Cultural Competence Plan
2019-2022

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countyofsb.org/behavioral-wellness
COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due July 28, 2016 to:

Office of Multicultural Services
1600 9th Street, Room 153
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integrates its responsibilities into the mental health system and substance use disorders

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Executive Summary

The Santa Barbara County Department of Behavioral Wellness is committed to engaging consumers, family members and individuals from diverse ethnic and cultural groups in developing, implementing and monitoring specialty mental health, and substance use programs and services. Stakeholders from multicultural communities are involved in various forums, including the Cultural Competency and Diversity Action Team (CCDAT), the Consumer and Family Member Action Team, the Behavioral Wellness Commission, Peer Recovery Learning Centers, Children’s System of Care Action Team, Regional Partnerships and various other community forums. The Department’s commitment to providing culturally competent services is embedded through a wide range of policies and procedures, including telephone access, human resources training and recruitment, bilingual allowances, cultural competence training, interpretation, translation, signage, and other areas documented in the plan. An analysis of the population of Santa Barbara County identified the threshold language of our county as Spanish.

A key strategy to advance the Department’s commitment to providing culturally competent services are a series of trainings that focus on ethnically and culturally diverse communities, including, but not limited to the following populations: Oaxaqueño/Indigenous Mexican, Native American, LGBTQ, African American, Filipino, Latinx, and military. Another major strategy for hiring and maintaining a diverse workforce is the requirement that the Department and contractors be able to provide sufficient Spanish-speaking bilingual and bicultural staff to meet the needs of their community. The county recognizes that this need may vary by region.

Through the Community Services and Supports (CSS), Workforce Education and Training (WET), and the Prevention and Early Intervention (PEI) components, the Mental Health Services Act (MHSA) supports a number of targeted initiatives for outreach, education, linkage, and assistance to underserved ethnic and cultural populations. Under this revised Cultural Competence Plan, efforts will be maximized as a new Ethnic Services and Diversity Manager assumes authority for department-wide cultural competence programs and activities.
CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

I. The county shall have the following available on site during the compliance review:

   A. Copies of the following documents that ensure the commitment to cultural and linguistic competency services are reflected throughout the entire system:
      1. Mission Statement;
      2. Statement of Philosophy;
      3. Strategic Plans;
      4. Policy and Procedure Manuals;
      5. Human Resource Training and Recruitment Policies;
      6. Contract Requirements; and
      7. Other Key Documents.

The Department of Behavioral Wellness (hereafter referred to as “the Department”) is committed to providing cultural and linguistic appropriate services as evidenced by its policies, procedures, and/or operational practices. The foundational framework is the National Standards for Cultural and Linguistically Appropriate Services in Health Care as promulgated by the Office of Minority Health-U.S. of health and Human Services. An equally key source document that provides guidance is to the Cultural Competency/Ethnic Services Manager is “The Framework for Advancing Cultural, Linguistic, and Racial & Ethnic Behavioral Health Equity in County Behavioral Health Services, developed by the State-wide /Cultural Competence/Equity and Social Justice Committee (CC/ESJC) and adopted by the California Behavioral Health Directors Association (CBGDA). With the Cultural and Linguistic Competency Policy (Exhibit 2), the Department formally established recognition of the importance of culturally-adapted care. The Department is dedicated to providing culturally and linguistically-adapted supports, services, and treatments that respond effectively to the diverse needs of all individuals. The Department recognizes that providing high-quality, conscientious, and equitable care requires cultural and linguistic adaptations that reflect the individual’s race, ethnic, and national heritage; primary or preferred language; age; physical or mental status, including mobility and developmental disabilities; spirituality or religious affiliation; veteran status; and gender identity and sexual orientation.

To institutionalize this commitment, and recognize the value of racial, ethnic, and cultural diversity, the Department has implemented, in addition to policies and operational practices, an annual organizational Cultural Competency Assessment measuring organizational proficiency, provider proficiency and confidence, and Accessibility of Language assistance services. The findings will be utilized for quality improvement and to modify policies/procedures and operational practices.

Quality Improvement Committee

The Department’s Quality Improvement Committee embodies in its charter, the process of continuous quality improvement. The mission statement reflects the dedication and focus
on quality improvement by performing system reviews and evaluations of the quality of specialty mental health and DMC-ODS services provided to beneficiaries and service recipients throughout the Behavioral Wellness system of care. A very substantial aspect of that mandate relates to reviewing and selecting performance indicators (Access, Timeliness to Services and Quality of Care standards) and using data to evaluate and improve the performance of the Santa Barbara County Behavioral Wellness System of Care and Recovery.

**Cultural Competency Diversity Action Team**

The major goal of this action team is to advocate for culturally competent services, provide guidance and recommendations for outreach to unserved/underserved/inappropriately served communities and reduce behavioral health disparities for racially, ethnically, and culturally diverse communities. To ensure accountability for the provision and maintenance of such care and services, the action team is prepared to work with all relevant parties to develop and implement empirically sound and culturally appropriate evaluation instruments and procedures. More details of this committee will be discussed in Criterion 4: Client/Family/Community Committee: Integration of the Committee within the County Mental Health and Substance Use Disorders System of the Cultural Competency Plan.

**Cultural Competency as a Core Principle of the Mental Health Services Act (MHSA)**

The MHSA requires meeting the needs of unserved/underserved/inappropriately served cultural groups and providing culturally competent services. A critical part of MHSA is stakeholder involvement in the community planning process. In keeping with this core principle, the Department ensures that community representation is part of the Cultural Competency Diversity Action Team. The Cultural Competency Diversity Action Team participates in reviewing and providing input on various MHSA system-wide initiatives to enhance inclusivity and reduce behavioral health disparities.

**Departmental Sponsored Action Teams**

In addition to, Regional Partnerships, various departmental sponsored Action Teams meet regularly to review barriers and implement solutions in key areas for cultural competency and compliance with the Mental Health Services Act. Areas of focus reviewed by the Action Teams include, and are not limited to: Adults, Children’s System of Care, Change Agents, Cultural Competency and Diversity, Crisis Services, Services for the Homeless, Housing, Peer Support Services, and Forensic Services. The Action Team meetings are open to the public and anyone interested in providing ongoing input and working on continuous quality improvement within Behavioral Wellness are welcome to join.

**Consumer/Family Voice**

Furthermore, the Department involves consumers and family members (including individuals who reflect the diverse populations in Santa Barbara County) in developing, implementing, and
monitoring of the Department’s programs and services. The Department ensures participation of consumers and family members who reflect cultural diversity on panels, committees, and in stakeholder groups whose work impacts current and future programs and services.

Consumers and family members participate in many of the hiring panels for the Department. To increase the involvement and comfort level of consumers and family members participating in our hiring panels, the Human Resource Department provides an information session/briefing on hiring ethical guidelines prior to the interviews. Consumer and family members are also well represented on the Cultural Competency and Diversity Action Team (CCDAT), the Behavioral Wellness Commission, and the Consumer and Family Member Action Team (CFMAT), where they provide the Department with the consumer perspective.

Furthermore, the Department strives to hire and maintain a diverse workforce that is representative of the county population. As such, the Department hires individuals with lived experience in both our children’s and adult programs to represent the consumer and family voice and help empower the consumer. Currently, 20.5% of Department staff members are bilingual and bicultural. The Department is committed to hiring sufficient Spanish-speaking bilingual and bicultural staff to meet the needs of our community and will continue to monitor this need on a quarterly basis as well as with a department-wide survey; conducted annually.

**Language Assistance Services**

The Department is committed to serving Limited English Proficient by ensuring interpretation services are available at no cost to the consumer. The Department has contracts with various qualified and competent language assistance companies to ensure that there is no language barrier in accessing mental health and alcohol and drug services. Similarly, consumers and their family members are provided, and have access to, informing materials and vital patient care documents in the consumer’s preferred language. (See Criterion 7-Language Capacity)

**Outreach and Engagement**

The Department is committed to innovative methods of outreach to increase engagement of unserved/underserved, hard-to-reach, and marginalized communities by incorporating technology to increase access to overall wellness and mental health and substance use disorders services. Through the Prevention and Early Intervention Community Health Education Project (CHEP), and ADP Prevention services, new initiatives have been set in place to teach community members from diverse populations and underserved communities about accessing social services and learning to advocate for systemic change. The Department has established programs and providers who provide outreach, engagement, and treatment to underserved populations in Santa Barbara County.

**Availability of Spanish Interpretation at Public Meetings**

All requests for Spanish interpretation at public meetings such as the Behavioral Wellness Commission, the Consumer Family Action, and all stakeholder meetings will be accommodated with advance notice.
Contracts with Cultural and Linguistic-specific Providers/Monitoring

The Department’s network of mental health and alcohol and drug providers serves all cultural and linguistic populations.

(Exhibit Provider List)

In addition, current contract reporting requirements for all County programs, as well as Community Based Organizations, report the following information:

- Staffing reports which include bilingual and bicultural capabilities by staff position
- Number and ethnicity of clients served
- Consumers preferred language
- Language in which the service was provided
- Interpretation services were provided, and who provided them; such as another clinician, a non-clinician staff person, or the language line, etc.

Commitment to recruitment of a Diverse Workforce

The Department strives to hire and maintain a workforce that is diverse and representative of the county population. Currently, 20.5% of Department staff members are bilingual and bicultural. The compliance of this requirement is written into all of our Community Based Organization contracts, and is and will continue to be monitored on a quarterly basis.

Cultural Competency Trainings

Mandatory annual cultural competency trainings are required of all departmental staff and contract providers to ensure continuity of skill development on cultural competency issues and promote health equity to the people we serve. Furthermore, trainings will focus on the required topics as mandated by Department of Health Care Services, including people who are disabled, elderly, LGBTQ, Oaxaqueño, Native American, African American, as well as communities who are marginalized, unserved, and underserved.

The following is a brief review of the documents that will be available onsite during compliance review.

1. Mission Statement

The mission of the Department of Behavioral Wellness is to promote the prevention of, and recovery from, addiction and mental illness among individuals, families, and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

2. Statement of Philosophy:

The Department is oriented toward supporting and promoting recovery for clients and problem solving for communities. It is the Department’s role to help individuals identify what brings purpose, meaning, and quality into their lives, and to identify personal goals for living, learning, working, and maintaining social relationships. The Department is invested in building upon the assets available within communities to support the well-being of individuals and families, including addressing environmental conditions that exacerbate individual, family, and
neighborhood mental health, alcohol, and other drug related problems. As clients of the Department recover, their identity as a service recipient becomes less central, and they become more engaged in community life in a positive role (i.e. volunteer, employee, neighbor, artist, author, student, parent, sibling, son/daughter, partner, friend, advocate, member of a faith community, etc.).

3. Guiding Principles

Client and Family-Driven System of Care and Recovery
Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.

Partnership Culture
We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.

Peer Employment
Client and family employees are trained, valued, and budgeted-for in ever-increasing numbers as part of a well-trained workforce.

Integrated Service Experiences
Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies, and organizations.

Cultural Competence, Diversity, and Inclusivity
Our culturally diverse workforce represents our community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes, and policies that enable staff and providers to communicate with people of all ethnicities, gender identities, sexual orientations, religious beliefs, and abilities.

Focus on Wellness, Recovery, and Resilience
We believe people with psychiatric and/or substance use disorders are able to recover, live, work, learn, and participate fully in their community.

Strengths-Based Perspective
Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.

Harm Reduction
Where indicated for clients with Substance Use Disorder to maximize client engagement and recovery success.

Fiscal Responsibility
We efficiently leverage finite resources to provide the highest quality care to our clients, including those whom are indigent.
Transparency and Accountability
There are no secrets. We do what we say we will do, or we explain why we can’t.

Continuous Quality Improvement
We reliably collect, and consistently use, data relating to outcomes in our system of clients and other pertinent populations (such as people who are incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

4. Policies and Procedures
Through a number of policies and procedures, the Department identifies and addresses various cultural and linguistic competency areas. While there are policies and procedures focused exclusively on the rights of clients from diverse backgrounds, other procedures and policies are imbedded with information related to accessibility of services, and supports through cultural and language adaptations. Below is a listing of several policies with a summary of the policy function and/or specific language from the policy related to cultural competency. All policies are available as exhibits in the Cultural Competence Plan and on the Department’s website via this link: http://countyofsb.org/behavioral-wellness/policies.

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<td>1. Accessing a Welcoming and Integrated System of Care</td>
<td>Defines the Department's position on access to mental health and alcohol/drug services and its commitment to cultural competence.</td>
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<td>2. Cultural and Linguistic Competency</td>
<td>Department’s commitment to cultural and linguistic competency system-wide, including the endorsement of the National CLAS standards, the participation of the Cultural Competency and Diversity Action Team (CCDAT), and the adoption of the Cultural Competence Plan.</td>
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<td>3. Beneficiary Rights</td>
<td>Ensures beneficiary rights are clearly communicated to the beneficiaries, which includes ensuring that oral interpretation services are accessible in ALL non-English languages.</td>
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<td>4. Mental Health Plan Outreach</td>
<td>Defines the Department's commitment to community outreach to provide the community information on access to mental health services.</td>
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<td><strong>5. Non-discrimination</strong></td>
<td>To ensure all clients who obtain services at clinics operated by Behavioral Wellness or its contract providers are treated in a non-discriminatory manner and are received in a warm and welcoming manner.</td>
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<td><strong>6. Beneficiary Problem Resolution Process</strong></td>
<td>To ensure beneficiary complaints and grievances are responded to in a sensitive, timely, appropriate and culturally competent manner, and the rights of beneficiaries are upheld throughout the problem resolution process.</td>
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<td><strong>7. Consumer Information Checklist</strong></td>
<td>It is the policy of the Department that consumers will be provided with culturally and linguistically appropriate services by ensuring they will be provided with adequate written and verbal information regarding the Department's services and their rights as a client.</td>
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<td><strong>8. Beneficiary Information Materials</strong></td>
<td>To ensure all Medi-Cal beneficiaries are provided with, and have, timely access to critical beneficiary informing materials regarding specialty mental health services and substance use disorder services.</td>
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<td><strong>9. Mental Health Plan - Visually and Hearing Impaired and Beneficiaries with Limited Reading Ability</strong></td>
<td>Ensures the Department will provide appropriate interpretive services and written materials to beneficiaries with special visual, hearing, and linguistic needs.</td>
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<td><strong>10. Language Services for Limited English Proficiency (LEP) Beneficiaries</strong></td>
<td>To ensure Limited English Proficient (LEP) beneficiaries and families receive equitable access to care by providing service and treatment in their primary or preferred language, including threshold and non-threshold languages.</td>
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<td><strong>11. Patients' Rights Advocacy</strong></td>
<td>Addresses Department adherence to all laws and regulations relating to the provision of patient rights advocacy, including ensuring all agreements are in a language the client understands.</td>
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<td><strong>12. Contracted Provider Relations</strong></td>
<td>Santa Barbara County MHP monitors provider satisfaction, documentation standards, as well as provider selection and retention. There are annual reviews with regards to the types of providers required to meet the cultural and linguistic needs of beneficiaries.</td>
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<tr>
<td>13. Service Availability for Routine Conditions</td>
<td>Ensures procedures for the access of medically necessary specialty mental health and substance use disorder services within the county’s MHP and Drug Medi-Cal Organized Delivery System, including referral for routine services, appointment scheduling and after-hours service availability.</td>
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<td>14. Mandatory Trainings</td>
<td>Cultural Competence and Client/Family Culture as required trainings completed annually by all staff.</td>
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<td>15. Accessibility for Persons with Physical Disabilities</td>
<td>Ensures equitable access to services and bars any discriminatory treatment towards individuals with physical disabilities.</td>
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<td>16. Notice of Adverse Benefit Determination</td>
<td>All Notice of Adverse Benefit Determinations forms, regardless of type, must include attachments with (1) information on how to access the form and other information in a different language or alternative format, (2) information on the Department's non-discrimination policy, and (3) free language services.</td>
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<tr>
<td>17. 24/7 Toll-free Access Line</td>
<td>Ensures compliance with requirements for a 24/7 toll-free access line for beneficiaries and community members seeking information, referrals and authorization for specialty mental health and/or substance use disorder services in accordance with the standards set forth by the California Department of Health Care Services (DHCS).</td>
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<td>18. Network Adequacy Standards and Monitoring</td>
<td>The Department ensures beneficiaries of specialty mental health and substance use disorder services timely access to care and access to a sufficient number of high-quality, cultural-competent, and effective service providers within reasonable travel distance in accordance with the standards set forth by the California state Department of Health Care Services (DHCS).</td>
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<td>19. Bilingual Allowance</td>
<td>To outline certification and bilingual allowance standards for linguistically proficient staff who serve non-English speaking clients, including Spanish, the Santa Barbara County’s threshold language, and American Sign Language (ASL), in an effort to provide services in a culturally competent, respectful and efficient manner</td>
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<td>20. Non-Discrimination and Institutional Safeguards for Religious Providers</td>
<td>The Department will identify, track and monitor all Religious Providers that are part of the Alcohol and Drug Program’s contracted provider network.</td>
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<td>21. Drug Medi-Cal Organized Delivery System Care Coordination</td>
<td>The Department ensures that each beneficiary receiving treatment shall have an identified primary contact and be provided information on how to contact that individual; this individual shall be responsible for care coordination to meet the beneficiary needs.</td>
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22. Substance Use Disorder Provider Monitoring and Documentation Review

The Department monitors all CBOs providing prevention, secondary prevention, treatment and aftercare services at a level of frequency that ensures program accountability and compliance with best practices, contract requirements, and applicable federal, state and local laws.


Policy at the County and Department level address equality and diversity in recruitment, hiring, and training practices.

County of Santa Barbara – Americans with Disabilities Act Policy (Exhibit 23)

If you have a protected disability as defined under the Americans with Disabilities Act (ADA), our organization is required to provide you with reasonable accommodations for these purposes:

1) To ensure you can apply for employment; and
2) To enable a qualified individual with a disability to perform essential job functions.

In the employment process, reasonable accommodation is any modification or adjustment to the employment process that makes it possible for you to apply for employment. In job performance, reasonable accommodation is any modification or adjustment to the job, the work environment, or the way things are usually done that makes it possible for a qualified person with a disability to perform a job.

If such an accommodation is needed, the interviewer must be advised of the type of accommodation that may be effective. For certain types of accommodations (such as providing a reader or interpreter), reasonable advance notice is needed. We are not permitted to ask if an accommodation is needed, or if a protected disability is present. Reasonable accommodations to perform essential job functions are discussed after receiving a conditional offer of employment.

Accommodations must be made only when they do not pose an undue hardship for the employer. The employer decides which accommodation will be made. Consideration will be given to suggestions concerning accommodations which will be most effective. However, the employer reserves the right (as the Americans with Disabilities Act permits) to choose the accommodation which is believed will best serve both employee and organization's needs.

County of Santa Barbara – Non-Discrimination Policy (Exhibit 24)

The County Code, Chapter 27, Article II, Section 27-30, states that no employee of the County “...shall be discriminated against in violation of any applicable state or Federal law, rule or regulation which may now or hereafter specifically prohibit discrimination on such grounds as
Department of Behavioral Wellness – Code of Conduct: Diversity and Equal Opportunity (Exhibit 22)

The Department actively promotes diversity in its workforce at all levels of the organization. Our Department is committed to providing an inclusive work environment where everyone is treated with fairness, dignity, and respect. We will make ourselves accountable to one another for the manner in which we treat one another and for the manner in which people around us are treated. Santa Barbara County Department of Behavioral Wellness is an equal opportunity workforce, and no one shall discriminate against any individual with regard to age, ancestry, race, color, religion, sex, national origin, marital status, physical or mental disability, economic status, appearance, medical condition, or sexual orientation with respect to any offer, or term or condition, of employment. The Department makes reasonable accommodations to the individual needs of qualified individuals with disabilities.

Department of Behavioral Wellness – Mandatory Training Policy

It is the policy of the Santa Barbara County Mental Health Plan (SBC MHP) to comply with all relevant state and federal laws, regulations, contracts, and guidelines with regard to trainings. It is also the policy of the SBC MHP to provide further trainings to promote compliance with laws, regulations, contracts, guidelines, and department Policies and Procedures.

Code of Conduct is a training which describes and discusses the MHP Compliance Plan and MHP Code of Conduct, for the purpose of informing staff of relevant legal and ethical issues and encouraging compliance with legal and ethical standards.

It is the policy of the SBC MHP to require annual Cultural Competence trainings to be completed each year by staff members. Staff have an option to take online training through the Relias web portal or in-person training. The training requirement can be satisfied if the employee attends an equivalent training conducted or hosted by a Community Based Organization (CBO).

5. Contract Requirements (Exhibit 25)

Providers entering into contract with the Department to provide Specialty Mental Health and Substance Use Disorder Services must meet certain cultural and linguistic service requirements and submit reports periodically. Below are excerpts from the Mental Health and Substance Use Disorder Statement of Work template that highlight areas specific to culture and language:

- **Staffing.** Contractor shall submit quarterly staffing reports to County. These reports shall be on a form acceptable to, or provided by, County and shall report actual staff hours worked by position and include the employees’ names, licensure status, bilingual and bicultural capabilities, budgeted monthly salary, actual salary, hire date, and, if applicable, termination date. The reports shall be received by County no later than 25 calendar days following the end of the quarter being reported.

- **Programmatic.** Contractors receiving MHSA-funding and DMC-ODS funding shall track and report the following to County in Contractor’s Quarterly
Programmatic Report per MHSA and DMC-ODS requirements, if not entered into the County’s Management Information System (MIS).

a. Client age;
b. Client zip code;
c. Number of types of services, groups, or other services provided;
d. Number of clients served in which language (English/Spanish/Other);
e. Number of groups offered in which language (English/Spanish/Other).

- **Cultural Competence.** Contractor shall report on capacity to provide culturally competent services to culturally diverse clients and their families upon request from County, including:
  
a. The number of bilingual and bicultural staff (as part of the quarterly staffing report), and the number of culturally diverse clients receiving Program services
  
b. Efforts aimed at providing culturally competent services such as staff training, changes or adaptations to service protocol, community education/outreach, etc.
  
c. At all times, the Contractor’s Program(s) shall be staffed with personnel who can communicate in the client preferred language, or Contractor shall provide interpretation services, including American Sign Language (ASL).

- Contractor will strive to fill direct service positions with bilingual staff in County’s threshold language (Spanish) that is reflective of the specific needs of each region. Contractor percentage goals are calculated based on U.S. Census language data by region: Santa Barbara service area (including Goleta and Carpinteria) - 30%; Santa Maria service area (including Orcutt and Guadalupe) - 48%; Lompoc service area (including Buellton and Solvang) - 33%

- Contractor shall provide services that consider the culture of mental illness, the ethnic and cultural diversity of clients and families served, and materials provided to the public must also be printed in Spanish (threshold language).

- Contractor shall provide staff with regular training on cultural competence, sensitivity, and responsiveness related to the cultures within the community.

- Services and programs offered in English must also be made available in Spanish if clients identify Spanish as their preferred language.

- As applicable, a measurable and documented effort must be made to conduct outreach service, and services to the underserved/non-served/marginalized communities of Santa Barbara County.

- Contractor shall establish a process by which Spanish speaking staff who provide direct services in Spanish, or serve as interpreter, are tested for proficiency in speaking, reading, and writing the Spanish language.
Relevant Culturally Competent and Threshold Translated Documents

Spanish is Santa Barbara County’s sole threshold language. The majority of Department brochures, flyers, and forms have been translated into Spanish by a contracted nationally-certified translator. Translated materials include information related to available services, mental health/substance use conditions, beneficiary rights, satisfaction surveys, grievances, informed consent, release of information, and privacy practices. The Medical Records Administrator, Privacy Officer, and Ethnic Services and Diversity Manager work collaboratively to identify and process documents requiring translation. Documents are available by request to all Department and contracted provider sites, and can also be located and downloaded from the Behavioral Wellness website.

The Department’s website features a Spanish-language section visible on the homepage titled “En Español” (“In Spanish”) and explains how to obtain services, what programs are available, and frequently asked questions. Visitors can also select to have the entire website translated to Spanish, the threshold language, with a Google translate widget located on the upper right-hand corner of the homepage. Below is a screenshot of the homepage with the Spanish-language section and Google translate widget circled in red.

The Translation Review Committee was established in order to assure there is no exception to every word translated on every document disseminated to the public by the Department.
The following is a selection of documents translated in Spanish. All are available for review in the Exhibits section.

<table>
<thead>
<tr>
<th>General</th>
<th>Quality Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to the Department of Behavioral Wellness</td>
<td>Medi-Cal Beneficiary Booklet</td>
</tr>
<tr>
<td>Behavioral Health Services in Santa Barbara County</td>
<td>Mental Health Plan Services</td>
</tr>
<tr>
<td>Access Flyer</td>
<td>MHP Provider Directory</td>
</tr>
<tr>
<td>Guide to Medical Services</td>
<td></td>
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<tr>
<td>Satisfaction Surveys</td>
<td></td>
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<tr>
<td>Beneficiary Brochure</td>
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<tr>
<td>State Fair Hearings</td>
<td></td>
</tr>
<tr>
<td>Guide for Latinxs and Their Families</td>
<td></td>
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<tr>
<td>HIPAA: Notice of Privacy Practices</td>
<td></td>
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<tr>
<td>Compliance Hotline Flyer</td>
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<tr>
<td><strong>Adult Services</strong></td>
<td><strong>Quality Care Management</strong></td>
</tr>
<tr>
<td>Santa Barbara Adult Services Information</td>
<td>Medi-Cal Beneficiary Booklet</td>
</tr>
<tr>
<td>Carpinteria Outreach flyer</td>
<td>Mental Health Plan Services</td>
</tr>
<tr>
<td>Santa Maria Adult Services</td>
<td>MHP Provider Directory</td>
</tr>
<tr>
<td>Mental Health Services for Adults</td>
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<tr>
<td>Anxiety Disorders in Adults</td>
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<tr>
<td><strong>Children &amp; Transition-Age Youth Services</strong></td>
<td><strong>Quality Care Management</strong></td>
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<tr>
<td>Children's Services Countywide</td>
<td>Medi-Cal Beneficiary Booklet</td>
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<tr>
<td>Children's Services Santa Maria</td>
<td>Mental Health Plan Services</td>
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<td>Children's Services Lompoc</td>
<td>MHP Provider Directory</td>
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<tr>
<td>Mental Health Services for Adults</td>
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<tr>
<td>Children and Youth Crisis Line Brochure</td>
<td></td>
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<tr>
<td><strong>Online Only</strong></td>
<td><strong>Quality Care Management</strong></td>
</tr>
<tr>
<td>About the Department of Behavioral Wellness</td>
<td>Medi-Cal Beneficiary Booklet</td>
</tr>
<tr>
<td>AOD Services</td>
<td>Mental Health Plan Services</td>
</tr>
<tr>
<td><strong>Video</strong>: Access to Behavioral Health Services in SBC (In Mixteco)</td>
<td>MHP Provider Directory</td>
</tr>
<tr>
<td><strong>Video</strong>: Mental Health: A guide for Latinxs and Their Families</td>
<td></td>
</tr>
<tr>
<td>10 Edu Brochures: ADHA, Bipolar Disorder, Teen Depression, Suicide, other topics</td>
<td></td>
</tr>
<tr>
<td><strong>Booklets for Parents and Teens about Drug Abuse</strong></td>
<td></td>
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</tbody>
</table>
II. County recognition, value, and inclusion of racial, ethnic, cultural and linguistic diversity within the system

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

The county shall include the following in the CCPR Modification:

A. Provide a copy of the county’s CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic, and other relevant small county cultural communities with mental health disparities.
B. A one-page description addressing the county’s current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.
C. Share lessons learned on efforts on the items A and B above and any identified county technical assistance needs. Information on the county’s current MHSA Annual Plan may be included to respond to this requirement.

Practices and activities that demonstrate community outreach and engagement.

Homeless Outreach Services

The Department of Behavioral Wellness Homeless Services program provides outreach and engagement to people experiencing homelessness, or at imminent risk of homelessness, and serious persistent mental illness and/or chronic substance abuse in South Santa Barbara County. The needs of chronically homeless individuals, whom are hard to engage, are usually complex, which require greater time invested to promote stability and engagement in services. Outreach services are delivered to the community at-large, special population groups, human service agencies, and to unserved or underserved homeless individuals. These services aim to enhance the mental health of the general population, prevent the onset of mental health problems in individuals and communities, and assist those persons experiencing distress who are not reached by traditional mental health treatment services to obtain a more adaptive level of functioning. Homeless Services works with the local Continuum of Care (CoC), the Housing Authorities of the City and County of Santa Barbara, the United Way North’s Home for Good, local emergency and transitional shelters, and other agencies serving people experiencing homelessness or at risk of homelessness in our community.

Meeting the needs of people experiencing both homelessness and behavioral health challenges is an important priority for the Department of Behavioral Wellness. Behavioral Wellness augmented this initiative by securing additional funding to expand Homeless Outreach Services into both the North and West regions of the County. This will be accomplished through the utilization of one time Homeless and Mentally Ill Outreach and Treatment (HMIOT) monies, awarded by the Department of Health Care Services (DHCS) January 1, 2019 for eighteen months. Historically,
Homeless Outreach Services have been centralized in South Santa Barbara County and there were no stand-alone Behavioral Wellness Homeless Outreach Services in Lompoc or Santa Maria. The funding allowed for the hiring of (2) full time civil service practitioners, (1) a full time civil service case worker, and (1) extra help part time administrative office professional. The continued expansion of Homeless Services, in all three regions of the County, will only continue to enhance the mental health system’s ability to respond to long term needs of persons with severe mental illness who are homeless or at risk of homelessness. The constructed teams adopted engagement strategies that meet the specific needs of the homeless populations in each region.

In addition to the secured HMIOT funding, the Department was awarded a cash donation on behalf of the Gordon Family Trust. Behavioral Wellness used the donation and grant funds to purchase at least one mobile vehicle for homeless outreach and service delivery. The mobile vehicle was retrofitted with technology and has the ability to accommodate medical personnel for the treatment of clients in the field. The medical staff provide ongoing medical assistance and connect clients to available shelters as necessary. This mobile outreach team has been able to reach homeless and difficult to engage clients in locations around the County. These services are an extension of those currently provided by Homeless Outreach and Crisis teams. The mobile vehicle contains a commemoration plaque to the Gordon Trust in recognition of this generous donation.

Successful outreach often involves a high degree of interagency collaboration and multi-disciplinary team outreach. Behavioral Wellness Homeless Services continues to strive towards maintaining a high degree of collaboration with other Santa Barbara County CoC and is responsible for facilitating a weekly South County Coordinated Outreach Team meeting. This provides CoC service providers with an opportunity to discuss sub-regional outreach coverage, engagement strategies, outreach collaboration, and service coordination. We hope to replicate this in other sub-regions of the County, in conjunction with program expansion into these regions.

Additionally, of significance to these efforts is the ongoing partnership Behavioral Wellness has with the United Way North, which acts as the lead agency for Santa Barbara County’s Coordinated Entry System (CES). The CES represents a CoC-wide process for facilitating access to all homeless-designated resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention. Coordinated entry is the community process by which the Santa Maria/Santa Barbara County CoC supports the development of a comprehensive and efficient crisis response system that improves ease of access to resources in the CoC’s geographic area. Homeless Services regularly attends the bi-monthly CES case conference to ensure that there is access to staff who can appropriately respond to people experiencing homelessness and assist with connection to the mental health system of care.

The United Way North provides 4 FTE AmeriCorps members to serve with Behavioral Wellness. The resulting expansion of these services, through the inclusion of the AmeriCorps members, has also successfully enhanced the mental health system’s ability to respond to long term needs of
persons with severe mental illness who are homeless or at risk of homelessness, and who are not receiving adequate mental health services. This has also enabled the mental health system to more efficiently connect people experiencing homelessness to Santa Barbara County’s CoC and thereby their enrollment in the CES.

The Program expansions are consistent with the MHSA principles of recovery, resiliency, cultural competency, and creating a greater continuity of care. The Homeless Services program is providing extensive outreach and engagement services. Teams have also adopted strategies that meet the specific needs of homeless populations in each region, and also provide housing retention support and assistance, employment and education support, rehabilitation services, and other necessary supports for individuals experiencing homelessness or at imminent risk of homelessness. The program model utilized is culturally and linguistically competent and appropriate. The only threshold language identified in Santa Barbara County is Spanish. Consequently, the goal has been to have 40% of direct service staff on this team and others be bilingual (Spanish/English) and bicultural.

**Forensic Full Services Partnership Justice Alliance**

Justice Alliance provides licensed mental health professionals in each region of the County to link persons involved with the legal system to wellness- and recovery- oriented services. The Justice Alliance Program serves adults with severe mental illness in custody, out of custody, at risk of being in custody, or on probation. Clinicians conduct outreach and assessments in the county jail, courts and community, and provide Full Service Partnership (FSP) services to clients that qualify until they are able to link the consumer to the longer term FSP Program such as ACT or Community Supports services. Justice Alliance also provides treatment in partnership with existing programs in the outpatient clinics, and assists PHF personnel with treatment of individuals committed there by the courts for competency restoration. Overall, this is a “specialized FSP program” serving a specialized forensic population. This program ensures access to and engagement into appropriate level of care for this special population.

Identified individuals may have co-occurring substance abuse conditions. Many of the individuals assessed are unserved or underserved members of ethnically diverse populations, and in need of integrated, and simultaneous, mental health and substance abuse treatment.

Justice Alliance staff members work closely with the Court, Probation, Public Defender, Sheriff, District Attorney, Community-Based Organizations and other Department of Behavioral Wellness treatment teams to make treatment recommendations, facilitate access to treatment, and provide follow-up progress reports to the Court and other appropriate parties. Justice Alliance staff are responsible for the initial assessment for levels of care and disposition process. Staff members identify appropriate ACT consumers and ensure that consumers are placed in the appropriate regional ACT Programs or Community Supports Teams through outreach, engagement, and coordination with the FSP teams. When consumers do not qualify for ACT services, staff will refer consumers to the appropriate specialized outpatient teams.
In addition, Justice Alliance staff provide competency restoration services to misdemeanants found Incompetent to Stand Trial (IST), as well as provide treatment to individuals receiving outpatient competency restoration services. When providing outpatient restoration services, the team utilizes various residential resources including Alameda House and Cottage Grove housing facilities, and crisis residential units.

**ADP Prevention Services**

The Department of Behavioral Wellness Alcohol and Drug Program (ADP) provides community outreach and engagement services throughout each region of Santa Barbara County. Every five (5) years County ADP completes a Strategic Prevention Plan (SPP) including a needs assessment that requires community engagement and stakeholder input. Community members review national and local alcohol and other drug (AOD) use and abuse trends to help shape prevention efforts. All SB cultures are included in the stakeholder process. Primary prevention efforts are agreed upon by a consensus of community members as the plan is developed, finalized and submitted to the State Department of Health Care Services (DHCS). Currently, the 2017-2022 plan identified four (4) priorities: Excessive youth alcohol use; binge drinking; marijuana use; and prescription drug abuse (PDA) to address. An extensive RFP process was launched to award contracts to the most culturally competent agencies. The contract deliverables included building community-based coalitions to address specific cultural needs. As a result, media campaigns have been developed to address specific cultural groups such as cannabis use among youth and safe storage and proper disposal of prescription drugs, two issues disproportionately affecting youth and Latino cultures.

**ADP Treatment Services**

County ADP treatment services offer a full continuum of care based upon the Drug Medi-Cal Organized Delivery System (DMC-ODS). The development of the DMC-ODS Implementation Plan (IP) involved extensive community input and engagement. Stakeholder meetings were organized to assess community and cultural needs. Stakeholder and data driven needs assessments identified specific needs for Latino youth, pregnant and postpartum women and single childless adults that shaped the IP. Since the SB DMC-ODS was implemented on December 1, 2020, contracted treatment service providers have provided intensive outreach to engage youth in treatment services and adults in perinatal and non-perinatal residential treatment services. Monthly CBO collaborative, Behavioral Wellness Commission (BWC) meetings and cycles of intensive clinical and administrative trainings afford opportunities to assess and provide culturally competent outreach and intervention services. As a result of these efforts and in concert with DHCS guidance, County ADP has begun developing intensive care coordination protocols and systems to target clients with multiple and complex needs, many of whom are ethnic minorities, people of color and specific cultures who have barriers to treatment access and engagement.

**County’s current involvement efforts and level of inclusion with underserved communities through Mental Health Services Act (MHSA) and Prevention and Early Intervention (PEI)**

Through contracts with regional Community-Based Organizations (CBOs), the Department supports outreach and accessible services to several targeted populations, including Spanish speaking communities, Indigenous Mexican communities (i.e. Mixtec, Zapotec) and Native
American communities. These CBOs have effectively engaged underserved populations by employing culturally appropriate interventions in familiar settings and building trust and partnership within the community. The following are the PEI outreach and engagement programs to provide mental health awareness, education, destigmatized mental illness and support to culturally underserved communities.

**Promotora Programs by La Casa de la Raza and Community Health Centers of the Central Coast.**

This program mobilizes Community Mental Health Educators – known in the Latinx community as *Promotoras* – from culturally underserved populations to address individual and family mental health and wellness needs. As trusted members of their community, Community Mental Health Educators assist with navigation and linkage to culturally and linguistically appropriate services. Information and guidance are provided through various culturally-adapted modes of engagement and outreach, including educational workshops, presentations in community-based locations (e.g. schools, churches), and support groups.

In the Santa Barbara region, Casa de La Raza established ongoing Spanish speaking community groups called *Cafecitos*. Their other outreach efforts include work with the Family Resource Center. The groups are fully active and have a consistent flow of families coming in for support. The groups were reviewed for length and quantity of weekly groups in FY 18-19 by testing bi-weekly meetings that are shorter in duration.

**Community Health Centers of the Central Coast**

Community Health Centers of the Central Coast (CHCCC) is contracted to provide Community Mental Health Educators known in the Hispanic/Latinx community as *Promotoras* who connect with unserved or underserved communities in the Santa Maria, Guadalupe, and Lompoc areas of the County. Activities address multiple barriers to accessing services, such as those related to culture, language, transportation, location, stigma, and institutional mistrust or fear. Specifically, CHCCC utilizes mobile clinics to reach remote outposts of the community to provide primary care access and mental health education and support. Memorandums of Understanding have been developed and established with local low-income housing programs to program on-site support groups to predominant Spanish-speaking communities.

**Santa Ynez Tribal Health Clinic**

In the mid-county area, Santa Ynez Tribal Health Clinic offers community wellness trainings and activities. Bimonthly, the clinic issues *The Samala Magazine*, a publication focused on Native community wellness, which is distributed to all clinic members; approximately 780 tribal homes. Recent topics covered included bullying and health, sleep disorders, diet, stress, and training peer supports on mental health needs of tribal patients at Vandenberg Air Force Base. The clinic has also increased the number of clients served by engaging with existing tribal programs such as Camp Kalawa Shaq (tribal youth summer program) and a tribal educational backpack event which attracts a large volume of youth and families. Partnerships with these programs provide ample opportunities for one-on-one education and small group information dissemination. In July 2018, the clinic hosted a, first of its kind, SafeTALK training that taught participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources.
trained in suicide intervention; 14 community participants attended. A regional gathering of tribal organizations and facilities was also held that provided educational workshops related to patient engagement in community-based wellness interventions.

Program Performance (FY 17-18) for La Casa de la Raza, Community Health Centers, and Santa Ynez Tribal Health Clinic

<table>
<thead>
<tr>
<th>Outreach Events</th>
<th>LCDLR</th>
<th>SYTHC</th>
<th>CHCCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL # EVENTS</td>
<td>93</td>
<td>41</td>
<td>181</td>
</tr>
<tr>
<td>TOTAL # PARTICIPANTS</td>
<td>523</td>
<td>390</td>
<td>6,310</td>
</tr>
<tr>
<td>TOTAL # FAMILIES SERVED</td>
<td>249</td>
<td>*</td>
<td>487</td>
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<table>
<thead>
<tr>
<th>EVENT TYPE</th>
<th>LCDLR</th>
<th>SYTHC</th>
<th>CHCCC</th>
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</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>4</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Training</td>
<td>12</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>Forum</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Support Group</td>
<td>72</td>
<td>0</td>
<td>104</td>
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<table>
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<tr>
<th>PRIMARY LANGUAGE OF EVENT</th>
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<th>CHCCC</th>
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<tr>
<td>English</td>
<td>0</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>Spanish</td>
<td>253 (groups only)</td>
<td>31 (groups only)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>*</td>
<td>0</td>
</tr>
</tbody>
</table>

*Data not reported by provider.

Each program provided various outreach events, trainings, forums, and support groups to their communities. CHCCC exceeded their contract goals by serving or “touching” thousands of individuals in North County through many outreach events, trainings, and support groups. La Casa de La Raza also exceeded its contract goals and served or “touched” over 500 individuals in South County. Santa Ynez Tribal Health Clinic served West County, and they served or “touched” almost 400 individuals through their various outreach events.

Involvement Efforts with Identified Racial, Ethnic, Cultural, and Linguistic Communities

The Department is committed to community outreach, engagement, and involvement with identified racial, ethnic, cultural, and linguistic communities. Due to the degree of stigma and distrust of government institutions experienced by many of low social economic communities, the department fosters a community development approach in order to establish trusting partnerships with diverse communities of Santa Barbara County. By utilizing this approach, the department is creating a bridge into the community and thereby seeking to improve the wellness of unserved and underserved community members. However, the department also demonstrates its presence by attending various community and health events and providing community presentations.

Furthermore, Community outreach, engagement, and involvement efforts are discussed, planned and driven by the Office of Strategy Management. The Department recognizes that engagement and outreach occur daily through the work of Department and contracted provider staff, and these efforts can be difficult to capture formally and quantify. Engaging hard-to-reach segments of the
community is central to the Department’s organizational culture and is done so at every available opportunity. Below is an overview of outreach and engagement efforts precipitated by the Department.

**Strengthening Community Outreach and Engagement**

Behavioral Wellness established the Behavioral Wellness Response Team in December of 2017 in response to the impact of the Thomas Fire in Santa Barbara County, and continues to provide ongoing community crisis and trauma response. During the 2017-2018 year, the department was contacted by schools countywide for support of student deaths or traumatic events; by first responder agencies for critical incident stress debriefings; and by other county departments for team support in the aftermath of critical incidents.

Behavioral Wellness provided broad response efforts and community support following the Thomas Fire and January 9th Debris Flow which resulted in the loss of 23 community members and had unprecedented impact on our community. Behavioral Wellness provided 24/7 response in a variety of ways including: supporting the Community Information Emergency Call Center, supporting the community in connecting to family and coping with devastating loss, supporting the community at Local Assistance Centers, supporting people returning to damaged or destroyed homes and neighborhoods, providing crisis counseling for those who were directly impacted or lost family members, and remaining connected to long-term recovery efforts through leadership of the Community Wellness Team and Community Long- Term Recovery group.

The Community Wellness Team, as led by the Department of Behavioral Wellness, is a collaboration of 13 local agencies working together to support the wellness of our community in response to the Thomas Fire and January 9th Debris Flow in Santa Barbara County. This collaborative team also coordinated a continuum of services available to meet the needs of individuals impacted by the collective and individual trauma experienced in our county. Services provided by the Community Wellness Team include immediate crisis response; short- and long-term grief, trauma, and bereavement counseling for children and adults in an individual or group format; school support; spiritual care; critical incident stress debriefings and counseling for first responders or other impacted entities; and groups offered through the intensive outpatient program at Cottage Hospital designed for this response.

When Vista Del Mar hospital burned as a result of the Thomas Fire, Behavioral Wellness staff immediately drove to Ventura to connect with Santa Barbara County clients and aid in their return to a safe place. This created a direct impact on the Psychiatric Health Facility who immediately applied for a waiver to accommodate clients which would place the hospital over census.

Behavioral Wellness has hosted countless resource tables, offering resource and outreach information, at forums and events at schools and in the community. Behavioral Wellness has provided many trainings and presentations on services throughout the community as well.

**Solicitation of Diverse Input to Local Mental Health Planning**
Stakeholder announcements inviting community members to participate in MHSA stakeholder planning meetings are routinely translated into Spanish to encourage a diverse variety of community members to participate.

Behavioral Wellness staff members are routinely made available to provide simultaneous interpretation upon request at any Department-sponsored community meeting such as the Behavioral Wellness Commission, the Consumer and Family Member Action Team meetings, and other events. Behavioral Wellness staff is available to interpret at events sponsored by CBOs who provide mental health services, and for advocacy groups. Interpretation equipment is also available on loan to CBOs and other organizations.

Behavioral Wellness is committed to better engaging and serving unserved and underserved communities. Given that Spanish is the only threshold language of Santa Barbara County, Behavioral Wellness has incorporated ethnic specific groups in order to better serve the diverse community.

- In Southern Santa Barbara County, *El Nuevo Amanecer* is a Latinx/Spanish support group for consumers and family members struggling with mental illness and/or alcohol and drug use. The support group meets twice a month and has active members who provide advocacy and outreach to and for the Spanish-speaking community.

- Santa Maria based Latinx/Spanish support group offers consumers and family members a forum to discuss their struggles while building community and decreasing the stigma associated with mental illness. The group meets on a monthly basis and is held in a community setting. The group has spearheaded advocacy activities to draw awareness to the needs of monolingual Spanish speaking community members.

- The Department is collaborating with Marian Medical Center in Santa Maria to assist in developing job descriptions and training curriculum for *promotoras* providing services for mothers with postpartum mental health disorders.

- Members of the Consumer and Family Member Action Team (CFMAT) are consumers, and family members, who provide input on the development, implementation, and review of Behavioral Wellness programs. Spanish interpretation services are always available upon request for the ongoing monthly meetings.

- Key MHSA planning documents and feedback forms are translated into Spanish and posted to the Behavioral Wellness website. All documents in English or Spanish are made available via US Postal Service at no charge upon request.

- The involvement of the underserved communities was critical in the development of two key aspects of the PEI Plan. The *Promotora* Program and the Community Health Clinics programs were created to respond to the feedback from the Spanish speaking/Latinx, Oaxaqueño, Native American, LGBTQ, and Transition Age Youth (TAY) communities. The *Promotora* program is providing liaisons dedicated to helping unserved and underserved people gain access to services and knowledge about mental health conditions. The Community Health Clinics have Spanish-speaking representatives dedicated to helping Spanish-speaking individuals access affordable mental health services in a neighborhood setting in both North and South Santa Barbara County.
Information sharing and training are key instruments in developing and advancing the skills and abilities of community organizations and partners. All contracted providers and partners are invited to attend cultural competence trainings; space permitting. Future trainings currently in development will place a “spotlight” on local communities traditionally underserved and misunderstood, including the Mixtec/Indigenous migrants living and working in Santa Maria, and transgender youth and adults. Trainings will be held throughout the county and/or in a central county location, such as Buellton, to encourage attendance, or online to promote access to as many learners as possible. Another incentive to attend a training is the availability of Continue Education Units.

Presently and in the past year, several training opportunities were made available online, through the Relias Learning platform, as part of the Cultural Competency and Diversity Action Team. In addition, there were a variety of in-person, experiential trainings through select training events.

**Contract Requirements for Latinx Community**

- The Recovery Learning Center charters require contractors to include monolingual and bilingual consumers and family members as advisory board’s members. CBOs are required to provide services and groups in Spanish. Unlike the traditional consumer and family member advocacy efforts, the Latinx consumer and family members advocated for planning sessions and charters that reflect the familial cultural values which calls for consumers and family members to be included in all aspects of the RLC planning and service provision components.

**Lessons Learned from Homeless Outreach Services**

As the coordinated entry system increasingly identifies and prioritizes the most vulnerable individuals for homeless housing, all HUD-funded programs will be increasingly more likely to encounter serving people with moderate to severe mental health conditions and substance use disorders. To safely be able to manage and accommodate the needs of this population, intensive wraparound/housing retention services will be needed to serve the recently housed, chronically homeless clients, whom are Severe Persistent Mentally Ill. This is essential to promote a more stable transition into permanent housing, to prevent recidivism, and to connect clients with mainstream supports.

The Department of Behavioral Wellness is actively working with Santa Barbara County’s Coordinated Entry System to develop a protocol for sharing client data electronically, which will enhance the ability of the system to identify and count youth who are homeless and have been diagnosed with serious emotional disturbances. Although Behavioral Wellness serves many youths who have serious emotional disturbances, as well as many youth who are homeless, youth are tracked based on mental health, rather than based on their housing status, and so the number of youth who are both homeless and experiencing a serious emotional disturbance is not currently being tracked in a reportable manner.
Enhancing information technology for adequate data housing resources is essential. Behavioral Wellness partnered are with the County Housing and Community Development in updating the Countywide Homeless Housing Plan. The Phase I posted for public review was completed in March 2019 and anticipate Phase II, with more stakeholder feedback, will be for FY 19-20.

**Lessons Learned from Forensic Full-Service Partnership Alliance**

In 2018, the Department approved hiring of an Extra-Help Case Worker for the Justice Alliance Santa Barbara team, similar to the Santa Maria region, which was necessary because of the increased rehabilitative service needs. When the team increased efforts to provide outpatient competency restoration treatment—to divert those found to be IST from the PHF—it discovered many of these individuals had time consuming rehabilitation service needs that were not needed when consumers were in the PHF. Hiring the Extra-Help Case Worker freed up time for Practitioners and Psychologists to be engaged in more Assessment and Evaluation activities. Still, the Justice Alliance team experienced an uptick in IST referrals in 2018, up to 60 from 45 in 2017, many of whom required extensive case management. Initial data suggests the workload continued to increase in 2019.

With the above considerations in mind due to increased community restorations, the Department has been examining the feasibility of providing additional support staff to the Justice Alliance team, to include Administrative Office Professionals (AOPS) and Case Workers. The Department applied for grant funding from the AB 1810 diversion bill, to fund two full time Case Workers for the team, and it has prioritized the forensic services for new AOP positions. Behavioral Wellness hired additional case workers with the grant funding starting summer 2019.

**Lessons Learned from Utilizing the *Promotora* Program**

The implementation of health educators, *promotoras*, has facilitated a system acting as a cultural broker helping people obtain direct services to unserved and underserved community members that otherwise would not seek out, or attend, support groups due to stigma, childcare issues, and transportation barriers. Furthermore, CHCCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers at their worksites and has partnered with local Spanish- and Mixteco-language radio stations to bring free lunches to workers. These lunchtime “meet and greets” allow agricultural workers to interact informally with CHCCC outreach staff and build a personal connection that over time facilitates access and linkage to services. CHCCC also conducts ongoing radio and television outreach, education, and anti-stigma efforts, and has undertaken an annual health fair for migrant farmworkers. The health fair focuses on health and mental health support and information services. Many of the participants are Spanish- and Mixteco-speaking farmworkers. Mental health and educational services are delivered in a culturally informed and responsive primary care setting that promotes the integration of self-care.

**Identify County Technical Assistance Needs**

The Department and community partners need support and assistance on research and development of new and innovative methods to reach isolated communities. Small ethnic groups, including Mixtec, American Indian, Alaskan Native, Asian, Black/African American, Hawaiian and Pacific Islanders are becoming more visible in our community.
III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

The county shall include the following in the CCPR Modification (2010):

A. Detail who is designated the county’s CC/ESM responsible for cultural competence who promotes the development of appropriate mental health services that will meet the diverse needs of the county’s racial, ethnic, cultural, and linguistic population.

In August 2019, Alice Gleghorn, Ph.D., Director of the Department of Behavioral Wellness, appointed Maria Arteaga, JD, as Ethnic Services and Diversity Manager for the Department. Ms. Arteaga concurrently serves as the Peer Empowerment Manager. Ms. Arteaga’s responsibilities include research, development, and implementation of the Department’s Cultural Competence Plan as well as chairing and coordinating the Cultural Competency and Diversity Action Team (CCDAT). Ms. Arteaga is bilingual in Spanish and a first generation Mexican-American raised in Ventura County. Her exposure and experience in working with diverse communities and identifying mental health disparities in the multi-cultural communities makes her uniquely qualified to lead in this role.

As Ethnic Services and Diversity Manager, Ms. Arteaga advocates and takes a leadership role in the development and implementation of policies, programs, practices, and services that address the cultural and linguistic needs of all communities in Santa Barbara County and has direct access to Dr. Gleghorn to discuss issues impacting mental health issues related to racial, ethnic, cultural, and linguistic populations within the county.

Written description of the Cultural Competence responsibilities of designated CC/ESM.

The Ethnic Services and Diversity Manager will plan, implement, monitor, and evaluate the Department’s cultural and linguistic healthcare and outreach services and programs. Ms. Arteaga duties will include:

- Develop and manage the implementation of the Cultural Competence Plan, including a training and education program.
- Facilitate and coordinate the development and on-going management of the Cultural Competency and Diversity Action Team (CCDAT).
- Develop programs and processes to assess the cultural competency of staff.
- Develop a minimum core curriculum standard for annual diversity trainings.
- Identify the behavioral health care needs of ethnically and culturally diverse populations as they impact county systems of care, make appropriate and meaningful recommendations to management, and coordinate and promote quality and equitable care.
• Maintain an ongoing relationship with community organizations, planning agencies, and the community at large.

• Visit and assess Behavioral Wellness contract agency facilities and make recommendations about facility changes and location in accordance with the needs of diverse populations.

• Plan, organize, provide, and document outreach and engagement activities and efforts.

• Develop, manage, and document process for monitoring access responsiveness and provide corrective feedback regarding all unserved and underserved cultural populations.

• Develop and implement translation and interpretation services.

• Gather data on penetration and retention rates, and based on identified disparities, make recommendations to Quality Improvement Committee (QIC), Department leadership, and the Department director.

• Update the Cultural Competence Plan annually.

• Other duties to ensure services in the mental health system of care are culturally, linguistically, and ethnically responsive to our diverse County of Santa Barbara population.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR Modification (2010):

A. Evidence of a budget dedicated to cultural competence activities which may include, but not limited to the following:
   1. Budget amount spent on Interpreter and Translation services;
   2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
   3. Budget amount allocated towards outreach to racial and ethnic county-identified target populations;
   4. Special budget for culturally appropriate mental health services; and
   5. If applicable, financial incentives for culturally and linguistically providers, non-traditional providers, and/or natural healers.

The amount of funding provided for cultural competency related services and activities is immeasurable. Culturally competent service funding is embedded in all programs, services, personnel salaries and benefits, training, etc. Certain activities, such as interpreter and translation services and contracts with service providers such La Casa de la Raza, Community Health Centers, Santa Ynez Tribal Health Clinic, Pacific Pride Foundation, and the Independent Living Resource Center are examples of services and supports budgeted to address cultural competency needs.

• Budget amount spend on Interpreter and Translation Services:
i. FY- 2017-2018 was $148,036.71
ii. FY- 2018-2019 was $276,055.56

Reduction of racial, ethnic, cultural, and linguistic mental health disparities and outreach and engagement to racial and ethnic county-identified target population:

<table>
<thead>
<tr>
<th>Mental Health Education and Support to Culturally Underserved Communities (Promotora Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider: La Casa de la Raza, Community Health Centers of the Central Coast (CHCCC), Santa Ynez Tribal Health Clinic (SYNTHC)</td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures $253,400</td>
</tr>
<tr>
<td>Estimated CSS Funding $253,400</td>
</tr>
<tr>
<td>Estimated Medi-Cal FFP $0</td>
</tr>
<tr>
<td>Estimated 1991 Realignment $0</td>
</tr>
<tr>
<td>Estimated Behavioral Health Subaccount $0</td>
</tr>
<tr>
<td>Estimated Other Funding $0</td>
</tr>
<tr>
<td>Average Cost Per Consumer (7223 Consumers) $33</td>
</tr>
</tbody>
</table>

Homeless Outreach Services-Behavioral Wellness, Good Samaritan, United Way

<table>
<thead>
<tr>
<th>Homeless Outreach Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider: Behavioral Wellness, Good Samaritan, and United Way</td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures $916,100</td>
</tr>
<tr>
<td>Estimated CSS Funding $178,800</td>
</tr>
<tr>
<td>Estimated Medi-Cal FFP $679,200</td>
</tr>
<tr>
<td>Estimated 1991 Realignment $0</td>
</tr>
<tr>
<td>Estimated Behavioral Health Subaccount $0</td>
</tr>
<tr>
<td>Estimated Other Funding $58,100</td>
</tr>
<tr>
<td>Average Cost Per Consumer (182 Consumers) $5,033</td>
</tr>
</tbody>
</table>

Partners in Hope: Mental Wellness Centers, Transitions Mental Health Association and Behavioral Wellness

<table>
<thead>
<tr>
<th>Partners in Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider: Mental Wellness Center, Transitions Mental Health Association and Behavioral Wellness</td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures $901,800</td>
</tr>
<tr>
<td>Estimated CSS Funding $901,800</td>
</tr>
<tr>
<td>Estimated Medi-Cal FFP $0</td>
</tr>
<tr>
<td>Estimated 1991 Realignment</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Estimated Behavioral Health Subaccount</td>
</tr>
<tr>
<td>Estimated Other Funding</td>
</tr>
<tr>
<td>Average Cost Per Consumer (1,274 Consumers)</td>
</tr>
</tbody>
</table>

PEI Early Childhood Mental Health - CALM, Santa Ynez Valley People Helping People

<table>
<thead>
<tr>
<th>PEI Early Childhood Mental Health (ECMH)</th>
<th>CALM, Santa Ynez Valley People Helping People (SYPHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
<td></td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures</td>
<td>$428,100</td>
</tr>
<tr>
<td>Estimated CSS Funding</td>
<td>$132,100</td>
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<tr>
<td>Estimated Medi-Cal FFP</td>
<td>$296,00</td>
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<tr>
<td>Estimated 1991 Realignment</td>
<td>$0</td>
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<tr>
<td>Estimated Behavioral Health Subaccount</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated Other Funding</td>
<td>$0</td>
</tr>
<tr>
<td>Average Cost Per Consumer (185 Consumers)</td>
<td>$2,314</td>
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</tbody>
</table>

School-Based Prevention/Early Intervention Services for Children and TAY (START)

<table>
<thead>
<tr>
<th>School-Based Prevention/Early Intervention Services for Children and TAY (START)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider:</td>
<td>Family Services Agency, Council on</td>
</tr>
<tr>
<td></td>
<td>Alcoholism and Drug Abuse</td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
<td></td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures</td>
<td>$502,600</td>
</tr>
<tr>
<td>Estimated CSS Funding</td>
<td>$354,400</td>
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<tr>
<td>Estimated Medi-Cal FFP</td>
<td>$148,200</td>
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<tr>
<td>Estimated 1991 Realignment</td>
<td>$0</td>
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<tr>
<td>Estimated Behavioral Health Subaccount</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated Other Funding</td>
<td>$0</td>
</tr>
<tr>
<td>Average Cost Per Consumer (100 Consumers)</td>
<td>$5,026</td>
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</table>

PEI Early Detection and Intervention Teams for Transitional-Age Youth (TAY)-Behavioral Wellness

<table>
<thead>
<tr>
<th>PEI Early Detection and Intervention Teams for Transition-Age Youth (TAY)</th>
<th>Behavioral Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Estimated Funding FY 2019/20:</td>
<td></td>
</tr>
<tr>
<td>Estimated Total Mental Health Expenditures</td>
<td>$1,179,900</td>
</tr>
<tr>
<td>Estimated CSS Funding</td>
<td>$0</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Estimated Medi-Cal FFP</td>
<td>$1,179,900</td>
</tr>
<tr>
<td>Estimated 1991 Realignment</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated Behavioral Health Subaccount</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated Other Funding</td>
<td>$0</td>
</tr>
<tr>
<td>Average Cost Per Consumer (202 Consumers)</td>
<td>$5,841</td>
</tr>
</tbody>
</table>

**Criterion 1 Exhibits:**

1. Accessing a Welcoming and Integrated System of Care Policy
2. Cultural and Linguistic Competency Policy
3. Beneficiary Rights Policy
4. Mental Health Plan Outreach Policy
5. Non-Discrimination Policy
6. Beneficiary Problem Resolution Process Policy
7. Consumer Information Checklist Policy
8. Beneficiary Information Materials Policy
9. Mental Health Plan - Visually and Hearing Impaired, and Beneficiaries with Limited Reading Ability Policy
10. Language Services for Limited English Proficiency Policy
11. Patients' Rights Advocacy Policy
12. Contractor Provider Relations Policy
13. Service Availability for Routine Conditions Policy
14. Mandatory Trainings Policy
15. Accessibility for Persons with Disabilities Policy
16. Notice of Adverse Benefit Determination Policy
17. 24/7 Toll-Free Line Policy
18. Network Adequacy Standards and Monitoring Policy
19. County of Santa Barbara Americans with Disabilities Act Policy
20. County of Santa Barbara Non-Discrimination Policy
21. Department of Behavioral Wellness Code of Conduct: Diversity and Equal Opportunity Policy
22. Bilingual Allowance Policy
23. Non-Discrimination and Institutional Safeguards for Religious Providers
24. Drug Medi-Cal Organized System Care Coordination
25. Substance Use Disorders Monitoring and Documentation Review
26. Contract Requirements
27. Welcome to the Department of Behavioral Wellness
28. Behavioral Health Services in Santa Barbara County
29. Access Flyer
30. Access Cards
31. Guide to Medical Services
32. Satisfaction Surveys
33. Beneficiary Brochure
34. State Fair Hearings
35. Guide for Latinos and Their Families
36. HIPAA: Notice of Privacy Practices
37. Compliance Hotline Flyer
38. Santa Barbara Adult Services Information
39. Carpinteria Outreach Flyer
40. Santa Maria Adult Services
41. Mental Health Services for Adults
42. Anxiety Disorders in Adults
43. Children's Services Countywide
44. Children's Services Santa Maria
45. Children's Services Lompoc
46. Children's Services Santa Barbara
47. Children and Youth Crisis Line (SAFTY) Brochure
48. Medi-Cal Beneficiary Booklet
49. Mental Health Plan Services
50. Provider Directory
51. Patients' Rights Flyer
52. Patients' Rights Brochure
53. Advance Directives for Medical and/or Psychiatric Healthcare
54. General Information About Mental Illness
55. Schizophrenia Information
56. PTSD Information
57. Mood Disorders in Adults: Depression and Bipolar Disorder
58. Veterans Treatment Court of Santa Barbara County
59. DMC-ODS Beneficiary Handbook
60. DMC-ODS Provider Directory
61. DMC-ODS Provider List
62. Practice Guidelines
63. Alcohol and Other Drugs Strategic Prevention Plan 2017-2022
64. Mental Health Appeal Forms
65. Mental Health Change of Clinician Form
66. Consent Forms
67. Mental Health Grievance Form
68. Alcohol and Drug Program Grievance Form
69. Release of Information – Consent for Release of Patient Information or Records
70. Request for a Second Opinion
CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The county shall include the following in the CCPR:

A. Summarize the county’s general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

Santa Barbara County, California, is a county located in the southern region of the U.S.A. state of California and the largest city is Santa Maria. The county has a total area of 3,789 square miles, of which 2,735 square miles is land and 1,054 square miles (27.8%) is water.

Santa Barbara County has a mountainous interior abutting several coastal plains on the west and south coasts of the county. The largest concentration of population is on the southern coastal plain, referred to as the "south coast" – the part of the county south of the Santa Ynez Mountains. This region includes the cities of Santa Barbara, Goleta, and Carpinteria, as well as the unincorporated areas of Hope Ranch, Summerland, Mission Canyon, Montecito, and Isla Vista.
North of the Santa Ynez range in the Santa Ynez Valley are the towns of Santa Ynez, Solvang, Buellton, Lompoc, Los Olivos and Ballard. North of the Santa Ynez Valley are the cities of Santa Maria and Guadalupe, and the unincorporated towns of Orcutt, Los Alamos, Casmalia, Garey, and Sisquoc. In the extreme northeastern portion of the county are the small cities of New Cuyama, Cuyama, and Ventucopa.

Santa Maria’s industry is largely comprised of agriculture, forestry and fishing (27%) (https://livability.com/ca/santa-maria/business) while health care, social assistance and educational services account for over 9% of the employment. With a population of slightly more than 104,000, Santa Maria’s poverty rate hovers over 18%. Conversely, Lompoc’s data suggests a disparity in the employment and poverty levels despite its smaller size and similar industries in health care and retail employment. Currently consisting of a 56% Hispanic population of almost 44,000 residents, Lompoc has over a 20% poverty rate. (https://datausa.io/profile/geo/lompoc-ca).

To the north of the mountains is the arid and sparsely populated Cuyama Valley where oil production, ranching, and agriculture dominate the land use in the privately-owned parts of the Cuyama Valley; the Los Padres National Forest is adjacent to the south, and regions to the north and northeast are owned by the Bureau of Land Management and the Nature Conservancy.

Mainstays of the county's economy include engineering, resource extraction (particularly petroleum extraction and diatomaceous earth mining), winemaking, agriculture, and education. The software development and tourism industries are important employers in the southern part of the county.

(Portions of General Population description was retrieved from the Mental Health Services Act Update Fiscal Year 19-20 and Wikipedia 2019.)

Selected Data for Santa Barbara County, California
(U.S. Census Bureau)

Please note: The U.S. Census does not recognize “Hispanic/Latinx” as an ethnicity or race. “Hispanics/Latinxs” may be of any race. Consequently, the sum of “Persons of Hispanic or Latinx origin” and all the recognized racial designations does not add up precisely to 100%. This is due to a small number of “Hispanics/Latinxs” who did not designate themselves as “White” may be double counted in a racial designation such as “Black persons”, “Persons Reporting Two or More Races,” etc.

<table>
<thead>
<tr>
<th>Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population estimates, July 1, 2018, (V2018)</td>
<td>446,527</td>
</tr>
<tr>
<td>Population estimates base, April 1, 2010, (V2018)</td>
<td>423,947</td>
</tr>
<tr>
<td>Population, percent change - April 1, 2010 (estimates base) to July 1, 2018, (V2018)</td>
<td>5.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age and Sex</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons under 5 years, percent</td>
<td>6.20%</td>
</tr>
<tr>
<td>Persons under 18 years, percent</td>
<td>22.10%</td>
</tr>
<tr>
<td>Category</td>
<td>Value</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Persons 65 years and over, percent</td>
<td>15.30%</td>
</tr>
<tr>
<td>Female persons, percent</td>
<td>50.00%</td>
</tr>
<tr>
<td><strong>Race and Hispanic Origin</strong></td>
<td></td>
</tr>
<tr>
<td>White alone, percent</td>
<td>85.40%</td>
</tr>
<tr>
<td>Black or African American alone, percent</td>
<td>2.40%</td>
</tr>
<tr>
<td>American Indian and Alaska Native alone, percent</td>
<td>2.20%</td>
</tr>
<tr>
<td>Asian alone, percent</td>
<td>6.00%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander alone, percent</td>
<td>0.30%</td>
</tr>
<tr>
<td>Two or More Races, percent</td>
<td>3.70%</td>
</tr>
<tr>
<td>Hispanic or Latinx, percent</td>
<td>45.80%</td>
</tr>
<tr>
<td>White alone, not Hispanic or Latinx, percent</td>
<td>44.10%</td>
</tr>
<tr>
<td><strong>Population Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Veterans, 2013-2017</td>
<td>22,974</td>
</tr>
<tr>
<td>Foreign born persons, percent, 2013-2017</td>
<td>23.00%</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
</tr>
<tr>
<td>Housing units, July 1, 2018, (V2018)</td>
<td>158,333</td>
</tr>
<tr>
<td>Owner-occupied housing unit rate, 2013-2017</td>
<td>52.30%</td>
</tr>
<tr>
<td>Median value of owner-occupied housing units, 2013-2017</td>
<td>$509,400</td>
</tr>
<tr>
<td>Median selected monthly owner costs -with a mortgage, 2013-2017</td>
<td>$2,241</td>
</tr>
<tr>
<td>Median selected monthly owner costs -without a mortgage, 2013-2017</td>
<td>$580</td>
</tr>
<tr>
<td>Median gross rent, 2013-2017</td>
<td>$1,496</td>
</tr>
<tr>
<td>Building permits, 2018</td>
<td>928</td>
</tr>
<tr>
<td><strong>Families and Living Arrangements</strong></td>
<td></td>
</tr>
<tr>
<td>Households, 2013-2017</td>
<td>144,015</td>
</tr>
<tr>
<td>Persons per household, 2013-2017</td>
<td>2.94</td>
</tr>
<tr>
<td>Living in same house 1 year ago, percent of persons age 1 year+, 2013-2017</td>
<td>79.80%</td>
</tr>
<tr>
<td>Language other than English spoken at home, percent of persons age 5 years+, 2013-2017</td>
<td>39.70%</td>
</tr>
<tr>
<td><strong>Computer and Internet Use</strong></td>
<td></td>
</tr>
<tr>
<td>Households with a computer, percent, 2013-2017</td>
<td>89.40%</td>
</tr>
<tr>
<td>Households with a broadband Internet subscription, percent, 2013-2017</td>
<td>82.30%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>High school graduate or higher, percent of persons age 25 years+, 2013-2017</td>
<td>80.40%</td>
</tr>
<tr>
<td>Bachelor's degree or higher, percent of persons age 25 years+, 2013-2017</td>
<td>33.30%</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
</tr>
<tr>
<td>With a disability, under age 65 years, percent, 2013-2017</td>
<td>5.80%</td>
</tr>
<tr>
<td>Persons without health insurance, under age 65 years, percent</td>
<td>10.50%</td>
</tr>
<tr>
<td><strong>Economy</strong></td>
<td></td>
</tr>
<tr>
<td>In civilian labor force, total, percent of population age 16 years+, 2013-2017</td>
<td>63.90%</td>
</tr>
<tr>
<td>In civilian labor force, female, percent of population age 16 years+, 2013-2017</td>
<td>58.50%</td>
</tr>
<tr>
<td>Total accommodation and food services sales, 2012 ($1,000)</td>
<td>1,428,929</td>
</tr>
</tbody>
</table>
Total health care and social assistance receipts/revenue, 2012 ($1,000) 2,637,280
Total manufacturers’ shipments, 2012 ($1,000) 4,157,565
Total merchant wholesaler sales, 2012 ($1,000) 3,475,600
Total retail sales, 2012 ($1,000) 4,853,808

**Transportation**
Mean travel time to work (minutes), workers age 16 years+, 2013-2017 19.4

**Income and Poverty**
Median household income (in 2017 dollars), 2013-2017 $68,023
Per capita income in past 12 months (in 2017 dollars), 2013-2017 $32,872
Persons in poverty, percent 12.60%

(Data source: https://www.census.gov/quickfacts/santabarbaracountycalifornia)

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**II. Medi-Cal population service needs (Use CAEQRO data if available.)**

The county shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).
   1. The County’s Medi-Cal population
   2. The County’s client utilization data

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

---

**Behavioral Wellness Clients Served Calendar FY 2017/2018**

In addition to looking at the general population of County of Santa Barbara, demographic data on all of those served in the County of Santa Barbara Mental Health Plan is also presented. The following data represents all clients that received at least one service in FY 2017-2018. The County of Santa Barbara in FY 2017-2018 served 12,635 unduplicated clients.

**Race/Ethnicity:** Of the clients served in FY 2017/2018 by Behavioral Wellness 39.04% were White/Caucasian, Hispanic/Latino accounted for 37.67%, African American 3.58% followed by Asian Pacific Islander at 1.72%, Native American Indian at 1.02% and other 16.9%. These percentages reflect the diversity of the clients served in Behavioral wellness.

**Age:** The majority of clients served in FY 2017/2018 by Behavioral Wellness were 26+ years (51.40%) and the Transitional-Age Youth population representing 22.12%. In the Children’s
system of care, children under the age of 5 represent 2.56% of those served. In the adult system of care, older adults (60+) represent 11.04% of those served.

**Gender:** In the overall system, slightly more Males (55.06%) were served than Females (44.30%) in FY 2017-2018.

**Language Spoken:** The majority of our client population report their preferred Language to be English. Spanish preferred, accounted for 10.54% of our client population.

### Alcohol and Drug Program Clients Served for FY 17/18

**Alcohol & Drug Programs (ADP)**

Behavioral Wellness contracts with community-based organizations to deliver alcohol and other drug prevention and treatment services. Nearly all adult substance abuse treatment services are provided in outpatient settings, almost a third (28%) of which are outpatient Narcotic Treatment Program (methadone) services. Twelve percent (12%) are social model detoxification services. Finally, all youth substance abuse treatment services are provided in outpatient settings.

In FY 2017/18, **4,300 unique clients** were open to ADP: 91% adults and 9% youth. Among both adults and youth, just about two-thirds of ADP clients were male.

<table>
<thead>
<tr>
<th>ADP - Unique Clients</th>
<th>Adult &amp; Youth</th>
<th>Adult</th>
<th>Youth</th>
<th>Missing DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,77</td>
<td>2,53</td>
<td>24</td>
<td>*</td>
</tr>
<tr>
<td>Female</td>
<td>1,51</td>
<td>1,39</td>
<td>12</td>
<td>*</td>
</tr>
<tr>
<td>Missing/Other</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,300</td>
<td>3,9</td>
<td>36</td>
<td>1</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1,81</td>
<td>1,76</td>
<td>50</td>
<td>*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2,21</td>
<td>1,90</td>
<td>30</td>
<td>*</td>
</tr>
<tr>
<td>African American</td>
<td>112</td>
<td>106</td>
<td>*</td>
<td>2%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>51</td>
<td>48</td>
<td>*</td>
<td>1%</td>
</tr>
<tr>
<td>Native American</td>
<td>30</td>
<td>30</td>
<td>*</td>
<td>0%</td>
</tr>
<tr>
<td>Asian**</td>
<td>46</td>
<td>44</td>
<td>*</td>
<td>1%</td>
</tr>
<tr>
<td>Other/Unknown**</td>
<td>40</td>
<td>37</td>
<td>*</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,300</td>
<td>3932</td>
<td>367</td>
<td>1</td>
</tr>
</tbody>
</table>

*Number not included due to small sample size

**Note. Combined small sample sizes into a larger ethnic group for protection of client privacy**
Over half (51%) of all APD clients served were Hispanic and 42% were White. Whereas among adult ADP client’s ethnicity was more equally divided between Whites (45%) and Hispanics (48%), this was not the case among ADP youth: 83% were Hispanic and 14% were White. The adult and youth ADP system of care served proportionally dissimilar ethnic populations.

**County’s Medi-Cal Eligible Population**

Race/Ethnicity- The ethnic breakdown of the County’s Medi-Cal eligible beneficiaries is presented in Table 1. As the table indicates, ethnicity of the County’s Medi-Cal eligible population is diverse. People who identify as White/Caucasian make up 63.1% of the population. Other ethnic groups comprising notable proportions of the population include: Hispanic/Latinx 23.2%, African American 1.5%, Asian/Pacific Islander 2.3%, Native American 0.4%, and other accounted for 9.6%.

**Age:** 0-5 years old (14.8%), 6-17 years old (27.7%), 18-59 years old (47.9%), and 60+ (9.72%)

**Gender:** More than half the population 50.62% is Female, while Males account for 49.38% of the population.

**Language Spoken:** Data provided by the EQRO did not contain information related to language spoken.

**County’s Medi-Cal Beneficiaries Receiving Specialty Mental Health Services**

As Table 1 indicates, the Race/Ethnicity of the County’s Medi-Cal eligible clients receiving mental health specialty services are as diverse as the overall Medi-Cal eligible population: White/Caucasians 57.5%, Hispanic/Latinx 17.9%, Asian/Pacific Islander 1.5%, African-American 3.2%, Native American 0.6%, and other 19.3% are represented in the mental health system. Compared to the general Medi-Cal eligible population, the White/Caucasian, Hispanic/Latinx, and Asian/Pacific Islander population are slightly underrepresented. African-American, Native American, and Other populations are slightly over represented.
**Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity
Santa Barbara MHP**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Average Monthly Unduplicated Medi-Cal Enrollees</th>
<th>% Enrollees</th>
<th>Unduplicated Annual Count Beneficiaries Served</th>
<th>% Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>94,616</td>
<td>63.1%</td>
<td>3,534</td>
<td>57.5%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>34,694</td>
<td>23.2%</td>
<td>1,100</td>
<td>17.9%</td>
</tr>
<tr>
<td>African-American</td>
<td>2,249</td>
<td>1.5%</td>
<td>194</td>
<td>3.2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3,393</td>
<td>2.3%</td>
<td>93</td>
<td>1.5%</td>
</tr>
<tr>
<td>Native American</td>
<td>533</td>
<td>0.4%</td>
<td>39</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other</td>
<td>14,365</td>
<td>9.6%</td>
<td>1,188</td>
<td>19.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>149,848</strong></td>
<td><strong>100%</strong></td>
<td><strong>6,148</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

**Age:** As Table 2 indicates, the majority of the specialty mental health clients are adults between the ages of 18 and 60+ years (63.31%). Children and youth (0-17) represent approximately 36.69%.

**Gender:** Table 2 shows that the majority of the Medi-Cal eligible recipients receiving mental health services are Female, as with the general Medi-Cal eligible population, the percentages are slightly lower for Males. Males account for 49.38% of the Medi-Cal recipients receiving specialty mental health services as compared to 46.36% in the County’s general Medi-Cal population. Females represent 50.62% of the Medi-Cal recipients receiving specialty mental services as compared to 53.64% in the general Medi-Cal population.

**Language Spoken** - Data on language spoken was not available for the Medi-Cal population.
Table 2 DHCS Approved Claims and MMEF Data

<table>
<thead>
<tr>
<th></th>
<th>SANTA BARBARA</th>
<th>MEDIUM</th>
<th>STATEWIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Number</td>
<td>Approved</td>
</tr>
<tr>
<td></td>
<td>Number of</td>
<td>of</td>
<td>Claims</td>
</tr>
<tr>
<td></td>
<td>Eligibles per</td>
<td>Beneficiaries</td>
<td>served per</td>
</tr>
<tr>
<td></td>
<td>Month (4)</td>
<td>Year</td>
<td>served per</td>
</tr>
<tr>
<td>TOTAL</td>
<td>149,848</td>
<td>6,148</td>
<td>$41,053,851</td>
</tr>
<tr>
<td>AGE GROUP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>22,110</td>
<td>515</td>
<td>$1,620,641</td>
</tr>
<tr>
<td>6-17</td>
<td>41,455</td>
<td>1,741</td>
<td>$12,274,632</td>
</tr>
<tr>
<td>18-59</td>
<td>71,703</td>
<td>3,350</td>
<td>$23,113,046</td>
</tr>
<tr>
<td>60+</td>
<td>14,580</td>
<td>542</td>
<td>$4,045,533</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80,384</td>
<td>3,112</td>
<td>$20,353,672</td>
</tr>
<tr>
<td>Male</td>
<td>69,465</td>
<td>3,036</td>
<td>$20,700,180</td>
</tr>
<tr>
<td>RACE/ETHNICITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>94,616</td>
<td>3,534</td>
<td>$21,343,003</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>34,694</td>
<td>1,100</td>
<td>$6,329,583</td>
</tr>
<tr>
<td>African-American</td>
<td>2,249</td>
<td>194</td>
<td>$1,316,187</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3,393</td>
<td>93</td>
<td>$541,462</td>
</tr>
<tr>
<td>Native American</td>
<td>533</td>
<td>39</td>
<td>$269,566</td>
</tr>
<tr>
<td>Other</td>
<td>14,365</td>
<td>1,188</td>
<td>$11,254,050</td>
</tr>
</tbody>
</table>

Figures 1A show three-year (CY 2015-17) trends of the MHP’s overall penetration rates, compared to both the statewide average and the average for medium MHPs.
Provide an analysis of disparities as identified in the above summary (Figure 1A)

The overall penetration rate in the County of Santa Barbara (MHP) for FY 2017/2018, based on Medi-Cal eligible receiving specialty mental health services is 4.10%, compared to 4.52% statewide. Differences are found when comparing different demographic categories.

**Race/Ethnicity:** The MHP’s penetration rates for Race/Ethnicity ranges from 3.74% to 8.27%. Asian/Pacific Islander and Hispanic account for the lowest penetration rate at (2.74% API) to 3.17% (Hispanic). On the other hand, Native Americans, Caucasians, and African Americans account for the highest penetration rates (7.32% Native American, 3.74% Caucasian and 8.63% African American).

**Age:** The penetration rates for age range from 2.33% to 4.67%. Children under the age of 5 represent a slightly higher penetration rate at 2.33% compared to the statewide penetration rate at 2.07%. Children between ages of 6 and 17 represent the lowest penetration rate at 4.20% compared to 6.31% statewide. Adults between the ages of 18 and 59 represent a penetration rate of 4.67% compared to 4.71% statewide. The Older Adult population has a penetration rate of 3.72% which is higher than the statewide penetration rate of 2.78%. It is worth noting, the possibility of lower penetration rates for some age, race, cultural, and ethnic groups are underreported due to services being delivered to communities by community partners that are not part of the MHP.

**Gender:** The penetration rates for females were slightly lower than that of males. Although there was not a significant difference, the female penetration rate was 3.87%, whereas male penetration rate was 4.37%. The County’s MHP penetration rates for both males and females are lower than the statewide rates, which indicate the county is serving both females and males at a lower rate than California overall.

**Language Spoken:** Penetration rates were unable to be calculated due to the lack of available Medi-Cal data.

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

The county shall include the following in the CCPR Modification (2010):

- Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender other relevant small county cultural populations.
- Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support analysis.
Data for the 200% Federal Poverty Level population were taken from the California Department of Mental Health “CPES Estimates of Need for Mental Health Services for California, County of Santa Barbara and data for Medi-Cal beneficiaries and Medical beneficiaries served were taken from the EQRO Medi-Cal Approved Claims for the County of Santa Barbara MHP.”

A total of 138,712 people fell into the <200% FPL population category (minus Medi-Cal) and 10,898 cases. From those data, the following description of ethnicity/race, age, gender, and language are drawn.

**Race/Ethnicity:** The estimated need for mental health services in the County of Santa Barbara that meet the 200% Federal Poverty Level by race/ethnicity is the following: Hispanic (8.83%) and White (8.69%), followed by Asian/Pacific Islander (9.02%). African American make up 8.68% of the population and Native American 8.81%. It must be noted, Medi-Cal clients are assumed to be included in the 200% FPL population and raise concern with the accuracy of the 200% FPL estimates and ability to accurately analyze differences among the racial categories.

**Age:** The majority of the 200% FPL population and client population are adults. Children under the age of 18 represent a lower percentage of both the 200% FPL population and client population.

**Gender:** The distribution of gender is opposite in the 200% FPL population and client populations. Males account for a larger percent of the 200% FPL population (8.84%) whereas females account for a larger percent of the client population (8.79%).

**Language Spoken:** Data on language spoken was not provided or available for the 200% FPL population.

The overall penetration rate in the County of Santa Barbara for FY 2017-2018, based on 200% Poverty minus Medical is 7.86% compared to 4.10% for the County of Santa Barbara total system. In comparing the penetration rate of a medium size county with the County of Santa Barbara, it should be noted it is the same. Additionally, the County’s penetration rate compared to the statewide penetration rate is slightly lower.

**Race/Ethnicity:** Penetration rates for all race/ethnicities are much higher in the 200% FPL population compared to the statewide penetration rate. The 200% FPL rate for people who identify as White is (8.69%), Asian/Pacific Islander (8.38%), African American (8.68), Native American (8.81%), and Hispanic/Latino (8.83%).

**Age:** The penetration rates for age are higher in the 200% FPL population than in the county of Santa Barbara.

**Gender:** The penetration rates for females is higher than that of males in the 200% FPL population as compared to the County’s penetration rate.
Language Spoken: Penetration rates were unable to be calculated due to the lack of available 200% Poverty Population and Medi-Cal data.

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

The county shall include the following in the CCPR Modification (2010):

A. From the county’s approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, and gender and other relevant small county cultural populations.
B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

The Department has not conducted a CSS population assessment since 2005. Despite relatively little change in population size and demographics over the past twelve years, using data and analysis from this assessment may not accurately represent present issues, including mental health disparities. Plans to produce a new population assessment within this 3-year plan.

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

The county shall include the following in the CCPR Modification (2010):

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

The PEI planning process resulted in stakeholders identifying all six populations as priorities:

1. Trauma Exposed Individuals  
2. Individuals Experiencing Onset of Serious Psychiatric Illness  
3. Children and Youth in Stressed Families  
4. Children and Youth at Risk for School Failure  
5. Children and Youth at Risk of/or Experiencing Juvenile Justice Involvement  
6. Underserved Cultural Populations

Research conducted during both the CSS and PEI planning processes identified disparities within target populations. For example, access to services between Caucasians and Latinxs was
identified to be a major disparity within target populations. A number of the PEI projects and strategies formulated to reach underserved segments of the Latinx community are as follows:

- Mental health programs were strengthened in community health clinics
- Service settings that reduce stigma and geographical barriers for access by Latinxs countywide
- New TAY mental health teams for detection and early intervention will focus on underserved youth in both North and South County
- Early childhood mental health programs will target underserved Latinx children countywide
- A school-based program in South County will provide prevention and early intervention services to children and youth who have been underserved
- Community health educators from Latinx communities will provide outreach, education, and linkages to underserved members of the Latinx community

The community health education component of PEI will also focus on additional underserved cultural groups that include, but are not limited to, Latinx, Native American, Oaxacan, and LGBTQ populations.

The PEI planning process was conducted in five phases in order to identify the target populations
CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. The county shall include the following in the CCPR Modification (2010)
   A. List the identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI).
   B. Describe the process and rationale the county used to identify and target the population(s) with disparities.

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

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

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

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

Prevention and Early Intervention (PEI) stakeholder forums were held every year in each major population center in Santa Barbara County (Santa Maria, Lompoc, and Santa Barbara). Stakeholders were briefed on MHSA guidelines and research conducted by the University of California, Santa Barbara. Stakeholders broke into workgroups by age of the target populations (children, TAY, adults and older adults). After a discussion they were asked to prioritize priority populations. A series of focus groups were also held targeting specific populations (Latinx, TAY, LGBTQ, etc.) known from past planning processes (CSS, WET) to be under-represented in conventional stakeholder processes such as community forums.

Community interest focused on providing prevention and early intervention services for school-age children at risk for failure, children and youth with involvement and/or at risk of involvement with CWS, young adults in crisis, adults in the criminal justice system, older adults who are isolated and/or experiencing a serious mental health condition, and underserved cultural populations of all ages.

The PEI planning process was conducted in five phases in order to identify the target populations.

Phase One: Research conducted by the University of California, Santa Barbara (UCSB).
To obtain a solid research foundation from which to build the PEI planning process, a team of researchers with the UCSB Gevirtz Graduate School of Education compiled comprehensive information regarding mental health risk factors and prevalence (including national, state, and local data). The data was then presented at all PEI planning meetings.

Phase Two: Regional Stakeholder Forums.
In March 2009, three community forums, one in each of the County’s major population centers (Santa Maria, Lompoc, and Santa Barbara), offered stakeholders a background about MHSA and PEI guidelines, a summary of the research findings by UCSB, and participation in one of four workgroups based on the four age groups (children, TAY, Adults and Older Adults) that prioritized community mental health needs and priority populations.

Two means of informing stakeholders about the PEI Community Forums were used. First, the Department announced the forums at a number of major stakeholder groups, including the CFMAC, the Latinx Advisory Committee (LAC), the Santa Barbara County Mental Health Commission (MHC) and Latinx consumer and family member support groups in North and South County. Second, to ensure widespread coverage, emails were sent to 275 individuals or representatives of various organizations throughout the County reflecting the following key PEI constituencies and all age groups:

VI. Alcohol and Drug Treatment
VII. Community Centers
VIII. Individuals with a Serious Mental Illness
IX. Education
X. Employment
XI. Faith-Based
XII. Family Members of Individuals with a Serious Mental Illness
XIII. Homeless Activists
XIV. Law Enforcement
XV. Mental Health
XVI. Physical Health
XVII. