Table of Contents

Criterion 1: Commitment to Cultural Competence ................................................................. 3
  I. County Mental Health System Commitment to Cultural Competence ............................... 3
  II. Recognition, value, and inclusion of diversity within the system ...................................... 4
  III. Designated Cultural Competence/Ethnic Services Manager ........................................ 9
  IV. Budget Resources for Cultural Competence Activities ..................................................... 10

Criterion 2: Updated Assessment of Service Needs ................................................................. 11
  I. General Population .............................................................................................................. 11
  II. Medi-Cal Population and Client Utilization ...................................................................... 12
  IV. MHSA Community Services and Supports (CSS) ............................................................ 20
  V. MHSA Prevention and Early Intervention (PEI) .............................................................. 23
  VI. MHSA Workforce Education and Training (WET) ........................................................... 26

Criterion 3: Strategies and Efforts for Reducing Disparities ................................................... 27
  I. Target populations with disparities ..................................................................................... 27
  II. Disparities in each of the populations ................................................................................. 27
  III. Strategies for the reducing those disparities ..................................................................... 28
  IV. Measurement and monitoring of activities/strategies for reducing disparities ................. 34
  V. What has been working well and lessons learned .............................................................. 35

Criterion 4: Integration of the Client/Family Member/Community Committee .......................... 38

Criterion 5: Culturally Competent Training Activities ............................................................ 42
  I. Annual Cultural Competence Training Requirement .......................................................... 42
  II. Process for the incorporation of Client Culture Training throughout the mental health system 45

Criterion 6: Commitment to Growing a Multi-cultural Workforce ......................................... 46

Criterion 7: County Mental Health System Language Capacity ............................................. 51
  I. Bilingual Workforce Capacity ........................................................................................... 51
  II. Interpreter Services .......................................................................................................... 52
  III. Provide bilingual staff and/or interpreters for threshold languages .................................. 56
  IV. Provide services to all LEP clients not meeting the threshold language criteria ............... 59
  V. Translated documents, forms, signage, and client informing materials ............................ 60

Criterion 8: County Mental Health System Adaptation of Services ........................................ 62
  I. Client driven/operated recovery and wellness programs .................................................... 62
  II. Responsiveness of mental health services ....................................................................... 65
  III. Quality Assurance ......................................................................................................... 69

Attachments .......................................................................................................................... 74
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 that 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 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 live 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 and the MHSA Annual Updates are examples of this, where the MHSA Coordinator sponsors community stakeholder meetings.

- DHHS Mental Health participation in existing community meetings where mental health services, education, and planning are discussed. These meetings are sponsored by local community-based organizations and associations that represent and/or serve diverse stakeholders. In these instances, a 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 experience as clients and family members; current and former foster youth; transition age youth; DHHS administration; program providers; community-based and organizational providers of local public health, behavioral health, social services, and vocational rehabilitation services; and agencies that serve and/or represent diverse racial and ethnic groups, and unserved/underserved, Native American, and rural communities.

Below are examples of stakeholder entities with which DHHS 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 January 2019, 847 people have participated in Mental Health Services Act (MHSA) stakeholder activities. Of these, 75% 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>36%</td>
</tr>
<tr>
<td>Eel River Valley</td>
<td>11%</td>
</tr>
</tbody>
</table>

1 MHSA community planning process data, 2008-2019. Tables and charts on this and the following three pages reflect data gathered from demographic forms collected during the planning process.
<table>
<thead>
<tr>
<th>Location</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Humboldt</td>
<td>9%</td>
</tr>
<tr>
<td>Eastern Humboldt</td>
<td>6%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>70%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>14%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>0%</td>
</tr>
<tr>
<td>16-25</td>
<td>8%</td>
</tr>
<tr>
<td>26-59</td>
<td>72%</td>
</tr>
<tr>
<td>60+</td>
<td>20%</td>
</tr>
</tbody>
</table>

As the chart below illustrates the percentage of stakeholder participation for Hispanic/Latino, African American, and American Indian/Alaska Native was greater than that of Humboldt County’s general population. Hispanic/Latino stakeholders were 14% of participants as compared to 10% of the general population. African American stakeholders were 2% of participants as compared to 1% of the general population. American Indian/Alaska Native were 10% as compared to 5% of the general population. 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.
Individuals who identified as American Indian or Alaska Native represented 18 separate tribes. These tribes are Anishnabee, Chumash, Karuk/Yurok, Wiyot/Tolowa, Cherokee, Hupa, Navajo, Yurok, Chickasaw, Creek, Osage, Potowatami, Wiyot, Tolowa, 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 with 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-two percent were family members of those who have been diagnosed with a serious mental illness.

The LGBTQ community, people who have experienced homelessness, and people who have
experienced the justice system or child welfare services are also tracked, as they are traditionally underserved populations. Those whose primary language is Spanish or who have military service are also identified. As the chart below shows, 19% 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
- Participates in the development of the Cultural Competency Plan and the Mental Health Services Act Plans and Updates, and coordination of the components of
MHSA Plans

- Receives data reports on the racial/ethnic and cultural demographics of individuals participating in or being served by Mental Health Services Act programs and activities, and includes data in reports and recommendations
- Is a participant in the Superior Region Ethnic Services Manager conference calls, 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>Number of Residents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td>Native American</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>White</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>134,623</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Foreign-born residents 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</th>
<th>Number of Residents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>22</td>
<td>0%</td>
</tr>
<tr>
<td>Oceana</td>
<td>178</td>
<td>3%</td>
</tr>
<tr>
<td>North America</td>
<td>385</td>
<td>5%</td>
</tr>
<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>Latin America</td>
<td>3,423</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,340</strong></td>
<td><strong>100%</strong></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”.

---

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Number of Speakers</th>
<th>Percentage of Speakers</th>
<th>Number of Speakers Who Report Not Speaking English Well</th>
<th>Percentage of Speakers Who Report Not Speaking English Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>1,726</td>
<td>1%</td>
<td>856</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other Indo-European</td>
<td>2,586</td>
<td>2%</td>
<td>577</td>
<td>0.5%</td>
</tr>
<tr>
<td>Spanish</td>
<td>6,904</td>
<td>5%</td>
<td>4,294</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>11,216</td>
<td>8%</td>
<td>5,727</td>
<td>4%</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Residents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-15</td>
<td>22,304</td>
<td>17%</td>
</tr>
<tr>
<td>Transition Age 16-25</td>
<td>21,409</td>
<td>16%</td>
</tr>
<tr>
<td>Adults 26-59</td>
<td>64,151</td>
<td>48%</td>
</tr>
<tr>
<td>Older Adults 60+</td>
<td>26,759</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Residents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>67,028</td>
<td>50%</td>
</tr>
<tr>
<td>Male</td>
<td>67,595</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

II. Medi-Cal Population and Client Utilization

The following table shows the average number of eligible 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 2017. 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, was used to obtain information on primary language. C-IV data for 2017 show a different total number for the Medi-Cal population.
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>1,950</td>
<td>3%</td>
<td>68</td>
<td>1%</td>
</tr>
<tr>
<td>African-American/Black</td>
<td>1,003</td>
<td>2%</td>
<td>163</td>
<td>3%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>7,305</td>
<td>13%</td>
<td>440</td>
<td>9%</td>
</tr>
<tr>
<td>Native American</td>
<td>4,313</td>
<td>8%</td>
<td>487</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/Other/Unknown</td>
<td>8,160</td>
<td>14%</td>
<td>724</td>
<td>15%</td>
</tr>
<tr>
<td>White</td>
<td>33,851</td>
<td>60%</td>
<td>3,092</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56,582</strong></td>
<td><strong>100%</strong></td>
<td><strong>4,974</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao</td>
<td>15</td>
<td>&lt;1%</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Hmong</td>
<td>234</td>
<td>&lt;1%</td>
<td>20</td>
<td>0%</td>
</tr>
<tr>
<td>Spanish</td>
<td>1,382</td>
<td>2%</td>
<td>43</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>140</td>
<td>&lt;1%</td>
<td>651</td>
<td>13%</td>
</tr>
<tr>
<td>English</td>
<td>58,350</td>
<td>97%</td>
<td>4,258</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60,121</strong></td>
<td><strong>100%</strong></td>
<td><strong>4,974</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

---

3 Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims.
4 Humboldt County Mental Health Avatar Electronic Health Records.
<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>1</td>
<td>&lt;1%</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Female</td>
<td>28,908</td>
<td>51%</td>
<td>2,233</td>
<td>45%</td>
</tr>
<tr>
<td>Male</td>
<td>27,671</td>
<td>49%</td>
<td>2,740</td>
<td>55%</td>
</tr>
<tr>
<td>Total</td>
<td>56,579</td>
<td>100%</td>
<td>4,974</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with and without Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>6,284</td>
<td>11%</td>
<td>39</td>
<td>1%</td>
</tr>
<tr>
<td>6-17</td>
<td>11,174</td>
<td>20%</td>
<td>779</td>
<td>16%</td>
</tr>
<tr>
<td>18-59</td>
<td>33,074</td>
<td>58%</td>
<td>3,671</td>
<td>74%</td>
</tr>
<tr>
<td>60+</td>
<td>6,048</td>
<td>11%</td>
<td>485</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>56,580</td>
<td>100%</td>
<td>4,974</td>
<td>100%</td>
</tr>
</tbody>
</table>

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.

