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Criterion 1: Commitment to Cultural Competence

I. County Mental Health System Commitment to Cultural Competence

Humboldt County Department of Health and Human Services (DHHS) Mental Health is committed to the provision of culturally competent services which are effective, equitable, understandable, respectful and responsive to diverse cultural health beliefs and practices. At DHHS Mental Health, services are delivered in a consumer’s preferred language with attention to health literacy and other communication needs. Delivery of these elements does not happen by accident but rather develops through a well thought out plan of action. It is with this in mind that the Cultural Competence Plan (CCP) is developed. Because this plan covers a behavioral health department, it is important to combine the Cultural and Linguistic Standards (CLAS) required by Substance Abuse programs with the Department of Health Care Services (DHCS) Standards required for Mental Health Programs (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. DHHS Mental Health is the only local agency responsible for responding to psychiatric crises in the community, providing emergency psychiatric services and inpatient psychiatric services.

DHHS’s Commitment to Cultural Competence 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 living better lives
- DHHS Mental 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.

- DHHS Mental Health Cultural Competence Committee: Discussed in Criterion 4
- Community Outreach, Engagement and Involvement
- Policies, Procedures, and Practices. Several policies and procedures address cultural competence 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.

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

Humboldt County DHHS Mental 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 mental 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 Mental Health sponsored education and planning meetings. These are widely advertised meetings inviting people to gather to discuss mental health services. The stakeholder meetings held in the process of updating the Mental Health Services Act (MHSA) Three Year Plan Update are an example of this, where the MHSA Coordinator sponsored community stakeholder meetings.

- DHHS Mental Health participation in existing community meetings where mental health services, education, and planning are discussed. These are meetings sponsored by local community-based organizations and associations that represent and/or serve diverse stakeholders. In these instances a Mental Health staff person attends and requests that mental 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 comes in this way.
Participants reflect the diversity of Humboldt County, including individuals with client and family member experience, current and former foster youth, transition age youth, DHHS administration, providers with program, and direct service experience, community-based and organizational providers of local public health, behavioral health, social services, vocational rehabilitation services, and agencies that serve and/or represent diverse racial and ethnic groups, unserved/underserved, Native American, and rural communities.

Below are examples of stakeholder entities with which DHHS Mental 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 Mental Health organizational providers
- Humboldt Allies for Substance Use Prevention
- Behavioral Health Board
- Youth Advisory Board
- Open Door Clinics
- K’ima:W Medical Clinic
- DHHS Employee Services
- DHHS Public Health
- DHHS Social Services
- DHHS Employment Training Division

Community outreach, engagement and involvement is clearly demonstrated in the Mental Health Services Act (MHSA) stakeholder process. From 2008 through February 2018\(^1\), 821 people have participated in Mental Health Services Act (MHSA) stakeholder activities. Of these, 67% provided demographic information. The following tables reflect this demographic data.

<table>
<thead>
<tr>
<th>Location</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Humboldt</td>
<td>28%</td>
</tr>
<tr>
<td>Eureka</td>
<td>35%</td>
</tr>
<tr>
<td>Eel River Valley</td>
<td>11%</td>
</tr>
<tr>
<td>Southern Humboldt</td>
<td>9%</td>
</tr>
</tbody>
</table>

\(^1\) MHSA community planning process data, 2008-2018. Tables and charts on this and the following three pages reflect data gathered from demographic forms collected during the planning process.
As the chart below illustrates, and as described here, the percentage of stakeholder participation for Hispanic/Latino and American Indian/Alaska Native is greater than that of Humboldt County’s general population. Hispanic/Latino stakeholders were 14% of participants as compared to 10% of the general population, and American Indian/Alaska Native were 11% as compared to 5% of the general population. For Black/African American the participation was the same as the general population, at 1% each. For Asian/Pacific Islander, the participation was the same as the general population, at 2% each. For Multiracial/Other, MHSA stakeholder participation was 2% as compared to 4% of the general population.

<table>
<thead>
<tr>
<th>Location</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Humboldt</td>
<td>6%</td>
</tr>
<tr>
<td>Unknown</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>68%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>14%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>1%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>11%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 Years Old</td>
<td>0%</td>
</tr>
<tr>
<td>16-25 Years Old</td>
<td>8%</td>
</tr>
<tr>
<td>26-59 Years Old</td>
<td>71%</td>
</tr>
<tr>
<td>60+ Years Old</td>
<td>21%</td>
</tr>
</tbody>
</table>
Individuals who identified as American Indian or Alaska Native represented 15 separate tribes. These tribes are Anishnabee, Chumash, Karuk/Yurok, Wiyot/Tolowa, Cherokee, Hupa, Navajo, Yurok, Chickasaw, Hupa/Yurok, Ponca Sioux, Choctaw, Karuk, and Sioux-Modoc. The greatest number of participants were from the local Hupa, Karuk, Wiyot, Tolowa and Yurok tribes (50%).

Community members that provided input and reported that Spanish is their primary language was 6%. One percent reported Other Language. Spanish is the County’s only Threshold Language with almost 6% of Medi-Cal beneficiaries reporting that Spanish is their primary 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, 8% of those providing input are transition age youth, with 72% reporting being adults between ages 26-59, and 20% being older adults age 60 and over.

Community members who provide input and have lived experience as clients of mental 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. Nineteen percent of those participating in the stakeholder process were diagnosed with a serious mental illness. Fifty percent were family members of those who have been diagnosed with a serious mental illness.

The LGBTQ community, people who have experienced homelessness, the justice system or child welfare services are also tracked as they are traditionally underserved populations. Those whose primary language is Spanish or who have military service are also identified. As the chart below shows, 20% of stakeholders identify as LGBTQ. Twenty-five percent had experience with homelessness, 43% had experience with the justice system, 26% had experience with the child welfare system, 6% stated Spanish is their primary language, and 4% had military experience.
III. Designated Cultural Competence/Ethnic Services Manager

The duties and responsibilities of the DHHS Mental Health Cultural Competence/Ethnic Service Manager are overseen by the Mental Health Director. It is the responsibility of both the Cultural Competence/Ethnic Service Manager and the Mental 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 Manager:

- Is a member of the DHHS Mental Health Management Team
- Is a member of and co-facilitator for the Mental Health Cultural Competence Committee
- Facilitates provision of cultural competence training to mental health staff
- Facilitates broad and diverse stakeholder representation in the program planning process
- Oversees 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, when they occur
- Is a member of the California Behavioral Health Directors Association (CBHDA) Cultural Competency, Equity, and Social Justice Committee (CCESJC), and participates in conference calls and meetings, when they occur

IV. Budget Resources for Cultural Competence Activities

DHHS 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 program activities are specifically funded services to culturally diverse groups:

- Humboldt County Transition Age Youth Collaborative (HCTAYC)
- Homeless Outreach
- Rural Outreach

Department wide services include:

- Cultural competency 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 mental health services
• Compensation for culturally and linguistically competent providers and non-traditional providers/healers
Criterion 2: Updated Assessment of Service Needs

I. General Population

Five percent of residents are Native American, 2% are Asian/Pacific Islander, 1% are African American, 77% are White, 10% are Hispanic/Latino, and 4% are multiracial or other.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Residents who are foreign born are approximately 5.5% of the population. Approximately half of those who are foreign born are naturalized citizens. In addition, approximately half of those foreign born are from Latin and North America.

<table>
<thead>
<tr>
<th>Foreign Born Population by Region of Birth</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>1,330</td>
<td>18%</td>
</tr>
<tr>
<td>Asia</td>
<td>2,002</td>
<td>27%</td>
</tr>
<tr>
<td>Africa</td>
<td>22</td>
<td>.03%</td>
</tr>
<tr>
<td>Oceana</td>
<td>178</td>
<td>3%</td>
</tr>
<tr>
<td>Latin America</td>
<td>3,423</td>
<td>47%</td>
</tr>
<tr>
<td>North America</td>
<td>385</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,340</td>
<td>100%</td>
</tr>
</tbody>
</table>

Residents who do not speak English at home are 8% of the population. Of those who do not speak English at home, 36% (4% of total population) do not speak English “very well”.

---

Of the residents who are 25 years and older, 90% are high school graduates and 26% have a bachelor’s degree or higher. Approximately 1% of residents are grandparents who are responsible for their grandchildren. Fifty percent of the population is female and 50% is male. Median family income is $30,830. The median income for full time workers is $42,014 and for female full-time workers it is $34,652.

### Language

<table>
<thead>
<tr>
<th>Language</th>
<th># speaking</th>
<th>% speaking</th>
<th># speaking “not well”</th>
<th>% speaking “not well”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>6,904</td>
<td>5%</td>
<td>4,294</td>
<td>3%</td>
</tr>
<tr>
<td>Other Indo-European</td>
<td>2,586</td>
<td>2%</td>
<td>577</td>
<td>.5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1,726</td>
<td>1%</td>
<td>856</td>
<td>.5%</td>
</tr>
<tr>
<td>Total</td>
<td>11,216</td>
<td>8%</td>
<td>5,727</td>
<td>4%</td>
</tr>
</tbody>
</table>

II. Medi-Cal Population and Client Utilization

The following table shows the average number of Humboldt County Medi-Cal recipients per month and their percentage of the total population, as well as Client Utilization without and with Medi-Cal in Calendar Year 2016. The data source for most of these data is Behavioral Health Concepts (BHC), Mental Health’s External Quality Review Organization. BHC did not have data about primary language however, so another system, C-IV, had to be used to obtain information on primary language. C-IV data for 2016 show a different total number for the Medi-Cal population.
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Medi-Cal #³</th>
<th>Medi-Cal %</th>
<th>Utilization # with &amp; without Medi-Cal⁴</th>
<th>Utilization % with &amp; without Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native</td>
<td>4,323</td>
<td>8%</td>
<td>188</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>2,288</td>
<td>4%</td>
<td>43</td>
<td>1%</td>
</tr>
<tr>
<td>African American</td>
<td>989</td>
<td>2%</td>
<td>82</td>
<td>3%</td>
</tr>
<tr>
<td>White</td>
<td>33,701</td>
<td>61%</td>
<td>2,121</td>
<td>61%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>6,815</td>
<td>12%</td>
<td>432</td>
<td>12%</td>
</tr>
<tr>
<td>Multiracial/ Other</td>
<td>7,292</td>
<td>13%</td>
<td>641</td>
<td>18%</td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,507</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Medi-Cal # ⁵</th>
<th>Medi-Cal %</th>
<th>Utilization # with &amp; without Medi-Cal⁶</th>
<th>Utilization % with &amp; without Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>55,362</td>
<td>95%</td>
<td>3,308</td>
<td>94%</td>
</tr>
<tr>
<td>Spanish</td>
<td>2616</td>
<td>5%</td>
<td>64</td>
<td>2%</td>
</tr>
<tr>
<td>Hmong</td>
<td>310</td>
<td>&lt;1%</td>
<td>20</td>
<td>1%</td>
</tr>
<tr>
<td>Lao</td>
<td>21</td>
<td>&lt;1%</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>221</td>
<td>&lt;1%</td>
<td>114</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>58,530</td>
<td>100%</td>
<td>3,507</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Medi-Cal #⁷</th>
<th>Medi-Cal %</th>
<th>Utilization # with &amp; without Medi-Cal⁸</th>
<th>Utilization % with &amp; without Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>28,323</td>
<td>51%</td>
<td>1,681</td>
<td>48%</td>
</tr>
<tr>
<td>Male</td>
<td>27,083</td>
<td>49%</td>
<td>1,825</td>
<td>52%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,507</td>
<td>100%</td>
</tr>
</tbody>
</table>

³ Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2016.
⁴ Humboldt County Mental Health Avatar Electronic Health Records.
⁵ C-IV Ad-Hoc Report for Calendar Year 2016
⁶ Humboldt County Mental Health Avatar Electronic Health Records.
⁷ Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2016.
⁸ Humboldt County Mental Health Avatar Electronic Health Records.
An analysis of disparities for those in the County with Medi-Cal versus those that are served by the Humboldt County Department of Health and Human Services Mental Health is confounded by the number of individuals without Medi-Cal who utilize emergency services or are seen for a one-time assessment. An analysis of disparities for those in the County with Medi-Cal versus those that are served by the Humboldt County Department of Health and Human Services Mental Health with Medi-Cal provides a more accurate comparison to determine disparities. This is shown in the table below, which sets forth the Medi-Cal Population and Client Utilization with Medi-Cal for Race/Ethnicity. The remainder of this section focuses on utilization data from those clients with Medi-Cal, with the exception of language.

