Mendocino County Health & Human Services
Behavioral Health & Recovery Services
Cultural Competence Plan 2020-2023
Annual Update FY 22-23

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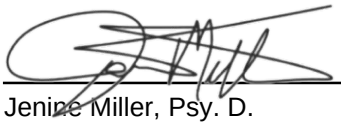
I hereby certify that I am the official responsible for the administration of County Mental Health Services in and for said County and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Cultural Competency Plan in preparing and submitting this 3- Year Plan/Annual Update, including stakeholder participation requirements.

The Mendocino County Cultural Competency Annual Update has been developed in accordance with Welfare and Institutions Code Section 5600, Title 9 of the California Code of Regulations section 1810.410, and DMH Information Notice 10-02 and 10-17.



12/29/22

Jenine Miller, Psy. D. Signature Date
Local Mental Health Director

County: Mendocino

Date: December 28, 2022

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INTRODUCTION

Mendocino County is 3,878 square miles and is located in Northern California, spanning eighty-four (84) miles from north-to-south, and forty-two (42) miles east-to-west. It is the 15th largest by area of California's counties but the 38th largest by population, with a population of 86,740 according to the 2019 Census and a population density of 25 people per square mile.

In 2019, the US Census Bureau estimated that 64.3% of Mendocino County's population identify as White (not Hispanic or Latino), 25.8% Hispanic or Latino, 1.1% African American, 6.3% American Indian/Alaska Native, 2.3% Asian, 0.3% Native Hawaiian or Pacific Islander, and 3.9% identify as belonging to two or more ethnicities. Please note, that this exceeds 100% as the percentages overlap in some categories. Furthermore, statistics show that 49.7% of the population is male and 50.4% female.[1] These statistics show a decrease from the prior three-year plan in the percentage of Mendocino County residents that identify as White alone (not Hispanic or Latino) or of two or more race/ethnicities, and an increase in Mendocino County residents that identify as Hispanic or Latino, Black/African American, Asian, Native Hawaiian and/or Pacific Islander. The statistics also show a slight increase in the percentage of residents that identify as female. The 2019 population estimates by the US Census show that in Mendocino County, 21.1% of residents are under 18 years of age, and 23.1% of the population is 65 years of age or older, leaving 55.8% of the population between the ages of 18-65. Additionally, the US Census 2019 data indicates that 5.7% of the population is under 5 years of age.

Mendocino County is home to ten federally recognized sovereign nations: Round Valley Indian Tribes, Manchester Band of Pomo Indians, Hopland Band of Pomo Indians, Guidiville Rancheria, Coyote Valley Band of Pomo Indians, Pinoleville Pomo Nation, Potter Valley Tribe, Cahto Tribe of the Laytonville Rancheria, Redwood Valley Band of Pomo Indians, Sherwood Valley Rancheria of Pomo Indians. The land that makes up Mendocino County is the ancestral homeland of the Pomo people; Northern, Central and Northeastern Pomo, as well as Coast Yuki, Wintun, and Cahto people. Mendocino County was established as a county when California became a state in 1850. The county is believed to be named for Antonio de Mendoza, who sent an expedition to the Mendocino coast in the late 1500s, subsequent to Spain identifying the land that is Mendocino County as part of "New Spain" in 1521. The land was then claimed by Mexico after the Mexican War for independence ended in 1821. Two Mexican land grants were established in Mendocino County in Hopland and the Ukiah Valley in the mid 1800s, but there was minimal European or Mexican occupation until the mid to late 1800s when growing occupation contributed to the "Mendocino War." The Mendocino War was created by the Eel River Rangers systematically resettling, raiding, and massacring native people who had already been constrained to the reservation on the Nome Cult Farm beginning in 1852. The forced march, known as the "California Trail of Tears" or "Konkow Trail of Tears"[2] and relocations resulted in the genocide of hundreds of native people and reducing the native population by what is estimated to be 80%. In addition, the relocation of several diverse and not always cooperative native bands to one location created additional trauma[3]. These traumas contribute to significant institutional distrust and reluctance to work with governmental services as a precaution against retraumatization.

[1] (U.S. Census Bureau, 2016)

[2] (California Trail Interpretive Center, 2022)

[3] (Buamgardner, 2006)

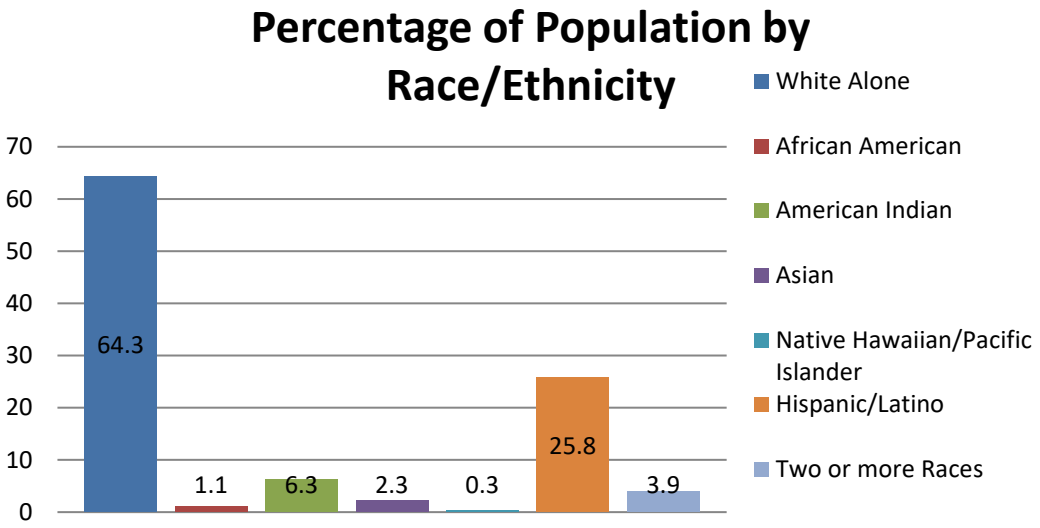
Mendocino County has very high rates of trauma. Healthy Mendocino, a website that captures various health indicators, indicates the rate of adults that experienced four or more adverse childhood experiences in childhood is 30.8% almost twice the state average of 16.7%. Adverse Childhood Experiences (ACEs) are defined as a traumatic experience occurring during a person's formative childhood years.[4] Adverse childhood experiences include neglect, physical, emotional, and/or sexual abuse, physical or emotional neglect, and household dysfunctions including mental illness, substance abuse, violence toward the mother, and incarcerated relative. Additionally Healthy Mendocino lists that the rate of substantiated Child Abuse in Mendocino County is 20.7 cases per 1,000 children. This rate is much higher than the California rate of 7.5 cases per 1,000 and the federal rate of 9.1 cases per 1,000 children.[5]

Mental Health prevalence rates indicate that 5% (1 in 20) of the population has a serious and chronic mental health concern and 20% (1 in 5) of the population experience some level of mental illness in their lives.[6] Based on those prevalence rates, we can extrapolate that Mendocino County should have 4,337 individuals with serious and chronic mental illness, and 17,349 individuals' will experience a mental illness. The National Alliance on Mental Illness prevalence information further breaks down that 19% of mental illnesses in adults are Anxiety Disorders, 8% are Depression, 4% are Post Traumatic Stress disorders, 4% are Dual Diagnoses, 3% are Bipolar Disorder, 1% Schizophrenia, 1% Obsessive Compulsive Disorder. NAMI data further states that 21% of people experiencing homelessness have a serious mental illness. These are the individuals that we anticipate will be utilizing the Mental Health Services Act funded services.

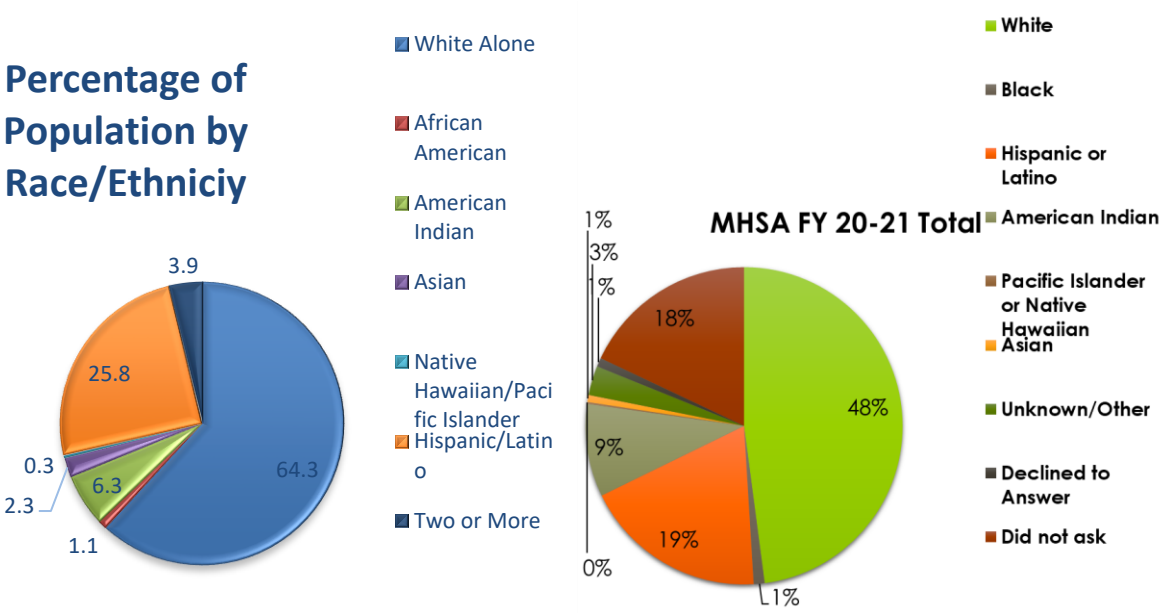
Mendocino County specialty mental health reviews the specialty mental health services network annually for Network Adequacy to review the provider network and ensure that our capacity meets ratio standards set by the Department of Health Care Services as well as to inform our analysis of our progress toward health equity and overcoming behavioral health disparities. The standards are determined based on anticipated Medi-Cal enrollment, expected utilization of services, characteristics of the Medi-Cal population, and other factors. Network Adequacy standards consider linguistic capacity to respond to beneficiaries with limited English proficiency as well as culturally responsiveness training.

