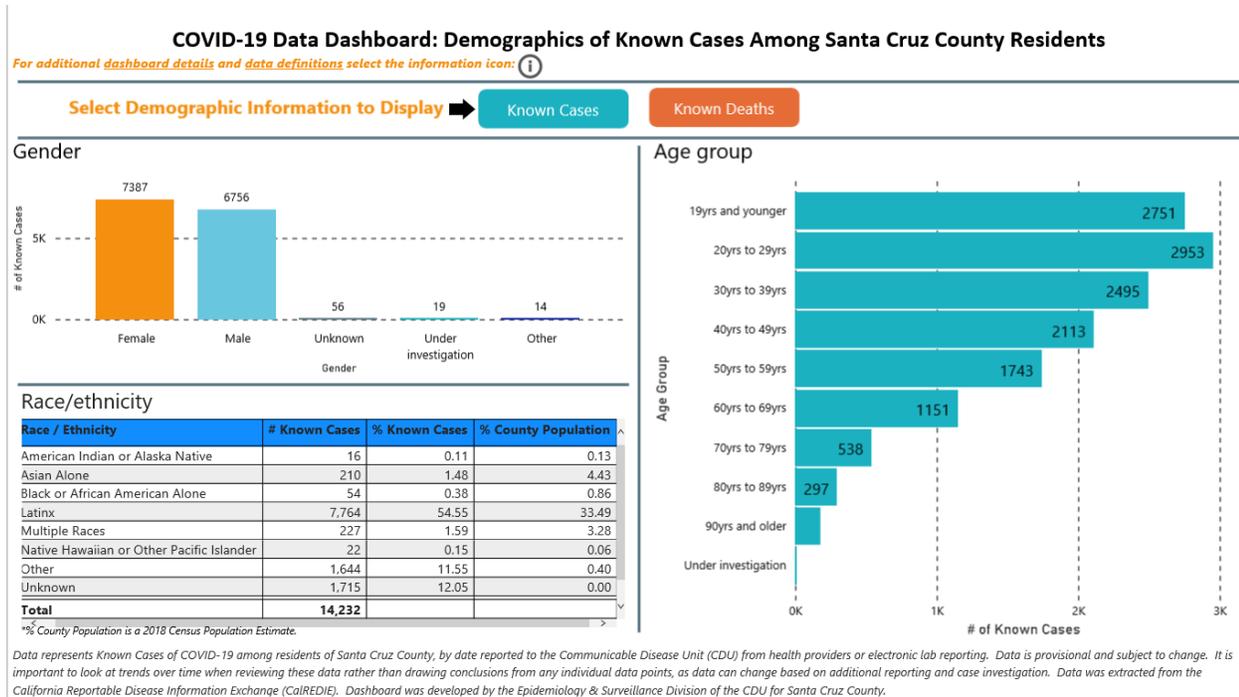
The County of Santa Cruz Behavioral Health Services values providing culturally and linguistically appropriate services. The criterion and questions (**in bold**) are those previously set forth by the State. Santa Cruz County has adopted the term "Culturally and Linguistically Appropriate Services", or CLAS.

In the development of our Cultural Competency Plan, Santa Cruz County Behavioral Health Services has incorporated language that expands on the importance of diversity and inclusion. The terms "cultural humility" and "culturally responsive" have been included in this report to represent the Cultural Competency Plan. BHS values the increased development of staff cultural humility and delivery of culturally responsive services. Cultural humility involves an ongoing process of self-exploration and self-critique combined with a willingness to learn

from others. It centers the relationship with client with the intention of honoring their beliefs, customs, and values; acknowledging differences, and accepting others for who they are. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Responsive” centers client care with the capacity to respond to the needs of clients from diverse cultural backgrounds to improve health outcomes. This includes the increased awareness of the client’s cultural factors and how these impact behavioral health needs, recognition of the providers own culture, and how both affect the patient-provider relationship. These commitments are reflected in day-to-day practice, in policies, procedures, and in the Quality Improvement workplan.

### COVID-19 IMPACT on Santa Cruz County residents

On March 17, 2020, Santa Cruz County began Shelter in Place orders due to COVID-19. Since Santa Cruz County Public Health began the tracking of first COVID + cases, the Hispanic/Latinx community has been impacted the greatest. At the time of writing, there have been 7,764 known Latinx COVID cases, which is 54.55% of all cases and 33.49% of the community populations. Below data shows county-wide demographics.



BHS quickly prioritized the safety of staff and beneficiaries by providing telehealth (phone and video) services and modifying office spaces with safety protocols for those in need of in-person services. This includes the creation of designated computer rooms for those with limited access to technology. To help the transition to telehealth services and become familiar with online platforms, providers offered support to beneficiaries through video and print tutorials, and in collaboration with county IT.

Essential services were kept open to the public with safety protocols in place as well. Although traditional approaches to increasing cultural competency and CLAS services through training, outreach and collaboration were impacted, this report will identify how BHS addressed community need and the reduction of health disparity by transitioning to online formats when possible, modifying office spaces with safety protocols, and collaboration with local agencies to increase technological equity to under resourced communities.

## **CRITERION 1.**

### **COMMITMENT TO CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES**

#### **I. County Behavioral Health system commitment to Culturally and Linguistically Appropriate Services**

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

Santa Cruz County Behavioral Health Services (BHS) has made an intentional effort to reach underserved, unserved, and inappropriately served communities in equitable, new and innovative ways. BHS intends to advance health equity, improve quality, and help eliminate health care disparities. BHS' efforts are guided by The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).

Santa Cruz County follows Culturally and Linguistically Appropriate Services (CLAS) principals and standards throughout County Behavioral Health Services. The Behavioral Health Director works closely with the management team to ensure that all services and programs continue to integrate the values and standards of providing culturally and linguistically appropriate services throughout the County Behavioral Health System.

Santa Cruz County Behavioral Health Services developed specific CLAS standards and enacted policies that include the following:

- Program policies and administrative practices that reflect the cultural, ethnic, and linguistic diversity of the Medi-Cal beneficiary population to be served.
- Integrating the value of cultural diversity throughout the Division and to provide the most culturally and linguistically appropriate services possible to beneficiaries.
- Provide services to beneficiaries at locations within the county, and through telehealth to increase accessibility to the populations we serve.
- Utilization of Human Resources to develop policies that enable managers to specify bilingual staff recruitment in positions and advertisements.
- Expansion of training policies to increase staff access to training in cultural & linguistic issues. The expectation is for all staff to complete these trainings on a yearly basis. Current policy identifies staff training to be 7 CLAS course credits annually.
- Every employee in the Division is responsible for ensuring that CLAS issues are addressed in all programs, proposals, and descriptions.

Related policies and procedures include:

- ⇒ Behavioral Health Network Adequacy, Policy 2107, Section 9.e & f
- ⇒ Implementing Culturally & Linguistically Appropriate Services, Policy 3101
- ⇒ Linguistically Appropriate Services, Policy 3105
- ⇒ Service Access for Visually or Hearing Impaired, Policy 3108
- ⇒ Contract Requirements for Cultural Competence Standards, Policy 3111
- ⇒ Outreach to Medi-Cal Beneficiaries, Policy 3113
- ⇒ Availability of Culturally Competent Staff, Policy 3115
- ⇒ Culturally & Linguistically Appropriate Services Education Plan, Policy 3116

**B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system.**

**The vision of the County is....**

*Santa Cruz County is healthy, safe and more affordable community that is culturally diverse, economically inclusive and environmentally vibrant.*

**Mission:** An open and responsive government, the County of Santa Cruz delivers quality, data-driven services that strengthen our community and enhance opportunity.

**3-Tier Values System:**

1. The County of Santa Cruz provides services and supports partnerships built on: Accountability, Collaboration, Compassion, Effectiveness, Innovation, Respect, Support, Transparency, and Trust.
2. HSA Values: BHS is a department of Health Services Agency (HSA), with the departmental mission to promote and ensure a healthy community and environment by providing education, outreach and comprehensive health services in an inclusive and accessible manner. The values of the HSA department are: Integrity, Quality, Compassion and Respect, Equity and Justice, Collective Impact, Capacity Building and Positivity.
3. BHS Values: In 2020, BHS identifies key values for our particular division by conducting surveying of current MHP and DMC-ODS providers and active clients to prioritize key BH-specific values based on foundational work done by both County, HSA and Trauma-Informed Principles. These values shall drive our MHP and DMC-ODS focus areas and be included in operational decisions and quality improvement work plans.

The values of the BHS division are:

<b>Inclusion &amp; Engagement</b>	Cultural humility & responsiveness • Human connection and relationship • Universal dignity, respect, kindness, and compassion • Offerings of support and gratitude • Transparency and collective communication • Timely accessibility • Inclusion of client voice/choice • Dependability
<b>Operational Excellence &amp; Service Stewardship</b>	Excellent effective care and customer service delivery • Adaptability • Ethics • Responsibility • Accountability • Innovation • Utilize outcomes to improve care, support program decisions and share with other healthcare providers and the greater community.

<b>Targeted Treatment &amp; Evidence-Based Services</b>	Trauma-informed care • Individualized “Voice & Choice” care • Targeted Health • Clinical quality & fidelity to EB practices • Utilize data outcome to inform decisions • Workforce Training
<b>Equity &amp; Sustainability</b>	Promote resiliency and recovery (personal/social/environmental/economic) • Collective impact • Equity for All • Justice • Integrity • Collaboration • Holding hope & Eliminating stigma • Positivity • Capacity building
<b>Safety</b>	For all who provide and receive services from BHS, including staff, clients, contractors, partners, stakeholders, and our community at large. Safety includes physical, emotional and self-care when at county facilities, remote work setting and/or in community

Copies of the following are available:

- Behavioral Health Strategic Plan
- BHS QI Work Plan 2020-21
- Policy and Procedures
- Contract Requirements

**County Recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system**

**A. A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural and linguistic communities with mental health and substance use disorder disparities; including recognition and value of racial ethnic, cultural and linguistic diversity within the system.**

The County of Santa Cruz Behavioral Health Services (BHS) recognizes the value of racial, ethnic, cultural, and linguistic diversity within our system. Through the existing programs and support of Mental Health Services Act (MHSA), BHS can do outreach and establish cultural and linguistically appropriate practices, activities, and programs that are tailored to our diverse community.

South Santa Cruz county remains a focus of outreach efforts due to their large Spanish speaking, immigrant, and Mexican and South American indigenous populations. These communities include the city of Watsonville and Pajaro and often face extra challenges in accessing mental health services due to stigma, language and literacy needs, fear of deportation, impacts of structural racism in education, employment, and criminal justice systems, and limited financial resources.

**The Mariposa Wellness Center:**

Our Wellness Centers are a prime example. The Mariposa Wellness Center is located in Watsonville, which is largely a Latino community. This Wellness Center promotes consumer-operated services to support recovery, and strives to reflect the cultural, ethnic and racial diversity of mental health consumers. The center is a place for families and adult consumers to share information, learn about services and get support for engaging in wellness and educational activities. Due to the COVID-19 pandemic modifications to in-person services were made by providing limited in-person mental health groups at the center with safety protocols in place, as well as mental health zoom groups and individual sessions both via telephone and in-person. The Mariposa Wellness Center continues to collaborate with

Second Harvest by providing food distribution and delivery to their clientele during the Shelter-in-Place order to those in need. They have also collaborated with the Santa Cruz Warriors to provide care packages for Thanksgiving for the most in need clientele in Watsonville. Health literacy around Covid and Mental Health was made to Spanish and Mixtec speaking communities. This effort was made in collaboration with the LISTOS program, and information was provided in both English, Spanish, and Mixtec as well as bags of groceries that were delivered. Programs such as Mariposa are part of a national movement to promote recovery.

### **Mental Health Client Action Network (MHCAN):**

Another successful program is the (MHCAN), located in Santa Cruz. MHCAN is a peer run, self-help, drop-in center where people with psychiatric disabilities can congregate and socialize in a safe place, free from the stigma of mental illness imposed by society. Due to the Covid-19 pandemic, MHCAN shifted their services from in-person to online by providing virtual 1:1 peer support, classes, and support groups such as: physical fitness, 12-step groups, self-care, relapse prevention, substance use, mental wellness, and recreational opportunities such as role-playing games, poetry, chess. MHCAN's peer-based model helps clients reclaim their dignity through self-help.