<table>
<thead>
<tr>
<th>Ages</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Utilization # with &amp; without Medi-Cal</th>
<th>Utilization % with &amp; without Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>6,329</td>
<td>11%</td>
<td>107</td>
<td>3%</td>
</tr>
<tr>
<td>6-17</td>
<td>11,026</td>
<td>20%</td>
<td>986</td>
<td>28%</td>
</tr>
<tr>
<td>18-59</td>
<td>32,363</td>
<td>58%</td>
<td>2,096</td>
<td>60%</td>
</tr>
<tr>
<td>60+</td>
<td>5,689</td>
<td>10%</td>
<td>318</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,507</td>
<td>100%</td>
</tr>
</tbody>
</table>

Humboldt County’s Penetration Rate as compared to other small counties and to the State of California in the category of race/ethnicity is presented in the chart below.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Utilization # with Medi-Cal</th>
<th>Utilization % with Medi-Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>4,323</td>
<td>8%</td>
<td>223</td>
<td>7%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2,288</td>
<td>4%</td>
<td>54</td>
<td>2%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>989</td>
<td>2%</td>
<td>69</td>
<td>2%</td>
</tr>
<tr>
<td>White</td>
<td>33,701</td>
<td>61%</td>
<td>1,920</td>
<td>64%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>6,815</td>
<td>12%</td>
<td>245</td>
<td>8%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>7,292</td>
<td>13%</td>
<td>489</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

9 Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2016.
10 Humboldt County Mental Health Avatar Electronic Health Records.
Humboldt County’s penetration rate for Native Americans with Medi-Cal receiving services to Native American residents with Medi-Cal is 5%. For other small counties the penetration rate is 5% and statewide it is 7%. There is a slight disparity in that 7% of clients with Medi-Cal served are Native American while 8% of residents with Medi-Cal are Native American. This could be due to the 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. Another cause for this disparity 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. They reside on tribal lands, rural unincorporated, and incorporated areas. A number are very traditional and, while others know that they are Indian, they may not be as traditional and the identification isn’t as strong. 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 2% penetration rate for Asian/Pacific Islanders, which is the same for other small counties and statewide. Asian/Pacific Islanders with Medi-Cal are 2% of clients served while 4% of residents with Medi-Cal are Asian/Pacific Islander. One cause for this disparity is linguistic access. According to 2000 census data, approximately half of Asian/Pacific Islander residents speak another 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. Another cause for the disparity 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 is a lack of knowledge about mental health services and many families are hesitant to use them because of a lack of understanding about what counseling and other mental health services are, since sometimes there is no equivalent in their countries of origin.

There is a 7% penetration rate in Humboldt County for African Americans as compared to 8% for other small counties and Statewide. The percentage of clients served with Medi-Cal and residents with Medi-Cal is the same for African Americans at 2%. While there is no apparent disparity, 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% in Humboldt County, 6% small counties and 6% statewide. White clients served with Medi-Cal are over represented at 64% while only 61% of residents with Medi-Cal are White.

The penetration rate for Hispanic/Latinos is 4% in Humboldt County, 4% for small counties and 3% statewide. Hispanic/Latinos with Medi-Cal are 8% of clients served while 12% of residents with Medi-Cal are Hispanic/Latino. One cause for this disparity is linguistic access. Approximately 66% speak Spanish at home and 26% speak English less than “very well.” Approximately 61% of Hispanic/Latinos with Medi-Cal have a primary language of Spanish which is 5.58% of those with Medi-Cal, which meets the 5% threshold criteria. Another cause for the disparity could be the varying levels of acculturation and a lack of knowledge about available services. Some Hispanic/Latino families do not always 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 is also a barrier. Some are often resistant to receiving mental health services because they believe that mental illness is shameful. Another cause 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 7% penetration rate for Multiracial/Other as compared to 7% for other small counties and 6% statewide. Multiracial/Other clients with Medi-Cal are 16% of clients served while 13% of residents with Medi-Cal are Multiracial/Other. This is a disparity.

**Humboldt County Medi-Cal Population and Client Utilization with and without Medi-Cal for Language**

As already discussed, BHC’s data did not include primary language. Thus the comparison was
made between utilization of clients with and without Medi-Cal with data from Avatar Electronic Health Records, and the Medi-Cal population data in the C-IV system. This information is presented in the chart on page 14.

**Humboldt County Medi-Cal Population and Client Utilization with Medi-Cal for Age**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Utilization #</th>
<th>Utilization %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>6329</td>
<td>11%</td>
<td>104</td>
<td>3%</td>
</tr>
<tr>
<td>6-17</td>
<td>11,026</td>
<td>20%</td>
<td>940</td>
<td>31%</td>
</tr>
<tr>
<td>18-59</td>
<td>32,363</td>
<td>58%</td>
<td>1,723</td>
<td>58%</td>
</tr>
<tr>
<td>60+</td>
<td>5689</td>
<td>10%</td>
<td>233</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

Humboldt County’s penetration rate for ages 0-5 is 2%, for other small counties the average is 1% and statewide it is 2%. There is a disparity with 3% of ages 0-5 with Medi-Cal served, while they are 11% 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 for this disparity is 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 is another cause. Families may interpret mental health symptoms as bad behavior that requires stronger discipline rather than mental health services. Another cause is the ability to access services including the hours services are available and transportation to locations where services are provided.

There is a 9% penetration rate for children and youth age 6-17 as compared to 7% for other
small counties and 6% statewide. Ages 6-17 are 31% of clients with Medi-Cal served while 20% of residents in the county with Medi-Cal are in this age group. Thus 13% 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%, the same percentage as for other small counties and Statewide. Adults in this group are 58% of clients with Medi-Cal served and 58% of residents in the county with Medi-Cal.

There is a 4% penetration rate for Adults ages 60+ as compared to 3% for other small counties and 3% Statewide. A disparity exists for Adults ages 60+ with 8% of clients served with Medi-Cal in this age group, while 10% of residents in the county with Medi-Cal are in this age group. One cause for this disparity 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 mate 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\(^{11}\) for Sex/Gender

<table>
<thead>
<tr>
<th>Sex/Gender</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Utilization #</th>
<th>Utilization %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>28,323</td>
<td>51%</td>
<td>1,452</td>
<td>48%</td>
</tr>
<tr>
<td>Male</td>
<td>27,083</td>
<td>49%</td>
<td>1,548</td>
<td>52%</td>
</tr>
<tr>
<td>Total</td>
<td>55,405</td>
<td>100%</td>
<td>3,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^{11}\) Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2016.
Humboldt County’s penetration rate for Females with Medi-Cal receiving services compared to residents who are Female with Medi-Cal is 5%, for other small counties the average is 5% and statewide it is 4%. There is a 6% penetration rate for Males as compared to 5% for other small counties and 5% 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 are Male while 49% of residents in the county with Medi-Cal are Male.

III. 200% of Poverty

This category is not analyzed for the current update.
IV. MHSA Community Services and Supports (CSS)

The MHSA CSS client data represents a subset of the Client Utilization data for those clients who are receiving services in an MHSA CSS funded program. This data is confounded at times because it reflects the people participating in a CSS program rather than those people that are served through alternative funding.

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.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>CSS #</th>
<th>CSS %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>109</td>
<td>9%</td>
<td>4,323</td>
<td>8%</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>13</td>
<td>1%</td>
<td>2,288</td>
<td>4%</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>African American/ Black</td>
<td>39</td>
<td>3%</td>
<td>989</td>
<td>2%</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>946</td>
<td>76%</td>
<td>33,701</td>
<td>61%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>101</td>
<td>8%</td>
<td>6,815</td>
<td>12%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/ Other</td>
<td>42</td>
<td>3%</td>
<td>7,292</td>
<td>13%</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>1250</td>
<td>100%</td>
<td>55,405</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Native Americans make up 9% of CSS clients, 8% of those with Medi-Cal and 5% of the general population. Asian/Pacific Islanders make up 1% of CSS clients, 4% of those with Medi-Cal and 2% of the general population. African Americans make up 3% of CSS clients,
2% of those with Medi-Cal and 1% of the general population. Whites make up 76% of CSS clients, 61% of those with Medi-Cal and 77% of the general population. Hispanic/Latinos make up 8% of CSS clients, 12% of those with Medi-Cal and 10% of the general population. Multiracial/Other make up 3% of CSS clients, 13% of those with Medi-Cal and 4% of the general population.

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>MHSA CSS #</th>
<th>MHSA CSS %</th>
<th>Medi-Cal Population #</th>
<th>Medi-Cal Population %</th>
<th>General Population #</th>
<th>General Population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>1031</td>
<td>82%</td>
<td>55,362</td>
<td>95%</td>
<td>123,407</td>
<td>92%</td>
</tr>
<tr>
<td>Spanish</td>
<td>6</td>
<td>&lt;1%</td>
<td>2616</td>
<td>5%</td>
<td>6,904</td>
<td>5%</td>
</tr>
<tr>
<td>Hmong</td>
<td>3</td>
<td>&lt;1%</td>
<td>310</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Lao</td>
<td>0</td>
<td>0%</td>
<td>21</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>210</td>
<td>17%</td>
<td>221</td>
<td>&lt;1%</td>
<td>4,312</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>1250</td>
<td>100%</td>
<td>58,530</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Those whose primary language is English make up 82% of CSS clients, 95% of the Medi-Cal population, and 92% of the general population. Those whose primary language is Spanish make up <1% of CSS clients, 5% of the Medi-Cal population, and 5% of the general population. Those whose primary language is Hmong make up <1% of CSS clients, <1% of Medi-Cal clients, and 0% of the general population. Those whose primary language is Lao make up 0% of CSS clients, <1% of the Medi-Cal population, and 0% of the general population. Other or Unknown make up 17% of CSS clients, <1% of the Medi-Cal population, and 3% of the general population.

<table>
<thead>
<tr>
<th>Ages</th>
<th>CSS #</th>
<th>CSS %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>3</td>
<td>1%</td>
<td>6,392</td>
<td>11%</td>
<td>22,304</td>
<td>17%</td>
</tr>
<tr>
<td>6-17</td>
<td>168</td>
<td>13%</td>
<td>11,026</td>
<td>20%</td>
<td>21,409</td>
<td>16%</td>
</tr>
<tr>
<td>18-59</td>
<td>740</td>
<td>59%</td>
<td>32,363</td>
<td>58%</td>
<td>64,151</td>
<td>48%</td>
</tr>
<tr>
<td>60+</td>
<td>339</td>
<td>27%</td>
<td>5,689</td>
<td>10%</td>
<td>26,759</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>1250</td>
<td>100%</td>
<td>55,405</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Ages 0-5 make up 1% of CSS clients, 11% of those with Medi-Cal and 17% of the general population. Ages 6-17 make up 13% of CSS clients, 20% of those with Medi-Cal and 16% of the general population. Ages 18-59 make up 59% of CSS clients, 58% of those with Medi-Cal and 48% of the general population. Ages 60+ make up 27% of CSS clients, 10% of those with Medi-Cal and 20% of the general population.

<table>
<thead>
<tr>
<th>Sex/Gender</th>
<th>CSS #</th>
<th>CSS %</th>
<th>Medi-Cal</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>602</td>
<td>48%</td>
<td>28,323</td>
<td>51%</td>
<td>67,028</td>
<td>50%</td>
</tr>
</tbody>
</table>
Females make up 48% of CSS clients, 51% of those with Medi-Cal and 50% of the general population. Males make up 52% of CSS clients, 49% of those with Medi-Cal and 50% of the general population.

V. MHSA Prevention and Early Intervention (PEI)\textsuperscript{12}

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 relatively small number who fully complete a demographic form. Some people may only complete some of the nine categories of demographic form questions. The data reflects the people participating in a PEI activity rather than those people that may be served as a mental health client.

PEI programs have 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. The tables and charts below reflect the data currently available. Because there are so many “unknowns” this data should not be used to make determinations about disparities.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>PEI #</th>
<th>PEI %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>187</td>
<td>4%</td>
<td>4,323</td>
<td>8%</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>76</td>
<td>2%</td>
<td>2,288</td>
<td>4%</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>African American/ Black</td>
<td>43</td>
<td>1%</td>
<td>989</td>
<td>2%</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>2,369</td>
<td>51%</td>
<td>33,701</td>
<td>61%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>666</td>
<td>14%</td>
<td>6,815</td>
<td>12%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/ Other</td>
<td>305</td>
<td>7%</td>
<td>7,292</td>
<td>13%</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1022</td>
<td>21%</td>
<td>55,405</td>
<td>100</td>
<td>134,623</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>4668</td>
<td>100%</td>
<td>55,405</td>
<td>100</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

\textsuperscript{12} Humboldt County Department of Health and Human Services, MHSA Prevention and Early Intervention spreadsheets and reports, FY 2016-17.
Native Americans make up 4% of PEI participants, 8% of the Medi-Cal population, and 5% of the general population. Asian/Pacific Islanders make up 2% of PEI participants, 4% of the Medi-Cal population, and 2% of the general population. African Americans make up 1% of PEI participants, 2% of the Medi-Cal population, and 1% of the general population. Whites make up 51% of PEI participants, 61% of the Medi-Cal population, and 77% of the general population. Hispanic/Latinos make up 14% of PEI participants, 12% of the Medi-Cal population, and 10% of the general population. Multiracial/other make up 7% of PEI participants, 13% of the Medi-Cal population, and 4% of the general population. For 21% of PEI participants, Race/Ethnicity was not captured.