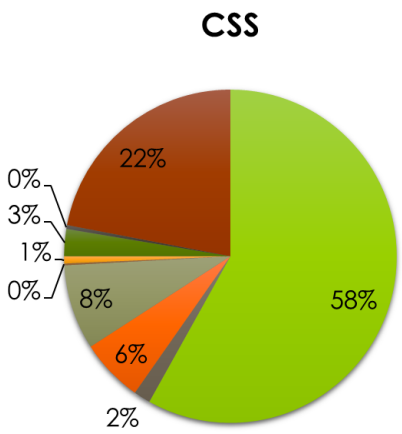
Mendocino County BHRS expands our specialty mental health and substance use services capacity by using Mental Health Services Act funding to engage service providers that can increase access to specialty populations and provide preventative and augmented supports to behavioral health services. BHRS prioritizes service providers that reach out to populations that may have barriers to accessing typical specialty services either due to cultural barriers or geographic barriers. The following charts demonstrate the MHSA services provided in fiscal year 20-21 compared to the county demographics as a whole.

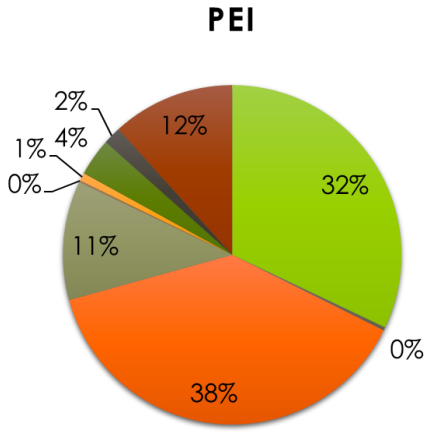
[4] (Healthy Mendocino, 2019)
[5] (Healthy Mendocino, 2019)
[6] (NAMI, 2020)



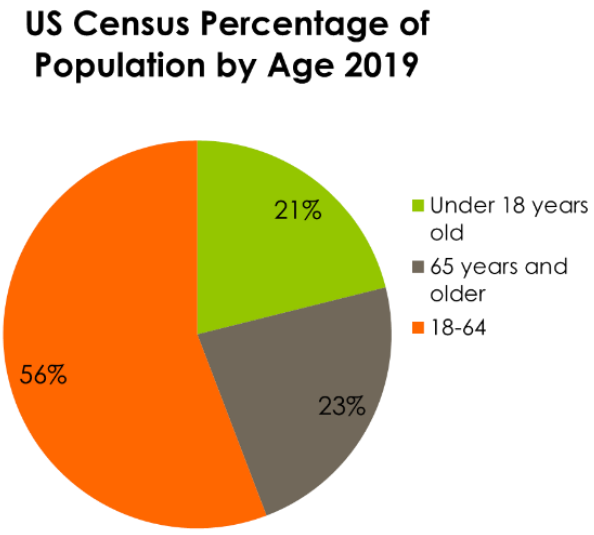
MHSA Programs Reported Race for 2020-2021 1-4 Quarters			
	CSS	PEI	Total
White	2042	723	2765
Black	57	7	64
Hispanic or Latino	216	865	1081
American Indian	290	256	546
Pacific Islander or Native Hawaiian	6	4	10
Asian	25	17	42
Unknown/Other	92	81	173
Declined to Answer	13	38	51
Did not ask	773	265	1038
Total	3514	2256	5770

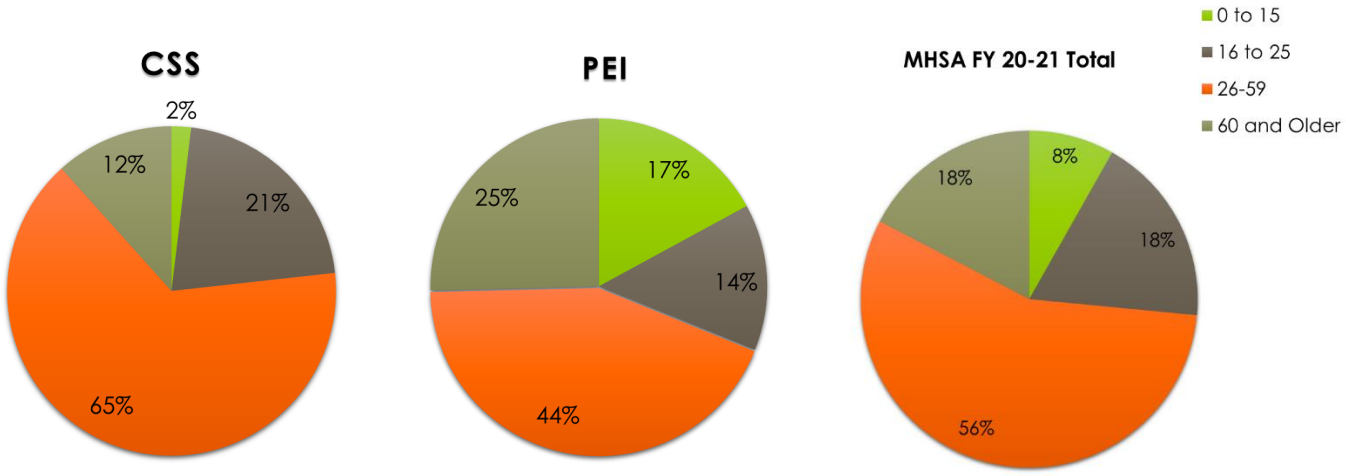






MHSA Programs Reported Gender for 2020-2021			
	CSS	PEI	Total
Male	1633	584	2217
Female	1253	1480	2733
Transgender	7	21	28
Genderqueer	0	7	7
Questioning or unsure	0	4	4
Another gender identity	0	1	1
Declined to Answer	6	0	6
Did not ask	606	321	927
Total	3505	2418	5923





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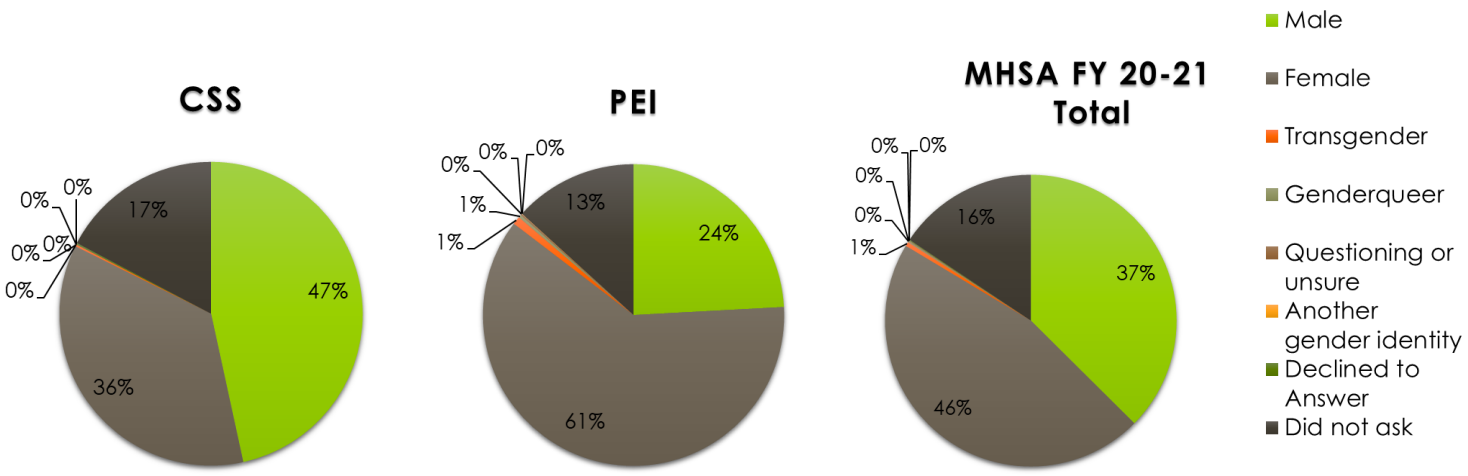


In reviewing the above data related to Mendocino County BHRS capacity, we have identified several strengths. Mendocino County BHRS PEI services are serving Native American and Latino communities at higher rates than the general county population. BHRS service providers are collecting data on non-binary gender identities beyond census categories, and we find it rewarding when individuals receiving services feel safe to self-identify.

Challenges: CSS services are serving rates comparable or slightly under the general population. The unknown and "did not ask" categories are much larger than the MHSA team would like. While we recognize that there are reasons it may be difficult to obtain the data in some treatment settings and there are many reasons individuals may feel unsafe to self-report, it is our goal to create environments of care and support where clients do feel comfortable self-identifying, and providers are able to engage in those conversations in the course of services. Census categories do not match the MHSA data reporting requirements, which can create challenges clarifying the representation by demographics. We have heard repeatedly from stakeholders that Census based data does not reflect their self-identities, and is outdated based on racial categories which are based on skin color and inherent systemic racism and classification. Stakeholders feel that these are neither reflective of self-identity nor culturally responsive. BHRS has tried to adapt data collection regarding demographics to be closer to MHSA categories and stakeholder feedback, however we agree that there is more work to do in this area.

Barriers to Program Implementation & strategies to overcome barriers: The COVID-19 Pandemic, related Public Health orders, and subsequent workforce shortages have had a dramatic impact on services moving into 22-23. Most service providers were able to maintain services through FY 20-21 with modified interactions to maintain safety precautions. We did have one MHSA service provider that was not able to continue services into fiscal year 21-22. We also had several service providers with dramatic staff changes which impacted capacity and business processes during fiscal year 21-22. We anticipate these impacts that have been reported at stakeholder meetings to be reflected in the data, which will be reviewed in the next annual update and final fiscal year stakeholder reviews. Modifications to services delivered and quantity of services provided were requested by service providers throughout the year to continue to serve the Mendocino County stakeholders and public.

Bilingual Proficiency in threshold languages: Based on Mendocino County's 2021 NACT submission, Mendocino County has twenty five25/244 direct service providers that are fluent in Spanish of a total of two hundred and forty-four direct service providers for a total of 10% of the service providers. Additional support staff are bilingual that are able to translate and that are not direct service providers. One direct services provider is fluent in Chinese.

BHRS recognizes that historical trauma, institutional and governmental distrust, systemic racism, and pervasive stigma around substance use and mental illness are significant factors in individuals seeking behavioral health treatment. We consistently collect feedback, review data, and work to create successful strategies to reduce these barriers to treatment and to create successful prevention efforts to minimize risk factors and maximize resilience.

Annual Update Changes and Notations

This Annual Update to the Cultural Responsiveness Plan has been updated to reflect the most current Cultural Competence Plan Requirement guidance from the Department of Health Care Services, including re-organization along the Cultural and Linguistically Appropriate Service Standards. Where applicable, we have added references to the relevant Criteria in prior Cultural Responsiveness Plans and Plan Updates.

