Sonoma County Department of Health Services
Behavioral Health Division
Cultural Competency Plan 2023

Send Word and PDF to MCBHD-CCPR@dhcs.ca.gov by December 31, 2023.

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CHECKLIST OF THE 2010 CULTURAL COMPETENCY PLAN REQUIREMENTS CRITERIA

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Criterion 1: Commitment to Cultural Competence

Sonoma County's Department of Health Services, Behavioral Health Division (DHS- BHD), is committed to meeting the cultural and linguistic needs of our community, for individuals from all racial, ethnic, cultural, and linguistical backgrounds, not just to attain individual health outcomes but also to ensure health equity for the thousands of community members seeking services. This endeavor is reflected in our mission, philosophy, policies, and procedures throughout our mental health system.

Most importantly, DHS-BHD develops data-informed strategic plans based on community engagement and client utilization. The identification of behavioral health disparities, vulnerable populations, emerging trends, and barriers to services is an ongoing quality improvement plan that involves a complex process of examining systemwide data, seeking consumer satisfaction and feedback, assuring regulatory compliance, and balancing budgets.

Holding true to Mental Health Services Act (MHSA) values, our system is driven by clients and family members, focused on wellness and resilience, and philosophically aligned with the belief that recovery is possible. Providing culturally responsive and linguistically appropriate services is central to these values.

I. County Mental Health System commitment to cultural competence. The county shall have the following available on site during the compliance review

A. Copies of the following documents are available to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policies and Procedure Manuals;
5. Other Key Documents (Public reports, such as the Annual Quality Improvement Work Plans and corresponding Evaluations by fiscal year);

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

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

MHSA has provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations. Sonoma County continues to expand the inclusion of consumers, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. Consequently, Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate mental health system of care. At the foundation for the development of this system of care, Sonoma County continues to be driven by the following MHSA Guiding Principles:

- **Community collaboration**: Individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural responsiveness**: Adopting behaviors, attitudes, and policies that enable providers to work effectively in cross-cultural situations.
- **Client and family driven system of care**: Adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Focus on wellness, including recovery and resilience**: People diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities.
- **Integrated service experiences**: Services for clients and families are seamless; clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

DHS-BHD has established a system and structure for a community-engaged planning process as a basis for developing the Three-Year Program and Expenditure Plans and inclusive actions taken under MHSA governance. This structure is anchored with an MHSA Steering Committee and includes the Cultural Responsiveness Committee, the Community Program Planning (CPP) Process Workgroup, and the Mental Health Board. Furthermore, additional outreach and engagement is made through related but independent community committees and advisory councils, such as First 5 Sonoma County and Health Action Sonoma County. The California Code of Regulations, Title 9, states that counties must ensure that stakeholders reflecting the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity, have the opportunity to participate in the CPP process (CCR § 3300).

The commitment to an open and inclusive process is seeded throughout the MHSA committees that are convened by Sonoma County DHS-BHD. The following guiding principles are adhered to in membership and practice:

- Inclusive and representative
- Transparent and easy for all participants to understand
- Collaborative and in partnership with consumers, families, and the community
- Broad participation from diverse groups throughout Sonoma County within a safe space for expression of diverse perspectives
- Culturally responsive

The most recent draft of the Sonoma County MHSA Program and Expenditure Plan Update FY 2023-2026 with FY 2020-21 Annual Report contains the CSS Program Plan and Community Program Planning Process (CPPP) to date.

B. A one-page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.

As noted in the section preceding, DHS-BHD works with stakeholders through established MHSA Steering Committee, Cultural Responsiveness Committee, and the Community Program Planning Workgroup. In addition, DHS-BHD has had various ad hoc interactions with the peer community, community at-large, industry groups such as Health Action Sonoma, law enforcement, First 5, and other coalitions throughout the year. DHS-BHD has consciously

monitored the representation of committee stake holders against the county's demographic make-up. The following chart provides an overview of stakeholder engagement opportunities that have been instituted into regular practice.

Committee/Board	Open, appointed or elected	Composition of members	Number of seats	Meeting Frequency
MHSA Stakeholders	Open to the public	Consumers and family members nonprofit providers of health, social services, criminal justice, education; Contractors and providers of the health department and behavioral health division; interested members of the public.	Undefined	Bi-annually
MHSA Steering Committee	Application and selection process managed by the MHSA Coordinator and Department of Health Services, Behavioral Health Division administration	Members represent the following: · Clients · Families of clients · Providers of mental health, substance use, and social services · Persons with disabilities · Education field · Health care · Law enforcement · Veterans and/or representatives · College-age youth · Other advocates · Individuals from diverse cultural and ethnic groups	20-25 seats	Quarterly
Community Program Planning Workgroup	Combination of voluntary and appointed	MHSA Steering Committee members, Stakeholders	4-8 members	Monthly or as determined by members
Equity Steering Committee	Appointed	Sonoma County Behavioral Health Division employees, and a Department of Health Services equity liaison, who have extensive foundational training in anti-racism and equity through the Sonoma County and Department of Health Services offices of equity	7 members	Monthly or as determined by members
Cultural Responsiveness Committee (on hold, restarting soon)	Combination of voluntary and appointed	Contractors, Mental Health Board, Individuals and/or family members of individuals with lived experience, Equity Steering Committee members, MHSA Steering Committee members, Stakeholders, BHD staff	Up to 12 members	Bi-annual or as determined by members
Life Worth Living Coalition (Suicide Prevention)	Combination of voluntary and appointed	Contractors, individuals and/or family members with lived experience, BHD staff, law enforcement, educational organizations,	Currently 18 members	Monthly or as determined by members

		public health, and members of other organizations and fields as needed		
Peer Advisory Council	Voluntary	Individuals with lived experience; BHD director; BHD Cultural Responsiveness, Inclusion & Training Coordinator	Currently 10 members	Monthly or as determined by members
Mental Health Board	Appointed by Board of Supervisors	Member of the public vested in mental health services. Fifty percent of the Board membership shall be consumers or the family members of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers and at least 20% shall be family members of consumers.	16 members: 3 representatives for each of the 5 county districts and one Supervisor	Monthly, third Tuesday at 5:00 p.m. Check calendar.
Board of Supervisors	Elected		5 district representatives	Weekly on Tuesday at 8:30 a.m.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

Description of the Stakeholder Community Planning Process (CPP)
The Sonoma County Community Program Planning Workgroup was established in August of 2020. The general purpose of the CPP Workgroup is to support community engagement of local stakeholders to obtain input on the development of the county's MHSA Three-year plans and annual program updates. More specifically, the members of the CPP Workgroup were tasked with the following:

1. Identify and conduct outreach to stakeholders for community engagement.
2. Support the distribution of MHSA Plans and Updates upon public release.
3. Co-facilitate the annual Stakeholder meeting: encourage stakeholders to provide relevant input on key system considerations, review MHSA Plan and Updates and provide input through public channels.
4. Develop cost-effective methods of community engagement.
5. Report back to the MHSA Steering Committee, Mental Health Board, and any other governing bodies as necessary.
6. Report back to the engaged stakeholder communities on how their input resulted in changes to MHSA plans, programs and/or budgets.

In 2021, during the second year of the pandemic and stay-at-home orders, CPP Workgroup general meetings shifted to focus on preparing for the Request for Proposal (RFP) process for MHSA Prevention, Early Intervention Services (PEI). Members from the CPP Workgroup were joined by additional community members to form the MHSA PEI RFP Stakeholder group. This group met five times from January to April. The MHSA PEI RFP Stakeholders were instrumental in defining populations of interest for prevention and early intervention services, analyzing the data to recommend funding categories and shaping language of the RFP

solicitation. In addition, CPP workgroup members supported community outreach, distribution of the RFP, and community education on the funding opportunity. In the fall of 2021, the CPP Workgroup developed a Strategic Plan that defined their Mission, Vision, and Values. In addition, priority actions were determined and shaped into a workplan that ultimately recommended a series of listening sessions that are place-based within communities of color and other communities that still experience mental health disparities based on age, geography, gender, or other characteristics. This Strategic Plan was shared with the MHSA Steering Committee and DHS-BHD leadership with a final adoption in January 2022.

Funding of $150,000 was identified to implement the listening sessions in FY 2022-23 with the support of a facilitator. A community-based participatory research model is employed by identifying co-facilitators within populations of interest and building capacity for cofacilitators to design and implement an inquiry within their own communities. From August to October of 2022, the CPP Workgroup determined twelve populations that were of interest to engage for inquiry into their perceptions of appropriate mental health support and services, what is available and what is still needed.

- Latinx Immigrant Adults
    - Sonoma Valley
    - Low-Wage Earners
    - North County Farmworkers and/or their Families
- Latinx US-Born Adults
- Latinx Youth
- African Americans
- Local Indigenous People
- Asian American Pacific Islanders
- People with Disabilities
- Older Adults
- LGBTQI
- Unhoused Women

Within these populations, individuals and organizations were identified by the facilitator and CPP Workgroup members for the role of co-facilitator. Seventeen co-facilitators were identified and participated in orientation and a comprehensive training. These co-facilitators are compensated with a stipend for both attending training and conducting outreach and the listening sessions. Listening sessions were then conducted over a three-month period and all participants were provided with a stipend for their attendance.

The qualitative data was analyzed with co-facilitators and CPP Workgroup members in July of 2023. The project will culminate with a listening session report containing findings and recommendations that will be utilized by the County for shaping future programming for the MHSA system of care. This report will be disseminated back to the community of participants, stakeholders, Mental Health Board, MHSA Steering Committee, and DHS-BHD leadership.

Innovation Projects Focused on Underserved Populations
Several innovation projects funded through MHSA in Sonoma County have a specific focus on engagement with underserved populations.

Organization/Project Name	Focus and Funding
On the Move/Nuestra Cultura Cura Social Innovation	Community defined practices for mental health in the Latino/x community A total of $736,584 MHSA funding is being allocated for the 3-year Innovation project.
Early Learning Institute/Instructions Not Included, Dads Matter	Screening and supporting new parents, inclusive of non-birth parent (fathers and partners). A total of $689,860 MHSA funding is being allocated for the 3-year Innovation project.
Crossroads to Hope	Expanding access to community mental health, substance use disorder, and trauma treatment as an alternative to incarceration, by developing facility space for both housing and service delivery to individuals who are being diverted to the community from the County jail. A total of $560,379 is allocated for three fiscal years.
Sonoma County Human Services Department/ Collaborative Care Enhanced Recovery Project (CCERP)	Case management for older adults 50+ years with an emphasis on Spanish speaking population. A total of $998,558 MHSA funding is being allocated for the 3- year Innovation project.
First 5 Sonoma County/ New Parent TLC	Training gatekeepers to refer new parents, with a specific focus on LGBTQ+ parents and Spanish language. A total of $394,586 MHSA funding is being allocated for the 3-year Innovation project.

Peer Advisory Council

Our Peer Advisory Council is a new committee, which has met for about six months and is still in planning stages for its structure and goals. Designed to increase peer access to the Behavioral Health Director, the committee is facilitated by the Cultural Responsiveness, Inclusion & Training Coordinator. We are "moving at the speed of trust," working to repair and rebuild institutional relationships that have been strained in the past, and we are incorporating values of participatory decision-making to move against typical hierarchical structures that can impede relationships. We are currently working to define mission, membership, authority, and scope, recognizing that the voices of people with lived experience should be central in our planning of behavioral health treatment services.

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

Sonoma County's title for this position is Cultural Responsiveness, Inclusion, and Training Coordinator. This position reports to and has direct access to the Behavioral Health Director regarding issues related to the racial, ethnic, cultural, and linguistic populations within the county and the DHS-BHD workforce.

A. Detail who is designated the county's CC/ESM 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 Cultural Responsiveness, Inclusion, and Training Coordinator position is held by Lisa Nosal, LMFT. She is responsible for ensuring behavioral health services are provided in a culturally appropriate and responsive manner to the diversity of our clientele. This involves participation in several cross-cutting areas in DHS-BHD. That includes:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive.
- Workforce, Education, and Training: developing a workforce pipeline to diversify the incoming behavioral health workforce that includes participation in the development of strategies related to recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current DHS-BHD workforce is appropriately attending to the needs of our diverse clientele.
- Program Design and Development: participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- Leadership Development: Strengthening management, administrative, and other staff performance.
- Participation in the Sonoma County Department of Health Services Equity Circle.

Sonoma County DHS-BHD uses the California Behavioral Health Directors Association (CBHDA) April 2016 *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services* as the basis for the implementation of CC-ESM responsibilities.

In addition, the Behavioral Health Division identified priority areas for FY 21-22 that will drive the cultural competency goals for the remainder of the fiscal year and into the next.

FY 22-23 Goals	Details	Activities
I. Restart the Cultural Responsiveness Committee (CRC)	The monthly CRC meetings were suspended pending new leadership, the hire of the CRIT Coordinator, and the establishment and training of the DHS Equity Circle.	The BHD Equity Steering Committee will serve as the advisory board for the re-establishment of the Cultural Responsiveness Committee, connecting it to existing systems in at the Department and County levels.
II. Implement a Trauma-Informed Systems division transformation project	A trauma-informed system requires a foundation in cultural humility and equity. By creating structures that emphasize equity, resiliency, collaboration, safety, empowerment, and an understanding of the effects of trauma and stress, BHD will create better conditions for fostering diversity, equity, inclusion, and belonging for both staff and clients.	Working with Trauma Transformed, a Bay Area clearinghouse that promotes and trains trauma-informed systems, BHD is providing staff training, leadership learning, organizational assessment, and transformation of policies, practices, and protocols.
III. Oversee a staff training program to reduce racial, ethnic, cultural and linguistic mental health disparities and on the topics identified in the last staff Cultural Competence survey. Implement annual minimum standard for mandatory cultural competency training for all Division staff.	12 hours of all-staff training in FY2023-2024 will be devoted explicitly to cultural responsiveness and cultural humility trainings, and 30 additional hours of training have major components focusing on cultural responsiveness and equity. Additionally, Quality Management and Leadership staff for both BHD and contracted providers will receive six hours of training in Anti-Racist Results-Based Accountability.	All-staff training explicitly focused on cultural responsiveness will include: • Cultural Humility • Anti-Racism • Gender-Inclusive Language & Treatment All-staff training with major components of cultural responsiveness include: • Harm Reduction (multiple trainings) • Trauma Informed Systems

IV. Institute strategies to diversify and support a diverse behavioral health workforce at all levels of DHS-BHD.	Conduct pipeline activities to both encourage behavioral health career pathways and to support promotional opportunities. Implement recruitment, hiring, development, support, and retention strategies that support workforce diversification.	Work with local universities to create a formal pipeline program. Using Trauma Transformed principles and systems and additional training from The Management Center and other equity-forward organization, increase management and supervisory capacity for supporting a diverse workforce. As part of both BHD leadership and the DHS Equity Circle, work with both groups to create an inaugural Health Equity Plan for the department to guide and support ongoing work for diversity, equity, inclusion, and belonging for both staff and clients.
V. Implement strategies to support increasing services to the Latinx/Latine community	Work with the Quality Improvement Manager to increase Latinx/Latine access to specialty mental health services. Identify supports to improve services from a cultural perspective and experience.	Participate on QI Performance Improvement Project workgroup Identify resources and supports for Latinx/Latine beneficiaries and their families that support treatment and recovery. Attend regional and statewide CC/ESM meetings for TA exchange on strategies and best practices.

VI. Responsible for development and implementation of Cultural Competency Plan (CCP) for DHS-BHD	Review and develop the planning, policy, compliance, and evaluation of system and services to affect change and improvement to equity measures.	Attend Quality Improvement Committee (QIC), and MHSA Steering Committee to assist in development of a culturally responsive division and recommend actions for policy and practice adaptations. Work with DHS Office of Equity to develop Health Equity Steering Plan for the department.

IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:

1. Budget amount allocated for Interpreter and translation services

Currently, Sonoma County BHD has $166,192 budgeted for interpreter and translation services through Language Link (spoken language) and Communique (American Sign Language).

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities

Allocations in the FY 2023-24 budget for the Sonoma County Behavioral Health Division, to reduce disparities and increase equity system-wide.

Budget Allocation Description	FY 23-24
Cultural Responsiveness, Inclusion & Training Coordinator (1 FTE)	$251,500
Support staff (0.5 FTE)	$16,908
West County Community Services – Peer Education and Training	$147,926
DHS-BHD Workforce Education & Training Activities	$400,000

3. Budget amount allocated towards outreach, community engagement and prevention to racial and ethnic county-identified target populations

Priority Population	Organization(s)	FY 23-24
Latinos/x	Latino Service Providers, La Luz	$148,739
Latinos/x	Innovation: New Parent TLC/Unidos	$537,192
Native Americans	Sonoma County Indian Health Project	$42,443
Black/African Americans	Community Baptist Church Collaborative	$127,327

4. Budget for culturally appropriate mental health clinical services

Priority Population	Organization(s)	FY 23-24
Latinos/x	On the Move	$233,154
Latinos/x	Buckelew and UC Davis, Early Psychosis Learning Healthcare Collaborative Network/ TAY Spanish Speaking Community	$129,699
Latinos/x	La Luz	$50,402
Native Americans	Sonoma County Indian Health Project	$85,988

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

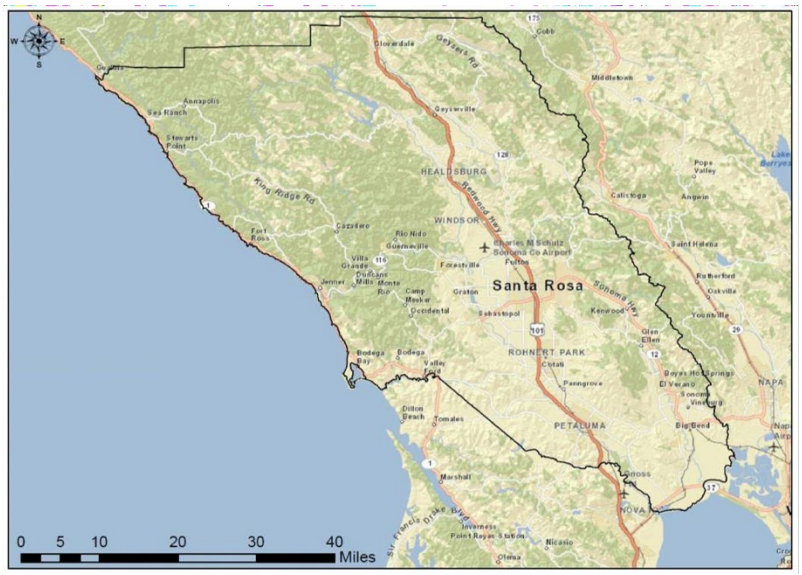
The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

Criterion 2: Updated Assessment of Service Needs

A population assessment is necessary to identify the cultural and linguistic needs of the County and to determine/confirm emerging population(s) of need. This assessment is also critical in designing and planning for the provision of culturally responsive and effective mental health services.

I. General Population

A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.



Sonoma County, located within the San Francisco Bay Area, about 45 minutes north of San Francisco has a population of 488,863 people across a region of 1,576 square miles.[1] A large, urban-rural county with 76 miles of Pacific Ocean coastline, Sonoma County is known for its Mediterranean climate that supports an agricultural industry including vineyards producing world class wine. In addition to agriculture, the County's major industries include healthcare, hospitality, and manufacturing. The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.

Santa Rosa is the county's most populous city with 178,127 people (U.S. Census Bureau, 2020) and is home to over one-third of county residents. The County seat and DHS-BHD's main campus are located in Santa Rosa. Beyond Santa Rosa, the main population centers are Petaluma (population 59,776) and Rohnert Park (population 44,390) to the south, and Windsor to the north (population 26,344).[2] Sonoma County is geographically dispersed with limited public transportation and bicycle and pedestrian infrastructure, which can make it challenging for individuals living in more rural areas and those without a personal vehicle.