### **Community Partners:**

#### **NAMI-SCC**

The Santa Cruz County chapter of the National Alliance for Mental Illness (NAMI) continues to offer support groups and classes in English and Spanish, and speaker events during the pandemic through online platforms, as well continuing to offer their emotional support and resource (phone) line for those with mental health conditions and their family members. BHS continues to work collaboratively with NAMI-SCC as through our Behavioral Health Crisis Intervention Team and share resource information to all teams to encourage beneficiaries and their family members to seek support. This year NAMI-SCC shared their list serve to help BHS promote the Stakeholders events mentioned above. NAMI-SCC also offers Provider Trainings for BHS, which helps to expand clinician's awareness of the experiences, challenges, and strengths of mental health beneficiaries and their families as they navigate the mental health system, and how to increase support and collaboration with client wellness teams.

#### **Community Action Board (CAB).**

CAB is a community-based program which strives to eliminate poverty through collaboration, social change, advocacy, and connection to essential services. They offer whole-person services throughout Santa Cruz County to underserved communities, including at-risk youth and immigrants. Workgroups were planned in 2020 to continue the connection and dialogue with the focus groups, however due to the COVID-19 pandemic, these workshops were postponed to explore considerations options for safe and equitable participation. Technological means, such as Zoom were considered, however, based on the challenges facing many of our populations, the current pandemic, and available support/resources; the

decision was made to move forward in the planning process with the data available from the previous 2019 community stakeholders meetings.

### **CAB Parent Support Group:**

BHS's collaboration with the Community Action Board (CAB) expanded this year to include the development of a parent support group for parents with youth on probation. The parent support group curriculum is provided in Spanish as parents attending are primarily monolingual Spanish speaking. The curriculum is developed and facilitated by two Childrens Behavioral health staff and two CAB staff members. Curriculum topics include: self-esteem, safety, COVID-19 impacts on community, sex education, positive parenting skills, identity, mindfulness, and reproductive health, healthy and relationships. The parent support group has evolved to include established curriculum as well, including LISTOS California (disaster preparation information in Spanish), and Cara y Corazon, a culturally based family strengthening program. The parent support group was transitioned to a virtual (on-line) meeting space due to the COVID-19 pandemic. Facilitators provided technical support to attendees to help with access and education on utilizing laptops, computers, tablets, and smart phones as well as on-line meeting platforms. Referrals to the parent support group are currently placed through Santa Cruz County Juvenile Probation.

### **BHS' Recovery Wave Internet Substance Use Disorder Recovery Resources**

The Recovery Wave internet page is available in English and Spanish. Here is the link to the Spanish page: [http://www.recoverywave.org/LA\\_OLA/index.html](http://www.recoverywave.org/LA_OLA/index.html) and English: <http://www.recoverywave.org/>

The listed community and treatment provider services offer services in Spanish, such as 12-Step programs, Refuge Recovery and DMC-ODS treatment providers.

### **COE Student Success:**

On September 30, 2020 Childrens Behavioral Health hosted, in collaboration with the Santa Cruz County Office of Education, the Student Success Project Family Focus Forum. This online focus forum centered the needs of Pajaro Valley Unified School District (PVUSD) families (an under-resourced, primarily Spanish speaking community in south Santa Cruz County), and included breakout groups in English and Spanish to focus on tools for success in distance learning and an opportunity to voice parent and student needs. Participants received certificates of participation/recognition and a \$20 Gift Card.

### **Presentations:**

Behavioral Health Services provided presentations at events hosted by the Special Parents Information Network (SPIN), the Diversity Center, Santa Cruz County Immigration Project (SCCIP), Pajaro Valley Prevention and Student Assistance (PVPSA), Calciano Youth Symposium and the Santa Cruz Libraries. These presentations focused on Mental Health services for adults and children, distance learning support, youth empowerment, and the impact of COVID-19 on mental health.

### **Pajaro Valley Prevention and Student Assistance (PVPSA):**

BHS regularly collaborated with PVPSA, a local agency in Watsonville which focuses on serving students and families of the Pajaro Valley by providing health education, mental health counseling, substance abuse and prevention services, as well as community policy advocacy. In March 2020, PVPSA became a DMC-ODS provider to focus on serving south county Hispanic/Latinx youth. In addition to Santa Cruz County Behavioral Health staff presenting and participating at events hosted by PVPSA, PVPSA regularly sends newsletters, and promotion of events that focus on parent information, advocating for student equity, and youth empowerment. These materials are shared with beneficiaries as many receive services through Santa Cruz County Behavioral Health and PVPSA.

### **Mobile Emergency Response Team for Youth (MERTY):**

MERTY is in the early phases of an outreach program for their services, targeting our south county partners including (but not limited to): Salud Para La Gente, Doctors on Duty, PVPSA, Watsonville Hospital, PVUSD, and Kaiser. MERTY expands the mobile emergency response team to serve south Santa Cruz county youth (5-21 years old) and includes a Behavioral Health mobile office van and bilingual clinician and family specialist.

### **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 alcohol and drug BH commissions, and community organizations in the behavioral health system's planning process for services.**

Santa Cruz County Behavioral Health Services (BHS) staff and contract providers engage with the diverse clientele and family members who reside within the community. We provide Prevention and Early Intervention programs to persons across the lifespan, including culturally and linguistically appropriate services to infants, preschoolers, teenagers, adults, older adults and parents. The Behavioral Health Director attends the Local Behavioral Health Board monthly, and other staff and managers attend upon request. The Behavioral Health Department Directors facilitate bi-weekly to monthly Contractor & Partner meetings where updates on services are provided. County staff participate in a variety of boards and commissions, such as the Santa Cruz Community Foundation Diversity Partnership Advisory Board, the Queer Youth Task Force, Trauma-Informed Consortium, Special Education Local Plan Area (SELPA), Harm Reduction Coalition and Justice Council. We have close partnerships with law enforcement, county jail, juvenile hall, probation, child welfare, schools, health clinics, local shelter facilities, food pantry service providers and community-based agencies. Santa Cruz County is geographically small, and staff are able to have close working relationships with a variety of service providers, which enhances our ability to engage and coordinate services for consumers in a variety of locations. Due to the close partnership between Behavioral Health, Santa Cruz County Office of Education, and School Districts throughout Santa Cruz county, both students and their families have been able to receive referrals to needed services, and creative efforts have been made to meet the mental health and substance use disorder needs of undocumented students and their families.

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

Substance Use Disorders Services (SUDS) has a robust Spanish speaking team which provides SUDS client's greater choice in providers. With the increased number of bilingual providers, SUDS now offers outpatient group services in Spanish. SUDS provides presentations to county Integrated Behavioral Health (IBH) on their Spanish speaking substance use services, and outreaches to local substance use treatment programs such as Janus and New Life, as well as at monthly network provider meetings. Additionally, BHS has MHP Spanish speaking staff members who are dedicated to meeting the culturally appropriate needs of their clients and offer input and suggestion on how to increase such services across the division.

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally appropriate workforce, and to include individuals with client and family member experience who can provide client- and family-driven services, that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes.

Due to the COVID-19 pandemic, in-person trainings were not available for the majority of 2020, therefore access to culturally responsive education, training and workforce development was expanded to include webinars, videos, on-line trainings and conferences, and book club discussion groups. This expansion facilitated the creation of a CLAS Education Plan Policy which was implemented on 12/7/2020. Topics offered through this education plan include:

Cultural & Linguistic Appropriate Services trainings, such as:

- Effects of implicit bias in the workplace, community, client-care, and organization.
- LGBTQIA Voices of Color
- Cultural Case Formulation and Assessment
- Barriers in Mental Health Services for Trans, Queer and Non -binary Latino Communities
- The mental health impacts of COVID-19 on Latinx, immigrant, LGBTQ+, elder communities.
- Racial injustice and trauma in mental health settings and in client experiences.
- Delayed due to COVID and reallocated resources.
  - Culturally sensitive ASAM Assessments
  - Providing Trans-Affirming Care
  - Communicating Effectively through an Interpreter
  - Triangle Speakers – Queer diversity training
  - Trauma-Informed Systems
  - NAMI (Peer to Peer, Family to Family)
- 2019 Calciano (Community training) focused on ACES (Adverse Childhood Experiences) and treatment

### Additional CLAS Training Opportunities:

The Cultural COMPASS newsletter is distributed by the Childrens Behavioral Health Cultural Humility Sub-Committee (a sub-committee under TIS) and includes current culturally responsive topics impacting clients and staff, and offers education, clinical considerations, and resources to help increase staff cultural humility and quality of CLAS. Each newsletter contains a set of discussion question that supervisors facilitate at weekly team meetings.

Topics covered by the Cultural COMPASS include:

- Systemic Racism
- Provide culturally sensitive and appropriate services during pandemic
- White Supremacy
- White Fragility
- Indigenous Perspectives
- Neurodiversity

The White Fragility and White Supremacy newsletters were followed by all-staff break out group discussions, as these topics require smaller, more intentional spaces to manage challenging emotions that may arise.

This year, the Cultural Humility Sub-Committee, QI, and Management team began discussing and planning the expansion of the Cultural Humility Sub-Committee focus areas to be inclusive of Behavioral Health Staff and client topics.

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

**A. Evidence that the County Behavioral Health 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.**

The Santa Cruz County Behavioral Health Services (BHS) has designated a person who is identified as the Cultural Competence/CLAS Coordinator. Our current CLAS Coordinator is of bi-lingual bi-cultural Spanish ethnicity. The CLAS Coordinator collaborates with other department staff, behavioral health committees, contracting agencies, and assigned managers to spear the BHS' efforts to increase culturally responsive services. Related staff development trainings and other educational opportunities are provided so that the diverse needs of the county's racial, ethnic, cultural, and linguistic populations are being met. However, the responsibility for ensuring the provision of culturally and linguistically appropriate services is not the sole responsibility of one person. We believe that these standards need to be infused throughout our division, and therefore is the responsibility of every staff person.

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

The CLAS Coordinator reviews CLAS-related policy, in accordance with State and Federal Regulations, and along with the core leadership team evaluates the competencies of staff in providing culturally competent services. The CLAS Coordinator is a vital member of the Quality Improvement Steering Committee. Other responsibilities include:

- Identifying needed CLAS trainings and coordinating trainings with the training team
- Evaluating Cultural Competence educational opportunities outside of our own offerings
- Updates to the CLAS Plan
- Supporting in updating CLAS policies and procedures
- Logging completed CLAS hours
- Providing support to staff and management in matters related to acquiring and tracking CLAS hours.
- Attend Quality Improvement Steering Committee meetings
- Participating in the agency's adoption of a Cultural Humility model
- Attending Cultural Humility Sub-Committee meetings
- Attending EQRO audit meetings and other DHCS audit sessions
- Attending Cultural Competency, Equity and Social Justice (CCESJC) monthly State and Regional Meetings

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

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

The Santa Cruz Behavioral Health Services (BHS) pays a differential for bilingual staff that provide bilingual services. In addition, BHS has designated funding to support community meetings, public forums, focus group meetings, which may require translation and/or interpretation services. BHS has a budget to pay for translation and interpretation needs of non-threshold language needs. There is also a budget for workshops, community meetings, trainings, and staff development needs as they relate to CLAS and assuring that these standards are adhered to throughout the division's organization as well as its contractors.

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

###### **1. Interpreter and translation services;**

BHS has a designated budget to cover costs for translation and interpretation needs of threshold language needs, including ASL. BHS pays a differential hourly rate for bilingual staff who are required to provide bilingual services to their monolingual Spanish-speaking clients. Santa Cruz County provides funding to support community meetings, public forums, focus group meetings, which may require translation and/or interpretation services in the threshold language.

###### **2. Reduction of racial, ethnic, cultural, and linguistic behavioral health disparities;**

BHS statistics confirm that there is a disparity in access and service delivery to the Latino community and to persons speaking the threshold language (Spanish). BHS' mental health

services penetration rate is slightly higher than the state average. DMC-ODS penetration rate is slightly lower than the state average. Regardless to the state comparison data, we realize that these numbers are quite low for our mission and community needs. As such, increasing access to services for Latinos was established as an overall goal for the Mental Health Services Act and DMC-ODS. Our BHS QI work plan includes an increased focus on addressing disparities.