Please note that throughout this plan there are several terms which we interchange with comparable terms; the chosen terms are based on stakeholder feedback and a desire to respond to the cultural priorities of our community. Some of these include:

- Cultural Competence: This will be interchanged with preferred terms of Cultural Humility and Cultural Responsiveness in an effort to reflect a constant state of change and learning as

opposed to a fixed or static accomplishment.

- Mission Statement: This will be interchanged with Commitment, Vision, or Goals statement to avoid a term associated with the Mission period in history which is correlated with colonialization and trauma for several cultural groups.
- Race: This will be predominantly interchanged with Ethnicity except where required to compare disparity with census racial designations. Mendocino County stakeholders have repeatedly and formally requested to move away from race as it is a meaningless socially constructed category based on color, and to some degree continental geography, but does not reflect ethnicity, culture, or other commonalities among people.

Standards and Values in Health Equity, Cultural Responsiveness, and Reducing Disparities

Mendocino County Behavioral Health and Recovery Services (BHRS) values and strives towards behavioral health equity utilizing multiple resources, strategies, standards and guiding principles. Culturally and Linguistically Appropriate Service (CLAS) Standards are a federal standard, but we also operate using the guidance, resources and directives of California Department of Health Care Services Cultural Competence Requirements for a Cultural Responsiveness Plan, Government Alliance on Race and Equity (GARE) Racial Equity Toolkit, California Reducing Disparities Project (CRDP), The Framework for Advancing Cultural, Linguistic, Racial, and Ethnic Behavioral Health Equity developed by California Behavioral Health Director's Association (CBHDA), the Community Mental Health Equity Project compiled by the Center for Applied Research Solutions, among others.

CLAS STANDARDS

The National Cultural and Linguistically Appropriate Service (CLAS) Standards are set by the United States Health and Human Services (HHS) Office of Minority Health (OMH) to improve the quality of health services and reduce disparities in health care. The standards are to provide organization and guidance toward health equity.

The Standards are organized into three categories: Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability under the Principal Standard.

The Principal Standard

1. Standard 1: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Standard 5: Offer language assistance to individuals who have limited English Proficiency and /or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Standard 8: Provide easy-to-understand print and multimedia materials and signage in languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluation the impact of CLAS on health equity and outcomes and inform service delivery.
12. Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Standard 14: Create conflict & grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Standard 15: Communicate the organizations progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

DHCS CULTURAL COMPETENCE PLAN REQUIREMENTS

The California Department of Health Care Services and California Code of Regulations, Title 9, Section 1810.410 outline requirements for a Cultural Competence Plan to reduce behavioral health disparities and instill cultural humility and responsiveness as a foundational value of the county/public behavioral health system. The Cultural Competence Plan Requirements were organized into eight criteria:

Criterion 1: Commitment to Cultural Competence

> Commitment to Cultural Competence includes identification of a Cultural Competence/Ethnic Services Manager that is involved in management and the development of a Mission/Vision statement, policies practices, and training procedures that include cultural responsiveness. This includes developing relationships with diverse groups, boards, commissions and other stakeholders. Commitment to cultural competence is also reflected in allocation of funding to culturally and linguistically responsive activities.

Criterion 2: Updated Assessment of Service Needs

> Assessment of Service Needs includes a review of the demographics of the general population, the Med-Cal population, and the population served by treatment and prevention activities. The assessment will look for existing/continuing disparities, identify targeted strategies to reduce disparities, and any reduction in disparities from applied strategies.

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

Criterion three strategies shall outline targeted populations and strategies amongst treatment, prevention, and community wide populations. Strategies will also address workforce approaches.

Criterion 4: Integration of the Committee within the County System

Integration of the Community, including clients, family members, and the larger community into the behavioral health system through the development of a committee that reviews and addresses cultural responsiveness issues and is reflective of the community. The committee will review and provide input into the development of the cultural competence plan goals, mission/vision, and activities.

Criterion 5: Culturally Competent Training Activities

Culturally competent training activities include the training of the behavioral health workforce in addition to training stakeholders and the community. The expectation is that cultural responsiveness is a consideration in all training and that 100% of the behavioral health workforce will be trained in cultural responsiveness over the period covered by the three-year cultural competence plan.

Criterion 6: Growing a Multicultural Workforce

Growing a multicultural workforce includes ensuring recruitment, hiring, and retention practices include culturally responsive considerations and practices, and include representation of the community and a peer workforce.

Criterion 7: Language Capacity

Ensuring language capacity criteria are met includes monitoring and increasing the bilingual capacity of the behavioral health workforce. This includes providing resources and strategies to ensure accessibility for those with limited English proficiency and translation when bilingual providers are unavailable in the preferred language of beneficiaries. It also includes ensuring that beneficiaries are aware of these resources and services, and that there are policies in place to ensure staff utilize them.

Criterion 8: Adaptation of Services

Adaptation of services includes the recovery focus of services beyond office-based treatment delivery, and provision of services in flexible environments such as wellness centers, outreach based services, flexible times and locations of service delivery, services that are accessible to all abilities, consideration of facilities that are non-threatening and reduce stigma, and services that maintain quality of care while being flexible to the needs of the individual.

FRAMEWORK FOR ADVANCING CULTURAL, LINGUISTIC, RACIAL, AND ETHNIC BEHAVIORAL HEALTH EQUITY

California Behavioral Health Director's Association worked together as an association of counties to develop guiding principles for the development of culturally responsive, equitable services. The guiding principles included feedback from communities served, and stakeholder feedback collected by Ethnic Services Managers and Cultural Diversity/Competence Committees throughout California's counties. These twenty-two principles are organized in six larger categories: Commitment to Cultural Competence and Health Equity, Identification of Disparities and Assessment of Needs and Assets, Implementation of Strategies to Reduce Identified Disparities, Community Driven Care, Workforce Development, and Provision of Culturally and Linguistically Appropriate Services.

Commitment to Cultural Competence and Health Equity

1. Address cultural competence at all levels of the system including policy, programs, operations, treatment, research and investigation, training, and quality improvement. This principle aligns with CLAS Standard 1 and CCPR Criterion 2 and 3.

2. Demonstrate commitment to cultural and linguistic competence in all agency policy and practice documents including the mission/vision statement, statement of values, strategic plans, and policy and procedure manuals.

3. Demonstrate commitment to cultural competence in behavioral health strategic planning and budgeting. Include allocations in annual budgets for cultural competence activities. This aligns with CLAS Standard 2.

4. Establish the Cultural Competence/Ethnic Services Manager as a member of the leadership team of the organization and task them to provide oversight of cultural and linguistic competence activities and functions. This principle aligns with CLAS standard 3.

5. Establish identifiable goals, objectives, procedures and functions for system-wide and regional operations that are designed to enhance and monitor cultural and linguistic competence. This aligns with CLAS standard 9.

Identification of Disparities and Assessment of Needs and Assets

6. Collect, compile, and analyze population statistics across language, ethnicity, age, gender, sexual orientation, socioeconomic status markers, etc., and catchment area, and compare them to County Client Services Information data across the same statistical areas. This aligns with CLAS standard 11.

7. Assess and regularly monitor behavioral health disparities for cultural, racial and ethnic populations throughout the system of care, including, but not limited to; access, outreach, engagement, retention, and outcome data across and within (disaggregated) cultural, ethnic, linguistic, and regional communities.

8. Evaluate needs, strengths, and assets within the cultural, ethnic, linguistic communities served. This aligns with CLAS standard 12.

9. Collaborate with other system partners with racial, ethnic, and cultural populations experiencing disparities (education, criminal justice, child welfare, public health, health care) to identify the intersection of disproportionality in these systems and behavioral health.

Implementation of Strategies to Reduce Identified Disparities

10. Develop, implement, and monitor strategies for elimination of identified disparities (including upstream approaches that address the social determinants of health) and track impacts of those strategies on the disparities.

11. Utilize a quality improvement framework to monitor and evaluate Cultural Competence Plans and disparity elimination activities and share improvement targets and progress with stakeholders. This aligns with CLAS standard 10.

12. Support evaluation, research, and investigation of culturally and linguistically competent community-defined and evidence-based practices.

Community Driven Care

13. Establish and implement a transparent and inclusive process for obtaining client, community, and staff input related to cultural competence planning, implementation, monitoring and evaluation.

14. Include cultural, racial, and ethnic populations as active partners in all aspects of the services they are receiving, including outreach and engagement, assessment, plan development, and treatment. This aligns with CLAS standard 13.

15. Develop formal and informal relationships with community members, community organizations, and other partners to maximize the delivery of effective culturally, ethnically and linguistically appropriate care, and monitor the outcomes of these partnerships. This aligns with CLAS standard 13.

Workforce Development

16. Establish workforce recruitment strategies that ensure adequate levels of consumer/peer (persons with lived experience), community (navigators, community health workers), administrative, support, and professional staff, reflective of the diversity of the populations served. Emphasize professional development opportunities, self-care strategies to address stress and micro-aggressions, and other retention efforts. Develop corrective measures to address severe shortages impacting ability to serve county populations. This aligns with CLAS standard 3.

17. Provide ongoing cultural competence and quality improvement training to consumers/peers (persons with lived experience), community (navigators, community health workers), administrative, support, and professional personnel, in order to effectively address the needs of cultural, racial, and ethnic populations, including linguistic capacity. This aligns with CLAS standard 4.

Provision of Culturally and Linguistically Appropriate Services.

18. Ensure access to culturally and linguistically appropriate services (treatment interventions, engagement strategies, outreach services, assessment approaches, community-defined practices) for all diverse populations by making them: available, accessible, acceptable, and accommodating, and sensitive to historical, cultural, and religious experiences and values of diverse populations, inclusive of gender roles, sexual orientation, generational differences, etc. This aligns with CLAS standard 1.

19. Make available behavioral health services that are responsive to the numerous stressors and social determinants of health experienced by cultural, racial and ethnic populations which have a negative impact on the emotional and psychological state of individuals.

20. Include the family as a natural resource, as appropriate, when working with individuals experiencing emotional difficulties from cultural, racial, and ethnic populations.

21. Incorporate client spirituality and partnerships with faith-based communities as, appropriate, in the provision of culturally competent prevention, early intervention, and recovery services.

22. Partner with community entities trusted and accepted in the community, as appropriate, to provide services in less stigmatizing settings (primary care, faith-based organization, community organizations, etc.).