**Primary Language**

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>PEI #</th>
<th>PEI %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>3158</td>
<td>68%</td>
<td>55,362</td>
<td>95%</td>
<td>123,407</td>
<td>92%</td>
</tr>
<tr>
<td>Spanish</td>
<td>503</td>
<td>11%</td>
<td>2616</td>
<td>5%</td>
<td>6,904</td>
<td>5%</td>
</tr>
<tr>
<td>Hmong</td>
<td>9</td>
<td>&lt;1%</td>
<td>310</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Lao</td>
<td>0</td>
<td>0%</td>
<td>21</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>&lt;1%</td>
<td>221</td>
<td>&lt;1%</td>
<td>4,312</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>981</td>
<td>21%</td>
<td></td>
<td></td>
<td>134,623</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>4668</td>
<td>100%</td>
<td>58,530</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Those whose primary language is English make up 68% of PEI participants, 95% of the Medi-Cal population, and 92% of the general population. Those whose primary language is Spanish make up 11% of PEI participants, 5% of the Medi-Cal population, and 5% of the general population.
Those whose primary language is Hmong or Lao make up less than 1% of PEI participants and Medi-Cal participants. Those whose primary language is other make up <1% of PEI participants and 3% of the general population. For 21% of PEI participants Primary Language was not captured.

**Age**

PEI Programs 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. In addition, for 21% of PEI participants Age was not captured.

<table>
<thead>
<tr>
<th>Ages</th>
<th>PEI #</th>
<th>PEI %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-5 (Medi-Cal)</td>
<td></td>
<td></td>
<td>6,329</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children 0-15 (MHSA)</td>
<td>3393</td>
<td>73%</td>
<td>22,304</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children 6-17 (Medi-Cal)</td>
<td></td>
<td></td>
<td>11,026</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Age Youth 16-25 (MHSA)</td>
<td>76</td>
<td>2%</td>
<td>3,850</td>
<td>14%</td>
<td>21,409</td>
<td>16%</td>
</tr>
<tr>
<td>Adults 18-59 (Medi-Cal)</td>
<td></td>
<td></td>
<td>32,363</td>
<td>58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults 26-29 (MHSA)</td>
<td>181</td>
<td>4%</td>
<td>13,742</td>
<td>48%</td>
<td>64,151</td>
<td>48%</td>
</tr>
<tr>
<td>Older Adults 60+ (MHSA and Medi-Cal)</td>
<td>35</td>
<td>&lt;1%</td>
<td>5,689</td>
<td>10%</td>
<td>26,759</td>
<td>20%</td>
</tr>
<tr>
<td>Not stated/Unknown</td>
<td>983</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4668</td>
<td>100%</td>
<td>55,405</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Sex/Gender**

Because sex/gender is unknown for 94% of PEI participants, valid comparisons cannot be made.

<table>
<thead>
<tr>
<th>Sex/Gender</th>
<th>PEI #</th>
<th>PEI %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>202</td>
<td>4%</td>
<td>28,323</td>
<td>51%</td>
<td>67,028</td>
<td>50%</td>
</tr>
<tr>
<td>Male</td>
<td>88</td>
<td>2%</td>
<td>27,083</td>
<td>49%</td>
<td>67,595</td>
<td>50%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>&lt;1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unknown</td>
<td>4368</td>
<td>94%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4668</td>
<td>100%</td>
<td>55,405</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>
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.

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 relatively 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.

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. The tables and charts presented in Criterion 2 reflect the data currently available. Because there are so many “unknowns” this data was not used to make determinations about disparities.

II. Disparities in each of the populations

Medi-Cal Population (CY 2016 data). There is a disparity in serving Native Americans, Asian/Pacific Islanders, and Hispanic/Latino populations. There is a disparity for serving children ages 0-5 and those age 60+. There is a disparity in serving those whose primary language is not English. There is no data available on the LBGTQIA Medi-Cal population to identify disparities.

MHSA Community Services and Supports (CY 2016 data). There is a disparity in serving Asian/Pacific Islanders, Hispanic/Latinos, and Multi-racial populations. There is a disparity in serving children ages 0-5 and in serving children 6-17. There is a disparity in serving those whose primary language is not English. There is no data available on the LBGTQIA Medi-Cal population to identify disparities.

Workforce Education and Training (April 2018 data). When compared to the client population served, it is apparent that Whites are overrepresented in the Mental Health workforce, and all other racial/ethnic categories in the workforce are underrepresented. When the workforce is compared to the general population, however, disparities are not present for Native Americans, African Americans, or Multi-racial/Other. The greatest disparity is for Hispanic/Latino, where 10% of the general population is Hispanic/Latino as compared to the workforce at 6%. For Asian Americans, 2% of the general population is Asian American as compared to 1% of the workforce.
Prevention and Early Intervention (FY 2016-17 data). As already stated, there are so many "unknowns" in the PEI data that it was not used to make determinations about disparities.

III. Strategies for the reducing those disparities

**Strategies for the next three years** are listed below. Their details are found in the narrative following.
1. Mental Health staff training
2. Mental Health Cultural Competence Committee Projects
3. MHSA Local Implementation Agreements
4. MHSA Making Relatives Program
5. Collaboration with organizations serving the 0-5 population
6. Improve data collection for LGBTQIA populations
7. Continue existing, successful strategies in all programs and services

**Strategies addressing race/ethnicity disparities.** Strategies for the next three years include the following:
1. Staff trainings that are inclusive and bring a culturally diverse perspective to staff, including when appropriate attendance by community members and groups.
   a. Leaders from DHHS, Mental Health, Public Health and Social Services will be attending the Racial Equity Consulting and Organizational Change Intensive in Fall 2018. This Intensive is sponsored by The Equity Alliance of the North Coast. DHHS leaders are the Directors and Deputy Directors of the agency as a whole and its programs, and will include additional key staff. The Intensive will focus on increasing the ability of anyone in a consulting role to have their expertise fully utilized and their recommendations implemented with a racial equity lens. After the Intensive, DHHS leaders will develop a plan for increasing training and other activities that increase cultural competence in the agency.
   b. Planning has started for bringing a racial equity training, which will be conducted by The Equity Alliance of the North Coast, to Mental Health staff in the Spring of 2019. This training will focus on reducing racial bias in service delivery, and will be informed by the information and learning obtained by Department leaders as well as through meetings with Mental Health line staff.
   c. Mandatory annual cultural competence training through the Relias E-Learning system will continue, as will the mandatory annual interpreter and language line trainings.
   d. The Cultural Competence Committee will research and/or develop additional trainings on Client Culture/Working with the Clients Served that includes a client’s personal experience, inclusive of racial, ethnic, cultural and linguistic communities. One such training is in the initial planning stages at this time.
   e. The Cultural Competence Committee will research and/or develop training that includes parent/caretaker personal experiences with family focused treatment, navigating multiple agency services, and resiliency.
2. Cultural Competence Committee projects. During the past few months the Cultural Competence Committee developed a Recommendation Form that is proving to be a valuable tool for moving projects forward. Now when a cultural competence project is suggested there is a form that can be completed and forwarded to the Quality Improvement Coordinator and then the Mental Health Director for approval. The Recommendation Form has been used twice so far. One of the recommendations, a Latino Outreach Project, was approved and is in progress to develop a Spanish language PSA to be broadcast on local radio program Radio Bilingué.

3. MHSA Local Implementation Agreements. A new MHSA program for 2018/19 and 2019/20, Local Implementation Agreements, will 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. One of the funded projects, Social, Emotional, Mental Health Student Engagement, will be facilitated by the Klamath Trinity Joint Unified School District. Eighty-nine percent of the District’s students are Native American children from Hoopa, Yurok, and Karuk Tribes, and the Tsnungwe People. The Adverse Childhood Experience Study (ACES) performed with students, staff and community members indicates that 70.6% have an ACEs score of 2 or more, and 31.4% have an ACEs score or 4+. The funded project will provide education in the topics of Suicide Prevention/Self Harm, Healthy Relationships, Anger Management/Emotional Regulation, Self Esteem, Conflict Resolution, Setting Standards/Goal Setting, and Self-Advocacy/Communication.

4. MHSA Making Relatives Program. A new MHSA program for 2018/19, the Making Relatives Program brings together a consortium of four tribal organizations to create a continuum of care that is a community informed, culturally grounded, systematized approach to tribal mental health. The continuum of care will include a range of supports for mental wellness and suicide prevention in an early intervention and family supportive cultural framework for tribal youth. MHSA funding will be focused on developing the consortium and developing a foundation for the program, including one member of the consortium becoming an organizational provider for County mental health services.

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

Strategies addressing age disparities. DHHS Mental Health will continue to work closely 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 collaboration has included partnering with these groups to fund ACES Collaboration grants, to address Adverse Childhood Experiences, and grants through Measure S funding, which was county funding to address health and safety needs in the County. One of the MHSA Local Implementation Agreements will also target postpartum patients and families including toddler-ages through Open Door Community Health Centers Expansion of the Maternal Infant Dyad Implementation (MInD)-I
Project. The MInD-I Project is a quality improvement initiative created to help screen for and treat prenatal and postpartum depression, reducing mental illness symptoms and improving outcomes for mother and infant. These strategies will further the work accomplished through the Program Improvement Plan for ages 0-5, discussed further in Section V below, What’s Been Working Well.

MHSA Community Services and Supports will continue to support the Older and Dependent Adults Expansion Program. This interdisciplinary team including Social Services social workers, Public Health nurses, a psychiatrist, Mental 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. Mental health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports. In addition, one of the MHSA Local Implementation Agreements will focus on older adults. The *Dispelling Stigma: Hoarding Education, Treatment and Prevention Conference*, coordinated by the Area 1 Agency on Aging, will include a one day conference on hoarding, a self-help support group for people who hoard, a self-help support groups for families of people who hoard, and the development of a Task Force on hoarding. While people of any age can have a hoarding disorder, symptoms appear to be three times more common in older adults.

Another strategy under consideration is to continue to develop events that target specific age groups. For example, Mobile Outreach did a series of three visits through the summer of 2017 to Weitchpec, a remote community in Eastern Humboldt, organizing youth oriented activities that provided an opportunity for engagement with families and children. Mobile Outreach has also worked collaboratively with In Home Supportive Services to provide outreach to older and dependent adults. Developing outreach and events with community organizations can broaden the reach.

**Strategies addressing language disparities.** Spanish is the only non-English language that meets the threshold requirements set by DHCS. DHHS MH recognizes the need for linguistically competent care for all clients. Thus over the years, the MH Cultural Competency Committee 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. An example of one effort, the Latino Outreach Project, was presented above, under “Cultural Competence Committee Projects.” Mental Health will continue to seek ways to use media, Radio Bilingüe, and other venues to present information about mental health services to diverse populations.

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 an MHSA stakeholder meetings. These strategies will be continued over the next three years. In addition,
a stakeholder request form has been submitted to the MH Quality Improvement Unit to add language and translation services provided to each progress note for more accurate and thorough data collection.

**Strategies addressing LGBTQIA disparities.** The strategy to address this disparity is to improve data collection. Without data, we cannot determine disparities. There is no Medi-Cal data on the LBGTQIA population, and it is unknown if there will be a move at the State level to start collecting these data. OR this information. In October 2017 Humboldt County Mental Health added a custom field in the electronic health record (Avatar) client demographic screens and a new line on the paper Client Information Sheet for client gender identity. Documenting client gender in Avatar will help improve client and staff interaction and cultural compliance within DHHS Mental Health and our community. Adding a gender field will also improve data collection and help our Cultural Competence Committee make data driven decisions in choosing future projects.

For PEI Programs, data collection will improve as more PEI Programs consistently use the demographic forms that ask for detailed information on LGBTQIA participants. In addition, conversations will begin with DHHS Employee Services to see if information on gender identity can begin to be captured for the workforce.

**Strategies addressing workforce disparities.** There is a lack of racial and ethnic diversity in the mental health workforce, especially for the Latino/Hispanic population. Strategies to address this have had little success in the past as all position recruitments must go through Humboldt County Human Resources, with little control given to Mental Health or Mental Health programs. However, with a change in the leadership of County Human Resources in the past year, some of the recruitment efforts have been shared with County departments. Programs can now provide more recruitment specifications, including specific requests such as “bilingual preferred,” can modify job descriptions, and the places where advertisement for the position will be made can be suggested to increase recruitment of employees from other cultural backgrounds.