---

7 Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2017.
8 Humboldt County Mental Health Avatar Electronic Health Records.
9 Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2017.
10 Humboldt County Mental Health Avatar Electronic Health Records.
Medi-Cal Penetration Rates in Humboldt County as compared to other small counties and to the State of California in the category of race/ethnicity are presented in the chart below.

Humboldt County’s penetration rate for Native Americans with Medi-Cal receiving services to Native American residents with Medi-Cal is 5%. For other small counties the penetration rate is

---


4% and statewide it is 6%. 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 areas, 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 is not 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 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 1% of clients served while 3% 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 6% penetration rate in Humboldt County for African Americans as compared to 7% for other small counties and Statewide. The percentage of clients served with Medi-Cal and the percentage of residents with Medi-Cal are both 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, 5% for small counties and 6% statewide. White clients served with Medi-Cal are over represented at 66% while only 60% 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 9% of clients served while 13% 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 5% penetration rate for Multiracial/Other as compared to 7% for other small counties and 7% statewide. Multiracial/Other clients with Medi-Cal are 15% of clients served while 14% of residents with Medi-Cal are Multiracial/Other. This is a slight disparity, the same percentage as in 2016.

**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 13.

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

<table>
<thead>
<tr>
<th>Ages</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>6,284</td>
<td>11%</td>
<td>103</td>
<td>3%</td>
</tr>
<tr>
<td>6-17</td>
<td>11,174</td>
<td>20%</td>
<td>1,022</td>
<td>34%</td>
</tr>
<tr>
<td>18-59</td>
<td>33,074</td>
<td>58%</td>
<td>1,616</td>
<td>54%</td>
</tr>
<tr>
<td>60+</td>
<td>6,048</td>
<td>11%</td>
<td>262</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>56,580</td>
<td>100%</td>
<td>3,003</td>
<td>100%</td>
</tr>
</tbody>
</table>

The Penetration Rate in Humboldt County as compared to other small counties and to the State of California in the category of age is presented in the chart below.
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 2% 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 34% of clients with Medi-Cal served while 20% of residents in the county with Medi-Cal are in this age group. Thus 14% 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 54% 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 9% of clients served with Medi-Cal in this age group, while 11% 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** for Sex/Gender

<table>
<thead>
<tr>
<th>Sex/Gender</th>
<th>Number of Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>Number of Consumers Utilizing DHHS-MH Services (with Medi-Cal)</th>
<th>Percentage of Consumers Utilizing DHHS-MH Services (with Medi-Cal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>289,087</td>
<td>51%</td>
<td>1,471</td>
<td>49%</td>
</tr>
<tr>
<td>Male</td>
<td>27,671</td>
<td>49%</td>
<td>1,532</td>
<td>51%</td>
</tr>
<tr>
<td>Total</td>
<td>56,579</td>
<td>100%</td>
<td>3,003</td>
<td>100%</td>
</tr>
</tbody>
</table>

Humboldt County’s penetration rate for females with Medi-Cal receiving services compared to 

---

13 Behavioral Health Concepts (BHC)/California External Quality Review Organization, Medi-Cal Approved Claims Data for HUMBOLDT County MHP Calendar Year 2017.
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. 49% of clients with Medi-Cal served are female while 51% of
residents in the county with Medi-Cal are female. 51% of clients with Medi-Cal served are male
while 49% of residents in the county with Medi-Cal are male.

There is no state data available that includes information about gender other than
male/female. The DHHS/MH Client Information Form has checkboxes for Birth Sex: Male,
Female, and Gender: Same as Birth Sex, Male-to-Female Transgender, Female-to-Male
Transgender, Unknown, Other. As of September 2019 data from the Medical Records system
shows there are 25 female-to-male transgender clients, 18 male-to-female transgender clients,
12 other and 8 unknown.

IV. MHSA Community Services and Supports (CSS)\(^\text{14}\)

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>Number of Participants in CSS Funded Programs</th>
<th>Percentage of Participants in CSS Funded</th>
<th>Medi-Cal Recipients</th>
<th>Percent of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific</td>
<td>26</td>
<td>1%</td>
<td>1,950</td>
<td>3%</td>
<td>3186</td>
<td>2%</td>
</tr>
<tr>
<td>African</td>
<td>87</td>
<td>3%</td>
<td>1,003</td>
<td>2%</td>
<td>1393</td>
<td>1%</td>
</tr>
<tr>
<td>Multiracial/Other</td>
<td>248</td>
<td>10%</td>
<td>8,160</td>
<td>14%</td>
<td>5914</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>209</td>
<td>8%</td>
<td>7,305</td>
<td>13%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Native American</td>
<td>223</td>
<td>9%</td>
<td>4,313</td>
<td>8%</td>
<td>6961</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>1760</td>
<td>69%</td>
<td>33,851</td>
<td>60%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Total</td>
<td>2553</td>
<td>100%</td>
<td>56,582</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^{14}\) Humboldt County Mental Health Avatar Electronic Health Records.
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, 3% 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 69% of CSS clients, 60% of those with Medi-Cal and 77% of the general population. Hispanic/Latinos make up 8% of CSS clients, 13% of those with Medi-Cal and 10% of the general population. Multiracial/Other make up 10% of CSS clients, 14% of those with Medi-Cal and 4% of the general population.
Those whose primary language is English make up 83% of CSS clients, 97% of the Medi-Cal population, and 92% of the general population. Those whose primary language is Spanish make up <1% of CSS clients, 2% 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 16% of CSS clients, <1% of the Medi-Cal population, and 3% of the general population.

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Number of Participants in CSS Funded Programs</th>
<th>Percentage of Participants in CSS Funded Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2553</td>
<td>100%</td>
<td>60,121</td>
<td>100%</td>
<td>134623</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data for age groups in CSS does not correlate exactly with the age groups for Medi-Cal and the General Population. MHSA incorporates a specific TAY population that Medi-Cal and the General Population does not. The MHSA age groups are 0-15, 16-25, 26-59, and 60+, while data for Medi-Cal and the General Population is broken out by ages 0-5, 6-17, 18-59 and 60+.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Participants in CSS Funded Programs</th>
<th>Percentage of Participants in CSS Funded Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>6,284</td>
<td>11%</td>
<td>22304</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-15</td>
<td>263</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-17</td>
<td>11,174</td>
<td>20%</td>
<td>21409</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-25</td>
<td>417</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-59</td>
<td>33,074</td>
<td>58%</td>
<td>64151</td>
<td>48%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26-59</td>
<td>1406</td>
<td>56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60+</td>
<td>467</td>
<td>18%</td>
<td>6,048</td>
<td>11%</td>
<td>26759</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>2553</td>
<td>100%</td>
<td>56,580</td>
<td>100%</td>
<td>134623</td>
<td>100%</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{15}

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.

\textbf{Race/Ethnicity}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
\textbf{Race/Ethnicity} & \textbf{Number of Participants in PEI Programs} & \textbf{Percentage of Participants in PEI Programs} & \textbf{Medi-Cal Recipients} & \textbf{Percentage of Medi-Cal Recipients} & \textbf{General Population in Humboldt County} & \textbf{Percentage of General Population} \\
\hline
Asian/Pacific Islander & 18 & <1\% & 1950 & 3\% & 3186 & 2\% \\
\hline
African American & 39 & 1\% & 1003 & 2\% & 1393 & 1\% \\
\hline
\end{tabular}
\end{table}

\textsuperscript{15} Humboldt County Department of Health and Human Services, MHSA Prevention and Early Intervention spreadsheets and reports, FY 2018-19.
<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Number of Participants in PEI Programs</th>
<th>Percentage of Participants in PEI Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiracial/Other</td>
<td>170</td>
<td>6%</td>
<td>8,160</td>
<td>14%</td>
<td>5914</td>
<td>4%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>172</td>
<td>6%</td>
<td>7,305</td>
<td>13%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Native American</td>
<td>103</td>
<td>4%</td>
<td>4313</td>
<td>8%</td>
<td>6916</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>738</td>
<td>27%</td>
<td>33,851</td>
<td>60%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1,495</td>
<td>56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,735</strong></td>
<td><strong>100%</strong></td>
<td><strong>56,582</strong></td>
<td><strong>100%</strong></td>
<td><strong>134,623</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

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 less than 1% of PEI participants, 3% 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 27% of PEI participants, 60% of the Medi-Cal population, and 77% of the general population. Hispanic/Latinos make up 6% of PEI participants, 13% of the Medi-Cal population, and 10% of
the general population. Multiracial/other make up 6% of PEI participants, 14% of the Medi-Cal population, and 4% of the general population. For 56% of PEI participants, Race/Ethnicity was not captured.