In 2021, 61.5% of residents identified as White, non-Hispanic, with 28.3% identifying as Hispanic or Latinx, the County's largest and fastest growing minority population.[3] The

[1] U.S. Census Bureau. (2020). Quick Facts, Sonoma County, California.
[2] Ibid.
[3] USAFacts, Our Changing Population: Sonoma County, California, https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county

County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx/Latine community in particular. While Latinx/Latine residents were over a quarter of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.[4] Additionally, there are an estimated 27,000 undocumented residents in the County.[5] Of those, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.[6] Individuals who are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services.

The County is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the Lytton Band of Pomo Indians. Native Americans make up 0.7% of the County's total population[7] and about 1% of Medi-Cal beneficiaries. According to USAfacts, in 2021 the Asian population composed 4.4% of the total population and African American/Blacks were 1.7%. Cultural and language differences can reduce access as well as the quality of services available—particularly for individuals in small communities and with lower levels of income.

Finally, Sonoma County is aging. The 65+ age group was the fastest growing between 2010 and 2021, with its population increasing from 14% to 21.1% (rate of 51.1% growth). The five to 19 year-old age group decreased the most, dropping from 19% to 14% (rate of 10.4% decline) between 2010 and 2021.[8] This data trend has serious implications for service delivery needs for the elderly and economic impacts for school districts. The intersectionality of race, age, economics, language, and gender have deep implications on access to housing, services, and healthcare.

Sonoma County's median household income is $91,607 (U.S. Census Bureau, est. 2021), however this is in contrast to the 9.1% of County residents living in poverty. Sonoma County's unemployment rate peaked at 14.5% in April 2020. The rate has since then decreased to just over 3.6% for February 2023 as reported by the Labor Market Information Division, California Employment Development Department.

While Sonoma County continues to recover from the COVID-19 pandemic and devastating fires and floods from the past five years, rising housing costs continue to be a key driver of economic instability. Over 60% of Sonoma County residents who rent their homes and over 30% of residents who own their homes experience housing-cost burden (i.e., spend 30% or more of their household income on rent or mortgage). Historic chronic underbuilding of housing created a disparity between supply and demand and limited the growth potential of the County's economy. Housing costs and underbuilding have the greatest impact on individuals and families with less financial security or who are experiencing home instability.

The severe wildfire seasons of 2017, 2019, and 2020, combined with the flood of 2019 and the Covid-19 pandemic that began in 2020, have transformed the lives of many Sonoma

[4] California Department of Health Care Services (2018). Medi-Cal Enrollees and Beneficiaries https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx
[5] Profile of the UnauthorizedPopulation: Sonoma County, Migration Policy Institute. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097
[6] Ibid, English Proficiency
[7] USAFacts, Our Changing Population: Sonoma County, California, https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county
[8] Ibid.

County residents. Sonoma County experienced a net 3.3% decrease in population from 2017 to 2021.[9]

The 2017 Complex Fires burned over 112,000 acres, destroyed over 5,000 homes, and took 24 lives. One in six households reported lost wages or employment and one in ten households reported an increase in housing or rent costs as a direct result of the fires. In 2019 an atmospheric river brought up to 20 inches of rain to Sonoma County over three days. The heavy rains caused the Russian River to rise 13 feet above flood stage to 45.4 feet in Guernevillle, which resulted in the worst flood event in Sonoma County in 24 years. The flood impacted Russian River communities including Guerneville, Jenner, Rio Nido, Monte Rio, Sebastopol, and Healdsburg. Over 40 people were rescued, 3,600 residents were evacuated and 8,000 were without power. Additionally, more than 2,000 homes and businesses were flooded, with 527 structures damaged and 31 declared uninhabitable due to flood damage. The flood impacted 578 businesses, totaling $35 million in damages.

After the flood in 2019, came the largest wildfire to burn in Sonoma County, the Kincade Fire, which was also the largest fire of the 2019 California wildfire season. The Kincade Fire burned over 77,000 acres in Geyserville, Windsor, and Healdsburg and resulted in the evacuation of 90,000 residents. The fire destroyed174 homes and 200 additional structures, including winery facilities.

The impact of COVID-19 is challenging to quantify in lives lost, jobs lost, businesses closed, revenue decreased, supply chain impaired, and workforce compromised. The estimated Gross Regional Product (GRP) lost $6.157 billion from 2020 to 2023, and the estimated loss of employers by 2023 is 6.9%.[10] The industries that were most impacted were lower-wage earners in retail, hospitality, and tourism. However, even strong economic sectors were impacted, including construction, education, and healthcare. The Sonoma County Economic Development Board projects that the long-term impacts depend on housing market (in)stability, ability to continue to build more housing, longer spell of unemployment, and subsequent pressure on non-profit and public programs, and the potential outmigration of lower-wage workers. In the midst of the COVID-19 pandemic, California experienced rare thunderstorms in August of 2020, which sparked 376 fires across the state. Two of those fires occurred in Sonoma County: the Walbridge Fire and the Meyers Fire. In total, the Walbridge and Meyers Fires destroyed 298 structures, including 150 residences and nine motor homes. A third major fire of 2020 started in September, the Glass Fire. The Glass fire burned over 67,484 acres and destroyed 1,555 structures, including 334 homes in Sonoma County. Approximately 2.5% of Sonoma's total housing units were lost in the 2017 fires, leading the County to require a total of 26,000 new units by 2020 to account for employment growth, fire losses, and overcrowding.

COVID-19, the fires, and the flood have impacted Sonoma County economically and have also brought mental health impacts across the county. Forty percent of households in Sonoma County reported individual and collective trauma experiences, such as being separated from a family member or suffering a significant disaster-related illness or injury.[11] In a poll conducted by the Kaiser Family Foundation, 45% of Americans said the virus and pandemic had a negative effect on their mental health. Young adults have experienced

[9] Ibid.
[10] Economic Impacts of COVID-10 on Sonoma County Economy, August 2020. Sonoma County Economic Development Board.
https://sonomaedb.org/Microsites/Economic%20Development%20Board/Documents/Archive/_Documents/Reports/_2020/Economic-Impacts-from-COVID19-Sonoma-County-Report.pdf
[11] Sonoma County Department of Health Services, Epidemiology and Assessment Unit. (2019)

several pandemic related consequences, such as closures of universities and high schools and loss of income, which may contribute to poor mental health. In May of 2020, YouthTruth conducted a survey with more than 5,000 Sonoma County high school students, in which 71% reported "feeling anxious about their future" due to disruptions in their lives and cited it as the number one barrier to distance learning. Prior to the pandemic, young adults were already at higher risk of poor mental health and substance use disorder, though many did not receive treatment.

During the 2020-21 academic year, YouthTruth conducted another survey with a total of almost 30,000 respondents: 18,366 high school students, 8,954 parents, and 1,996 school staff from 56 participating school in Sonoma County. Seventy-three percent of school staff, 72% of families and 57% of students reported that the pandemic had meaningfully affected their lives. Furthermore, of the nearly 2,000 school staff surveyed, 35% stated that they've seriously considered moving out of the area due to concerns of cost of living, wildfires, housing issues, and job availability.

The pandemic has also disproportionately affected the education and health of communities of color, low-income families, and families living in remote geographic areas of the county. Sixty-three percent of high school students surveyed reported at least one obstacle to learning, including feeling depressed, stressed, or anxious. In addition, barriers included distractions at home, family responsibilities, and limited or no internet access.[12]

Non-Hispanic Black adults (48%) and Hispanic or Latinx adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41%). Historically, these communities of color have faced challenges accessing mental health care. The pandemic also disproportionately affected LGBTQIA+ youth; almost 70% reported feeling so sad or hopeless almost every day that they stopped doing some usual activities, compared to just over 25% of straight youth (Kids Data, 2020).

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

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

1. The county's Medi-Cal population

Over one fourth (130,665) of the population is eligible for Medi-Cal (DHCS, 2022), and 7.8% of the population has an income below the Federal Poverty Level (FPL). California External Quality Review Organization (CalEQRO), BHC Behavioral Health Concepts, reports that Sonoma County's average monthly unduplicated number of Medi-Cal enrollees by Race/Ethnicity and language during Calendar Year 2021 are as follows:

[12] Leading Through Listening: Student & Community Voices in Sonoma County, 2020-21, YouthTruth. http://youthtruthsurvey.org/wp-content/uploads/2021/05/YouthTruth-Leading-through-Listening-in-SonomaCounty.pdf

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
White	36,206	27.7%
Latinx/Hispanic	52,228	40%
Asian/Pacific Islander	4,014	3.1%
Black/African American	2,054	1.55%
American Indian or Alaska Native	1,244	0.95%
Not Reported	34,919	26.7%
Total	130,665	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently. California's Department of Health Care Services (DHCS) Behavioral Health Information Notice 20-07 reports Spanish as a threshold language for Sonoma County. DHCS defines "Threshold Language" as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or 5% of the beneficiary population—whichever is lower—in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3).

Language	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
English	84,554	64.7%
Spanish	43,478	33.3%
Other/Unknown	2,633	2%
Total	130,665	100%

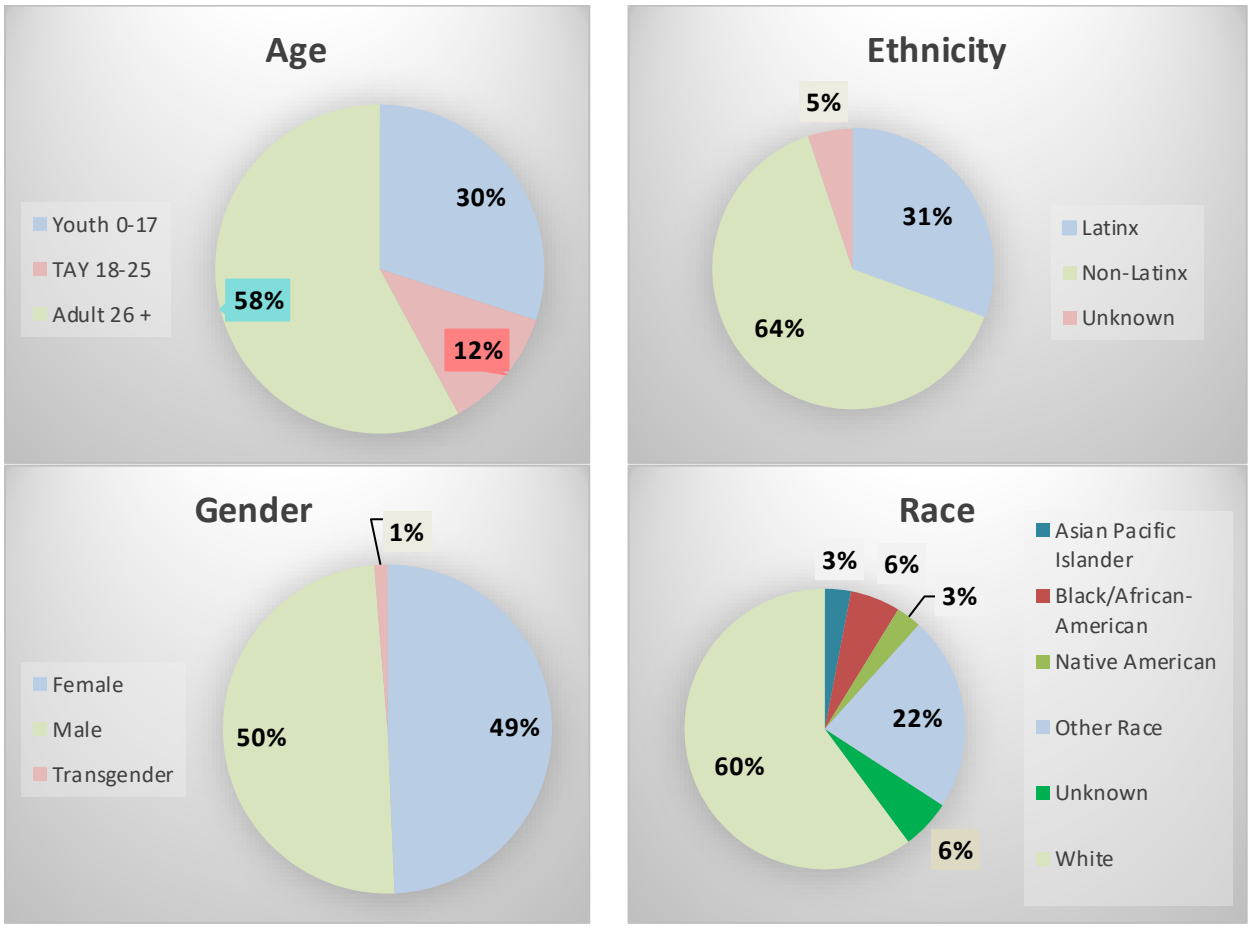
2. The county's client utilization data

Figures taken from Sonoma County's Annual Quality Assessment and Performance Improvement Work Plan Evaluation for Fiscal Year 2021-2022

FY 21-22 DEMOGRAPHICS MHP BENEFICIARIES SERVED

AGE	**UNIQUE BENEFICIARIES**	**PERCENT**
Youth (0-17)	1,038	30.04%
TAY (18-25)	416	12.04%
Adult (26+)	2,001	57.92%
RACE		
Asian Pacific Islander	104	3.01%
Black/African American	199	5.76%
Native American	101	2.92%
Other Race	776	22.46%
Unknown	197	5.70%
White	2,078	60.14%
ETHNICITY		
Latinx	1,055	30.54%
Non-Latinx	2,222	64.31%
Unknown	178	5.15%

GENDER		
Female	1,704	49.29%
Male	1,705	49.35%
Transgender	46	1.30%
GRAND TOTAL	**3,455**	**100%**



B. Provide an analysis of disparities as identified in the above summary. This can be a

narrative discussion of the data. Data must support the analysis.

Race/Ethnicity
From the Sonoma MHP EQRO Final Report for FY 2022-23:

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	41%	32%	1%	21%	2%	3%
MHP % Eligible	28%	26%	1%	40%	3%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	400	12.40%
Threshold language source: Open Data per BHIN 20-070		

The EQRO report stated, "Similar to the pattern seen statewide, White beneficiaries are disproportionately overrepresented among beneficiaries served relative to the Medical eligible population, whereas Hispanic/Latino beneficiaries are underrepresented." Of note, Sonoma County's recent data analysis shows a much smaller percentage of clients with "Other" racial identity than the EQRO report (22% vs. 32%), with only 5.15% falling into the "unknown" category of Latinx versus non-Latinx. Sonoma County's Quality Improvement team undertook a project to investigate the medical records of clients whose ethnicity was listed as "Other" or "Unknown" to determine if incomplete data entry had obscured the client's race or ethnicity in the medical record (e.g., clients who were first admitted to Crisis Stabilization during an acute psychiatric emergency and thus could not provide reliable demographic data), and to correct those charts when that had happened.

Using Sonoma County's most recent numbers, we see that the percentage of Latinx/Latine beneficiaries served is 30.54% for fiscal year 2021-2022. As the percentage of Latinx/Latine Medi-Cal eligible population in Sonoma County is 40%, Sonoma County has improved but still falls below where we should be. Similarly, the percentage of clients served in Spanish (12.4%) falls greatly below the percentage of Medi-Cal beneficiaries whose primary language is Spanish (33.3%). (The data clean-up seems to have removed the gap for Asian/Pacific Islander beneficiaries, and other identified racial categories are proportionate in service percentage and population percentage.)

While this closing gap shows promise for Sonoma County BHD intervention efforts, more work is needed and has been prioritized to achieve health equity for Sonoma County's Latinx/Latine population.

Age

From the Sonoma MHP EQRO Final Report for Fiscal Year 2022-2023:

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	13,072	78	0.60%	1.08%	1.96%
Ages 6-17	31,269	894	2.86%	4.41%	5.93%
Ages 18-20	7,025	212	3.02%	3.73%	4.41%
Ages 21-64	66,838	1,833	2.74%	4.11%	4.56%
Ages 65+	11,561	210	1.82%	2.26%	1.95%
Total	129,764	3,227	2.49%	3.67%	4.34%

While Sonoma County shows a lower penetration rate in all categories than both similar sized counties and the statewide average, the difference is fairly uniform across all age categories. The outlier for underserved populations is the 0-5 age range. This gap points to a need to continue strengthening our relationships with prenatal and perinatal healthcare providers and supports.

Interestingly, the smallest gaps are in the Ages 18-20 and Ages 65+ populations, two populations that tend to be at high risk for mental health concerns and behaviors. This points to strengths in coalition-building with community partners and in service delivery that we can continue to build on.

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

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

The following tables are made available by the CA Department of Health Care Services. These tables demonstrate mental health and alcohol and other drug prevalence estimates.

These tables are available to all California counties. To review the complete report, follow the following link:

https://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Children and Youth in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Youth Total	2,553	29,326	8.7
AGE			
00-05	982	11,292	8.7
06-11	839	9,625	8.71
12-17	732	8,409	8.71
GENDER			
Male	1,274	14,524	8.77
Female	1,279	14,902	8.64
ETHNICITY			
White - NH	748	8,570	8.73
African American - NH	63	702	9.04
Asian - NH	92	1,073	8.6
Pacific Islander - NH	6	69	8.83
Native - NH	22	241	9.12
Other - NH	0	0	0
Multi - NH	84	955	8.82
Hispanic	1,537	17,716	8.68

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Adult Total	6,305	76,006	8.71
AGE			
18-20	172	5,374	3.2
21-24	646	9,005	7.17
25-34	1,612	15,730	10.25
35-44	1,437	11,862	12.12
45-54	1,253	10,669	11.75
55-64	707	9,261	7.63
65+	477	14,104	3.38
GENDER			
Male	2,331	34,176	6.82
Female	3,974	41,830	9.5
ETHNICITY			
White - NH	3,869	42,589	9.08
African American - NH	140	1,446	9.66
Asian - NH	100	2,850	3.49
Pacific Islander - NH	7	151	4.47
Native - NH	89	766	11.64
Other - NH	0	0	0
Multi - NH	148	1,690	8.78
Hispanic	1,952	26,515	7.36
MARITAL STATUS			
Married	1,575	26,175	6.02
Sep/Wid/Div	2,594	24,469	10.6
Single	2,153	25,362	8.42
EDUCATION			
Grades 00-11	2,154	26,976	7.98
HS Graduate	3,541	40,124	8.82
College Graduate	610	8,906	

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

According to the data cited above, non-Hispanic Native Americans, African Americans, and multi-racial populations are disproportionately represented in estimated need. This data is supported by Sonoma County's capacity assessments and identification of priority populations.

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

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.

The utilization by Medi-Cal beneficiaries by age, race, ethnicity, and gender are below, and beneficiaries by geographical area follow.

AGE	**UNIQUE BENEFICIARIES**	**PERCENT**
Youth (0-17)	1,038	30.04%
TAY (18-25)	416	12.04%
Adult (26+)	2,001	57.92%
RACE		
Asian Pacific Islander	104	3.01%
Black/African American	199	5.76%
Native American	101	2.92%
Other Race	776	22.46%
Unknown	197	5.70%
White	2,078	60.14%
ETHNICITY		
Latinx	1,055	30.54%
Non-Latinx	2,222	64.31%
Unknown	178	5.15%
GENDER		
Female	1,704	49.29%
Male	1,705	49.35%
Transgender	46	1.30%
GRAND TOTAL	**3,455**	**100%**

GEOGRAPHIC LOCATION OF MHP BENEFICIARIES SERVED

North 7.04%

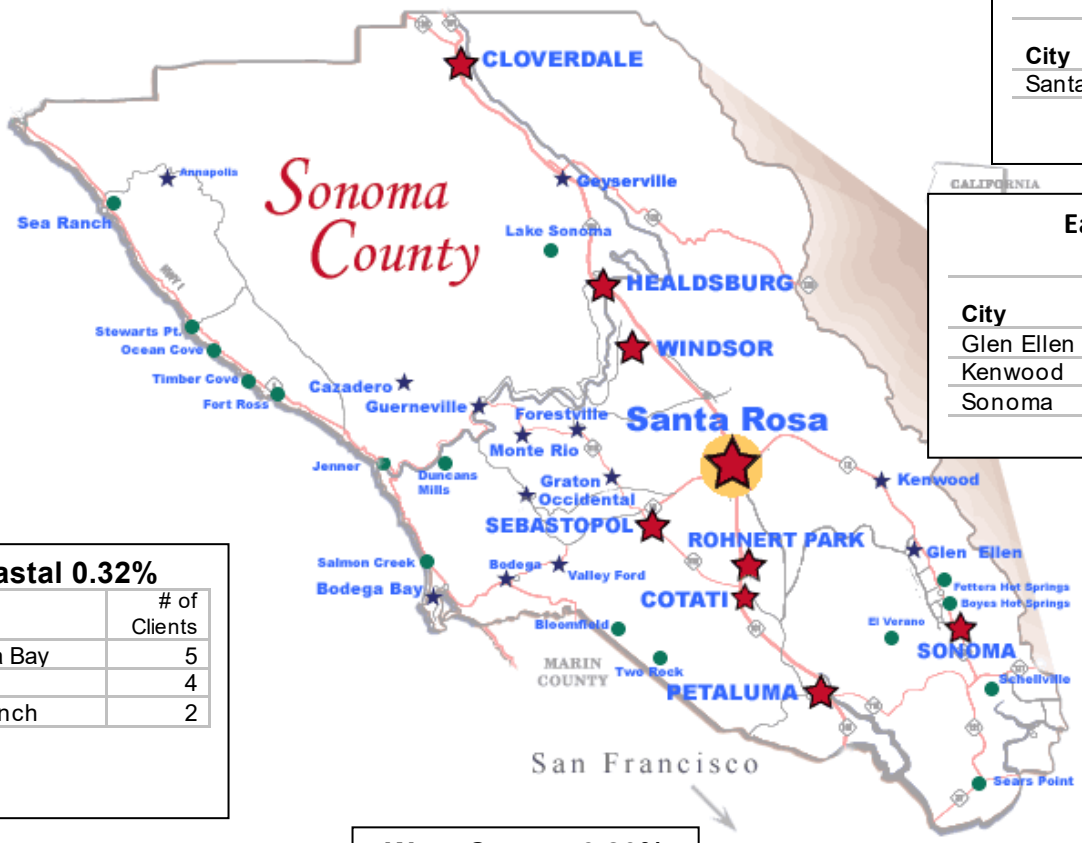
City	# of Clients
Cloverdale	71
Fulton	3
Geyserville	9
Healdsburg	58
Windsor	102

Central 58.08%

City	# of Clients
Santa Rosa	2006

East 4.63%

City	# of Clients
Glen Ellen	14
Kenwood	4
Sonoma	142



Coastal 0.32%

City	# of Clients
Bodega Bay	5
Jenner	4
Sea Ranch	2

West County 6.20%

City	# of Clients
Camp Meeker	1
Cazadero	2
Forestville	26
Graton	2
Guerneville	62
Monte Rio	8
Occidental	2
Rio Nido	3
Sebastopol	108

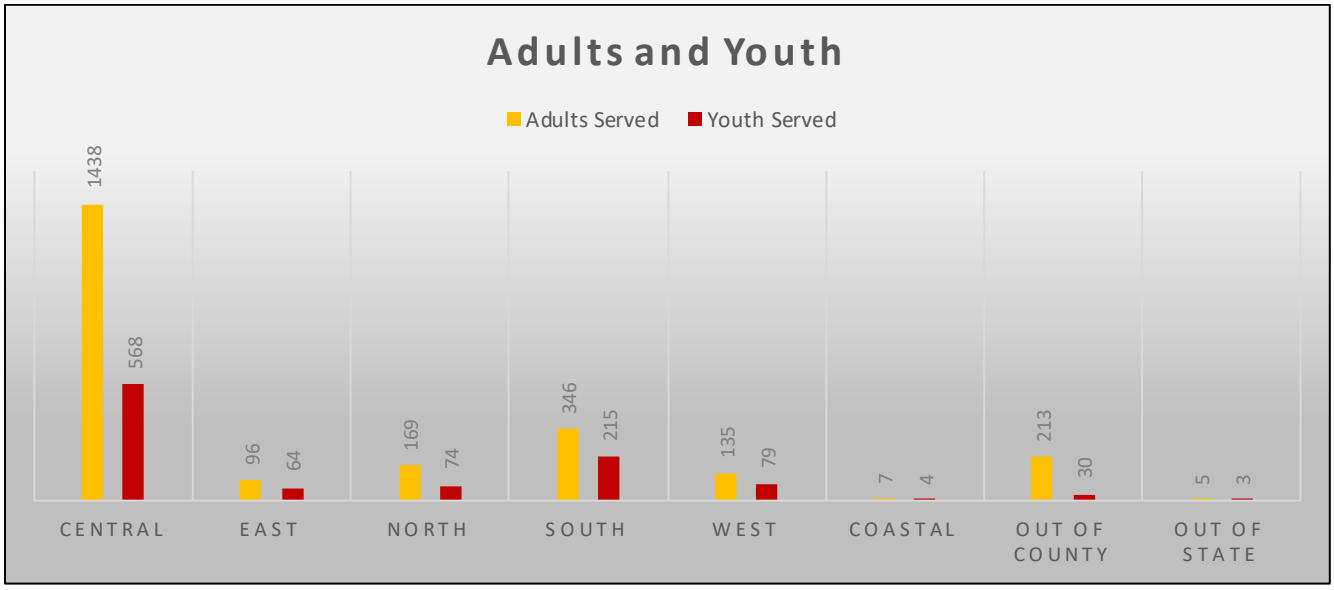
South 16.21%

City	# of Clients
Cotati	52
Penngrove	18
Petaluma	244
Rohnert Park	247

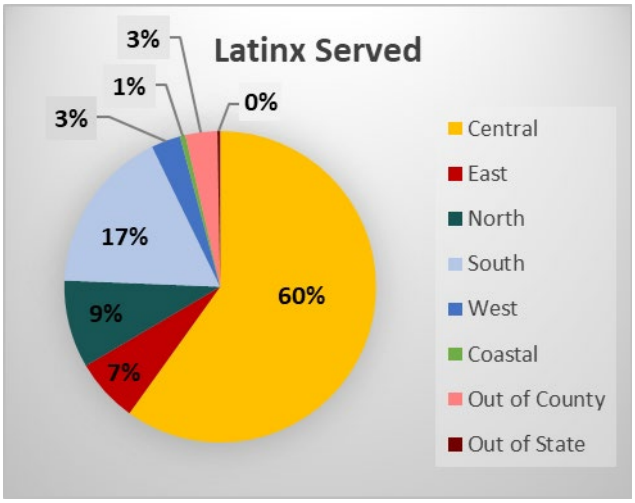
Out of County 7.27%

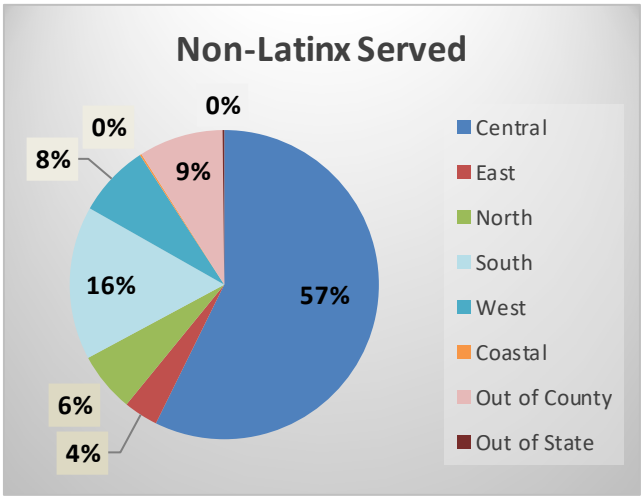
City	# of Clients
Out of County	243
Out of State	8

AGE GROUP MHP BENEFICIARIES BY REGION OF RESIDENCE



ETHNICITY OF MHP BENEFICIARIES BY REGION OF RESIDENCE





B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

The ethnicity analysis of beneficiaries served revealed a growing trend seen in previous years. Latinx/Latine clients are significantly more likely to be served in the Youth System of Care—approximately 51% of the youth served in FY21-22 identified as Latinx, versus 22% for adults. Regarding this year's growth in youth services, the majority of that growth (68%) was attributed to increases in Latinx/Latine youth served. In FY20-21, 417 Latinx/Latine youth were served, whereas a total of 525 Latinx/Latine youth were served in FY21-22. Finally, in terms of region of residence, Latinx/Latine beneficiaries are less likely to live in the West County area, and somewhat more likely to live in the East, North, and Central/Santa Rosa areas.

In every region of the county, the number of youth served increased. The total number of youth served (1,038) increased by 18% over last fiscal year, while the number of Transitional Age Youth (TAY) (416) decreased by 20%. Adults served (2,001) decreased by 4% in comparison to last year. A higher percentage of youth served resided in the southern part of Sonoma County.Twenty-one percent of youth (215) lived in South Sonoma County, versus 16% (66) for TAY and 14% (280) for adults. As consistent in previous years, adults were over three times more likely to be served out-of-county than youth.

The 2023 MHSA Capacity Assessment Report found that in fiscal year 2021-2022, 3,484 unique individuals were served by Sonoma County BHD, with a total of 2,378 clients served by Adult and Older Adult Services, 1,154 clients served by Youth and Family Services, and 65 clients served by TAY services. The racial and ethnic makeup of clients was similar to that of the county, with a majority of clients identifying as White and about a quarter identifying as Hispanic/Latinx. Most clients were between the ages of 26 and 59, and the majority were diagnosed with psychotic disorders and mood disorders, including schizophrenia, bipolar disorder, anxiety disorders, depressive disorders, and trauma related disorders. Almost half of all clients entered the system through the Access Teams and crisis services, and after entry, most clients utilized outpatient services. Analysis of client demographics across programs identified certain groups being over- and/or under-represented in the system of care. Notably, Latinx/Latine adult clients were underrepresented in the adult system, while Latinx/Latine youth were over-represented in the youth system of care, specifically within general outpatient programs and youth justice services, compared to the Medi-Cal- eligible population of Sonoma County. Other groups, such as Black and Native American clients. were also found to be overrepresented in unlocked residential programs.

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

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

Most recently, the MHSA Work Plan Summaries for the Integrated Plan for PEI have prioritized the following populations:

- Latinx/Latine
- African Americans
- Native Americans
- LGBTQIA+ youth and Older Adults
- 0-5 year olds and their caregivers

These culturally underserved groups were identified and validated through a variety of data sources, including the 2019 Sonoma County Capacity Assessment and FY 2020- 23 MHSA Three-year Program and Expenditure Plan; 2018-2020 EQRO data reports; documented meetings with stakeholders, MHSA Steering Committee, Mental Health Board and Health Action Chapters.

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

I. List the target populations with disparities your county identified in Medi- Cal and all MHSA components (CSS, WET, and PEI)

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

The FY 2020-2023 MHSA Three-Year Planning Process and preceding Capacity Assessment validated the populations most at-risk and in need of PEI services:

- Native Americans
- Latinx/Latine
- African/Black Americans
- LGBTQIA+

II. Then list disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Latinx Community (Medi-Cal, CSS, WET and PEI)
The County has had a low Latinx/Latine penetration rate in clinical services for the past several years. The County is working toward increasing both access to mental health services for Latinx/Latine clients and improving the cultural responsiveness of services for Latinx/Latine clients.

While the County offers behavioral health services for the Latinx/Latine community, targeted opportunities were limited. Recent listening sessions, conducted as part of the MHSA Community Program Planning process, identified the following concerns from Sonoma County Latinx/Latine populations:

- Culturally aware and relevant services
- Access to services
- Increased mental health concerns
- Increased bullying of children and youth
- Multi-generational families and their needs
- Youth service needs, increased depression/anxiety/stress among youth
- Need for more sensitive providers
- Racism and discrimination
- Need for formal and informal (i.e., peer) support
- Housing and homelessness
- Cultural taboos and stigma
- Education about mental health
- Need for geographically diverse services
- Need for community connectedness
- Need for more school-based services
- Intergenerational trauma
- Migration-based trauma

Native American Communities (PEI, WET, Medi-Cal)
The Native American population has access to the Sonoma County Indian Health Project (SCIHP), a Community Health Center that provides behavioral health, medical, dental, and other wellness related services predominantly to Native Americans in Sonoma. However, SCIHP is underutilized, likely due to mental illness stigma within the target population and limited culturally specific programs in remote geographic areas. As with the Latinx/Latine community, this could be leading Native American individuals with behavioral health needs to over rely on crisis services, as the majority of Native American consumers went to the CSU in fiscal years 2018-2019. As mentioned previously, Native American consumers were also overrepresented in locked long-term residential treatment. In fiscal year 2018-2019 they made up 7% of program episodes compared to only 2% of the MHSA population.

MHSA listening sessions with Indigenous groups in central Sonoma County and coastal Sonoma County are scheduled for fiscal year 2023-2024 to continue work on identifying and then addressing barriers and challenges, and building on community strengths.

LGBTQIA+ Youth and Young Adults (PEI, WET, CSS, Medi-Cal)
A recent survey conducted by a local nonprofit, Positive Images focused on learning more from the community of LGBTQIA+ youth (14-18 years) and young adults (18-30 years). The sample of over 100 respondents reported that up to 24% were nonbinary or transgender. This population continues to report that they are challenged with finding both healthcare and mental health services that support them in their identity and in meeting their health needs. Sixty-eight percent of the respondents reported that they had utilized mental health services in the past year. Furthermore, this population reported that 79% had received a diagnosis of depression, 77% of anxiety, 41% of PTSD, and 26% of ADD/ADHD. The most striking finding was that 25% had called the suicide hotline at least once in their life, and 4% had called more than three times in their life.

Sonoma County's most recent Consumer Perception Survey noted that the number of other-gender respondents increased significantly and dramatically for youth. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year. While the finding corresponds to Positive Image's survey results, the increase indicates that trans and gender-expansive behavioral health clients are either more comfortable disclosing their gender identity to their mental healthcare providers, or that more people from this community are seeking behavioral healthcare services with DHS-BHD.

A recent MHSA listening session for LGBTQIA+ people in Sonoma County identified the following concerns:

- Lack of culturally aware and relevant services, including fear of misgendering
- Need for both formal and informal (i.e., peer) support
- Need for community connectedness
- Need for increased and improved outreach and information
- Expanded mental health services
- Need for more sensitive, prepared providers
- Stigma and discrimination
- Increased stressors (natural disasters, national and local politics, Covid)
- Need for improved access to services beyond crisis services
- Housing and homelessness

- Physical activity and its relationship to mental wellbeing
- Depression and suicidal ideation

III. Then list strategies for the Medi-Cal population as well as those strategies identified in the MHSA plans (CSS, WET, and PEI) for reducing those disparities described above.

Latinx/Latine Community
Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and the social service sectors. LSP currently comprises over 1,600 members from neighborhood and community groups, mental health programs, public and private health service providers, education, law enforcement, immigration and naturalization agencies, social service agencies, community-based organizations, city and county governments, criminal justice systems, and the business community. The mission of LSP is to serve and strengthen Latinx families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

In 2021, PEI funds were opened to public bid to identify new approaches for prevention and early intervention for Latinx/Latine community members. Funding was shifted to support Youth Promotores who are bilingual and bi-cultural providing education and resources to both youth and adults in school and community settings. This model was initially funded and evaluated utilizing State MHSA funding administered by the Office of Health Equity, California Department of Health Services. In addition, PEI funding was allocated to a Latinx/Latine-serving organization in Sonoma Valley, reaching a geographical population in the eastern region of the county that was previously underserved.

In the fall of 2019, the County started to collaborate on a new MHSA Innovation Project, *Nuestra Cultura Cura*: A community-based Social Innovations Lab. The County has worked closely with local CBOs On the Move and La Plaza Latinx. This project specifically focuses on the unique cultural needs of the Latinx/Latine community surrounding mental health, as a means to raise awareness, reduce stigma, and increase access to mental health support.

La Plaza is set apart from traditional mental health programs by pairing clinical, therapy-based services with traditional mental health practices and cultural experiences that empower the Latinx/Latine community to recognize their own ability to heal. By providing a welcoming cultural approach, La Plaza creates a bridge for Latinx/Latine community members to access clinical services when needed. As a specific Innovations project, the *Nuestra Cultura Cura* Social Innovations Lab and its prototype strategies will create and promote a welcoming setting that will reduce mental health stigma, create appropriate, culturally based wellness activities, and provide a bridge to a variety of mental health resources. This Innovation Project was initiated in FY 2022-23.

African-American/Black Community
The Community Baptist Collaborative is focused on reducing mental health disparities in the African-American/Black population by increasing protective factors, building community, and decreasing mental health stigma. Projects include:

- Village Project: A weekly program for children ages 8-13 using a faith-based curriculum that focuses on character building.
- Saturday Academy: A weekly program that features topics of importance to youth of the

church and the community.
- Safe Harbor Project: Facilitated by African American peers that represent an at-risk population to assist people in dealing with "life-disrupting" events, and to provide education, support, and referral using music therapy, gardening, etc.

Native American Community
The Aunties and Uncles Project through Sonoma County Indian Health Project reduces mental health disparities in the local Native American communities by increasing access to mental health services through:

- Reducing mental health stigma and decreasing suicide through a "Community Defined Evidence Practice" of Culture as Prevention
- Providing community wellness gatherings (e.g. Gathering of Native Americans, GONA) to reinforce culture and intergenerational relationships as a protective factor
- Provide youth support and cultural and leadership education

The Aunties and Uncles Program receives both county PEI funding and State MHSA funding from the Office of Equity, California Department of Health Services. An evaluation of the program was conducted from 2018 to 2020. The primary focus of this evaluation was to measure changes in attitudes, knowledge, and behaviors among the Native population that reduce risk for or early onset of mental illness. The methodology employed a mixed-methods approach, collecting both quantitative and qualitative data, focused on both process and outcome. The evaluation reported the following findings:

- Post-AUP intervention, 90% of survey respondents felt that talking about emotions is important to Native youth compared to only 68% in the pre-survey results.
- Native youth seek out those who they trust, who are non-judgmental, have lived experiences, and have wisdom. For the majority, Native youth feel supported by adults to succeed (school, career), but don't feel as strongly that adults listen or will talk to them when they are struggling emotionally.
- 60% of the participants stated that suicide remained a taboo subject that is difficult to talk about among community members.
- Over half of the AUP participants (56%) reported improvements in mental health status, specifically with depression and anxiety.
- The value of cultural identity and recognition that culture is prevention was expressed by GONA and focus group participants. Specifically, intergenerational relationships, learning from elders, and being with other Native Americans were the most frequently repeated themes.
- Over two-thirds of TAY post-survey respondents stated feeling satisfied with their family life, that they were doing better in school and/or work, that they were better able to cope when things go wrong, and that they were better at handling daily life.
- Respondents to the Herth Hope Index signified having a positive outlook toward life (85%) and having short and/or long-term goals (81%). Finally, over 95% reported feeling that their life has value and worth.

LGBTQIA+ Youth Community
Positive Images is an agency in Sonoma County serving the unique needs of lesbian, gay, bisexual, transgender, queer, intersex, asexual, and otherwise marginalized gender/sexual identified populations, with an emphasis on identities and individuals at the margins. Their LGBTQIA+ Community Center hosts multiple weekly support groups, a youth leadership

development program, mentorship opportunities, an LGBTQIA+ Library, resource and referral station, and a Transformation Station. Positive Images offers a warm, welcoming, and affirming environment for young people to explore their individual identities, develop leadership skills, and contribute to our collective community. Positive Images staff lead LGBTQIA+ Cultural Competency Trainings and presentations that educate the greater community focusing on human connection, compassion, and inclusion.

Positive Images envisions a Sonoma County where all LGBTQIA+ people are valued, compassionate community members, creating a just society.

Older Adult Collaborative
The Older Adult Collaborative (OAC) comprises the primary senior services agencies in Sonoma County and is led by the Sonoma County Human Services Department, Adult & Aging Services Division. The community based, non-profit members serving older adults in their respective communities are:

- Council on Aging (COA)
- Petaluma People Services (PPSC)
- West County Community Services (WCCS)

The OAC utilizes Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), a prevention and early intervention evidence-based model, to reduce depression and suicide among older adults throughout Sonoma County by:

- Administration of a depression screening by both licensed experience professionals and peer/volunteers who are supervised by licensed professionals
- Referral of case-managed clients to counseling and psychotherapy for those older adults identified as at risk for depression

IV. Then discuss how the county measures and monitors activities/strategies for reducing disparities.

DHS-BHD uses a community driven Continuous Quality Improvement (CQI) model as part of our community planning process. Continuous Quality Improvement is the complete process of identifying, describing, and analyzing strengths and problems, and then testing, implementing, learning from, and revising solutions. Sonoma County BHD staff and managers monitor performance outcomes with contractors, working with them to make necessary adjustments in real time, in the effort to realize more effective programs, services, and activities.

Sonoma County is also moving to implement Anti-Racist Results-Based Accountability (AR-RBA) training for contracted and staff quality improvement and director-level staff, supported by a more in-depth AR-RBA training for DHS Equity Circle members. We hope AR-RBA's focus on "targeted universalism" can further reduce racial, ethnic, and other disparities.

Cultural Responsiveness Survey
Every three years, a division-wide Cultural Responsiveness (CR) Survey is conducted to identify disparities, assess cultural responsiveness needs of the staff and provide insight into future training and system planning (reflected in the Workforce Education and Training Plan) for DHS-BHD. Three levels of staff are requested to take the survey to address differing scopes of work and interactions with the communities served: Management, Clinical, and Administrative staff.

The following standardized tools are used to collect information:

- California Brief Multicultural Competence Scale (CBMCS)
- Contra Costa County Mental Health Division Cultural Competency Assessment Tool
- Sonoma County Mental Health Administrative Staff Cultural Assessment Tool

The last survey was completed in December 2020 and included only selected behavioral health staff and contractors, not just from those providing services in specialty mental health, but along the mental health services continuum—prevention, early intervention, treatment, and recovery—not specifically focused on staff of the Mental Health Plan. It also does not include substance use disorders staff or contractors. While this survey does provide DHS-BHD with some information, it does not reflect an accurate picture of the behavioral health division staff as a whole nor can the data be compared with previous surveys.

In December 2020, an email was sent out inviting behavioral health staff, contractors, and community members to participate in the CR Survey. A link to a survey monkey was sent in the email and the survey closed in February 2021. (No survey was conducted in 2023; the survey will be repeated in 2024.) Below reflects the characteristics and responses from that survey:

- 165 individuals responded
- 64.6% or 104 respondents identified Sonoma County Department of Health Service Behavioral Health Division as their place of work, specifically:

ANSWER CHOICES	RESPONSES	
Adult Services	26.83%	44
YFS/FASST/TAY Services	20.12%	33
Crisis/Outreach Services	13.41%	22
BH Administration	9.15%	15
Not Applicable	30.49%	50
TOTAL		164

- 35.40% or 57 respondents identified as contract service provider of DHS-BHD.
- 74.55% stated they were White, and 11.73% reported they were of Hispanic or Latino ethnicity.
- Only 1.82% stated they spoke Spanish as a primary language.
- 8.59% stated they were bisexual, 5.52% stated they were gay or lesbian, and 3.68% stated they were queer.
- 33.33% stated they had lived experience with mental health challenges.
- 62.11% were clinicians, 26.71% were management, and 11.18% were administrative support.
- Survey questions regarding working with a non-English speaking client varied from 76% feeling that they knew what to do if a caller (on phone) speaks a language different than theirs to only 52% stating they had training on how to use translation services and could access translation services from their work station.
- Only 42.5% reported feeling confident that they could get interpreter support within 15 minutes of recognizing client need.
- Regarding a level of awareness about multicultural issues, a higher percentage of survey respondents reported they had awareness of racial challenges in society

(96.7%) and institutional barriers that affected their clients (98%).

- However, the more specific the questions were regarding diverse groups (LGBTQ+, seniors) and the intersectionality of groups (low-income vs. high income Puerto Ricans), the lower the confidence level staff had regarding their knowledge and ability to work effectively with those groups.
- There was a significant recognition that the organization's staffing did not represent the populations of the broader geographic community being served. Only 22% felt that the organization represented the community and 39% felt that the organization did not.
- Survey respondents felt less confident that the overall service delivery system was effective in providing culturally appropriate and linguistically proficient mental health services to the ethnic, racial, and cultural groups served.
- Although, not necessarily representative of all staff, the overall sentiment of survey respondents indicated that ongoing cultural training, discussions, and refining practices is warranted to better serve Sonoma County residents.

Capacity Assessment Report

The Sonoma County MHSA Capacity Assessment Report released in 2023 made the following recommendations:

- Improve the transition of clients out of the CSU into less-intensive services, to reduce the amount of time that clients stay in the CSU and to provide clients with a better environment for recovery.
- Increase capacity for non-crisis services, including outpatient therapy, to reduce wait times for appointments and help prevent clients from escalating needs that may turn into crises. Increased capacity for non-crisis services may also help alleviate overstays in the CSU by providing clients who have been stabilized with more options for appropriate levels of care.
- Continue to integrate peer providers into the system of care. Services provided by peer providers and those with lived experience are highly valued by the community, serve a large number of clients, and may help reduce the burden of services on other cadres of providers.
- Invest in a sustainable workforce, exploring strategies for better recruitment and retention of staff that can alleviate the high levels of staff turnover and understaffing, which impact service availability.
- Explore the reasons behind over- and under-representation of specific populations in mental health services and in justice-related services to better understand possible service gaps and bias in the treatment of mental illness.

Consumer Perception Survey

In June 2022 DHS-BHD administered the Consumer Perception Survey. The goal of this survey is to collect data for the federal National Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data.

Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations. Section 3530.40 of Title 9 of the California Code of Regulations requires that semi-annual surveys be conducted (May and November). However, beginning in 2020, the Department of Health Care Services (DHCS) cancelled one of the survey periods due to the implementation of a system shift in submission processes.

DHCS has contracted with the University of California Los Angeles (UCLA) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There are a total of four surveys for consumer populations:

- Adults
- Older Adults
- Youth
- Family/Parents of Youth

The surveys contain items in the form of statements that consumers rate. These responses are aggregated into the following categories:

Adults and Older Adults	Youth and Family
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Quality and Appropriateness	Perception of Outcomes of Services
Perception of Outcomes of Services	Perception of Social Connectedness
Perception of Social Connectedness	Perception of Cultural Sensitivity
Perception of Functioning	Perception of Functioning

V. Share what has been working well and lessons learned through the process of the county's development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET, and PEI).

Despite the challenges faced by county over the past several years (budget crisis, firestorms, COVID), DHS-BHD has managed to gain ground on re-establishing the MHSA Steering Committee and corresponding community engagement in community planning, relevant committees and changes in cultural responsiveness of service delivery in PEI, WET, CSS, and Medi-Cal. This community engagement is the primary key that provides diverse experiences and perspectives shaping processes and decision-making.

Furthermore, engaging community members provides for a level of accountability and momentum that could not be achieved if the County were working in isolation. Adopting a Community-Based Participatory Research practice is challenging but rewarding and sustainable. For example, it may not be possible for BHD to hire a workforce that is equally representative of the community in gender, ethnicity, age, or life experience, but engaging a diverse community constituency to serve in various capacities within the mental health system is an achievable goal.

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

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.

A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), the inclusive committee shall demonstrate how cultural competence issues are included in committee work.

Due to an extended staff vacancy in the Ethnic Services Manager (now the Cultural Responsiveness, Inclusion & Training Coordinator) role, as well as DHS structural changes in creating a DHS Office of Equity and then recruiting and training a DHS Equity Circle, the BHD Cultural Responsiveness Committee has been placed on hold in an effort to ensure that when it restarts, the committee aligns with and can leverage and build on the work done at the departmental level and at the county level.

A Sonoma County Office of Equity was established in August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity. The champions in the Department of Health Services, called the DHS Equity Circle, have begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

While these structural changes are taking place, and while planning for the revamped Cultural Responsiveness Committee continues, the equity champions within the Behavioral Health Division have formed the Behavioral Health Equity Steering Committee, which began meeting monthly in the summer of 2023.

The BHD Equity Steering Committee comprises six Behavioral Health employees and one liaison from the DHS Office of Equity. The Cultural Responsiveness, Inclusion & Training Coordinator chairs the committee. The group membership is 43% Latinx/Latine, 14% White, 29% mixed race, and 14% Middle Eastern/North African. Several members are immigrants. At least two members identify as part of the LGBTQIA+ community. The committee contains both direct-service providers and administrative staff, from multiple job classifications.

The BHD Equity Steering Committee reports to the DHS Equity Circle and DHS Office of Equity, and, as Chair, the Cultural Responsiveness, Inclusion & Training Coordinator reports to the Behavioral Health Division Director. Eventually, this committee will serve as an advisory panel to the Cultural Responsiveness Committee, which we hope to resume in 2024.

Of note, a workgroup for a Quality Improvement project focusing on Latinx access to services will likely be moved under the Cultural Responsiveness Committee in order to better coordinate with the Office of Equity and the forthcoming Health Equity Action Plan for the Department of Health Services.

Quality Improvement Committee (QIC)
The Cultural Responsiveness, Inclusion & Training Coordinator regularly attends the monthly Quality Improvement Committee (QIC) meetings. The purpose of QIC is to oversee and be involved in quality improvement activities including policy issues, reviewing and evaluating results of QI activities, instituting needed QI actions, and following up on QI processes. Furthermore, QIC is one venue for community participation of the MHSA Community Planning Process. QIC members identify community issue related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of MHSA, analyze the mental health needs in the community, and identify and re-evaluate priorities and strategies to meet those mental health needs.

The areas of responsibility for the QIC are to monitor and review consumer relations/outcomes, develop and review the annual QI work plan, review data and work plan activities, and monitor performance improvement projects, including the Cultural Responsiveness Committee.

B. If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.

The Cultural Responsiveness, Inclusion & Training Coordinator attends QIC, MHSA Steering Committee, and MHSA CPP Workgroup. She facilitates the BHD Equity Steering Committee and will facilitate the Cultural Responsiveness Committee (CRC). She will be kept appraised of the MHSA planning processes.

Criterion 5: Culturally Competent Training Activities

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

A. The county shall develop a three-year training plan for required cultural competence training that includes the following: (The county may submit information from the county's WET plan provisions for training. The county shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).

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

The overall goal of division-wide staff development trainings for fiscal year 23-24 is to establish solid clinical frameworks for evidence-based practices that will improve client outcomes, increase staff efficacy and sustainability, and build foundational skills and mindsets on which BHD can build going forward.

Trainings in cultural humility, equity and anti-racism, and working with trans and gender-expansive populations will be required for all clinical staff, and open to contracted staff, in the spring of 2024. Trainings will be recorded so that staff who are not available on the day of the live training, including new staff, can access the trainings. Additionally, the County of Sonoma is working to create a required online equity and anti-racism training for all employees. (DHS-BHD's equity and anti-racism training will be adapted from that training and would fulfill the County requirement.)

2. How cultural competence has been embedded into all trainings.

All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation. The staff-development training series for fiscal year 23-24 is explicitly focused on important foundational skills for cultural responsiveness.

3. A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community- based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

The following chart documents the cultural competency training offered in the past year.

DATE	TITLE	LENGTH (HOURS)	PRESENTER(S)	AUDIENCE
2/2/2023	Monolingual English-Speaking Providers Who Use Interpreters	7	Dr. Jana Spalding, MD, CPSS; National Latino Behavioral Health Association	SCBH Staff

3/29/2023 & 3/30/2023	Intensive Skill-Building Curriculum for Bi-Lingual Clinical Staff	12	Dr. Jana Spalding, MD, CPSS; National Latino Behavioral Health Association	SCBH Staff
9/7/23	Trauma-Informed Systems 101	4	Paula Gonzalez, ASW; Trauma Transformed	SCBH Staff and Contractors
10/19/23	Trauma-Informed Systems 101	4	Paula Gonzalez, ASW; Trauma Transformed	SCBH Staff and Contractors
11/15/23	The Spirit of Harm Reduction	3	Maurice Byrd, LMFT; Harm Reduction Therapy Center	SCBH Staff and Contractors, community partners
12/13/23	Harm Reduction 101	3	Maurice Byrd, LMFT; Harm Reduction Therapy Center	SCBH Staff and Contractors, community partners

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

Workforce, Education, and Training Plan (WET)
DHS-BHD endeavors to provide a comprehensive workforce education and training program that supports diversity, equity, and inclusion and has both staff training and professional development opportunities available to all staff. WET programming provides workforce training and development opportunities for DHS-BHD staff, contractors, providers, clients/consumers, and family members. Through system-wide workforce training and development initiatives, WET aims to create and sustain a diverse, culturally responsive, and clinically effective workforce that provides the best possible care for Sonoma County communities.

The current fiscal year staff development training program is below.

<u>September & October: Trauma-Informed Systems</u>

Objective
To increase workplace satisfaction for staff and service satisfaction for clients

Background
Due to years of natural disasters (floods and fires), the Covid-19 pandemic, chronic clinical vacancies, and high turnover, all while staff continued providing service to the community, Sonoma County Department of Health Services, Behavioral Health Division, has remained in "crisis mode" for so long that it has started to dictate ways in which we serve clients, treat each

other, and design systems. Our contract with Trauma Transformed, which includes a division-wide training in "Trauma-Informed Systems 101" (one in-person, one virtual) will help us move out of crisis mode and toward creating healing environments, policies, and practices that mitigate the impact of stress and trauma for our clients, workforce, and all of us impacted by systems.

Description of Training
Sonoma County Behavioral Health and designated Homeless Services and network staff will participate in foundational TIS 101 workshops designed to:

- Understand effects of stress and trauma on individual, community, and organizational level.
- Learn the six core principles of trauma informed care and two to three strategies for applying these principles to practices.
- Learn strategies to develop organizational resilience and trauma-informed, equity-centered responses.

Evidence to Support its Use
Trauma-Informed Systems work through Trauma Transformed has been shown to increase job happiness and satisfaction, as well as client practice (e.g., more staff days on the job, greater client satisfaction, and reduced grievances and discipline). The United States Substance Abuse and Mental Health Services Administration (SAMHSA) includes Trauma-Informed Care in Behavioral Health Services as a Treatment Improvement Protocol (TIP), which are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements, and are considered a consensus on best practices.

Place in the Series
By focusing on trauma-informed systems and trauma-informed care as our foundation, we create and encourage skills for listening, collaboration, cooperation, and shared values. These skills will remain foundational to the entire fiscal year's training series.

DHS Strategic Plan Integration

Goal Three	**Objective One**	**Strategy One**
The Department of Health Services is a high achieving, high functioning organization	Build a highly competent, effective, and engaged workforce	Promote and support staff well-being and engagement
DHS Value: Excellence		

November, December & January: Harm-Reduction Therapy

Objective
To increase clinical expertise in helping clients reduce substance use and other risky activities

Background
Sonoma County has the second highest rate of overdoses in the Bay Area. Drug overdose deaths increased dramatically from 2016 to 2021 in Sonoma County, driven by opioids, with 87% of those deaths involving fentanyl. In May, members of the DHS-BHD Sentinel Events Committee requested division-wide clinical trainings to address recent client overdoses. Harm-

reduction therapy was identified as the federal and state best practice for addressing substance use, and the Harm Reduction Therapy Center (HRTC) in San Francisco was identified as a national leader in harm reduction and dual-diagnosis training for clinicians.

Description of Training Series
HRTC will provide three trainings:

- Spirit of Harm Reduction: The history of Harm Reduction and its purpose, development, and use with people that use drugs and other risky behaviors.
- Harm Reduction 101: Harm-Reduction Therapy and its clinical applications in working with people who are using drugs and also have a mental health diagnosis.
- Substance/Drugs Use: Education on the different classifications of drugs and their impact on the brain and behavior. Understanding the connection between drug use and mental health.

Evidence to Support its Use
At the federal level, the Biden-Harris Administration has identified harm reduction as a federal drug policy priority. SAMHSA describes harm reduction as "an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives." Harm-reduction strategies are shown to substantially reduce HIV and Hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment. In line with this, harm reduction is one of the four strategic priorities of the U.S. Department of Health and Human Services (HHS) Overdose Prevention Strategy.

At the state level, the harm-reduction framework is required by our MHSA Full-Service Partnerships, as described by the *Full Service Partnership Tool Kit*. Skills in harm-reduction therapy are also a required part of licensure as a mental-health therapist in California; clinical interventions to reduce harm are a required competency for Marriage and Family Therapist and Clinical Social Worker licensure. Providing support and training in harm-reduction therapy is therefore a supervisory ethical requirement for our system of care.

Harm-reduction therapy is supported at the federal and state level as the standard of care for clients who have issues with substance use.

Place in the Series
Harm-reduction therapy strategies build on the previous training series, trauma-informed care, by offering client-centered supportive intervention shown to decrease substance use. They will also provide a framework for further clinical skill development in future years to address risk behaviors like suicidal behavior, hoarding, and self-harm.

DHS Strategic Plan Integration

Goal Two	**Objective One, Strategy One**	**Objective Two, Strategy One**
Individuals, families, and communities access high quality and coordinated services for health, recovery, well-being, and self-sufficiency	Increase access to safety net services by strengthen coordination of services with emphasis on high-need residents	Improve community-wide capabilities to strengthen Public and Behavioral Health infrastructure by prioritizing and implementing core Public and Behavioral Health services
DHS Values: Equity, Excellence		

March, April & May: Cultural Humility & Cultural Responsiveness

Objective
To increase our clinical and professional skills in building and maintaining strong multicultural working relationships

Background
In the summer of 2020, the Sonoma County Board of Supervisors created the Sonoma County Office of Equity and took a meaningful step to recognize and celebrate our powerful role in unseating racial inequity in our communities. In January 2021, the Board approved a five-year strategic plan, which includes a Racial Equity and Social Justice pillar. The pillar is made up of specific goals and objectives that will lead to normalizing, organizing, and operationalizing a new way of seeing our challenges, conducting analysis, and implementing new policies to ensure a workforce reflective of the community we serve and to achieve racial equity in County service provision.

"Cultural humility involves an ongoing process of self-exploration and self-critique combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are," according to Katherine Yeager and Susan Bauer-Wu, who brought the concept forward in 2013.

Dr. Gloria Morrow was identified as a leading trainer in cultural humility through her trainings on the topic through the California Institute for Behavioral Health Solutions (CIBHS), a behavioral health consultancy for County MHPs. Other trainings that may be included in this series are to be coordinated with the Sonoma County Core Equity Team, DHS Equity Circle, and Translife, a Sonoma County trans-focused training organization.

By focusing on cultural humility as well as cultural responsiveness, DHS-BHD will work toward greater inclusion for staff and clients, better understanding of historical and current inequity, and developing tools for addressing disparities.

Description of Training Series
Dr. Morrow's training, similar to her training for CIBHS, will introduce the integration of two powerful concepts, "Building the Beloved Community" and "Cultural Humility," as a strategy for preparing the environment for providing culturally responsive services and helping marginalized clients to heal from racism-related trauma.

Learning Objectives:

- Identify at least three ways that racism-related trauma impacts the mental, physical, and spiritual well-being of marginalized clients.
- List at least three principles of the Beloved Community, and its rationale for effectively meeting the overall health and well-being of those we serve, especially those from marginalized communities.
- List at least three threats to building the beloved community.
- Identify at least three components of cultural humility and its role in building the beloved community.
- Identify at least three strategies for becoming culturally humble.
- Identify at least three strategies for Building the Beloved Community through Cultural Humility.
- List three ways staff can become more culturally responsive in creating an environment that embodies the principles of diversity, equity, and inclusion.
- Identify at least five strategies for staff to practice self-compassion.

Two additional trainings still being explored would bring in the trainings developed by the County Core Equity Team, with a focus on equity and anti-racism, and by the Translife Conference, with a focus on trans and gender-expansive populations.

Evidence to Support its Use

Cultural competency or responsiveness trainings are required as part of our mandate from DHCS and are monitored during our Triennial audits. Using the framework of cultural humility decenters the idea of "normal populations" and "marginalized populations" and allows us all to examine our experiences, identities, and beliefs so that we may better develop partnerships with others.

Bringing in training from the Sonoma County Core Equity Team would continue to further the Sonoma County Five-Year Strategic Plan Racial Equity and Social Justice Pillar, in which Objectives 2 and 4 are to invest in an ongoing and continually developing racial-equity learning program, including understanding the distinction between institutional, structural, interpersonal, and individual racism, for County leadership and staff and to develop a shared understanding of key racial and equity concepts across the County and its leadership.

Clinical training in working with trans populations has been requested often by DHS-BHD staff and would also address new state legislative requirements that will soon be enacted around TGI training for behavioral health professionals.

Place in the Series

By placing cultural humility and responsiveness after the mini-series on trauma-informed systems and harm reduction therapy, our staff will have developed and practiced skills in listening, self-reflection, and curiosity that will provide a strong base for discussion topics of race and culture that can often be charged or difficult. Starting the series with cultural humility will introduce ways they can bring these skills to these topics, and then Core Equity and TGI healthcare trainings will provide further opportunities to use and develop their growing awareness.

Sonoma County Five-Year Strategic Plan Integration

Pillar: Racial Equity and Social Justice		
Goal One: Foster a County organizational culture that supports the commitment to achieving racial equity.	**Objective 2:** Invest in an ongoing and continually developing racial equity learning program, including understanding the distinction between institutional, structural, interpersonal, and individual racism, for County leadership and staff by end of 2021.	**Objective 4:** Develop a shared understanding of key racial equity concepts across the County and its leadership.
Goal Two: Implement strategies to make the County workforce reflect County demographic across all levels.	**Objective 2:** Implement countywide strategies to recruit, hire, develop, promote and retain County employees of color, produce an annual report card assessing progress, and update strategies as needed.	
Sonoma County Value: Equity		

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

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

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

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

In the past, Sonoma BHD has conducted annual trainings with a diverse panel of peers (individuals with lived experiences of mental health challenges). This panel has been diverse in gender, ethnicity, age, ability and other factors that influence the person's experience. A more concerted effort needs to be made to outreach to the Latinx community and increase TAY representation on this panel. Due to staffing vacancies in the training coordinator role, this training has not been schedule for fiscal year 2023-2024, but will be given high priority in the upcoming fiscal year, as part of a hoped-for series on SAMHSA's recovery model and recovery-oriented care. Future guidance given to panelists will ask them to share their experiences in accessing treatment, navigating multiple agencies, quality of treatment including client-centered and family-focused approaches, and their ability to increase resiliency for greater positive outcomes.

Required trainings held in the past were responsive to both staff surveys and input from community providers. Peer panels and Latinx/Latine focused staff development has been a mainstay of the annual training plan(s). Moving forward, DHS-BHD will use multiple strategies to ensure staff receive trainings that will continue to include bringing together all staff via Zoom or in person, and with the use of the Relias learning management system that has just been rolled out, staff will have access to trainings that are tailored specifically for their job, or a particular population making cultural competency training more relevant to their particular work.

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

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

The Sonoma County DHS-BHD Workforce Education and Training (WET) plan seeks to realize some of the Organizational Excellence and Racial Equity and Social Justice goals of the Sonoma County Board of Supervisors approved a Five-Year Strategic Plan (2021-26), with specific focus on the goals of:

- Fostering an organizational culture in DHS-BHD that supports the commitment to achieving racial equity
- Implementing strategies to diversify the behavioral health workforce to ensure representation the behavioral health workforce reflect the County demographics at all levels of the organization
- Becoming an employer of choice with a diverse workforce that reflects our community and with a positive work culture that results in engaged and developed employees

Specifically, DHS-BHD is using MHSA funds to develop and implement a WET program designed to enhance the public behavioral health workforce with programs and activities that shall address workforce shortages and deficits to:

1. Conduct outreach, recruit, hire, employ, train and develop, retain, and create promotional opportunities for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of behavioral health service consumers seeking to work in the public behavioral health system.
2. Recruit, hire, employ, train, and create promotional opportunities for people with lived experience and their family members in DHS-BHD.
3. Educate the public behavioral health system workforce on incorporating culturally responsive, clinically appropriate evidence-based and community-defined practices that align with the general standards for the implementation of State Drug Medi-Cal and the Mental Health Plan.

Informing this section is also feedback received by staff regarding DHS-BHD's priorities. In the Fall of 2021, DHS-BHD went through a process to set the priorities for entire division. Some of the stated priorities will be addressed, in whole or in part, in this WET plan. These relevant areas include:

1. Developing wraparound service capacity for people with dual diagnosis
2. Diversification of the workforce
3. Developing paths for promotion for non-licensed staff
4. Increasing support for bilingual staff
5. Providing onboarding training for new staff
6. Providing ongoing training for existing staff
7. Investing in leadership and management training
8. Creating more efficient responses to assist with job performance issues

These activities and strategies constitute ongoing goals and activities within the division. The

Cultural Responsiveness, Inclusion & Training Coordinator is working closely with staff to provide supports for guidance for implementation of these activities and strategies.

A significant investment in workforce retention is our trauma-informed systems transformation project. This project is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work. DHS-BHD is in the process of an organizational assessment (Tools for Trauma-Informed Worklife) to help identify, and then target, areas of concern for employees regarding organizational culture.

Additionally, the DHS Equity Circle has begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

Current Behavioral Health Workforce Demographics

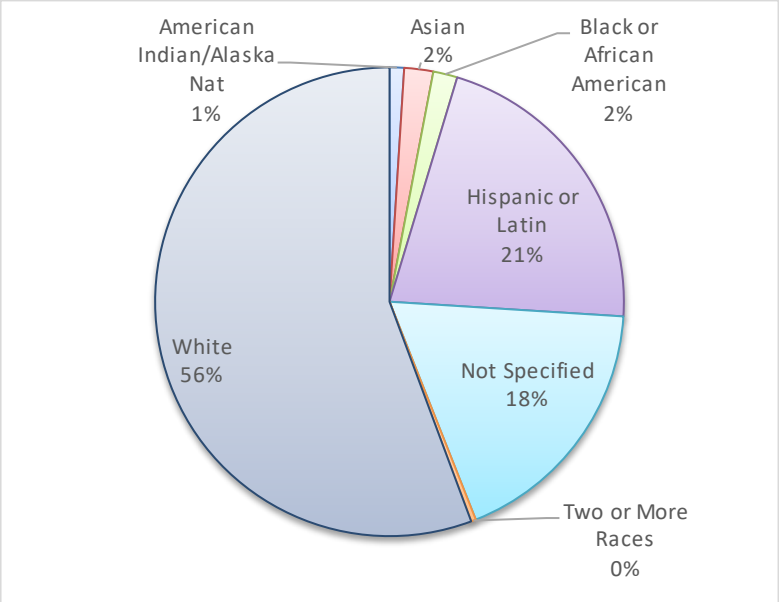
In order to focus on efforts to diversify DHS-BHD's workforce, the first step is to review the needs within DHS-BHD. To do so, data was collected about the current workforce racial and ethnic demographics to look for where there may be some areas for improvement. This information provides DHS-BHD with a starting point for conducting outreach, recruiting, hiring, and employing individuals who share the racial/ethnic, cultural, linguistic, gender, and/or sexual orientation characteristics of our behavioral health services.

The Sonoma County Five-Year Strategic Plan provides the context for its departments to inform policies and projects to prioritize over the next five years. Sonoma County chose to focus a strategic pillar on Racial Equity and Social Justice. The Board states, "Sonoma County's collective well-being and prosperity are impacted by significant racial inequities. By focusing on racial equity and social justice within the Strategic Plan, the Board of Supervisors can begin to institutionalize equity and address disparate impacts on people of color both internally and as an organization and in the community." Data shows that the greatest disparities occur along racial and socio-economic lines. If Sonoma County wants to start closing those gaps, we have to start there. Research and best practices nationally show that successful equity program begin with a focus on race. This sort of "targeted universalism" allows the development of a framework that centers the people most likely to be affected by disparities in ways that have been shown to improve conditions for people in all categories, including sexual orientation and gender.

For purposes of the Workforce, Education, and Training plan, DHS-BHD has also prioritized reviewing DHS-BHD's gender and sexual orientation workforce statistics to assist in making workforce decisions.

Sonoma County Human Resources provided the information about DHS-BHD's current workforce in the tables below. There are 300 employees.

Race and Ethnicity	BH Workforce		Sonoma County	
	#	%	Residents [13]	Medi-Cal Beneficiaries
American Indian/Alaska Native	3	1%	2.3%	1%
Asian (alone)	6	2%	5%	3.1%
Native Hawaiian or other Pacific Islander (alone)	-	-	0.4%	
Black or African American	5	1.7%	2.2%	1.6%
Hispanic or Latinx/Latine	64	21.3%	28.9%	40%
White	167	55.7%	85.7%	27.7%
White (alone, not Hispanic or Latinx)	-	-	60.6%	-
Two or More Races	1	0.3%	4.4%	-
Unspecified/Not Reported	54	8%	-	26.7%



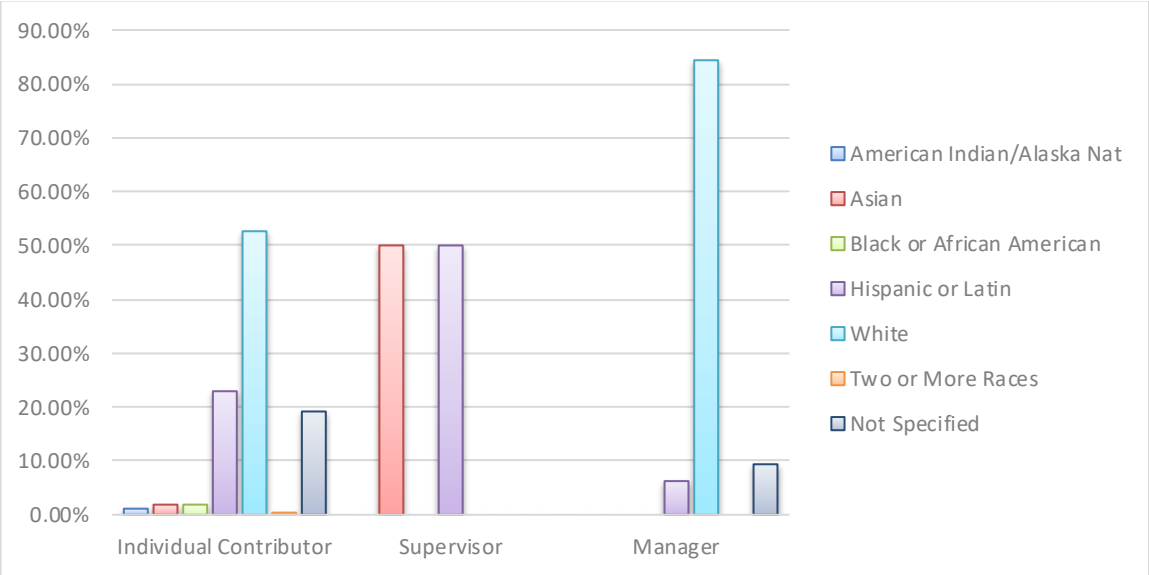
Data from these two charts indicates that DHS-BHD's entire workforce is underrepresented for Hispanic or Latinx/Latine staff, as compared to both the general population and especially to Medi-Cal eligibility. Reducing the disparity in representation continues to be a high priority in staff recruitment for the Division.

Behavioral Health Workforce by Job Class and Race/Ethnicity

When presented by reporting level, the racial and ethnic disparities in the Sonoma County Behavioral Health workforce become more stark. Based on the most recent data from the Sonoma County Human Resources Department, White employees are 84.4% of the 32 total managers in the division, with only 6.3% Latinx/Latine and 9.4% unspecified. While Latinx/Latine and Asian employees each constitute 50% of the supervisors in the division, please note that there are only two supervisor-level positions in total.

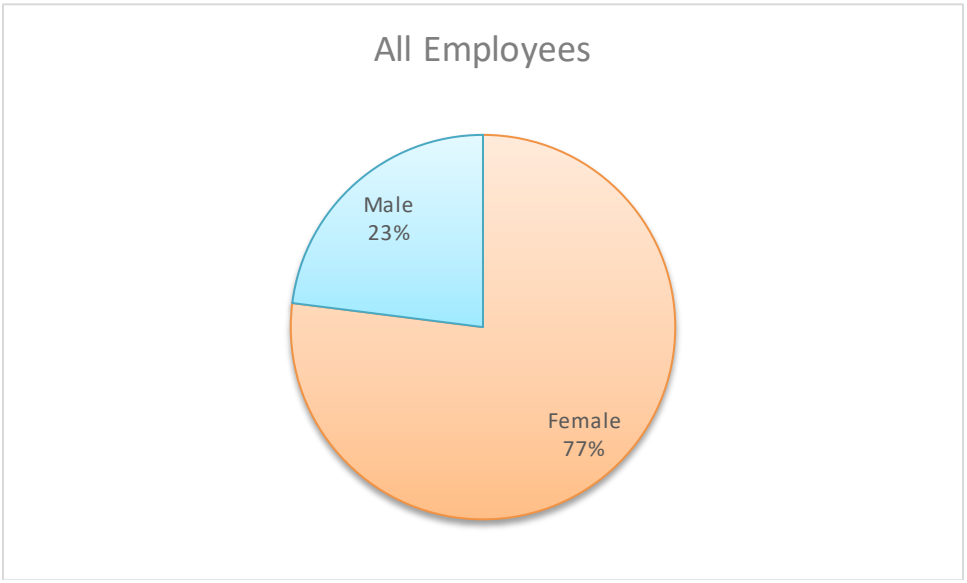
[13] 2022 U.S. Census

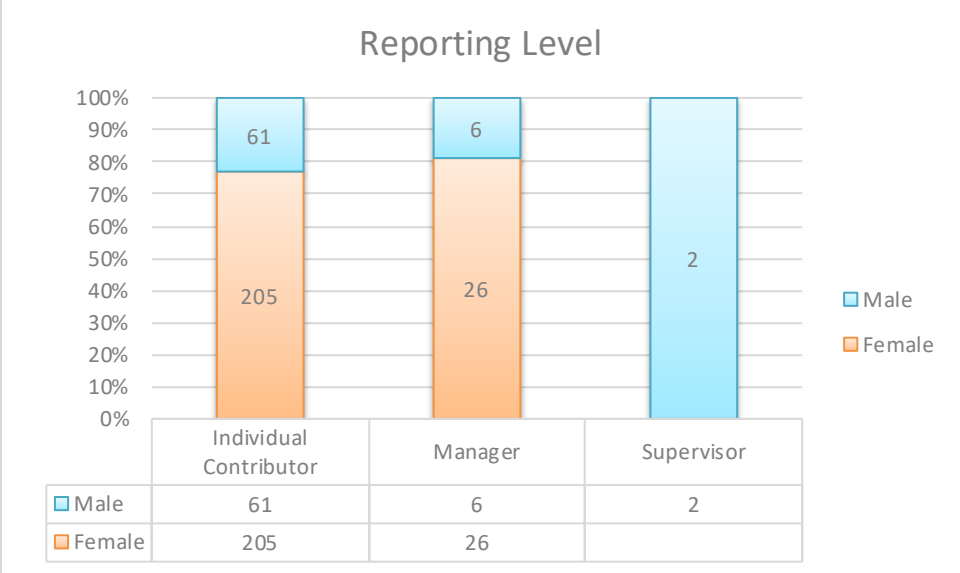
Reporting Level	American Indian / Alaska Native	Asian	Black/African American	Hispanic or Latinx / Latine	White	Two or More Races	Not Specified
Individual Contributor	1.1%	1.9%	1.8%	23%	52.6%	0.4%	19.2%
Supervisor	0%	50%	0%	50%	0%	0%	0%
Manager	0%	0%	0%	6.3%	84.4%	0%	9.4%



Gender

When considering gender balance in the workforce, it is most important to consider power and position in the current existing workforce, the gender make-up of management relative to its workforce, who tops the pay scales, and opportunities for advancement. Upon hire, the County asks gender identity of its incoming staff. Unfortunately, the County only provides two categories, male and female as options.





Data from these this chart indicates:

- 81.3% of DHS-BHD management staff is female.
- 77% of all non-management Division staff are female.

Sexual Orientation and Gender Expression

Gary Gates, a researcher at UCLAs Williams Institute, a think tank on sexual-orientation law, who based his findings on data from the US Census Bureau's 2008 American Community Survey, reported that the Santa Rosa Metropolitan Area ("in effect Sonoma County") was second "most gay" population in the nation, with 7.63 gay couples per 1,000 households, a rate 56 percent greater than the national average.[14] Unfortunately, information about sexual orientation is not a category collected of new hires into the workforce of Sonoma County. Nor is this information collected for Medi-Cal beneficiaries or consistently for DHS-BHD clients.

People who identify as lesbian, gay, bisexual, transgender, intersex, asexual, or otherwise queer often face social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion, and family rejection. Because of these stressors, people in the LGBTQIA+ communities are at risk for various behavioral health issues. A National Institute of Health study further found that although sexual orientation discrimination alone was not significantly associated with substance use disorders, sexual orientation discrimination in combination with racial/ethnic or gender discrimination—and racial/ethnic discrimination alone—was associated with greater odds of substance use.[15]

O'Brien et al, in "Mapping the Road to Equity: The Annual State of LGBTQ Communities Report, 2018," report that according to town hall meetings in California, a sizable proportion of therapists are not adequately trained or even willing to serve trans clients, and several trans people spoke of their difficulties in finding therapists who could provide the much-needed quality support.[16] This discomfort points to the need both for more training and also for

[14] Out4MentalHealth Sonoma County Mental Health Fact Sheet. https://californialgbtqhealth.org/wp-content/uploads/2021/06/Sonoma-Task-Force-Fact-Sheet-Final-1.pdf

[15] Sean Esteban McCabe, PhD, MSW, Wendy B. Bostwick, PhD, MPH, Tonda L. Hughes, PhD, RN, Brady T. West, MA, and Carol J. Boyd, PhD, MSN The Relationship Between Discrimination and Substance Use Disorders Among Lesbians, Gay, and Bisexual Adults in the United States, American Journal of Public Health; 2010 October; 100(10): 1946–1952.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2937001/

[16] O'Brien, R.P., Walker, P.M., Poteet, S.L., McAllister-Wallner, A., & Taylor, M. (2018). Mapping the road to equity: The

recruiting LGBTQIA+, specifically trans, therapists.

Recruitment and Hiring
Data regarding the current behavioral health workforce demonstrates the ongoing need to diversify is urgent and necessary. Over the previous years, DHS-BHD engaged in many efforts to diversify its workforce through innovative recruitment strategies including educational and employment pipeline opportunities. Previous outreach efforts of Latinx/Latine individuals into the behavioral health division workforce included a contract with a local non-profit, Latino Service Providers (LSP). Between 2015 through 2018, DHS-BHD contracted with LSP to assist, under the direction of the WET Coordinator, in the development of strategies for recruiting, assist with applying, and providing ongoing support for retaining behavioral health workforce. These activities included:

- Use print, radio, television, and social media targeting the Spanish-speaking Latinx/Latine community in recruitment strategies.
- Maintain a website for recruitment of bilingual Spanish, bicultural Latinx/Latine staff for DHS-BHD workforce.
- Participate in the North Bay Collaborative meetings
- Participate in the annual behavioral health career symposium in partnership with Sonoma County school districts.
- Support bilingual Spanish-speaking, bicultural Latinx/Latine applicants to apply for the behavioral health division positions.

The current contract with LSP provides for support and training of bilingual Youth Promotores in mental health. Many of these young adults expressed interest in pursuing a career in behavioral health, and in fiscal years 2021-2022 and 2022-2023, BHD has hosted interns from LSP in the MHSA coordinator's office and on the mental health treatment teams.

The Division will continue to coordinate with the County and Health Services Department Human Resources to identify best practices[17] for successful recruitment of a diverse workforce, with special attention to bilingual Spanish-speaking, bicultural Latinx/Latine individuals.

Managers have the lead role in recruiting, interviewing, and hiring a diverse workforce. It is the hiring manager in partnership with the Cultural Responsiveness, Inclusion & Training Coordinator who will shepherd the process by defining the role, getting input from the team, and weighing all the evidence to make a final decision.

Hiring
Current data for the Behavioral Health workforce demographics demonstrates a significant shortage of bilingual Spanish speaking, bicultural Latinx/Latine workforce in comparison to the number of bilingual Spanish speaking, bicultural Latinx/Latine Medi-Cal beneficiaries in Sonoma County. As a specialty provider, and in keeping with the Sonoma County Board of Supervisor's Five-Year Strategic Plan, it is vital that DHS-BHD implement strategies to diversify the behavioral health workforce to ensure the behavioral health workforce reflects the County demographics at all levels of the organization.

annual state of LGBTQ communities, 2018. Sacramento, CA: #Out4MentalHealth Project.
[17] GEM. (December 7, 2021). Think Diversity is a "Pipeline Problem"? Look to Your Process Instead. [Blog Post] Retrieved from https://www.gem.com/blog/diversity-hiring-pipeline-problem

Behavioral Health Clinician Intern Job Classifications
In 2012, DHS-BHD made a strategic decision to make systemic changes to its job classification and management structure as a recruitment strategy. This strategy set DHS-BHD aside from other organizations, making DHS-BHD a desirable place to work for newly graduated behavioral health clinicians. The strategy involved creating new job classification of Behavioral Health Clinical Intern positions for individuals to practice clinical work while gaining the supervised experience necessary to sit for the licensing exam. DHS-BHD also created the Clinical Specialist position to ensure oversight and accountability for the work of the Behavioral Health Clinician job classification.

Individuals who possess a graduate degree in counseling and/or social work, are registered with the CA Board of Behavioral Science Examiners, and need to gain the mandatory hours of qualifying supervised professional experience in order to take and pass the requisite law and ethics exam can be hired as Behavioral Health Clinical Interns. The Behavioral Health Clinical Interns practice under the licensure of their Clinical Supervisor. Once the Behavioral Health Clinician Intern completes their clinical hours, any other prerequisites, takes and passes their licensing exam, and is in good employment standing, they receive and automatic promotion to a Behavioral Health Clinician. The Behavioral Health Clinical Intern has three years to complete all prerequisites to obtain licensure.

This structure has historically been successful to recruit bicultural and bilingual staff. However, DHS-BHD has recognized that staff of color, particularly bilingual, bicultural Latinx/Latine staff, have experienced difficulty passing the licensing exam in the time allotted to do so. In 2017, DHS-BHD began tracking the licensing and certification process of Behavioral Health Clinical Interns to identify whether there was a propensity of DHS- BHD's staff of color having difficulty passing their licensing exam within the three-year timeframe. Data in 2017 indicated that 50% of the individuals having difficulty passing the exam were people of color. At that time, the WET Coordinator instituted a number of strategies to assist these individuals to pass their exams. These activities included providing exam preparation groups, and one-on-one coaching as well as guiding the candidates to use their staff development funds to purchase study materials. Because of these efforts, in 2018, the number of Behavioral Health Clinical Interns of color who had not passed their exam dropped to 36%.

Currently, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation. Additionally, BHD's new contract with Motivo, via CalMHSA, has diversified the pool of clinical supervisors available for both group and individual supervision. While BHD has started by using Motivo supervisors to fill a gap in LCSW supervision (versus LMFT supervision), future opportunities exist to increase access to bilingual, bilcultural supervisors.

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

The Workforce Education and Training program supports the mission of the Sonoma County Behavioral Health Division to promote recovery and wellness of Sonoma County residents. BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or substance use disorders to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-

focused system include:

- Self-direction
- Individualized and person-centered care
- Empowerment and shared decision-making
- Holistic approach that encompasses mind, body, spirit, and community
- Strengths-based
- Peer-support
- Focus on respect, responsibility, and hope

BHD fosters a collaborative approach by partnering with clients, consumers, family members, and the community to provide high quality, culturally responsive services.

BHD Workforce Education and Training goals are:

- To provide staff with high quality education and training that promotes and endorses the mission of the Behavioral Health Division.
- To contribute to the development and maintenance of a culturally competent workforce, including individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resilience.
- To teach and promote evidence-based and evidence-informed practices leading to measurable, values-driven outcomes in support of the Quality Improvement Workplan for the Behavioral Health Division.
- To encourage career development and increase job satisfaction by supporting the growth and refinement of a skillful workforce.
- To create and promote community outreach and training opportunities that encourage community stakeholder collaborations and facilitate forums for discussion and education around locally relevant behavioral health topics and needs.

In response to the QI Work plan and the Cultural Competence Plan, the Staff Development Training Series provides annual trainings on a core set of skills to support staff in refining and using skills in trauma-informed care and systems, harm reduction therapy, and cultural humility and responsiveness.

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

The WET Plan assessment agrees with known shortages of Spanish-speaking, culturally diverse providers, particularly Latinx/Latine staff to help match our Medi-Cal client base demographics. In addition, the plan calls for increasing the number of people with lived experience in the public mental health system workforce.

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

Workforce, Education and Training (WET) Plan for FY 23-26

Changes	Impacts
Workforce, Education and Training	
Comprehensive Training Program: All the trainings selected for the program will be focused on addressing the impairments of the primary diagnoses that DHS-BHD clients experience. All trainings will be evidence based or best practices for the impairments and diagnoses, and the trainings are designed for clinical staff, senior client support specialist, including peer support staff. This is an increase of $400,000 annually.	The addition of a Comprehensive training program can improve client outcomes, DHS-BHD program efficacy, improve staff retention and staff recruitment.

The goal of the WET component is to develop and retain a diverse, engaged, and clinically excellent workforce. Our WET program provides training for staff and contracted agencies to promote culturally responsive and clinically appropriate interventions to promote community wellness and staff development. At the end of 2022, the Division hired an Ethnic Services, Inclusion, and Training Coordinator (now the Cultural Responsiveness, Inclusion & Training Coordinator) to oversee this mission. The Sonoma County Behavioral Health Cultural Responsiveness, Inclusion & Training Coordinator position is responsible for ensuring behavioral health services are provided in a culturally responsive manner to the diversity of our clientele, and that our diverse staff are supported and respected in their work. This oversight involves participation in a number of cross-cutting areas in the division including:

- Policy Development: ensuring division policies are nondiscriminatory and inclusive.
- Workforce, Education, and Training: diversifying the incoming behavioral health workforce and supporting its ability to care for diverse clients, including developing strategies for recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current behavioral health workforce is appropriately attending to the needs of our diverse clientele.
- Program Design and Development: participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- Leadership Development: Strengthening management and administrative performance

Workforce, Education, and Training Activities

- The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients.

The Cultural Responsiveness, Inclusion & Training Coordinator will manage training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support, Career Pathways and Pipeline Program, Staff Skill Development, and Workforce Diversification.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Career Pathways	• Pipeline Programs • Career & Internship Fairs
Staff Skill Development	• Staff Development Trainings
WET Activities	• Strengths Model Care Management: an evidence-based practice demonstrating positive outcomes in the areas of psychiatric hospitalization, competitive employment, education, and a range of quality of life indicators.

System Level Support

Accreditation
The Division will continue to maintain accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT) and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education Units (CEUs) for these license types:

BRN
- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Registered Nurse (RN)
- Public Health Nurse (PHN)
- Nurse Practitioner (NP)
- Psychiatric Nurse Practitioner (PNP)

CAMFT
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Educational Psychologist (LEP)

CCAP
- Registered Alcohol Drug Technician (RADT)
- Certified Alcohol Drug Counselor I (CADC-I)
- Certified Alcohol Drug Counselor II (CADC-II)
- Licensed Advanced Alcohol Drug Counselor (LAADC)
- Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Career Pathways and Pipeline Program
The Cultural Responsiveness, Inclusion & Training Coordinator will continue the Internship and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline

programs with participating universities. This includes a Group Clinical Supervision and Educational Outreach Events.

Currently, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation for pre-licensed clinicians.

While Sonoma hoped to increase Peer Support Specialist services throughout the system of care, BHD was unable to fund additional FTE positions. Plans are continuing to create full-time roles for peers, and in the meantime BHD is working with West County Community Services (WCCS), a Sonoma County non-profit with programs including senior services, employment, housing, youth programs, behavioral health, and crisis counseling services. WCCS currently operates peer recovery programs throughout Sonoma County and offers a peer support specialist certification training. Participants learn active listening, emotional literacy, communication skills, cultural responsiveness, ethics and confidentiality, boundaries and self-care, trauma and addiction support, recovery and resilience, crisis intervention, suicide prevention, peer advocacy, and system transformation. As part of the training, peers have an opportunity to practice these skills in placements, including the Behavioral Health Division. The Behavioral Health division is working closely with West County Community Services to create opportunities for placement of individuals with lived experience who are considering a career in the public behavioral health workforce.

As part of the Pipeline Program, the Cultural Responsiveness, Inclusion & Training Coordinator will participate in several community career events at both the high school and college level. Particular focus will be given to encouraging Latinx/Latine and bilingual students to consider Behavioral Health as a career option.

Participating Universities

Program Category	Participants
Nursing Programs	• Sonoma State University (SSU) • Santa Rosa Junior College (SRJC)
Social Work Programs	• California State Long Beach • San Francisco State University (SFSU) • Humboldt State • San Jose State University • University of Southern California • Berkeley
MFT Programs	• SSU • University of San Francisco • SFSU
Mental Health Worker Programs	• SSU • SRJC

Workforce, Education, and Training Activities

The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, WET hopes to add a full-time clinical specialist role to support this program in the future.

WET Activities	Trainings
Staff Skill Development	• Staff Development Trainings
Comprehensive Training Program	Evidence-Based Practices: • Strengths Model Care Management • Family Systems • EMDR • CBT for Psychosis • Cognitive Behavioral Social Skills Training • DBT • Trauma-Focused CBT • Assertive Community Treatment • Harm Reduction • Trauma Informed Systems • CBT for Depression • Seeking Safety • Peer-Based Supports (WRAP, Transformative Mutual Aid Practices) • Psychopharmacology for Non-Medical Staff • Motivational Interviewing
Culturally Responsive Practices	• Incorporating and working with peers in the workforce • Cultural humility • Special concerns for LGBTQIA+ clients • Adapting Evidence-Based Systems to Community Need, “Fidelity vs Fit”

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

- BHD has lost a number of bilingual staff over the past several years and is challenged by the competition among the county's healthcare system.
- BHD leadership must support managers to attend to recruiting, interviewing, hiring, onboarding, training, and developing and supporting strategies that promote diversity in the workforce needs to attend to its hiring practice as well.

E. Identify county technical assistance needs.

DHS-BHD does not have any identified TA needs at this time.

Criterion 7: Language Capacity

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

Continuous efforts are made by the County to recruit and retain bilingual staff to more accurately reflect the diversity of Sonoma County, specifically focused on the Latinx/Latine and Spanish-speaking community. A significant development worth noting is the establishment of a countywide Office of Equity on August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity; the champions within the Behavioral Health Division constitute the Behavioral Health Equity Steering Committee, which began meeting in the summer of 2023. The champions in the Department of Health Services, called the DHS Equity Circle, have also begun initial training and planning with DHS leadership to create a Health Equity Action Plan, scheduled to be completed in 2024. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

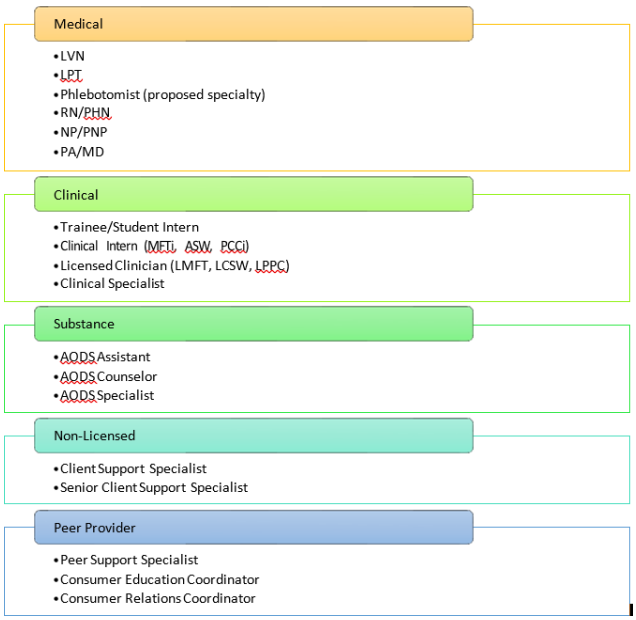
While not explicitly focused on bilingual capacity, BHD's trauma-informed systems transformation project is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work. BHD is in the process of an organizational assessment (Tools for Trauma-Informed Worklife) to help identify, and then target, areas of concern for employees regarding organizational culture.

The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

As of the most recent data provided by Sonoma County Human Resources, there are 52 bilingual employees in BHD, staffing the three categories of Management, Administrative, and Clinical.

Career Ladders

The Cultural Responsiveness, Inclusion & Training Coordinator will support the development of promotional opportunities with career tracks to support a Grow-Your-Own Model from entry-level intern/student through supervision and management. This includes formalizing an Internship & Traineeship program, expanding the Peer-Provider program, providing clinical support to pre-licensed and paraprofessional staff, and providing management-level training and support.



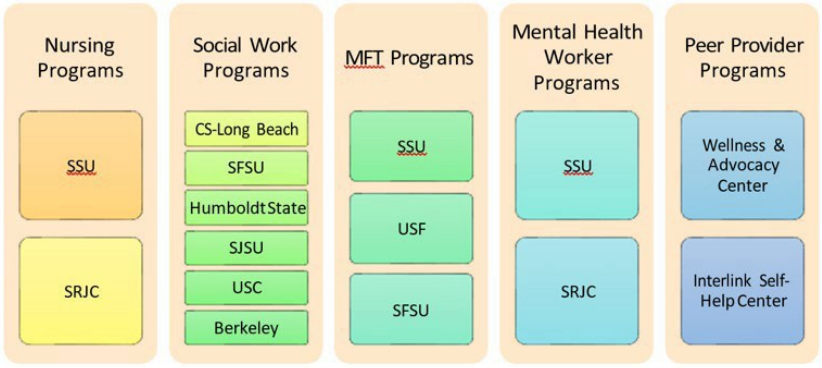
Internships & Pipeline Programs

To increase and diversify the clinical workforce, BHD works with local universities to assist staff in obtaining clinical licensure and to develop pipeline programs with participating post-secondary schools and universities. The purpose of the pipeline program is to cultivate interest in healthcare careers, particularly in hard-to-fill areas with high-risk, underserved populations. Additionally, the pipeline program preserves diversity in the workforce and reduces health disparities for the consumers. The Cultural Responsiveness, Inclusion & Training Coordinator plans and participates in several community career events at both the high school and college level. Particular focus is given to encouraging Latinx/Latine and bilingual students to consider Behavioral Health as a career option.

BHD is currently working toward allowing peer providers who are still in training through West County Community Services to volunteer in our programs in order to gain experience working with clients and to help BHD ensure that its programs are centering the needs and voices of clients.

Career & Internship Fairs

The Cultural Responsiveness, Inclusion & Training Coordinator, in coordination with Sonoma County Human Resources, engages in outreach through internship and career fairs at Santa Rosa Junior College, Sonoma State University, and University of San Francisco.



As part of a push to reduce our staff vacancy rate, Sonoma County held its first ever Behavioral Health Job Fair on site in November 2023, which resulted in five job offers for clinical staff.

Community Health Workers and Pro Promotores

Community health workers and *promotores* (CHW/Ps) have been part of the health care landscape in the United States for decades. Payers and providers increasingly recognize their essential role in supporting people with complex medical and social and behavioral health

needs. The roles that CHW/Ps fill vary widely, including helping individuals navigate the complicated health care system, connecting them to resources to address their social needs, and accompanying them to visits with health providers. Whatever role they play, the work of CHW/Ps is characterized by a deep connection to their community and the lived experience that they share with their clients. They can draw on their knowledge of available resources and the social networks that define their communities, bridging geographic and cultural gaps between the health care system and consumers. CHW/Ps' shared life experience can provide an essential human connection between health care providers and the patients they serve. The behavioral health division is interested in engaging CHP/Ps to build and diversify its behavioral health workforce.

Latino Service Providers (LSP) is a non-profit organization in Sonoma County that works with the community partners to exchange information to increase awareness of available resources, access to programs and services, enhance interagency communication, and promote development within the Latinx/Latine community. LPSs Youth Promotor Internship program seeks to address the mental health inequities in the Latinx/Latine community by meaningfully engaging Latinx/Latine youth in issues related to mental health in the Latinx/Latine community by training youth as community health workers in hopes of inspiring them to seek a career in public behavioral health. As of July 1, 2022, LSP has trained over 150 youth promotores and retained alumni over the years.

BHD is in its second year of hosting pro promotores interns, who have worked with both administrative and the clinical staff to learn about how mental health services are provided in county settings. Additionally, the Department of Health Services has recently hired a Health Program Manager to oversee Community Health Workers at a department level, and BHD is excited to explore ways in which the CHWs may be able to support our behavioral health clients.

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

As of March 2023, the Behavioral Health Division (BHD) had the following positions filled by bilingual Spanish speaking staff in the following job classifications.

Position	Bilingual Staff
AOD Counselor I	1
AOD Counselor II	6
AOD Intake Interviewer	1
AOD Specialist	1
Clinical Specialist	1
Clinician	9
Clinician Intern	7
FNP/PA	1
Health Program Manager	1
Nurse	1
Office Assistant II	2
Senior Client Support Specialist	8
Senior Office Assistant	12
Social Services Worker	1

3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to the staffing referenced above, BHD uses Language Link for spoken languages and Communique for American Sign Language.

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

A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:

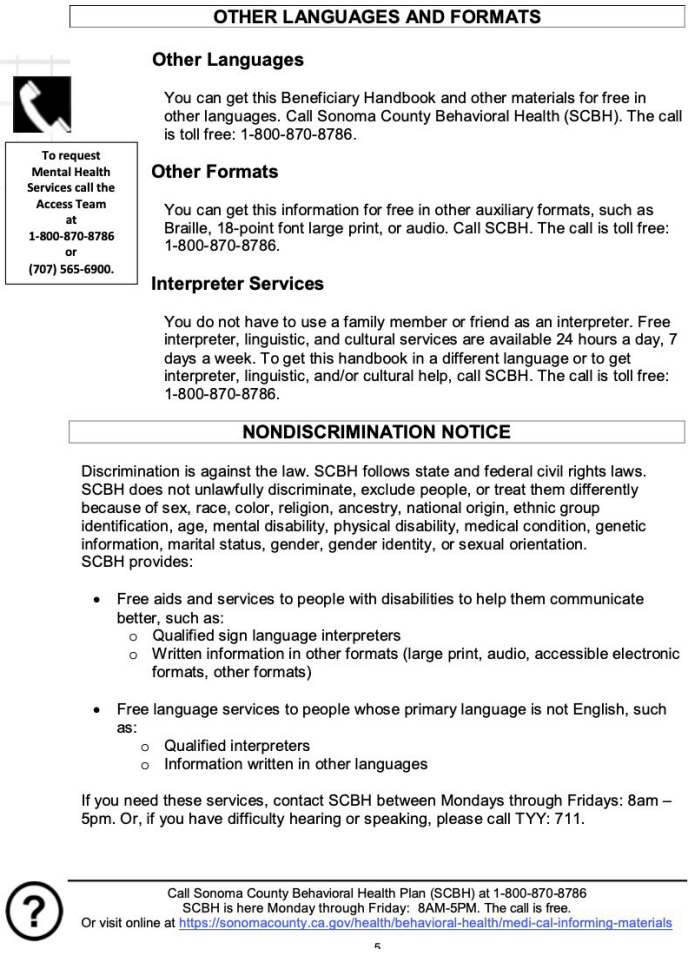
1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

Within the BHD Beneficiary Handbook, Sonoma County has an acknowledgement of nondiscrimination and a corresponding policy addressing access to services in languages other than English and formats that are accessible to people with different abilities. The BHD policy is to use a bilingual staff member to provide interpretation services whenever needed. Sonoma County BHD has a 24-hour phone line that is answered by a live person. If bilingual staff are unavailable, BHD uses other resources to provide interpretation. These other resources include:

- CTS Language Link
- CA RELAY TDD

2. Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available. Use new technology capacity to grow language access.

Sonoma BHD does not solely rely on language lines, though that is one tool to support access to individuals who have limited English proficiency. In addition, BHD has interpreter services on contract and is always seeking to hire a diverse multilingual staff to serve the community. Since the beginning of the Covid-19 pandemic, staff providing telehealth services have expanded their use of video language conferencing.



OTHER LANGUAGES AND FORMATS

To request Mental Health Services call the Access Team at 1-800-870-8786 or (707) 565-6900.

Other Languages

You can get this Beneficiary Handbook and other materials for free in other languages. Call Sonoma County Behavioral Health (SCBH). The call is toll free: 1-800-870-8786.

Other Formats

You can get this information for free in other auxiliary formats, such as Braille, 18-point font large print, or audio. Call SCBH. The call is toll free: 1-800-870-8786.

Interpreter Services

You do not have to use a family member or friend as an interpreter. Free interpreter, linguistic, and cultural services are available 24 hours a day, 7 days a week. To get this handbook in a different language or to get interpreter, linguistic, and/or cultural help, call SCBH. The call is toll free: 1-800-870-8786.

NONDISCRIMINATION NOTICE

Discrimination is against the law. SCBH follows state and federal civil rights laws. SCBH does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
SCBH provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact SCBH between Mondays through Fridays: 8am – 5pm. Or, if you have difficulty hearing or speaking, please call TYY: 711.

Call Sonoma County Behavioral Health Plan (SCBH) at 1-800-870-8786
SCBH is here Monday through Friday: 8AM-5PM. The call is free.
Or visit online at https://sonomacounty.ca.gov/health/behavioral-health/medi-cal-informing-materials

5

3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol.

Sonoma County BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (see Attachment A), provides the protocols to implement language access at no cost, 24 hours a day, seven days a week.

Furthermore, multilingual signage is provided at all BHD county lobbies and at the entryways to contracted providers.

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

Contained in the Sonoma County Mental Health Plan Beneficiary Handbooks provided to all consumers/beneficiaries is a multilingual notice informing them of their right to access services in their primary language, free of charge. This notice is located on the first two pages of the handbook.

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

The Sonoma MHP EQRO Final Report for Fiscal Year 2022-23 shows that nearly one in eight beneficiaries served in the MHP speak Spanish.

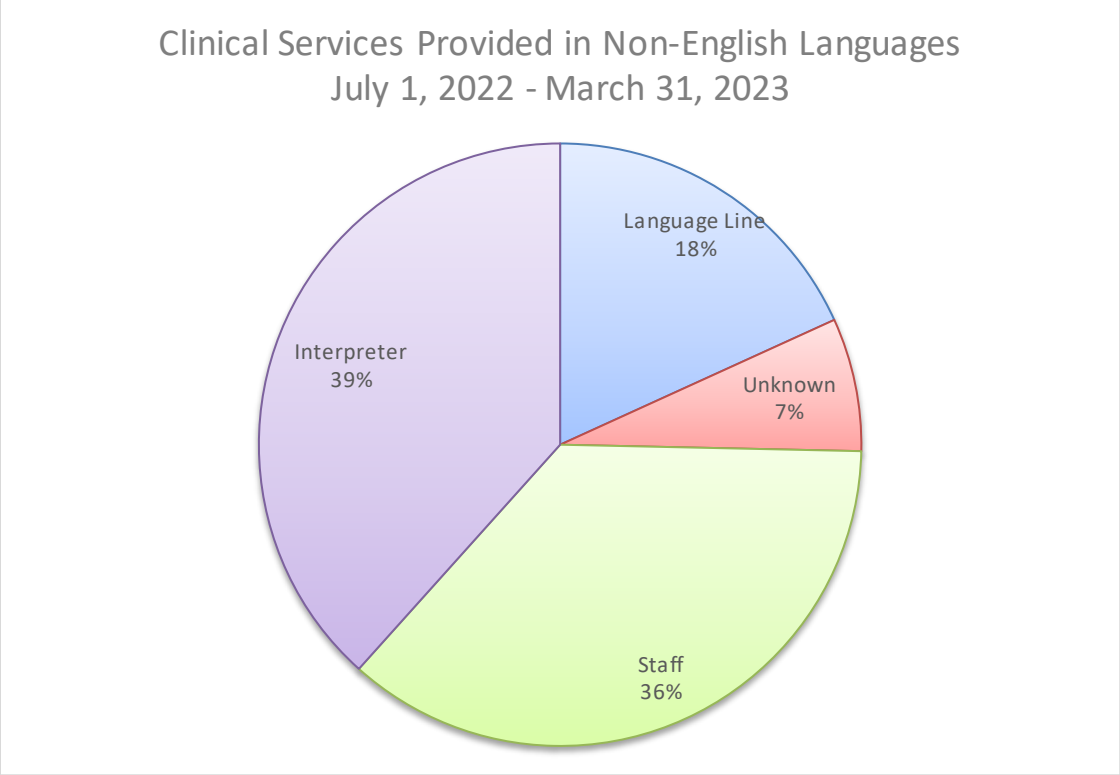
Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	400	12.40%
Threshold language source: Open Data per BHIN 20-070		

Data from Sonoma County's most recent Network Adequacy Certification Tool show a total of 1022 clinical services provided in non-English languages from July 1, 2022, through March 31, 2023.

Service Description	Encounters
ASSESSMENT	41
ASSESSMENT NON CLAIMABLE	3
COLLATERAL	89
COLLATERAL NON CLAIMABLE	5
CRISIS INTERVENTION	2
CRISIS INTERVENTION NON CLAIMABLE	3
CSU NON MEDI-CAL CLAIMABLE	19
ECM Encounter	1
ECM Outreach Telehealth	1
EM MED SUPPORT OFFICE Time Based Est CLT	390
EM MED SUPPORT OFFICE Time Based New CLT	28
INDIVIDUAL THERAPY	1
INDIVIDUAL THERAPY NON CLAIMABLE	17
MEDICATION SUPPORT NON EM	153
PLAN DEVELOPMENT	18
PLAN DEVELOPMENT NON CLAIMABLE	2
REHABILITATION SERVICES INDIVIDUAL	74
TARGETED CASE MANAGEMENT	158
TARGETED CASE MGMT NON CLAIMABLE	8
TELEHEALTH ASSESSMENT	7
TELEHEALTH PLAN DEVELOPMENT	1
TELEHEALTH TARGETED CASE MANAGEMENT	1
Grand Total	**1022**

While the Avatar electronic health record did not capture which language was used, it does show whether an interpreter was used, the clinical staff member spoke the required language, or the Language Line was used.



The tables below show Language Line utilization for July 1, 2022, through March 31, 2023, for the 24/7 Access Line, for face-to-face encounters, and for telehealth services:

Language Line Use – 24/7 Access Line	
Language	**Encounters**
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	1
Spanish	56
Tagalog	
Vietnamese	3
American Sign Language (ASL)	
Burmese	
German	1
Punjabi	1
Tigrinya	2

Language Line Use – Face to Face	
Language	**Encounters**
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	
Spanish	23
Tagalog	
Vietnamese	5
American Sign Language (ASL)	

Language Line Use – Telehealth	
Language	**Encounters**
Arabic	
Armenian	
Cambodian	
Cantonese	
Farsi	
Hmong	
Korean	
Mandarin	
Other Chinese	
Russian	
Spanish	343
Tagalog	
Vietnamese	
American Sign Language (ASL)	
Burmese	2
Tigrinya	1

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

Records show that in FY 20-21, the number of calls taken by the Language Line diminished as bilingual staffing and availability increased. This is an obvious cause and effect, that the more bilingual staffing is available, the less reliance on the Language Line is needed. In the data above, Language Line was used only 18% for clinical services in non-English languages, and bilingual staff or interpreters were used 75% of the time.

The goal of maintaining bilingual staffing is challenged by the fact that the BHD is in direct competition for a bilingual workforce with other health systems such as Kaiser Permanente, Sutter Health, St. Joseph's Health, and the community clinics throughout Sonoma County.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

At this time, there are no technical assistance needs identified.

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.

As noted in earlier in this document, Sonoma County DHS-BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (Attachment A), provides the protocols to implement language access at no cost, 24 hours, seven days a week. In addition, information for all language access is found on the first pages of the Beneficiary Handbook given to all consumers. Finally, as stated in Mental Health Policy MHP-21, "Required Informing Materials and Translation of written Documents" (Rev. 5-20-19), posters are required to be prominently displayed in the lobbies of BHD offices and posted by contractors providing mental health services to Medi- Cal beneficiaries. (See Attachment B).

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

As seen in Criterion 7, II.C. above, 1022 clinical services in language other than English were provided and documented between July 1, 2022, and March 31, 2023.

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

As of March 2022, BHD had 52 positions filled by bilingual Spanish-speaking staff.

Because the competition for attracting and retaining skilled workers has increased significantly, particularly for health professionals and for bilingual candidates, Sonoma County provides bilingual pay to certified bilingual staff working in specific, bilingual designated positions. In order to receive this premium, staff must meet the established job qualifications and also meet

the County's bilingual certification requirements. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

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

Bilingual skill testing is conducted by Sonoma County Human Resources (HR). The following process is used to test bilingual (English/Spanish) skills:

- The Department Head or Designee determines the level of proficiency (basic/fluent) required to perform the duties of the position:
    - Basic: the ability to verbally communicate in English and Spanish effectively, conversationally proficient. The individual will speak only, and work will be limited to providing verbal information to clients and to the public. They will not translate text or transcribe verbal communications.
        - Example: an Office Assistant or Receptionist primarily assists the public by answering questions, such as the location of another building, the restroom, locating an appropriate form, etc.
    - Fluent: the ability to speak, read, write, and translate between English and Spanish, at a highly proficient level. Translation is defined as the process of translating words or text from one language into another. This level is used for positions where employees may have a higher degree of interaction with and responsibility to the public or clients.
        - Example: a Social Service Worker primarily assigned to work in a courtroom setting, in which their clients need verbal information translated from English to Spanish.
- The Department submits a certified/complete Bilingual Proficiency Exam Request Form to HR.
- HR schedules the individual(s) for the next available exam session.
    - "No Shows" and last-minute cancellations will not be automatically rescheduled.
- HR tests the examinee(s) at the level requested by the Department.
    - Basic: This exam has 7 work-related exam questions. Exam Raters may allow some mixed language use and can simplify the questions to aid the examinee in understanding and responding to the questions. Speech may not be grammatically correct. The Raters will assess the examinee's ability to understand and use a common vocabulary, handle day-to-day verbal communication, and determine whether the examinee can be easily understood by a monolingual person.
    - Fluent: This exam has 3 sections: conversational, oral reading/translation, and a writing performance exercise. At this highly proficient level, the examinee is expected to fully comprehend and correspond in both English and Spanish. With the understanding that specialized terms in their area of responsibility will be learned on the job, Exam Raters assess

the examinee's command of language to determine their ability to perform the duties of the position.

- Within approximately one week of the exam:
  - If the candidate has passed the exam, HR will send exam results to the examinee, HR Liaison, and Payroll Clerk. This formal notice is viable for the duration of the examinees' employment with the County of Sonoma and should be placed in their personnel file.
  - If the candidate has failed the exam, HR will notify the HR Liaison and Payroll Clerk to discuss applicable next steps. After that conversation has occurred HR will send results to the examinee, HR Liaison, and Payroll Clerk.

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

A. Policies, procedures, and practices 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.

As noted earlier, the Beneficiary Handbook and corresponding policies clearly provide for language access through bilingual staffing, language interpreters, or the Language Line (last resort) for all aspects of the continuum of care. In addition, materials translated into the threshold language of Spanish are available to all staff.

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.

The MHP maintains a policy to ensure that all client and MHP contact providers link non-English speaking clients to culturally and linguistically competent mental specialty mental health services regardless of language spoken. Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters," (see Attachment A) explains the process.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

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

Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters," clearly states the three policy positions above. Please see Attachment A.

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

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

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

As noted previously, Spanish is the only threshold language for Sonoma County. The Mental Health Plan Member Service Handbook is published in English and Spanish and kept on file for regular review, updating, and access by staff on a common computer drive. Forms, including Informed Consent and Release of Information, are generated through the semi-statewide electronic health record, SmartCare, and are available in Spanish. In addition, consumers/beneficiaries can access all documents in English and Spanish on the County's website:

https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/Behavioral%20Health/_Documents/Beneficiary-Handbook-with-Taglines-rem.pdf

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

BHD conducts quarterly chart audits and is required to include one chart for a client who prefers Spanish (threshold language) for services.

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

Each year, DHS-BHD administers the Consumer Perception Survey in May. This survey is offered in English and Spanish. The goals of this survey are to collect data for the federal Nation Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data. The Consumer Perception Survey is a state issued and controlled survey, and the BHD cannot change labels, age categories, or wording of questions. The Quality Improvement Manager summarized the results and made the following recommendations:

2022 Consumer Perception Survey Summary and Recommendations
Satisfaction with services varied between the four population groups surveyed. For adults, satisfaction increased across all domains relative to the previous year. Given the large sample size of adult respondents (160), this finding is a substantive one. One possible explanation for the increase in satisfaction could be related to the network's return to more in-person service offerings starting in 2022. This explanation is also supported by higher rates of satisfaction with adult social connectedness, in comparison to the two previous COVID-pandemic years. A separate exploration of service data from 2021 and 2022, focusing specifically on the location type of service, will help shed more light on this theory.

Of all four groups analyzed, youth had lowest overall satisfaction scores. Youths and families experienced two years of declining general satisfaction rates, which was most pronounced in both the outcome and perception of functioning domains. Ratings on satisfaction with social connectedness continued to decrease for youth; however, they were slightly better for families. A promising strength for both youth and families, evident in three years' worth of satisfaction data, pertains to consistently high satisfaction with the cultural appropriateness of youth services. Youth and families consistently score this among the highest domains.

The analysis of satisfaction by gender, ethnicity, and race is complicated by low sample sizes in all but the adult groups. Several observations are worth making, however. First, the number of other-gender respondents increased significantly and dramatically for youth. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year. This finding suggests that youth serving programs may benefit from extra training and resources to support youth and families for which gender identity issues are emergent.

Finally, a complex and somewhat contradictory finding relates to satisfaction for mixed-race or multi-racial beneficiaries. Satisfaction scores tended to be below the minimum satisfaction threshold for mixed race adults and youth. By contrast in parents/families who identified their children as mixed race, satisfaction scores were higher. Furthermore, while mixed race had low satisfaction scores generally, they showed high satisfaction with the cultural appropriateness of services. This pattern suggests that while consumers find staff respectful of their cultural identity, the program or service model itself may be less effective in meeting the needs of this group. Further investigation and consideration of practice interventions and approaches that have an evidence base in mixed-race populations is warranted and recommended.

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

The standard practice for Sonoma County BHD is to have translated documents proofread by at least two bilingual staff to ensure accuracy and accessibility.

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

To monitor readability and access for those needing an appropriate reading level, documents are proofread by utilizing Word options in the software to show readability statistics. This application will provide a Felsch-Kincaid Grade Level for the selected content.

Criterion 8: Adaptation of Services

I. Client driven/operated recovery and wellness programs

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

Sonoma County is seeking to build on four client-driven/operated recovery and wellness programs provided under the auspices of West County Community Services:

- Wellness and Advocacy Center, Santa Rosa
- Interlink Self-Help Center, Santa Rosa
- Petaluma Peer Recovery Program, Petaluma
- Russian River Empowerment Center, Guerneville

In addition, Positive Images, a MHSA PEI funded program for the LGBTQIA+ community, uses a peer-based and peer-led socio-educational model with support groups, social activities, community education, and activism.

II. Responsiveness of mental health services

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

As required, Sonoma County provides a Provider Directory to all new clients, which has descriptive information regarding types of services available, populations served, and/or linguistic capabilities. DHS-BHD develops contracts with a number of community-based organizations who provide non-traditional mental health services.

The following chart illustrates the contractors and their focus in working with specific populations that are traditionally underserved.

Agency / Population Focus	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
Latino Service Providers/ Latinx		X	X	X
Sonoma County Indian Health Project/ Native Americans		X	X	X
Positive Images / LGBTQIA+		X	X	X
Community Baptist Church Collaborative / African Americans		X	X	X

Santa Rosa Community Health Centers/ Communities of Color		X	X	X
Alliance Health Center/ Latinx	X	X	X	X
West County Health Services/LGBTQII		X	X	X
Alexander Valley Health Center/Latinx	X	X		

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.

DHS-BHD provides each beneficiary/consumer with the DHCS required Guide to Medi-Cal Mental Health Services in either English or Spanish. Also, both documents can be found on the County's website:

https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials

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

DHS-BHD Mental Health Policy MHP-21, "Required Informing Materials and Translation of Written Documents," states that DHS-BHD and its contracted providers will provide to all beneficiaries written informing materials that are critical to obtaining Specialty Mental Health Services at the first face- to-face contact and/or upon request. In addition, informing materials will be displayed in the lobbies of all county-owned/operated programs and contract provider programs. (See Attachment B.)

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

BHD's Access team is located within the main Behavioral Health Campus at The Lakes business complex in Santa Rosa. Clinical services, including crisis and peer services, are co-located and centralized to provide easier access. In addition, a main bus line has a stop in front of BHD complex. This Behavioral Health Campus is located in the southern section of Santa Rosa and is close to the heart of the Latinx/Latine community, known as Roseland, where many Medi-Cal beneficiaries reside. This area is also accessible to many parts of Sonoma County given its proximity to the major highways. DHS-BHD also maintains clinics in the outlying areas of Sonoma, Petaluma, Guerneville, and Cloverdale to provide easier access for clients living in the east, south, west, and north areas of the county.

Since the Covid pandemic in 2020, BHD has also expanded the use of virtual clinical services to augment in-person services, which can help alleviate transportation issues.

Hours of operations are generally 8am-5pm, Monday through Friday. Our five Full Service Partnerships provide services to clients beyond those hours, as needed, including weekends. We also have several options for after-hours services. Optum provides after-hours phone coverage to provide information and referrals, and our screening team is generally available until 7pm on weekdays. Our Crisis Stabilization Unit and our Crisis phone line provide services 24 hours a day, seven days a week. Our Mobile Support Team currently operates 11am to 7pm and will soon expand to offer 24/7 coverage.

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)

All county-owned facilities have access for people with disabilities. Many locations have upgraded their waiting rooms to be more client-centered, culturally inclusive, and inviting.

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.)

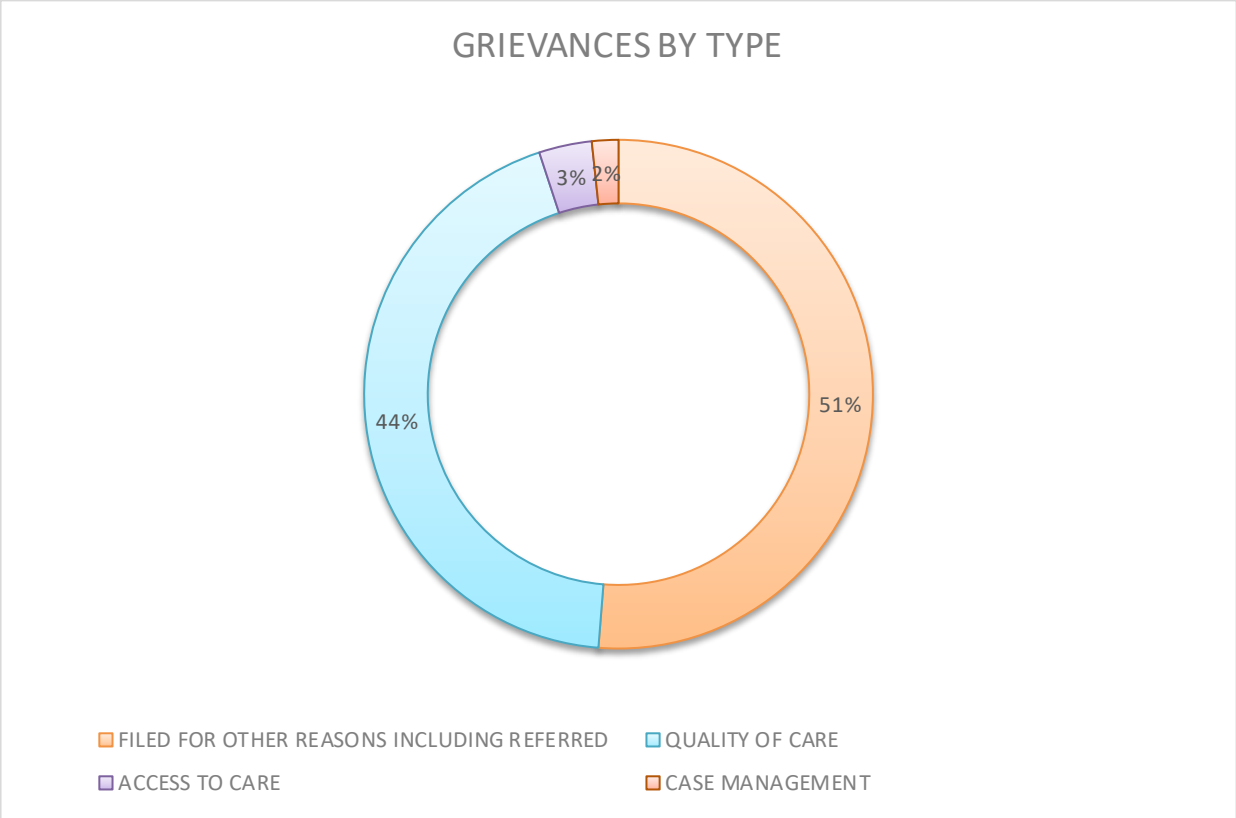
As part of the MHSA planning process, in order to provide more services to the Latinx/Latine population, it was decided to co-locate services as much as possible with the community health centers (FQHCs and Sonoma County Indian Health Project). In addition, BHD has a variety of community-based nonprofits that provide an array of prevention, early intervention, and clinical services in locations that are accessible to the populations intended to be served and in an appropriate cultural setting.

III. Quality Assurance

A. 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.

Prominently displayed in the Beneficiary Handbook and on the County's DHS-BHD website is a statement of Client Rights and guidelines to file a grievance in English and Spanish. DHS-BHD records all Medi-Cal Beneficiary grievances and appeals filed through the fiscal year. In FY 2022-23, a total of 119 grievances were filed resulting in 119 "Resolved" (per DHCS, a grievance is "resolved" when it has reached completion and been closed by the Plan), 27 Active (still pending or in process as of June 1st), and 16 cases referred (to the source of grievance). Grievances are reviewed quarterly and/or annually by the Quality Assurance Manager to determine if trends and patterns warrant a policy review or development, provider credentialing review, training implications, or other quality improvement concerns. A new Behavioral Health Grievance and Discrimination Grievance Policy has gone into effect for FY 23-24 that incorporates both Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) grievances, including discrimination grievances. An updated Grievances Procedure with the addition of Discrimination Grievances has gone into effect as well.

The chart below summarizes the types of grievances filed.



Attachment A

COUNTY OF SONOMA

DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 11/25/2002 REVISION DATE: 03/02/2020 APPROVED BY: _____ Behavioral Health Services Director	POLICY NO: MHP - 08 POLICY NAME: **Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters** REFERENCE/AUTHORITY: 1. MHP Contract, Exhibit A, Attachment I, MHP Contract, Attachment 11, Item 3 2. CCR 1810.410 3. DMH Information Notice 10-17

POLICY:

The Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD), Mental Health Plan (MHP) maintains a policy to ensure that all beneficiaries and MHP contracted providers are informed about specialty mental health services (SMHS) offered by the MHP and have procedures in place to link Non-English speaking beneficiaries to culturally and linguistically competent providers.

Beneficiaries will have access to culturally and linguistically competent staff or interpreters at all key points of contact and in all DHS-BHD programs. All oral interpretation and sign language services will be provided free of charge to all MHP beneficiaries.

It is the policy of the MHP to use a DHS-BHD county-certified bilingual staff member who speaks the primary language of the person seeking treatment whenever possible. It is expected that DHS-BHD programs will assist each other in this regard to provide essential language services whenever possible. Furthermore, it is the policy to not use family members to interpret for the beneficiary, or for the beneficiary to interpret for the family; except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services.

PROCEDURE:

I. Definitions

A. **Beneficiary:** Individuals who receive SMHS provided by the MHP.

B. **Key points of contact:** Common points of access to SMHS from the MHP, including but not limited to the MHP's 24-hour toll-free line, the Beneficiary Grievance and Appeals Process, MHP contract providers, or any other central access locations established by the MHP.

C. **Threshold language:** A language that has been identified as the primary language, as indicated on the Medi-Cal eligibility Data System (MEDS) of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

II. Standards for Linking Non-English Speaking Beneficiaries to SMHS

A. Key points of contact, such as the Access Team, Crisis Stabilization Unit (and other MHP program locations, will have posted a notice in English and Spanish that beneficiaries have a right to free language assistance services, including sign language services, and how to access these services. Beneficiaries with LEP are informed of these rights and how to access services by the use of interpreters.

B. A statewide toll-free telephone number will be available 24 hours a day, 7 days a week, with language capability in all languages spoken by beneficiaries of the County.

C. For beneficiaries who are deaf or hearing-impaired, a telephone communication device for the deaf (TTY machine) will be used [TTY: 711].

D. See ***MHP – 21 Required Informing Materials and Translation of Written Documents*** policy for requirements concerning written document formatting, translation, and threshold languages.

III. Use of Bilingual Staff and Interpreters

A. When there is no clinical staff member who can speak the beneficiary's preferred language, it is the policy of the MHP to use county-certified, bilingual staff as interpreters to assist beneficiaries and staff in providing mental health services for those beneficiaries who do not speak English, or have LEP capability.

B. Whenever possible, and when practical, attempts should be made to use County-certified, bilingual clinical staff for clinical services. This is especially important when providing an initial assessment, discontinuing a 5150 detention, or for evaluating any high-risk situations, including homicide or suicide ideation.

C. If county-certified, bilingual clinical staff are not available, County-certified, bilingual clerical staff may be used.

D. Telephone calls: When it has been determined that a caller needs an interpreter,

the staff receiving the call should make all efforts to find either a County-certified bilingual staff member in their program with the necessary language skills, or use the SCBH designated language line vendor to request a telephone interpreter for interpretive services (see attached instructions).

E. Face-to-Face interviews: When setting up a face-to-face meeting with a beneficiary, it is incumbent upon the staff to ascertain the need for an interpreter, and arrange for one prior to the meeting. This includes beneficiaries who are deaf/hearing-impaired and need sign-language interpretative services. Allow sufficient time for the meeting to ensure adequate interpretation. Medication services appointments are to be extended for additional time to ensure a thorough clinical assessment.

F. If the staff member involved with the beneficiary does not speak the beneficiary's preferred language, then the staff member should consult with their Health Program Manager (HPM) regarding the use of another County-certified bilingual team member who does speak the beneficiary's preferred language to either provide the service, or to provide interpretation.

G. If there is no other county-certified bilingual staff member available within that team, then it is permissible to seek help from DHS-BHD staff from outside of that team. Staff should inform their HPM of their need.

H. The HPM may contact another HPM to request the use of County-certified bilingual staff supervised by this HPM.

I. The requesting HPM should make a determination as to the level of service needed, and should be as specific as possible regarding:
1. The acuity of the situation (e.g. emergency vs: urgent vs. regular appointment)
2. The type of service necessary (clinical vs. administrative)
3. The nature of the relationship requested (e.g. clinical or administrative)

J. If no county-certified bilingual staff member is available to provide interpretive services, then a MHP designated vendor for interpretive services may be used to assist in providing the service. (see attached list of vendors.)

K. If using a contracted vendor, it is advisable to give them as much notice of the meeting as possible.

IV. Use of an Interpreter when conducting a Face-to-Face Interview

A. Pre-Interview and Interview

1. Staff should instruct interpreter as to the nature of the meeting prior to the interview. Review topics to be covered and any potentially sensitive topics;

2. Provide for additional length of session time;

3. Review seating arrangements. Whenever possible, the interpreter should sit (slightly behind and to the side of the beneficiary);

4. The interpreter should interpret everything spoken by either party;

5. Staff should instruct the beneficiary "do not say anything that you do not want to be interpreted";

6. The interpreter should always ask for clarification from the clinician and the beneficiary if something is not clear;

7. Pay attention to nonverbal cues and impact of culture.

B. Post-Interview

1. Review session to see if there are any areas of concern that were not discussed or any areas that may still be unclear;

2. Clarify cultural factors, beliefs, behaviors that could influence assessment and diagnosis;

3. Discuss issues that may have been difficult or problematic for the interpreter;

4. Discuss planning for future sessions as appropriate.

C. Family Member Interpretation

1. A family member shall not be allowed to interpret for the beneficiary, nor should the beneficiary be allowed to interpret for or to the family:

2. Except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services;

3. The reasons for using a family member to interpret must be documented in the progress note, including the offer to utilize free interpreter services and the beneficiary's decline of such services.

4. Minor children should not be used as interpreters.

5. Family members shall never be used to interpret when evaluating someone to discontinue a 5150 detention, or for evaluation of any high risk situation, including evaluation of suicidal or homicidal ideation.

V. Documentation and Claiming for Services

A. Documentation of a beneficiary's preferred language other than English must be entered in the Initial Assessment and in the individual Progress Note, and whether the service provided was in a language other than English and if so, whether an interpreter was used.

1. If an interpreter is used, the Progress Note should include who provided the interpretation, and what language was spoken. If the staff member conducted the session in a different language, the Progress Note should reflect what language was spoken.

2. Documentation that interpreter services are offered to the beneficiary and the beneficiary's response to the offer is documented in the Progress Note.

B. The staff member providing interpretative services does not claim for interpretative services. For example- if a county-certified, bilingual staff member provides interpretative services for beneficiary at the request of another staff member, only the requesting staff member is allowed to claim for services provided.

C. Translation and Interpretative services are non-reimbursable and cannot be claimed to Medi-Cal.

SCBH FORMS:

1. MHS 403 Free Language Assistance Poster (English & Spanish)
2. Behavioral Health Services Staff Available for Bilingual Interpretation List
3. http://sc-intranet/dhs/bh-policies.htm

ATTACHMENTS:

1. Instruction sheet: How to Request Interpretation Services with CTS Language Link
2. CTS Account Number Codes by SCBH PROGRAM list
3. Communique ASL Interpreter Request Form

Attachment B

COUNTY OF SONOMA

DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 03/31/2017	POLICY NO: MHP-21
REVISION DATE: 05/20/2019	POLICY NAME: **Required Informing Materials and Translation of Written Documents**
APPROVED BY: _____ Behavioral Health Services Director	REFERENCE/AUTHORITY: 1. Code of Federal Regulations, Title 42, §438.10 2. Code of Federal Regulations, Title 45, §92.8 3. California Code of Regulations, Title 9, Chapter 11, §1810.360 and §1810.410 4. Department of Health Care Services (DHCS), Mental Health Substance Use Disorders Services Information Notice NO.: 18-020 and 18-043 5. DHCS-Sonoma County Behavioral Health Mental Health Plan Contract 17-94619 6. 81 Federal Register Volume 81, Issue 96 31375, Nondiscrimination in Health Programs and Activities

POLICY:

The Sonoma County Behavioral Health Division (SCBH) and its contracted providers will provide to all Medi-Cal beneficiaries served by the Sonoma County Mental Health Plan (MHP) written informing materials that are critical to obtaining Specialty Mental Health Services (SMHS). Informing materials will be provided to Medi-Cal beneficiaries at the first face-to-face contact and upon request. Additionally, informing materials will be displayed in the lobbies of all MHP county-owned/operated programs and contracted provider programs. Electronic versions of informing materials will be available on the SCBH website.

Informing materials will be available in Sonoma County's threshold languages and upon request, alternative formats will be available to beneficiaries at no cost and in a format that the beneficiary can easily understand. Upon request, oral and alternative interpretation of informing materials will be provided; this includes the availability of auxiliary aids and services, such as TTY/TDY and American Sign Language. Language Assistance Taglines and a Non-Discrimination Notice shall be included in all informing materials, and posted in MHP county-owned/operated programs and contracted provider programs.

Definitions:
Sonoma County's *threshold languages* are English and Spanish. This means that these languages have been identified as the primary language of either 3,000 Medi-Cal beneficiaries or 5% of the beneficiary population, whichever is lower, in the County geographic area. Thus, all written informing materials are available in English and Spanish.

Informing materials include, but are not limited to, program literature that is critical to assisting beneficiaries in accessing mental health services, explain the beneficiary problem resolution and fair hearing process, and identify beneficiary rights and protections.

Alternative formats for written materials include, but are not limited to, large print or oral interpretation/audio format. The MHP readily has large print formats available and other formats (e.g., audio, braille) will be provided upon request.

Language Assistance Taglines is a notification explaining the availability of written or oral translation and includes the toll-free and TTY/TDY telephone number of the MHP's customer service unit. This notification is written in English, large-print (18-point font), and the top 16 non-English languages spoken by individuals with Limited English Proficiency.

Non-Discrimination Notice is a notification that the MHP must comply with non-discrimination and accessibility requirements.

PROCEDURE:

I. Informing Materials Provided to all Medi-Cal Beneficiaries

The following documents must be provided to beneficiaries at the first face-to-face contact with them and upon request:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County MHP Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form*-with County addressed envelope
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
F. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)

NOTE: An acknowledgement of receipt must be obtained from all beneficiaries who are offered the identified informing materials (Use MHS 115–Consent for Treatment).

II. Informing Materials Postings for Medi-Cal Provider Lobbies

The following documents must be readily available in the lobbies of all Medi-Cal certified provider sites:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County Mental Health Plan Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
G. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
F. *Free Language Assistance Services* (Taglines)
G. *Point to Your Language*
H. *Consumer Notification of Licensing Boards*

I. *Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
J. *Request for Change of Service Provider*
K. *Non-Discrimination Notice*

III. Translation of Written Materials

SCBH staff and contractors will provide to Medi-Cal beneficiaries, informing materials in Sonoma County's threshold languages (English and Spanish) and in Large print (18-point font) format.

When applicable, SCBH staff will also ensure that other SCBH documents are translated into threshold languages, or provided in alternative formats upon request. For this purpose, SCBH contracts with a language interpretation and translation service (See policy *MHP 08-Linking Non-English Speaking Beneficiaries to Mental Health Services and Use of Interpreters*).

A. Requests for written translation of formal SCBH documents are to be e-mailed to the Mental Health Plan Quality Assurance Manager (MHP-QA Manager) for review and authorization.

    i. Less formal document translation, such as a single letter to a client during the course of treatment, may be translated by SCBH bilingual staff without going through the MHP-QA Manager (SCBH maintains a list of bilingual staff).

        a. In these cases, review of the document by at least one other bilingual staff person is recommended before distribution of the document.

B. Either the contracted language service or the identified bilingual staff person provides translation into Latin American Spanish, the type of Spanish that is most relevant to the County's Spanish-speaking clients.

C. To ensure both accuracy of translation and cultural appropriateness, upon receipt of a translated document, the MHP-QA Manager will request review of the document by at least one bilingual SCBH staff member, who will notify the MHP-QA Manager of any recommended edits.

    i. Any edits will be made by Quality Assurance (QA) staff before the document is released for use by SCBH and/or MHP contracted provider.

D. With previously published SCBH documents, if an error in translation is identified; if content is deemed culturally insensitive for any reason; or if a document must be adapted to be accessible to persons with limited reading proficiency, the MHP-QA Manger will make necessary modifications/edits by adhering to the abovementioned review and approval process prior to re-release of the document.

E. When a revised document becomes available, QA staff will inform all applicable SCBH staff and/or MHP contracted providers of the change and request that any outdated documents be discarded and replaced by the revised version.

i. QA staff will save the current document in a shared folder on the SCBH network for all staff to access and archive the outdated document.

ii. QA staff will update the SCBH website with the revised document.

FORMS/BROCHURES:

1. *Guide to Medi-Cal Mental Health Services Handbook*
2. *Sonoma County Mental Health Plan Provider Directory*
3. *HIPAA Provider's Notice of County Privacy Practices*
4. *MHS 406-Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
5. *MHS 157-Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
6. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
7. *MHS 162-Free Language Assistance Services* (Taglines)
8. *Point to Your Language*
9. *MHS 402-Consumer Notification of Licensing Boards*
10. *MHS 400-Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
11. *MHS 109-Request for Change of Service Provider*
12. *MHS 158-Non-Discrimination Notice*
13. *MHS 115*-Consent for Treatment

ATTACHMENTS:

1. Medi-Cal Informing Materials available online at:
   http://www.sonoma-county.org/health/publications/medi-calinforming.asp