DHHS continues to recruit and hire peer coaches for positions in the Transition Age Youth Division, Mobile Outreach, Regional Services, Hope Center and Comprehensive Community Treatment.

DHHS is a registered HRSA site for student loan repayment programs and recruits through that site for diverse staff.

DHHS also partners with Humboldt State University to implement a distributed education Bachelors of Social Work and Masters of Social Work programs. This provide current county residents and human service workers a career path. The Masters of Social Work Program offers a specialty in Native American/Tribal Communities.
IV. Measurement and monitoring of activities/strategies for reducing disparities.

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

- 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
- DHCS Behavioral Health Information Systems (BHIS) Data Collection and Reporting (DCR) for MHSA CSS Full Service Partnership data
- MH Quality Improvement Dashboard Client Concerns/Grievances (by ethnicity) and Change of Provider Requests (by ethnicity and gender)
- MHSA PEI spreadsheets for PEI participant demographics
- DHHS Employee Services database
- 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 Mental Health, and have been working well, include the following:

- Interpretation and translation services with contracted interpreter/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’s 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.

- DHHS Child Welfare Services is using the Humboldt Practice Model (HPM) in working with clients. 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 Mental Health.

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 Mental Health involvement in the family teams, the Cultural Coaches are also available for coaching and support to Mental 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 Mental 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/Regional Services 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. Mobile Outreach 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. Mobile Outreach provides an integrated response with Social Services, Mental 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 Mobile Intervention Services Team also provides outreach and services to people with severe mental illness who experience homelessness.

- Providing psychiatric telemedicine services to Southern and Eastern Humboldt County residents. Telemedicine in these outlying areas provides greater access to mental health services as well as reduced cost and inconvenience to clients.

- 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. CCT offers expanded hours of operation. Nursing Care as well as Case Management services are available 7 days a week. Nurses cover the hours from 8:00am to 7:00pm and Case Managers work 8:00am to 5:00pm.
including weekends, with expanded hours on Mondays to provide a family group until 7:00pm.

- Since 2009 Mental Health has implemented a decentralized access process for its Children and Family Services (C&FS) division. Presently C&FS Clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management and Crisis Services. They are working 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 on Monday afternoons. Two Crisis Mental Health clinicians are dispatched to Emergency Rooms and Same Day Services in Eureka to evaluate minors for Crisis needs. In addition, there are two Access Clinicians work four, ten-hour days to facilitate returning phone calls after 5:00 PM.

- Cultural competence training has provided all 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.

- Education and advocacy activities provided to clients and family members through MHSA WET funds have had a very successful impact on their ability to identify and articulate their needs for culturally appropriate services.

- Children’s Mental Health just completed a Program Improvement Plan (PIP) focused on ages 0-5. The PIP study question was: Will improving staff competency in serving children ages 0-5 through participation in trainings and increased opportunity in working with the population lead to improved outcomes for the children served? While the results were inconclusive in regard to improved outcomes for children, the PIP was successful in providing additional training to interested staff members through the 0-8 Mental Health Collaborative for clinicians to increase their skills, knowledge and comfort serving children in the 0-5 age group. Four clinicians began the certification process in the Infant Preschool Family Mental Health Initiative, and play therapy as a service available through Children’s Mental Health was adopted with a dedicated play therapy room.

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

The purpose of the Mental Health Cultural Competence Committee (MHCCC), as set forth in DHHS Mental Health Policy No. 0100.305, is to promote the integration of the values, concepts, principles and practice of cultural competence as established in the Department of Health and Humboldt Services-Mental Health Cultural Competence Plan as required by the Department of Health Care Services (DHCS). The MHCCC is a subcommittee of the Quality Improvement Committee. The goals of the MHCCC are:

- Develop and maintain a broadly representative committee that is reflective of this community
- Continue to identify disparities and service needs through analyzing data
- Develop (and articulate current) culturally specific service delivery strategies
- Identify training opportunities for all staff
- 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 specific programs.

The MHCCC is composed of active members from Mental Health programs, including Administration, MHSA, Substance Use Disorders Treatment, Community Corrections Resource Center, Children’s Mental Health and the Transition Age Youth Division. There are active community members on the committee, including from the Humboldt County Transitional Age Youth Collaboration, the National Alliance on Mental Illness, and a community member with lived experience. In addition to the active members there are approximately twenty other staff members who are unable to attend meetings, but are on the distribution list to receive information about MHCCC activities. The MHCCC meets monthly, no less than ten times each year. The MHCCC is co-facilitated by a Program Manager in the Performance Management/Quality Improvement Unit and the MHSA Coordinator/Ethnic Services Manager.

The MHSA Coordinator provides periodic MHSA updates at meetings. During the 30-day public comment periods for MHSA plans or updates, the Committee is notified and may provide comment. The Committee is also notified and members may attend the public hearing.
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 for all mental health related staff (administration, management, direct service and support staff), and organizational providers to participate in at least one cultural competency training annually.

There are almost 300 mental health related staff that need cultural competency training. Because there are few opportunities for mental health staff to participate in cultural competence training, staff will primarily obtain these trainings through the Relias E-Learning system. Staff may also travel out of the area, if there are opportunities and funding available. On occasion cultural competence trainings are provided by the Humboldt County Department of Health and Human Services, Humboldt County Office of Education, the local university, the Equity Alliance of the North Coast, LatinoNET and other community partners. If such trainings become available, some staff may be able to attend if budget and workload allows.

The Relias E-Learning system was rolled out to all of DHHS MH in February 2018. Relias has a course catalog of over 500 courses. The course catalog currently includes six cultural competence topics: Cultural Diversity (1 hour); 10 Steps to Fully Integrating Peers into your Workforce (1 hour); A Culture-centered Approach to Recovery (1 hour); Advocacy and Multicultural Care (1.5 hours); Infusion of Culturally Responsive Practices (1.75 hours); and On—Boarding and Cultural Development (1 hour). The Culture-centered Approach to Recovery course was assigned to all DHHS MH staff in fiscal year 2017-18. During the next three years, the other Relias trainings will be assigned to staff, at least one per year. Since Relias consistently updates its courses, it is anticipated that over time there will be at least one new cultural competence course per year.

In addition to the courses available in the Relias course catalog, four online trainings developed by DHHS MH have also been added to Relias. These are Role of Peer Coaches and Parent Partners in Mental Health Services; Documenting Chosen Gender Identity and Gender Expression; Introduction to Recovery Oriented Practices; and Working with Interpreters. These four training are in addition to the online training developed in 2014, Mental Health Language Line. Finally, the policy 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.

Relias will be critical to capturing the number and job classifications of participants in cultural
competence training, as it will not only provide the training but will track and report any classroom based trainings as well.

Regardless of the strategy utilized or what agency is providing the trainings, all training opportunities are well advertised through email and flyers to staff, stakeholders and community members.

2. **How cultural competence has been embedded in all trainings**
   The Humboldt County Department of Health and Human Services requests that all contracted trainings include a cultural competency component.

3. **A report list of annual training for staff with attendance by job function.**
   Over the past three years, DHHS MH staff have participated in a variety of trainings with topics focused on specific populations that are, or have been underserved or underrepresented, in the mental health system. A list of these trainings is below.

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How long and often</th>
<th>Attendance by function</th>
<th># attendees</th>
<th>Date</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing Workplace Mental Health</td>
<td>Equip managers with skills to address mental health issues in the workplace</td>
<td>6 hours, 1 time only</td>
<td>Administration Direct Services</td>
<td>3 1 Total: 4</td>
<td>4/2/15</td>
<td>Wellness Works staff</td>
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<tr>
<td>Role of Peer Coaches and Parent Partners in Mental Health Services</td>
<td>Working with staff with lived experience</td>
<td>Online</td>
<td>Administration Direct Services Support Staff</td>
<td>Unknown Unknown Total: 249</td>
<td>June 2015</td>
<td>N/A (online)</td>
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<tr>
<td>NAVIGATE IRT Training</td>
<td>Working with TAY experiencing first episode psychosis</td>
<td>11 hours, 1 time</td>
<td>Direct Services Administration</td>
<td>25 1 Total: 26</td>
<td>4/21-22/15</td>
<td>Piper Meyer, Ph.D.</td>
</tr>
<tr>
<td>NAVIGATE Family Training</td>
<td>Working with families of TAY experiencing first episode psychosis</td>
<td>10 hours, 1 time</td>
<td>Direct Services Administration</td>
<td>20 1 Total: 21</td>
<td>4/24-25/15</td>
<td>Shirley M. Glynn, Ph.D.</td>
</tr>
<tr>
<td>NAVIGATE Community Introduction</td>
<td>Session for community members to understand</td>
<td>2 hours, 1 time</td>
<td>Contract Direct Services General Public Direct Services</td>
<td>6 2 4</td>
<td>8/24/15</td>
<td>Shirley M. Glynn, Ph.D.</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>How long and often</td>
<td>Attendance by function</td>
<td># attendees</td>
<td>Date</td>
<td>Name of Presenter</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transition to Independence Process (TIP) Training</td>
<td>Working with TAY</td>
<td>7 hours, repeated twice a year under contract</td>
<td>Direct Services</td>
<td>13</td>
<td>11/16-17/15</td>
<td>Joseph Solomita, LCSW and Coral Huntsman, MFT</td>
</tr>
<tr>
<td>Cultural Training</td>
<td>Working with local American Indian tribes</td>
<td>22.5 hours, repeated every 6-12 months</td>
<td>Direct Services</td>
<td>11</td>
<td>12/1-3/15</td>
<td>Kishan Lara-Cooper, Ed.D.; Crystal Richardson; Chris Peters, MSW; Vincent Feliz, MSW</td>
</tr>
<tr>
<td>Youth Mental Health First Aid</td>
<td>Working with youth</td>
<td>4 hours, 1 time</td>
<td>Administration</td>
<td>1</td>
<td>1/28/16</td>
<td>Sarah Nelson, Kris Huschle</td>
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<tr>
<td>Working in the Culture of Trauma Informed Care</td>
<td>Working with American Indian tribes, TAY</td>
<td>6 hours, 1 time</td>
<td>Direct Services</td>
<td>5</td>
<td>2/26/16</td>
<td>Melanie Lowry MSW, Andres Castro MS, Diana Nunes Mizer, Rebecca Lowry MSW, Gillian Wadsworth, LCSW</td>
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<tr>
<td>TIP Training</td>
<td>Working with TAY</td>
<td>10 hours, repeated under contract</td>
<td>Direct Services</td>
<td>16</td>
<td>3/14-15/16</td>
<td>Joseph Solomita, LCSW and Coral Huntsman, MFT</td>
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<tr>
<td>Y.O.U.T.H. Training Project: I’m Too Sexy for my Social Worker</td>
<td>Working with TAY</td>
<td>3 hours; 1 time</td>
<td>Direct Services</td>
<td>10</td>
<td>5/6/16</td>
<td>Youth Training Project staff</td>
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<td>Documenting chosen gender identity and gender expression</td>
<td>LGBTQ</td>
<td>Online</td>
<td>Direct Services</td>
<td>73</td>
<td>June 2016</td>
<td>N/A (online)</td>
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<tr>
<td>Narrative Work with Young People and Families</td>
<td>Working with children, TAY</td>
<td>2 hours, 1 time</td>
<td>Direct Services</td>
<td>1</td>
<td>6/1/16</td>
<td>Ronnie Swartz, Ph.D.</td>
</tr>
<tr>
<td>Cultural Training</td>
<td>Working with</td>
<td>22.5</td>
<td>Direct Services</td>
<td>5</td>
<td>6/14-</td>
<td>Kishan Lara-Cooper, Ed.D.; Crystal Richardson; Chris Peters, MSW; Vincent Feliz, MSW</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>How long and often</td>
<td>Attendance by function</td>
<td># attendees</td>
<td>Date</td>
<td>Name of Presenter</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------</td>
<td>--------------------</td>
<td>-------------------------</td>
<td>-------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Crimes Against the Elderly</td>
<td>Working with the elderly</td>
<td>6 hours, 1 time</td>
<td>Direct Services</td>
<td>14</td>
<td>6/22/16</td>
<td>Paul Greenwood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Administration</td>
<td>1 Total: 15</td>
<td></td>
<td>JD</td>
</tr>
<tr>
<td>Civil Rights</td>
<td>Non-discrimination</td>
<td>1 hour, repeated yearly</td>
<td>Direct Services</td>
<td>1</td>
<td>7/12/16</td>
<td>Tanya Clark</td>
</tr>
<tr>
<td>Civil Rights</td>
<td>Non-discrimination</td>
<td>1 hour, repeated yearly</td>
<td>Direct Services</td>
<td>2</td>
<td>8/25/16</td>
<td>Tanya Clark</td>
</tr>
<tr>
<td>Trauma Informed Services</td>
<td>Working with children and TAY</td>
<td>4 hours, 1 time</td>
<td>Direct Services Administration Community Partners</td>
<td>40</td>
<td>9/14/16</td>
<td>Brent Crandal Ph.D., Al Killen-Harvey, LCSW</td>
</tr>
<tr>
<td>Children's Mental Health Summit</td>
<td>Working with children, TAY</td>
<td>12 hours, one time</td>
<td>Direct Services Administration Contract Direct Services</td>
<td>5</td>
<td>9/29-30/16</td>
<td>Rachel Talamantez, EdD, LMFT, IFECMH Specialist, RPM; Dr. Kishan Lara-Cooper; Sheri Graham-Whitt, MFT; Meg Walkley, MSW, IFECMH; Kathryn O'Malley, RN, PHN; Emi Botzler-Rodgers, MFT; Beth Heavilin, IFECMH; Michele Stephens, LCSW; Jennifer Powell, MFT</td>
</tr>
<tr>
<td>Civil Rights</td>
<td>Non-discrimination</td>
<td>1 hour, repeated yearly</td>
<td>Direct Services</td>
<td>2</td>
<td>10/20/16</td>
<td>Tanya Clark</td>
</tr>
<tr>
<td>Civil Rights</td>
<td>Non-discrimination</td>
<td>1 hour, repeated yearly</td>
<td>Direct Services</td>
<td>1</td>
<td>11/15/16</td>
<td>Tanya Clark</td>
</tr>
<tr>
<td>Cultural Training</td>
<td>Working with local American</td>
<td>22.5 hours, 1 time</td>
<td>Direct Services Contract Direct Services</td>
<td>6</td>
<td>1/17-19/17</td>
<td>Kishan Lara-Cooper, Ed.D.; Crystal Richardson; Chris Peters, MSW; Vincent Feliz, MSW</td>
</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>How long and often</td>
<td>Attendance by function</td>
<td># attendees</td>
<td>Date</td>
<td>Name of Presenter</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-----------------------------</td>
<td>-------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indian tribes</td>
<td>repeated every 6-12 months</td>
<td>Services</td>
<td>Total: 7</td>
<td></td>
<td></td>
<td>Crystal Richardson; Chris Peters, MSW; Vincent Feliz, MSW</td>
</tr>
<tr>
<td>Restorative Justice and Understanding Youth Perspectives</td>
<td>Working with TAY</td>
<td>2.5 hours, 1 time</td>
<td>Direct Service</td>
<td>6</td>
<td>3/10/17</td>
<td>Youth Training Project</td>
</tr>
<tr>
<td>Substance Use and Trauma in Families: Understanding, Strategies, and Hope</td>
<td>Working with children, TAY, families</td>
<td>6 hours, 1 time</td>
<td>Direct Service</td>
<td>12</td>
<td>3/22/17</td>
<td>Sue Grenfell, MFT</td>
</tr>
<tr>
<td>Mental Health First Aid</td>
<td></td>
<td>8 hours, 1 time</td>
<td>Direct Service</td>
<td>2</td>
<td>5/19/17</td>
<td>Robin Baker</td>
</tr>
<tr>
<td>TIP and Wraparound Training</td>
<td>Working with TAY</td>
<td>12 hours, 1 time</td>
<td>Direct Service</td>
<td>12</td>
<td>June 2017</td>
<td>Coral Huntsman, MFT</td>
</tr>
<tr>
<td>Advancing Recovery Oriented Practices</td>
<td>Client cultural understanding</td>
<td>Online</td>
<td>Direct Service Administration Support staff</td>
<td>93 16 43</td>
<td>June 2017</td>
<td>N/A (online)</td>
</tr>
<tr>
<td>Advancing Recovery Services</td>
<td>Client cultural understanding</td>
<td>Online</td>
<td>Contract Direct Services Contract Administration Contract Support staff</td>
<td>41 11 1</td>
<td>June 2017</td>
<td>N/A (online)</td>
</tr>
<tr>
<td>Working with Interpreters</td>
<td>Staff training in working with interpreters</td>
<td>Online</td>
<td>Direct Service Administration Support staff</td>
<td>97 16 48</td>
<td>June 2017</td>
<td>N/A (online)</td>
</tr>
<tr>
<td>Cultural Training</td>
<td>Working with local American Indian tribes</td>
<td>22.5 hours, repeated every 6-12 months</td>
<td>Direct Service</td>
<td>7</td>
<td>10/17-19/17</td>
<td>Kishan Lara-Cooper, Ed.D.; Crystal Richardson; Chris Peters, MSW; Vincent Feliz, MSW</td>
</tr>
<tr>
<td>A Culture Centered Approach to Recovery</td>
<td>Incorporating culture into recovery practices</td>
<td>1 hour</td>
<td>All MH staff</td>
<td>162</td>
<td>June 2018</td>
<td>Relias ELEarning</td>
</tr>
</tbody>
</table>
Four of the listed trainings are the cultural competency trainings developed by DHHS MH and already discussed:
- Role of Peer Coaches and Parent Partners in Mental Health Services, June 2015
- Documenting Chosen Gender Identity and Expression, June 2016
- Advancing Recovery Practices, June 2017
- Working with Interpreters, June 2017