THEME 1: Governance, Leadership, and Workforce

Including Criteria 1, 3, & 6: County Commitment to Cultural Responsiveness, Strategies to Reduce Behavioral Health Disparities, & Growing a Multicultural Workforce

I. **Primary Standard** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

A. Workforce Development

1. Cultural Competence/Ethnic Services Manager (CC/ESM)

a. Karen Lovato, Senior Program Manager; is the designated Ethnic Services Manager. The position was appointed in 2014, by the Assistant Director of Health Services, and Karen Lovato has held it since that time. In addition, BHRS has Cultural Diversity Coordinator role filled by a Senior Program Specialist, to facilitate Cultural Diversity Committee meetings and activities. This position was vacated during this fiscal year and is in recruitment until filled. The ESM designation is incorporated in all aspects of other duties making it impossible to determine a designated percentage of time allocated. Cultural responsiveness duties are the primary responsibility of the Cultural Diversity Coordinator Sr. Program Specialist, taking no less than 75% of allocated time when filled. Tasks include but are not limited to:
   i. Ensure completion of the Cultural Responsiveness Plan
   ii. Ensure adherence to cultural and linguistically appropriate standards and regulations
   iii. Ensure facilitation of Cultural Diversity meetings
   iv. Review, update, and maintain Policy & Procedures that pertain to diversity and cultural competence & ensure other Policies and Procedures incorporate cultural responsiveness
   v. Ensure & document facilitation of trainings in cultural responsiveness
   vi. Monitor disparities in services to cultural, ethnic, or linguistic groups and develop strategies to minimize barriers
   vii. Participate in the development of the MHSA Plan
   viii. Regularly meet with members of the Quality Improvement team
   ix. Serve as liaison and work in collaboration with behavioral health service providers and key community groups

b. As a program manager over mental health programs, including MHSA oversight and working closely with substance use prevention and treatment programs and reporting to the Behavioral Health Director, the ESM is positioned to ensure the cultural and linguistic responsiveness of Behavioral Health programs.

c. Cultural diversity and other BHRS stakeholder activities are held in way that are accessible throughout the county to collect feedback from our diverse demographic and geographic county.

d. BHRS utilizes MHSA funds to ensure dedicated cultural responsiveness

activities, training, access resources, and staff time to implement the Cultural Responsiveness plan and goals.

e. The Cultural Responsiveness Plan and activities are shared with the community through posting on the BHRS Website, routine Cultural Diversity Committee Meetings, reports in BHRS Quality Improvement Committee and Quality Assurance and Performance Improvement meetings, reports to the Behavioral Health Advisory Board, stakeholder emails and community public service announcements, and other stakeholder communications.

f. Additional policies for reference include:
    i. MH Policy & Procedure No. I. A-1B Philosophical Principles & Goals of the Mendocino County Mental Health Managed Care Plan
    ii. Mendocino County Policy # 10 Equal Employment Opportunity
    iii. Mendocino County Policy # 23 Harassment Prevention
    iv. BHRS P/P No. I.A-3B Culturally and Linguistically Responsive Services
    v. BHRS P/P No. V.A-1B Code of Ethics
    vi. BHRS P/P No. IV.A-1M Quality Assessment & Performance Improvement Program
    vii. BHRS P/P No. IV.A-4M Written Material in Threshold Languages
    viii. BHRS P/P No. IV.A-6M Services to Beneficiaries in Primary or Preferred Languages
    ix. BHRS Policy IV.A-2B Quality Improvement Committee

2. Commitment of budget resources to promote diversity, equity, inclusion, and accessibility. Mendocino County budgets for, but not limited to:

a. Interpreter Services:
    i. Language Line Solutions for any language translation services
    ii. Contract with Deaf Counseling Advocacy/Communique for sign language translation services: (Contract for $6,000 for Mental Health and $12,500 for SUDT per year)
    iii. Pay differential for bilingual staff that provide translation services in the course of duties

b. Cultural Competency Training:
    i. Contract for annual Cultural Responsiveness Trainings to Native Americans: Six thousand dollars ($6,000) budgeted
    ii. Contract for Cultural Responsiveness Training for Latino Cultures $5,000 budgeted
    iii. Additional funding as available for additional trainings identified and prioritized by the Cultural Diversity Committee meeting and other stakeholders

c. Culturally specific treatment and prevention services toward the reduction of disparities:
    i. MHSA funds targeted to services therapeutic to Native American individuals: Consolidated Tribal Health Project Contract ($107,000) Round Valley Indian Health Center/Yuki Trails Contracts ($52,500)
    ii. MHSA funds targeted to therapeutic services to Latino individuals: Through Administrative Service Organizations with Nuestra Alianza de Willits ($48,000)

d. Outreach to targeted populations:
    i. MHSA funded programs to geographically isolated areas: Laytonville Healthy Start Family Resource Center, Tapestry Family Services, Action Network, Yuki Trails, and Full Service Partnerships
    ii. MHSA funded programs to seniors: ($78,375)

e. Refer to BHRS MHSA Three Year Program and Expenditure Plan for additional budgeted activities for cultural responsiveness and accessibility

3. Recruitment, Hiring, and Retention of a multicultural workforce.

a. BHRS aims to continuously grow a multicultural and multilingual (bilingual Spanish in particular) workforce that is skilled in recovery and peer provider models. Mendocino County offers pay differentials for bilingual staff that use their linguistic capacity in 10% or more of their work. Mendocino County is an Equal Opportunity Employer.

b. Mendocino County posts recruitments on social media, and during Board of Supervisor Meeting breaks to reach a wider audience of potential candidates.

c. Mendocino County BHRS participates in the Workforce Education and Training Regional model to provide scholarships and stipends for local providers and students to expand and increase their training and education. Prioritization is given for those that are bilingual, bicultural, and those with lived experience.

d. BHRS is participating in the Peer Certification process and working with individuals with lived experience in our community to complete the certification process.

e. Targeted trainings have been offered for the bilingual behavioral health workforce and community to strengthen skills. In FY 2016/17 Promotora Trainings were provided. In 2020 we held a series of Behavioral Health interpreter trainings including training for bilingual speakers and the English-speaking staff using bilingual interpreters.

f. BHRS Managers regularly review and discuss morale, unit culture, and the inclusivity and training needs of BHRS.

g. BHRS has a chronic workforce shortage, and BHRS continuously works to adapt our recruitment and growth opportunities for individuals in the behavioral health field, especially those that will increase representation and accessible responsive services to our community.

4. Priorities for Governance, Leadership, and Workforce.

a. Governance priorities:
    i. To resume pre-pandemic relationships with Tribal Leaders and Promotores in the Latino/a/x community, as evidenced by participate in the Cultural Diversity Committee, attendance at least 60% of stakeholder meetings, and improved timeliness of signatures and submissions of formal documents such as contracts and invoices
    ii. Identification of cultural liaisons for at least the Native American

community, the Latino/a/x community, and the LGBTQ+ Youth Community to participate in the Cultural Diversity Committee on a regular basis by Spring of 2023

b. Leadership priorities:
    i. To build and bring together a Task force of diverse stakeholders, including peers for the further development of Crisis Intervention Teams within the community. Task force meetings to begin in 2023
    ii. To further advance community-based crisis response modalities building on cultural liaisons, peer supports, and natural supports to resolve crisis situations in the community and with voluntary care more often than involuntary care as evidenced by an increase in field-based crisis contacts each year and a reduction in involuntary holds each year

c. Workforce priorities
    i. To reduce vacancies to fewer than 20% in the BH workforce by FY 2023/24
    ii. To improve representation of the BHRS workforce to be comparable to the county demographic distribution
    iii. To successfully engage in the peer certification process as evidenced by having at least nine peers certified by start of FY 2023/24

5. Anticipated challenges in meeting Governance, Leadership, and Workforce priorities.

a. Governance challenges:
    i. Pandemic isolation and workforce challenges impacted Tribal communities and governments more significantly than the larger population. Turnover in contacts has been a challenge and may impact renewal of contacts, training, and relationships to successfully engage in meaningful program planning development
    ii. Individuals from Tribal communities have joined together to discuss improving outreach strategies, enhancing, expanding, and sustaining these relationships will hopefully expand up and out to include Tribal leaders and more Tribal community members

b. Leadership challenges:
    i. Impacts of the pandemic such as workforce challenges and isolation have made crisis responses more complex. More populations are facing mental health and substance crises regardless of protective factors. The BHRS workforce is facing more complex crisis that require more specific and broader cross training for crisis that are substance, mental health, age, and/or cognitive in nature. More individuals needing crisis resolution and fewer facility based and involuntary resources available will require broader more creative strategies to respond to the need
    ii. Mendocino County crisis responders have been working to overcome challenges of rural California for many years. We have good relationships, and most leaders are interested in voluntary community based solutions

c. Workforce Challenges:
    i. Workforce shortages of clinicians, and early challenges of peers

completing legacy Peer Certification options indicate that available staff at the clinical and peer levels will be a challenge

ii. Mendocino County has a strong history of building and growing our own workforce in both county and community organizations. Building of past successes and further identifying specific hurdles (costs associated with graduate school for clinicians, and support navigating formalities and technology for peers) will help identify further targeted strategies to overcome those challenges

B. Cultural Responsiveness Training Activities

1. Training Plan.

a. Mendocino County makes trainings in cultural responsiveness, humility, and awareness available to the community and BHRS workforce. BHRS providers and staff are expected to take a minimum of two cultural responsiveness trainings per year. The minimum standard of two trainings per year is monitored by supervisors, reported to County BHRS annually, and reported in the Cultural Responsiveness Plan and Network Adequacy Certification Tool. 100% of staff are expected to complete at least 2 hours of training each year.

b. Mendocino County prioritizes trainings in Native American and Latino/a/x cultures annually, in addition to other topics which are prioritized by stakeholder input. Under, inappropriately, un-, and/or over- represented groups historically prioritized by stakeholders for training include but are not limited to: Native American, Latino/a/x, LGBTQ (youth in particular, and transgender in particular), veterans, elder/senior, homeless, and Jewish cultures.