BHS continues to provide South County services in our larger facility to provide increased access to behavioral health services in a welcoming environment, including substance use disorder services and psychiatric services. In addition, the new behavioral health clinic remains on the same campus as the county medical clinic, to promote access to holistic culturally and linguistically appropriate medical services. One particularly successful strategy to address disparities in access among underserved populations includes the early decision to locate BHS' second Wellness Center program, Mariposa, in the heart of downtown Watsonville, a community which houses a large number of Latino Medi-Cal beneficiaries and their families.

BHS used Workforce Education and Training funds to develop behavioral health materials, in English and Spanish, which are used to provide awareness and education for consumers, youth and family members of diverse racial, ethnic, cultural, and linguistic populations in the county. BHS is committed to ensuring that client forms are published in English and Spanish and distributed simultaneously to avoid language disparity and use of outdated forms. Worksheets and Safety Plans are encouraged to be reviewed for linguistic and cultural relevancy.

The BHS Prevention & Early Intervention (PEI) Plan also focuses on addressing the existing disparities in every project.

### **3. Outreach to racial and ethnic county-identified target populations;**

The funding for this comes primarily from the Community Services and Supports and the Prevention & Early Intervention components of the Mental Health Service Act; and SABG prevention funding.

The Community Services and Supports (CSS) plan and funds are organized around 4 population groups defined by age: children, transition age youth (16-25), adults, and older adults. We consider the needs of individuals who are currently unserved by the behavioral health system and the needs of those who are under-served or inappropriately served in each of the four groups. Increasing access to services to Latinos and Mixteco bajo speaking communities was established as an overarching goal for the plan.

Our outreach efforts in the Prevention Early Intervention (PEI) Plan are focused on engaging persons prior to the development of serious mental illness or serious emotional disturbances, or in the case of early intervention, to alleviate the need for additional mental health treatment and/or to transition to extended mental health services. Each project in this plan also addresses disparities in access to services by including a focus on the needs of Latino

children/families, as well as lesbian, gay, bisexual, transsexual, and questioning (LGBT) youth and their families.

Examples of our outreach efforts include (but are not limited to) the following:

- Coordination of services with county primary care clinics with a focus on predominantly Spanish speaking community in Watsonville.
- Veteran Advocate to engage, support and link to services in the community
- High school outreach to inform, educate, and dispel myths about mental illness, and encourage students to consider public sector careers in behavioral health.
- Establishment online and print materials describing signs and symptoms of mental illness and substance use disorder to provide awareness, education and direction for consumers, community partners and family members.
- Community presentations at non-profit agencies, NAMI, local high schools, community colleges and universities.
- Sheriff and Police Liaisons. Mental Health clinicians respond with law enforcement to assess mental health issues and engage individuals in services. Currently we are partnered with the Santa Cruz Police Department, the County of Santa Cruz Sheriff Department, and the Watsonville Police Department.
- Local school district presentations
- SUDS and Family Preservation Court education collaboration to increase awareness of SUD challenges on family stability.

#### **4. Culturally appropriate behavioral health services;**

Currently the Behavioral Health Director works closely with the MHSA Coordinator, Quality Improvement Director, CLAS Coordinator, and all management staff to ensure that all services/programs continue to integrate CLAS values and standards throughout the County Behavioral Health System.

We offer trainings with the overarching goal of increasing culturally appropriate skills in order to improve behavioral health services. Trainings reflect the core values of consumer and family driven services, community collaboration, recovery/resilience strength-based services, integrated services, and increasing cultural awareness and skills.

#### **5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.**

Santa Cruz County Behavioral Health Services (BHS) designates some positions as bilingual only and encourages bilingual/bicultural persons to apply for all positions. Santa Cruz County Personnel Department evaluates and certifies staff in their ability to use Spanish (our threshold language). Staff passing level one (1) are able to communicate orally. Staff passing level two (2) are also able to read and write in another language. Staff that are certified as being bilingual receive a differential in pay. The current CLAS Coordinator is certified as bilingual level 2 as well as other Quality Improvement staff.

## **CRITERION 2**

## UPDATED ASSESSMENT OF SERVICES NEEDS

### I. General Population

Recent (2019) estimates of Santa Cruz County, the population in Santa Cruz County is between 251,413- 262,382 (a difference within 10,000) according to US Census Bureau. Santa Cruz County has only one region.

Population Demographics by Race		
Race	Population	% of Total
<b>Total Population</b>	262,382	100
White	190,208	72
Hispanic or Latino	84,092	32
Some Other Race	43,376	16
Two or More Races	12,318	4
Asian	11,112	4
Black or African American	2,766	1
American Indian	2,253	Below 1%
Three or more races	1,087	Below 1%
Native Hawaiian Pacific Islander	349	Below 1%
Native Hawaiian	155	Below 1%

Population Demographics by Race and gender.			
	Male	Female	Total
<b>Total Population</b>	130,913	131,469	262,382
White	94,629	95,579	190,208
Hispanic or Latino	42,749	41,343	84,092
Some Other Race	22,171	21,205	43,376
Two or More Races	6,114	6,204	12,318
Asian	5,062	6,050	11,112
Black or African American	1,603	1,163	2,766
American Indian	1,160	1,093	2,253
Three or more races	541	546	1,087
Native Hawaiian Pacific Islander	174	175	349
Native Hawaiian	79	76	155

Demographic population of multigenerational homes	
homes in Santa Cruz County with multiple generations.	
Total Population:	94,355
Home has three or more generations:	3,860
Home does not have three or more generations:	90,495

**Male Age Breakdown:**

Population in households in Santa Cruz County	
Total Population:	251,413
Male Population:	125,178
Under 5 years:	7,702
5 to 9 years:	7,677
10 to 14 years:	7,886
15 to 17 years:	4,954
18 and 19 years:	3,807
20 years:	2,594
21 years:	2,743
22 to 24 years:	6,095
25 to 29 years:	8,825
30 to 34 years:	7,996
35 to 39 years:	7,938
40 to 44 years:	8,389
45 to 49 years:	8,993
50 to 54 years:	9,555
55 to 59 years:	9,622
60 and 61 years:	3,601
62 to 64 years:	4,400
65 and 66 years:	2,134
67 to 69 years:	2,507
70 to 74 years:	2,848
75 to 79 years:	1,896
80 to 84 years:	1,537
85 years and over:	1,479

**Female Age Breakdown:**

Female Population:	126,235
Under 5 years:	7,256
5 to 9 years:	7,342
10 to 14 years:	7,408
15 to 17 years:	4,811
18 and 19 years:	3,448
20 years:	2,408
21 years:	2,566
22 to 24 years:	5,518
25 to 29 years:	8,296
30 to 34 years:	7,823
35 to 39 years:	7,695
40 to 44 years:	8,472
45 to 49 years:	9,359
50 to 54 years:	10,134
55 to 59 years:	9,875
60 and 61 years:	3,447
62 to 64 years:	4,473
65 and 66 years:	2,235
67 to 69 years:	2,707
70 to 74 years:	3,238
75 to 79 years:	2,600
80 to 84 years:	2,397
85 years and over:	2,727

The overall breakdown of the population is: 50/50% female/male; race of 72% White (Not of Latino origin), Latinos make up 32% of the county population, 4% are Asian, 1% are African-Americans, and remainder include American Indian and Alaskan Native persons; and age. Regarding age, 11% of the population is over 65 years old; persons under 18 years comprised 22% of the population, and 18-64 years old equals 67%. The primary language in Santa Cruz County is English, with 31.9% of households speaking a language other than English. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.4%) is female.

**II. Medi-Cal population service needs**

The average monthly Medi-Cal enrollment is 77,537 indicated in available 2018 data.

The Medi-Cal population and client utilization rate by race, ethnicity, age, and gender, are as shown below. In Santa Cruz the breakdown of the Medi-Cal monthly population served for mental health needs by race is 37.2% White (Not of Latino origin), Latinos make up 38.4% of the county served population, 2.0% African-Americans, 1.5% Asian/Pacific Islander and 0.6% American Indian and Alaskan Native persons served.

**Total Beneficiaries Served** Table 1 provides details on beneficiaries served by race/ethnicity in the Mental Health Plan (MHP) for Calendar Year 2018.

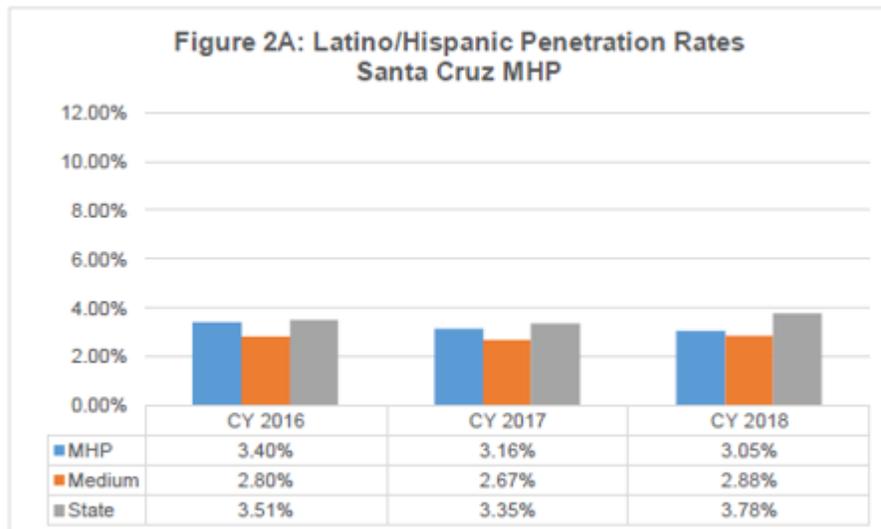
Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Santa Cruz MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	21,327	27.5%	1,240	37.2%
Latino/Hispanic	41,980	54.1%	1,281	38.4%
African-American	724	0.9%	68	2.0%
Asian/Pacific Islander	1,563	2.0%	50	1.5%
Native American	320	0.4%	19	0.6%
Other	11,626	15.0%	679	20.3%
<b>Total</b>	<b>77,537</b>	<b>100%</b>	<b>3,337</b>	<b>100%</b>

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

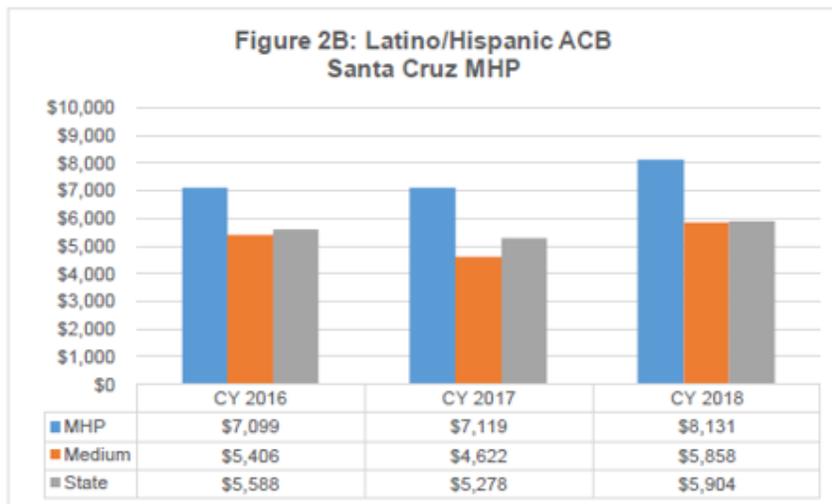
**Source of data:** FY 2019-20 Medi-Cal Specialty Mental Health External Quality Review

### MHP Beneficiaries Latino/Hispanic Penetration Rates in FY 2018-19

The primary language in Santa Cruz County is English, and threshold language is Spanish. Santa Cruz County is a Medium sized MHP. Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP’s Latino/Hispanic penetration rates and annual average approved claims per beneficiary (ACB), compared to both the statewide and medium MHPs average.