Mental Health Organizational Providers are required to provide an annual cultural competency training to their staff. This requirements is a part of their contract with Mental Health. Organizational Provider staff also received the Advanced Recovery Practices Training and were required to complete it.

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 multicultural knowledge, cultural sensitivity, cultural awareness, social/cultural diversity, and training staff in use of MH interpreters. These are listed in the table above.

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, and
During the next year two trainings on client culture will be developed. One will be an online training, which will be made available on the Relias ELearning platform and assigned to all staff to complete. The other is an advanced recovery training that is being developed by a Peer Advocate in partnership with the peer-facilitated Wellness Center (Hope Center).

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.
The Peer Advocate is creating a self-advocacy training for clients to present to the community at large, including Mental Health staff, which will include the parent/caretaker personal experiences. This will be completed by April 2019.
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. Current workforce data is presented in the sections below.

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

MHSA Workforce Education and Training (WET)\textsuperscript{13}

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>WET #</th>
<th>WET %</th>
<th>Medi-Cal #</th>
<th>Medi-Cal %</th>
<th>Utilization #</th>
<th>Utilization %</th>
<th>Gen Pop #</th>
<th>Gen Pop %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>14</td>
<td>5%</td>
<td>4,323</td>
<td>8%</td>
<td>223</td>
<td>7%</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4</td>
<td>1%</td>
<td>2,288</td>
<td>4%</td>
<td>54</td>
<td>2%</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>African American/Black</td>
<td>5</td>
<td>1%</td>
<td>989</td>
<td>2%</td>
<td>69</td>
<td>2%</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>233</td>
<td>83%</td>
<td>33,701</td>
<td>61%</td>
<td>1,920</td>
<td>64%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>16</td>
<td>6%</td>
<td>6,815</td>
<td>12%</td>
<td>245</td>
<td>8%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>10</td>
<td>4%</td>
<td>7,292</td>
<td>13%</td>
<td>489</td>
<td>16%</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>282</td>
<td>100%</td>
<td>55,405</td>
<td>100%</td>
<td>3,000</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

\textsuperscript{13} Humboldt County Department of Health and Human Services, Employee Services database, April 2018
Native Americans make up 5% of the workforce, 7% of clients, and 5% of the General Population. Asian/Pacific Islanders make up 1% of the workforce, 2% of clients, and 2% of the General Population. African American/Blacks make up 1% of the workforce, 2% of the clients served, and 1% of the General Population. Multiracial/other make up 4% of the workforce, 16% of the clients served and 4% of the General Population. Hispanic/Latinos make up 6% of the workforce, 8% of the clients served, and 10% of the General Population. Whites make up 83% of the workforce, 64% of the clients served, and 77% of the General Population.

It is apparent that Whites are overrepresented in the MH workforce when compared to the client population served. However, the disparities between the workforce and the general population are not present for Native Americans, African Americans, or Multiracial/other. The greatest disparity is for Hispanic/Latino, where 10% of the general population is Hispanic/Latino as compared to 6% of the workforce. For Asian Americans, 2% of the general population is Asian American as compared to 1% of the workforce.

The tables below show the racial/ethnic distribution of the workforce by type of job.

<table>
<thead>
<tr>
<th>Unlicensed Direct Service staff</th>
<th>Native American</th>
<th>Asian/Pacific Islander</th>
<th>African American/Black</th>
<th>White</th>
<th>Hispanic/Latino</th>
<th>Multiracial/Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Managers</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>45</td>
<td>6</td>
<td>1</td>
<td>59</td>
</tr>
<tr>
<td>Employment Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Peer Support</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>63</td>
<td>7</td>
<td>2</td>
<td>81</td>
</tr>
</tbody>
</table>
Five Mental Health staff receive the bilingual pay differential for speaking Spanish as well as English. These are three case managers, one Program Coordinator and one Psychiatric Nurse. There may be more staff who can 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. Five staff is less than 2% of the workforce.

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 to increase the number of staff who are proficient Spanish speakers from six to 14 fulltime equivalent positions, to increase staff who are proficient Hmong speakers from one to four fulltime equivalent positions, and to increase peer client and family member staff from seven and a half to 16 fulltime equivalent positions. Goals also included increasing the number of staff who ideally are individuals from the county’s local communities and identify as
Hispanic/Latino, Asian/Pacific Islander, and Native American. Only one of these goals were met. Mental Health now has 16 fulltime equivalent peer personnel positions that are filled.

Workforce strategies identified in the Cultural Competence Plan of 2011 intended to contribute to the increase and availability of a more multicultural workforce included:

- 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 local tribes. With the change in County Human Resources practices, it is anticipated that these practices will be expanded.
- The distance learning programs through Humboldt State University provide current 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, including training for the Milestones of Recovery Scale (MORS), Transition to Independence Process (TIP) Model for transition aged youth, have been successful in bringing new practices to the agency.
- The employment and job training outreach of the Mobile Outreach program 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 always available to provide information and linkages in Spanish.

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 has only recently changed recruitment practices to allow more program input into job descriptions and recruitment strategies. It is hoped that these changes will lead to increased recruitment and hiring of qualified staff from diverse cultures.

Development of a job description for peer personnel was also subject to the slow pace of Human Resources. It took almost two years for the job descriptions to be developed and for recruitment to begin.

E. Identify county technical assistance needs.

While trainings for Mental Health staff on working with interpreters are available, there is a need for training for interpreters in working with clinicians and other direct services staff. Humboldt County would benefit from interpreter trainings offered locally or via technology.
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, though the strategies have been in place 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 Mobile Outreach 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.

Mental Health Branch staff are encouraged to sign up for vocational Spanish courses in Medical Terminology, provided through the local Humboldt State University and College of the Redwoods.

The Mental Health Branch actively attracts qualified candidates with bilingual language capacity for intern placements in nursing and individual therapy through Humboldt State University. Some of these internships have resulted in hiring former interns after graduation.

Eligible and interested Mental Health staff are encouraged to take the Spanish Bilingual Proficiency Examination administered through the County Personnel 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 one full time Interpreter/Translator whose assignments include interpreting for integrated programs. The Mental Health Branch encourages its staff to apply for the Mental Health Services Act Loan Assumption Program, which is being offered to mental health professionals in the public mental health system.
2. As already stated, DHHS Mental Health has five 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 amounts to $15,000 in Fiscal Year 2018-2019. (Source: Department of Health and Human Services Finance Department). This includes Mental Health expenditures for contracted interpreters and language line services, and the Department of Health and Human Services’ Interpreter/Translator position.

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 loan repayment awards under the Mental Health Services Act Loan Assumption Program. Currently DHHS Mental Health employs three Case Managers, one Program Coordinator and one Psychiatric Nurse who have passed the Spanish Bilingual Proficiency Examination.

II. Interpreter Services

A. Policies, Procedures, and Practices, including:
1. 24 hour phone line
DHHS-Mental 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 the threshold language of the county, as well as all other languages prevalent in the county, spoken by beneficiaries of DHHS Mental Health.
A Text Telephone (TTY) can be connected to DHHS Mental 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 100.108 Interpreters
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

2. New technologies
The Quality Improvement Work Plan for Fiscal Year 2017-2018 included the goal “Implement Remote Video Interpreting Service for American Sign Language throughout the Mental Health Plan” with the objective to have a functional ASL Video interpreting solution in place by June 30, 2018. Contacts with several companies providing remote video interpretation services in health care environments were established and there have been demonstrations and testing. Implementation is still in progress.