Mendocino County BHRS Training Overview for 2020-2023

Training Event	Description of Training including rationale/need for training	How long and often	Target Staff/Stakeholder type	Anticipated Timeline of Training	Purpose to Develop/ Topics cover
Native American History and Culturally Competent Practices	Overview of Native American History, culturally competent practices, disparities, and strategies to overcome.	Annually, 3-6 hours	• *Direct Service providers* • *Support Service providers* • *Administration* • *Interpreters* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.* • *General Community*	June 30, 2020 April 21, 2021 Mini Training June 30, 2021 June 30, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Latino History and Culturally Competent Practices	Overview of Latino History, culturally competent practices, disparities, and strategies to overcome	Annually, 3-6 hours	• *Direct Service providers* • *Support Service providers* • *Administration* • *Interpreters* • *Mental Health*	March 9, 2020 June 12, 2021 Mini Training February 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity

			Board • *Peers & Peer Providers* • *Community Orgs.* • *General Community*		• Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Webinar Training on Targeted Cultural Competence issues	Intersection of Traditional Medicine and Behavioral Health in the Latinx Community	As available	*Varies by Webinar, most made available to all stakeholders*	May 14, 2019 May 21, 2019	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Family Focused Treatment • Navigating Multiple Agency Service • Resiliency
ASIST	Applied Suicide Intervention Skills Training	3 per year, 16 hours	• *Direct Service providers* • *Support Service providers* • *Administration* • *Interpreters* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.* • *General Community*	3 per year July 19 & 20, 2018 December 13 & 14, 2018 July 25 & 26, 2019 December 3 & 4, 2019 On hold during pandemic due to restrictions to virtual trainings	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Safe Talk, Suicide Alertness For Everyone (Tell, Ask, Listen, Keep Safe)	Suicide Alertness for Everyone	3 per year, 3 hours	• *Direct Service providers* • *Support Service providers* • *Administration* • *Interpreters* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.* • *General Community* • *Schools*	March 12, 2019 On hold during pandemic due to restrictions to virtual trainings	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Peer Provider Training	Peer certification training	To be determined	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers*	Tabled Pending Legislation for Certification	• Peer Cultural awareness & sensitivity • Navigating Multiple Agency Services • Resiliency • Social Diversity • Family Focused

			• *Community Orgs.*		Treatment
CLAS Standards Training	Review of the National Cultural and Linguistically Appropriate service Standards	1-2 hours, Annually	• *Direct Service providers* • *Support Service providers* • *Administration* • *Interpreters* • *Peer Providers*	August 2017 August 2018 July 2019 July 2020 And upon new hire	• Cultural awareness & sensitivity • Navigating Multiple Agency Services • Training staff to use interpreters
Mental Health Awareness	Awareness raising event about mental health topics for the general community	Annually, Varies	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	Annually, May May 12, 2019 Virtual Support groups beginning September 2020 Including Emotion Management, Talking Circle, Process Group, Self Care, Parent Support Group, Grupo De Apoyo General	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Substance Use Awareness	Awareness raising event about substance use topics for the general community	Annually, Varies	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	Virtual Support groups beginning September 2020 Including Red Road Support Group	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Gang Culture, Mini Training on Targeted disparities during Cultural Diversity Committee Meeting	Gang awareness with intervention and prevention techniques	1 hour As prioritized by Committee	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	October 24, 2019	• *Risk Prevention* • *Social Diversity* • *Cultural Awareness and Sensitivity* • *Resiliency*
Marijuana Culture, Mini Training on Targeted disparities during Cultural Diversity Committee Meeting	Discussion of Marijuana Culture and impacts on Behavioral Health Care	1 hour As prioritized by Committee	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs*	December 13, 2017	• Peer Cultural awareness & sensitivity • Navigating Multiple Agency Services • Resiliency • Social Diversity

Veteran Culture, Mini Training on Targeted disparities during Cultural Diversity Committee Meeting	Discussion of Veteran Culture and impacts on Behavioral Health Care	1 hour As prioritized by Committee	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	December 11, 2019 February 11, 2020 November 15, 2022	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Gender Diversity	Discussion of Gender Spectrum and responsiveness in behavioral health Care	Varies	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	2018	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Social Diversity
Crisis Intervention Team Training	Intensive three day training with law enforcement, behavioral health, and other first responders around behavioral health symptoms, needs, and family experience. Concepts of Recovery	Three Day Sessions, At least one per year	• *Direct Service providers* • *Law Enforcement & First Responders* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs*	2018 2019 February 19- 21, 2020 Get Safe CIT	• Peer Cultural awareness & sensitivity • Navigating Multiple Agency Services • Resiliency • Risk Prevention • Family Focused Treatment
Father Engagement, Mini Training on Targeted disparities during Cultural Diversity Committee Meeting	Discussion of the role of the father in the family unit and impacts of absent fathers	1 hour As prioritized by Committee	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	May 6, 2020	• Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Behavioral Health Interpreter training for Bilingual Speakers	Training on language and strategies when interpreting behavioral health treatment sessions from English to Spanish	14 hour training	• *Direct service Providers* • *Interpreters*	June 1-4, 2020 8:30 am – 12:00 noon	• Cultural awareness & sensitivity • Social diversity
Behavioral Health Interpreter training for monolingual English speakers	Strategies and best practices for using language interpretation	*7 hours*	• *Direct service Providers*	June 2-3, 2020 1 - 4:30 pm	• Cultural awareness & sensitivity • Social diversity
Adverse Childhood Experiences	Review of Adverse Childhood Experiences and the impact on mental wellbeing	*1 hour*	• *Direct Service Providers* • *Provider support positions*	June 10, 2020	• Peer Cultural awareness & sensitivity • Navigating Multiple Agency Services • Resiliency • Risk Prevention

					• Family Focused Treatment
Implicit Bias, Mini Training during Cultural Diversity Committee Meeting	Overview of Implicit bias and implications in care.	*1 hour*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers Community Orgs*	March 5, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Culture and Mental Health, Mini Training during Cultural Diversity Training	Overview of cultural impacts and interpretations of mental illness.	*1 hour*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs 4*	April 20, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity
Religion and Mental Health, Mini Training during Cultural Diversity Committee Meeting	Discussion of religious interpretations and impacts of mental illness	*1 hour*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.* • *2*	December 17,2021	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity
Building Engagement in CDC, Discussion during Cultural Diversity Committee Meeting	Discussion of rebuilding participation in CDC post pandemic. Exploration of strategies.	*1 hour*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	February 26, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity
Diversity, Equity, and Inclusion Training	Defining and differentiating between terms and impacts of Diversity, Equity, and Inclusion and the	*3 hours*	• *Direct Service providers* • *Support Service providers*	June 17, 2021 June 27, 2022	• Cultural formulation • Multicultural Knowledge • Cultural

	application in Behavioral Health. Developing common language around privilege and implicit bias. Discussion of strategies to reduce disparity and inequity.		• *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*		awareness & sensitivity • Social diversity • Resiliency
Bridging the Divide	Crisis Intervention and de-escalation training	*5 hours*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.*	July 21, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Resiliency •
Suicide Prevention Workshop, with Kevin Briggs	Discussion with trained suicide negotiator, followed by a Question, Persuade, Refer community Suicide Prevention Training	*3.5 hours*	• *Direct Service providers* • *Support Service providers* • *Administration* • *Mental Health Board* • *Peers & Peer Providers* • *Community Orgs.* • *Law Enforcement*	September 9, 2022	• Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Resiliency

THEME 2: Communication and Language Assistance

Including Criteria 6 & 7: Growing a Multicultural Workforce and Language Capacity

II. Theme 2: Communication and Language Assistance

A. Communication and Language Assistance: CLAS Standards 5, 6, 7, & 8

1. Language translation, print, signage, and multimedia resources.

a. Mendocino County has two threshold languages currently: English & Spanish.

b. BHRS policies require informing materials to be in all threshold languages, including but not limited to Member Handbook, Problem Resolution materials, Beneficiary Satisfaction surveys and results, Informed Consent forms, Release of Information forms, and Behavioral Health educational materials.

c. BHRS policies require communication and correspondence with beneficiaries to be in their preferred language, and that notation of the client preference is noted in the treatment chart.

d. BHRS requires translated materials be reviewed by another person fluent in the language to ensure accuracy of translated materials.

e. BHRS requires written materials are screened for limited English proficiency, and do not contain words and content above a 6th grade reading level.

f. Additional information available in policies:
   i. County Policy # 10 Equal Employment Opportunity
   ii. BHRS P/P No. I.A-3B Culturally and Linguistically Responsive Services
   iii. BHRS P/P No. IV.A-4M Written Material in Threshold Languages
   iv. BHRS P/P No. IV.A-6M Services to Beneficiaries in Primary or Preferred Languages

2. Dedicated resources and strategies for expanding bilingual staff capacity.

a. BHRS Workforce Education and Training (WET) is working with the regional partnership on various incentives and strategies to increase the diversity development of the behavioral health workforce. Mendocino County is part of the Superior Region.

b. Mendocino County pays for use of Language Line Solutions for interpreter services when bilingual staff are not available.

c. Mendocino County offers differential pay for qualified bilingual providers that use their bilingual skills as a percentage of their duties. There are additional differentials for work in remote geographical areas and nontraditional work hours.

d. BHRS policies prioritize preferred language capacity for beneficiaries.

3. BHRS policies prioritize preferred language capacity for beneficiaries.
    a. The following are the primary policies that address language needs:
        i. County Policy # 10 Equal Employment Opportunity
        ii. BHRS P/P No. IV.A-4M Written Material in Threshold Languages
        iii. BHRS P/P No. IV.A-6M Services to Beneficiaries in Primary or Preferred Languages

    b. BHRS trains staff in use of the Language Line Solutions and California Relay Services at least once per year. Staff are encouraged to schedule extra time to practice use, if needed.

    c. Signage in use of Language Line Solutions and California Relay Services are posted in all lobby locations in large print, and are also noted on the BHRS website, and as taglines to all informing materials.

4. **Ensuring Language Assistance is appropriate and competent.**

    a. BHRS requires translated materials be reviewed by another person fluent in the language to ensure accuracy of translated materials.

    b. BHRS tests use of language line with bilingual test callers periodically throughout the year.

    c. BHRS maintains a list of bilingual staff who can translate when services are not able to be provided in the preferred language, with Language Line Solutions as a backup alternative.

    d. In FY 21/22 BHRS has 25/244 direct mental health service providers that are fluent in Spanish, in addition to additional support staff that are able to translate that are not direct service providers. One provider is fluent in Chinese.

5. **Preferred Language Availability.**

    a. BHRS requires that written informing materials are available in all threshold languages, large print, and audio formats. Availability of these formats is posted and noted on the documents and signage in the BHRS lobby and on the BHRS website

    b. BHRS posts a large poster size list of sample languages available via the Language Line stating language translation services are available free to the beneficiary in each of the sample languages.

    c. BHRS Policy requires preferred languages to be documented in the treatment chart as well as whether a service was provided in a language other than English.

    d. BHRS has several policies to ensure staff are aware of, trained in, and clear on how to provide services in threshold and beneficiary preferred languages.
        i. BHRS P/P No. IV.A-4M Written Material in Threshold Languages
        ii. BHRS P/P No. IV.A-6M Services to Beneficiaries in Primary or Preferred Languages

e. BHRS requires translated materials be reviewed by another person fluent in the language to ensure accuracy of translated materials.

f. BHRS requires written materials are screened for limited English proficiency, and do not contain words and content above a 6th grade reading level.

g. Closed Beneficiary Satisfaction Surveys and results in threshold languages can be viewed on the BHRS website on the Quality Assessment & Performance Improvement page.

