Humboldt County
Department of Health &
Human Services

Behavioral Health

Cultural Competence Plan Updated 2022

Contents

Criterion 1: Commitment to Cultural Competence

I. County Mental Health System Commitment to Cultural Competence

Humboldt County Department of Health and Human Services (DHHS) Behavioral Health is committed to the provision of culturally competent services that are effective, equitable, understandable, respectful and responsive to diverse cultural practices and beliefs, including beliefs about health and behavioral health. Behavioral Health services are delivered in a consumer's preferred language and with consideration of the individual's or family's culture. Because this Cultural Competence Plan (CCP) covers a behavioral health program that includes Substance Use Disorder (SUD) programs, it is important to combine the Cultural and Linguistic Standards (CLAS) required by SUD programs with the Department of Health Care Services (DHCS) Standards required for Mental Health Plans (MHP). In most cases the requirements are similar.

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 134,623 spread over 3,573 square miles, or 37.7 persons per square mile. Forty-nine percent of residents live within the incorporated areas while over half of residents live in the outlying rural areas of the County. Eureka is the largest community in the County and is the county seat of government. The County is home to eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria, and Big Lagoon Rancheria.

DHHS is an integrated Health and Human Services Agency under the State's Integrated Services Initiative (AB315 Berg) and includes the former Departments of Mental Health, Public Health, Employment Training, Veterans Services, Public Guardian and Social Services. Effective May 2020, DHHS Mental Health was renamed DHHS Behavioral Health. DHHS Behavioral Health is responsible for responding to psychiatric crises in the community, providing emergency psychiatric services and inpatient psychiatric services.

The DHHS and Behavioral Health commitment to cultural competence and responsiveness is reflected at all levels through:

- DHHS Mission and Vision
    - Mission: To reduce poverty and connect people and communities to opportunities for health and wellness
    - Vision: People helping people live better lives
- Behavioral Health Vision and Intention. The language in italics was new in 2021 to reflect the strengthened commitment to racial and cultural equity.
    - Vision: We are committed to engaging in relationships that are authentic, caring,

respectful and inclusive so as to be responsive to the needs of the staff and community we serve
    - Intention: To use relationships to create a culture that *advances racial and cultural equity, dismantles systemic and structural racism,* and promotes and sustains health, wellness, and recovery
- DHHS Behavioral Health Strategic Plan. The language in italics was new in 2021 to reflect the strengthened commitment to racial and cultural equity.
    - Fiscal Solvency: Responsibly maximizing revenue and decreasing/managing expenditures, *with a conscious consideration of how this advances, or hinders, racial and cultural equity,* to be able to provide needed mental health and substance use disorder services to the community
    - Collaboration: Attend to relationships to decrease barriers, strengthen partnerships, *and advance racial and cultural equity* in order to achieve collective impact goals as effectively and efficiently as possible
    - Workforce Development: Supporting a healthy and engaged, *racially and culturally diverse* workforce to grow in knowledge, skills, and abilities, and to have consistent opportunity to develop as leaders
    - Service Delivery: Offering a continuum of high quality and accessible services that are culturally responsive and tailored to the unique needs of those we serve
    - Compliance and Quality: Assuring all programs and services are provided in a compliant and high-quality manner, *with a conscious consideration of how they advance, or hinder, racial and cultural equity,* by utilizing data and internal processes to inform decision making at all levels
- DHHS Racial Equity Strategic Plan
    - Behavioral Health participates and aligns with the work outlined by the plan, which was rolled out to all BH staff.
    - Designed in partnership with the Racial Equity Steering Committee and Department of Health and Human Services leadership.
    - The long-term goal of the equity work in the strategic plan and throughout DHHS is to develop an organization that is anti-racist, or actively working to advance equity by dismantling systemic and structural racism within the agency and the community. The plan is broken down into six main goals:
        - Develop a permanent Cultural and Racial Equity Team to facilitate Equity efforts across DHHS.
        - Training and coaching for all staff.
        - Coach, support, and prepare staff in supervisory roles.
        - Develop External and Internal Racial Equity Coaching Capacity.
        - Improve hiring, recruitment, and retention.
        - Listen to, understand, and improve experiences of Black, Indigenous, and People of Color (BIPOC) staff within DHHS.
- DHHS BH Managers meetings: One meeting per month focused on equity; DHHS contracts with Stepping Stone Consulting and Humboldt Area Foundation.
    - Meeting to support Behavioral Health Managers in developing equity-related skills and implementing racial equity efforts across programs.
    - Training opportunities, activities, and discussions on racial equity topics (e.g. implicit

bias)
    - Establish an arena to discuss roll out of DHHS Racial Equity Strategic Plan across departments while providing support so that goals and time frames are met.
- DHHS Behavioral Health Strategic Initiatives
    - Improve Program outcomes that support the triple aim of better care, better health, and better value.
    - Provide integrated and coordinated team-based care with a focus on hard to engage clients.
    - Improve workforce recruitment, retention, and training to meet current client care needs.
    - Utilize data to improve and inform clinical and program decisions.
    - Align electronic health record system to meet regulations and best business practices.
    - Promote a working environment that values open communications and efficient teamwork.
    - Roll-out California Advancing and Innovating Medi-Cal (CalAIM) plans of transforming and strengthening Medi-Cal to offer people services that are more equitable, coordinated, and follow a person-centered approach.
    - Partner with CalMHSA to transition to a new Electronic Health Record (EHR) with the intent of establishing consistent workflows, configuration, and functionality.
    - Communicate staffing challenges and department barriers through leadership memos that keep existing staff informed of strategies/initiatives being implemented to help improve work life quality.
- Policies, Procedures, and Practices. Three new policies and procedures were developed in 2021 that focus on racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic (institutional) and structural racism and structural inequality, and to set the foundation for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Policy, Procedure and Form Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) now reviews all new policies, existing policies that are due for review, forms and documents using the Tool to identify language that could be changed or added to advance racial and cultural equity. From September 2021 through September 2022, a combined total of 266 Behavioral Health policies, procedures, and forms received ESM review. The purpose of the third policy is "To ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was used during the budget cycle in early 2022.

  Several other already existing policies and procedures address cultural responsiveness and will be set forth in this document. For example, 100.106, Quality Improvement, section 1.4 reads: To encourage respect for the individual clients' rights of self-determination, including

such concepts as cultural and linguistic preference, timely access to needed services, alternatives to treatment and providers, participation in healthcare decisions, and rights to make grievances and appeals.

- DHHS Behavioral Health Cultural Responsiveness Committee: Discussed in Criterion 4
- DHHS Racial Equity Steering Committee, formed in August 2020, has continued to meet regularly and in the past two years has developed a Racial Equity Plan, Training Plan, and a new online training on equity terms. In early 2022 the DHHS Racial Equity Manager was hired. The Ethnic Services Manager is a member of this Committee.
- Community Outreach, Engagement and Involvement. This is discussed further in the next section.

II. Recognition, value, and inclusion of diversity within the system

Humboldt County DHHS Behavioral Health recognizes and values the inclusion of racial, ethnic, cultural, and linguistic diversity through 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 behavioral health disparities. Community members, clients and family members are involved in several ways.

- The Humboldt County Behavioral Health Board maintains a membership comprised of at least 50% of members who have lived experience as a client or family member and two members who represent transition age youth.
- DHHS Behavioral Health sponsored education and planning meetings. These meetings invite people to gather to discuss behavioral health services. The stakeholder meetings held in the process of updating the Mental Health Services Act (MHSA) Three Year Plan Update and the MHSA Annual Updates are examples of this, where the MHSA Coordinator sponsors community stakeholder meetings. In addition, new in 2021, MHSA community meetings focused on MHSA projects were held. These community meetings are separate from the stakeholder meetings focused on Three Year Plans and Annual Updates as they focus on some specific program or aspect of MHSA. Four MHSA community meetings have been held to date. Some other examples are monthly meetings in Eastern Humboldt with several tribal and agency representatives in the area; meetings in Southern Humboldt with providers and schools; the DHHS Education/ Leadership meeting with providers and school representatives; meetings with Open Door Clinic staff to discuss collaboration; Family Advisory Board meetings; and meetings with Emergency Room/Hospital staff. Due to COVID-19 restrictions, these meetings have been held virtually via Zoom or WebEx.
- DHHS Behavioral Health participation in existing community meetings where behavioral health services, education, and planning are discussed. These meetings are sponsored by local community-based organizations and associations that represent and/or serve diverse stakeholders. In these instances, a Behavioral Health staff person attends and requests that behavioral health services planning be on the agenda for a specific meeting. This dramatically increases the number and diversity of individuals providing input. Much of the MHSA stakeholder input gathered for the Three Year Plan and Annual Update comes in this

way. Some examples are the meetings of the Northern Humboldt Family/Community Resource Centers, the Family Advisory Board, the Eastern Humboldt Services Group, Southern Humboldt Working Together, Promotores de Humboldt meetings, and more.

Participants in the MHSA stakeholder process reflect the diversity of Humboldt County, including individuals with experience as clients and family members; current and former foster youth; transition age youth; DHHS administration; program providers; community-based and organizational providers of local public health, behavioral health, social services, and vocational rehabilitation services; and agencies that serve and/or represent diverse racial and ethnic groups, and unserved/underserved, Native American, and rural communities.

Below are examples of stakeholder entities with which DHHS Behavioral Health participates:

- Humboldt County Transition Age Youth Collaboration
- Family and Community Resource Centers
- Law Enforcement Chiefs Association Humboldt
- United Indian Health Services
- Suicide Prevention Network
- 0-8 Mental Health Collaborative
- First 5 Humboldt
- NAMI (National Alliance on Mental Illness)
- Family Advisory Board
- *Promotores de Humboldt*
- DHHS Behavioral Health organizational providers
- Humboldt Allies for Substance Use Prevention
- Behavioral Health Board
- Youth Advocacy Board
- Open Door Clinics
- K'ima:W Medical Clinic
- Southern Humboldt Working Together
- DHHS Employee Services
- DHHS Public Health
- DHHS Social Services

Community outreach, engagement, and involvement is clearly demonstrated in the Mental Health Services Act (MHSA) stakeholder process. During the planning process for the Annual Update for 2022-2023, conducted from November 2021-March 2022[1], 72 individuals attended one of ten stakeholder meetings and/or provided input via email for the Draft Annual Update 2022-2023. Of these, approximately 31% provided demographic information. The following tables reflect this demographic data.

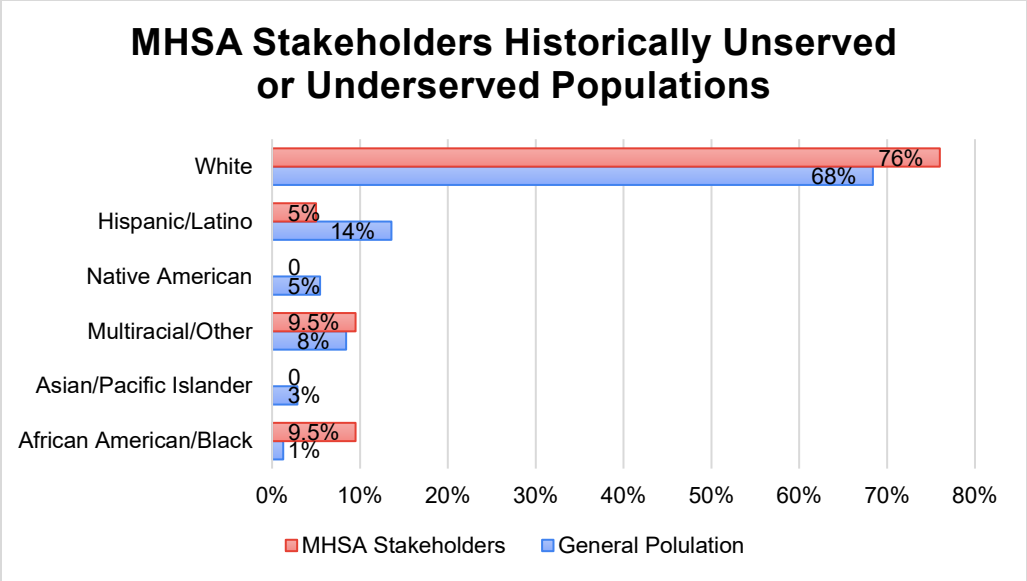
[1] MHSA community planning process data, 2021-2022. Tables and charts on the following pages reflect data gathered from demographic forms collected during the planning process.

Residence Location	Percent
Northern Humboldt	29%
Eureka	57%
Eel River Valley	0%
Southern Humboldt	9%
Eastern Humboldt	0%
Other/Unknown	5%

Ethnicity	Percent
White/Caucasian	76%
Hispanic/Latino	5%
Black/African American	9.5%
Asian/Pacific Islander	0%
American Indian or Alaska Native	0%
Multiracial/Other	9.5%

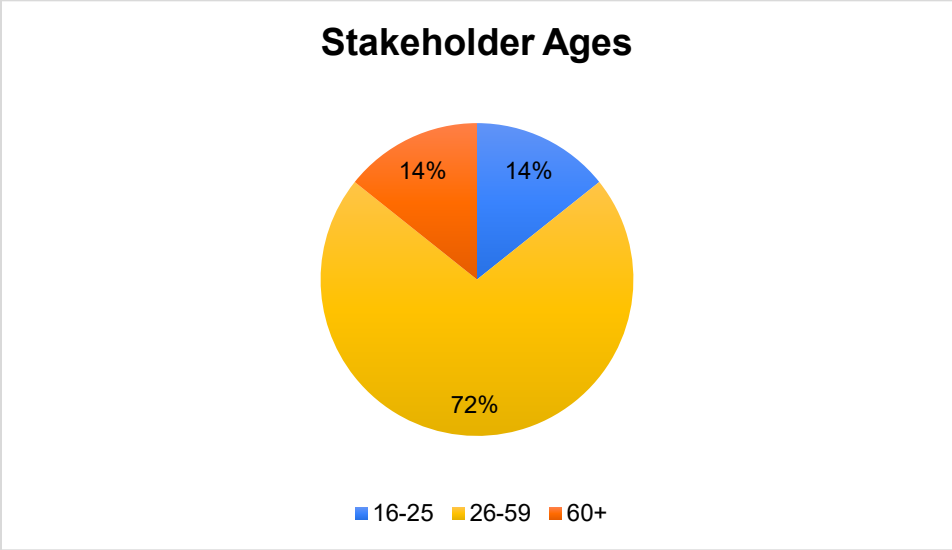
Age Group	Percent
16-25	14%
26-59	72%
60+	14%

As seen in the chart below, Hispanic/Latino stakeholders were 5% of participants as compared to 14% of the general population. American Indian/Alaska Native participants were 0%, as compared to the 5% of the general population. For Multiracial/Other participants the participation in the MHSA stakeholder process was 9.5%, as compared to the 8% of the general population. The Asian/Pacific Islander participants that attended MHSA stakeholder meetings was 0%, as compared to the 3% of the general population. For African American/Black participants, the participation in the MHSA stakeholder process was 9.5%, as compared to the 1% of the general population.



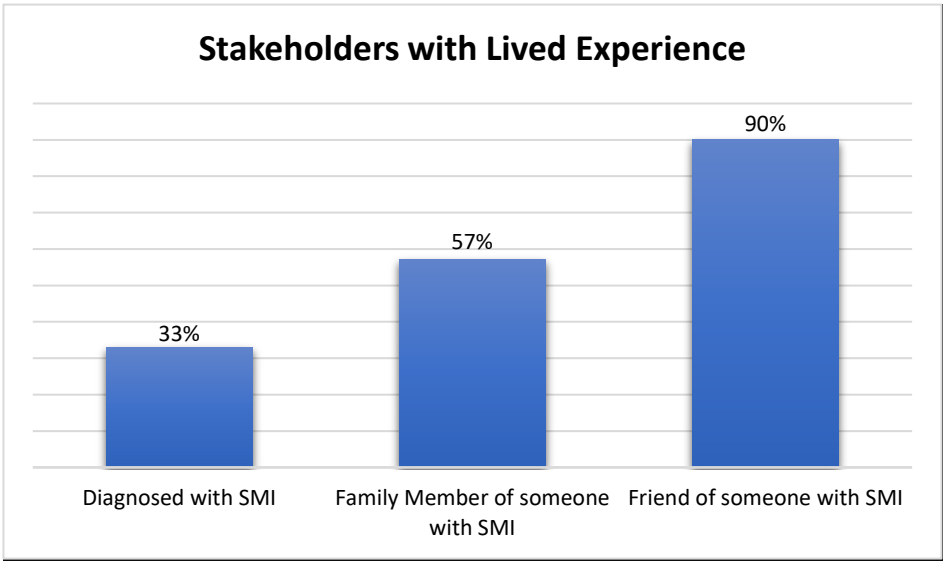
For those completing the demographic form English was the primary language for almost all providing input. Only two stakeholders stated that their primary language was other than English. Though the MHSA community survey was available in Spanish, there were no responses to the Spanish language survey. The County currently does not have a Threshold Language.

Capturing and tracking the age range of those providing input is also important, as transition age youth have been identified as an underserved population. As this chart illustrates, 14% of those providing input were transition age youth between ages 16-25, with 72% reporting being adults between ages 26-59, and 14% being older adults aged 60 and over.

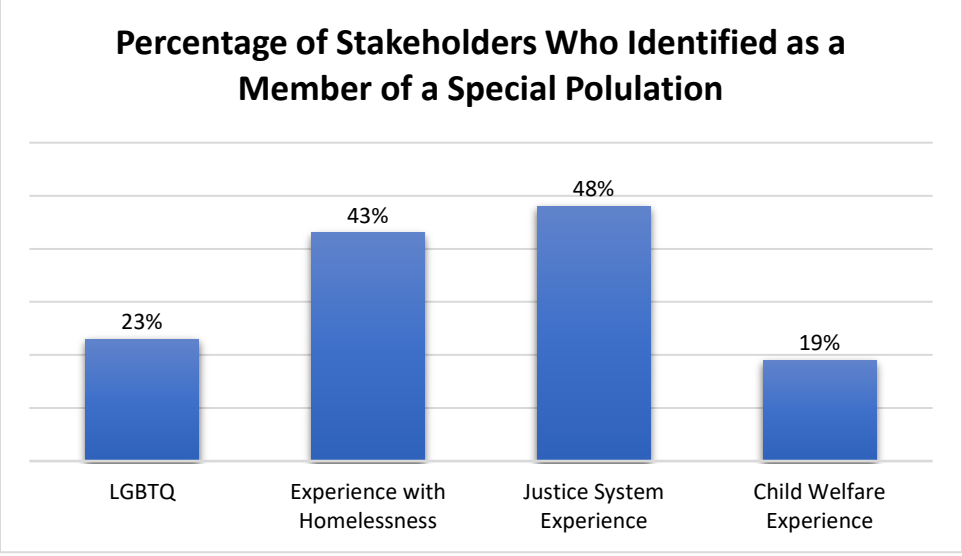


Community members with lived experience as clients of behavioral health services and family members of clients are two important populations to capture and track as their direct

experience with services is vital to the success of program planning. Thirty-three percent of those participating in the stakeholder process were diagnosed with a serious mental illness. Fifty-seven percent were family members of those who have been diagnosed with a serious mental illness. Ninety percent were friends of someone with serious mental illness.



The LGBTQ community, people who have experienced homelessness, and people who have experienced the justice system or child welfare services are also tracked, as they are traditionally underserved populations. Twenty-three percent identified as LGBTQ, 43% had experience with homelessness, 48% had justice system experience, and 19% had child welfare experience.



III. Designated Cultural Competence/Ethnic Services Manager

The duties and responsibilities of the DHHS Behavioral Health Ethnic Services Manager are overseen by the Behavioral Health Director. It is the responsibility of both the Ethnic Service Manager and the Behavioral Health Leadership Team to ensure the development and delivery of behavioral health services to meet the diverse cultural, ethnic, and linguistic needs of clients and family members. The Ethnic Services Manager:

- Is a member of the DHHS Behavioral Health Management Team
- Is a member of and co-facilitator for the Behavioral Health Cultural Responsiveness Committee
- Is a member of the Outpatient Continuous Quality Improvement (OP-CQI) Committee
- Facilitates provision of cultural training to behavioral health staff
- Facilitates broad and diverse stakeholder representation in the program planning process
- Participates in the development of the Cultural Competency Plan and the Mental Health Services Act Plans and Updates, and coordination of the components of MHSA Plans
- Receives data reports on the racial/ethnic and cultural demographics of individuals participating in or being served by Mental Health Services Act programs and activities, and includes data in reports and recommendations
- Is a participant in the Superior Region Ethnic Services Manager conference calls
- Is a member of the California Behavioral Health Directors Association (CBHDA) Cultural Competency, Equity, and Social Justice Committee (CCESJC), and participates in monthly conference calls and meetings
- Is a member of the DHHS Racial Equity Steering Committee

IV. Budget Resources for Cultural Competence Activities

DHHS Behavioral Health does not have a specific budget dedicated to cultural competency activities. Cultural competence is considered an over-arching value that is embedded in all programs and activities throughout the department.

The following programs include specifically funded services for culturally diverse groups:

- Humboldt County Transition Age Youth Collaboration (HCTAYC) and the Youth Advocacy Board
- Homeless Outreach
- Rural Outreach through Regional Services
- Two Feathers Native American Family Services to serve Native youth through providing behavioral health services, as a county organizational provider

Department-wide services include:

- Cultural training

- Bilingual staff employed at the Department receive a pay differential
- Full time Interpreter/Translator staff person
- Contract Interpreters/Translators
- 24 hour Language Line
- Culturally appropriate behavioral health services, such as those provided by the TAY Division, contract with Two Feathers Native American Services serving Native youth, and HCTAYC initiatives for LGBTQ+
- Racial Equity work to address structural and systemic racism through the DHHS Racial Equity Steering Committee. This group has developed a Racial Equity Plan, Training Plan, and an online training on equity terms.
- Compensation for culturally and linguistically competent providers who have passed the County bi-lingual proficiency exam, or who have indicated experience and qualifications on the Interpreter/Translator Resume, and for non-traditional providers/healers through referral to Two Feathers Native American Services and to United Indian Health Services

Criterion 2: Updated Assessment of Service Needs

I. General Population

According to the 2020 decennial redistricting data, 5% of residents are Native American, 3% are Asian/Pacific Islander, 1% are African American, 68% are White, 14% are Hispanic/Latino, and 8% are multiracial or other.

Race/Ethnicity[2]	Number of Residents	Percentage
African American/Black	1,729	1%
Asian/Pacific Islander	3,931	3%
Multiracial/Other	11,498	8%
Native American	7,454	5%
Hispanic/Latino	18,535	14%
White	93,316	68%
Total	136,463	100%

Foreign-born residents are approximately 5.4% of the total population. Approximately half of those who are foreign born are naturalized citizens. In addition, approximately 45% of those foreign born are from Latin and North America.

Foreign Born Population by Region of Birth[3]	Number of Residents	Percentage
Africa	82	1%
Oceana	207	3%
North America	471	6%
Europe	1,081	15%
Asia	2,206	30%
Latin America	3,329	45%
Total Foreign Born	7,376	100%

Residents who do not speak English at home are 12% of the population. Of those who do not

[2] P1 RACE DECENNIAL CENSUS
[3] ACS B05006 PLACE OF BIRTH FOR THE FOREIGN-BORN POPULATION IN THE UNITED STATES

speak English at home, 4,481 (3% of total population) do not speak English “very well”.

Primary Language: Language Spoken at Home - Population 5 years and over	Number of Speakers in Humboldt County	Percentage of Speakers in Humboldt County	Number of Speakers Who Report Not Speaking English "Very Well"	Percentage of Speakers Who Report Not Speaking English "Very Well"
Asian/Pacific Islander	2,979	2%	1,370	46%
Other Indo-European	1,488	1%	208	14%
Spanish	9,872	8%	2,780	28%
Other Languages	858	1%	123	14%
English	113,779	88%		
Total	128,976	100%	4,481	3%

Of the residents who are 25 years and older, 94% are high school graduates and 30% have a bachelor’s degree or higher[4]. Approximately 19% of residents are grandparents who are responsible for their grandchildren[5]. Fifty-one percent of the population is female and 49% is male. Median family income is $69,499. The median income for a male full-time worker is $40,769 and for female full-time workers it is $39,134.[6]

Age Range[7]	Number of Residents	Percentage
Children 0-14	21,364	16%
Youth Age 15-24	20,890	15%
Adults 25-59	59,564	44%
Older Adults 60+	34,492	25%
Total	136,310	100%

Gender[8]	Number of Residents	Percentage
Female	68,883	51%
Male	67,427	49%
Total	136,310	100%

[4] ACS S1501 EDUCATIONAL ATTAINMENT
[5] ACS S1002 GRANDPARENTS
[6] ACS S1903 ACS 1-Year Median Income
[7] ACS S0101 AGE AND SEX
[8] ACS DP05 ACS DEMOGRAPHIC AND HOUSING ESTIMATES

II. Medi-Cal Population and Client Utilization

The following four tables show the average number of eligible Humboldt County Medi-Cal recipients per month and their percentage of the total population, as well as Client Utilization in Calendar Year 2020. These four tables include all clients using services, with and without Medi-Cal. The data source for most of the data is Behavioral Health Concepts (BHC), Behavioral Health's External Quality Review Organization. BHC did not have data about primary language however, so another system, CalSAWS, was used to obtain information on primary language. CalSAWS data for 2020 shows a different total number for the Medi-Cal population.

Race/Ethnicity	Number of Medi-Cal Recipients[1]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[2]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
Asian/Pacific Islander	1,783	3%	58	1%
African American/Black	1,020	2%	133	3%
Hispanic/Latino	7,720	13%	414	10%
Native American	4,245	7%	382	9%
Multiracial/Other/Unknown	9,754	17%	615	15%
White	32,813	57%	2,491	61%
Total	57,335	100%	4,093	100%

Primary Language	Number of Medi-Cal Recipients[3]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[4]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
Hmong	307	<1%	10	<1%
Spanish	2,873	5%	44	1%
Other	239	<1%	523	13%
English	58,324	94%	3,516	86%
Total	61,743	100%	4,093	100%

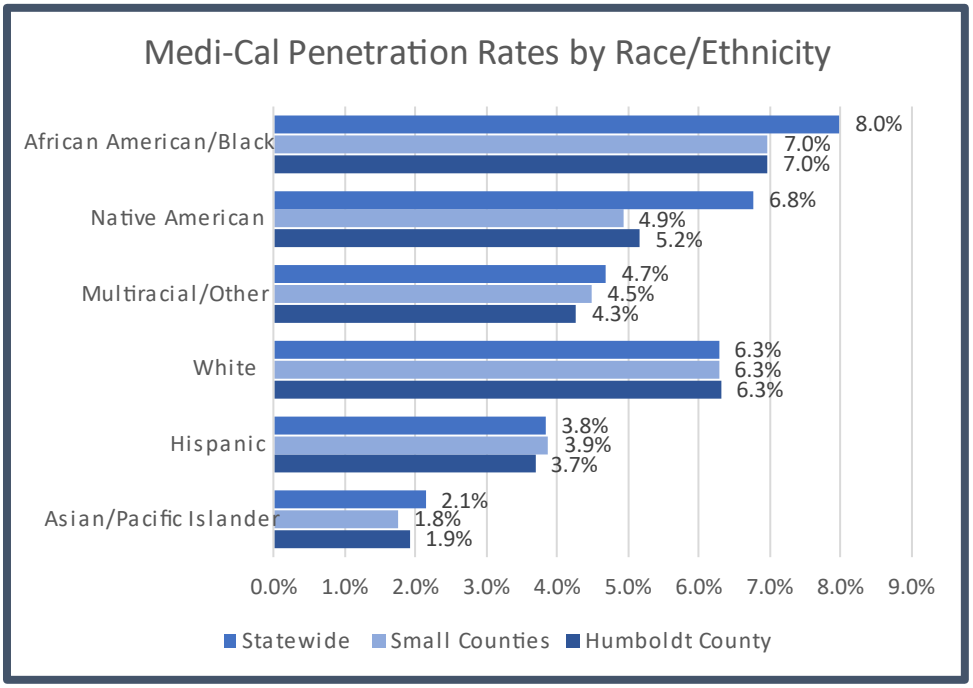
Gender	Number of Medi-Cal Recipients[5]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[6]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
Unknown			3	<1%
Female	29,522	51%	1,900	46%
Male	27,811	49%	2,190	54%
Total	57,333	100%	4,093	100%

Age	Number of Medi-Cal Recipients[7]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[8]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
0-5	6,010	11%	94	2%
6-17	11,493	20%	916	22%
18-59	32,781	58%	2,640	65%
60+	7,050	13%	443	11%
Total	57,334	100%	4,093	100%

As previously stated, the four tables above showed the numbers and percentages for all consumers utilizing BH services regardless of payor (Medi-Cal or non Medi-Cal) for those services. The table below shows the disparities for those with Medi-Cal only.

Race/Ethnicity	Number of Medi-Cal Recipients[1]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with Medi-Cal)	Percentage of Consumers Utilizing DHHS-BH Services (with Medi-Cal)
Asian/Pacific Islander	1,783	3%	34	1%
African American/Black	1,020	2%	71	2%
Native American	4,245	7%	219	7%
Hispanic/Latino	7,720	13%	284	9%
Multiracial/Other	9,754	17%	416	13%
White	32,813	57%	2,066	67%
Total	57,335	100%	3,090	100%

Medi-Cal Penetration Rates in Humboldt County as compared to other small counties and to the State of California in the category of race/ethnicity are presented in the chart below.



Humboldt County's penetration rate for Native Americans with Medi-Cal receiving services is 5.2%. For other small counties, the penetration rate is 4.9% and statewide it is 6.8%. The percentage of clients served with Medi-Cal and the percentage of residents with Medi-Cal are equal at 7%. Discrepancy in penetration rates is likely due to increased service collaboration with Native American agencies providing mental health services in the county, including United Indian Health Services, with five locations that provide a wide range of services to the local

Indian communities, and tribes providing mental health services to their tribal members. Another cause for this slight difference could be the historical legacy that has created a mistrust of the public mental health system. Native Americans in Humboldt County vary in their levels of acculturation. These communities reside on tribal lands, rural unincorporated, and incorporated areas. Although some families have always resided in the area by their own choice, there are many whose ancestors were forcibly removed from traditional lands and were relocated from other parts of the United States by the government. Most families are aware of, or personally experienced, forcible placement in boarding schools and have had negative experiences with social programs that promised improvements in services but did not deliver on these promises.

There is a 1.9% penetration rate for Asian/Pacific Islanders, for other small counties the penetration rate is 1.8% and statewide is 2.1% penetration rates. Asian/Pacific Islanders with Medi-Cal are 1% of clients served while 3% of residents with Medi-Cal are Asian/Pacific Islander. One cause for this slight difference is linguistic access. According to the 2019 American Community Survey (ACS) census data, approximately half of Asian/Pacific Islander residents speak a language other than English at home and approximately half of those speak English less than "very well." Humboldt County Asian/Pacific Islander residents come from a variety of backgrounds, experiences, and age groups including immigrants, refugees, and the American-born. Specific populations include Vietnamese, Mien, Hmong, Chinese, Cambodian, Filipino, Asian Indian, Laotian, Korean, Japanese, Thai, Native Hawaiian, and Samoan. Since attitudes towards mental health care and its access vary drastically from country to country, there may be stigmas or assumptions people utilize that influence their decision to utilize mental health services when migrating to United States. Another cause for the slight difference in utilization of services could be the varying levels of acculturation within households. Children who are born in the United States are more highly acculturated and bilingual, while parents may primarily speak their native language. There may be a lack of knowledge about mental health services and many families may be hesitant to use them because of a lack of understanding about what counseling and other mental health services are available. This effect can be further exacerbated if Behavioral Health outreach is not reaching some of these communities as effectively.

There is a 7% penetration rate in Humboldt County for African Americans as compared to 7% for other small counties and 8% statewide. The percentage of clients served with Medi-Cal and the percentage of residents with Medi-Cal are both at 2%. While the percentage of clients served is the same as the percentage of those with Medi-Cal, promotion of services acknowledging the historical trauma of discrimination, which many African American families have experienced for generations, and a positive emphasis on the Black/African American identity are necessary to support culturally appropriate services.

The penetration rate for Whites is 6.3% in Humboldt County, 6.3% for small counties and 6.3% statewide. White clients served with Medi-Cal are at 67% while only 57% of residents with Medi-Cal are White.

The penetration rate for Hispanic/Latinos is 3.7 in Humboldt County, 3.9% for small counties

and 3.8% statewide. Hispanic/Latinos with Medi-Cal are 9% of clients served while 13% of residents with Medi-Cal are Hispanic/Latino. Approximately 5% of Hispanic/Latinos with Medi-Cal have a primary language of Spanish which is 1% of those with Medi-Cal, which does not meet the 5% threshold criteria. While there is very little difference between clients with Medi-Cal and those served, it is important to note that there are varying levels of acculturation and a lack of knowledge about available services. Some Hispanic/Latino families do not consider mental health or developmental issues in children to be of concern because of a cultural value for accepting individuals as they are or interpreting the causes of mental illness as disciplinary problems. Stigma can also be a barrier. Some may be resistant to receiving mental health services because they believe that mental illness is shameful. Another factor could be the number of families that live below the Federal Poverty Level, with limited resources for transportation, jobs, insurance, housing, and food. Finally, fear of deportation for those who are undocumented inhibits them from seeking services.

There is a 4.3% penetration rate for Multiracial/Other as compared to 4.5% for other small counties and 4.7% statewide. Multiracial/Other clients with Medi-Cal are 13% of clients served while 17% of residents with Medi-Cal are Multiracial/Other.

Humboldt County Client Utilization for Language

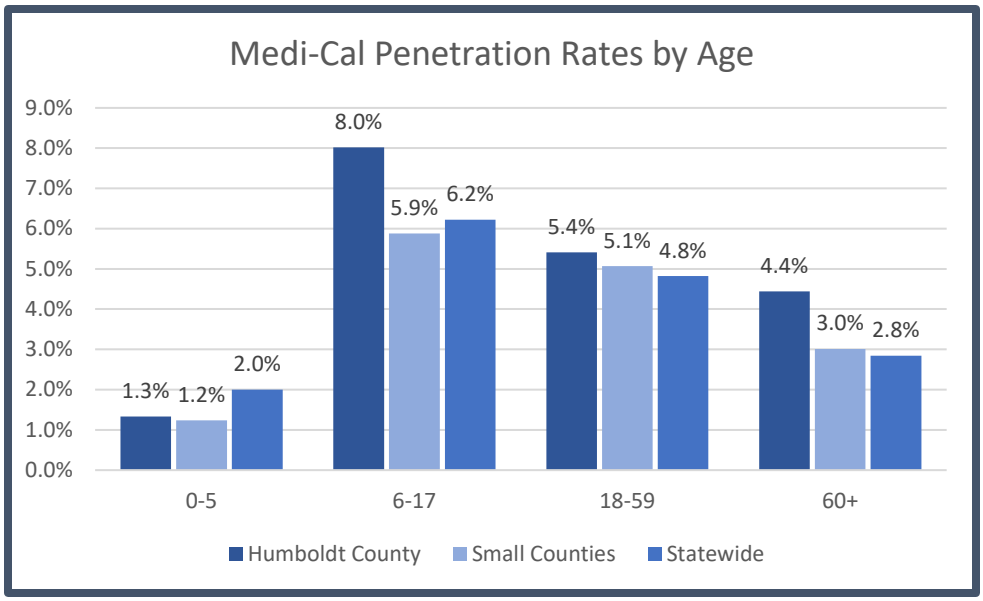
As already discussed, BHC's data did not include primary language. Thus, the comparison was made between utilization of services for all clients, regardless of payor, with data from Avatar Electronic Health Records and the Medi-Cal population data in the CalSAWS system. This information is presented in the chart on page 15.

Humboldt County Medi-Cal Population and Client Utilization with Medi-Cal[9] for Age

The Penetration Rate in Humboldt County as compared to other small counties and to the State of California in the category of age is presented in the chart below**.**

Ages	Number of Medi-Cal Recipients	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with Medi-Cal)	Percentage of Consumers Utilizing DHHS-BH Services (with Medi-Cal)
0-5	6,010	10%	80	3%
6-17	11,493	20%	922	30%
18-59	32,781	57%	1,775	57%
60+	7,050	12%	313	10%
Total	57,334	100%	3,090	100%

[9] Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2019.



Humboldt County's penetration rate for ages 0-5 is 1.3%, for other small counties the average is 1.2% and statewide it is 2%. There is a disparity with 3% of ages 0-5 with Medi-Cal served, while they are 10% of residents in the county with Medi-Cal. One cause for this disparity is the relatively low incidence of mental health services provided to very young children ages 0 to 5 years old. Another cause may be the stigma associated with mental health services and children. Families may fear their children being labeled at a young age or that they will be judged as poor parents. A lack of understanding of mental health may be another cause. Families may interpret mental health symptoms as bad behavior that requires stronger discipline rather than mental health services. Another cause may be the ability to access services including the hours services are available and transportation to locations where services are provided.

There is a 8% penetration rate for children and youth age 6-17 as compared to 5.9% for other small counties and 6.2% statewide. Ages 6-17 are 30% of clients with Medi-Cal served while 20% of residents in the county with Medi-Cal are in this age group. Thus 10% more are served in this age group than are residents with Medi-Cal in the County.

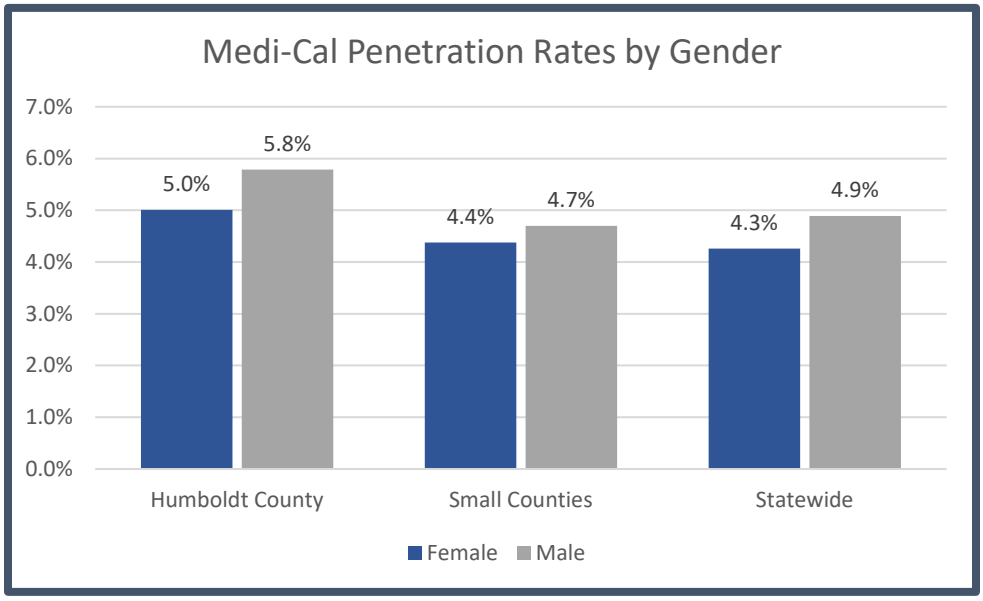
For Adults ages 18-59 the penetration rate in Humboldt County is 5.4%, 5.1 for small counties and 4.8% Statewide. Adults in this group are 57% of clients with Medi-Cal served and 57% of residents in the county with Medi-Cal.

There is a 4.4% penetration rate for Adults ages 60+ as compared to 3% for other small counties and 2.8% Statewide. A slight difference exists for Adults ages 60+ with 10% of clients served with Medi-Cal in this age group, while 12% of residents in the county with Medi-Cal are in this age group. One cause for this difference could be the misconception that normal aging is characterized by an increase in mental health issues. For example, stressful life events, such as declining physical health, the loss of family members, friends or a significant other often increase with age.

Transition Age Youth: Humboldt County's larger penetration rate for this group as compared to other small counties and statewide is a direct result of the Department of Health and Human Services concerted efforts to identify and provide needed services to Transition Age Youth. Through stakeholder input and educational activities, the Department has implemented both administrative and service delivery initiatives that have resulted in culturally appropriate services for racially and ethnically diverse Transition Age Youth.

Medi-Cal Population and Client Utilization with Medi-Cal[10] for Sex/Gender

Sex/Gender	Number of Medi-Cal Recipients	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with Medi-Cal)	Percentage of Consumers Utilizing DHHS-BH Services (with Medi-Cal)
Female	29,522	51%	1,479	48%
Male	27,811	49%	1,611	52%
Total	57,333	100%	3,090	100%



Humboldt County's penetration rate for females with Medi-Cal receiving services compared to residents who are female with Medi-Cal is 5.0%, for other small counties the average is 4.4% and statewide it is 4.3%. There is a 5.8% penetration rate for males as compared to 4.7% for other small counties and 4.9% statewide. 48% of clients with Medi-Cal served are female while 51% of residents in the county with Medi-Cal are female. 52% of clients with Medi-Cal served

[10] Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2020.

are male while 49% of residents in the county with Medi-Cal are male.

There is no state data available that includes information about gender other than male/female. The DHHS/BH Client Information Form has checkboxes for Birth Sex: Male, Female, and Gender: Same as Birth Sex, Male-to-Female Transgender, Female-to-Male Transgender, Unknown, Other, so there is some information about gender. As of October 2022, data from the Medical Records system shows there are 30 female-to-male transgender clients, 12 male-to-female transgender clients, 6 are another gender identity and 2 are Unsure/Questioning.

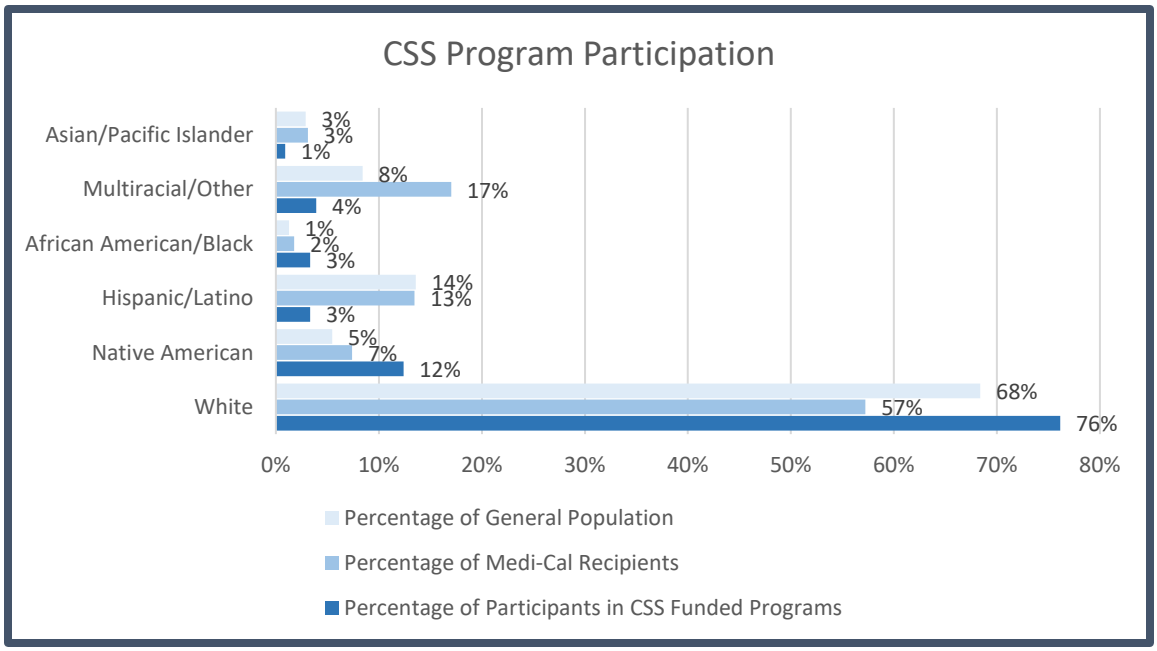
IV. MHSA Community Services and Supports (CSS)[11]

The MHSA CSS client data represents a subset of the Client Utilization data for those clients who are receiving services in a MHSA CSS funded program. CSS programs with client data for 2019 are Comprehensive Community Treatment (CCT)/Full Service Partnership and Older and Dependent Adults. Data for the CCT Program comes from the State of California Data Collecting and Reporting system (DCR) and data for Older and Dependent Adults comes from the electronic health record (EHR).

The table below shows the number and percentage, by race/ethnicity, served by CSS programs, those with Medi-Cal in Humboldt County, and the general population.

Race/Ethnicity	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County	Percentage of General Population
White	252	76%	32,813	57%	93,316	68%
Native American	41	12%	4,245	7%	7,454	5%
Hispanic/Latino	11	3%	7,720	13%	18,535	14%
African American/Black	11	3%	1,020	2%	1,729	1%
Multiracial/Other	13	4%	9,754	17%	11,498	8%
Asian/Pacific Islander	3	1%	1,783	3%	3,931	3%
Total	331	100%	57,335	100%	136,463	100%

[11] Humboldt County Behavioral Health Avatar Electronic Health Records.



Native American makes up 12% of CSS clients, 7% of those with Medi-Cal and 5% of the general population. One percent are Asian/Pacific Islander CSS client. However, Asian/Pacific Islander makes of 3% of those with Medi- Cal and 3% of the general population. African American makes up 3% of CSS clients, 2% of those with Medi-Cal and 1% of the general population. White makes up 76% of CSS clients, 57% of those with Medi-Cal and 68% of the general population. Hispanic/Latino makes up 3% of CSS clients, 13% of those with Medi-Cal and 14% of the general population. Multiracial/Other makes up 4% of CSS clients, 17% of those with Medi-Cal and 8% of the general population.

Primary Language	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County*	Percentage of General Population*
Asian/Pacific Island	0	0%	441	1%	2,979	2%
Spanish	0	0%	2,873	5%	9,872	8%
Other/Unknown	268	81%	105	<1%	2,346	2%
English	63	19%	58,324	94%	113,779	88%
Total	331	100%	61,743	100%	128,976	100%

*Because the DCR does not collect client primary language data, the language data available for participants in CSS funded programs is from the EHR and only for the Older and Dependent Adults program. Thus the primary language for 81% of participants in CSS funded programs for CY 2020 is unknown, making a comparison to Medi-Cal recipients and the general population impossible.

Age	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County*	Percentage of General Population
0-5	0	0%	6,010	10%	5,798	4%
6-17	0	0%	11,493	20%	20,080	15%
18-59	196	59%	32,781	57%	75,940	56%
60+	135	41%	7,050	12%	34,492	25%
Total	331	100%	57,334	100%	136,310	100%

Those clients age 0-5 make up 0% of CSS clients, 10% of the Medi-Cal population, and 4% of the general population. Those age 6-17 make up 0% of CSS clients, 20% of the Medi-Cal population, and 15% of the general population. Those 18-59 make up 59% of CSS clients, 57% of Medi-Cal clients, and 56% of the general population. Clients 60+ make up 41% of CSS clients, 12% of the Medi-Cal population, and 25% of the general population.

Gender	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County	Percentage of General Population
Female	154	47%	29,522	53%	68,883	51%
Male	177	53%	27,811	50%	67,427	49%
Total	331	100%	56,161	100%	136,310	100%

Females make up 47% of CSS clients, 53% of those with Medi-Cal and 51% of the general population. Males make up 53% of CSS clients, 50% of those with Medi-Cal and 49% of the general population.

V. MHSA Prevention and Early Intervention (PEI)[12],[13]

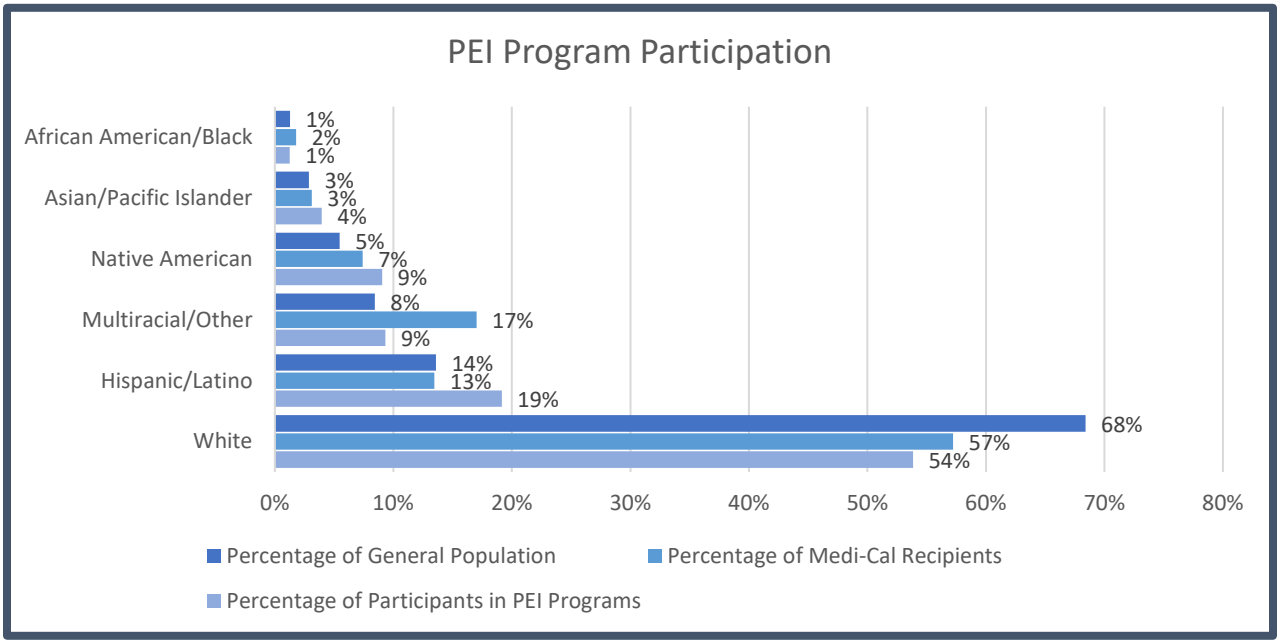
For all but one program, the MHSA PEI data represents those who have participated in PEI activities and completed a demographic form. Because of the nature of many PEI activities—trainings, media campaigns, community education—there are many more people reached than are reflected in the small number who fully complete a demographic form. Some people may only complete some of the nine categories of demographic form questions. Some people

[12] Humboldt County Department of Health and Human Services, MHSA Prevention and Early Intervention spreadsheets and reports, FY 2021-22.
[13] California Department of Education https://www.cde.ca.gov/ds/sd/

decline to complete the survey at all, and as it is a voluntary survey, they have that right. In addition, people participating in a PEI activity are not, for the most part, behavioral health clients. Some programs did not begin gathering data until the beginning of calendar year 2018. Other programs gathered some, but not all, of the required data elements in prior years. FY 21/22 continued to have fewer PEI participants than in past years due to the continuation of the COVID-19 shelter-in-place order and temporary closure of programs. The one program for which data is pulled from another source is Multi-Tiered System of Support (MTSS). For this program, data is pulled from the California Department of Education.

Race/Ethnicity

Race/Ethnicity	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County	Percentage of General Population
Unknown	626	3%				
White	9,874	54%	32,813	57%	93,316	68%
Hispanic/Latino	3,512	19%	7,720	13%	18,535	14%
Multiracial/Other	1,708	9%	9,754	17%	11,498	8%
Native American	1,660	9%	4,245	7%	7,454	5%
Asian/Pacific Islander	727	4%	1,783	3%	3,931	3%
African American/Black	231	1%	1,020	2%	1,729	1%
Total	18,338	100%	57,335	100%	136,436	100%



Native American makes up 9% of PEI participants, 7% of the Medi-Cal population, and 5% of the general population. Asian/Pacific Islander makes up 4% of PEI participants, 3% of the Medi-Cal population, and 3% of the general population. African American makes up 1% of PEI

participants, 2% of the Medi-Cal population, and 1% of the general population. White makes up 54% of PEI participants, 57% of the Medi-Cal population, and 68% of the general population. Hispanic/Latino makes up 19% of PEI participants, 13% of the Medi-Cal population, and 14% of the general population. Multiracial/other makes up 9% of PEI participants, 17% of the Medi-Cal population, and 8% of the general population.

Primary Language

Those whose primary language is English make up 90% of PEI participants, 94% of the Medi-Cal population, and 88% of the general population. Those whose primary language is Spanish make up 5% of PEI participants, 5% of the Medi-Cal population, and 8% of the general population. One percent of PEI participants' primary language are Asian and Pacific Island languages. For 3% of PEI participants, the primary language was unknown/not captured. Less than 1% of PEI participant's primary language was listed as Other, <1% of the Medi-Cal population and 2% of the general population.

Primary Language	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County*	Percentage of General Population*
Asian and Pacific Island languages	262	1%	441	1%	2,979	2%
Other	56	<1%	105	<1%	2,346	2%
Spanish	939	5%	2,873	5%	9,872	8%
English	16,551	90%	58,324	94%	113,779	88%
Unknown	530	3%				
Total	18,338	100%	61,743	100%	128,976	100%

Age

PEI demographic forms collect data on age as defined by MHSA. For MHSA, Children are ages 0-15, Transition Age Youth are ages 16-25, Adults are 26-59, and Older Adults are age 60+. Except for the Older Adult category, this is different than how Medi-Cal defines age. The chart below indicates the number and percentages using both MHSA and Medi-Cal definitions, but they cannot be accurately compared.

Age	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County	Percentage of General Population
Children 0-5 (Medi-Cal)			6,010	10%	5,798	4%
Children 0-15 (MHSA)	14,534	79%				
Children 6-17 (Medi-Cal)			11,493	20%	20,080	15%
Transition Age Youth 16-25 (MHSA)	3,339	18%				
Adults 18-59 (Medi-Cal)			32,781	57%	75,940	56%
Adults 26-29 (MHSA)	308	2%				
Older Adults 60+ (MHSA & Medi-Cal)	73	<1%	7,050	12%	34,492	25%
Not stated/Unknown	84	<1%				
Total	18,338	100%	57,334	100%	136,310	100%

Sex/Gender

Fifty percent of PEI participants were male, 49% female, less than 1% unknown, and less than 1% Other.

Gender	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Medi-Cal Recipients	Percentage of Medi-Cal Recipients	General Population in Humboldt County	Percentage of General Population
Other	94	<1%				
Male	9,236	50%	27,811	49%	67,427	49%
Female	8,940	49%	29,522	51%	68,883	51%
Unknown	68	<1%				
Total	18,338	100%	57,333	100%	136,310	100%

VI. MHSA Workforce Education and Training (WET)

WET is discussed in Criterion 6.

Criterion 3: Strategies and Efforts for Reducing Disparities

I. Target populations with disparities

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

For most PEI programs, the MHSA data represents those who have participated in PEI activities and completed a demographic form. Because of the nature of many PEI activities—trainings, media campaigns, community education—there are many more people reached than are reflected in the small number who fully complete a demographic form. Some people may only complete some of the nine categories of demographic form questions. In addition, the data reflects the people participating in a PEI activity rather than those people that may be served as a mental health client. The one program that is an exception to obtaining PEI data through demographic forms is the Multi-Tiered System of Support (MTSS). Due to the nature of the MTSS activities, demographic data for Fiscal Year 2021-22 (the most recent available) was obtained from the California Department of Education website.

PEI programs have also varied greatly in their gathering of data. Some programs did not begin gathering data until the beginning of calendar year 2018. Other programs gathered some, but not all, of the required data elements in prior years. COVID-19 and the shelter-in-place order that began in March 2020 caused either the closing down of PEI programs or a move to providing any services virtually. Staff were unable to obtain demographic information when activities were conducted virtually. The tables and charts presented in Criterion 2 reflect the data currently available both from the demographic forms and the Department of Education website.

II. Disparities in each of the populations

Disparity is the condition of being unequal and is a noticeable difference between one or more things. Disparity usually refers to a difference that is unfair. In this section, a simple descriptive analysis is used to describe the differences in the data. Most of the differences identified are slight.

Medi-Cal Population (CY 2020 data). There is a very slight difference in serving Asian/Pacific Islander (3% of Medi-Cal recipients and 1% of clients), a slight difference in serving Multiracial (17% of Medi-Cal recipients and 15% of clients) populations, a very slight difference in serving African-American/Black (2% of Medi-Cal recipients and 3% of clients), a difference in serving Hispanic/Latino (13% of Medi-Cal recipients and 10% of clients), and a difference in serving Native American (7% of Medi-Cal recipients and 9% of clients). For age, the greatest difference is for serving children ages 0-5 (11% of Medi-Cal recipients and 2% of clients). There is a slight difference in serving those ages 60+ (13% of Medi-Cal recipients and 11% of clients). There is a disparity in serving those whose primary language is not English (6% of Medi-Cal recipients and less than 14% of clients). There is no data available on the LGBTQIA Medi-Cal population to

identify disparities.

MHSA Community Services and Supports (CY 2020 data). There is a difference in serving the Hispanic/Latino population (3% of CSS clients, 13% of Medi-Cal recipients, 14% of the general population) and the Multiracial population (4% of CSS clients, 17% of Medi-Cal recipients, 8% of the general population). There is a slight difference in serving Asian/Pacific Islander (1% of CSS clients, 3% of Medi-Cal recipients and 3% of the general population). There is a difference in serving children ages 0-5 (none served in CSS) and in serving children 6-17 (none served in CSS). There is not enough data to determine language disparity. There is no data available on the LGBTQIA Medi-Cal population to identify differences.

MHSA Prevention and Early Intervention (2020-21 data from PEI spreadsheets and 2021-22 data from California Department of Education. There is a difference in serving Multiracial populations (9% of PEI participants and 17% of Medi-Cal recipients). However, compared to the general population of 8% Multiracial there is a 1% difference. There is a slight difference in serving African American populations (1% of PEI participants, 2% of Medi-Cal recipients, 2% of the general population). The data on age could not be analyzed.

Workforce Education and Training (September 2022 Employee Services data). In looking at Employee Services data alone, White is overrepresented in the BH workforce when compared to the client population served and the general population (76% workforce, 67% client population, 68% general population). There are fewer Native Americans in the workforce than clients served, though the difference with the general population is only 2% (3% workforce, 7% clients served, 5% general population). The African American/Black workforce is greater compared to clients served and the general population (3% workforce, 2% clients served, 1% general population). For Asian/Pacific Islander the percentage of the workforce smaller when compared to clients served and general population, though both clients served and general population percentages are the equal (2% workforce, 3% clients served, 3% general population). For Multiracial/other/unknown the percentage of the workforce is less than the clients served and the general population (7% workforce, 17% clients served, 8% general population). For Hispanic/Latino the percentage in the workforce and clients served varies by three percent, though both are less than the general population (10% workforce, 13% clients served, 14% general population).

DHHS Workforce Development Survey. In August and September 2021 DHHS Quality Management Services (QMS) conducted an online DHHS Workforce Development Survey. The purpose of the survey was to assess the state and make-up of the current workforce; assess the state of the workplace culture at DHHS as perceived by staff; gather opinions about the development and promotional opportunities at DHHS; gauge staff familiarity with agency projects and initiatives; and collect branch or division specific information. This branch/division specific information included questions specifically for BH staff. The response rate of BH staff to the survey was 51%. Results for BH show the following:

- 74% White

- 8% American Indian/Alaska Native
- 5% Hispanic/Latino
- 2% African American
- 5% Multiracial

The Workforce Development Survey also indicated that 3% of the workforce is LBGTQIA. There is no Medi-Cal data with which to compare this but as of October 2022, data from the Medical Records system shows there are 30 female-to-male transgender clients, 12 male-to-female transgender clients, and 6 are another gender identity.

III. Strategies for reducing those disparities

In this section, progress on addressing the strategies from the 2021 Plan will be discussed, and any new/revised strategies for the upcoming year will be detailed.

Strategies addressing race/ethnicity disparities.

1. Policies and Procedures addressing racial and cultural equity. As discussed in last year's Cultural Competence Plan, three new policies were developed in 2021 that address BH's commitment to racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic(institutional) and structural racism and structural inequality, and to set the foundations for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Written Materials Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) now reviews all new policies, and existing policies that are due for review, using the Tool to identify language that could be changed or added to advance racial and cultural equity. In 2022, approximately 250 policies/forms were reviewed by the ESM. The purpose of the third policy is "To ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was used during the budget cycle in 2022.

2. Staff training and development opportunities that are inclusive and bring a culturally diverse perspective to staff, including when appropriate attendance by community members and groups.

a) During 2021 the DHHS Racial Equity Steering Committee developed a Racial Equity Strategic Plan that includes a high-level goal for training and coaching. This goal includes a

training plan that was implemented in 2022. One of the trainings developed by the Steering Committee is a training on equity terms. This training is mandatory for all DHHS staff and is online on the NEOGOV platform. The training includes 24 terms with definitions. Several of the terms include video links that focus on the term. The BH Ethnic Services Manager is an active member of the Steering Committee

b) A new Cultural Awareness training was developed as the BH mandatory annual cultural competence training and was assigned to all BH staff through the NEOGOV online platform. Criterion 5 sets forth the participation results of this training as well as other cultural competence training for FY 2021/22.

c) BH Managers Training and Leadership Development meetings. At one meeting per month, BH Managers participate in a focused learning opportunity on a racial/cultural equity topic. During the past year these topics have included a presentation on the DHHS Racial Equity Plan and its rollout; targeted universalism; an activity having to do with why Black, Indigenous, and People of Color (BIPOC) don't always bring their authentic selves to work; Native American heritage month discussions, expectations for DHHS leaderships with ongoing equity work; an activity on implicit bias; conversations on privilege; a learning activity on coded language and microaggressions, and how to engage in anti-racism work.

3. Behavioral Health Cultural Responsiveness Committee (BHCRC) projects. During the past year, no projects were completed and two are on hold.

a. On hold: *Mental Health Services for the Spanish-speaking community.* A focus on this topic was first started in 2018 as the Latino Outreach Project. Its intent was to develop a Spanish language public service announcement (PSA). Because there was no funding to further the project it was not implemented. In 2021 the focus was reignited with the intent of creating another recommendation for addressing the mental health services needs of the Spanish-speaking community. Three BHCRC meetings were focused on the topic with participation from BH staff and community members. Instead of moving forward with a PSA, a different recommendation was sent to BH Administration for approval in January 2022. This recommendation is set forth below. It is still under consideration by Administration for the 2023-2024 fiscal year.

1. Recruit and hire a Spanish-speaking, culturally proficient individual to provide outreach and act as liaison to the Hispanic/Latino/Spanish-speaking Humboldt County community. Activities will include:

--Participate in Mobile Outreach visits and events that take place in communities where there is a large population of Spanish-speaking individuals, such as Fortuna
--Attend Community health fairs
--Attend local events where the distribution and sharing of information about BH is appropriate and Hispanic/Latino/Spanish-speaking individuals are expected to attend
--Provide cultural coaching to BH staff

b. On hold: *Welcoming Environments Year 2.* Due to the COVID-19 pandemic restrictions this project was placed on hold until business returned to usual and BH sites were more routinely seeing clients. This project will be reviewed by the CRC and adjusted accordingly to fit with current COVID-19 regulations, ensure cultural competent care, optimize surveys to fit current regulations, and include client feedback in a more effective manner.

4. MHSA Local Implementation Agreements. Local Implementation Agreements provide funds for community organizations to implement locally developed projects for prevention and early intervention. These projects must focus on early intervention, outreach for increasing recognition of early signs of mental illness, prevention, access and linkage to treatment, stigma and discrimination, and suicide prevention. In 2021 two Local Implementation Agreements were approved for funding that address race/ethnicity. These projects concluded in 2022.

Bear River Band of the Rohnerville Rancheria, Seeking Safety for Community Wellness.
Bear River Social Services provided evidence-based Seeking Safety groups and individual sessions to four members of the Bear River Band of the Rohnerville Rancheria Tribe living in the service area of Humboldt County. All four participants were tribal members between the ages of 26-59. Outcomes were measured with the use of standardized tools, and a reduction in depression and anxiety in all participants was noted.

Two Feathers Native American Family Services, Cultural Coordinator.
A part-time Cultural Coordinator assisted in the development and implementation of cultural programming. Over the period of the grant 37 cultural events were facilitated with over 2000 attendances at the events. These events were important to the community, which experienced a long period of not being able to gather in person due to COVID-19.

In July 2022 two Local Implementation Agreements were approved that focus on race/ethnicity and education. One grant is to the Bear River Band of the Rohnerville Rancheria to conduct the Bear River Neurofeedback program, which will provide this new psychotherapy service to clients during individual counseling sessions. The second grant is for the McKinleyville Family Resource Center to provide teens, youths, and adults Mental Health First Aid training. These trainings will be provided in both English and Spanish. Both projects will conclude in 2023.

In addition to the strategies discussed above, existing strategies will continue to be implemented through the Department as a whole and through Behavioral Health specifically. These existing strategies are described in Section V below, What's Been Working Well.

Strategies addressing age disparities. DHHS Behavioral Health continued its work with First 5 Humboldt and the 0-8 Mental Health Collaborative to provide funding opportunities for agencies that serve children ages 0-5 and their families. Past and current collaboration includes partnering with these groups to fund ACES Collaboration grants that address Adverse Childhood Experiences, and grants through Measure S funding, which was County funding to address

health and safety needs in the community. Last year's Local Implementation agreement with Two Feathers Native American Family Services, referenced above, also included cultural groups for parents and children ages 0-5.

Two of the Local Implementation Agreements approved to start in July 2022 focused on very young children and their families.

Changing Tides Family Services, Attachment Vitamins—Addressing Attachment, Stress and Trauma in Early Childhood. Changing Tides will provide a ten-week intervention group, Attachment Vitamins, which is designed to help caregivers of children ages birth to five learn about child development and the impact of stress and trauma, reflect on the child's experiences and the possible meanings of the child's behaviors, and promote secure attachment and safe socialization practices.

First 5 Humboldt, Early Childhood Mental Health Prevention and Early Intervention through Evidence-Based Parenting Education. First 5 Family Support Navigators will be trained in the Triple P-Positive Parent Program© System and Parents as Teachers© model and will offer these parent education opportunities within the community on an ongoing basis.

For older adults, MHSA Community Services and Supports will continue to support the Older and Dependent Adults Expansion Program. This interdisciplinary team includes Social Services social workers, Public Health nurses, a psychiatrist, Behavioral Health clinicians and case managers. The team conducts multi-disciplinary team meetings, provides case management planning, investigates suspected abuse and neglect, and provides linkage to the full range of services. Behavioral Health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports. The Older and Dependent Adults Program also includes an outreach, prevention and education component. In fiscal year 2021-2022, 135 individuals were contacted by the Mental Health Clinician through this outreach component.

Strategies addressing language disparities. At one time Spanish was the only non-English language that met the threshold requirements set by DHCS. State data now indicates that Spanish is no longer a threshold language, and Humboldt County has no threshold languages. Because DHHS BH recognizes the need for linguistically competent care for all clients, however, the BHCRC has identified strategies to address disparities for non- proficient English speakers. Some of these strategies have been completed in the past few years, and efforts continue to be underway for others.

Accomplishments over the years include revising the Interpreter Policy and Procedure and training staff on that procedure; monitoring the use of interpreters by language and program; translating program specific information brochures into Spanish; translating MHSA stakeholder materials into Spanish; and having a Spanish language interpreter available at MHSA stakeholder meetings. These strategies will be continued. In addition, the BH Quality Improvement unit has improved capturing data regarding the use of interpreters from paper format to electronic. Reports can now conveniently be run out of the Electronic Health Record.

Strategies addressing LGBTQIA disparities. The strategy to address this disparity was to improve data collection. Without data, disparities cannot be determined. There is no Medi-Cal data on the LGBTQIA population, and it is unknown if there will be a move at the State level to start collecting it. In October 2017, Behavioral Health added a custom field in the electronic health record (Avatar) client demographic screens and a new line on the paper Client Information Form for client gender identity. As discussed in last year's Plan, the choices for gender identity were further expanded to include Genderqueer, Unsure/Questioning and I prefer not to answer. As of October 2022, data from the Medical Records system shows there are 30 female-to-male transgender clients, 12 male-to-female transgender clients, and 6 are another gender identity.

Improved data collection about this population also happened through the DHHS Workforce Development Survey, as discussed in last year's Plan. The data from this 2021 survey showed that 3% of the workforce is LGBTQIA+. Conversations with DHHS Employee Services revealed that information on gender identity cannot be collected as it is confidential information and cannot be asked of employees or staff.

The Humboldt County Transition-Age Youth Collaboration (HCTAYC) has worked on policy recommendations for the LGBTQI+ population and developed thorough action steps backed by community data/surveys. These policy recommendations have been presented to Behavioral Health Administration and are listed below:

1. Develop a county oversight structure to ensure well-being and accountability to LGBTQI+ & Two-Spirit Transition Age Youth.
2. Youth-serving organizations collaborate to create a new Humboldt County LGBTQI+ & Two-Spirit TAY Resource Center with youth-friendly hours, staff, and a central location for youth on public transportation routes.
3. Ensure all Humboldt County youth-serving agencies promote environments in which LGBTQI+ & Two-Spirit youth are safe, treated respectfully, and have full access to services.
4. Ensure all Humboldt County youth-servicing agencies follow the laws, requirements, and responsibilities of TAY-serving agencies with respect to LGBTQI+ & Two-Spirit Youth.
5. Develop safe families and living environments for LGBTQI+ & Two-Spirit Youth.
6. Design specialized community health, mental health, sexual health and substance use services to address unique challenges of LGBTQI+ & Two-Spirit Youth.
7. Launch an outreach and access campaign to increase awareness about the programs and services available in Humboldt County and ensure youth access to those supports.
8. Increase utilization of peer professionals who reflect the diversity of LGBTQI+ & Two-Spirit Transition Age Youth.

Strategies addressing workforce disparities. Programs are actively involved in recruitment efforts by providing more recruitment specifications, including specific requests such as "bilingual preferred," tailoring job descriptions, and by actively pursuing/accepting feedback from the community when it comes to where job openings are advertised as a means of promoting a more diverse and culturally competent work force. While a direct correlation

between these recruitment practices and an increase in staff from diverse cultures cannot be drawn, the Employee Services database shows an increase in staff identifying as Hispanic from 16 in 2018, 24 in 2019, 27 in 2020, and 23 in 2021. In 2022 this number increased to 28. This increase may be attributed to the county's recovery from the COVID-19 pandemic, which has a direct influence in BH's ability to hire new staff. Aside from this, roll out of the Racial Equity Strategic Plan along with trainings that focus on equity may have improved hiring methods.

DHHS continues to recruit and hire peer coaches for positions in the Transition Age Youth Division; Regional Services; Hope Center, and Comprehensive Community Treatment. As of September 2022, two of the 13 peer support staff identify as African American and one as Hispanic Latino.

Behavioral Health has a close working relationship with the Housing, Outreach and Mobile Engagement (HOME) program, which is a program under the Social Services branch of DHHS. HOME has Behavioral Health positions integrated within the program. These positions are under the clinical oversight and direction of BH and offer supports to ensure success in housing and other HOME services. DHHS also continues to recruit and hire peer coaches for HOME with an emphasis on the importance of a recovery model that individuals with lived experience bring much value to.

DHHS has registered HRSA sites for student loan repayment programs and recruits through that site for diverse staff. In 2022 the number of sites remained the same at 10 when compared to 2021.

DHHS also collaborates with Cal Poly Humboldt to implement a distance education program for Bachelors of Social Work and Masters of Social Work. This provides current county residents and human service workers a career path. The Masters of Social Work Program offers a specialty in Native American/Tribal Communities.

Finally, as discussed further in Criterion 6, BH is participating in the Superior Region Workforce Education and Training (WET) program, which aims to increase the recruitment and retention of behavioral health staff through peer scholarships, graduate student stipends, and loan repayment programs.

IV. Measurement and monitoring of activities/strategies for reducing disparities.

Data to measure and monitor activities and strategies is obtained from the following sources:

- United States Census
- Avatar electronic health record for client data

- Behavioral Health Concepts/California External Quality Review Organization, for Medi-Cal approved claims data
- Department of Health Care Services (DHCS) threshold language data
- CalSAWS
- DHCS Behavioral Health Information Systems (BHIS) Data Collection and Reporting (DCR) for MHSA CSS Full Service Partnership data
- BH Quality Improvement Dashboard Client Concerns/Grievances (by ethnicity) and Change of Provider Requests (by ethnicity and gender)
- MHSA PEI spreadsheets for PEI participant demographics
- California Department of Education
- California Department of Health Care Access and Information (HCAI) (formerly Office of Statewide Health Planning and Development)
- DHHS Employee Services database
- DHHS Workforce Development Survey
- DHHS Quality Management Services (QMS) Evidence Based Practices Dashboards
- DHHS Integrated Progress & Trends Report

V. What has been working well and lessons learned

Strategies in the Department as a whole that benefit Behavioral Health, and have been working well, include the following:

- Interpretation and translation services with contracted interpreters/translators, a DHHS Interpreter/Translator job classification, and bilingual staff have all worked well. The Translator/Interpreter Job Classification has proven to be a very successful strategy and has allowed programs and staff to communicate with clients both in writing and orally in a more effective and efficient manner than the on-call contracted interpreters/ translators.
- Cultural service matching is honored when appropriate and available. The client and/or family's choice of provider is used.
- Partnering with culturally specific organizations at an agency level to identify service gaps and culturally appropriate service delivery options has been successful. This partnering has also led to the ability to provide culturally appropriate referrals for cultural and spiritual resources.
- DHHS Quality Management Services (QMS) includes a spectrum of evaluation services from data management, data verification, statistical analysis, and interpretation, to written progress reports. These written reports include the Evidence Based Practices Dashboards and the Integrated Services and Trends Report. QMS services increase the Department's capacity for outcomes based program planning and improvement and offer a measure of how a program or service, over time, affects the community. QMS also continues to build system capacity to develop, coordinate, and integrate resources to provide workforce development opportunities to staff, clients, parents, families, community partners, and providers.
- The Humboldt Practice Model (HPM) arose out of a five year California Partners for Permanency grant to reduce long-term foster care. In Humboldt County, Native American children are disproportionally represented in the foster care system, so grant activities were

focused on working closely with the Native American community to develop HPM. In 2017, training on the HPM was rolled out to staff in DHHS Behavioral Health, and an adaptation of HPM for BH and other DHHS branches is near finalization.

As a result of HPM, DHHS Child Welfare Services contracts with Native American Cultural Coaches to provide coaching and support to social workers who have cases in the Native American community. Because some of these cases also have DHHS Behavioral Health involvement in the family teams, the Cultural Coaches have also been available for coaching and support to Behavioral Health clinicians and case managers who are part of the family team. The Cultural Coaches have provided valuable insight and strategies for working with Native American families in a culturally respectful manner.

Strategies in DHHS Behavioral Health that have been successful include the following:

- Flexible service provision. Rural communities in the county face difficulty in accessing transportation to the Eureka area, where most county services are located. The mobile outreach component of the HOME Program addresses this barrier through using mobile engagement vehicles to provide culturally appropriate services, with efforts focused on reducing cultural and ethnic barriers to access that tend to exist in more traditional mental health settings. This outreach provides an integrated response with Social Services, Behavioral Health, and Public Health as an outreach program for individuals with a variety of physical, behavioral, and social needs as well as prevention and education activities, thereby reducing the stigma associated with accessing behavioral health services. The program links with and provides support to existing community organizations such as Family and Community Resource Centers, community clinics, and Tribal Organizations in order to reach those previously unserved and underserved populations in those areas of the county. During the COVID-19 pandemic, telehealth services were expanded and are available to any client who has phone service or an internet connection capable of supporting telehealth appointments via Zoom, Webex, or FaceTime.

  The Regional Services Program and the McKinleyville Family Resource Center provide clinicians, case managers, and substance abuse counselors in the Eastern, Northern, and Southern regions of the County. Some staff reside in those areas, and some travel from Eureka on a weekly basis to provide services wherever the clients may be.

  The Mobile Intervention Services Team (MIST) also provides outreach and services to people with severe mental illness who experience homelessness. Services were provided in Eureka and Arcata from 2016 through June 2020. Because MHSA funding for MIST ended in June 2020, MIST no longer works in Eureka. However, the City of Arcata received grant funding for the program and staff are now working with the Arcata Police Department to continue these services. MIST also received Behavioral Health Justice Intervention Services (BHJIS) grant funding, which will aid the program with embedding Behavioral Health staff into Humboldt County Sheriff's Office patrol operations to co-respond to mental health

calls. Through the BHJIS grant, MIST will be able to provide a wide range of appropriate services, both for immediate crises and follow up in the least restrictive manner possible.

- Providing psychiatric telemedicine services to Southern and Eastern Humboldt County residents. Telemedicine in these outlying areas provides greater access to behavioral health services as well as reduced cost and inconvenience to clients.
- Collaboration and Coordination. Children and Adults Behavioral Health staff have been meeting with K'ima:W Medical Center staff on the Hupa Tribe Reservation over the past three years to discuss ways in which there can be better collaboration and coordination of services for those residing on the reservation. During the past years these meetings have been held virtually due to the COVID-19 pandemic.
- The Comprehensive Community Treatment (CCT)/Full Service Partnership program makes available intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, or other needed community services) to achieve recovery. Personal Services Coordinators (PSCs), including peer clients and peer family members whenever possible, provide services in the community, which alleviates the potential challenge for clients to travel to the main clinic locations.
- Children's Behavioral Health clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management, peer/parent support services, and crisis services. They work closely with families, regional Family Resource Centers, Tribes, and schools to determine needs and determine how best to provide services. Services can be provided in the field, including in the Wellness Center at Hoopa High School on the Hupa Reservation. Telehealth services through Zoom are available if needed/requested by clients or families. One crisis clinician is dispatched to Emergency Rooms and Same Day Services in Eureka to evaluate minors who are in crisis. In addition, there is a case manager assigned to the Children's Mobile Response Team.
- There are Mobile Response Teams for Adult and Children's Services that provide crisis intervention in the field to address an immediate crisis in the least restrictive manner possible. The Teams can provide face-to-face counseling and supportive interventions, assessment of mental health (including 5150/5585 evaluations), facilitation of transportation to the Crisis Stabilization Unit, coordination of appropriate community-based services, and provide family support services.
- Cultural training has provided staff an improved knowledge of the diverse cultures in our community as well as an increased understanding of how their own cultural beliefs and values influence their interactions with co-workers and clients.
- Transition Age Youth. Through stakeholder input and educational activities, BH has implemented both administrative and service delivery initiatives that have resulted in culturally appropriate services for racially and ethnically diverse Transition Age Youth. These include:
    - Creation of the TAY Division itself, serving the TAY "culture"
    - Trainings focused on cultural competence/cultural humility with curriculum developed by youth and focused on youth culture
    - SUD policy recommendations with focus on youth
    - Addressing stigma and discrimination through trainings, youth leadership development and a pre/post Stigma Discrimination Reduction survey

- Policy recommendations for serving LGBTQI+ youth
- Founding of the Humboldt Houseless Youth Support Collaboration to better serve and document youth impacted by homelessness

Criterion 4: Integration of the Client/Family Member/Community Committee

The purpose of the Behavioral Health Cultural Responsiveness Committee (BHCRC) is to strengthen Behavioral Health's ability to provide client, family and community-driven, culturally and linguistically responsive services to Humboldt County's diverse population. The efforts of BHCRC will be guided by the values of wellness, recovery, inclusion, respect, social justice, equality and equity as they collaborate with all divisions and programs of Behavioral Health to promote client/family/community-driven and culturally responsive engagement, attitudes and practices. The BHCRC is a subcommittee of the Behavioral Health Continuous Quality Improvement Committee.

The BHCRC was the Mental Health Cultural Competence Committee through May 2020. The name was changed to reflect DHHS Mental Health's name change to DHHS Behavioral Health, and to better reflect Committee members' thinking about the word "competence." Concurrent with the name change the BHCRC developed a Vision and Mission, which it had not had before.

Vision: To strengthen our commitment to building relationships that are authentic and culturally responsive to the needs of both community and staff.

Mission: To support and advise DHHS Behavioral Health to strengthen its ability to provide client, family, and community-driven, culturally and linguistically responsive services to Humboldt County's diverse populations, guided by the values of wellness, recovery, inclusion, respect, social justice, equality and equity.

In 2020 the Committee developed and implemented a webpage on the Humboldt County website at https://humboldtgov.org/2837/Cultural-Responsiveness-Committee The webpage includes the Purpose, Vision, Mission and Goals of the BHCRC, meeting times, facilitator names and a contact email. In 2021 another webpage, Cultural Responsive Resources, was developed to include links to resources that community members could find helpful. Categories include Community Partners, LGBTQ+, LatinX, Native American & Tribal Communities, Black & African American, and Asian & Pacific Islander. These resources are found at https://humboldtgov.org/2881/Cultural-Responsive-Resources

The goals of the BHCRC includes those established in the Humboldt County Cultural Competency Plan submitted to the California Department of Health Care Services. The Committee's objectives will be based on the Plan. Projects will be guided by the following framework:

- Develop and maintain a broadly representative committee that is reflective of this

community

- Continue to identify disparities and service needs through analyzing data
- Develop, articulate and implement current culturally specific service delivery strategies
- Identify training opportunities for all staff to increase cultural awareness and foster inclusivity
- Identify advocacy training opportunities for unserved and underserved cultural groups
- Strengthen the hiring and retaining of culturally and linguistically competent staff
- Improve language capacity
- Continue to improve the ability to identify and provide (or refer) clients to culturally relevant programs
- Assess the degree to which Behavioral Health environments are welcoming to diverse cultures and implement strategies to increase the sense of welcoming

The BHCRC is composed of active members from Behavioral Health programs, including Administration, MHSA, Substance Use Disorder Treatment, Children's Behavioral Health and the Transition Age Youth Division. In addition to the active members there are approximately twenty other staff members who are on the distribution list to receive information about BHCRC activities. The BHCRC meets monthly, no less than ten times each year. During the COVID-19 pandemic the BHCRC met monthly and virtually via the WebEx or Zoom platforms. The BHCRC is co-facilitated by a Program Manager in the Performance Management/Quality Improvement Unit and the MHSA Coordinator/Ethnic Services Manager. At times the BHCRC has had community member involvement, and it is always a committee objective to recruit the active participation of community members. Three meetings in 2022 focused on learning activities regarding mental health stigmas, information on the McKinleyville Family Resource Center, and neo pronoun workshop included community participants.

DHHS Behavioral Health's approach to consumers and family member involvement is multifold. For example, the BHCRC is a subcommittee of DHHS Behavioral Health's Continuous Quality Improvement Committee (CQI), and consumer involvement in quality improvement activities is a priority and made a part of the Quality Improvement Work Plan. Consumer employees such as Peer Coaches and Parent Partners are represented in both BHCRC and CQI. Until the COVID-19 pandemic the Quality Improvement unit regularly conducted focus groups to get direct input from consumers and family members. QI leadership attended NAMI meetings quarterly and periodically reported out at Behavioral Health Board meetings. During these occasions, participants were invited to become involved in QI committee work. Staff plan to resume these activities as in person meetings return.

The projects and activities conducted by the BHCRC in 2022 are discussed in Criterion 3.

Criterion 5: Culturally Competent Training Activities

I. Annual Cultural Competence Training Requirement

A. Three Year Training Plan:

1. Steps taken to provide training to 100% of staff over a three-year period

The objective is that all Behavioral Health related staff (administration, management, direct service and support staff), and organizational providers participate in at least one cultural competency training annually.

Almost 400 behavioral health staff need cultural competency training. Staff will primarily obtain these trainings through the Relias and NEOGOV E-Learning management systems, which serve as online portals for staff to access a variety of trainings; including a new training called Exploring Racial Equity: Common Terms. Prior to the COVID-19 pandemic, staff sometimes traveled out of the area if there were opportunities and funding available. Also, prior to COVID-19, on occasion cultural competence trainings were provided by the Humboldt County Department of Health and Human Services, Humboldt County Office of Education, Cal Poly Humboldt, the Equity Alliance of the North Coast, LatinoNet and other community partners. As these trainings become available, staff may be able to attend if budget and workload allows.

The Relias E-Learning management system was rolled out to all of DHHS Behavioral Health in February 2018. Relias has a course catalog of over 500 courses. The course catalog currently includes multiple competence topics including but not limited to Cultural Diversity; 10 Steps to Fully Integrating Peers into your Workforce; A Culture-Centered Approach to Recovery; Advocacy and Multicultural Care; Infusion of Culturally Responsive Practices; On-Boarding and Cultural Development; Cultural Competence & Sensitivity in the LGBTQ Community; Cultural Dimensions of Relapse Prevention; Groundwork for Multicultural Care; Cultural Competence Training: Advancing Recovery Practices; Cultural Competence; Cultural Issues in Treatment for Paraprofessionals; Mindfulness, Meditation & Spirituality as Tools for Recovery.

In addition to the courses available in the Relias course catalog, six online trainings developed by DHHS Behavioral Health are also available on the county intranet page, and/or in Relias. These are Peer Coaches & Parent Partners Cultural Competency Training; Documenting Chosen Gender Identity and Gender Expression; Introduction to Recovery Oriented Practices; Cultural Competence Training: Working with Interpreters; Mental Health Language Line; and The

Recovery Model. A policy on Room Assignments for Transgender Patients has been placed in Relias and staff have been assigned to review the policy and certify that they have read it.

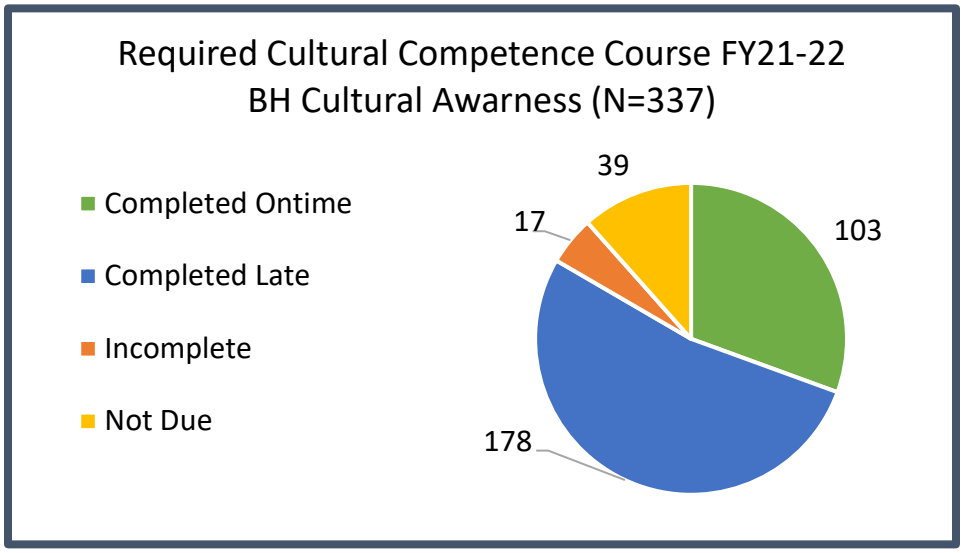
Regardless of the strategy utilized or what agency is providing the trainings, training opportunities are well advertised through email and flyers or bulletins to staff, stakeholders, and community members, as well as directly assigned to staff members in Relias and NEOGOV.

2. How cultural competence has been embedded in all trainings

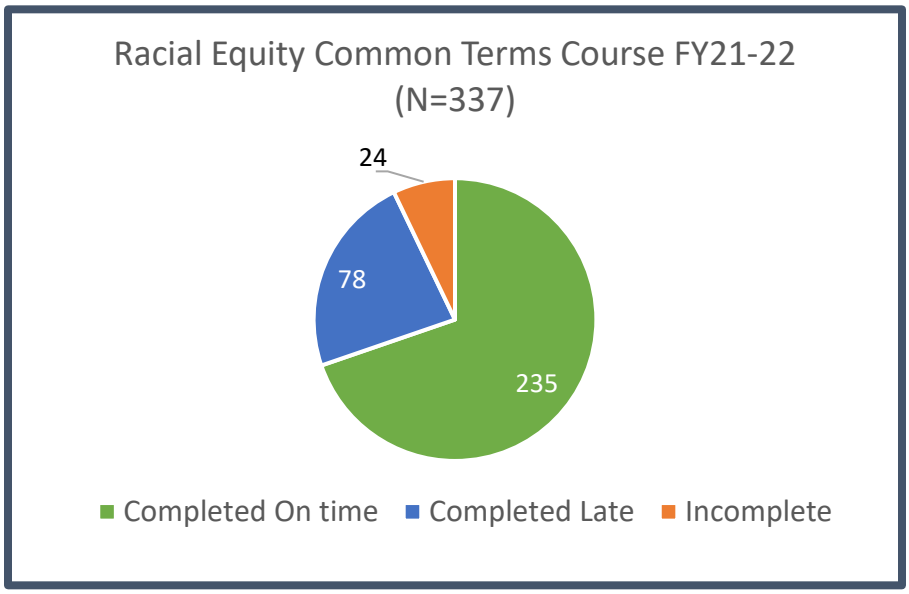
As appropriate, Humboldt County DHHS and DHHS Behavioral Health include cultural competence components in trainings where applicable. Examples include the Milestones of Recovery Scale outcome measure training, Introduction to DHHS for new hires and Behavioral Health compliance training, which includes an overview of the work of the Cultural Responsiveness Committee.

3. A report list of annual training for staff with attendance by job function.

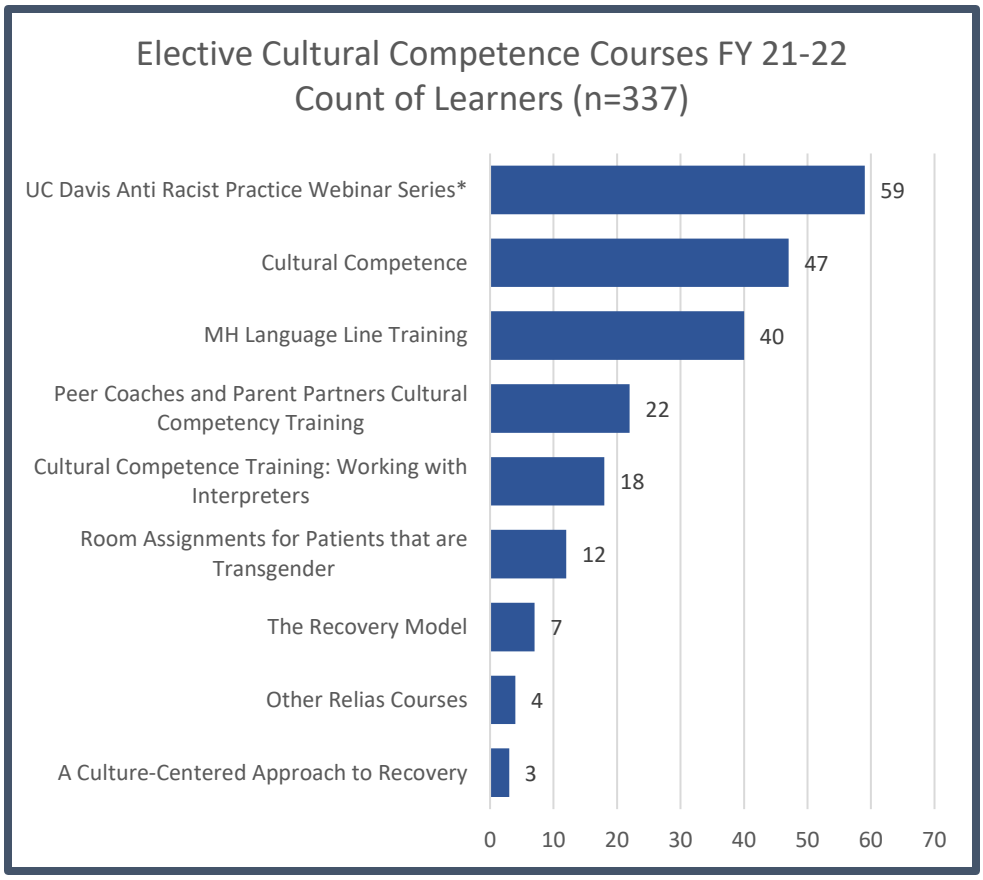
In FY 2021-2022, all Behavioral Health staff were required to complete the Behavioral Health – Cultural Awareness Training on NEOGOV. The Behavioral Health – Cultural Awareness training serves as an introduction to cultural awareness as well as the Cultural Responsiveness Committee and its function. This new course was developed through the efforts of the Cultural Responsiveness Committee and launched May 4, 2021. The NEOGOV e-learning platform was used to allow for greater staff participation and ease of use as this would allow staff without access to Relias to easily access the training online during the COVID-19 public health emergency. There was a total of 337 staff enrolled in the training. 103 completed the course on time, 178 completed the course late, 17 are incomplete and 39 are in progress or not due.



In FY 2021-2022, all Behavioral Health staff were required to complete the DHHS Racial Equity Steering Committee new training titled Exploring Racial Equity: Common Terms training on NEOGOV. The Exploring Racial Equity: Common Terms training serves as an introduction and primer for racial equity terms and broader efforts that are being developed and implemented by DHHS leadership through the Racial Equity Strategic Plan. This new course was developed through the efforts of the Racial Equity Steering Committee and was launched December 2021. The NEOGOV e-learning platform was used to allow for greater staff participation as the course was developed for all county staff and to easily access the training online during the COVID-19 public health emergency. There was a total of 337 BH staff enrolled in the training and 313 successfully completed the course; of which 235 completed the course on time and 78 were late to completion, this indicates a 93% completion. The Exploring Racial Equity: Common Terms training is utilized as part of the onboarding process for new staff and must be completed within 30 days of hire.



Behavioral Health staff also completed elective courses in Relias and NEOGOV. In FY 2021-2022, staff completed 189.5 hours of cultural competence trainings. When compared to 337 current enrolled users, this indicates 63% of BH staff completed additional cultural competence trainings. The increased access to NEOGOV and Relias allowed staff to increase elective completions from 117 in FY19-20 to 202 in FY20-21. With the addition of the UC Davis Anti-Racist Practice Webinar Series and the new Cultural Awareness Training, cultural competence training hours increased overall. Under one of the goals outlined in the strategic plan, there is work being conducted to develop a permanent cultural and racial equity team to facilitate equity efforts across DHHS, which involved hiring a new Racial & Cultural Equity Manager that oversees the Racial Equity Steering Committee and helps facilitate the roll out of the DHHS-wide Racial Equity Strategic Plan. The committee is identifying and/or developing a variety of training courses that will be incorporated into the annual required cultural competence training courses, a goal that is outlined in the strategic plan.



Cultural Competence Course	Hours Completed	Job Functions Trained
Using Interpreters	0.5	PSYCHIATRIC NURSE
Behavioral Health Services and the LGBTQ+ Community - Retired 12/4/2021	1	MH CLINICIAN
Best Practices for Working with LGBTQ Children and Youth - Retired 10/2/2021	1.25	MH CLINICIAN
Cultural Dimensions of Relapse Prevention - Retired 3/5/2022	1.25	SUD COUNSELOR
A Culture-Centered Approach to Recovery	3	MH CASE MANAGER, PSYCHIATRIC NURSE
Room Assignments for Patients that are Transgender	3	MH WORKER, PSYCHIATRIC NURSE, PSYCHIATRIC TECH
The Recovery Model	7	MH CASE MANAGER, MH CLINICIAN, BH DIRECTOR, PEER COACH, PSYCHIATRIC NURSE

Cultural Competence Course	Hours Completed	Job Functions Trained
Cultural Competence Training: Working with Interpreters	9	MH CLINICIAN, PSYCHIATRIC NURSE, SUD COUNSELOR
Peer Coaches and Parent Partners Cultural Competency Training	11	ADMIN ANALYST, ADMIN SECRETARY, MH CASE MANAGER, MH CLINICIAN, MH WORKER, MEDICAL OFFICE ASSISTANT, PEER COACH, SUD COUNSELOR,
Cultural Competence	23.5	ADMIN ANALYST, ADMIN SECRETARY, MH CASE MANAGER, MH CLINICIAN, MH WORKER, MEDICAL OFFICE ASSISTANT, PEER COACH, SUD COUNSELOR, PHYSCIAN/PSYCHIATRIST, PSYCHIATRIC NURSE, PSYCHIATRIC TECH, DIETICIAN,
MH Language Line Training	40	ADMIN ANALYST, ADMIN SECRETARY, DEPUTY BRACH DIRECTOR, MH CASE MANAGER, MH CLINICIAN, MH WORKER, MEDICAL OFFICE ASSISTANT, PEER COACH, SUD COUNSELOR, PHYSCIAN/PSYCHIATRIST, PSYCHIATRIC NURSE, PSYCHIATRIC TECH, DIETICIAN,
Behavioral Health - Cultural Awareness*	51.5	MH CASE MANAGER, OFFICE ASSISTANT, MEDICAL OFFICE ASSISTANT, NUTRITION AIDE, MH CLINICIAN, MEDICAL RECORDS MANAGER, YOUTH SUPPORT

Cultural Competence Course	Hours Completed	Job Functions Trained
		SPECIALIST, PROGRAM MANAGER, PSYCHIATRIC NURSE, SENIOR SUBSTANCE ABUSE COUNSELOR, PEER COACH, NURSE CASE MANAGER, BH ADMINISTRATION, ADMIN ANALYST, ADMIN SECRETARY, OTHER ADMINISTRATIVE and SUPPORT STAFF
UC Davis Anti Racist Practice Webinar Series*	88.5	MH CASE MANAGER, OFFICE ASSISTANT, MEDICAL OFFICE ASSISTANT, NUTRITION AIDE, MH CLINICIAN, MEDICAL RECORDS MANAGER, YOUTH SUPPORT SPECIALIST, PROGRAM MANAGER, PSYCHIATRIC NURSE, SENIOR SUBSTANCE ABUSE COUNSELOR, PEER COACH, NURSE CASE MANAGER
Exploring Racial Equity: Common Terms*	116	MH CASE MANAGER, OFFICE ASSISTANT, MEDICAL OFFICE ASSISTANT, NUTRITION AIDE, MH CLINICIAN, MEDICAL RECORDS MANAGER, YOUTH SUPPORT SPECIALIST, PROGRAM MANAGER, PSYCHIATRIC NURSE, SENIOR SUBSTANCE ABUSE COUNSELOR,

Cultural Competence Course	Hours Completed	Job Functions Trained
		PEER COACH, NURSE CASE MANAGER, BH ADMINISTRATION, ADMIN ANALYST, ADMIN SECRETARY, OTHER ADMINISTRATIVE and SUPPORT STAFF
	356.5	

B. Annual cultural competence training topics shall include: cultural formation, multicultural knowledge, cultural sensitivity, cultural awareness, social/cultural diversity, interpreter training in MH settings, training staff in use of MH Interpreters

Trainings over the past three years have included Exploring Racial Equity Common Terms, multicultural knowledge, cultural sensitivity, cultural awareness, social/cultural diversity, and training staff in use of interpreters. These are listed in the table above. In August of 2020 UC Davis offered a four-part webinar series on Anti-Racist Practice. The course included foundational anti-racist practice, disproportionality and systemic racism, implicit bias and microaggressions, and allyship. This course has since been added to the county's learning management system NEOGOV. Many Behavioral Health staff have taken this training, and discussed the topic during staff meetings, leadership meetings and at the Cultural Responsiveness Committee.

II. 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.

Cultural trainings provided in Relias often include the consumer perspective via imbedded video clips with interviews, or role-played scenarios. The Cultural Responsiveness Committee hosted a learning activity done by the Hope Center regarding "Mental Health Stigmas and Actions We Can Take Against Them." Through this activity, attendees received a unique peer focused understanding on language and actions that often create or increase stigma in the mental

health community. Attendees were encouraged to consistently seek ways to improve self-awareness and advocacy when encountering stigmatizing language/behaviors.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's personal experiences with family focused treatment, navigating multiple agency services, and resiliency.

Going forward, through increased collaboration with the local Family Advisory Board, Youth Advocacy Board as well as peer coaches and parent partners, staff will continue to explore options to hold cultural trainings with involvement of people with lived experience and their family members via Webex/Zoom, or in-person as appropriate under COVID-19 conditions.

Criterion 6: Commitment to Growing a Multi-cultural Workforce

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

Workforce data is provided below.

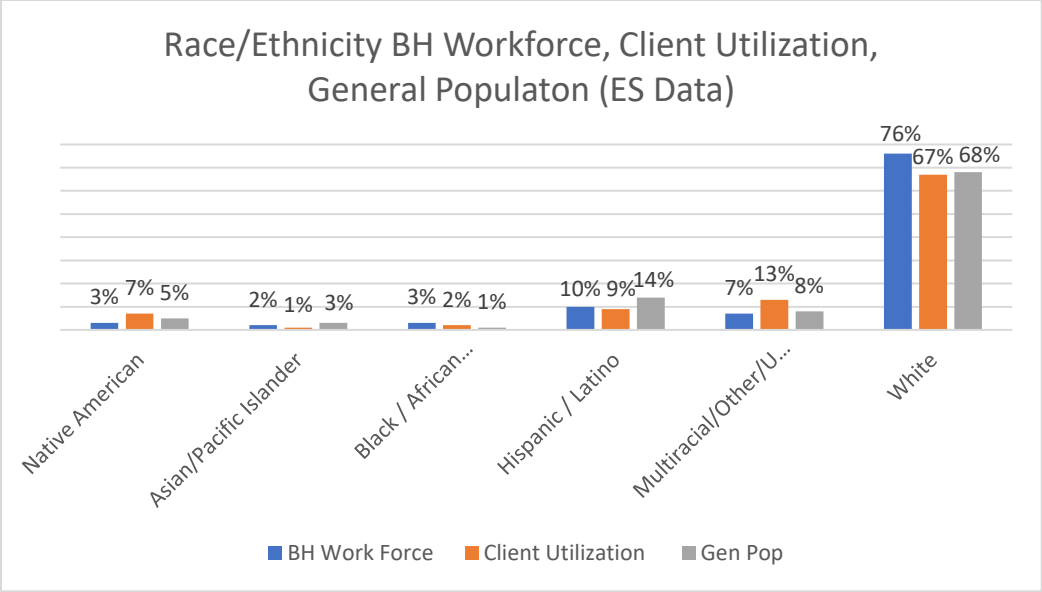
B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and client utilization.

Data for this section was obtained from two sources: the DHHS Employee Services database and the DHHS Workforce Development survey. The Employee Services database includes all Behavioral Health (BH) staff as of September 2022. The DHHS Workforce Survey was a voluntary survey and was completed by 51% of BH staff. Each of these is presented in the sections below.

1. **DHHS Employee Services (ES) data[14]**

Race/Ethnicity	ES #	ES %	Medi-Cal #	Medi-Cal %	Utilization #	Utilization %	Gen Pop #	Gen Pop %
Native American	10	3%	4,245	7%	219	7%	7,454	5%
Asian/Pacific Islander	5	2%	1,783	3%	34	1%	3,931	3%
African American/ Black	8	3%	1,020	2%	71	2%	1,729	1%
White	218	76%	32,813	57%	2,066	67%	93,316	68%
Hispanic/ Latino	28	10%	7,720	13%	284	9%	18,535	14%
Multiracial/ Other/Unknown	19	7%	9,754	17%	416	13%	11,498	8%
Total	288	100%	57,335	100%	3,090	100%	136,463	100%

[14] Humboldt County Department of Health and Human Services, Employee Services database (EMPS), September 2022.



African American/Black makes up 3% of the workforce, 2% of the clients served, and 1% of the general population. Asian/Pacific Islander makes up 2% of the workforce, 1% of clients, and 3% of the general population. Multiracial/other/unknown make up 7% of the workforce, 13% of the clients served, and 8% of the general population. Native American makes up 3% of the workforce, 7% of clients, and 5% of the general population. Hispanic/Latino makes up 10% of the workforce, 9% of the clients served, and 14% of the general population. White makes up 76% of the workforce, 67% of the clients served, and 68% of the general population.

In looking at Employee Services data alone, it is apparent that White is overrepresented in the BH workforce when compared to the client population served and the general population. There are fewer Native American in the workforce than clients served, though the difference with the general population is only 2%. The African American/Black workforce is greater compared to clients served and the general population. For Asian/Pacific Islander the percentage of the workforce is greater than the percentage of clients served by 1%, though both are less than the general population. For Multiracial/other/unknown the percentage of the workforce is less than the clients served and the general population. For Hispanic/Latino the percentage in the workforce and clients served varies by only one 1%, though both are less than the general population.

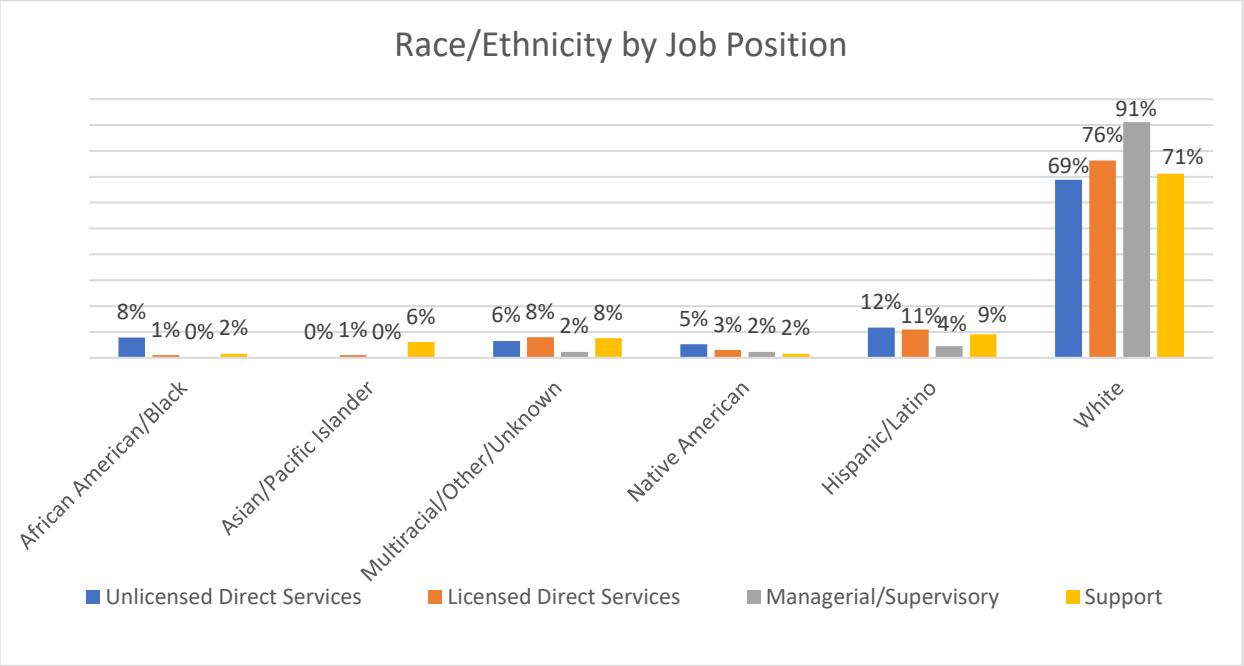
The tables below, with data gathered from the Employee Services database, show the racial/ethnic distribution of the workforce by type of job. The chart below the tables provides a visual reference for this distribution. This data shows that the White population is greatly overrepresented in the Managerial/Supervisory category, and overrepresented in the Licensed Direct Services category and the Support staff category, as compared to the general population of Humboldt County.

Unlicensed Direct Service Staff	Native American	Asian/ Pacific Islander	African American / Black	White	Hispanic/ Latino	Multiracial/ Other/ Unknown	Total
Case Mgr.	2	0	2	31	5	1	41
Peer Support	0	0	2	10	1	0	13
MH Worker	2	0	2	7	1	2	14
Other	0	0	0	5	2	2	9
Totals	**4**	**0**	**6**	**53**	**9**	**5**	**77**

Licensed Direct Service Staff	Native American	Asian/ Pacific Islander	African American/ Black	White	Hispanic/ Latino	Multiracial/ Other/ Unknown	Total
Psychiatric Nurse	1	0	1	20	1	2	25
Psychiatric Tech	0	1	0	4	1	0	6
Clinician	1	0	0	41	7	4	53
Other Licensed	0	0	0	1	1	1	3
SUD Counselor	1	0	0	11	1	1	14
Totals	**3**	**1**	**1**	**77**	**11**	**8**	**101**

Managerial and Supervisory	Native American	Asian/ Pacific Islander	African American / Black	White	Hispanic / Latino	Multiracial / Other/ Unknown	Total
Supervising Clinician	0	0	0	16	0	1	17
Mgrs., Supervisor, Dir., Deputies	1	0	0	22	1	0	24
Supervising Psych. Nurse	0	0	0	3	1	0	4
Totals	**1**	**0**	**0**	**41**	**2**	**1**	**45**

Support Staff	Native American	Asian/ Pacific Islander	African American/ Black	White	Hispanic/ Latino	Multiracial/ Other/ Unknown	Total
Analyst, IS, QI, ES, Fiscal	1	3	1	20	4	3	33
Clerical	0	0	0	20	2	2	25
Other Support Staff	0	1	0	7	0	0	8
Totals	**1**	**4**	**1**	**47**	**6**	**5**	**66**

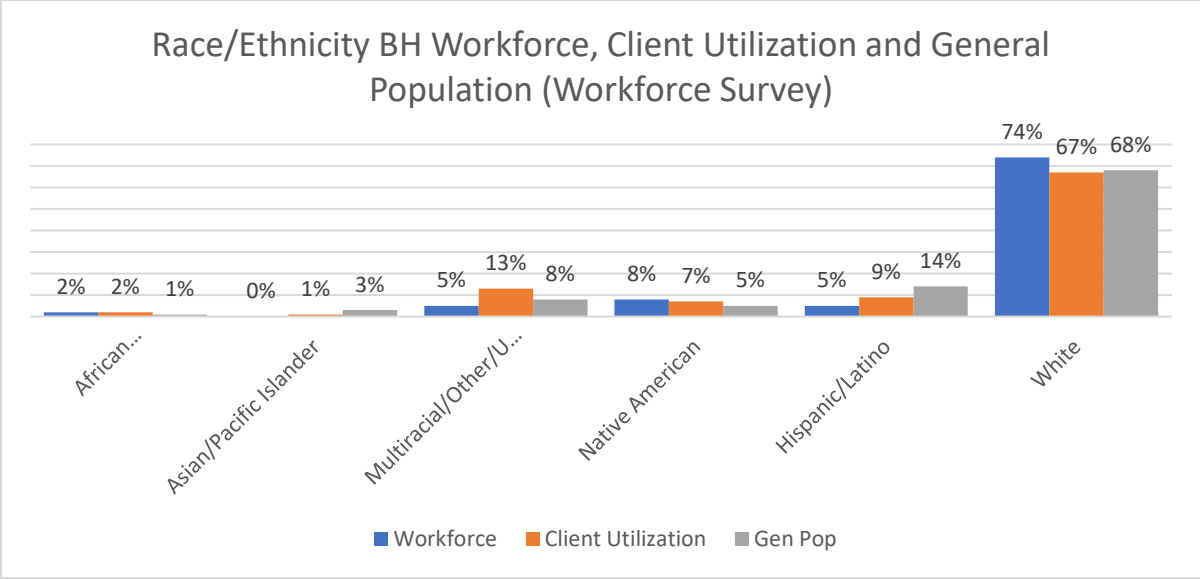


Three Behavioral Health staff receive the bilingual pay differential for speaking another language as well as English. These are one Case Managers, one Program Coordinator, and one Clinician. There may be more staff who speak a language other than English but do not receive the bilingual differential, but this information is not available in the DHHS Employee Services database. It is a positive trend that the number of staff who are Hispanic/Latino increased from 16 in 2018 to 28 in 2022.

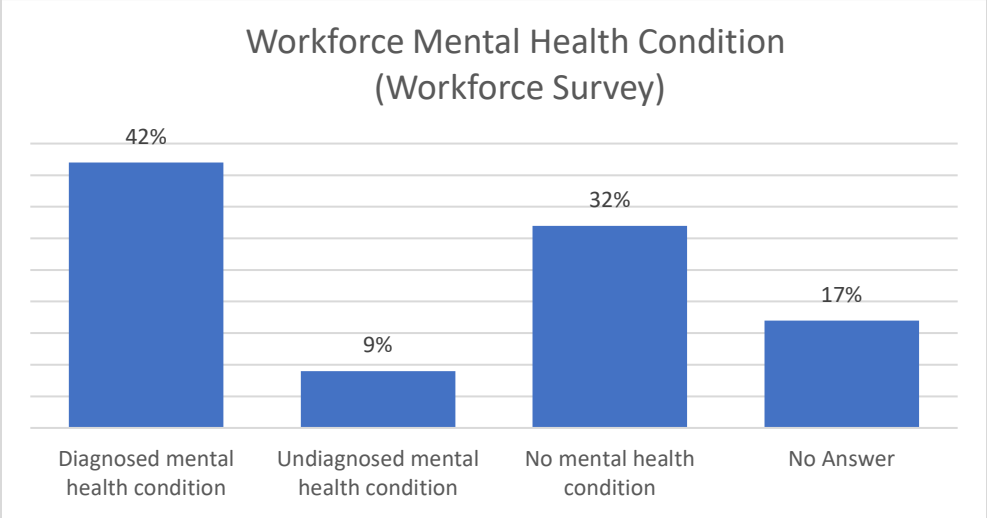
2. Workforce Demographics Using DHHS Workforce Development Survey

In August and September 2021 DHHS Quality Management Services (QMS) conducted a workforce survey of all DHHS staff. It should be noted that this survey will be conducted again in 2023 with the intent of future surveys being conducted every other year. The survey had break out sections for each Branch of the agency to complete, with specific questions for each Branch. Fifty-one percent of BH staff completed the survey. Data from that survey showed the following for BH staff:

- Seven percent are ages 20-30; 19% are ages 31-40, 29% are ages 41-50; 23% are ages 51-60; 18% are ages 60+.
- Seventy-four percent are White, 8% are American Indian/Alaska Native, 5% Hispanic/Latino, 5% are Multiracial, 2% are African American, and 3% preferred not to answer. This is depicted on the chart below.

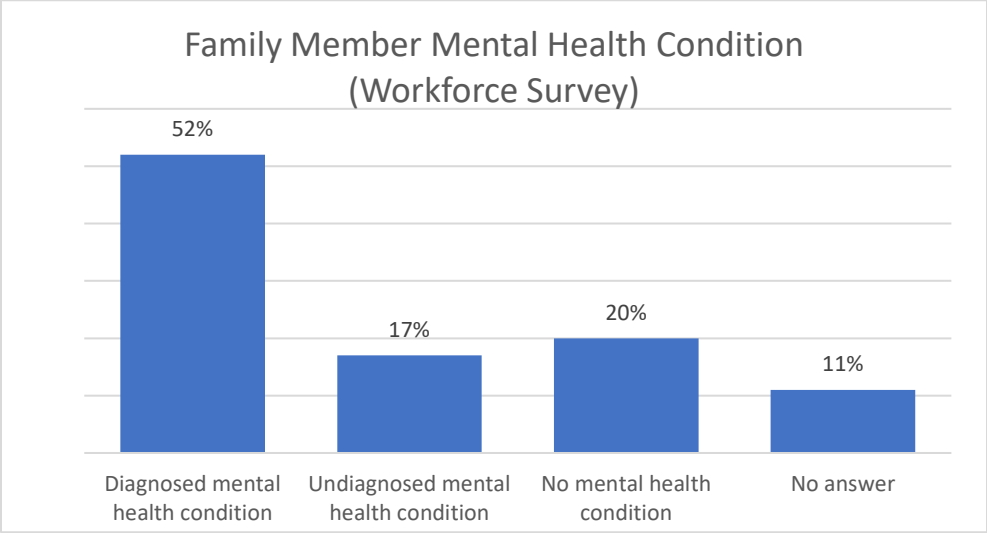


- Nine people indicated they speak Spanish as well as English; two speak French, and one uses American Sign Language. English is the only language spoken by the remainder.
- Sixty-eight percent are heterosexual, 7% Queer, 3% Gay or Lesbian, 5% Other orientation, and 17% preferred not to answer this question.
- For current gender identity, 73% are female, 21% are male, four people are non-binary, and four people preferred not to answer.
- Sixty-nine percent have no disability, 8% have a chronic health condition, 8% have a physical/mobility issue, 6% selected Other. Nine percent preferred not to answer.
- Thirty-two percent have been homeless, lived on the streets, in a shelter, or couch surfed, 60% have not experienced these conditions, and 9% preferred not to answer.
- Forty-two percent have experienced a diagnosed mental health condition, 9% have experienced an undiagnosed mental health condition, 32% have not experienced a mental health condition, and 17% preferred not to answer. This is depicted in the chart below.



- Fifty-two percent have a family member with a diagnosed mental health condition, 17%

have a family member with an undiagnosed mental health condition, 20% do not have a family member with a mental health condition, and 11% preferred not to answer. This is depicted in the chart below.



In looking at the Workforce Development survey results it is again apparent that White is somewhat overrepresented in the workforce. However, the greatest disparity between the workforce, clients served and the general population is found in the Hispanic/Latino category.

C. Summary of targets reached to grow a multicultural workforce

The goals to grow a multicultural workforce, as stated in the 2009 Workforce Needs Assessment, were 1) to increase the number of staff who are proficient Spanish speakers from six to 14 fulltime equivalent positions, 2) to increase staff who are proficient Hmong speakers from one to four fulltime equivalent positions, 3) to increase peer client and family member staff from seven and a half to 16 fulltime equivalent positions, and 4) increasing the number of staff who are individuals from the county's local communities and identify as Hispanic/Latino, Asian/Pacific Islander, and Native American. These goals have remained consistent over the years since 2009, as only the goal of increasing peer staff has been explicitly met. In fiscal year 19/20 there were 19 full-time equivalent peer personnel. Unfortunately, due to staff leaving during the COVID-19 pandemic, this number dropped to 13 in 2022. However, as can be seen in the results from the DHHS workforce survey, 42% of the workforce has a diagnosed mental health condition and 9% an undiagnosed condition, and 52% have a family member with a diagnosed mental health condition and 17% an undiagnosed condition. Thus while the number of staff with the job title of "peer" and "parent partner" is limited, the number of staff who are actually peers and family members is large.

Workforce strategies identified in the Cultural Competence Plan of 2011 have been reiterated in the Plans and Updates since that time and will be continued. These are:

- Advertising all job recruitments at culturally specific locations and through culturally

specific organizations. This has been done, with job announcements sent to LatinoNet, the Promotores distribution list, and to local tribes. DHHS Employee Services regularly asks recruiting programs for recruitment distribution lists to expand the reach of activities. Postings to Facebook and Instagram have also been added as recruitment tools.

- The distance learning programs through Cal Poly Humboldt continue to provide county residents and human service workers a career path. The Masters of Social Work Programs offer a specialty in Native American/Tribal Communities. This has been successful in bringing new social workers to the agency.
- Staff development opportunities, as discussed in Criterion 5.
- The employment and job training outreach of the Mobile Outreach program of HOME have reached outlying areas of the county that have a larger representation of Native American and Latino populations. One of the Mobile Outreach staff is bilingual in Spanish and is consistently available to provide information and linkages in Spanish.

New workforce strategies since 2020 include the following:

Increasing the number of Health Resource and Service Administration (HRSA) certified sites. In September 2020 there were seven HRSA sites. Application to certify an additional three sites was made, and these were approved. BH now has ten HRSA certified sites, which means those who are working there can receive educational loan repayment.

Workforce Education and Training (WET) Regional Partnership activities in the Superior Region. These activities were originally scheduled to begin in 2021, but a delay in receiving the contract from California Mental Health Services Authority (CalMHSA), the fiscal agent for the funds, prevented beginning them until 2022. WET support for the Loan Repayment Program was advertised in the spring, and applicants were approved in the summer. A total of seven individuals were approved to receive a Loan Repayment Award. The Peer Scholarship Program has been advertised with an application deadline of September 30, 2022, and it is anticipated that awards will be made by the end of December. It is hoped that these supports will increase the numbers in the BH workforce through providing monetary support for committing to work in the public mental health system for a specified period of time, usually two years.

One component of the WET Regional Partnership activities, the retention component, did begin in 2021 because the contract for the activities was with the California Institute of Behavioral Health Solutions (CIBHS). These retention activities focused on trainings for the Superior Region. Training topics for fiscal year 2021-2022 were: Building the Beloved Community Through Cultural Humility; Systemic Barriers to Health Equity; What Happened to YOU--Trauma-Informed ACEs Assessment, Prevention and Intervention; Self-Care, Burnout, Compassion Fatigue; Applied Motivational Interviewing; Engaging and Supporting People with Co-Occurring Conditions: Learning and Practicing Interventions that Work; Integrated Care in Rural Communities; Understanding Social Isolation and Loneliness; Using Telehealth to Address Vicarious Trauma and Promote Self-Care and Self-Compassion. A total of 5 BH staff attended these online trainings in the past year.

The DHHS Racial Equity Steering Committee has developed a Racial Equity Plan which includes strategic goals and objectives. One high level goal is to improve hiring, recruitment and retention. Objectives under this goal are to obtain baseline data; improve the hiring selection process; and improve retention of Black, Indigenous, People of Color (BIPOC) staff. The Ethnic Services Manager is an active member of the Steering Committee, was involved in the development of the Racial Equity Plan and will be involved in implementation of the objectives.

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

Being a part of a government agency with its own rules and guidelines for recruitment of employees is a challenge. County Human Resources changed recruitment practices in 2017 to allow more program input into job descriptions and recruitment strategies. So far, there has only been an increase in the number of Hispanic/Latino employees, but it is hoped that over time the number of diverse employees will increase.

E. Identify county technical assistance needs.

While trainings for Behavioral Health staff on working with interpreters are available, there is a need for training for interpreters in how to work with clinicians and other direct services staff. Humboldt County workforce would benefit from trainings offered to interpreters locally or via virtual platforms.

Criterion 7: County Mental Health System Language Capacity

I. Bilingual Workforce Capacity

A. Evidence of dedicated resources and strategies to grow bilingual staff capacity, including:
1. WET Plan evidence
The original Workforce Education and Training Plan included the goals to increase the number of staff who are proficient Spanish speakers from six to fourteen fulltime equivalent positions and staff who are proficient Hmong speakers from one to four fulltime equivalent positions. These goals have not yet been met, even though strategies such as advertising all job recruitments at culturally specific locations, providing a career path through HSU distance learning programs or expanding the number of HRSA certified locations to get education loan repayment have been attempted for several years. See Criterion 6, I.C above for more information about WET.

DHHS still participates in a "grow your own" effort with local educational systems and with community-based organizations serving the growing Latino community. This includes participation in school-based job and career fairs, cultivation of community connections through *Promotores* serving the area, and assuring that information about tuition and loan support programs reach potentially eligible students in the cultural and language groups of Humboldt County. DHHS, through its Housing, Outreach and Mobile Engagement (HOME) program, is providing employment and job training information in their mobile engagement vehicles. These vehicles serve the outlying areas of the county that are populated by Native American and Latino people on a regular schedule. One of the vehicle coordinators is bilingual in Spanish. One or multiple Spanish speaking staff always travel with the vehicle to provide services in Spanish. This strategy may also assist in building workforce likely to remain in the community.

DHHS Behavioral Health staff are encouraged to sign up for vocational Spanish courses in Medical Terminology, provided through the local Cal Poly Humboldt and College of the Redwoods.

DHHS Behavioral Health actively seeks to attract qualified bilingual candidates for intern placements in Licensed Vocational Nursing through College of the Redwoods and individual therapy through Humboldt State University's Master of Social Work program. Some of these internships have resulted in hiring former interns after graduation.

DHHS Behavioral Health participates in the National Health Service Corps Loan Repayment Program (HRSA). Ten Behavioral Health program sites are certified HRSA sites. Coming up in 2022 Behavioral Health will be participating in the Superior Region WET Partnership program. This was discussed further in Criterion 6.

Eligible and interested Behavioral Health staff are encouraged to take the Spanish Bilingual

Proficiency Examination administered through the County Human Resources Department. DHHS has a job classification titled Interpreter/Translator. This classification is not limited to a particular language and can be used by multiple programs. DHHS Public Health has two allocated full time Spanish/English Interpreter/Translator positions whose assignments include interpreting for integrated programs.

2. As already stated, DHHS Behavioral Health has four staff who receive the bilingual pay differential.

3. Total dedicated resources for interpreter services
The total dedicated resources for interpreter services in addition to bilingual staff was approximately $15,000 in Fiscal Year 2020-2021. (source: Department of Health and Human Services Finance Department). This includes Behavioral Health expenditures for contracted interpreters and language line services, and the Department of Health and Human Services' Interpreter/Translator position.

Job Title	Number of Spanish Bilingual Proficiency Tested Staff
Case Manager	1
Program Coordinator	2
Mental Health Clinician	1

Additional resources include Bi-lingual Specialty Pay for staff who passed the county Spanish Bilingual Proficiency Examination and work in a position that is formally designated as needing bilingual language skills, and potential loan repayment awards under the WET Regional Partnership grant Repayment Program. Currently DHHS Behavioral Health employs one Case Managers, two Program Coordinators within HOME, and one Mental Health Clinician who have passed the Spanish Bilingual Proficiency Examination.

II. Interpreter Services

A. Policies, Procedures, and Practices, including:

1. 24 hour phone line
DHHS-Behavioral Health has policies, procedures and practices in place for meeting client's language needs, including a 24/7 telephone line with state-wide toll-free access that has linguistic capability via Language Line services to meet any future threshold language of the county, as well as all other languages prevalent in the county, spoken by beneficiaries of DHHS Behavioral Health.

A Text Telephone (TTY) can be connected to DHHS Behavioral Health's statewide toll-free number for use with deaf, hearing-impaired or speech-impaired callers. Receptionists and staff are also trained to utilize California Relay Services.

Below is a list of policies regarding language capacity. For the full text of these policies and procedures see Attachments.

Attachment 1: Policy 100.603 Selection of Interpreters

Attachment 2: Policy 100.604 Access to Interpreters and Culturally and Linguistically Competent Providers

Attachment 3: Policy 100.605 Obtaining Interpretation, Translation and Telephone Services for Clients with Physical Impairments or Limited English Proficiency

Attachment 4: Policy 100.606 Speech to Speech Relay Service

Attachment 5: Policy 100.607 Text Telephone (TTY) Use

Attachment 6: Policy 100.608 Access to Interpreter Services – Language Line Use

Attachment 7: Policy 100.617 Translation of Written Materials

2. Video Remote Interpreting
DHHS Behavioral Health will utilize its existing contract provisions with Language Line Services, Inc. to activate remote video interpreting including Sign Language. DHHS Behavioral Health has started the process by involving the Information Systems group to guide acquisition of appropriate equipment and how to set up the functions needed to connect a video interpreter across programs in our systems of care.

3. Protocol for implementing language access
DHHS Behavioral Health has implemented the following protocol: The toll-free Access number for Humboldt County DHHS Behavioral Health is 1-888-849-5728. This phone line is answered by the receptionists at the main clinic (720 Wood Street, Eureka) during regular business hours. Calls after regular business hours are forwarded to an answering service, Lacuna Health. If the caller does not speak English Language Line services are utilized. All staff at Lacuna Health have been trained to utilize California Relay services. The Behavioral Health Quality Improvement unit provided Lacuna Health with an updated script to use when answering calls, and worked with the answering service on optimizing instructions for their call operators as well as improving call operator performance in following the script.

All Behavioral Health front office and direct service staff are trained to access Language Line services for calls coming in from persons who have limited English proficiency. DHHS Behavioral Health has created several trainings that are available to staff through the Relias e-Learning platform and /or on the county intranet website. Training participation is being tracked via Relias or Kaizen Training Tracker for those Behavioral Health staff not eligible to use Relias. These trainings are entitled “Serving Clients when English is not their Primary Language; “Working with Interpreters”, and “Mental Health Language Line Training”. They include information about California Relay Services.

B. Evidence that clients are informed in writing in their language, of their rights to language assistance services
It is the policy of DHHS Behavioral Health to assure that the Informing Materials (including the Beneficiary Handbook) be provided to beneficiaries when they first access services and upon request. Beneficiary brochures printed in English and Spanish are provided upon request and made available at the lobbies of all its access points and in all contracted providers' waiting areas.

The Beneficiary Handbook includes information about a beneficiary's right to receive written information in the threshold language and that DHHS Behavioral Health must make oral interpreter services available free of charge for people who speak other languages. DHHS Behavioral Health does not currently have a threshold language but makes informing materials available in Spanish regardless.

In addition, a bilingual English-Spanish sign named "Did you know?" along with the poster "Interpretation Services available" (the latter also assisting in language identification) are posted in the lobbies of all access points and programs, including contracted providers.

Informing Materials are located visibly within easy reach of people living with disabilities, and accessible without staff assistance at all service delivery locations. When requested, staff are available to explain to a client the contents of Informing Materials.

At time of the initial assessment, staff will provide the client with an Informing Materials Packet and ask the client to sign DHHS-BH Form #1196 Informing Materials Packet – Client Acknowledgement. Documentation that this information was provided is entered into the client's record by submitting the completed Form #1196.

Staff, whether employed by DHHS Behavioral Health or a Contract Provider, are responsible for keeping a current supply at each location. The Provider Relations Coordinator will provide all Access Points and Contract Providers with printed Beneficiary Brochures and Informing Materials as well as posters and signage to display and make available in their lobbies and/or waiting rooms within three days of receipt of a request. DHHS Behavioral Quality Improvement unit periodically checks access points for compliance with all posting requirements.

C. Evidence that persons are accommodated who have Limited English Proficiency (LEP) by using bilingual staff or interpreters
DHHS Behavioral Health prohibits the expectation that families provide interpreter services for their family members who are receiving or requesting services, although this can be facilitated at the client's specific request and with appropriate releases. Minor children should not be used as interpreters.

DHHS Behavioral Health has implemented the following procedure to accommodate persons who have LEP. All front office and direct service staff are trained on the following steps to provide appropriate interpreter services to clients.
Step 1: Identify language spoken. If in doubt, use Language Line services for language

identification assistance or when face to face with a client, use Language Identification Card or Interpreting Services Available poster.
Step 2: Offer the client free interpreter service by providing the Interpreter List composed of local community providers.
Step 3: If the client declines to use a local interpreter, staff will contact Language Line Services.
Step 4: If steps 2 and 3 fail to meet the client's needs, or client declines those services, ask client if he or she prefers to have an adult family member or other support provide the interpreter services.
Step 5: Document steps 1 through 4 in client's chart.
Appropriate translated materials are distributed or posted at all points where clients access the behavioral health system.

DHHS Behavioral Health maintains a current Provider Directory in electronic form and provides a paper version upon request. It includes information about cultural capabilities, linguistic capabilities and specialties for each licensed, waivered, or registered behavioral health provider and licensed substance use disorder services provider employed by or contracted with DHHS Behavioral Health to deliver Medi-Cal services.

This list is updated monthly and offered to clients during the intake process, where clients are also informed in a language that they understand that they have the right to free language assistance services. A link to the directory, which is posted on the Behavioral Health public facing website, is posted in the lobbies of all access points, and at Contract Provider sites.

When a client requests a specific provider from the Provider Directory, DHHS Access Staff will review the request and make every effort to link the client with the provider of his/her choice as appropriate.

D. Historical challenges on items A, B, and C. Lessons Learned
While DHHS Behavioral Health's training plan includes training on accessing interpreters, occasionally staff members are not familiar with the use of language line services and therefore do not meet the needs of Limited English Proficiency clients at initial contact call-ins. There are comprehensive onboarding processes in place that include accessing interpreters in the training plan. To monitor for quality of Access calls, the DHHS Behavioral Health Quality Improvement unit conducts monthly test calls in a non-English language and regularly reports results at the Outpatient Quality Improvement Committee meetings. This strategy assures that issues are detected and addressed immediately.

Historically it has been a challenge to recruit and retain diverse staff members who are bilingual. As stated in Criterion 2, approximately 68% of Humboldt County's population is White, 14% Hispanic/Latino, 5% Native American, 3% Asian/Pacific Islander and 1% African American.

Bi-lingual employees are encouraged to test for Spanish Bilingual Proficiency through the County Human Resources Department. Currently four DHHS Behavioral Health staff members have been certified as bilingual (see section I. Bi-lingual Workforce Capacity above). Historically,

passing both the written and oral part of the exam has been challenging. Standards are high because certification does not only attest for interpretation capability but also the ability to translate complex legal documents. Key for passing is being proficient in both English and Spanish. The County Human Resources Department does not give out study guides or other materials prior to the test.

DHHS Behavioral Health maintains an Interpreter List comprised of community members who have contracted for interpretation services. This list, including instructions on how to access a community interpreter, is made available to DHHS Behavioral Health staff on the county intranet website. It continues to be challenging to develop a certification and credentialing mechanism for those interpreters. Community interpreters interested in contracting with Behavioral Health are asked to provide an Interpreter / Translator Resume that assesses each individual's translation skills and credentials, interpretation skills and credentials, cultural competencies, and specialties. Currently there are 11 Spanish language Interpreters and one Hmong interpreter listed.

It has been a challenge to maintain the interpreter list due to interpreters relocating or taking fulltime employment. Coordinating appointments with these individuals can be difficult because they have other work obligations and limited availability. Another challenge is the interpreters' varying levels of ability and areas of experience.

There are no challenges concerning informing clients in writing in their primary language of their rights to language assistance services. Appropriate signage and informing materials are widely available.

E. County technical assistance needs
While the California Department of Health Care Services has made available a Mental Health Interpreter Training Curriculum to county mental health programs, there is a need for Interpreter Training geared towards meeting the needs of small counties. DHHS Behavioral Health would benefit from interpreter trainings offered locally at low cost. DHHS Behavioral Health's Language Line provider offers Interpreter Certification online courses. However, these are cost prohibitive for locally contracted interpreters as they work few hours under contract and would have to pay out of pocket.

III. Provide bilingual staff and/or interpreters for threshold languages

A. Evidence of availability of interpreter and/or bilingual staff
DHHS Behavioral Health checks the California Health and Human Services (CHHS) open data portal quarterly for threshold language updates. Quarterly certified eligible counts by month of eligibility, county, and threshold language have been posted since January 2015 to the most recent reportable month. Humboldt County has not met the threshold of 3,000 Medi-Cal beneficiaries or 5 percent of total Medi-Cal beneficiary population, whichever is lower, going back to January 2015.

Program	Number of Spanish Bilingual Proficiency Tested Staff
Children's Behavioral Health	1
HOME	2
Mobil Response Team	1

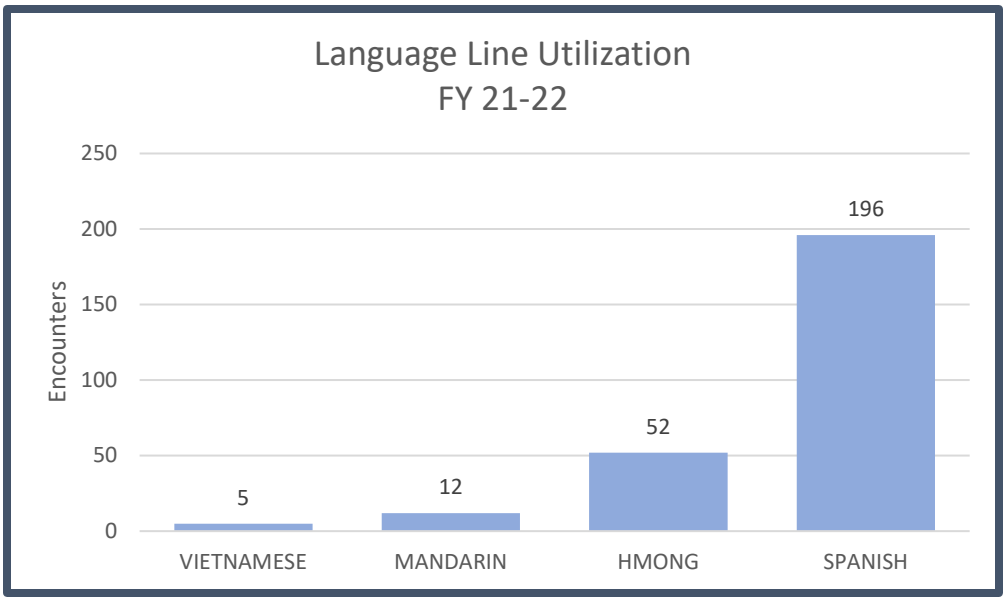
The DHHS Employee Services unit reports that the department currently (as of September 2022) employs four bilingual (English/Spanish) staff receiving bilingual specialty pay. These employees have been certified as bilingual by the Human Resources Director following achieving a passing score on the proficiency exam. Their functions are Case Managers for Mobile Response Team (1); two Program Coordinator for HOME (2); and a Mental Health Clinician at Children's Behavioral Health (1).

DHHS Behavioral Health maintains an interpreter list composed of contracted local community providers, with 11 Spanish interpreters and one Hmong interpreter currently available. Front office and direct services staff are instructed to offer clients the use of a community interpreter before utilizing the telephonic language line. Clients are given an interpreter list that includes the name and contact number of each interpreter and the language they interpret. DHHS Behavioral Health clinical staff contacts client-selected interpreters from this list to arrange for their services.

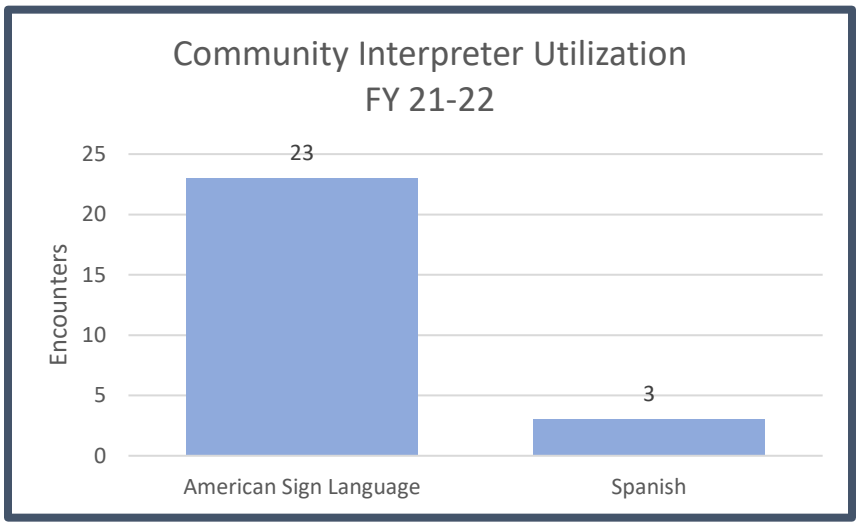
DHHS has a job classification titled Interpreter/Translator. This classification is not limited to a particular language and can be used by multiple programs. DHHS Public Health is actively recruiting for one of two full time Spanish/English Interpreters/Translators who are bi-lingual and bi-cultural. The interpreters' assignments include interpreting for integrated programs as well as document translation.

B. Evidence that interpreter services are offered and provided and recording of response to offer.
It is the policy of DHHS Behavioral Health to offer and provide interpreter services to Behavioral Health beneficiaries. Use of interpretation services is captured in the electronic Health Record (Avatar) Progress Note forms. Any encounters using interpreter services to assist a beneficiary (Language Line Services, on-site interpreter or a staff member who is using bilingual language skills) are documented. DHHS Behavioral Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Responsiveness Committee.

In Fiscal Year 2021-22, 265 encounters required Language Line Services. The chart below shows these encounters broken out by language used.



In Fiscal Year 2021-22, 26 client encounters required community interpreter services. The chart below shows these encounters broken out by language used.



C. Evidence of providing linguistically proficient staff or contracted services during regular day operating hours

As stated above in section III. A, four DHHS Behavioral Health staff members receive bi-lingual pay. Their functions are a Case Manager for Mobile Response Team (1); two Program Coordinators for HOME (2); and a Mental Health Clinician for Children's Behavioral Health (1).

DHHS Behavioral Health maintains an interpreter list composed of contracted local community providers, with eleven Spanish interpreters and one Hmong interpreter currently available.

These community providers are contracted and can be accessed when the need for interpretation arises. Humboldt County DHHS has two full-time Interpreter/Translator positions assigned to Public Health. However, as stated above, one of these positions is currently vacant. The positions are available to provide interpretation services in integrated programs that are collaborations between Behavioral Health and Public Health programs and translates documents for Behavioral Health upon request.

As mentioned in section III. B., the Electronic Health Record provides reporting capabilities that serve as the mechanism to track the use of interpretation services.

D. Evidence that interpreters are trained and monitored for language competence
The Department of Health and Human Services "County Qualification Assessment Process for Bi-lingual Proficiency" is as follows:
The County Human Resources (HR) Department periodically administers a Spanish Bilingual Proficiency Examination to eligible and interested County employees. Employees are made aware that in order to receive Bilingual Specialty Pay they must not only pass the test(s) but must also be in a position that is formally designated by the department as needing the skills of someone who is proficient in both English and Spanish. Programs who need employees with either oral only, or oral and written proficiency in Spanish, or are aware of an eligible bi-lingual staff member are advised to contact DHHS Employee Services to discuss their needs. Eligible staff may complete the Bilingual Proficiency Exam Registration Form online, submit the form to their hiring authority/supervisor for pre-approval, and then submit the form to the County HR department for review and final approval. Upon final approval the HR department will contact the staff with further instructions regarding the oral and/or written exam process. Bilingual allocations are subject to rotational status depending on program needs. Since Specialty Pay is based on the specific position, it may be discontinued if the employee receiving it transfers or promotes to another position.

Contracted Community Interpreters provide a resume indicating their experience and credentials prior to contracting.

IV. Provide services to all LEP clients not meeting the threshold language criteria

A. Policies, procedures and practices for referring and linking to culturally and linguistically appropriate services
DHHS Behavioral Health's policy on access to interpreters and culturally and linguistically competent providers is all-inclusive and does not distinguish between clients who speak a potential threshold language versus those who speak other languages. See Section II. A. above, referenced Policy and Procedure 0100.604.

B. Written plan for assisting such clients
As stated above, DHHS Behavioral Health's policy and procedure on access to interpreters and

culturally and linguistically competent providers is all-inclusive and does not distinguish between clients who speak a potential threshold language versus those who speak other languages. Therefore, DHHS Behavioral Health does not require a separate plan for such clients.

C. Policies, procedures and practices that comply with Title VI of the Civil Rights Act of 1964
DHHS Behavioral Health prohibits the expectation that families will provide interpreter services for their family members who are receiving or requesting services, although this can be facilitated at the client's specific request and with appropriate releases. The expectation that minor children should not be used as interpreters is clearly spelled out in policy & procedure 0100.604 (referenced above in Section II. A.) and is included in staff training materials about working with interpreters.

V. Translated documents, forms, signage, and client informing materials

A. Written information for threshold languages
As stated above in III., Humboldt County has not met the threshold of 3,000 Medi-Cal beneficiaries or 5 percent of total Medi-Cal beneficiary population, whichever is lower, that speak a language other than English, going back to at least January 2015. However, DHHS Behavioral Health provides translated clinical and non-clinical documents for the purpose of information and education to clients with Limited English Proficiency (LEP) and their family members as outlined in policy and procedure 0100.617 Translation of Written Materials (referenced above in Section II. A.) The procedure includes a mechanism for ensuring accuracy of translated materials in terms of both language and culture. Informing materials translated into Spanish are available in the waiting areas of all service access points. The bi-annual Consumer Perception Survey, client comment cards and the patient satisfaction survey at the psychiatric health facility are available in Spanish. Beneficiary problem resolution and fair hearing materials, confidentiality statement, release of information, informed consent, health history form, service orientation brochures for clients and a variety of educational materials are available in Spanish as well.

B. Evidence in clinical chart that clinical findings are communicated in clients' preferred language
As stated above in Section III.B., DHHS Behavioral Health captures the use of interpretation services in the electronic Health Record Progress Note forms.

Any encounters using interpreter services to assist a beneficiary (Language Line Services, on-site interpreter, or a staff member who is using bilingual language skills) are documented. DHHS Behavioral Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Responsiveness Committee.

C. Consumer satisfaction survey translated into threshold languages, including summary of

results
Humboldt County does not presently have a threshold language. DHHS Behavioral Health participates in the bi-annual Consumer Perception Survey administered by DHCS, using the translated survey forms as needed. Results are reported out at Continuous Quality Improvement Committees, distributed to all Behavioral Health staff via a staff bulletin, and made available to clients in the lobby of the main clinics. The return rate of surveys completed in Spanish language remains very low, between zero and three total surveys during each collection period over the past six years. Due to this low participation, DHHS Behavioral Health has not translated the survey results into Spanish.

D. Report mechanisms for ensuring accuracy of translated materials for both language and culture
As stated above in Section V. A., DHHS Behavioral Health provides translated clinical and non-clinical documents for the purpose of information and education to clients with Limited English Proficiency (LEP) and their family members as outlined in policy and procedure 0100.617 Translation of Written Materials (referenced above in Section II. A.) The procedure includes a mechanism for ensuring accuracy of translated materials in terms of both language and culture.

Pertinent Informing Materials, signs, brochures, posters, and forms are translated by either the DHHS Public Health's Translator/Interpreter or a qualified contracted community interpreter. These translations always undergo a second review by either bi-lingual staff who have passed the county bi-lingual proficiency exam, or a qualified contracted community interpreter/ translator.

DHHS Behavioral Health's contract with LanguageLine Solutions, Inc. covers translations as well, and LanguageLine Solutions is used for all translations of clinical documents upon a client's request.

E. Report mechanisms for ensuring translated materials are at appropriate reading level (6th grade)
Per DHHS Behavioral Health's policy, clinical staff may review the translated version of a document with clients to assess the level of understanding as indicated. If clients consistently identify wording that reflects a more regional or colloquial form of expression, or wording that is hard to understand, clinical staff informs the Quality Improvement Coordinator to explain and request changes. DHHS Behavioral Health also has available Microsoft Word's readability statistics feature that analyzes documents for readability in English and Spanish language ("Flesch-Kincaid Grade Level"), indicating how many years of education a person needs in order to understand the level of writing. DHHS Behavioral Health adjusts contents based on these mechanisms.

Criterion 8: County Mental Health System 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.

The Humboldt County Department of Health and Human Services is dedicated to the provision of human services with a holistic approach. This includes behavioral health and substance use disorder services. All services promote emotional health and mental wellness and to treat illness. The Department is dedicated to providing all services/programs in a client/family/ community driven manner based on recovery and wellness principles that are responsive to cultural differences. The Department continuously evaluates the effectiveness of services and programs for the purpose of quality improvement. Two programs in Behavioral Health are designed to operate specifically as client driven.

The Hope Center serves unserved and underserved populations of transition age youth, adults and older adults who have mental health challenges and their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from SAMHSA, and the resources necessary for people with and without a mental health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of all seven of the negative outcomes that may result from untreated mental illness. These negative outcomes are suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

Hope Center staffing consists of a full time Peer Coach III who oversees the Center, three full time Peer Coach II positions, and two extra help Peer Coach I positions. Peer Support is an evidence based practice that is recognized by the State of California as billable service through Medi-Cal for licensed Peer Support Specialists. Many of the Peer Coaches will complete the certification requirements through CalMHSA to become a certified Peer Support Specialist. This recently enacted certification allows for a state-wide system for recognizing the Peer Support service for Medi-Cal billing and applies consistent requirements for individuals providing Peer Support within California. Most of the current Peer Coaches are already trained as Certified Peer Support Specialists through Recovery Innovations (RI) International. Many of the Hope Center Peer Coaches have additional training from Western Mass Recovery Learning Community (RLC) in Hearing Voices Network Facilitation, Alternatives to Suicide Facilitation, and Conversations about Suicide. The Hope Center is currently looking for additional training

opportunities for the Wellness Recovery Action Plan (WRAP) program. There are plans to have all Peers trained in WRAP and integrate it back into the Hope Center.

Hope Center goals are to:

- Build on the dimensions of wellness
- Incorporate recovery pathways
- Validate strengths and honor the person
- Build sustainable living skills
- Build community engagement
- Promote self-advocacy
- Keep Hope Center a safe location for all participants
- Reduce stigma and discrimination within the system of care and the broader community
- Develop an inviting community space alongside an educational setting
- Encourage individuals to find their personal strengths and identify their personal recovery goals
- Develop a more sustainable hybrid setup
- Break the stigma of "us and them"

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff to people with a behavioral health diagnosis. The Hope Center has been slowly integrating in person services while maintaining a zoom community. There are plans to re-introduce hybrid classes next year. The Hope Center has introduced Recovery Innovations "My Wellness plan" course to the curriculum as well as a reading club focused on individuals' experiences with mental health. There are plans of creating a stronger community connection by tabling at local events. In 2018 the Hope Center created an Advisory Board made up of four participants and a staff member. Unfortunately, the Advisory Board was unable to sustain itself during the COVID-19 outbreak, but staff are working diligently to support participants in re-establishing the Advisory Board. The Advisory Board's purpose is to be a voice for the Center and give input to staff. Participants meet once a month to discuss topics of concern, ideas, and thoughts about Mental Health and the role of the Center in the community. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

Also, due to the pandemic, and due to a lack of available staff who were supporting other programs in need, recent data was not maintained well. A total of 112 unduplicated participants for FY 2021-22 were recorded. The number of duplicated participants is 3,824 for FY 2021-22, which includes individual peer support on site, in Zoom meetings, in-person with social distancing and masking as well as recently added hybrid classes. Of the 32 individuals who completed demographic forms, 9% were ages 16-25, 59% were ages 26-59, and 25% were age 60+. Six percent did not respond to the question. Forty-one percent of Hope Center

participants were female, 50% male, and 9% did not respond to the question. Fifty-six percent of Hope Center participants were White, 6% were Multiracial/Other, 22% were Hispanic/Latinx, 0% were American Indian, 0% were Asian/Pacific Islander, and 3% were Black/African American. Thirteen percent did not respond to the question. Nineteen percent identified as LGBTQ, 56% had experience with homelessness, 81% had been diagnosed with a serious mental illness (SMI), 56% had a family member diagnosed with SMI, and 9% had military experience.

The second client-driven program is a part of the Transition Age Youth (TAY) Division, serving youth and young adults ages 16-26. The TAY Division consists of co-located DHHS services including Behavioral Health, Extended Foster Care, Independent Living Skills, and the Humboldt County Transition Age Youth Collaboration (HCTAYC). TAY taps into supports and services from other DHHS programs as well, including Public Health, Employment Training, CalFresh, Medi-Cal and Substance Use Disorder services. TAY also collaborates with community partners such as Juvenile Probation, Community Resource Centers through St. Joseph Providence Health, and Family Resource Centers.

The HCTAYC component of the TAY Division is client driven. HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulation, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people's needs, resulting in these larger system outcomes. It also directly attends to the lives of system-impacted youth at-risk of, or struggling with, mental health challenges through the development of resilience and self-efficacy via leadership. It is the result of this advocacy program that needed systems and services, such as the creation of the TAY Division in 2012, have come to fruition. This advocacy has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of CANS. These policies have all significantly contributed to the statewide transition-age youth system of care's ability to best serve youth.

HCTAYC demographic information was obtained from 153 demographic surveys completed by individuals participating in 30-MHSA-funded events or trainings between July 1, 2021 and June 30, 2022. These are duplicated responses as one person could complete more than one survey having attended multiple events. Sixty-five percent of the people who responded to the demographics survey selected White, non-Hispanic; 15% selected American Indian/Alaska Native, representing local tribes such as Cherokee, Dakota, Rosebud Sioux, Tolowa, and Pomo. Nine percent selected Asian. Three percent selected Black/African American. Two percent wrote Latino under other, and 4% preferred not to answer. Of the 153 survey responses, 7% selected more than one race. The primary language of participants was roughly 95% English, and the rest of responses included Spanish, Karuk/Yurok, Portuguese, Palauan, and preferred not to answer. Fifty-nine percent of the participants were within 19-25 years old and forty-one percent were within 16-18 years old. However, HCTAYC youth engaged people of all ages in

trainings, presentations, community coalitions, and policy recommendation outreach efforts.

While 71% of the survey respondents had an assigned birth sex of female, 51% identified as such. Twenty percent of the survey respondents had an assigned birth sex of male, 21% identified as such. Six participants identified with more than one gender identity category, and 6 more preferred not to answer. The remaining respondents (20%), identified with a gender category other than female or male, with the genderqueer category (9%) being the most frequently selected. Their current gender identities were 55% female; 21% male; 6% wrote in non-binary, 9% genderqueer, 1% trans male; 4% prefer not to answer; 2% questioning/unsure.

Forty-seven percent had experience with homelessness, 50% did not, and 3% preferred not to answer. One hundred five (105) survey participants stated they had a personal mental health condition, 38 stated they did not, while 10 preferred not to answer. One hundred seventeen (117) stated they have a family member with a mental health condition, 24 stated they did not, and 12 preferred not to answer.

Thirty-eight participants reported involvement in foster care and/or the child welfare systems, 111 did not have this involvement, and 3 preferred not to answer. Twenty-four participants reported involvement in the juvenile justice system, 126 did not have this involvement, and three selected preferred not to answer.

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.

The TAY Division, as discussed above, is a culturally specific program for transition age youth. At this time there are no other culturally specific programs provided by DHHS. However, DHHS consistently provides referrals to community based, culturally appropriate services. Native Americans can seek mental health counseling services directly through United Indian Health Services (UIHS) or through their own tribes, such as the Yurok, Wiyot, or Hupa Tribes. Referrals can be made to UIHS or another tribal counseling program. Two Feathers Native American Family Services is now an organizational provider with DHHS Behavioral Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty mental health services waiver.

In addition to direct referrals to culturally specific programs, DHHS Behavioral Health makes available the following resources. These are widely distributed in the community and are available in Behavioral Health programs' public access areas, in contract provider clinics, and in non-profit organizations such as Humboldt 211.

- Humboldt Community Resource List with information and links to organizations providing services in over forty categories. Resources include those specific to Native

Americans, Spanish-speakers, LGBTQ community, seniors, youth, and disability. This is available in print format as well as online by searching the Humboldt County website for "Humboldt Community Resource List."

- Behavioral Health's informational flyer about its programs.

In addition to the availability of the Language Line for interpretation services, DHHS Behavioral Health has an interpreter list with resources for Spanish and Hmong speakers. If a client speaks one of these languages, they have the option of requesting a live interpreter or using the Language Line, free of cost.

B. Evidence that the county informs clients of the availability of the above listings in their member services brochure.

Clients are informed about the availability of alternatives and options of cultural/linguistic services in the Behavioral Health Access Brochure and Beneficiary Handbook.

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

In addition to providing clients with the Beneficiary Booklet, DHHS Behavioral Health has implemented the policy titled "Community Information and Education Plans." This policy states that Behavioral Health will provide information to underserved populations in the community in order to enable access to specialty mental health services. Information is disseminated through distribution of flyers and brochures, participation in community presentations, forums, and meetings, coordination with physical health care, and via outreach by case managers and other clinical staff. In addition, Behavioral Health ensures that the Informing Materials (including a list of current providers with culture-specific information, Problem Resolution Processes and Advance Directives) is provided to clients when they first access services and upon request. Beneficiary Brochures printed in English and Spanish are provided upon request and made available in the lobby areas of all access points including with contract providers. In addition, the Housing, Outreach and Mobile Engagement (HOME) program, discussed further in section D. below, provides information about cultural and linguistic services available.

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

The HOME program focuses on bringing services and supports to facilitate the ease with which individuals can access services and supports. The Behavioral Health integration with HOME as

well as Regional Services engage clients by meeting them in the communities in which they live. These programs address the barrier of rural community access to services, most of which are based in Eureka. HOME staff travel to provide their outreach and services to the further corners of Humboldt County. There is also a Mobile Engagement Vehicle (MEV), a converted RV which acts as rolling office space and visits communities located throughout Humboldt County. There are regularly scheduled visits to Northern, Eastern and Southern Humboldt as well as the Eel River Valley. Some services, such as counseling, may require an appointment, but other services can be had right on the spot at the MEV. These services also link with and provide support to existing community organizations such as Family Resource Centers, Community Resource Centers, community clinics, and Tribal Organizations.

The Housing component of HOME also focuses on bringing services and supports to where people are. HOME staff provide services and supports to five different housing projects. The first housing project supported by MHSA funding is in Arcata and has 15 studio apartments for behavioral health clients. Another housing project in Eureka has 15 subsidized apartments. In Eureka, construction was completed in 2020 at another 50-unit apartment building with community and meeting space for tenants. This development has 25 units for eligible DHHS clients. A fourth project completed in 2021 is a 25-unit project in Rio Dell. This project is individual small homes with all utilities and amenities that are fully ADA compliant for eligible clients. In 2022, another housing project was completed in the Pine Hill area of Eureka with 30 units for homeless individuals. For all projects, HOME and Behavioral Health staff provide services on-site. There are also resident services staff on site. In addition to clinical services, recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma are available. All projects also include community spaces for events, supportive services, and recreation.

The Mobile Intervention and Services Team (MIST) serves people in Arcata with severe mental illness who are homeless and have frequent contact with law enforcement. Through use of the Behavioral Health Justice Intervention Services (BHJIS) grant, MIST will continue to embed Behavioral Health staff into Humboldt County Sheriff's Office patrol operations to co-respond to mental health calls. This will allow MIST to continue to provide a wide range of appropriate services, both for immediate crises and follow up in the least restrictive manner possible.

The Regional Services program addresses rural community access and provides behavioral health clinicians, case managers and a substance abuse counselor in the Eastern Humboldt and Southern Humboldt regions of the County. Staff are either based at one of the DHHS outlying offices or travel to meet clients where they are.

The Comprehensive Community Treatment (CCT)/Full Service Partnership program makes available intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, or other needed community services) to achieve recovery. Partnership Services Coordinators/Case Managers can provide services to clients in their own

homes, which can alleviate the potential challenge for clients to travel to the main clinic locations.

DHHS Children's Behavioral Health (CBH) clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management and crisis services. They work closely with regional Family Resource Centers, Tribes, and Schools to determine where the need is. Clients who have been assessed and are waiting to be assigned to a counselor are offered a walk-in appointment. One crisis clinician is dispatched to Emergency Rooms in Eureka to evaluate minors for crisis needs. In addition, there are two case managers that respond to minors in crisis.

Humboldt BRIDGES to Success staff work with staff at local public schools to provide short-term, school-based behavioral health intervention and support to students who are in crisis or at risk of crisis. The program is school-based, and services are available and accessible through public schools throughout the County.

Both the Children's Mobile Response Team and the Adult Mobile Response Team provide short-term behavioral health crisis intervention and support in Humboldt County.

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)

Humboldt County was under Department of Justice review regarding ADA accessibility in facilities and has been putting in place the processes and building updates for other County, non-Behavioral Health buildings. While work has been ongoing, all of the remediations ordered by the consent decree have not yet been completed. Once those priorities are met all County Facilities will be fully assessed for ADA compliance. Some buildings rented by Behavioral Health have already had work performed on the outside of the buildings - ramps and parking lots - to create better access. These improvements are found at the locations housing Outpatient Services, Sempervirens, and Crisis Services; at the HOME program; and at the Children's Behavioral Health Clinic at Humboldt Plaza.

In order to create a welcoming environment to clients of diverse cultural backgrounds, Behavioral Health has implemented the following:

- Artwork produced by people with lived experience is on display on the walls of program waiting areas and group therapy rooms as well as at the Crisis Stabilization Unit. This artwork can be purchased and is rotated regularly with new pieces. Posters produced by the Youth Training Project are posted in lobby areas.
- Spanish language posters and Spanish educational materials are available and have been distributed to programs for posting.
- "Every BODY has an issue" first place winning poster of the 2010 Prevention and Early

Intervention Program to reduce stigma and discrimination related to mental health is also widely posted throughout the agency.

- Posters promoting acceptance of Lesbian/Gay/Bisexual/Queer/Questioning/ Transgender youth obtained from the Y.O.U.T.H. (Youth Offering Unique Tangible Help) Training Project are posted throughout DHHS.

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.

As an integrated agency, the Humboldt County Department of Health and Human Services Behavioral Health staff is co-located with other DHHS programs including but not limited to:

- Child Welfare Services and Children's Behavioral Health Clinic, including the Mobile Response Team and Foster Care Unit, are co-located at Humboldt Plaza.
- Child Welfare Services are integrated with the Extended Foster Care Unit in the TAY Division.
- CalWORKs Program, providing services to clients who have mental health, substance use, or domestic violence issues to address barriers to employment.
- Older Adults and Dependent Adults Program, a partnership between Social Services, Adult Protective Services, In Home Support Services, Public Health Nursing, and Behavioral Health.
- Expanded Outpatient Medication Support Services, providing medication support to people with a serious mental illness residing in remote rural areas utilizing video conferencing equipment.

Some outpatient programs, such as Older Adults and Healthy Moms, are located in mixed residential and business areas, therefore reducing the stigma attached to receiving services at the main Behavioral Health clinic. Over the past several years, DHHS has worked with partners in the McKinleyville area to develop The Center at McKinleyville, which began providing services in 2022. This is a one-stop location for services, information, and activities for community members in the McKinleyville area. Services currently provided by the McKinleyville Family Resource Center (MFRC), DHHS, and Open Door Community Health Center are located together so that community members have one place to go to access a wide variety of services. This site is a non-stigmatizing community setting. The Center is not a DHHS facility. Leadership and decision-making are shared between the MFRC, DHHS, and Open Door, with MFRC as the primary partner to ensure community voice will guide decisions. Additionally, DHHS has opened a new clinic site in Fortuna. Services provided at the Fortuna Clinic include Children's Behavioral Health staff who focus on children, youth, and families in the greater Fortuna area (Eel River Valley). This includes those who are currently involved with, or are at risk of, Child Welfare involvement due to mental health and substance use disorders.

III. Quality Assurance

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

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

The Quality Improvement unit of Humboldt County DHHS Behavioral Health ensures that individuals receive thoughtful and timely response to requests for problem resolution, including grievances, appeals, requests for change of provider, requests for culture-specific providers, and requests for second opinions. The Quality Improvement Coordinator (QIC) or designee coordinates, facilitates, logs, and tracks all requests for problem resolution. The QIC or designee is the assigned staff member responsible for responding to clients' questions regarding the status of their requests for problem resolution. Trended data from the problem resolution process is utilized in the Quality Improvement program in order to improve quality of care. All requests for problem resolution are reported to DHHS Behavioral Health's Outpatient Continuous Quality Improvement Committee on a quarterly basis. DHHS Behavioral Health Quality Improvement unit submits the required Annual Beneficiary Grievance and Appeal Report (ABGAR) to the Department of Health Care Services every year by October 1.

For an analysis of disparities, there are two areas to review: 1) ABGAR results (grievances only) and 2) all concerns, including grievances, requests for second opinions, and requests for change of provider.

Grievance Only Disparity Analysis

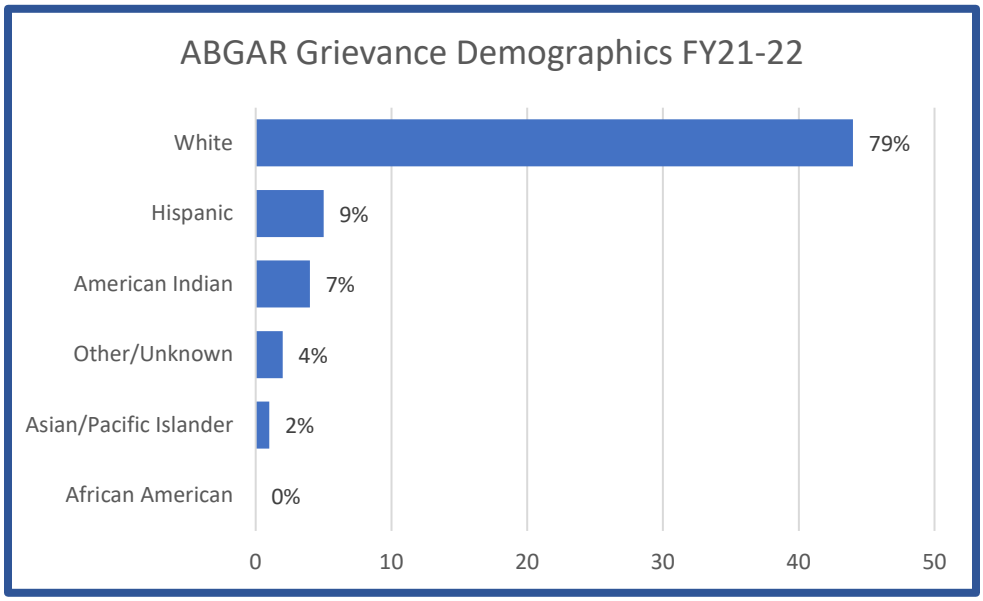
The table below shows grievances by category in the ABGAR reports for FY 19-20 through FY 21-22. All grievances were resolved according to protocol, and there were zero grievances filed under the category "Cultural Appropriateness."

ABGAR	Grievances FY 19-20	Grievances FY 20-21	Grievances FY 21-22	Percent of Total
Quality Of Care				
Staff Behavior Concerns	27	14	27	36%

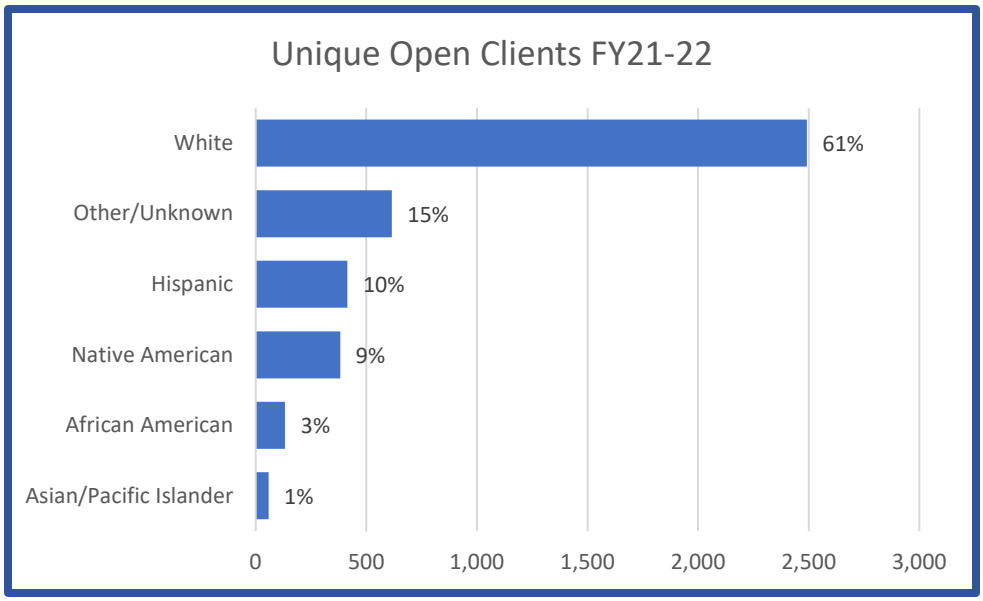
ABGAR	Grievances FY 19-20	Grievances FY 20-21	Grievances FY 21-22	Percent of Total
Treatment issues or Concerns	6	11	12	16%
Medication Concerns	3	2	0	0%
Cultural Appropriateness	0	0	0	0%
Other quality care issues	3	2	7	9%
Quality of Care Total	**39**	**29**	**46**	**62%**
Other				
Financial	1	1	0	0%
Lost Property	2	2	0	0%
Operational	1	2	1	1%
Patients' Rights	5	3	2	3%
Peer Behaviors	0	0	0	0%
Physical Environment	2	2	4	5%
Other Grievances not listed Above	4	3	1	1%
Other Total	**15**	**13**	**8**	**11%**
Access				
Service Not Available	0	0	0	0%
Service not Accessible	1	0	1	1%
Timeliness of Services	0	0	0	0%
24/7 toll free access line	0	0	0	0%
Linguistic Services	0	0	0	0%
Other Access issues	0	1	1	1%
Access Total	**1**	**1**	**2**	**3%**
Confidentiality Concerns	1	0	2	**3%**
Change of Provider	1	7	16	**22%**
Grand Totals	**57**	**50**	**74**	

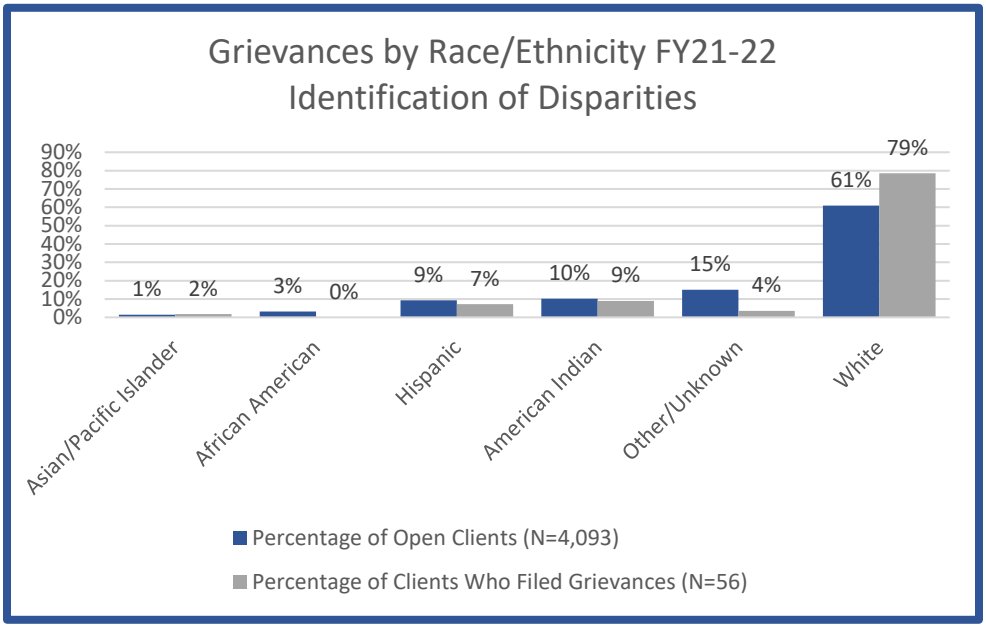
Grievances are reviewed from the perspective of potential ethnic disparities. In order to determine if certain ethnic groups are over- or underrepresented in filing concerns, client demographic data of unique beneficiaries receiving services are compared to QI client grievance data. The data sources for this analysis are Avatar reports and Behavioral Health QI Grievance Database. Ethnicity percentages are based on number of unique clients (children or adults receiving outpatient and/or inpatient services) who had an open episode during FY 21-22 (N=4,093); and number of unique clients who filed grievances in FY 21-22 (N=56).

ABGAR FY21-22 Race/Ethnicity	Unique Clients Who Filed Grievances	Percentage
African American	0	0%
Asian/Pacific Islander	1	2%
Other/Unknown	2	4%
American Indian	4	7%
Hispanic	5	9%
White	44	79%
Total	56	100%



Race/Ethnicity	Unique Open Clients	Percentage
Asian/Pacific Islander	58	1%
African American	133	3%
Native American	382	9%
Hispanic	414	10%
Other/Unknown	615	15%
White	2,491	61%
Total	4,093	100%



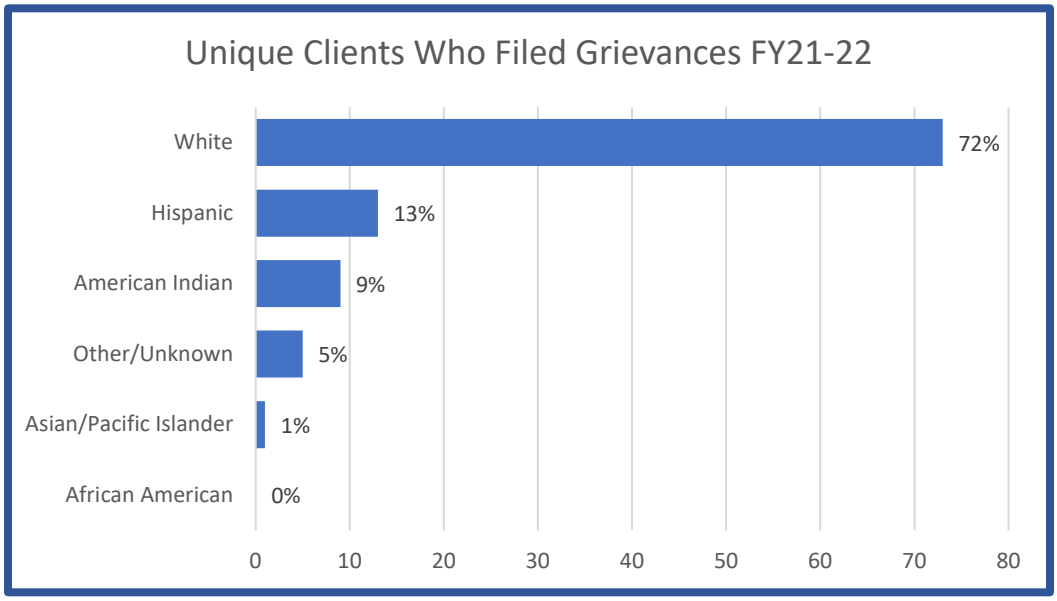


The data show that Whites are overrepresented in relation to their population in our system of care. Of fifty-six grievances filed, 79% were filed by Whites, 7% were filed by Hispanics, and 15% were filed by the Other/Unknown category. American Indians were represented at 9%, Asian and Pacific Islanders were represented at 2%, while African American were underrepresented having no grievances in FY 21-22.

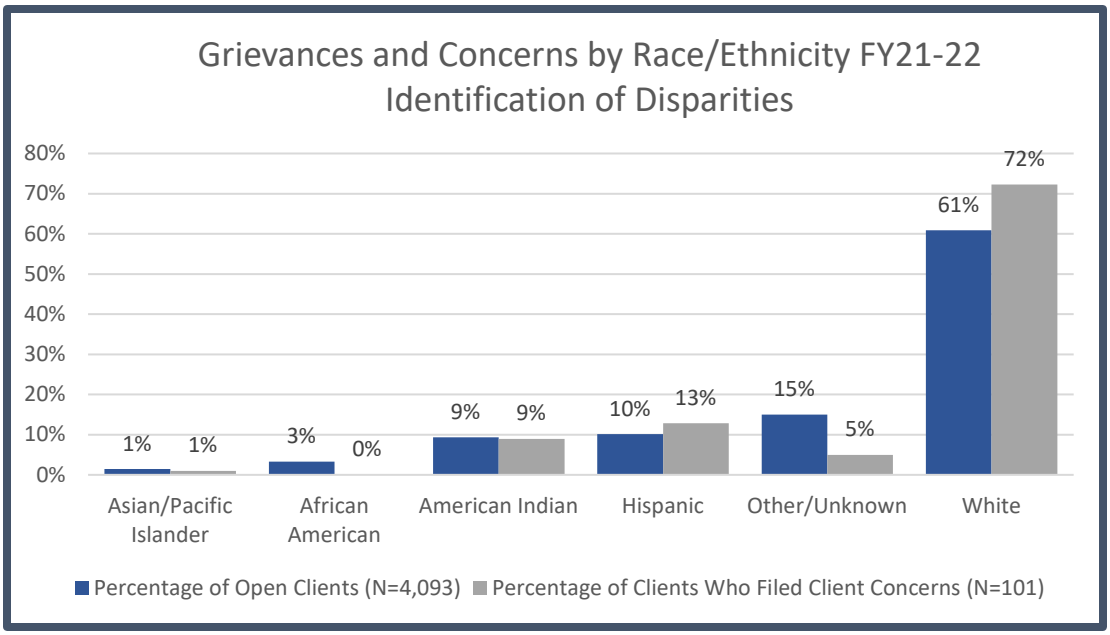
All Grievances and Concerns Disparity Analysis

In this section, client demographic data of unique beneficiaries with an open episode in FY 21-22 (N=4,093) are compared to the number of unique clients who filed grievances and concerns including requests for second opinion and request for change of provider in FY 20-21 (N=101). The data sources for this analysis are same as above. All concerns were resolved according to protocol.

Race/Ethnicity	Unique Clients Who Filed Grievances	Percentage
African American	0	0%
Asian/Pacific Islander	1	1%
Other/Unknown	5	5%
American Indian	9	9%
Hispanic	13	13%
White	73	72%
Total	101	100%



Race/Ethnicity	Percentage of Open Clients (N=4,093)	Percentage of Clients Who Filed Client Concerns (N=101)
Asian/Pacific Islander	1%	1%
African American	3%	0%
American Indian	9%	9%
Hispanic	10%	13%
Other/Unknown	15%	5%
White	61%	72%
Total	100%	100%



A total of 101 grievances and concerns were filed. Seventy-two percent of grievances were filed by Whites, and 13% were filed by Hispanics. American Indians and Asian/Pacific Islander were equally represented at 9% and 1% respectively. African Americans were underrepresented with no grievances or concerns reported. Lastly Other/Unknown were underrepresented at 5% in comparison to their population size in the Behavioral Health system of care.

This analysis shows that White is overrepresented in having grievances and concerns in relation to their population size in the system of care. For Hispanic, there is only a 3% difference in having grievances and concerns in relation to the population size in the system of care. However, none of these grievances and concerns were related to cultural appropriateness, so no firm conclusions can be drawn from this analysis. Of note is the trend shows an increase in the number of grievances (74 in FY21-22) despite being in a decline previously (50 in FY 20-21). However, overall concerns stayed the same at 101. The increases in Grievances were in the areas or Quality of Care and Change of Providers.

The trainings and efforts of the Racial Equity Steering Committee, and the new Behavioral Health Cultural Awareness training, may lead to increased awareness of implicit bias and cultural sensitivity and may have an impact on the slight disparities observed regarding grievances and concerns. This data will continue to be monitored over time.

Attachments

Attachment 2:Policy 100.603 Selection of Interpreters

Attachment 3: Policy 100.604 Access to Interpreters and Culturally and Linguistically Competent Providers

Attachment 4: Policy 100.605 Obtaining Interpretation, Translation and Telephone Services for Clients with Physical Impairments or Limited English Proficiency

Attachment 5: Policy 100.606 Speech to Speech Relay Service

Attachment 6: Policy 100.607 Text Telephone (TTY) Use

Attachment 7: Policy 100.608 Access to Interpreter Services – Language Line Use

Attachment 8: Policy 100.617 Translation of Written Materials

Attachment 9: Policy 0100.150 Racial and Cultural Equity in Behavioral Health

Attachment 10: Policy 0100.151 Racial and Cultural Equity Document Review in Behavioral Health

Attachment 11: Policy 0100.152 Racial and Cultural Equity Buget Review in Behavioral Health