**Source of data:** FY 2019-20 Medi-Cal Specialty Mental Health External Quality Review

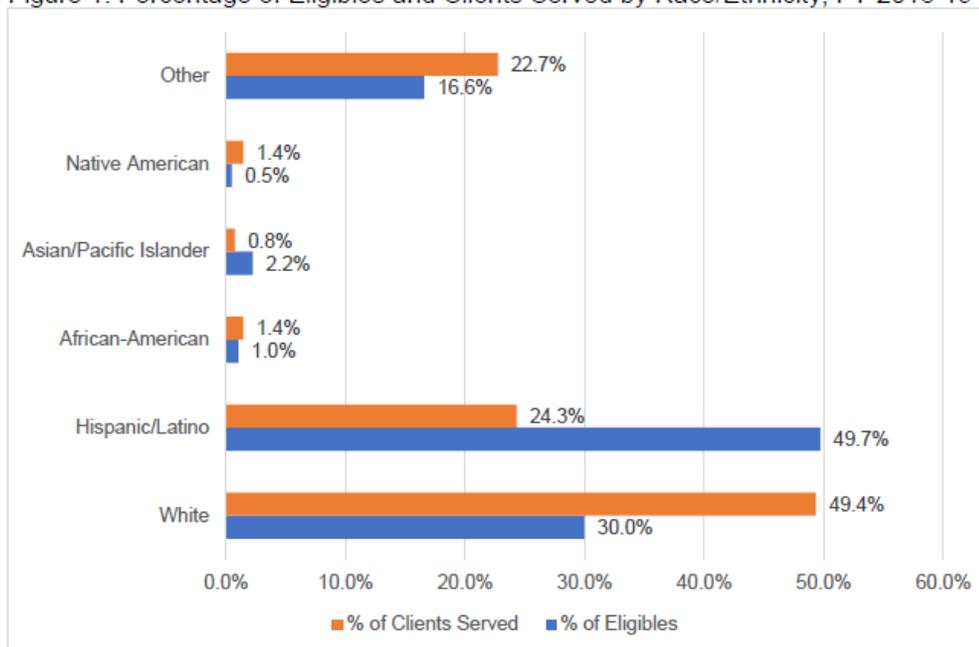


**Source of data:** FY 2019-20 Medi-Cal Specialty Mental Health External Quality Review

### DMC–ODS Beneficiaries Served by Race/Ethnicity in FY 2018-19

BHS Substance Use Disorder DMC-ODS services network-wide include 49.4% White, 24.3% Latino, 1.4% Native American, 1.4% African-Americans, and 0.8% Asian/Pacific Islander for FY18-19.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19



**Source of data:** FY 2019-20 Drug Medi-Cal Organized Delivery System External Quality Review

## DMC-ODS, Penetration Rates, by Race/Ethnicity, FY 2018-19

Table 3 that follows shows the DMC-ODS penetration rates by race/ethnicity compared to medium counties and statewide rates. White clients had the highest penetration rate at 4.19%, followed by African Americans at 3.58%. The Latino/ Hispanic population's penetration rate was relatively low compared to other race/ethnicity groups at 1.24 percent, but still higher than the statewide average.

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19					
Santa Cruz				Medium Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	17,247	723	4.19%	1.92%	1.77%
Latino/Hispanic	28,613	356	1.24%	0.55%	0.66%
African American	586	21	3.58%	1.51%	1.27%
Asian/Pacific Islander	1,282	*	n/a	0.25%	0.16%
Native American	283	*	n/a	1.87%	1.62%
Other	9,537	333	3.49%	1.37%	1.05%
<b>TOTAL</b>	<b>57,548</b>	<b>1,465</b>	<b>2.55%</b>	<b>1.05%</b>	<b>0.93%</b>

**Source of data:** FY 2019-20 Drug Medi-Cal Organized Delivery System External Quality Review

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

Overall penetration rates have been low, which is in alignment with statewide average and that of similar sized MHPs. Latino penetration rates have consistently been higher than statewide and similar sized MHP averages. Santa Cruz County Behavioral Health continues to investigate and address the underlying reasons for low Latino/Hispanic penetration rates, including obtaining a community perspective, expanding outreach efforts, and meeting the linguistic needs of the community.

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year. Regarding the calculation of penetration rates, the Santa Cruz MHP uses the same method used by CalEQRO.

The race/ethnicity results in the DMC-ODS table can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total beneficiaries served as clients. As the table shows, there are distinct differences. Those persons who are White accessed DMC-ODS services more readily than others, at a rate of more than twice their proportions of enrollees. In contrast, persons who are Latino/Hispanic were less likely to

access treatment. Data for other ethnic groups is limited, with the exception of the “Other” race/ethnicity, who appear to be accessing services proportionately. Santa Cruz is exploring the reasons for low utilization by some subgroups and what can be done to increase it, especially within the Hispanic/Latino community.

**DMC-ODS, Penetration Rates, by Age, FY 2018-19**

Table 1 shows Santa Cruz’s penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties. Santa Cruz has a higher overall penetration rate of 2.55% compared to the consolidated rate for all DMC-ODS counties statewide of 1.05%. Santa Cruz County served 1,465 clients in FY 2018-19 which was an increase of 588 (67%) from FY 2017-18.

Table 1: Penetration Rates by Age, FY 2018-19

Table 1: Penetration Rates by Age, FY 2018-19					
Santa Cruz				Medium Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	8,696	61	0.70%	0.20%	0.27%
Ages 18-64	42,538	1,287	3.03%	1.27%	1.12%
Ages 65+	6,312	117	1.85%	0.97%	0.69%
<b>TOTAL</b>	<b>57,546</b>	<b>1,465</b>	<b>2.55%</b>	<b>1.05%</b>	<b>0.93%</b>

Source of data: FY 2019-20 Drug Medi-Cal Organized Delivery System External Quality Review

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

**A. Summarize the 200 % of poverty**

Population and poverty estimates may not be comparable to other geographic levels due to methodology differences that exist between different data sources.

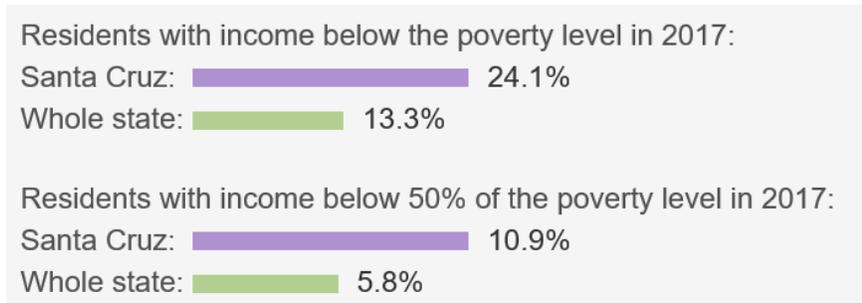
The 2017 US Census Bureau Small Area Health Insurance Estimates, reports that of the counted 222,179 residents under the age of 65 years old, there were 16,345 Uninsured individuals (7.4%). This data includes all races, sexes and incomes.

**Santa Cruz Poverty Data for 2018**

In 2018, Santa Cruz County is ranked 28<sup>th</sup> among counties within California, with 14.7% of residents living in poverty. The poverty line for California in 2018 is based on the federal guidelines, which begins at \$12,140 for a single person, adding \$4,320 for each additional person. Poverty Statistics for Santa Cruz County, July 2018 Estimate, US Census Bureau Statistics indicate the total Santa Cruz County population estimate as 274,255

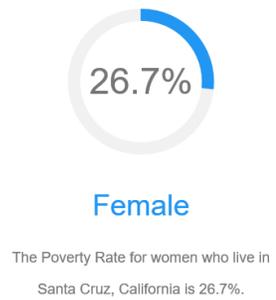
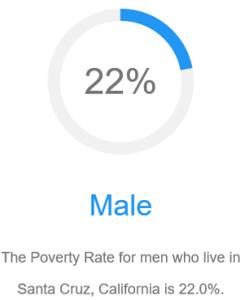
Based on 2017 data, the poverty rate across the state of California is 13.3%. The Santa Cruz poverty rate is 24.1%. One out of every 4.1 residents of Santa Cruz live in poverty. 13,326 of 54,577 Santa Cruz residents reported income levels below the poverty line in the last year.

Santa Cruz has a dramatically higher than average percentage of residents below the poverty line when compared to the rest of CA.



Below is a table that compares 2017 Santa Cruz populations based on ethnicity with the national poverty rate.

Race	Population	Poverty Rate	National Poverty Rate	Population
Asian	3,584	38.7%	11.9%	5.6%
Other	2,835	38.7%	23.8%	4.4%
Two Or More Races	3,389	24.8%	18.4%	5.3%
White	37,596	19.8%	10.3%	58.8%
Hispanic	10,349	37.2%	22.2%	16.2%



Breakdown of Santa Cruz, California Poverty Rate By Age

Age	Poverty Rate
Children Under 6	15.5%
Children 6 to 11 Years Old	17.2%
Adolescents 12 to 17 Years Old	30.2%
Adults 18 to 59 Years Old	29.2%
Adults 60 to 74 Years Old	10.9%
75 to 84 Years Old	8.8%
Over 85 Years Old	12.1%

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

There are several disparities identified on this poverty and utilization data. Approximately 1/4 of Santa Cruz County residents are under the 200% poverty level: 1 in 4 individuals. The largest age group percentage is the 63% of minors under the age of 18 years old. Next is the adult 18-59 year old age group with approximately 29% of those individuals in this age group meeting the poverty threshold. Hispanic individuals have twice the rate of poverty when compared to White, non-Hispanics within those groups: approximately 37% of Hispanic individuals meet the poverty criteria, vs. 20% of white, non-Hispanic individuals. Slightly more females (26.7%) meet the poverty levels compared to males (22%).

**IV. MHSA Community Services and Supports**

**A. From the county 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).**

**Population Assessment:**

The population in Santa Cruz County is estimated to be around 262,382 for 2019. As mentioned above, the overall breakdown of the population is: 50/50% female/male; race of 72% White (Not of Latino origin), Latinos make up 32% of the county population, 4% are Asian, 1% are African Americans, and remainder include American Indian and Alaskan Native persons; and age. Regarding age, 11% of the population is over 65 years old; persons under 18 years comprised 22% of the population, and 18-64 years old equals 67%. The primary language in Santa Cruz County is English, with 31.9% of households speaking a language other than English. The threshold language in Santa Cruz is Spanish. Slightly more than half of the population (50.4%) is female. Santa Cruz County has only one region.

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

The Santa Cruz County Mental Health Plan (MHP) is serving ethnic groups at comparable rates as reflected in the overall population. However, when comparing the Mental Health consumers against the Medi-Cal population the Mental Health Plan is falling short of serving Latinos. The Mental Health Plan appears to be serving Black and Asian consumers at comparable rates to their representation among Medi-Cal beneficiaries. White consumers are over-represented.

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

**A. Which PEI priority population(s) did the county identify in their PEI plan?**

The Mental Health Services Oversight and Accountability passed new regulations concerning PEI in October 2015. The updated requirements do not require "priority populations".

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

No longer applicable.

**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).**

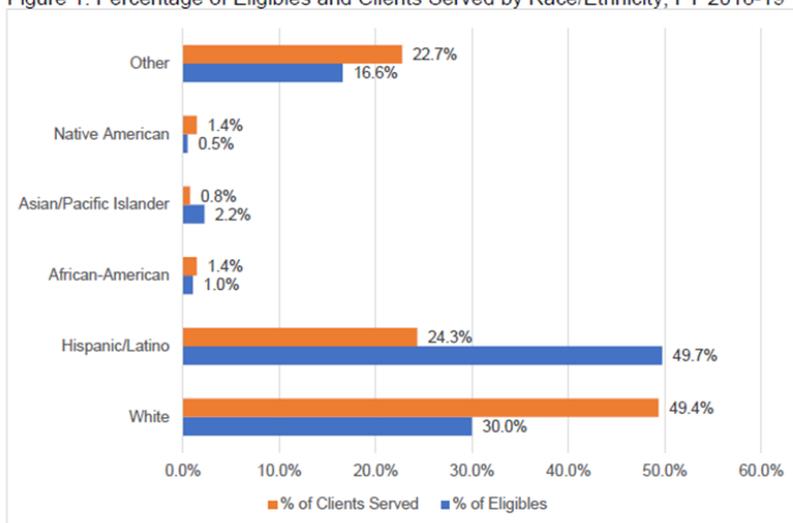
Our target population is Latino and Spanish speaking consumers.