3. Protocol for implementing language access
DHHS Mental Health has implemented the following protocol:
The toll-free Access number for Humboldt County DHHS Mental 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 forward to an answering service, New Connections. If the caller does not speak English, the call is forwarded to the Crisis Stabilization Unit for use of Language Line services. All staff at New Connections have been trained to utilize California Relay services. The Mental Health Quality Improvement Unit provided New Connections with a script to use when answering calls.
All 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 Mental Health started using Relias e-Learning platform in the summer of 2016, initially rolling the system out for inpatient services, and starting this year, to include outpatient services. DHHS Mental Health has created several trainings that are available to staff on the county intranet website; some of these trainings have been uploaded into Relias as well. Training participation is being tracked via Survey Monkey or Relias. The trainings include information about California Relay Services. The trainings are entitled “Serving Clients when English is not their Primary Language; “Working with Interpreters”, and “Mental Health Language Line Training”.

B. Evidence that clients are informed in writing in their language, of their rights to language assistance services
It is the policy of DHHS Mental 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 Humboldt County’s only threshold language, Spanish, are provided upon request and made available at the lobbies of all its access points and at its 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 Mental Health must make oral interpreter services available free of charge for people who speak other languages.

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 disabled persons, 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-MH 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 Health Branch 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 Mental Health Quality Improvement unit periodically checks access points for compliance with all posting requirements.

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

DHHS Mental 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 mental health system.

DHHS Mental 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 all network providers, including each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by DHHS Mental Health, each provider organization or individual practitioner contracting with DHHS Mental Health, and each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by a provider
organization 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 Mental Health public facing website, is posted in the lobbies of all access points, and at Contract Provider sites as well. When a client requests for 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 Mental 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. To address the issue, front office and direct service staff were trained or re-trained to access Language Line Services in July 2018. To monitor for quality, the DHHS Mental Health Improvement unit conducts one test call per month in a non-English languages 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 80% of Humboldt County’s population is White, 8% Hispanic/Latino, 6% Native American, 2% Asian/Pacific Islander and 1% African American.

Bi-lingual employees are encouraged to test for Spanish Bilingual Proficiency through the County Personnel Department. Currently 5 DHHS Mental 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 Personnel Department does not give out study guides or other materials prior to the test.

DHHS Mental 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 Mental 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 Mental 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 13 Spanish language Interpreters, one Hmong, one French, one Lao/Thai and one Russian language interpreter listed.
It has been a challenge to maintain the interpreter because interpreters may no longer be available because they moved or taken fulltime employment. Another challenge is the interpreters’ varying levels of ability and areas of experience. Coordinating appointments with these individuals can be difficult because they have other work obligations and limited availability.

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 Mental Health would benefit from interpreter trainings offered locally at low cost. DHHS Mental 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
According to the California Department of Health Care Services (formerly Department of Mental Health) Information Notice 11-07, Humboldt County met threshold language for Spanish language at 5.92% or 1,695 individuals who were Medi-Cal beneficiaries. The second largest language population was Hmong at 1.13% or 324 individuals. DHCS has not provided a more current Information Notice regarding threshold languages since 2011. Medi-Cal is providing somewhat newer information. The August 2013 Medi-Cal Threshold Language Summary indicates that Humboldt County met threshold Language for Spanish language at 5.29%, or 1,510 individuals.

The DHHS Employee Services unit reports that the department currently (as of May 2018) employs 19 bilingual (English/Spanish) staff receiving bilingual specialty pay. These employees have been certified as bilingual by the Personnel Director following achieving a passing score on the proficiency exam. At present, five DHHS Mental Health staff members receive bi-lingual pay. Their functions are Case Managers (3), Program Coordinator for Mobile Outreach Services, (1) and Psychiatric Nurse at Sempervirens Psychiatric Health Facility (1).

DHHS Mental Health maintains an interpreter list composed of contracted local community providers, with currently thirteen interpreters listed for Spanish, and one for Hmong. Front Office and direct services staff are instructed to offer clients this interpreter list that includes the name and contact number of each Interpreter and the language they are providing
DHHS Mental Health clinical staff contacts interpreters from this list directly 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 has hired a full time Interpreter/Translator. This staff has participated in a number of cultural competency trainings through the local LatinoNet as well as through DHHS and other community organizations (e.g. “Teens and their Uniqueness” workshop, educational session addressing stigma and discrimination reduction, Transgender Communities, 4-day conference on Hispanic issues). In addition, the staff has attended two local interpreter trainings: a one-day workshop through the LatinoNet, and a ten week course (2 hours per week) for social services and medical providers. The interpreter’s assignments include interpreting for integrated programs.

B. Evidence that interpreter services are offered and provided and recording of response to offer

It is the policy of DHHS Mental Health to offer and provide interpreter services to Mental Health beneficiaries.

In October 2018, DHHS Mental Health replaced its old paper-form based tracking mechanism to capture 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 who accompanies the beneficiary, or a staff member who is using bilingual language skills) are documented. Going forward, DHHS Mental Health Quality Improvement will run reports out of the electronic Health Record to monitor use and documentation of interpretation services. The Quality Improvement Unit has issued Avatar Info Bulletin 18-A010 to inform staff of this change.

In Fiscal Year 2017-2018, 211 client encounters required Language Line services. The chart below shows these encounters broken down by quarter and language used.
In Fiscal Year 2017-2018, 123 client encounters required community interpreter services. The chart below shows these encounters broken down by quarter and language used.
C. Evidence of providing linguistically proficient staff or contracted services during regular day operating hours

As stated above in section III. A., five DHHS Mental Health employees have been certified as bilingual by the Personnel Director following achieving a passing score on the proficiency exam. Their functions are Program Coordinator, Case Manager and Psychiatric Nurse.

DHHS Mental Health maintains an interpreter list composed of local community providers, with currently 12 interpreters listed for Spanish, and 1 for Hmong. Other languages represented include French, Lao, Thai and Russian. These community providers are contracted, and can be accessed when the need for interpretation arises. The Humboldt County Department of Health and Human Services employs a full time Interpreter/Translator assigned to its Public Health Branch. This staff is available to provide interpretation services in integrated programs that are collaborations between Mental Health and Public Health programs.

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 Bilingual Proficiency” is as follows:

The DHHS Personnel Department periodically administers a Spanish Bilingual Proficiency Examination to eligible and interested County employees. Participation requires the submittal of a Bilingual Proficiency Examination Registration Form directly to the Personnel Department. Employees are being 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 designed by the department as needing the skills of someone who is proficient in both English and Spanish. Departments who need employees with either oral only or oral and written proficiency in Spanish should contact Personnel to discuss their needs. After Personnel receives a request from a department they will provide a list of all employees in that department in the appropriate job classification who were successful on the Bilingual Proficiency Examination. Specialty Pay becomes effective after a department receives the list, makes a selection and processes the necessary paperwork. Since Specialty Pay is based on the specific position it is normally 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 Mental Health’s policy on access to interpreters and culturally and linguistically competent providers is all inclusive and does not distinguish between clients who speak the 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 Mental 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 the threshold language versus those who speak other languages. Therefore DHHS Mental 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 Mental Health prohibits the expectation that families will provide interpreter services for their family members who are receiving or requesting services; although at the client’s specific request and with appropriate releases, this can be facilitated. 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
DHHS Mental 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 language. 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., in October 2018, DHHS Mental Health replaced its old paper-form based tracking mechanism to capture 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 who accompanies the beneficiary, or a staff member who is using bilingual language skills) are documented. Going forward, DHHS Mental Health Quality Improvement will run reports out of the electronic Health Record to monitor use and documentation of interpretation services.
C. Consumer satisfaction survey translated into threshold languages, including summary of results
DHHS Mental 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 Mental 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 0 and 2 total surveys during each collection period over the past five years. Due to this low participation, DHHS Mental 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 Mental 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 were translated by the departments Translator/Interpreter, and underwent a second review by either bi-lingual staff who have passed the county proficiency exam, or a qualified contracted community interpreter/translator. Multiple documents received a third review by a bilingual Mental Health Branch staff with lived experience as a client of the Social Services Branch. Input from the reviewers was incorporated in the final versions of the documents.

DHHS Mental 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 Mental 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 Mental 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 Mental 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 mental health and substance use disorder services. All services promote health and mental wellness as well as 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 respond to cultural differences. The Department continuously evaluates the effectiveness of services and programs for the purpose of quality improvement. Two programs are client-driven.

The Hope Center serves unserved and underserved populations including 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, 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 is peer driven with a full time Peer Coach III who oversees the Center and two full time and one full time Peer Coach I staff. Staff supervision and consultation is provided by a Senior Program Manager. Peer coaches are trained as Certified Peer Support Specialists through RI International. The Peer Coach III has additional training through CAMHPRO and CASRA as a train the trainer in the Superior Region Provider Core Competency Training. The supervisors of the peers has gone through a Peer Supervisor Training through RI International.

Two Peer Coaches are teaching “My Wellness My Doctor and Me,” a class that teaches how to communicate with your doctor and be prepared for visits. There are role playing and discussions on symptoms and side effects. Another class is WELL, a 16 session class where participants can drop in to any session. It covers many topics such as the pathways of recovery, conflict resolution, substance challenges, social wellness, self-esteem, budgeting and goal setting.

In 2018 the Hope Center created an Advisory Board made up of four participants, one volunteer and two staff. The Board’s job is to be a voice for the center and give input to staff. Members meet once a month and Board members serve for one year. The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality
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 and volunteers to people with a mental health diagnosis.

Hope Center Goals:
- Build on the dimensions of wellness
- Incorporate recovery pathways
- Validate strengths and honor the person
- Build sustainable living skills
- 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
- Encourage individuals to find their personal strengths and identify their personal recovery goals
- Break the stigma of the us and them

The second client-driven program is a part of the Humboldt County 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 and Community and Family Resource Centers.

TAY is client-driven due to its partnership with HCTAYC. HCTAYC brings together transition age youth, DHHS, Y.O.U.T.H. Training Project and the California Youth Connection, and is committed to making change and improving services for youth in Humboldt County as they transition into adulthood and become independent. The direction is guided by youth input, while DHHS provides funding, logistical support and help in various ways as needed. HCTAYC fosters youth development, advocacy, community engagement, and promotes youth wellness. It provides a youth voice that informs system policy, regulation and practice at the local, state, and national levels. HCTAYC has developed policy recommendations for DHHS systems improvement, including several Mental Health Branch programs. HCTAYC is made up of a Youth Advisory Board, who are trained extensively in facilitation, public speaking and leadership.

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-
The TAY Division, as discussed above, provides 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 generally 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. DHHS has also contracted with Red Deer Consulting, which has provided access to traditional healers for community members seeking those services. In addition to direct referrals, DHHS Mental Health makes available the following resources. These are widely distributed in the community and are available in Mental 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 at the following link to the Humboldt County website document center at: This is a link to the Humboldt County website to get to the Community-Resource-List=
- Mental Health Branch’s informational flyer about its programs

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

**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 Mental Health Branch Access Brochure and Beneficiary Booklet.

**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 Mental Health has implemented the policy titled “Community Information and Education Plans.” This policy states that Mental 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 informally via outreach by Case Managers and other clinical staff. In addition, Mental 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 Mobile Outreach Program, discussed further in 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;**

DHHS Mobile Outreach uses innovative approaches for engaging clients by meeting them in the communities in which they live, or on board one of the outreach vehicles that carry DHHS program outreach to the furthest corners of Humboldt County. Mobile Outreach addresses the barrier of rural community access to the services, most of which are based in Eureka. The Mobile Intervention and Services Team (MIST) and Regional Services also address the barriers of rural community access. MIST is a collaborative program between DHHS Mental Health and the Eureka Police Department. MIST targets people with severe mental illness who are homeless in the City of Eureka and have frequent contact with law enforcement. Regional Services provides mental health clinicians and case managers in the Eastern Humboldt and Southern Humboldt regions of the County.

These services connect outlying communities with DHHS services so residents do not need to come to Eureka to initially access Mental Health, Public Health or Social Services programs. Regional Services staff are based at one of the DHHS outlying offices or travel in vans to meet clients where they are. Mobile Outreach also has a Mobile Engagement Vehicle (MEV), a converted RV which acts as rolling office space and visit communities located throughout Humboldt County. They have a regular schedule of 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 at the MEV. These services also link with and provide support to existing community organizations such as Family and Community Resource Centers, community clinics, and Tribal Organizations.

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/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. CCT offers expanded hours of operation. Nursing Care as well as Case Management services are available 7 days a week. Nurses cover the hours from 8:00am to 7:00pm and Case Managers work 8:00am to 5:00pm including weekends, with expanded hours on Mondays to provide a family group until 7:00pm.

Since 2009 the Mental Health Branch has implemented a decentralized access process for its Children and Family Services (C&FS) division. Presently C&FS Clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management and Crisis Services. They are working 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 on Monday afternoons. Two Crisis
Mental Health clinicians are dispatched to Emergency Rooms and Same Day Services in Eureka to evaluate minors for Crisis needs. In addition, there are two Access Clinicians work four, ten-hour days to facilitate returning phone calls after 5:00 PM.