**Primary Language**

<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Number of Participants in PEI Programs</th>
<th>Percentage of Participants in PEI Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao</td>
<td>0</td>
<td>0%</td>
<td>15</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Hmong</td>
<td>0</td>
<td>0%</td>
<td>234</td>
<td>&lt;1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>&lt;1%</td>
<td>1382</td>
<td>2%</td>
<td>4,312</td>
<td>3%</td>
</tr>
<tr>
<td>Spanish</td>
<td>15</td>
<td>&lt;1%</td>
<td>140</td>
<td>&lt;1%</td>
<td>6,904</td>
<td>5%</td>
</tr>
<tr>
<td>English</td>
<td>1131</td>
<td>41%</td>
<td>58,350</td>
<td>97%</td>
<td>123,407</td>
<td>92%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1585</td>
<td>58%</td>
<td>58,350</td>
<td>97%</td>
<td>134,623</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2735</strong></td>
<td><strong>100%</strong></td>
<td><strong>60,121</strong></td>
<td><strong>100%</strong></td>
<td><strong>134,623</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Those whose primary language is English make up 41% of PEI participants, 97% of the Medi-Cal population, and 92% of the general population. Those whose primary language is Spanish make up less than 1% of PEI participants, less than 1% of the Medi-Cal population, and 5% of the general population. There were no participants whose primary language is Hmong or Lao, compared to less than 1% for Medi-Cal recipients, and 0% for the general population. Those whose primary language is other make up <1% of PEI participants, 2% of Medi-Cal recipients and 3% of the general population. For 58% 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 from 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 58% of PEI participants Age was not captured.
<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Participants in PEI Programs</th>
<th>Percentage of Participants in PEI Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-5 (Medi-Cal)</td>
<td>6,284</td>
<td>11%</td>
<td></td>
<td></td>
<td>22,304</td>
<td>17%</td>
</tr>
<tr>
<td>Children 0-15 (MHSA)</td>
<td>0</td>
<td>0%</td>
<td></td>
<td></td>
<td>22,304</td>
<td>17%</td>
</tr>
<tr>
<td>Children 6-17 (Medi-Cal)</td>
<td>11,174</td>
<td>20%</td>
<td></td>
<td></td>
<td>21,409</td>
<td>16%</td>
</tr>
<tr>
<td>Transition Age Youth 16-25</td>
<td>307</td>
<td>11%</td>
<td></td>
<td></td>
<td>21,409</td>
<td>16%</td>
</tr>
<tr>
<td>Adults 18-59 (Medi-Cal)</td>
<td>33,074</td>
<td>58%</td>
<td></td>
<td></td>
<td>64,151</td>
<td>48%</td>
</tr>
<tr>
<td>Adults 26-29 (MHSA)</td>
<td>733</td>
<td>27%</td>
<td></td>
<td></td>
<td>67,595</td>
<td>50%</td>
</tr>
<tr>
<td>Older Adults 60+ (MHSA &amp;</td>
<td>110</td>
<td>4%</td>
<td></td>
<td></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>56,580</td>
<td>100%</td>
</tr>
<tr>
<td>Total age</td>
<td>2,735</td>
<td>100%</td>
<td>56,580</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Sex/Gender**

Because sex/gender is unknown for 59% of PEI participants, valid comparisons cannot be made.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Participants in PEI Programs</th>
<th>Percentage of Participants in PEI Programs</th>
<th>Medi-Cal Recipients</th>
<th>Percentage of Medi-Cal Recipients</th>
<th>General Population in Humboldt County</th>
<th>Percentage of General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>38</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>394</td>
<td>14%</td>
<td>27,671</td>
<td>49%</td>
<td>67,595</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>689</td>
<td>25%</td>
<td>28,908</td>
<td>51%</td>
<td>67,028</td>
<td>50%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1,614</td>
<td>59%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,735</td>
<td>100%</td>
<td>56,579</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

Disparity is the condition of being unequal, and is a noticeable difference between one or more things. Disparity usually refers to a difference that is unfair. In this section, a simple descriptive analysis was used to describe disparities. There was no analysis as to whether the disparities cited are statistically significant. The next Plan Update will incorporate statistical significance.

Medi-Cal Population (CY 2017 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 ages 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 (FY 2018-19 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 (August 2019 Employee Services data and Workforce Demographic Survey, September 2019). Looking first at the information available for DHHS Employee Services, August 2019, it is apparent that Whites are overrepresented in the Mental
Health workforce, and other racial/ethnic categories, excepting Asian American, are underrepresented. When the workforce is compared to the general population the disparity is most apparent for Hispanic/Latino, where 10% of the general population is Hispanic/Latino as compared to the workforce at 7%.

When looking at the data available from the Workforce Demographic Survey, September 2019, the picture still indicates disparities. In that survey 83% were White, 7% Other, and 6% Multiracial. However, this survey showed that 16% of those responding stated a Hispanic ethnicity, which is positive when compared to 10% of the general population.

The Workforce Demographic Survey also indicated that 21% of the workforce is LBGTQIA, with one person reporting being a Transgender Female. There is no Medi-Cal data with which to compare this but, as of September 2019, data from the Medical Records system shows there are 25 Female-to-Male Transgender clients, 18 Male-to-Female Transgender clients, 12 Other, and 8 Unknown. With the data available, it appears that there is a disparity in serving Transgender clients.

Prevention and Early Intervention (FY 2018-19 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 reducing those disparities

In this section, progress on addressing the strategies from the 2018 Plan will be discussed, and any new/revised strategies for the upcoming year will be detailed.

**Strategies addressing race/ethnicity disparities.**

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 attended the Racial Equity Consulting and Organizational Change Intensive in fall 2018. This Intensive is sponsored by The Equity Alliance of the North Coast. The Intensive focused 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 decided to continue meetings with The Equity Alliance to develop a plan for increasing training and other activities that increase cultural competence in the agency. As of this date, three meetings have been facilitated. A plan for training has not yet been announced, though it is anticipated that during 2020 it will be available.
   b) Planning began last year to bring a racial equity training, conducted by The Equity Alliance of the North Coast, to Mental Health staff in the Spring of 2019. Planning for this training was put on hold because DHHS leaders wanted to work further with The Equity Alliance to develop a training plan for the agency as a whole.
   c) Mandatory annual cultural competence training through the Relias E-Learning system continued, as did the mandatory annual interpreter and language line trainings. Criterion 5
sets forth the results of cultural competence training for FY 2018-19. Additional cultural competence trainings will be assigned through Relias in 2020.

d) A Cultural Competence Committee member researched and developed the Recovery Model Training—Social Inclusion, Collaborative Working and the Promotion of Hope and Autonomy, and presented to the Cultural Competence Committee in May 2019. Going forward, this training may be modified for upload into Relias E-Learning system and assigned to all staff, or presented live by a qualified individual.

e) The Cultural Competence Committee planned to research and/or develop training that includes parent/caretaker personal experiences with family focused treatment, navigating multiple agency services, and resiliency. This strategy was partially met through the Recovery Model training, highlighted above. However, research and development for the originally planned training still needs to occur.

2. Cultural Competence Committee projects. During the past year, four projects have been pursued.

Welcoming Environments. The objective of the Welcoming Environments project was to increase the welcoming quality of Mental Health locations and environments for diverse cultural and ethnic clients, those seeking services, and staff. In order to do this, a visual assessment at Mental Health locations was conducted through visits to Mental Health sites and an online survey was distributed to all Mental Health staff. Visits to 11 sites, one of which has six separate locations within the site, were conducted by a team of MHCCC members. 22 responses were received from the online survey.

Six of the locations visited were seen as visually welcoming or mostly welcoming to diverse populations, with seven being somewhat welcoming. Only three locations were seen as not welcoming in this perspective. Six of the locations were seen as welcoming or mostly welcoming in general, with nine as somewhat welcoming. Only one location was seen as not welcoming. The staff survey results indicate there are some programs where staff see efforts towards a welcoming environment, though these were less than half of the respondents. Their suggestions for increasing the sense of welcoming were good.

The results of the site visits and staff survey were shared with the managers of the programs/locations visited and with Mental Health Administration. A list of websites with resources for posters, decorations or other information was provided so program staff could choose items that will increase the welcoming nature of their sites. In addition, posters and brochures representing diverse populations from the Each Mind Matters campaign were made available to programs. Two programs took advantage of the Each Mind Matters materials and displayed posters and brochures. In addition, the team conducting the site visits noted that two locations had made efforts prior to the site visit to increase the welcoming atmosphere of their sites.

Latino Outreach. The purpose of this project was to develop a Spanish language PSA to be broadcast on local radio program Radio Bilingüe. A workgroup of the Cultural Competence Committee met with the Humboldt County Promotores to get their input, developed scripts in English and Spanish, and submitted those to the DHHS Communications Group/Media for
approval. Media determined that there would need to be a budget to place the PSA on the station, so a search for funding began. Eventually DHHS Public Health agreed to run the PSA as a part of their Stigma, Suicide, and Violence Prevention Program, but by that time KHSU, the radio station that had run the Radio Bilingüe program, had closed down, and the program was no longer being broadcast locally. The project was suspended for a time, but recently the workgroup learned of another new Spanish language station. The radio PSA may still be possible, and the workgroup will also explore the development and distribution of print materials in Spanish.