6. Priorities for enhancing Language Assistance and Communication.

a. To increase bilingual Spanish providers each year up to minimum 25% of staff.

b. To monitor languages approaching threshold and to prepare for training and documentation of those languages into informing materials.

c. To maintain 100% of staff trained in use of the language line for translation as needed each fiscal year.

7. Anticipated challenges and barriers in enhancing Language Assistance & Communication.

a. Bilingual staff are needed in all sectors in Mendocino County, more competitive pay often pulls staff into other fields or county services.

b. Access to language data is limited and dated, it is hard to identify which and when languages are approaching threshold.

c. BHRS Staff are trained in Language Line utilization upon hiring and annually. However, data on when and how frequently staff are trained is difficult to monitor especially when including full system providers. Additionally, some staff feel challenges exist in using the technology to connect the call, so time to practice and develop confidence may also be a strategy to address this.

THEME 3: Engagement, Continuous Improvement, and Accountability

Including Criteria 1, 2, 3, 4, & 8: Commitment to Cultural Responsiveness, Assessment of Needs, Strategies to Reduce Disparities, Committee Integration, and Adaptation of Services

III. Theme 3: Engagement, Continuous Improvement, and Accountability

A. Engagement, Continuous Improvement, and Accountability CLAS Standards 9, 10, 11, 12, 13, 14, & 15

1. Cultural and Linguistically Appropriate goals, policies, and management accountability.

a. Mendocino County BHRS Commitment Statement: Mendocino County Behavioral Health & Recovery Services care for the people of Mendocino County whose lives are affected by serious mental illness and substance use. Behavioral Health & Recovery Services strives to:

- Deliver services in a respectful, responsive, and efficient manner with sensitivity to cultural diversity;
- Educate ourselves, individuals, families and the community about mental health, substance use, and the hopeful possibilities of treatment and recovery;
- Offer a culturally competent, gender responsive, trauma informed system of care for adults and adolescents while striving to meet linguistic challenges;
- Utilize holistic, person-centered recovery and promote healthy behaviors through prevention and treatment strategies.

b. Mendocino County BHRS Mental Health Plan Statement of Philosophy:

i. The Mendocino County Mental Health Plan serves the people of Mendocino County whose lives are affected by mental illness. The Plan strives to deliver services in a respectful, responsive, and efficient manner and with sensitivity to cultural diversity. It is our goal to educate ourselves, individuals, families, and the community about mental illness and the hopeful possibilities of treatment and recovery. Those we serve are supported in their efforts to maximize independent living and to improve quality of life through community-based treatment. In collaboration with other agencies, we seek to maximize the resources available and attend to concerns for the safety of individuals and the community. We will strive to manage our fiscal resources effectively and responsibly while ensuring that productivity and efficiency are important organizational values, which result in maximum benefits for all concerned.

As a community Mental Health delivery system, sanctioned under the Community Mental Health Services Act, Division 5, Welfare and Institutions Code, State of California, the Mendocino County Mental Health Plan is committed to the development of a culturally competent, comprehensive, and coordinated single system of care with a wide range of services, available and accessible to all residents of the county. Limited resources and regulatory mandates require prioritization of

services to the most at risk and needful populations. To that end, the MHP shall invest its direct services resources to those individuals in acute need, whether it be for those who have developed normative role functioning and are in need of crisis resolution or short-term outpatient treatment, or for those labeled chronically or severely mentally ill and in need due to a prevailing, disabling mental disorder. The goal of treatment shall be to assist people in developing their own mechanisms for dealing with stress and facilitating independent ways of dealing with problems.

ii. For additional detail See Policy I.A-1B Philosophical Principles and Goals of the Mendocino County Mental Health Managed Care Plan.

c. Mendocino County Strategic Plan:
   i. Mendocino County Strategic Plan for 2022-2027 prioritizes four goals with underlying objectives:
      a. An Effective County Government Organization
      b. A Safe and Healthy County
      c. A Thriving Economy
      d. A Prepared and Resilient County
   ii. For additional information, the Mendocino County Strategic Plan available online.

d. Mendocino County Policy and Procedures: available on the BHRS Website and upon request.

e. Other Key Mendocino County Documents available for reference:
   i. Mendocino County BHRS Mental Health Services Act Three Year Program and Expenditure Plan/Annual Updates, inclusive of all MHSA Component plans
   ii. Mendocino County BHRS Cultural Diversity Committee Meeting Documentation
   iii. Mendocino County BHRS Behavioral Health Advisory Board Meeting Documentation
   iv. Consumer Satisfaction Surveys & Results
   v. Mendocino County BHRS Organizational Charts
   vi. Mendocino County contract requirements

2. Collaborative Advisory Committee to help guide the behavioral health reducing disparities activities. Committee should represent county, contractor, peer/family member and diversity of community members.

a. The Cultural Diversity Committee (CDC) meeting meets regularly (monthly to quarterly depending on feedback from stakeholders, schedule determined annually). The committee continues to prefer quarterly meetings. The Cultural Diversity Committee is a chance for stakeholders comprising of Behavioral Health & Recovery Services providers, clients, and concerned community members to discuss cultural competency in provider agencies, disparities, culturally competent practices, and trainings to be brought to Mendocino County.

b. The Committee used to be combined with the Quality Improvement Committee, but stakeholders requested it separate to discuss training and more targeted data.

c. The CDC reports to QIC and other Quality Assessment and Performance Improvement meetings, groups, and activities including the Quality Improvement Workplan and Compliance Workplan.

d. The CDC also reports to the Behavioral Health Advisory Board, a body representing each of the five districts in Mendocino County with members that are client, family member, or community members from each district. This body formally advises the Board of Supervisors and the Behavioral Health Director on stakeholder input and feedback.

e. The CDC is organized and guided by stakeholder feedback and input, and BHRS P/P No. I.A-3B Culturally and Linguistically Responsive Services.

f. Feedback from CDC stakeholders informs BHRS on training priorities, Cultural Responsiveness Plan feedback, goals, and strategies, and other cultural responsiveness activities funded by MHSA or activities of the cultural diversity/responsiveness coordinator and ESM.

3. Needs Assessment and Identification of Populations of interest.

a. BHRS reviews population level data at least annually to identify disparities, improvements toward equity, and trends in service delivery. These trends are used to inform the community and system development, identify needs in services, and identify successful strategies.

b. BHRS reviews MHSA and Specialty Mental Health Services delivery data at least quarterly.

c. BHRS reviews County and Medi-Cal demographic data and penetration rates at least annually.

d. BHRS reviews staffing and training data annually to semiannually.

e. BHRS collects input from stakeholders on populations in need continuously through monthly, quarterly, semiannual, and annual stakeholder feedback opportunities in the form of meetings, in addition to direct stakeholder communication opportunities through problem resolution processes and direct email or phone calls.

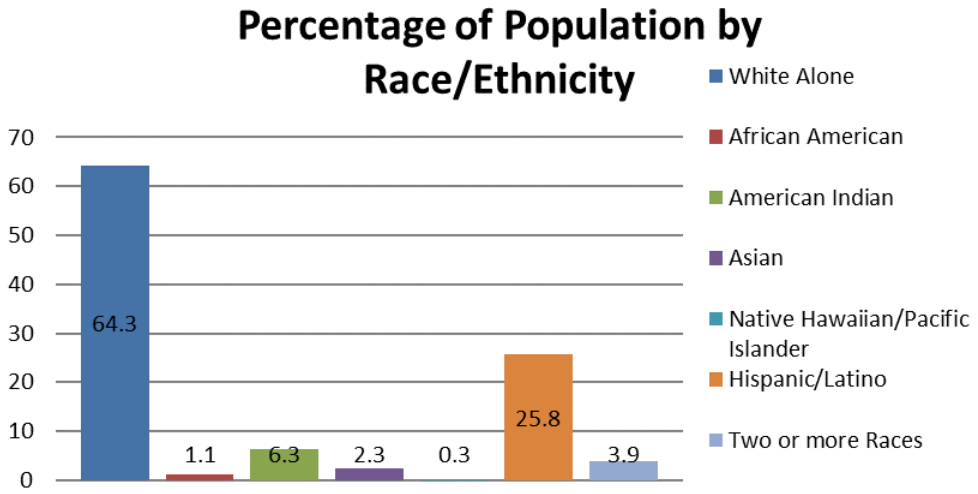
f. BHRS and Mendocino County BHRS stakeholders currently prioritize populations of interest as: Native American communities, Latino/a/x communities, LGBTQ communities (teens in particular), Elders/Seniors, homeless individuals. Individuals and communities in the remote areas of the county are also prioritized, especially if they are from populations of interest.

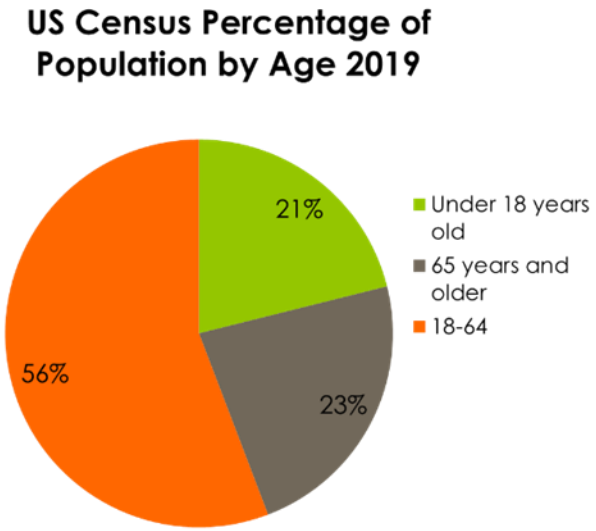
g. BHRS and Mendocino County BHRS stakeholders are exploring additional populations of interest including but not limited to veterans, Jewish communities, and Asian/Pacific Islander communities.