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Santa Cruz MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	21,327	27.5%	1,240	37.2%
Latino/Hispanic	41,980	54.1%	1,281	38.4%
African-American	724	0.9%	68	2.0%
Asian/Pacific Islander	1,563	2.0%	50	1.5%
Native American	320	0.4%	19	0.6%
Other	11,626	15.0%	679	20.3%
<b>Total</b>	<b>77,537</b>	<b>100%</b>	<b>3,337</b>	<b>100%</b>

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

**Source of data:** FY 2019-20 Medi-Cal Specialty Mental Health External Quality Review

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19



**Source of data:** FY 2019-20 Drug Medi-Cal Organized Delivery System External Quality Review

\*Using Census Bureau Quick Facts & EQRO data

Psychiatrists (adult and child) and Bilingual mental health providers (psychiatrist, therapists, and case managers) are the top two “hard to fill” positions.

In early Spring 2020, Santa Cruz conducted a Community Program Planning (CPP) process that included community stakeholder meetings including workgroup meetings and focus groups with Latinos, consumers, family members, homeless, veterans, youth and the LGBTQ populations. Prior CPPs established the priority population from the information gathered in these groups, and through workgroup discussions the stakeholders selected the priority populations. However, based on the regulations passed in October 2015, PEI does not have the Counties identify “priority populations”.

## **II. Identified disparities (within the target populations)**

### **A. List disparities from the above identified populations with disparities.**

Disparities exist in the Latino and Spanish speaking populations, including youth. We also note disparities in the LGBTQQ population, based on hearing from constituents.

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

### **A. List the strategies for reducing the disparities identified.**

One critical strategy is to hire bilingual bicultural staff, and work with contractors to increase our ability to serve Latino clients. We have continuous recruitment of bilingual clinicians. In addition, BHS has enhanced the access to interpretive services to include phone and video tele-interpretive services. Another strategy is to require trainings designed to educate staff on providing culturally and linguistically appropriate services. See below for additional strategies.

### **B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:**

#### **a. Medi-Cal population**

We looked at the Medi-Cal data and conclude that there are some disparities in the breakdown of the unserved, underserved populations. We need to do a better job of serving Latinos who identify Spanish as their primary language. We are working on breaking down language barriers, myths about mental illness, and have developed informational and educational brochures to inform, educate and provide resources to potential Medi-Cal clients and their families.

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

We looked at the Medi-Cal data and conclude that there are some disparities in the breakdown of the unserved, underserved populations. The data available to us did not

include language and this is an important factor to measure. The other disparity shown by this data is the need for services for older adults.

**c. MHS/CSS population**

No full-service partnerships were selected for the Children's programs. However, the general strategy to reduce disparities (for all CSS children and adult programs) was to increase bilingual and bicultural staff to be able to provide culturally and linguistically appropriate services to Latinos and Spanish speaking individuals.

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

The new PEI regulations do not require priority populations.

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

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

Additional strategies to address language and access disparities include developing different outreach activities to inform, educate, diffuse myths about mental illness and/or SUD and seeking consumer feedback in Spanish threshold language. We developed a substance use disorder brochure, modeled after the mental health brochure (which is in both English and Spanish), which informs the reader about how to cope and where to access services for them or a loved one. This is one way to provide resources and direction for consumers, family members, service providers, and community members. We also installed immediate feedback kiosks in the reception areas that are available in both Spanish and English languages to encourage consumers and family members to provide feedback on the services received.

The following strategies are carried out throughout the year to engage a wide range of different sectors of the community in Santa Cruz County. These are some of our efforts:

- Santa Cruz County Behavioral Health Services (BHS) is committed to acknowledge and address the impact of Stress and Trauma in our community and in our organizational systems. To this end BHS has trained a core team of certified Trauma Informed System trainers. BHS has offered this curriculum to over 700 individuals from diverse settings, including the City of Santa Cruz administrative staff, parks and recreation, public works, justice department court staff, Head Start, Behavioral Health staff, Community Action Board community agency.
- We provide numerous workshop topics across the three school districts within Santa Cruz County (PVUSD, Live Oak School District, and Santa Cruz City Schools) to create awareness about mental health and SUD challenges; mental health and SUD impacts of COVID-19 and distance learning, like depression, anxiety, suicide, stress disorder, panic attacks, eating disorders, bullying and cyberbullying, as well as drug and alcohol abuse, gang involvement, the impact of acculturation and immigration.
- We provide a culturally specific family strengthening curriculums for youth, family members and the community at elementary, middle schools and high schools,

shelters, community-based organizations, apartment complexes, Santa Cruz County medium security inmate facilities, detox and recovery centers. The purpose is to create awareness, education, and guidance in how individuals, families and the community may begin to process and heal their emotional pain. This model has been developed to work with Latino, including Indigenous communities. The parent classes are offered in English and Spanish.

- We provide MHFA (Mental Health First Aid) to develop more awareness, education about what is mental health, the high incidence of persons who may be experiencing mental health challenges, living with depression, suicidal ideation, anxiety, panic attacks, psychosis, substance abuse, and other crises. Through these efforts we educate the community to be able to see the signs, notify someone who can help, or provide resources and information. We have been able to provide these classes to the local agencies who interact with the homeless every day, students at three local high schools, and several recovery centers.
- We participate in several school and community annual parent conferences, where we present workshops on how to re-introduce, reconnect, and/or maintain family and cultural values to engage youth, families, local organization consumers and providers.
- We participate in health fairs throughout the community providing information and education about mental health, and our services. When we see that people are reluctant to come to the table, we mingle with the crowd, and find that they are more accepting of the information we have to offer.
- The LGBTQ community deals with different forms of discrimination, stigma, marginalization, and often feel that they are not being acknowledged. BHS continues to partner with the local Diversity Center, a LGBTQ center, to strengthen how the county supports the LGBTQ community and LGBTQ appropriate services. This partnership contributed to positive changes to the signage throughout the county buildings, making our environment more welcoming, embracing, and a safe place for everyone to seek services.

### **Related Programs and Strategies**

- Santa Cruz County Behavioral Health Services (BHS) participates in the various annual school and community parent conferences to engage, strengthen our relationship and commitment with youth, families, organizations and the community at large.
- Health fairs to provide awareness and education about the stigma of mental illness, how to help someone who may be struggling with depression, anxiety or other emotional challenges, what resources and services the county offers and where one can go for help.
- BHS plans to offer monthly workshops, seminars, presentations, and/or trainings in different topic areas addressing the diverse needs of our communities. We plan to offer a menu of trainings, workshop topics, presentations for staff to select from and this requirement, and when available, this will be included in the staff's yearly evaluation.

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

Our planning and implementation process has helped us strengthen our community involvement and stakeholder's participation, including consumer and family voices in our efforts to reduce disparities in the county's identified populations.

We work with county personnel to make continuous recruitment efforts for bilingual clinical positions.

Santa Cruz County has effectively made efforts to involve consumers and advocates in trainings, planning process, steering committees, and our Local Mental Health Board and AOD Commission. We are making ongoing efforts to improve our ability to increase more consumer and family participation.

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

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

Strategies and status:

- Hiring bilingual staff: we find having continuous recruitment for bilingual clinical positions is an effective tool.
- QI reviews: this is an effective way to engage management in reviewing disparities, monitoring penetrations rates, and brainstorm ways to improve services.
- Training staff on providing culturally and linguistically appropriate services. Santa Cruz County Behavioral Health Staff carries out survey evaluations for all trainings with Continuing Education.
- The various workshops, community trainings, presentations, groups and other outreach activities are ongoing. BHS carries out survey evaluations for workshops, and community presentations, educational trainings for youth, parents and community stakeholders.

BHS receives positive feedback from local agency providers who also work with the youth and families who attend the 8 to 10-week educational workshop series, as well as from consumers, families and organizations. Additionally, BHS receives positive feedback from probation officers, probation supervisors, managers, non-profit managers, professional colleagues and/or organizational administrators who report a positive change in behavior attitude, emotional health of to the youth, adults, families they serve, who also participate or have participated in our educational workshop series, presentations or support groups.

**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 of elimination of disparities.**

Santa Cruz County Behavioral Health Services (BHS) utilizes the QI Steering Committee to measure and monitor the effect of the identified strategies, objectives, actions and timelines in reducing disparities. This Quality Improvement Steering Committee monitors the QI Work Plan progress and reports service utilization rates on a quarterly basis, tracks services and populations and identifies disparities in access to services.

**C. Identify county technical assistance needs.**

Santa Cruz County Behavioral Health Services (BHS) was able to hire bilingual clinicians through our MHSa plans. With a continuous recruitment model for bilingual staff, recent clinical hires tend to be bilingual in our threshold language (Spanish). We would like to know how other counties address the issue of retaining bilingual staff, even when there are layoffs due to economic hardships.

**CRITERION 4**

**CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE:  
INTEGRATION OF THE COMMITTEE WITHIN  
COUNTY BEHAVIORAL HEALTH**

**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 Quality Improvement Steering Committee has played a key role in establishing a solid foundation for integrating “Culturally and Linguistically Appropriate Services” (CLAS) principals and standards throughout Santa Cruz County Behavioral Health Services. The CLAS Coordinator designated staff is a member of Quality Improvement. Quality Improvement aims to support the development and implementation of policies, procedures and standards. Quality Improvement staff reviews cultural issues, including penetration rates and outreach to diverse communities.

The Behavioral Health Director works closely with Behavioral Health Management to ensure that all services/programs continue to integrate cultural values and standards throughout the County Behavioral Health System. Management meets on a weekly basis.

Santa Cruz County Behavioral Health Services has a Cultural Humility Sub-Committee of the Trauma Informed Systems Initiative, with the overarching goals to create a safe and supportive client-care environment that promotes healing, and to create a safe and

supportive workplace with staff who are able to promote healing. The goal is to expand Cultural Humility practices throughout BHS and contracted providers to ensure service delivery aligns with the core principles.

**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 Committee is consistently making efforts to establish a workforce which is reflective of the community. Committee members consist of licensed and unlicensed staff from north and south county, as well as supervisors, and directors of diverse backgrounds.

**C. Organizational chart**

Santa Cruz County Behavioral Health Services (BHS) is the largest division of the Health Services Agency. The Director oversees all operations, including, Quality Improvement, Adult Mental Health, Children Mental Health, Substance Use Disorder Services and South County (Watsonville parallel services). There are Senior Behavioral Health Managers that oversee Managers, Supervisors, and clinical line staff, as well as Interns, peers, and family providers.

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

The management team consists of:

- Erik Riera, Behavioral Health Director
- Dr. Alex Threlfall Chief of Psychiatry
- Cybele Lolley, Quality Improvement Director
- Shaina Zurlin, Chief of Substance Use Disorder Services
- Lisa Gutierrez Wang, Director of Children's Services Pam Rogers-Wyman, Director of Adult Services
- Cassandra Eslami, Chief of South County Behavioral Health Services and Community Engagement /MHSA Coordinator
- Adriana Bare, Senior Health Manager for Administrative Services
- Emily Chung, Whole Person Care Program Director
- Andrea Turnbull, Program Manager, Acute Services
- Eli Chance, BH Program Manager, Adult Outpatient
- James Russell, Behavioral Health Manager, Adult Forensic Services
- Stan Einhorn, Behavioral Health Program Manager, Children's
- Lauren Fein, Behavioral Health Program Manager, Children's Services
- Meg Yarnell, Behavioral Health Program Manager, Children's Services
- Vanessa Bertsche-Shelton, Chief Public Guardian
- Vacant, CLAS Coordinator
- Janus of Santa Cruz, Executive Director
- Volunteer Center, Assistant Director
- Telecare, VP of Operations
- Encompass, Director of Quality Improvement
- NAMI representation
- Consumer representation

The membership individuals may change during the year, but the functions and organizations shall continue to be represented. We increased committee participation of direct service provider organizations who serve the key disparity/underserved populations, and also increased representation from the local community and underserved populations. The community has been underrepresented in previous year.

**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 including the following:**

**1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;**

Behavioral Health Management has the primary responsibility for ensuring the inclusion of cultural and linguistic services and programs.

Behavioral Health has a Cultural Humility Sub-Committee of the Trauma Informed Systems Initiative, with the overarching goals to create a safe and supportive client-care environment that promotes healing, and to create a safe and supportive workplace with staff who are able to promote healing.