**Workforce Demographic Survey.** The database used by DHHS Employee Services is over ten years old and the demographic data on employees is limited. Committee members wanted to gather addition information, if possible, so in August 2019 an online Mental Health workforce demographic survey was distributed via email with a link to the survey. The survey consisted of twenty questions, asking staff for information on race, ethnicity, sexual orientation, gender, language, mental illness diagnosis in self or family, and homelessness. Completion of the survey was voluntary and responses were anonymous. The survey was available for four weeks. Results of this survey are discussed in Criterion 6.

**Client Race/Ethnicity Data Gathering.** Clients accessing Mental Health services complete a Client Information Form (CIF) that has questions about race, ethnicity, and religious preference. The categories of these questions are determined by State requirements. However, it is possible for the categories on the local CIF to be expanded/modified as long as there is a crosswalk when data is uploaded to the State systems. The Cultural Competence Committee has submitted a recommendation, approved by the Mental Health Director, that the Race and Ethnicity categories of the CIF be changed to reflect those of the MHSA Prevention and Early Intervention Regulations, thus expanding the choices available for clients. Included in the recommendation is to add a checkbox on the form for “Indigenous Religious/Spiritual Practices.” This addition is important, as Humboldt County is home to six federally recognized tribes. The recommendation has been forwarded to a team that includes Medical Records and Information Services for their consideration of the changes.

3. **MHSA Local Implementation Agreements.** A new MHSA program for 2018/19 and 2019/20, Local Implementation Agreements, provides 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 for January-June 2019, **Social, Emotional, Mental Health Student Engagement**, was to 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. Unfortunately, the District did not begin the project after contracting with DHHS due to various issues, so this project was not completed.
For FY 2019-2020 three Local Implementation Agreement were approved for funding that address race/ethnicity disparities.

**Bear River Band of the Rohnerville Rancheria, Bear River Youth Suicide Prevention Program**
Bear River Social Services will hire a consultant to conduct a three-day intensive peer-counseling program for Bear River youth that focuses on suicide and related issues, such as depression, trauma, violence, and substance abuse. The program will take place in February 2020 and will serve 25 people, including 20 youth, two Bear River social workers, and at least three Bear River community members. The program is called Native H.O.P.E. (Helping Our People Endure).

**Making Headway Wellness Center, Community Mental Health Project**
This project of Making Headway Wellness Center has two goals: to increase mental health services in Spanish and English and to increase domestic violence services in Humboldt County. MHWC will provide individual, family, and group therapy in both English and Spanish, using TRD—a trauma-informed and trauma-responsive practice that focuses on supporting individuals who have experienced emotional and physical trauma. This will help break the financial barrier that limits access to services for the Spanish-speaking community. Increasing domestic violence services will be achieved through using grant funding to offset the financial burden for those who are charged with domestic violence and court-ordered to participate in group psychotherapy.

**McKinleyville Community Collaborative (Family Resource Center), Hospitality and Volunteering Program Coordinator**
MFRC will send three people to Mental Health First Aid (MHFA) Training of Trainers with the intent of serving two target populations: monolingual Spanish speakers and Native American youth in contact with the juvenile justice system. MHFA is a training that focuses on increasing awareness of mental health symptoms, decreasing stigma related to mental health treatment, and providing strategies for community members to assist each other in accessing mental health support. Two of the attendees will be bilingual English-Spanish.

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. This program is still in place, with a planned end date of December 31, 2019.

In addition to the strategies discussed 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 and current collaboration includes 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 for January-June 2019 also targeted postpartum patients and families including toddler-ages through Open Door Community Health Centers Expansion of the Maternal Infant Dyad Implementation (MInD)-I Project. Unfortunately, Open Door was unable to hire the needed staff for this program, so it was not completed.

For the MHSA Local Implementation Agreements for 2019-20, one project was funded that will focus on very young children and their families.

**First 5 Humboldt (in partnership with The Gathering Place).** Families Thriving Together – An Individualized, Therapeutic Parenting Program
This project partners a local therapist with a First 5 Humboldt/HCOE Child and Family Support Specialist. They will develop and implement an intensive therapeutic parenting program based on Infant-Family and Early Childhood Mental Health (IFECMH) best practices to utilize the research-based Family Strengthening Protective Factors as a framework. The program will be offered at The Gathering Place, a trauma-responsive therapeutic environment created by the local therapist.

For older adults, 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 to the MHSA Expansion Project, DHHS Older Adults is developing and fine-tuning its relationship with Redwood Coast PACE (Program of All-Inclusive Care for the Elderly), a specialized health plan that helps people age 55 and older who need a nursing home level of care to remain at home and in their community for as long as possible. DHHS Older Adults continues to provide medication support services as well as case management and individual therapy for several DHHS clients who are also receiving PACE services. Historically, once enrolled into PACE, PACE assumed full care of the patient and made referrals to specialty care on an “as needed” basis. Today, the idea behind the “shared patient approach” is to ensure that DHHS clients continue to receive mental health services while PACE recruits and hires the
licensed staff needed to accommodate the huge influx of beneficiaries coming into their program. Upcoming meetings between PACE and DHHS will discuss the role of DHHS Mental Health as a “specialty” service, with clearer guidelines around service timeframes, what the criteria looks like to justify receiving Specialty Mental Health Services, and redefining Mental Health’s role as the psychiatric ‘consultant’ while PACE provides the bulk of psychiatric care, including medication management, to shared patients who are in remission or have had long term stability on their current medication regimen.

During the past year, one of the MHSA Local Implementation Agreements focused on older adults. The Area 1 Agency on Aging presented a one-day conference on hoarding, *Dispelling Stigma: Hoarding Education, Treatment, and Prevention Conference*. The conference was attended by 105 people. In addition, the formation of a self-help support group for people who hoard, the formation of self-help support groups for families of people who hoard, and the development of a Task Force on hoarding were also completed this year. While people of any age can have a hoarding disorder, symptoms appear to be three times more common in older adults.

**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 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 MHSA stakeholder meetings. These strategies will be continued over the next three years. In addition, the MH Quality Improvement unit has improved capturing data regarding the use of interpreters from paper format to electronic. The progress note form in the electronic Health Record has been updated to capture use of interpretation services for more accurate and reliable data collection. The new fields include Services Utilized (client’s choice of interpreter, Language Line services, onsite interpreter, or practitioner bi-lingual language skills) and which language was accessed. Reports can now conveniently be run out of the electronic Health Record.

**Strategies addressing LGBTQIA disparities.** The strategy to address this disparity was to improve data collection. Without data, disparities cannot be determined. There is no Medi-Cal data on the LBGTQIA population, and it is unknown if there will be a move at the State level to start
collecting it. In October 2017, Mental Health added a custom field in the electronic health record (Avatar) client demographic screens and a new line on the paper Client Information Form for client gender identity. As of September 2019, data from the system shows there are 25 Female-to-Male Transgender clients, 18 Male-to-Female Transgender clients, 12 Other, and 8 Unknown.

Improved data collection about this population is also happening through the Workforce Demographic Survey, which is discussed in Criterion 6. This data shows that 21% of the workforce is LBGTQIA, with one person reporting being a Transgender Female. Conversations with DHHS Employee Services revealed that information on gender identity cannot be collected as it is confidential information, and cannot be asked of employees or staff.

**Strategies addressing workforce disparities.** A change in the leadership of County Human Resources in the past couple of years resulted in the sharing of recruitment efforts with County departments. Programs are providing 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. While a direct correlation between changes in recruitment practices and an increase in staff from diverse cultures cannot be drawn, the Employee Services database shows an increase in staff identifying as Hispanic from 16 in 2018 to 24 in 2019.

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. At this time, three of the 19 peer support staff are not White.

DHHS is a registered HRSA site for student loan repayment programs and recruits through that site for diverse staff. In the past year, availability has expanded to seven sites.

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

**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
• MH Mental Health Workforce Survey
• DHHS Quality Management Services (QMS) Evidence Based Practices Dashboards
• DHHS Integrated Progress & Trends Report

V. What has been working well and lessons learned

Strategies in the Department as a whole that benefit 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 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. In the past year, their services have expanded to working with adult mental health programs.

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 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 (MIST) also provides outreach and services to people with severe mental illness who experience homelessness.** At this time, services are provided in Eureka and Arcata. Planning to expand to other areas is in the discussion stage with the Humboldt County Sheriff’s Office.

- **Regional Services provide clinicians, case managers, and substance abuse counselors in the Eastern and Southern regions of the County.** Some staff reside in those areas, and some travel from Eureka on a weekly schedule to provide services wherever the clients may be.

- **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.