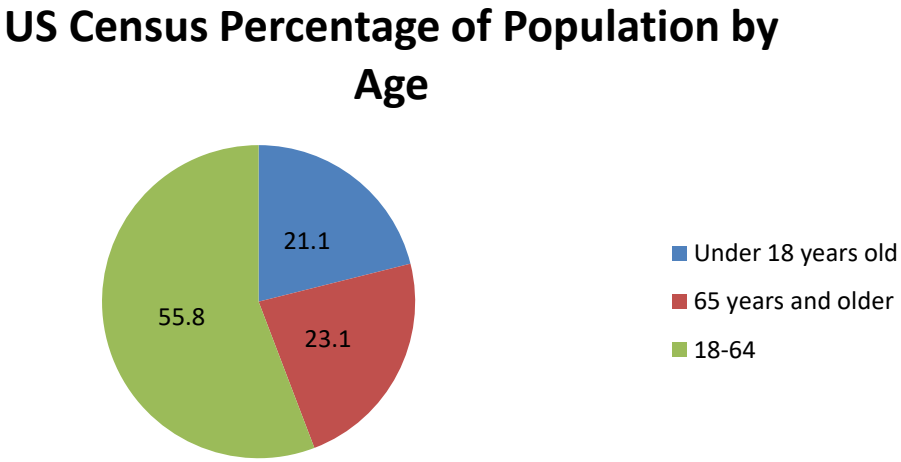
h. Additional assessments of needs and priority populations can be found in:
    i. Mendocino County MHSA Three Year Plan/Annual Updates
    ii. Quality Improvement Workplan & Evaluation

4. Demographic Data collection & monitoring to evaluate the impact of CLAS efforts on health equity and outcomes.

a. Mendocino Population Demographics from the 2019 Census data







b. Medi-Cal Population Demographics (from CAEQRO MHP ACA approved Claims)

	MENDOCINO					SMALL		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	13,345	557	$2,949,500	4.17%	$5,295	3.33%	$5,450	3.31%	$5,677
AGE GROUP									
18-59	11,802	526	$2,796,530	4.46%	$5,317	3.52%	$5,445	3.49%	$5,736
60 +	1,543	31	$152,970	2.01%	$4,935	1.61%	$5,537	1.84%	$4,730
GENDER									
Female	6,006	261	$1,174,069	4.35%	$4,498	3.36%	$5,262	3.18%	$5,196
Male	7,339	296	$1,775,431	4.03%	$5,998	3.30%	$5,623	3.44%	$6,110
RACE/ETHNICITY									
White	7,718	396	$2,026,193	5.13%	$5,117	3.55%	$5,556	4.41%	$5,502
Hispanic/Latino	3,370	74	$514,941	2.20%	$6,959	3.22%	$5,113	2.68%	$5,160
African-American	152	9	$35,018	5.92%	$3,891	4.40%	$6,265	5.61%	$5,750
Asian/Pacific Islander	337	6	$35,279	1.78%	$5,880	1.48%	$5,882	1.53%	$6,347
Native American	701	26	$166,062	3.71%	$6,387	2.92%	$5,856	4.41%	$5,828
Other	1,069	46	$172,008	4.30%	$3,739	3.42%	$5,971	3.75%	$6,769

c. Medi-Cal Client Utilization Data (From CAEQRO)

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	42,251	2,213	5.24%	$14,226,163	$6,428
CY 2020	39,837	2,406	6.04%	$17,688,237	$7,352
CY 2019	41,635	2,628	6.31%	$19,327,065	$7,354

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	4,404	52	1.18%	1.03%	1.59%
Ages 6-17	9,496	707	7.45%	5.00%	5.20%
Ages 18-20	2,047	129	6.30%	4.29%	4.02%
Ages 21-64	22,428	1,225	5.46%	4.15%	4.07%
Ages 65+	3,878	100	2.58%	2.09%	1.77%
Total	**42,251**	**2,213**	**5.24%**	**3.83%**	**3.85%**

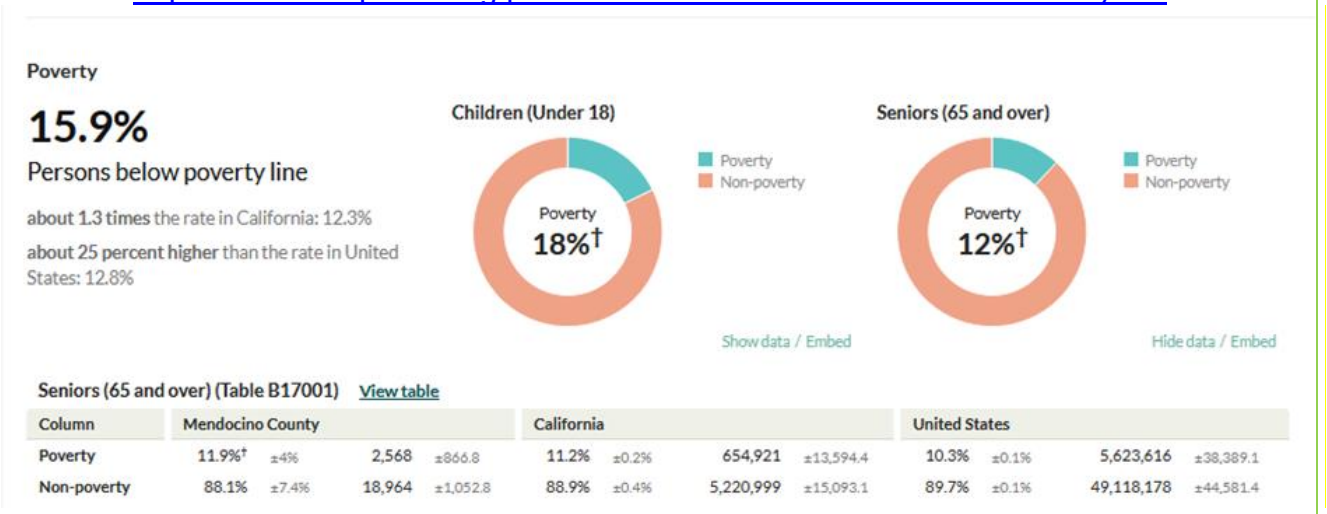
Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	171	7.81%
Threshold language source: Open Data per BHIN 20-070		

Table 7: PR Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# Annual Eligibles	# Beneficiaries Served	PR MHP	PR State
African-American	358	36	10.06%	6.83%
Asian/Pacific Islander	742	23	3.10%	1.90%
Hispanic/Latino	13,637	462	3.39%	3.29%
Native American	2,164	108	4.99%	5.58%
Other	4,685	226	4.82%	3.72%
White	20,667	1,358	6.57%	5.32%
Total	**42,253**	**2,213**	**5.24%**	3.85%

d. 100% of Poverty Population from https://censusreporter.org/profiles/05000US06045-mendocino-county-ca/



i. Mendocino County has 15.9% of people living at poverty level. Higher than the California and Federal poverty rates of 12.3 and 12.8% respectively. 18% of children in Mendocino County live at or below the poverty rate and 12% of seniors live at or below the poverty rate, higher than the state and federal poverty rate for children of 16% and 17 % respectively and 11% and 10% of seniors respectively.

e. Based on the information listed above, Mendocino County Behavioral Health and Recovery Services has better penetration rates than the state penetration rates in all categories except Native American for Medi-Cal claims. We suspect this is due to a large number of services to Native American communities going through Tribal Health Clinics and MHSA funded service providers and are not reflected in these rates. Similarly, Mendocino County has higher penetration rates than statewide rates for all ages except 0-5. We have higher penetration rates than similarly sized counties for all ages.

We look forward to gender and ethnic categorizations that are more diverse and varied than census racial designations, as we believe, and stakeholders have reflected that these designations are insufficient to accurately reflect individual and group identities.

5. **Strategies for addressing disparities among identified populations of interest.**

    a. BHRS identified the following specific goals for FY 21/22 which will carry over into 22/23:
        i. Increase participation at Cultural Diversity Committee Meetings, to an average of five or more attendees by identifying at least three Key Informants/cultural liaisons to lead and or co-facilitate CDC meetings by the end of 2023.
        ii. Improve tracking of staff attending training. During the pandemic, with virtual trainings, tracking of attendees and ensuring representation of attendees was challenged. Increase classification identification tracked from "total attendees" to indications of at least four categories of attendee tracked by the end of FY 2023.
        iii. Fill the Cultural Diversity Coordinator position to resume more frequent stakeholder communication and meetings, resuming at least two CDC meetings by the end of the FY, and completing at least two cultural diversity trainings.

    b. Participation in CDC activities and stakeholder communications have declined during the pandemic, initially virtual participation rose, then declined to almost nothing in the last year, loss of staffing contributed to a decline in activities and ability to regularly communicate with stakeholders. By focusing on working with trusted community liaisons we hope to build trust in the process again and gain insights from key stakeholders on the best ways to resume activities post pandemic restrictions. By learning from stakeholders, specifically cultural liaisons, we are being culturally humble to not assume known answers, or repeat unsuccessful strategies, and by giving community and stakeholders choice and ownership in how to move forward we are being trauma informed.

    c. In addition to MHSA funded Cultural Responsiveness activities, culturally specific outreach and prevention activities, BHRS has been increasing relationships with NAMI Mendocino to increase peer and family member supports.

    d. BHRS has also increased relationships with individuals from tribal communities to develop strategies to further improve outreach and services to tribal communities and overcome the historical trauma and institutional distrust associated with governmental services.
        i. Since building relationships with NAMI and the Native Connections meeting, BHRS has developed three large collaborations, two different month-long outreach and awareness raising events for suicide prevention month and overdose awareness month, and a community based suicide prevention awareness training. These relationships are building trust and generating new energy for community outreach and engagement which we hope will expand to increased involvement and trust among the peer and Native American Communities

6. **Assessments of CLAS related activities and integration measures. Continuous quality improvement and measurement of CLAS related measures.**

    a. Relative to comparably sized and statewide penetration rates, Mendocino County BHRS is seeing higher rates of all populations. However, relative to the population of Mendocino County, we would expect to see more Native American

and Latino/a/x individuals. We offer alternatives to Mendocino County Medi-Cal based services due to the stigma and historical trauma associated with these populations seeking treatment from governmental health care providers. Asian Pacific Islander and Black African American populations are slightly overrepresented in mental health services relative to the population as a whole.

b. Mendocino County revies data and conducts targeted outreach and MHSA funded service provision to Native American and Latino/a/x populations to reduce disparities. We continue to measure penetration rates and representation in services, trainings, and staffing. While we have had improvement over the years, the pandemic impacted small communities more dramatically and we lost a lot of the participation we had gained in prior years and with prior strategies.

c. Cultural liaisons and formal relationships with Tribal Leadership or Tribal Health have been successful strategies in the past. Funding tribal and community-based services that are in the community and not based on government buildings have also been successful. Programs that do not have screening or heavy data collection have been reported to be preferred, especially amongst populations with historical trauma.