The Quality Improvement (QI) staff has played a key role in establishing a solid foundation for integrating "Culturally and Linguistically Appropriate Services" (CLAS) principals and standards throughout County Behavioral Health. This included developing and implementing policies, procedures and standards, providing CLAS education opportunities, and processing completed staff CLAS hours; and completing a Spanish audit of Behavioral Health charts to ensure clients who prefer services in Spanish are receiving service in alignment with this preference.

The Behavioral Health Director works closely with the Management team to ensure that all services and programs continue to integrate CLAS values and standards throughout the Behavioral Health System.

The Local Mental Health Board serves to advise the Behavioral Health Department on current and ongoing issues as they relate to the effectiveness and quality of the mental health services for the county. It also serves to increase community awareness on issues related to mental health to ensure inclusion and dissemination of information.

**2. Provides reports to Quality Assurance/Quality Improvement Program in the county;**

The CLAS Coordinator participates in and attends the Quality Improvement Steering Committee which monitors the service delivery, capacity and accessibility, in addition to monitoring beneficiary satisfaction. CLAS/Cultural Competency goals continue to be established within the fiscal year QI Work Plan and monitored on a quarterly basis.

**3. Participates in overall planning and implementation of services at the county;**

The Behavioral Health Director works closely with the QI Director, Senior Leadership and Management Staff to ensure that all services/programs continue to integrate cultural values and standards throughout the County Behavioral Health System

**4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;**

The CLAS Coordinator is an integral member of the Quality Improvement (QI) Steering Committee. QI is responsible for oversight of the quality of care, grievances, and a regular review of the penetration data. QI informs and makes recommendations to the executive level. The Behavioral Health Director meets regularly with the Local Mental Health Advisory Board.

**5. Participates in and reviews county MHSA planning process;**

The CLAS Coordinator works with BHS Management. The MHSA Coordinator works with community and staff in development of MHSA plans. Stakeholder Engagement Sessions are held at various parts of the County to provide MHSA Updates.

**6. Participates in and reviews county MHSA stakeholder process;**

Santa Cruz County Health Service Agency and BHS convenes different stakeholder meetings, which include consumers, families, community members, agency representatives, county staff, service providers, and contractors. This process is utilized to gather stakeholder input, ideas and recommendations.

**7. Participates in and reviews county MHSA plans for all MHSA components**

The CLAS Coordinator participates in the county development of the MHSA plans.

**8. Participates in and reviews client development programs (wellness, recovery, and peer support programs); and**

Santa Cruz County has two Wellness centers in Santa Cruz County: Mental Health Client Action Network (MHCAN) in Santa Cruz, and Mariposa in Watsonville.

MHCAN is a consumer owned and operated program that provides a safe space for persons with psychiatric disabilities to congregate and socialize. They also offer a variety of programs, including groups, classes, and alternative treatments like acupuncture. Due to the Covid-19 pandemic, MHCAN shifted their services from in-person to online by providing virtual 1:1 peer support, classes, and support groups such as: services physical fitness, 12-step groups, self-care, relapse prevention, substance use, mental wellness, and recreational opportunities such as role-playing games, poetry, chess. also include co-occurring physical and substance use disorder supports through offering an acupuncture clinic and 12-step meetings. MHCAN's peer-based model helps clients reclaim their dignity through self-help.

Mariposa is located in the heart of downtown Watsonville, a community that houses many Anglo/Caucasian consumers as well as many underserved Latino consumers and their families. The Mariposa Wellness Center program quickly became a hub for engaging in

wellness and educational activities and support services, sharing information, and outreach activities for families and adult consumers.

The Mariposa Wellness Center promotes consumer-operated services to support recovery, and strives to reflect the cultural, ethnic and racial diversity of mental health consumers. Due to the covid-19 pandemic modifications to in-person services were made by providing limited in-person mental health groups at the center with safety protocols in place, as well as mental health zoom groups and individual sessions both via telephone and in-person.

#### **9. Participates in revised CCPR development.**

The CLAS Coordinator worked with service and community stakeholders and the QI Director to discuss, review and develop updates to the CLAS Plan. The plan is then distributed to the QIC Steering Committee for review and comments before finalized.

**B. Provide evidence that the Cultural Competence Committee participates in the above review process.** These responsibilities fall to Management and the Quality Improvement Committee. The Quality Improvement committee meets quarterly. We aim to expand the Cultural Humility committee into BHS to support the identification of CLAS needs, recommendations, strategic planning and implementation workgroup focuses. The CLAS Coordinator will participate in this committee and will provide outcome reports to the QI Steering Committee.

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

##### **1. Detailed discussion of the goals and objectives of the committee;**

Santa Cruz County Behavioral Health Services (BHS) developed a Cultural Awareness Mission Statement which demonstrates the values of our division. It reads as follows:

- Our goal is to support our consumers, youth, and family members with culturally appropriate resources, encouragement, tools and skills so they may achieve the quality of life they desire.
- As an agency we challenge ourselves to develop ever-greater cultural awareness and sensitivity to acknowledge and embrace individual differences, including language, beliefs, values, attitudes, healing practices, sexual orientation, gender, physical and mental abilities.
- We endeavor to build on existing strengths, develop new skills and maximize the opportunity for recovery and optimal health of our community.

The Cultural Humility Sub-Committee of the Trauma Informed Systems Initiative has the overarching goals to create a safe and supportive client-care environment that promotes healing, and to create a safe and supportive workplace with staff who are able to promote healing.

##### **a. Were the goals and objectives met?**

We have institutionalized the value of cultural diversity throughout the organization beyond trainings. We have also developed a standard in supporting all staff, to have a minimum of seven CLAS training hours every year. Additionally, a Staff of Color Gathering was developed to support staff's experiences of the racially charged socio-political climate and how these experiences impact their client's and their work with the community.

We have improved our ability to serve clients and their families at various county locations where such services are more accessible. We are addressing the issue of underutilization and/or overrepresentation of the target population being served to make sure that we are serving the right populations.

**2. Reviews and recommendations to county programs and services;**

Management is responsible for reviewing and recommending county and contract provider services. QI regularly reviews issues of disparity and access of services, as well as grievances and client satisfaction.

**3. Goals of cultural competence plans;**

The goals of the CLAS plan are embraced, reviewed, and continually improved to meet the cultural diversity needs of our population.

**4. Human resources report;**

<b>Health Services Agency Staff</b>						
<b>Ethnicity</b>	<b>2002</b>	<b>2003</b>	<b>2010</b>	<b>2016</b>	<b>2019</b>	<b>2020</b>
Caucasian	72%	61%	61%	59.5%	53%	52%
Latino	21%	18%	22%	29.3%	36%	37%
Asian	2%-	3%	3%	3%	5.6%	7%
Black	1%	1%	1%	1.3%	1%	1%
Native American	No Info	No Info	No Info	.4%	1%	1%
Mix	No Info	No Info	No Info	1.7%	2%	2%
Other	2%	7%	9%	1.7%	.4%	No Info
Unknown	1%	9%	4%	3%	1%	No Info
<b>Gender</b>	<b>2002</b>	<b>2003</b>	<b>2010</b>	<b>2016</b>	<b>2019</b>	
<b>Male</b>	No Info	No Info	No Info	35%	27%	27%
<b>Female</b>	No Info	No Info	No Info	65%	73%	73%
<b>Other</b>	No Info	No Info	No Info	0%	*	No Info

35% of Behavioral health staff are bilingual. Staff are primarily bilingual in English and Spanish, with a small number of staff also speaking Portuguese.

2020 data from HSA EEOC Occupational Category report

**5. County organizational assessment;**

The Santa Cruz County Behavioral Health Services (BHS) recognizes the value of cultural diversity. This value is reflected in everyday practice, in policies and procedures, in our Quality Improvement plan, in our contracts, and in acknowledging staff that participate in raising their own and others cultural knowledge.

The MHP works closely with consumer groups and advocates, including the Mental Health Client Action Network (MHCAN), Mariposa Wellness Center, and Community Action Board (CAB). Additionally, we have a close working relationship with the local NAMI, as well as community-based agencies, probation, law enforcement, child welfare, schools and school districts. The MHP interfaces with these groups to solicit input, share community resources and events, and to strengthen our services.

A historical challenge for our County is finding qualified personnel that are bilingual in our threshold language (Spanish). In order to address this matter, we have designated some positions as bilingual only, and have encouraged bilingual, bicultural persons to apply for all positions.

## 6 Staff Trainings

Trainings	Example of Trainings
Required Trainings	<ul style="list-style-type: none"> <li>• Law &amp; Ethics</li> <li>• Sexual Harassment</li> <li>• HIPAA</li> <li>• Culturally &amp; Linguistically Appropriate Services (CLAS)</li> <li>• ASAM</li> <li>• Compliance</li> <li>• Human Trafficking Protection</li> <li>• Trauma Informed Systems</li> </ul>
Advanced Specialized Mental Health and Substance Abuse Trainings	<ul style="list-style-type: none"> <li>• CBT</li> <li>• DBT</li> <li>• IMR</li> <li>• CANS/ANSA</li> <li>• Mindfulness</li> <li>• Supervisor training</li> <li>• Motivational Interviewing</li> <li>• Mental Health First Aid</li> </ul>
Provision of Culturally & Linguistically Appropriate Services	<ul style="list-style-type: none"> <li>• Cultural Humility training</li> <li>• LGBTQ panel presentation</li> <li>• Implicit Bias</li> <li>• Gang Dynamics training</li> <li>• VA training</li> <li>• Consumer Experience Presentations</li> <li>• Communicating Effectively through an Interpreter</li> </ul>
New Employee Volunteer	<ul style="list-style-type: none"> <li>• Orientation</li> <li>• Confidentiality/HIPAA</li> <li>• Mandated Reporting</li> <li>• Compliance</li> <li>• Treatment Plans, Assessments &amp; Progress Notes in support of client services documentation and billing</li> </ul>

## **CRITERION 5 CLAS 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.**

In the responses to Criterion #4 a sample of our previous training, is provided, as an example.

**1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.**

Every county employee in our division is required to complete seven training hours per evaluation year on provision of culturally and linguistically appropriate services.

**2. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.**

BHS is committed to follow the policies that have been established. Staff are required to meet their 7 hours of cultural awareness training hours per evaluation year. We have established a series of policies that underscore our commitment and practice, including the requirement for each staff to be evaluated on CLAS standards in their annual performance evaluation. In-person trainings were halted in March 2020 due to COVID-19 safety protocols. In order to support staff access to CLAS material, BHS distributed information on webinar, on-line trainings, and videos which qualify for CLAS hours. This expansion led to the development of a CLAS Education Plan Policy which outlines these content types (trainings, webinars, etc.) which staff can access for completion of CLAS Hours.

**3. How cultural competence has been embedded into all trainings.**

BHS has been developing a cultural shift within the county organization, within behavioral health, and throughout different layers of the organization. We are committed to provide appropriate and necessary staff development, education, and training for staff, and embed cultural concepts in our trainings.

### **II. Annual cultural competence trainings**

In 2020, BHS offered a variety of CLAS related trainings which enabled staff to complete 7 hours of CLAS training. In 2020, BHS is leveraging online resources such as Think Cultural Health, The National LGBTQ+ Health Education Center, and the Mental Health Technology Transfer Center (MHTTC) Network for content specifically created for Behavioral Health Professionals on Improving Cultural Competency for Behavioral Health Professionals.

<https://thinkculturalhealth.hhs.gov/education/behavioral-health>

<https://www.lgbthealtheducation.org/resources/in/behavioral-health/type/webinar/>  
<https://www.lgbthealtheducation.org/resources/in/behavioral-health/type/webinar/>

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

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

1. **Rationale and need for the trainings:** Describe how the training is relevant in addressing identified disparities;

Our cultural awareness trainings are offered with the goal of enhancing the cultural skill set of all staff. We have taken steps to create a cultural shift throughout the organization. BHS strives to include cultural issues in the trainings offered and has specific cultural awareness trainings on different topics. Such trainings cover the topics such as:

**Cultural formulation** Including assessing the patient's cultural identity and understanding how culture affects the explanation of the individual's illness, support system and the clinician-patient relationship as well as understanding how culture affects the assessment and diagnosis of culturally diverse individuals.