- **Children’s and Adults Mental Health staff have been meeting with K’ima:W Medical Center staff on the Hupa Tribe Reservation over the past year to discuss ways in which there can be better collaboration and coordination of services for those residing on the reservation.**

- **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.

- **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.

- The Mobile Response Team for Adult Services provides crisis intervention in the field to address an immediate crisis in the least restrictive manner possible. The Team can provide face-to-face counseling and supportive interventions, assessment of mental health and or substance use disorder, facilitation of transportation to the Crisis Stabilization Unit, coordination of appropriate community-based services, and provide family support services. Hours of operation are 8AM to 7PM.

- 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.

- 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, Children’s Mental Health and the Transition Age Youth Division. 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.

During the summer of 2019, the Quality Improvement Committee gathered demographic data as it relates to those participating in all QI activities. An anonymous survey was distributed during various QI meetings, including OP CQI, Sempervirens CQI (the inpatient Continuous Quality Improvement Committee), Committee on Performance Improvement Projects, Cultural Competency Committee, and Utilization Review Committee. Thirty-two surveys were completed. This demographic data helped to understand more fully who (staff and consumer/family members) are involved in Quality Improvement Activities. Data gathered is presented below.

Twenty-two percent of the thirty-two survey participants were ages 60+ and 78% were ages 26-59. 75% were female, 22% male, and 3% transgender. Everyone spoke English as their primary language.
Eighty-one percent were heterosexual/straight, 15% were LGBTQ, and 3% preferred not to answer.

Seventy-five percent were White, with 3% Hispanic, 6% were multiracial, with 3% Hispanic, 3% preferred no answer, 3% were Asian, 3% Black, and 3% Other.
Thirty-four percent reported having a disability, 19% reported no disability, and 47% did not answer. A chronic health condition, 27%, was the disability most noted. Thirty-four percent reported experiencing homelessness in their lives. Forty-seven percent reported being diagnosed with a mental illness and 3% reported an undiagnosed mental illness.

Sixty-six percent reported a family member experiencing a diagnosed mental illness, and 13% reported a family member experiencing an undiagnosed mental illness.
While this survey did not ask staff if they are currently clients of the DHHS mental health system, it does indicate that 47% have been diagnosed with a mental illness. Whether or not that diagnosis came from DHHS or another mental health system, it still indicates that mental health clients—current or former—are involved in the system. The same can be said of the 66% reporting that they have a family member diagnosed with mental illness—whether that family member’s diagnosis came from DHHS or not, these staff are family members.

DHHS Mental Health’s approach to consumers and family member involvement is multifold. For example, the MHCCC is a subcommittee of DHHS Mental Health’s Continuous Quality Improvement Committee (CQI), and consumer involvement in quality improvement activities is a priority and made a part of the Quality Improvement Work Plan. Consumer employees such as Peer Coaches and Parent Partners are represented in both MHCCC and CQI. The Quality Improvement unit regularly conducts focus groups to get direct input from consumers and family members. QI leadership attends NAMI meetings quarterly and periodically reports out at Behavioral Health Board meetings. During these occasions, participants are invited to become involved in QI committee work. A new approach this coming year is to make interest cards for participation in focus groups available in waiting areas and treating staff’s offices.

The purpose of surveying members of various QI related meetings and committees, including those employed by county, consumer employees, or volunteers with lived experience was to acknowledge that staff may have lived experience with Mental Illness as clients themselves or family members of clients, yet choose not to self-identify. The survey confirmed that this is indeed the case. It is our hope that staff’s lived experience influences the way they engage with clients in the course of their work to promote recovery and well-being as well as create a supportive work environment based on recovery principles and empathy.
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.

Almost 400 mental health related staff 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 (1.25 hour); 10 Steps to Fully Integrating Peers into your Workforce (1 hour); A Culture-Centered Approach to Recovery (1 hour); Advocacy and Multicultural Care (0.5 hours); Infusion of Culturally Responsive Practices (1.75 hours); and On-Boarding and Cultural Development (1 hour); Cultural Competence & Sensitivity in the LGBTQ Community (1 hour); Cultural Dimensions of Relapse Prevention (1.25 hours); Groundwork for Multicultural Care (1.25 hours); Cultural Competence Training: Advancing Recovery Practices Cultural Competence (0.5 hour); Cultural Issues in Treatment for Paraprofessionals (0.75 hour); and Mindfulness, Meditation & Spirituality as Tools for Recovery (1 hour).

In addition to the courses available in the Relias course catalog, five online trainings developed by DHHS MH have also been added to Relias. These are Peer Coaches & Parent Partners Cultural Competency Training; Documenting Chosen Gender Identity and Gender Expression; Introduction to Recovery Oriented Practices; Cultural Competence Training: Working with Interpreters; and The Recovery Model. These five 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.

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, as well as directly assigned to staff members in Relias.

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.
In FY 2018-2019, all Mental Health staff were assigned to complete a course titled “The Recovery Model” to fulfill this requirement.

In addition to “The Recovery Model,” mental health staff also completed elective courses in Relias. In FY 2018-2019, 286 staff completed 594 hours of cultural competence training. When compared to 376 current Relias users, this indicates a 76% overall compliance rate.
<table>
<thead>
<tr>
<th>Cultural Competence Course</th>
<th>Hours Completed</th>
<th>Job Functions Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Coaches &amp; Parent Partners</td>
<td>1</td>
<td>Clinician, Peer</td>
</tr>
<tr>
<td>Cultural Competency Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Competence &amp; Sensitivity in the LGBTQ Community</td>
<td>1</td>
<td>Leadership</td>
</tr>
<tr>
<td>Cultural Dimensions of Relapse Prevention</td>
<td>1.25</td>
<td>Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>Cultural Diversity - Retired 2/2/2019</td>
<td>1.25</td>
<td>Clinician</td>
</tr>
<tr>
<td>Groundwork for Multicultural Care</td>
<td>1.25</td>
<td>Administrative</td>
</tr>
<tr>
<td>Cultural Competence &amp; Sensitivity in the LGBTQ Community</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>2</td>
<td>Administrative, Clinician, Mental Health Worker</td>
</tr>
<tr>
<td>Cultural Competence &amp; Sensitivity in the LGBTQ Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Dimensions of Relapse Prevention</td>
<td>1.25</td>
<td>Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>Cultural Diversity - Retired 2/2/2019</td>
<td>1.25</td>
<td>Clinician</td>
</tr>
<tr>
<td>Groundwork for Multicultural Care</td>
<td>1.25</td>
<td>Administrative</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>2</td>
<td>Administrative, Clinician, Leadership</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Competence &amp; Sensitivity in the LGBTQ Community</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cultural Dimensions of Relapse Prevention</td>
<td>1.25</td>
<td>Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>Cultural Diversity - Retired 2/2/2019</td>
<td>1.25</td>
<td>Clinician</td>
</tr>
<tr>
<td>Groundwork for Multicultural Care</td>
<td>1.25</td>
<td>Administrative</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>2</td>
<td>Administrative, Clinician, Leadership</td>
</tr>
<tr>
<td>Cultural Competence &amp; Sensitivity in the LGBTQ Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Dimensions of Relapse Prevention</td>
<td>1.25</td>
<td>Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>Cultural Diversity - Retired 2/2/2019</td>
<td>1.25</td>
<td>Clinician</td>
</tr>
<tr>
<td>Groundwork for Multicultural Care</td>
<td>1.25</td>
<td>Administrative</td>
</tr>
<tr>
<td>Cultural Competence</td>
<td>2</td>
<td>Administrative, Clinician, Leadership</td>
</tr>
<tr>
<td>Mindfulness, Meditation &amp; Spirituality as Tools for Recovery</td>
<td>4</td>
<td>Leadership, Mental Health Worker, Peer, Psychiatric Technician</td>
</tr>
<tr>
<td>Advocacy &amp; Multicultural Care</td>
<td>4.5</td>
<td>Administrative, Leadership, Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>Cultural Competence Training: Working with Interpreters</td>
<td>106.5</td>
<td>Administrative, Case Manager, Clinician, Leadership, Mental Health Worker, Nurse, Other Direct Service, Peer, Psychiatric Nurse, Psychiatric Technician, Psychiatrist, Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>A Culture-Centered Approach to Recovery</td>
<td>217</td>
<td>Administrative, Case Manager, Clinician, Leadership, Mental Health Worker, Nurse, Other Direct Service, Peer, Psychiatric Nurse, Psychiatric Technician, Psychiatrist, Substance Use Disorder Counselor</td>
</tr>
<tr>
<td>The Recovery Model</td>
<td>250</td>
<td>Administrative, Case Manager, Clinician, Leadership, Mental Health Worker, Nurse, Other Direct Service, Peer, Psychiatric Nurse, Psychiatric Technician, Psychiatrist, Substance Use Disorder Counselor</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>594</strong></td>
<td></td>
</tr>
</tbody>
</table>

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.
A Cultural Competence Committee member researched and developed the Recovery Model Training—Social Inclusion, Collaborative Working and the Promotion of Hope and Autonomy, and presented to the Cultural Competence Committee in May 2019. Going forward, this training may be modified for upload into Relias E-Learning system and assigned to all staff, or presented live by a qualified individual.

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 Cultural Competence Committee planned to research and/or develop training that includes parent/caretaker personal experiences with family focused treatment, navigating multiple agency services, and resiliency. This strategy was partially met through the Recovery Model training, highlighted above. However, research and development for the originally planned training still needs to occur. The FY 2019/20 QI Work Plan includes as an “Effectiveness of Care” goal to increase Mental Health staff’s understanding of the use of the Recovery Model and inclusion of natural supports in mental health treatment. Planned activities include the creation of a pamphlet / handout for a client’s natural support system regarding “First Psychotic Break.”
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.

1. MHSA Workforce Education and Training (WET)\textsuperscript{16} Using DHHS Employee Services data

<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>11</td>
<td>3%</td>
<td>4,313</td>
<td>8%</td>
<td>294</td>
<td>10%</td>
<td>6,961</td>
<td>5%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3</td>
<td>1%</td>
<td>1,950</td>
<td>3%</td>
<td>41</td>
<td>1%</td>
<td>3,186</td>
<td>2%</td>
</tr>
<tr>
<td>African American/ Black</td>
<td>8</td>
<td>2%</td>
<td>1,003</td>
<td>2%</td>
<td>106</td>
<td>4%</td>
<td>1,393</td>
<td>1%</td>
</tr>
<tr>
<td>White</td>
<td>272</td>
<td>83%</td>
<td>33,851</td>
<td>60%</td>
<td>2,022</td>
<td>68%</td>
<td>103,958</td>
<td>77%</td>
</tr>
<tr>
<td>Hispanic/ Latino</td>
<td>24</td>
<td>7%</td>
<td>7,305</td>
<td>13%</td>
<td>300</td>
<td>10%</td>
<td>13,211</td>
<td>10%</td>
</tr>
<tr>
<td>Multiracial/ Other/Unknown</td>
<td>12</td>
<td>4%</td>
<td>8,160</td>
<td>14%</td>
<td>204</td>
<td>7%</td>
<td>5,914</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>330</td>
<td>100%</td>
<td>56,582</td>
<td>100%</td>
<td>2,967</td>
<td>100%</td>
<td>134,623</td>
<td>100%</td>
</tr>
</tbody>
</table>

\textsuperscript{16} Humboldt County Department of Health and Human Services, Employee Services database (EMPS), August 2019.
Native Americans make up 3% of the workforce, 10% of clients, and 5% of the General Population. Asian/Pacific Islanders make up 1% of the workforce, 1% of clients, and 2% of the General Population. African American/Blacks make up 2% of the workforce, 4% of the clients served, and 1% of the General Population. Multiracial/other/unknown make up 4% of the workforce, 7% of the clients served, and 4% of the General Population. Hispanic/Latinos make up 7% of the workforce, 10% of the clients served, and 10% of the General Population. Whites make up 83% of the workforce, 68% 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 and the general population.

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/Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Mgr./CHOW</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>46</td>
<td>4</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>Employment Svcs.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Peer Support</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>MH Worker</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>88</td>
<td>6</td>
<td>2</td>
<td>110</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Licensed 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/Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>2</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Psychiatric Tech</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Clinician</td>
<td>1</td>
<td></td>
<td></td>
<td>50</td>
<td>8</td>
<td>2</td>
<td>61</td>
</tr>
<tr>
<td>SUD Counselor</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Totals</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>83</td>
<td>12</td>
<td>4</td>
<td>102</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managerial and Supervisory</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/Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervising Clinician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Mgrs., Supervisor</td>
<td>1</td>
<td>0</td>
<td></td>
<td>23</td>
<td>2</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Supervising Psych. Nurse</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>
Six Mental Health staff receive the bilingual pay differential for speaking Spanish as well as English. These are two Case Managers, three Program Coordinators, and one Supervising Psychiatric Nurse. There may be more staff who speak a language other than English but do not receive the bilingual differential, but this information is not available in the DHHS Employee Services database. It is positive, however, that the number of staff who are Hispanic/Latino increased from 16 to 24 over the past year.

### 2. Workforce Demographics Using Mental Health Demographic Survey

In September 2019, the Mental Health Cultural Competence Committee facilitated an online Mental Health workforce demographic survey. The survey consisted of twenty questions, asking staff for information on race, ethnicity, sexual orientation, gender, language, mental illness diagnosis in self or family, and homelessness. An email from the Mental Health Director was sent to all staff with a link to the survey. Completion of the survey was voluntary and responses were anonymous. The survey was available for five weeks. Sixty percent of staff completed the survey.

- 81% are ages 26-59, 15% are ages 60+. Four people are ages 16-25.
- 82% are White, 7% are American Indian/Alaska Native, 6% are Other, 6% are Multiracial. Two people are Asian, four are Native Hawaiian or other Pacific Islander, and one is African American.
- 21 people, 12%, have Hispanic/Latino ethnic identity, with the majority being Mexican/Mexican American/Chicano.
- 97% speak English most often. One person speaks Spanish most often.
- 64% are heterosexual, 10% Bisexual, 5% Queer, 4% Gay or Lesbian, and 3% Other orientation. 13% preferred not to answer this question.
- For sex assigned at birth, 72% are female, 25% are male, and the rest preferred not to answer.
- For current gender identity, 70% are female, 23% are male, two people are non-binary.

<table>
<thead>
<tr>
<th>Managerial and Supervisory</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/Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>42</td>
<td>3</td>
<td>1</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support 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/Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyst, IS, QI, ES, Fiscal</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>31</td>
<td>1</td>
<td>4</td>
<td>38</td>
</tr>
<tr>
<td>Clerical</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>2</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Other Support Staff</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Totals</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>60</td>
<td>3</td>
<td>4</td>
<td>70</td>
</tr>
</tbody>
</table>
third gender, and one is transgender female. The others preferred not to answer.

- 69% have no disability, 12% have a chronic health condition, 8% have a physical/mobility issue. 6 people checked Other, and stated major depressive disorder, brain injury, mental illness, neurological, and mood disorder. 15 people preferred not to answer.
- 5 people are military veterans.
- 40% have been homeless, lived on the streets, in a shelter, or couch surfed. 58% have not experienced these conditions.
- 54% have experienced a diagnosed mental health condition, 6% have experienced an undiagnosed mental health condition, and 32% have not. 8% preferred not to answer.
- 59% have a family member with a diagnosed mental health condition, 17% have a family member with an undiagnosed mental health condition, and 18% do not have a family member with a mental health condition. 7% preferred not to answer.

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 explicitly met. Mental Health now has 19 full-time equivalent peer personnel.

Workforce strategies identified in the Cultural Competence Plan of 2011 were reiterated in the Update of 2018.

- 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. DHHS Employee Services regularly asks recruiting programs for recruitment distribution lists to expand the reach of activities.
- The distance learning programs through Humboldt State University continue to provide county residents and human service workers a career path. The Masters of Social Work Programs offer a specialty in Native American/Tribal Communities. This has been successful in bringing new social workers to the agency.
- Staff development opportunities, 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.

While not a strategy specifically set forth in the 2018 Plan Update, during 2019 the number of
certified HRSA sites went from two to seven. Being a certified site means those who are working there can get education loan repayment.

Workforce strategies from the 2018 Plan will be continued. In addition to those strategies, the following strategies will be implemented.

- The California State Legislature approved, in its 2019/2020 budget, funding to the Office of Statewide Health Planning and Development (OSHPD) to implement another Five Year Workforce Education and Training (WET) Plan. This Plan includes providing opportunities for the MHSA Regions in California to apply for funding to implement WET activities in their regions. Humboldt, as a member of the Superior Region, will be participating in this endeavor. Specifics of what the WET activities will be in the Region has not yet been determined.

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

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

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 workforce 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.

DHHS Mental Health 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.

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

DHHS Mental Health participates in the National Health Service Corps Loan Repayment Program (HRSA). Seven Mental Health program sites are certified HRSA sites, which could be an incentive to attract qualified bi-lingual providers.

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 six 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 is $15,000 in Fiscal Year 2019-2020 (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 two Case Managers, three Program Coordinators, and one Supervising 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. The Quality Improvement and Information Systems staff met to create a Project Plan. The team reached out to the local Jail Services who are using a specific ASL vendor to inquire about the quality of services and satisfaction with the product. This inquiry was affirmative and next we requested information and quotes from the vendor. The team held a phone conference with their representative to go over details and questions, and then conducted an initial Demo Call / Test Call at the IS office location. Testing went well and a second test at an actual service site (Sempervirens Psychiatric Health Facility) as well as on a mobile device were successful in terms of connectivity and call quality. Next steps will be to determine appropriate office space for installation of webcams and if designated mobile devices can be shared between users. The vendor provided a Professional Interpreter Services Agreement, which will be reviewed and finalized in accordance with our internal contract process. This project is anticipated to be completed in fiscal year 2019-20.

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 in 2017, 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 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 services, although this can be facilitated at the client’s specific request and with appropriate releases. Minor Children should not be used as interpreters.

DHHS 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 each licensed, waivered, or registered mental health provider
and licensed substance use disorder services provider employed by or contracted with DHHS
Mental Health to deliver Medi-Cal services.

This list is updated monthly and offered to clients during the intake process, where clients are
also informed in a language that they understand that they have the right to free language
assistance services. A link to the directory, which is posted on the 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 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,
ocasionally 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. This fiscal year, we also implemented a new and more comprehensive
onboarding process that includes accessing interpreters. 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 77% of Humboldt County’s population is
White, 10% Hispanic/Latino, 5% 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 six 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 nine Spanish language Interpreters and one Hmong interpreter listed.

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

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

E. County technical assistance needs

While the California Department of Health Care Services has made available a Mental Health Interpreter Training Curriculum to county mental health programs, there is a need for Interpreter Training geared towards meeting the needs of small counties. DHHS 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 August 2019)
employs six 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. Their functions are Case Managers for Children, Youth, and Family Services and for Community Comprehensive Treatment (2); Program Coordinators for Mobile Outreach Services; (3) and a Supervising Psychiatric Nurse at Sempervirens Psychiatric Health Facility (1).

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

DHHS has a job classification titled Interpreter/Translator. This classification is not limited to a particular language and can be used by multiple programs. DHHS Public Health has hired a full time Interpreter/Translator. This staff member 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. The Quality Improvement Unit has issued Avatar Info Bulletin 18-A010 to inform staff of this change. DHHS Mental Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Competence Committee.

In Fiscal Year 2018-2019, 245 encounters required Language Line Services. The chart below shows these encounters broken out by language used.
In Fiscal Year 2018-2019, 53 client encounters required community interpreter services. The chart below shows these encounters broken out by language used.

C. Evidence of providing linguistically proficient staff or contracted services during regular day operating hours
As stated above in section III. A, six DHHS Mental Health staff members receive bi-lingual pay. Their functions are Case Managers for Children, Youth, and Family Services and for Community Comprehensive Treatment (2); Program Coordinators for Mobile Outreach Services; (3) and a Supervising Psychiatric Nurse at Sempervirens Psychiatric Health Facility (1).
DHHS Mental Health maintains an interpreter list composed of contracted local community providers, with nine Spanish interpreters and one Hmong interpreter currently available. 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 Bi-lingual 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 designated 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 this can be facilitated at the client’s specific request and with appropriate releases. The expectation that minor children should not be used as interpreters is clearly spelled out in policy & procedure 0100.604 (referenced above in Section II. A.), and is included in staff training materials about working with interpreters.

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

A. Written information for threshold languages
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. DHHS Mental Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Competence Committee.

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 zero and three 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 of transition age youth, adults and older adults who have mental health challenges and their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from SAMHSA, and the resources necessary for people with and without a mental health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of all seven of the negative outcomes that may result from untreated mental illness.

The Hope Center is peer driven with a full time Peer Coach III who oversees the Center, three full time Peer Coach staff, two part time Peer Coach staff, and one volunteer. There are two to three Work Experience workers at the Center as well. Consultation is provided by a Senior Program Manager. The majority of the Peer Coaches are trained as Certified Peer Support Specialists through Recovery Innovations (RI) International. The Peer Coach III has additional training through the California Association of Mental Health Peer-Run Organizations (CAMHPRO) and the California Association of Social Rehabilitation Agencies (CASRA) as a Train-the-Trainer in the Superior Region Provider Core Competency Training. The supervisor of the peers has gone through a Peer Supervisor Training through RI International. The Peer Coach III is leading cross-training of other staff so everyone is able to do the work in the absence of one of the staff. Three staff and one volunteer have completed the Hearing Voices Network Facilitators Training.

Hope Center goals are to:
- Build on the dimensions of wellness
- Incorporate recovery pathways
- Validate strengths and honor the person
- Build sustainable living skills
- Build community engagement
- Promote self-advocacy
- Keep Hope Center a safe location for all participants
- Reduce stigma and discrimination within the system of care and the broader community
- Encourage individuals to find their personal strengths and identify their personal recovery goals
- Break the stigma of the us and them

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff and volunteers to people with a mental health diagnosis. Two Peer Coaches are teaching “My Wellness My Doctor and Me” classes that teach 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 Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

During fiscal year 2018-2019, the Hope Center interfaced with 1,032 unduplicated individuals. There were 13,148 sign ins to the program. Of the 1,032 Hope Center participants, 374 (36%) completed demographic forms. Eight percent of participants were ages 16-25, 76% of participants were ages 26-59, and 12% were age 60+. Forty-two percent of Hope Center participants were female, 51% male, and 6% did not respond to the question. Four participants reported their gender as Other. Sixty-three percent of Hope Center participants were White, 22% were Multiracial/Other, 13% were Hispanic/Latinx, 6% were American Indian, and 3% were Black/African American. There were two Asian/Pacific Islander participants, less than 1%. Six percent did not respond to the question. Eleven percent identified as LGBTQ, 65% has experience with homelessness, 66% had been diagnosed with a serious mental illness (SMI), 51% has a family member diagnosed with SMI, and 6% had military experience.

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.

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

During 2018-19, HCTAYC served 88 unique individuals according to sign-in sheet records collected at many activities, trainings, and events. However, not all participants sign-in during these activities and not all activities had sign-in sheets due to logistical constraints or staff error. It is estimated that HCTAYC has served at least 115 unique individuals in the reporting period. Almost 57% of participants were White, non-Hispanic. Fourteen percent were American Indian/Alaska Native, representing Cherokee, Karuk, Yaqui, Hupa, Yurok, Maido, Cocow tribes. Almost 5% were Black/African American, and 1% were Native Hawaiian or Pacific Islander. Hispanic/Latinx participants were almost 8%, less than 1% were Asian, 4% were other, and 3% preferred not to answer. Twenty-two percent of participants indicated their ethnicity as Mexican/Mexican American. Almost 22% of participants indicated their ethnic identity as European. Ten percent indicated Other, without specifying the category. Five percent said Central American, 2% said Eastern European, and less than 1% said African, Irish, Polynesian, Yurok, Irish, or other Native American. Thirty-three participants stated their assigned sex at birth was male; 88 stated female, and 15 preferred no answer. Their current gender identity was 30 male; 85 female; 9 prefer not to answer; 3 trans male; 2 questioning/unsure, and 10 genderqueer. Eighty-two participants stated they are straight/heterosexual, 47 stated LGBTQ/Other, and three preferred not to answer. Forty-five percent had experience with homelessness, 48% did not, and 7% preferred not to answer.
II. Responsiveness of mental health services

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

The TAY Division, as discussed above, 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 the last year, DHHS contracted with Two Feathers Native American Family Services, using MHSA Prevention and Early Intervention funding, to come together with Big Lagoon Rancheria, Trinidad Rancheria, and the Bear River Band of the Rohnerville Rancheria, to develop a consortium to create a community informed, culturally grounded, systematized approach to tribal mental health. Included in this approach will be the development of an indigenous mental health curriculum that seeks to meet the needs of the local tribal communities of Humboldt County. In addition to developing the consortium, Two Feathers has begun the process to become an organizational provider with DHHS Mental Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty mental health services waiver.

Specific strategies will include restoring relationships by bringing meaning back to the idea of “being a good relative.” This “Making Relatives” approach will assist youth through the creation of a team of relatives including family, community members, and professional service providers that mentor, model and support the youth and families in the achievement of wellness. With innovative components grounded in the western system of care “Wraparound,” this team will work with youth and families to reconnect to traditional cultural values and practices, including locally informed tribal child rearing and wellness practices and traditional life skills. An intensive in-home program that utilizes trained lay tribal staff that go into the family’s home (similar to grandparents, aunties, and uncles) to model and coach parenting and life and identity skills; connect youth and families to cultural activities and events in the community (thereby expanding the family’s community supports); connect the family to educational supports, psychoeducation on conceptualization of tribal mental health views that are more contextual and strength based, linkage to medical and behavioral health community based services; and providing crisis response.

In addition to direct referrals to culturally specific programs, 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 and Hmong speakers. If a client speaks one of these languages, they have the option of requesting a live interpreter or using the Language Line.

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;
The HOME (Housing, Outreach, and Mobile Engagement) program focuses on bringing services and supports to facilitate the ease with which individuals can access services and supports. One component of HOME, Mobile Outreach, engages clients by meeting them in the communities in which they live, or on board one of the outreach vehicles that carry DHHS staff 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. Mobile Outreach also has a Mobile Engagement Vehicle (MEV), a converted RV which acts as rolling office space and visits 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 Housing component of HOME also focuses on bringing services and supports to where people are. The first housing project supported by MHSA funding is in Arcata and has 15 studio apartments for mental health clients. Another housing project in Eureka has 15 subsidized apartments for HOME/MIST clients. In construction in Eureka is another 50-unit apartment building with community and meeting space for tenants. This development has 25 units for eligible HOME/MIST clients. Occupancy should begin in spring of 2020. A fourth project also in construction is a 25-unit project in Rio Dell. This project will be individual small homes with all utilities and amenities that are fully ADA compliant for eligible HOME/MIST clients. For all projects, HOME staff provide services on-site. There are also resident services staff on site. In addition to clinical services, recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma are provided. All projects also include community spaces for events, supportive services, and recreation.

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, the Eureka Police Department, and the Arcata Police Department. MIST targets people with severe mental illness who are homeless in the Eureka and Arcata and have frequent contact with law enforcement. In 2018-19, MIST began planning an expansion to outlying areas of the County in conjunction with the Humboldt County Sheriff’s Office (HCSO). This partnership with HCSO is still in the early development stage and a protocol for receiving referrals is being established. Regional Services provides mental health clinicians, case managers and a substance abuse counselor in the Eastern Humboldt and Southern Humboldt regions of the County. Staff are either based at one of the DHHS outlying offices or travel in vans to meet clients where they are.

The Comprehensive Community Treatment (CCT)/Full Service Partnership program makes available intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, or other needed community services) to achieve recovery. 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.

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. With that being said, some buildings rented by Mental Health have had work performed on the outside of the buildings—ramps and parking lots— to create better access. These improvements are found at the location housing Outpatient Services, Sempervirens, and Crisis Services; at the HOME program; and at the Children’s Mental Health Clinic.

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

- Artwork produced by people with lived experience is on display on the walls of program waiting areas and group therapy rooms as well as at the Crisis Services Unit. This artwork can be purchased and is rotated regularly with new pieces. Posters produced by the Youth Training Project are posted in lobby areas.
- Spanish language posters and Spanish educational materials are available and have been distributed to programs for posting.
- “Every BODY has an issue” first place winning poster of the 2010 Prevention and Early Intervention Program to reduce stigma and discrimination related to mental health is also widely posted throughout the agency.
- Posters promoting acceptance of Lesbian/Gay/Bisexual/Queer/Questioning/Transgender youth obtained from the Y.O.U.T.H. (Youth Offering Unique Tangible Help) Training Project are posted throughout the Department.

In addition, the Mental Health Cultural Competence Committee recently completed the Welcoming Environments project. The results of this project were discussed in Criterion 2.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. As an integrated agency, the Humboldt County Department of Health and Human Services 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. Over the past several years, DHHS has worked with partners in the McKinleyville area to develop The Center at McKinleyville. This will be a one-stop location for services, information, and activities for community members in the McKinleyville area. Services currently provided by the McKinleyville Family Resource Center (MFRC), DHHS, and Open Door Community Health Center will be located together so that community members have one place to go to access a wide variety of services. This will be a non-stigmatizing community setting. The Center will not be a DHHS facility. Leadership and decision-making will be shared between the MFRC, DHHS, and Open Door, with MFRC as the primary partner to ensure community voice will guide decisions. 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 FY17-18 and FY 18-19. All grievances were resolved according to protocol, and there were zero grievances filed under the category “Cultural Appropriateness.”

<table>
<thead>
<tr>
<th>ABGAR Category</th>
<th>Grievances FY 17-18</th>
<th>Grievances FY 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Not Available</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Service not Accessible</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Timeliness of Services</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>24/7 toll free access line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Linguistic Services</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other Access issues</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Access Total</strong></td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Quality Of Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Behavior Concerns</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Treatment issues or Concerns</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Medication Concerns</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other quality care issues</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Quality of Care Total</strong></td>
<td>54</td>
<td>37</td>
</tr>
<tr>
<td><strong>Change of Provider</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Confidentiality Concerns</strong></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lost Property</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Operational</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Patients’ Rights</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Peer Behaviors</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other Grievances not listed Above</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>Other Total</strong></td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>78</td>
<td>59</td>
</tr>
</tbody>
</table>
The charts below provide a summary of grievances received between July 1, 2018 and June 30, 2019, by race/ethnicity.

### Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Unique Open Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>62</td>
</tr>
<tr>
<td>African American</td>
<td>190</td>
</tr>
<tr>
<td>Hispanic</td>
<td>567</td>
</tr>
<tr>
<td>American Indian</td>
<td>584</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>895</td>
</tr>
<tr>
<td>White</td>
<td>3,419</td>
</tr>
<tr>
<td>Total</td>
<td>5,717</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 17-18 and fiscal year 18-19; and MH-QI Grievance database (ethnicity percentages based on number of unique clients who filed concerns during fiscal year 18-19).
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: White and African American clients are overrepresented in filing grievances, whereas all other races/ethnicities are underrepresented.

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. In the summer of 2019, DHHS Administration completed racial bias training with the local Equity Alliance and is considering ways to share what was learned with the DHHS workforce.

The information regarding disparities in filing grievances will be shared with the Cultural Competence Committee. The Committee will define steps to address these findings and develop strategies for improvement.
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
PURPOSE To ensure that mental health services are available for those who are deaf or whose primary language is not English.

DEFINITION(S) 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 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)

REFERENCE None
PURPOSE
Department of Health and Human Services Mental Health maintains a list of community Interpreters.

DEFINITION(S)

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.

FORM(S)/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
PURPOSE
Humboldt County Department of Health and Human Services Mental Health provides culturally and linguistically competent services.

DEFINITION(S)

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 Interpretation 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. Document steps 2.1. through 2.4. in client’s chart.
   2.6. 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
4. The Interpreter List will be 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/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.
- Title VI, Civil Rights Act 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80)
Humboldt County Department of Health and Human Services Mental Health obtains translation, interpretative and telephone services.

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.

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.

REFERENCE
CCR, title 9, chapter 11, section 1810.410.
COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH

POLICY NO.: 0100.606
POLICY TITLE: SPEECH-TO-SPEECH RELAY SERVICE (STS)

PROGRAM: ADMINISTRATION
AFFECTS: ALL
REVISION DATES: REVIEW DATES: 11/2/98, 12/21/99, 01/03/01, 02/22/02, 09/20/04, 09/05/08, 12/11/10, 04/29/13, 12/20/13, 01/14/14

APPROVED BY: [Signature]
MENTAL HEALTH DIRECTOR

PURPOSE
Humboldt County Department of Health and Human Services Mental Health provides Speech-to-Speech Relay Services to clients with hearing and speech impairment.

DEFINITION(S)
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).
REFERENCE

http://ddtp.cpuc.ca.gov/homepage.aspx

CCR, title 9, chapter 11, section 1810.410.
COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH

POLICY NO.: 0100.607

POLICY TITLE: TEXT TELEPHONE (TTY) USE


PROGRAM: ADMINISTRATION

AFFECTS: ALL

REVISION DATES:
REVIEW DATES: 11/02/98, 12/21/99, 01/03/01, 02/22/02, 09/20/04, 09/05/08, 12/11/10, 04/29/13, 12/20/13, 01/14/14, 1/4/18, 7/10/19

APPROVED BY: ____________________________
MENTAL HEALTH DIRECTOR

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.

---

**FORM(S)/ATTACHMENTS**

**REFERENCE**

http://ddtp.cpuc.ca.gov/

CCR, title 9, chapter 11, section 1810.410
**COUNTY OF HUMBOLDT**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**MENTAL HEALTH**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRAM: ADMINISTRATION</td>
<td>AFFECTS: ALL</td>
<td>REVISION DATES: 7/27/15, 1/4/18</td>
</tr>
<tr>
<td>APPROVED BY:</td>
<td></td>
<td>REVIEW DATES: 11/02/98, 12/21/99, 01/03/01, 02/22/02, 09/20/04, 09/05/08, 12/11/10, 04/29/13, 12/20/13, 01/14/14, 7/10/19</td>
</tr>
</tbody>
</table>

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

**DEFINITION(S)**
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:
   1.1. Use the CONF button to place the client on hold.
   1.2. To access Language Line Services, dial **1-800-874-9426** or **1-866-874-3972**.
   1.3. Enter on your telephone keypad your 6-digit Client ID: 5 0 1 1 8 1.
   1.4. Press 1 for Spanish.
   1.5. 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.
   1.6. Give Information
      1.6.1. MH Access Code: 1170424
      1.6.2. Your first and last name
   1.7. An Interpreter will be connected to the call.
   1.8. Brief the Interpreter. Summarize what you wish to accomplish and give any special instructions.
   1.9. 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(S)/ATTACHMENTS
Language Line Use FAQs

REFERENCE
Language Line Training rev July 2015
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
## County of Humboldt
### Department of Health and Human Services
#### Mental Health

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Policy Title</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>0100.617</td>
<td>Translation of Written Materials</td>
<td>6/27/16</td>
</tr>
</tbody>
</table>

**Program:** Administration  
**Affects:** All

**Approved by:** Mental Health Director

---

**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.

**Definition(s)**
- **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 Medical 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 Bulletinboard 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.

FORM(S)/ATTACHMENTS

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