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 is currently under Department of Justice review regarding ADA accessibility in facilities, and is putting in place the processes and building updates to meet a current consent decree. This decree has a deadline of September 2019. There are specific deadlines that are required to be met for other County, non-Mental Health buildings. Once those deadlines are met, all County Facilities will be fully assessed for ADA compliance. At this time, the consent decree items are priorities above full assessments for Mental Health facilities, but there is a plan in place to assess, identify, and update all facilities to ensure ADA compliance.

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

- Art work 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 Psychiatric Emergency Services unit. This art work 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 the Department.

In addition, the Mental Health Cultural Competence Committee currently has a project under development that will include evaluating the current “welcoming environments” of its facilities. This project will include a visual survey of public and office spaces and a staff survey to identify ways in which environments can be made more welcoming. Once these activities are completed, materials may be purchased to increase the sense of welcoming in Mental Health locations.

The Humboldt County Transition Age Youth Collaboration (HCTAYC) presented policy recommendations to Sempervirens (the county’s Psychiatric Health Facility), Crisis Services Unit (CSU) and the Crisis Line staff. The recommendations’ purpose is to improve the cultural appropriateness of services provided to culturally diverse transition age youth. The following is a list of changes resulted at Sempervirens:

- Extended visiting hours
- Additional diverse and healthful meals
• Magazines and other reading materials appropriate for diverse populations
• Increased art supplies
• Displayed client produced art work
• A mural, fresh paint, new bedspreads, wall paper, curtains, flooring
• HCTAYC facilitated training for clinical staff
• Admission folder containing diverse resources and content

3. Locating facilities in settings that are non-threatening and reduce stigma, including colocation 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 mental health staff is co-located with other DHHS programs including but not limited to:

• Child Welfare Services within the Emergency Response Unit, the Foster Care Unit, and the Extended Foster Care Unit in the TAY Division.
• CalWorks and HumWorks Program, providing services to clients who have mental health, substance use or domestic violence issues to address barriers to employment.
• General Relief, providing mental health assessments, referrals, and treatment.
• Older Adults and Dependent Adults Program, a partnership between Social Services, Adult Protective Services, In Home Support Services, Public Health Nursing, and Mental Health.
• Outpatient Medication 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, Healthy Moms, and Integrated Foster Care Behavioral Health Expansion, are located in mixed residential and business areas, therefore reducing the stigma attached to receiving services at the main Mental Health clinic. DHHS is currently working in McKinleyville to co-locate services with the Family Resource Center there, which will be a non-stigmatizing community setting. Finally, Mobile Outreach RVs and vans provide several types of services, so someone going into the RV or van could be assessing any type of service, not just mental health.

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 Mental 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 Mental Health’s Outpatient Continuous Quality Improvement Committee on a quarterly basis. DHHS Mental 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.

The table below shows grievances by category in the ABGAR reports for FY16-17 and FY17-18. All grievances were resolved according to protocol, and there were zero grievances filed under the category “Cultural Appropriateness”.

<table>
<thead>
<tr>
<th>ABGAR</th>
<th>Grievances FY 16-17</th>
<th>Grievances FY 17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
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<td></td>
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<tr>
<td>Service Not Available</td>
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<td>0</td>
</tr>
<tr>
<td>Service not Accessible</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Timeliness of Services</td>
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<td>1</td>
</tr>
<tr>
<td>24/7 toll free access line</td>
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<td>0</td>
</tr>
<tr>
<td>Linguistic Services</td>
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<td>1</td>
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<tr>
<td>Other Access issues</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
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<td><strong>5</strong></td>
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<tr>
<td><strong>Quality Of Care</strong></td>
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<tr>
<td>Staff Behavior Concerns</td>
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<td>33</td>
</tr>
<tr>
<td>Treatment issues or Concerns</td>
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</tr>
<tr>
<td>Medication Concerns</td>
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<td>3</td>
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<tr>
<td>Cultural Appropriateness</td>
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<td>0</td>
</tr>
<tr>
<td>Other quality care issues</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>54</strong></td>
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<td><strong>Change of Provider</strong></td>
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<td>Confidentiality Concerns</td>
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<tr>
<td><strong>Other</strong></td>
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<td>Patients’ Rights</td>
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<td>Peer Behaviors</td>
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<td>Physical Environment</td>
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<td>3</td>
</tr>
</tbody>
</table>
The charts below provide a summary of grievances received between July 1, 2016 and June 30, 2018, by race / ethnicity.

**Chart 1: Unique open clients FY16-17**

**Chart 2: Unique clients who filed a grievance in FY16-17**

<table>
<thead>
<tr>
<th>Other Grievances not listed Above</th>
<th>2</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Grand Totals</td>
<td>34</td>
<td>78</td>
</tr>
</tbody>
</table>
We are looking at client concerns from the angle 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 is compared to QI client concern data. The data sources for this analysis are Avatar reports (ethnicity percentages based on number of unique clients (children or adults receiving outpatient and/or inpatient services) who had an open episode during fiscal year 16-17 and fiscal year 17-18; and MH-QI Grievance database (ethnicity percentages based on number of unique clients who filed concerns during fiscal year 16-17 and fiscal year 17-18).

Chart 3: Disparity analysis FY16-17

To identify disparities and answer the question if the difference between these proportions is significant or if the data are similarly distributed by ethnicity for both populations, a Z-Test for two population proportions was applied to each race/ethnicity. Test significance of proportions showed significant for all data: Whites, Asian/Pacific Islanders and American Indian/Hawaiian /Alaska Natives are overrepresented in filing grievances, whereas all other race/ethnicities are underrepresented.
Chart 4: Unique open clients FY17-18

Chart 5: Unique clients who filed a grievance in FY17-18
Test significance of proportions (Z-Test) showed significant for all data: Whites and Asian/Pacific Islanders are overrepresented in filing grievances, whereas all other races/ethnicities are underrepresented except from Black or African-Americans, where there are no disparities.

Comparison rates between the general beneficiary population and ethnic beneficiaries clearly show disparities in filing grievances, but based on the grievances processed by the Quality Improvement unit, no concerns regarding “cultural appropriateness” were raised. The grievance category that came up the most in both fiscal years was “staff behavior concerns”. This begs the question if concerns around staff behavior may include a reflection of culturally insensitive behavior, without explicitly stating this. The Cultural Competence Committee is currently working with the local Equity Alliance on bringing Racial Bias training to Mental Health staff in the spring of 2019. It will be interesting to see if this training activity will have an impact on the disparities around grievances.
Attachments

Attachment 1: Policy 100.108 Interpreters
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 1
PURPOSE: To ensure that mental health services are available for those who are deaf or whose primary language is not English.

DEFINITION: Interpreter: A person who translates orally from one language to another.

POLICY: Department of Health and Human Services Mental Health shall provide qualified interpreters to ensure quality mental health services to all clients who are deaf or whose primary language is not English.

PROCEDURE: The following detailed policies on Interpreters can be found on DHHS Policies and Procedures Bulletin Board.

- 0100.603 Selection of Interpreters.
- 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers.
- 0100.605 Obtaining Interpretation, Translation and Telephone Services for Clients with Physical Impairments or Limited English Proficiency.
- 0100.606 Speech to Speech Relay Service.
- 0100.607 Text Telephone (TTY) Use.
- 0100.608 AT&T Language Line Services (Including FAQs).

FORM/ATTACHMENTS: None.

REFERENCE: None.
Attachment 2
County of Humboldt Department of Health and Human Services Mental Health

Policy Number: 0100.603.

Title: Selection of Interpreters.


Revision Date: None.

Review Dates: 11/2/98, 12/21/99, 1/3/01, 2/22/12, 2/22/02, 9/20/04, 9/5/08, 12/11/10, 1/5/12, 3/2/12, 8/30/12, 12/20/13, 1/14/14, 10/18/17.

Program: Administration.

Affects: All.

Approved and Signed by Mental Health Director Emi Botzler-Rodgers, MFT.

PURPOSE: Department of Health and Human Services Mental Health maintains a list of community Interpreters.

DEFINITIONS: None.

POLICY: Department of Health and Human Services (DHHS) - Mental Health will assure availability of Interpreters who are utilized for interpreter services to clients.

PROCEDURE:

1. Selection:
   DHHS - Mental Health will maintain a list of available persons to interpret in threshold languages and languages that are prevalent in the community per observation of personnel providing direct service to the community. The Interpreter List will, when possible, include the following information about each interpreter: name, contact number/email, HIPAA trainings, background check information, interpretation skills and credentials, specialties, cultural competency training, compensation rate, availability, and the language for which they are providing interpreter services.

2. Potential Interpreters will be provided an orientation packet on mental health practices, including information about access to services, beneficiaries’ rights, and confidentiality of mental health information. The packet includes the following forms to be completed and signed by the interpreter and returned to the Performance Management Unit: Interpreter Agreement, Declaration of Confidentiality, Independent Contractor and Sole Proprietorship Mandated Reporting Form (V-13-39), Request for Taxpayer Identification Number and Certification Form (W-9).

3. The Interpreter is responsible for submitting to the DHHS – Mental Health Financial Services a reimbursement invoice for services provided to beneficiaries. The Invoice for Interpreters form is included in the orientation packet.
4. Once all required documents have been received and approved by Performance Management Unit (Deputy Director or designee), the interpreter will be placed on the Interpreter List.

5. The original documents (Interpreter Agreement, Declaration of Confidentiality, Independent Contractor and Sole Proprietorship Mandated Reporting Form (V-13-39) and Request for Taxpayer Identification Number and Certification (W-9) Form) are then forwarded to the Budget Specialist in Mental Health Financial Services. A copy will be kept at Performance Management Unit.

6. As the Interpreter List is updated it will be available to programs.

7. Mental Health staff can receive approval from their supervisor and may contact an interpreter directly to arrange for their services.

FORMS/ATTACHMENTS:
Interpreter Agreement.
Declaration of Confidentiality.
Independent Contractor and Sole Proprietorship Mandated Reporting Form (V-13-39).
Request for Taxpayer Identification Number and Certification (W-9) Form.
Invoice for Interpreters Form.

REFERENCE:
CCR, title 9, chapter 11, section 1810.410.
Interpreter List.
Attachment 3
Purpose: Humboldt County Department of Health and Human Services Mental Health provides culturally and linguistically competent services.

Definition: None.

Policy: Department of Health and Human Services (DHHS) - Mental Health will obtain and provide culturally and linguistically competent services to clients 24 hours a day, 7 days a week.

Procedure:

1. Linking clients to DHHS interpreters:
   DHHS - Mental Health prohibits the expectation that families will provide interpreter services for their family members who are receiving or requesting services; although at the client's specific request and with appropriate releases, this may be facilitated.

2. All front office and direct service staff will be trained on the following steps to provide appropriate interpreter services to clients:
   2.1. 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.
   2.2. Offer the client free interpreter service.
   2.3. If the client declines to use a local interpreter, staff will contact Language Line Services.
   2.4. If steps 2.2. and 2.3. fail to meet client's needs, or client declines those services, ask client if he or she prefers to have family or other support provide the interpreter services.
   2.5. Minor Children should not be used as interpreters.
   2.6. Document steps 2.1. through 2.4. in client's chart.
   2.7. And complete form# 1157 Use of Interpretation Services Documentation Form.
3. Appropriate translated materials will be distributed or posted at all points where clients access the Mental Health system.

4. Linking clients to culturally competent Mental Health service providers: Humboldt County Mental Health will maintain a current list of contract providers. The list will contain the names, clinic addresses, telephone numbers, cultural and linguistic skills and specialty populations served by each provider. This list will be updated periodically and furnished to all Humboldt County Mental Health front office staff and to contract providers. The front office staff will make this list available to clients upon request and inform them in a language that they understand that they have the right to free language assistance services.

5. When a client requests a specific provider from the Contract Provider List, this information will be forwarded to the Access staff. The Access staff will make every effort to link the client with the provider of his or her choice.

FORM(S) ATTACHMENTS:
Form 1157 Use of Interpretation Services Documentation.
Directorio de Proveedores.
Interpreting Services Available Poster.
Interpreter List.
Language Identification Card.
Provider Directory.
Working with Interpreters training.

REFERENCE:
CCR, title 9, chapter 11, section 1810.410.
Attachment 4
PURPOSE: Humboldt County Department of Health and Human Services Mental Health obtains translation, interpretative and telephone services.

DEFINITION(S): None.

POLICY: Department of Health and Human Services (DHHS) - Mental Health obtains translation, interpretative, and telephone services whenever clients are in need of language line, or services that assist clients with hearing, visual, or speech impairments.