7. Partnerships with the Community to design, implement and evaluate policies practices, and services to ensure cultural and linguistic appropriateness.

a. BHRS has funded and continues to seek low stigma, easy access venues and service deliveries to increase access to those of priority populations and those with higher barriers to accessing treatment.
   i. BHRS has created mobile services and outreach programs that respond to street and home level needs
   ii. BHRS has funded through MHSA community based and tribal health programs that have more ease of access and reduce institutional distrust barriers to accessing treatment
   iii. BHRS has funded and expanded through MHSA funding the peer and wellness-based community services, working through Innovation funding to adapt and expand Native community crisis prevention versions of peer-based wellness centers
   iv. BHRS has collaborated with partners in the Native American and Latino/a/x to provide trainings and reduce stigma around seeking services

b. BHRS collects data quarterly from specialty mental health and mental health services providers. The data is compared to census data quarterly and to Medi-Cal utilization data annually. Data informs program planning and adjustments, as does stakeholder feedback and input. Multiple BHRS data review and analysis processes are completed in determining progress toward goals and planning for future year programming and system adjustments.

c. BHRS prioritizes following six PEI priority populations in community partnerships:

   1. Underserved cultural populations
   2. Individuals experiencing onset of serious psychiatric illness

3. Children/youth in stressed families
4. Trauma-exposed
5. Children/youth at risk of school failure
6. Children/youth at risk or experiencing juvenile justice involvement

Project and Agency	Target Population
Prevention Programs	
Senior Peer Services, Ukiah Senior Center, Redwood Coast Senior Center, Coastal Seniors	1,2,4
NAMI Family/Peer Outreach, Education and Support Program, NAMI	1,2,3,4,5,6
Positive Parenting Program (Triple P) First Five Mendocino	1,3
Adolescent School Based Prevention Services	3,4,5,6
Anderson Valley Early Intervention Program	1,2,3,4,5,6
Early Childhood Mental Health Program, Consolidated Tribal Health Project	1,2,3,4,5,6
Early Intervention Program	
Native American Community Connection, Consolidated Tribal Health Project	1,2,3,4,5,6
Outreach Program for Recognitions of Early Signs of Mental Illness	
South Coast Outreach for Early Recognition, Action Network	1,3,4
Mental Health Awareness Activities, CalMHSA	1,2,3,4,5,6
Mental Health Awareness Activities, Mendocino County BHRS	1,2,3,4,5,6
Community Training and Supports, Consolidated Tribal Health Project	1,4
Stigma & Discrimination Reduction Programs	
Breaking the Silence, Mendocino County Youth Project	1,3,4,5,6
School Based Support Programs, Point Arena, Mendocino County Youth Project	1,2,3,4,5,6
Resiliency & Prevention Services, Round Valley Family Resource Center, Native Connections	1,3,4
Cultural Diversity Committee Disparity Reduction Project, Mendocino County BHRS	1,2,3,4,5,6
Access and Linkage to Treatment Programs	
Mobile Outreach and Prevention Services, Mendocino County BHRS	1,2,4
Jail Discharge Planning, Mendocino County BHRS	1,2,4
Increasing Timely Access to Underserved Populations, Nuestra Alianza de Willits	1,2,3,4,5,6
School Aged Prevention Program, Consolidated Tribal Health Project	1,2,3,4,5,6
Linkage and Referral by Laytonville Healthy Start	1,2,3,4,5,6
Suicide Prevention Programs	

North Bay Suicide Prevention Hotline, North Bay Suicide Prevention Project	1,2,3,4,5,6
Mendocino County Suicide Prevention, Mendocino County BHRS	1,2,3,4,5,6

8. **Best Practices utilized to engage community members.**
    a. BHRS works with community centers, family resource centers, Tribal Health, and other stakeholder advocacy groups and meetings to engage stakeholders in spaces they already gather. We have attempted to engage places of worship in the past with minimal success.

    b. BHRS works with provider agencies to provide compensation and transportation to support participation. Direct compensation is challenging in the county system as it requires contractual relationships.

    c. Food is often provided at stakeholder meetings. Meeting times are influenced by stakeholder preference and request. Meetings have been held outside of business hours and on weekends, in addition to lunch hours and business hours to work toward including all schedules in attendance.

    d. BHRS had been utilizing telephonic connection to stakeholder meetings where possible, and with the pandemic all meetings went to a virtual format. Moving out of the pandemic, we will offer hybrid options for meetings that are allowed, and will follow state guidance, where hybrid options are no longer allowed for Brown Act meetings. We saw an increase in attendance with virtual meetings at the beginning of the pandemic, but it has waxed and waned over the course of the pandemic.

9. **Outreach and Engagement Efforts with diverse racial, ethnic, and linguistic communities. Including client driven/client operated recovery and wellness programs.**

    a. BHRS is dedicated to providing community outreach, engagement, de-stigmatization efforts, trainings, and education to all members of the County. The County continues to make changes and improvements in its ability to provide culturally responsive services to its Behavioral Health & Recovery Services clients. The County also provides culturally competent specialized services in its outreach and engagement of the underserved populations. The integration of all programs including MHSA Community Services and Supports promotes long term sustainability and leveraging of existing resources to make the entire system more efficient, integrated, coordinated, and to encourage the use of Evidenced Based Practices, Community Preferred Practices, and Emerging Practices. We are working to increase the engagement and involvement from community members in regular meetings and events such as: MHSA Forums, QIC meetings, Mental Health Advisory Board Meetings, Cultural Competency/Diversity Committee meetings, etc. County staff and providers travel throughout the County to various communities in order to provide a way for consumers with limited transportation options to participate in the forums/meetings/committees/events. The frequency of meetings are determined in response to the stakeholder groups and are anywhere from quarterly to monthly depending on the meeting and stakeholder preference.

Expansion of participation via teleconference was expedited due to the pandemic. This seems to have increased stakeholder ability to participate, but there are known technology and broadband disparities, that impacts certain populations. We are resuming traveling meetings and keeping the hybrid telehealth option where possible to allow for maximum attendance and comfort by stakeholders. Mendocino County continues to expand mobile services and outreach programs using MHSA and grant funding. We outreach to rural outlying areas with our Mobile Outreach and Prevention Services, we have a pilot Dual Response Mobile Crisis program responding with law enforcement to field based crises, we have a Jail Discharge Program that in-reaches to the jail to coordinate services just prior to release, we provide mental health education and outreach with targeted campaigns going into the remote areas of the county, and we are regularly opening opportunities for with more agencies to apply to offer community based organization based services for broader access for services.

b. Mendocino County works with several wellness centers, family resource centers, and drop-in centers for client driven, culturally and linguistically specific services. We contract with providers that are Latino/a/x specific and predominantly Spanish speaking; we contract with tribal health organizations for Native American specific resource centers, we contract with youth and senior specific centers, and we contract with resource centers in geographically isolated areas. The peer driven/client operated resource centers were significantly impacted by the pandemic. Several had to reduce hours and consider closing or altering service delivery due to workforce shortages and other impacts of during the pandemic.

10. Evidence of cultural and linguistic responsiveness to mental health service needs through education and informing materials.

a. BHRS provides beneficiary informing materials in all threshold languages including but not limited to the Member Handbook, Problem Resolution materials, Beneficiary Satisfaction surveys and results, Informed Consent forms, Release of Information forms, and Behavioral Health educational materials. These are available for reference on the BHRS Website.

b. BHRS provides numerous outreach and stakeholder informing activities each year. Routine stakeholder meeting schedules are available on our website. In addition, targeted outreach campaigns occur in April for Alcohol Awareness Month, May for Mental Health Month, September for Suicide Prevention Week/Month, and October for Recovery Month. In addition to these targeted campaigns, we attend as many health fairs and educational opportunities throughout the community as possible. We are continuously looking for opportunities to increase outreach and education activities.
    i. Outreach activities are posted on BHRS social media sites, shared in public service announcements, shared in stakeholder meetings and communications, and posted to the website

11. Community Partnerships with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

a. BHRS conducted intensive stakeholder meetings in the beginning of the Mental Health Services Act to prioritize and develop culturally responsible mental health services. Ongoing stakeholder feedback is collected on programs that are needed, programs that are succeeding, and areas for improvement. Targeted stakeholder input is sought prior to each three-year plan development, and new Requests for Proposals are sought at the beginning of each three-year plan cycle. Contractors' proposals are reviewed to ensure that our identified populations are served by providers that are able to meet MHSA and CDC expectations. Data is collected on services provided each quarter, and concerns are addressed as they arise with providers. Additionally, MHSA funded providers are required to have an Issue Resolution process which notifies BHRS of concerns and the resolution of concerns held by beneficiaries. This process mirrors the specialty mental health problem resolution process.

b. Specialty mental health providers report the cultural training and linguistic capacity annually in the network adequacy certification process.

12. Description of planned processes to assess the quality of care provided for consumers.

a. BHRS reviews penetration rates and representation in services and staffing compared to county distributions. These are reviewed internally and shared with the Behavioral Health Advisory Board quarterly and the Quality Improvement Committee annually.

b. BHRS reviews Beneficiary Satisfaction Surveys for consumer feedback into their experiences. Beneficiary Satisfaction Surveys are conducted twice a year. BHRS conducts an internal satisfaction survey periodically as well, as we have heard from stakeholders that the formal surveys are not preferred and are hard to complete.

c. BHRS reviews Grievances, Issue Resolutions and other problem resolution processes monthly and identifies trends. Providers are issued Corrective Action Plan letters when problems or issues result in changes needed or trends needing corrections. Issue Resolutions are submitted to MHSA oversight team and Grievances are submitted to Quality Assessment and Performance Improvement. The trends and results are reviewed during management meetings and are also reported to Quality Improvement Committee.

APPENDIX: FREQUENTLY USED TERMS AND ACRONYMS

- **BHRS-** Mendocino County Behavioral Health and Recovery Services
- **CCPR-** "CCPR" in this document shall mean the county's completed cultural competence plan submission inclusive of all requirements.
- **CLAS**- Cultural and Linguistically Appropriate Service Standards
- **CSS-** Community Service and Supports, a MHSA Component
- **Cultural Competency-** A continual learning process in which a person develops awareness, skills, and knowledge that improves their ability to communicate and participate in cross-cultural situations.
- **Cultural Humility-**A practice of understanding a one's own position, attitudes, biases and privileges in relation to their identity, power, and role in their own culture and in cross-cultural situations.
- **ESM-**Ethnic Services Manager
- **LEP-** Limited English Proficiency
- **LGBTQ+-** Lesbian Gay Bisexual Transgender Queer Plus
- **MHSA-**Mental Health Services Act
- **PEI-**Prevention and Early Intervention, a MHSA Component
- **WET-**Workforce Education and Training