**Multicultural knowledge** Provide basic knowledge of and guidelines for practice with diverse groups.

**Latino/a/x:** Hispanic/Latino population in the United States consisting of demographic, historical, sociopolitical, and geographic contexts that are critical to understanding the population as well as the diversity within. Specific concepts and frames of reference such as identity, acculturation, language, family values, religion and spirituality, traditional beliefs about health and illness, gender role socialization, and social class are discussed. Attention will be given to contemporary issues facing Latinos, including a discussion of factors that influence help seeking and receiving care.

**LGBTQ+:** Includes various aspects of providing effective mental health and substance use treatment services to LGBT individuals. Trainings can include topics related to legal issues, the "coming out" process, increasing LGBT-welcoming spaces, oppression trauma, substance use, LGBTQ+ elders, and gender identity.

**Implicit Bias:** Increasing awareness of our attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner, and how these impacts client services, the workplace, and organization.

**Cultural sensitivity:** Being aware that cultural differences and similarities exist and influence values, learning, and behavior.

**Cultural awareness:** Involves continually developing your awareness of your own and other's cultures to assist in the performance of your professional duties.

**Social/Cultural diversity:** Diverse groups, consumers, family, LGBTQ+, SES, Elderly, Disabilities, etc.

**Interpreter training:** Including training staff in the use of interpreters and training in the use of interpreters in the behavioral health setting.

Staff trainings are vital to ensuring cultural and linguistically appropriate services and includes staff on all levels, from administrative to management. These trainings focus on understanding the reality of the persons who may have different worldviews, persons who deal with the stigma of mental illness on a daily basis, and who may be reluctant to seek mental health and/or other services for themselves or a loved one. Trainings also focus on how to improve our skills in engaging and applying customer service principles in serving our consumers and families, as well as to reduce disparities associated with language barriers, access to services and low penetration rates.

Stigma regarding SUDs persists in marginalized communities and impedes: (1) use of medications to help with SUD treatments; (2) use of ASAM assessment criteria to support optimal care, versus court orders not driven by clients' clinical needs; and (3) support for new and expanded sites for service delivery (e.g., NIMBY or "not in my back yard" opposition). Continued education and work with media, the public, and community leaders are needed to push back on these biases and beliefs, which otherwise create barriers for clients to obtain housing, jobs, childcare, and other services.

## **2. Results of pre/post tests**

All sessions involving Continuing Education Units require participants to complete an evaluation of the session. Pre/ post tests for trainings for psychologists and trainings for California Consortium of Addiction Programs and Professionals (CCAPP) credits are used.

## **3. Summary report of evaluations**

It is standard practice to evaluate each training that we provide or sponsor. A sign-in sheet is used to track and confirm attendance, and there are specific requirements for cultural awareness training credit, Continuing Education training credit.

## **4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.**

We have created systems to track, monitor, and evaluate our training efforts. Behavioral Health builds from what we have learned and aims to consistently involve supervisory staff in how they may best support line staff, clinical staff and contract agency staff who are responsible for implementing programs and trainings.

Whenever feasible we have been moving away from the one-shot approach to trainings. Instead, we have been building on the idea of standardizing essential trainings supported through booster sessions, so that these efforts become standardized steps in the sustainability process. Some trainings are geared for supervisory staff, which can directly oversee and support the implementation of the skills learned in the trainings.

The CLAS Hour Report Form has been updated to include a 5-point Likert scale so staff can evaluate their perceived effectiveness of completed courses.

See Appendix A at end of report: This **optional staff/supervisor form** is intended to be used in support of or at the time of an employee's annual personnel evaluations to help structure a conversation regarding the integration of cultural competency issues into each employee's job performance.

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

We established a set of policies and procedures to provide the needed infrastructure. The methodology used to ensure staff complete their training and utilize their cultural awareness skills is embedded in these policies. Staff are required to receive seven hours of culture and/or language related training per evaluation year, and all supervisors evaluate staff on their “cultural competence” in their annual performance evaluation. Supervisors are responsible to oversee their staff and require them to attend needed trainings.

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

We have an established practice to include client culture as part of our trainings. Sometimes the trainings focus specifically on what it is like to live with a mental health or substance use disorder diagnosis, and other times the consumer perspective is included in clinical or cultural presentations.

**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.**

**A. Extract a copy of the Mental Health Service Act (MHSA) workforce assessment submitted to the state for the Workforce Education and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health and DMC-ODS System.**

We have an ongoing challenge of hiring and retaining bilingual bicultural psychiatrists as well as other licensed clinicians.

**B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.**

In comparing the data from the WET Plan assessment with the general population, Medi-Cal population, and the 200% of Poverty data, it raises several challenges: first the shortages of licensed clinicians, especially bilingual (Spanish) speaking clinicians. Second, our workforce does not reflect the ethnic diversity of the community; there is a shortage of Latino (a) staff throughout the system. There have not been positions designated for consumer and family members at the County. However, contract agencies have been able to hire consumers.

There is a severe shortage of Spanish speaking staff at almost all public agencies. The general population, Medi-Cal population and the 200% of Poverty data demonstrate that while our penetration rate is higher than the State average, we are not as effective at serving clients who identify Spanish as their primary language as we would like. We believe there is a

direct correlation to our shortage of Spanish speaking staff throughout our mental and behavioral health system.

**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.

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

Santa Cruz County Behavioral Health Services (BHS) included several actions that address efforts to grow a multicultural workforce. Although our WET services are not as robust as they once were (when we had the original funding), we do continue to do the following:

- Have continuous recruitment for bi-lingual behavioral health clinicians. Added the following statement that bilingual positions “require that the mental health clinician be fully fluent in Spanish and English to provide the full range of professional level mental health services in Spanish, including the facilitation of individual, group, family, and crisis counseling. Bilingual clinicians may be asked to translate written clinical materials and interpret for Spanish speaking clients that need to communicate with monolingual English-speaking mental health professionals.”
- Provide High School Outreach: To foster knowledge and create interest in mental health as a career path amongst high school students, with a focus on bilingual (Spanish) and bicultural students.

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

The WET program had several strategies that were very successful, such as support for public mental health employees in purchasing license preparation materials, and group support for license preparation. No WET funds have been available since prior to FY18-19 and as a result, we have not been able to continue these services.

**F. Identify county technical assistance needs.**

Hiring Spanish speaking staff. Learning from other counties about effective evidenced-based practices in CLAS.

## **CRITERION 7 LANGUAGE CAPACITY**

**I. Increase Bilingual Workforce Capacity**

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

Santa Cruz County Behavioral Health Services (BHS) designates some positions as bilingual only, and encourages bilingual, bicultural persons to apply for all positions. Santa Cruz County has a continuous recruitment for bilingual clinical staff. The bilingual job announcement indicates that bilingual positions “require that the mental health clinician be fully fluent in Spanish and English to provide the full range of professional level mental health services in Spanish, including the facilitation of individual, group, family, and crisis counseling. Bilingual clinicians may be asked to translate written clinical materials and interpret for Spanish speaking clients that need to communicate with monolingual English-speaking mental health professionals.”

We assess prospective employees in their ability to provide culturally aware services. Santa Cruz County Personnel Department evaluates and certifies staff speaking the threshold language (Spanish) in their ability to use Spanish. Staff passing level one is able to communicate orally. Staff passing level two are also able to read and write Spanish. Job openings are disseminated to all eligible employees within the Division by HSA Personnel.

Santa Cruz County Behavioral Health Services has policies regarding the provision of Culturally Aware Services, including training requirements that cover client cultural, and working with diverse groups (e.g. Latinos, and LGBTQ). Contract providers will adhere to cultural aware standards, as specified in their contracts.

We do not have staff whose sole job is to interpret. Santa Cruz Behavioral Health standard is to provide services in the threshold language therefore we rarely use interpreters. When interpreters are needed, we work with medically qualified interpreter services interpreter services or bilingual mental health professional on our staff. For example, a bilingual mental health clinician who is facilitating a IEP school meeting may utilize an approved interpreter service or bilingual mental health staff to mee the language needs of attendees. This allows the bilingual facilitator to focus on their task and provide equitable and quality services. We offer trainings to staff on how to be effective interpreters, and how to use interpreters effectively Interpreter services are also utilized for non-threshold languages and for sign language on an as-needed basis.

## **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:**

The County has a 24-hour phone line **(1-800-952-2335)** with statewide toll-free access that has linguistic capability for all Medi-Cal beneficiaries. It is answered during normal business hours by clerical and clinical staff that speak the threshold languages. In addition, Santa Cruz County has contracted with Language Services Associates.

To access a Qualified Interpreter, the following number is called (866) 937-7325 and when greeted the Santa Cruz County Behavioral Health Services Account Code 50492920 is used.

Staff are trained to use the language line; additionally, the protocol for using Language Services is outlined in a “quick reference guide” for staff.

To provide services for the hearing impaired, the County utilizes IRIS application from Language Services contract as well as a dedicated Access email address from County Behavioral Health Information webpage. For face-to-face evaluations of a client with a hearing disability, the Access Team shall provide assessments by a staff member in ASL (American Sign Language). If such a staff member is not available, the Access Team shall use an interpreter from the county contract service for the hearing impaired. To provide services for the visually impaired Behavioral Health provides audio recordings of pertinent beneficiary and provider information at all clinic sites. In addition, information will be provided over the phone to the visually impaired by the Access Team.

The Santa Cruz County Mental Health Plan has also implemented the “Service Access for Visually or Hearing Impaired” policy and procedures to ensure continuous services to the visually and hearing impaired.

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

Clients are informed in writing in their primary language that they have a right to free language assistance services. This information is posted and included in correspondence for grievance, appeal, change of treatment staff requests, and NOABD processes

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

The Santa Cruz Mental Health Plan and Drug Medi-Cal standard is to provide services in the threshold language. When interpreters are needed, we utilize medically qualified interpreter services and bilingual behavioral health professionals on our staff. For example, a bilingual behavioral health clinician may interpret for a monolingual psychiatrist. Interpreter services are also accessed for non-threshold languages and for sign language on an as-needed basis.

Service providers that contract with the County are required to have policies and procedures that are consistent with the County’s policy “Provision of Linguistically Appropriate Services”. It is prohibited to expect family members or friends to provide interpreter services.

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

Based on the trainings provided on how to interpret and how to use interpreters, staff have learned how to be a conduit of communication, and how the interpreter solely translates what is verbalized by each party and does not add to the conversation. Bilingual staff who are leading and facilitating coordinated care meetings have been encouraged to request interpreters to meet the language needs of attendees. This allows the bilingual facilitator to focus on their task and provide equitable and quality services.

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

A historical challenge for our Behavioral Health is finding qualified personnel that are bilingual in our threshold language (Spanish). To address this matter, we have designated some positions as bilingual only, and have encouraged bilingual, bicultural persons to apply for all positions. We assess prospective employees in their ability to provide culturally aware services. We also ask (in English) about their skills and abilities to perform the required duties in Spanish, and the Santa Cruz County Personnel Department evaluates and certifies staff speaking the threshold language (Spanish) in their ability to use Spanish. Staff passing level one are able to communicate orally. Staff passing level two are also able to read and write Spanish. Job openings are disseminated to all eligible employees within the Division by Health Services Agency Personnel (to encourage promotional opportunities).

Job announcements for bilingual clinical positions include language stating that bilingual positions: “require that the mental health clinician be fully fluent in Spanish and English to provide the full range of professional level mental health services in Spanish, including the facilitation of individual, group, family, and crisis counseling. Bilingual clinicians may be asked to translate written clinical materials and interpret for Spanish speaking clients that need to communicate with monolingual English-speaking mental health professionals.”

**F. Identify county technical assistance needs.**

The biggest challenge the County has is in finding Spanish Speaking psychiatrists and clinical staff.

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

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

The County’s standard is to provide services in the threshold language. When interpreters are used, we access approved medically qualified interpreter services or bilingual behavioral health professionals on our staff. For example, a bilingual mental health clinician may interpret for a monolingual psychiatrist.

It is prohibited to expect family members or friends to provide interpreter services. LEP individuals are informed (in a language that they understand) in the Behavioral Health brochures and in the intake process that they have a right to free language assistance services. This information is also posted.

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

Evidence can be found in the Service Request logs and documentation within the Behavioral Health’s Electronic Medical Records (EMR). This information is usually recorded in Assessments, Treatment Plans and it is also documented in progress notes. A Spanish Audit was implemented in 2020 to review chart of beneficiaries identified as Spanish preferred language and review for continuity of Spanish services and client documents. When there are

discrepancies, this information is provided to the teams as a means to continually improve of meeting the needs of Spanish speaking clients in a linguistically appropriate manner.

**c. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.**

At key points of contact the County provides services in the threshold language for the beneficiary and staff to communicate effectively. Clients speaking in the threshold language will be assigned to clinicians that speak their language, whenever possible. Medically qualified interpreter services are utilized when other options are unavailable.

When a client or client's family needs a translator to assist during a mental health or SUD assessment or evaluation, it is the responsibility of the clinician to either arrange or provide the translation services. The standard is to provide services in the threshold language. When interpreters are needed, we generally use other mental health professionals on our staff or medically qualified interpreter services. For example, a bilingual mental health clinician may interpret for a monolingual psychiatrist. When bilingual staff are leading and facilitating coordinated care meetings, they are encouraged to request interpreters to meet the language needs of attendees. This allows the bilingual facilitator to focus on their task and provide equitable and quality services.

It is prohibited to expect family members or friends to provide interpreter services. LEP individuals are informed (in a language that they understand) in the County brochures and in the intake process that they have a right to free language assistance services.

**d. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).**

Staff speaking the threshold language (Spanish) are evaluated and certified by the Santa Cruz County Personnel Department in their ability to use Spanish. Staff passing level one (1) are able to communicate orally. Staff passing level two (2) are also able to read and write Spanish.

**IV. Provide services to all LEP clients not meeting threshold language criteria who encounter the behavioral 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.**

Behavioral Health Services has a policy "Linguistically Appropriate Services" that addresses how we meet the needs of consumers who do not meet the threshold language criteria. Evidence can be found in the Electronic Medical Records.

Our current policy states it is prohibited to expect family members or friends to provide interpreter services. LEP individuals are informed (in a language that they understand) in the

intake process that they have a right to free language assistance services. Medically qualified interpreter services are utilized when staff are not available to provide client language needs.

**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.**

Behavioral Health Services has a policy “Linguistically Appropriate Services” that addresses how we meet the needs of consumers who do not meet the threshold language criteria. It states: “If the beneficiary speaks a language other than a threshold language and there is no provider in the Mental Health Plan or DMC-ODS pilot who speaks the beneficiary’s language, the program will contract with someone to provide these services. The program may request the assistance of a neighbor county program to provide these services. LEP beneficiaries will be informed (in a language that they understand) that they have a right to free language assistance services.” We have a standing contract with an interpreter service and also use a language services vendor, when appropriate.

**C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:**

1. **Prohibiting the expectation that family members provide interpreter services.**
2. **A client may choose to use a family member or friend as an interpreter after being informed of the availability or free interpreter services; and**
3. **Minor children should not be used as interpreters.**

The Behavioral Health “Linguistically Appropriate Services” policy complies with Title VI of the Civil Rights Act of 1964. It is prohibited to expect family members or friends to provide interpreter services. A beneficiary may choose a family member or a friend as an interpreter after being informed of the availability of free interpreter services. Minor children are not used as interpreters.

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

**A. Culturally and linguistically appropriate written information for threshold languages:**

Behavioral Health Services has available general program literature for the identified threshold language that is culturally and linguistically appropriate.

Materials translated into the County’s threshold languages include such things as The DMC-ODS Guide for Medi-Cal Beneficiaries, The Mental Health Plan Guide for Medi-Cal Beneficiaries, Provider Directory for both MHP and DMC-ODS, Consent for Treatment, Satisfaction Surveys, Grievance Resolution Request brochure, etc. Clients are informed in writing in their primary language that they have a right to free language assistance services. This information is posted as well as included in correspondence for procedures related to grievances, appeals, change of treatment staff, and NOABD.

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

This information is recorded in the Electronic Medical Record in client admissions, progress notes, treatment plans, assessments, intake forms, and scanned documents

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

Santa Cruz Behavioral Health Services (BHS) uses surveys as required by DHCS MHP Consumer Perception Survey and DMC-ODS Treatment Perception Survey. The Consumer Perception Survey has four forms Adult (for ages 18-59), Older Adult (for age 60+), Youth Services Survey (for ages 13-17 and transition-age youth), and Youth Services Survey for Families (for parents/caregivers of youth under age 18). The DMC-ODS has a survey for Youth and for Adult participants. Each of these forms is available in English and Spanish. They are sent out per DHCS survey cycle.

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

Bilingual Level II Clinical and/or Administrative staff within the BHS program reviews and approves the final draft translations. The Cultural Humility Committee has made themselves available for Bilingual Level II committee members to review translated materials for linguistic and cultural accuracy and relevance.

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

It is our aim, as identified in the “Linguistically Appropriate Services” policy to ensure accessibility and understanding of services, through communications in the beneficiary’s primary language. Bilingual Level II Quality Assurance staff develop and review translated materials for linguistic and cultural accuracy and relevance, including required font size, cognitive ability, and reading level.

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

There are two Wellness centers in Santa Cruz County: Mental Health Client Action Network (MHCAN) in Santa Cruz, and Mariposa in Watsonville. Both have transitioned to on-line platform to provide services in a safe manner due to the COVID-19 pandemic. Mariposa has also modified office procedures and spaces to comply with COVID-19 safety protocols.

MHCAN is a consumer owned and operated program that provides a safe space for persons with psychiatric disabilities to congregate and socialize. They also offer a variety of programs, including groups, classes, and alternative treatment (like acupuncture). Due to the COVID-19 pandemic, MHCAN shifted their services from in-person to online by providing virtual 1:1 peer support, classes, and support groups. Classes and groups include: physical fitness, 12-step groups, self-care, relapse prevention, substance use, mental wellness, and recreational opportunities such as role-playing games, poetry, chess. MHCAN's peer-based model helps clients reclaim their dignity through self-help.

Mariposa is located in the heart of downtown Watsonville, a community that houses many Anglo/Caucasian consumers as well as many underserved Latino consumers and their families. The Mariposa Wellness Center program quickly became a hub for activities and support services for adult mental health consumers as well as for outreach activities. The center is a convenient, friendly, easily accessible gathering place for families and adult consumers to share information, learn about services and get support for engaging in wellness and educational activities. Activities for consumers generally take place in the daytime and in the early evening, to accommodate work schedules. The program is designed to provide supports for recovery. It strives to reflect the cultural, ethnic and racial diversity of mental health consumers and their families. Some groups are peer run and mental health staff provide others. Services are provided in Spanish and English.

DMC-ODS SUD treatment services and community support services have also adapted to COVID-19 limitations by transitioning to on-line meeting, group and individual service adaptation. In-person services are now conducted in open yet confidential outside spaced with appropriate PPE for all attending persons.

## **II. Responsiveness of behavioral 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 behavioral health provider.**

The MHP and DMC-ODS informing materials apprise beneficiaries of their rights and is provided in the beneficiaries preferred language. Additionally, the Mental Health Plan and DMC-ODS networks have clinicians that speak the threshold language, and some that are bicultural. The clinic site in Watsonville (a predominantly Latino city) is staffed with clinicians and clerical staff that are bilingual, and most are bicultural as well.

- 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 MHP informing materials and the DMC-ODS informing materials notify beneficiaries of the availability of this listing. The CLAS Plan is posted on the BHS website.

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

The “Outreach to Medi-Cal Beneficiaries” describes the general principles of our outreach efforts to inform the community of available behavioral health services through planned activities that reflect the varying cultural and linguistic needs of our target populations.

The Division conducts a variety of outreach efforts to the cultural and linguistically diverse community. These include the following activities:

- a. Community Collaboration: Managers and supervisors represent Behavioral Health and take a leadership role in community collaborations.
- b. Staff Presentations: Staff respond to invitations to provide information about services, with priority given to those presentations that would allow staff to reach our target population. These strategies inform, educate, and help diffuse myths about mental illness
- c. Mailings & Newsletters: Mailings to the target population or articles presented in community newsletters and/or publications, as well as the Behavioral Health newsletter “We Are Serious About Mental Health & Recovery”.
- d. Informing Materials: Behavioral Health’s MHP and DMC-ODS materials (in both English and Spanish), notify the reader about signs and symptoms of mental illness and substance use disorder impact across the lifespan, and how to access services for them or a loved one. This is one way to provide resources and direction for consumers, family members, service providers, and community members.
- e. Program Activities: Outreach activities are a part of service provision in the Children’s Mental Health and Adult Mental Health, and DMC-ODS Plan and programs.

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

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

BHS facility signage is posted in both English and Spanish. At our current South County location in Watsonville psychoeducational material, wall art and décor are provided in culturally respect and threshold language (Spanish) capabilities to ensure a welcoming and inviting environment for clients. At each BHS location, services (including reception and direct clinical services) are provided in Spanish. In addition, Santa Cruz County Behavioral Health Services larger facility in Watsonville provides increased access to behavioral health services in a welcoming environment, including substance use disorder services and psychiatric services. In addition, the new behavioral health clinic will remain on the same campus as the

county medical clinic, to promote access to holistic culturally and linguistically appropriate medical services.

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

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

Santa Cruz County Behavioral Health Services has policies and procedures that contain requirements to assure that culturally and linguistically competent medically necessary services. In addition, this is incorporated into network provider contracts.

### **IV. Quality Assurance**

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

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

Santa Cruz Behavioral Health Services (BHS) uses surveys as required by DHCS MHP Consumer Perception Survey and DMC-ODS Treatment Perception Survey. The Consumer Perception Survey has four forms Adult (for ages 18-59), Older Adult (for age 60+), Youth Services Survey (for ages 13-17 and transition-age youth), and Youth Services Survey for Families (for parents/caregivers of youth under age 18). The DMC-ODS has a survey for Youth and for Adult participants. Each of these forms is available in English and Spanish. They are sent out per DHCS survey cycle.

In addition, Grievances, Appeal, State Fair Hearing, Change of Treatment Staff requests are identified by age, gender and ethnicity.

**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 County periodically conducts a survey designed to measure staff experiences and/or opinions regarding the valuation of cultural diversity in the Division's workforce, the provision of culturally and linguistically appropriate services, and their training needs.

A Survey of Needs was completing this year which identified many staff were already taking part in CLAS activities on their own time. The survey also identified what types of CLAS formats staff would like to take part in such as book groups and team discussion on issues of Diversity, Equity, and Inclusion.

**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.**

All grievances, in writing or orally, are treated the same regardless of insurance status of the consumer. The same timeframes are used as well as protocols described in Federal Managed Care Parity rules. Grievances and requests to change providers and complaints are tracked and analyzed. The Quality Improvement staff shares aggregate data to the state as well as shared with the Quality Improvement Steering Committee. The data includes break down by ethnicity, age grouping, gender and language.

Appendix A: Supplemental BHS employee survey at time of annual performance evaluation:

## **Appendix A:**

### **EMPLOYEE CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES FEEDBACK FORM**

This **optional form** is intended to be used in support of or at the time of an employee's annual personnel evaluations to help structure a conversation regarding the integration of cultural competency issues into each employee's job performance. **These are suggested questions only**, meant to assist having a thorough and thoughtful dialogue. The personnel evaluation may be between a supervisor and administrative employee, supervisor and clinician or manager and supervisor. Notes taken on the form, by the supervisor/manager, will be kept only in the supervisor/manager's file to be used for professional development purposes. The agreed-on goal (question # 7) may be included in the formal written evaluation.

- 1. Describe a specific circumstance with a client/clinician/community group or staff member where you think your own values (socio-economic, religious, ethnic, etc.) affected the other person (client/ supervisee/staff member) in either a positive or negative way.**
- 2. Would you consciously repeat this circumstance again? Why or why not?**
- 3. How do you react and relate when an experience of a client, clinician or staff member is very different than or opposed to your own?**
- 4. How has this affected your clinical, supervisory or work relationships?**
- 5. Describe a specific circumstance when you made culturally based assumption(s) in relation to a client, supervisee or other staff? Describe what effect that had on the other person.**
- 6. Describe a specific circumstance when you made gender based or sexual orientation-based assumption(s) about a client, supervisee or staff member. Describe what effect that had on that person.**
- 7. Develop at least one goal for the next year that is specific to increasing your sensitivity to how the needs of your clients, supervisees or co-workers might be different from your own.**