PROCEDURE:

1. For assistance for clients with speech impairments, see policy and procedure 0100.606 Speech-to-Speech Relay Service (STS).

2. For assistance for clients with hearing impairments, see policy and procedure 0100.607 Text Telephone (TTY) Use and 0100.306 Services to Clients with Hearing Impairments.

3. For assistance with foreign language interpretation, see policy and procedure 0100.608 AT&T Language Line Use.

4. For assistance for clients with visual impairments, see policy and procedure 0100.609 Serving Clients with Vision Impairments.

FORMS/ATTACHMENTS:
0100.606 Speech-to-Speech Relay Service (STS).
0100.607 Text Telephone (TTY) Use.
0100.608 AT&T Language Line Use.
0100.609 Serving Clients with Vision Impairments.
0100.306 Services to Clients with Hearing Impairments.
REFERENCE:
CCR, title 9, chapter 11, section 1810.410.
Attachment 5
PURPOSE: Humboldt County Department of Health and Human Services Mental Health provides Speech-to-Speech Relay Services to clients with hearing and speech impairment.

DEFINITIONS: California Speech-to-Speech Relay Service (STS): a part of the California Relay Service (CRS), a program of the California Public Utilities Commission (CPUC). It is a service that allows persons with hearing and speech disabilities to access the telephone system to place and receive telephone calls. STS enables persons with a speech disability to make telephone calls using their own voice (or an assistive voice device) rather than a text telephone (TTY). Trained operators function as human voicers for STS users who have trouble being understood on the telephone.

POLICY: Department of Health and Human Services (DHHS) - Mental Health obtains translation, interpretative, and telephone services whenever clients are in need of language line, or services that assist clients with hearing, vision, or speech impairments.

PROCEDURE:
Please refer to policy number 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers and policy number 0100.605 Obtaining Interpretation, Translation, And Telephone Services For Clients With Physical Impairments Or Limited English Proficiency.

1. If a Mental Health staff member wishes to call a client with a speech impairment:
   A special phone is not needed for STS. To get connected directly to a specially trained STS Communications Assistant dial the designated STS toll free California Speech-to-Speech Number 866-988-4288 and ask the Communications Assistant to call the person with a speech impairment. The Communications Assistant will repeat the client’s spoken words, making the words clear to the other party.

2. If a Mental Health staff member wishes to call a Spanish speaking client with a speech impairment, dial 866-288-4151.
3. Persons with speech impairments may also place STS calls. They need to call the relay center at the same number above 866-988-4288 (or 866-288-4151 if Spanish speaking) and indicate they wish to make an STS call to Mental Health.

4. There are many options to personalize phone calls through STS that will make calls easier. You may call Customer service for California STS at 866-288-1909 to ask for options to customize your calls or create a personal profile. (Spanish Customer service number is 866-288-4151).

FORM/ATTACHMENTS: None.

REFERENCE:
Link to Deaf and Disabled Telecommunications website.
http://ddtp.cpuc.ca.gov/homepage.aspx
CCR, title 9, chapter 11, section 1810.410.
Attachment 6
PURPOSE: Department of Health and Human Services - Mental Health provides a text telephone line.

DEFINITION(S): Text Telephone (TTY): a small telecommunications device with a keyboard for typing and a screen for reading conversation. A TTY is often used by people who are deaf, hard of hearing, or speech-impaired.
California Relay Service (CRS): provides specially-trained operators to relay telephone conversations back and forth between people who are deaf, hard of hearing, or speech-impaired and all those they wish to communicate with by telephone.

POLICY: Department of Health and Human Services (DHHS) - Mental Health provides a TTY line for use with callers who are deaf, hearing-impaired or speech impaired.

PROCEDURE:

1. If a MH staff member wishes to call a client with a hearing impairment at his/her residence, from a standard telephone to TTY:
   1.1. Dial a voice relay operator: 1-800-735 2922 (English) or 1-800-855-3000 (Spanish).
   1.2. Give the relay operator the area code and TTY number you wish to call.
   1.3. The operator will voice what the TTY user says to you and type to the other party what you say.
   1.4. The conversation can go back and forth as long as you wish.
   1.5. You will need to talk slower than usual because everything you say is being typed.
   1.6. There are no charges for using the relay service. Usual charges for long distance calls will apply.

2. If a client with a hearing impairment wishes to call MH, from TTY to standard telephone:
   2.1. Dial a TTY relay operator: 1-866-660-4288 (English) or 1-866-985-4288 (Spanish).
   2.2. Give the relay operator the area code and voice phone number you wish to call.
   2.3. The operator will type what the other party voices to you, and voice to the other party what you type on your TTY.
2.4. The conversation can go back and forth as long as you wish.

2.5. There are no charges for using CRS. The usual charges for long distance calls will apply.

3. **When meeting with a client with a hearing impairment at MH, using TTY:**
   
   Please note: the TTY Phone is stored at 720 Wood Street, Same Day Services Office, in a marked box.

3.1. Setting up the Phone:

   3.1.1. This will require 2 separate phones; one can be a cell phone if no personal health information is disclosed.
   
   3.1.2. Set up the TTY machine by plugging the cord into the TTY machine and then into the wall outlet.

3.2. Connecting to the TTY voice relay operator.

   3.2.1. Calling within the state of California, dial: **1-800-735 2922 (English) or 1-800-855-3000 (Spanish).** Note: Calling long distance Outside of California, dial **1-800-855 2881**.

   3.2.2. This connects to the California Relay Service operator.

   3.2.3. Give the relay operator the desk phone number so that the relay operator can call back and you will answer the phone.

   3.2.4. The desk phone will ring and then the staff can pick up the receiver.

   3.2.5. Place the phone receiver into the TTY phone receiver cradle.

   3.2.6. This begins the process for the communication.

   3.2.7. The staff person will speak into their phone (which is the 2nd phone in the room).

   3.2.8. **NOTE:** at the end of each statement, please say "**Go ahead**". **This must be done for both the client and the staff person.**

   3.2.9. There is a key on the TTY phone to use if preferred for the client, "**GA**" (Go ahead).

   3.2.10 There will be a print out on the TTY phone of the conversation. The conversation will also be imprinted on the front of the keyboard.

**FORMS/ATTACHMENTS:** None.

**REFERENCE:**

Link to Deaf and Disabled Telecommunications website http://ddtp.cpuc.ca.gov/

CCR, title 9, chapter 11, section 1810.410.
County of Humboldt Department of Health and Human Services Mental Health

Policy Number 0100.608.

Title: Access to Interpreter Services – Language Line Use.


Revision Date: 7/27/15, 1/4/18.


Program: Administration.

Affects: All.

Approved and Signed by Mental Health Director Emi Botzler-Rodgers, MFT.

PURPOSE: Humboldt County Department of Health and Human Services - Mental Health provides access to language interpretive services over the telephone.

DEFINITIONS: None.

POLICY: Department of Health and Human Services (DHHS) - Mental Health obtains interpretation, translation, and telephone services whenever clients are in need of language line, or services that assist clients with hearing, vision, or speech impairments.

PROCEDURE:
Please refer to Policy and Procedures 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers and 0100.605 Obtaining Interpretation, Translation, and Telephone Services for Clients With Physical Impairments or Limited English Proficiency.

1. When receiving a call from a client with limited English proficiency:
   1. Use the CONF button to place the client on hold.
   2. To access Language Line Services, dial 1-800-874-9426 or 1-866-874-3972.
   3. Enter on your telephone keypad your 6-digit Client ID: 5 0 1 1 8 1.
   4. Press 1 for Spanish.
   5. Press 2 for all other languages (Speak the name of the language at the prompt).
      You may press 0 or stay on the line for assistance with language identification.
   6. Give Information.
      1.6.1. MH Access Code: 1170424
      1.6.2. Your first and last name.
   7. An Interpreter will be connected to the call.
   8. Brief the Interpreter. Summarize what you wish to accomplish and give any special instructions.
   9. Add client with limited English proficiency to the line:
      1.9.1. by pushing the CONF button once when using AT&T Voice Dynamic Network Application (VDNA) Polycom system, OR
      1.9.2. by pushing the CONF button twice when using Nitsuko / NEC phone system.
2. When placing a call to a client with limited English proficiency:

2.1 To access Language Line Services, dial **1-800-874-9426** or **1-866-874-3972**.

2.2 Follow steps 1.3. to 1.7. above. Request the language your client speaks. When the interpreter is connected, put the interpreter on hold by using the **CONF** button.

2.3 Call the client with limited English proficiency.

2.4 Conference in the interpreter.

    2.4.1. by pushing the CONF button **once** when using AT&T Voice Dynamic Network Application (VDNA) Polycom system, OR

    2.4.2. By pushing the CONF button **twice** when using Nitsuko / NEC phone system.

2.5. If you need assistance when placing a call to a client with limited English proficiency, you may press 0 to transfer to a representative.

To hear a free recorded demonstration of typical call scenarios, call 1-800-821-0301.

FORM/ATTACHMENTS: Language Line Use FAQs.

REFERENCE:
California Code of Regulations, title 9, chapter 11, section 1810.410.
0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers.
0100.605 Obtaining Interpretation, Translation, and Telephone Services for Clients With Physical Impairments or Limited English Proficiency.
Attachment 8
Purpose: The Department of Health and Human Services (DHHS) - Mental 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.

Definitions:

**Limited English Proficiency (LEP)** – A legal term referring to a level of English proficiency that is insufficient to ensure equal access to medical services without a health care interpreter.

**Interpretation** – Is the act of verbal communication, which is a process of accurate transposition of spoken words from one language to another.

**Translation** – Is the act of translating a written expression, of the meaning of a word, speech, book, etc. in another language.

**Threshold Language** – A language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3). Humboldt County’s only Threshold Language is Spanish.

Policy: The Department of Health and Human Services (DHHS) - Mental Health provides interpretation (verbal) and translation (written) services to clients with Limited English Proficiency (LEP) and their family members. DHHS – Mental Health has a mechanism for ensuring accuracy of translated materials in terms of both language and culture.

Procedure:

1. Requests for translation of clinical documents that contain personal health information (PHI):
   1.1. Senior Program Manager (SRPM) or designee approves the request for translation of a clinical document.
   1.2. SRPM or designee forwards the document(s) to be translated to the Quality Improvement Coordinator (QIC) or designee.
   1.3. QIC or designee contacts Language Line Solutions to request a quotation of the cost, and arranges for translation services through Language Line Solutions.
   1.4. QIC or designee sends the translated clinical documents back to the SRPM or designee who will arrange for treating staff to give the document to the client.
   1.5. SRPM or designee forwards the translated document to Medical Records for inclusion in the client’s health record.
2. Requests for written translation of non-clinical documents in threshold languages will be given priority, (such as forms, flyers, surveys, program brochures, educational materials):
   
   2.1. SRPM or designee approves the request for translation of a non-clinical document.
   
   2.2. SRPM or designee contacts the Public Health (PH) Interpreter/Translator to ask about availability and turn-around time for translation services.
   
   2.3. If a reasonable turn-around time can be expected, PH Interpreter/Translator translates the document.
   
   2.4. A second review to assure accuracy of translated materials in terms of both language and culture is required.
   
   2.5. If a reasonable turn-around time for a second review through PH can be expected, the PH Interpreter/Translator may arrange for a second review. Alternatively, the SRPM or designee may arrange for the second review through a community interpreter, or qualified bi-lingual staff.
   
   2.6. If the PH Interpreter/Translator is unavailable, SRPM or designee contacts a qualified, contracted Community Interpreter/Translator.
   
   2.7. After the Community Interpreter /Translator has provided the translation, the SRPM or designee arranges for a second review through either the PH Interpreter/Translator, another contracted Community Interpreter /Translator or DHHS Mental Health bi-lingual staff.
   
   2.8. If neither the PH Interpreter/Translator nor contracted Community Interpreters/Translators are available, the SRPM or designee requests that QIC or designee contacts Language Line Solutions to request a quotation of the cost, and arranges for translation services through Language Line Solutions as appropriate.
   
   2.9. SRPM or designee sends translated document to QIC or designee for tracking purposes.
   
   2.10. Program staff or Quality Improvement staff makes the translated document available on the DHHS Bulletin Board as appropriate, or arranges with print shop to obtain hard copies for distribution to programs.
   
   2.11. 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, clinical staff informs the QIC to explain and request changes.

FORMS/ATTACHMENTS: None.

REFERENCE:
MHSUDS Information Notice No.: 15-042 Annual Review Protocol For Consolidated Specialty Mental Health Services And Other Funded Services Fiscal Year 2015-2016.
CFR, title 42, section 438.10(d) (i),(ii).
CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e) (4).
CFR, title 42, section 438.10(d) (2).
MHP Contract, Exhibit A, Attachment I.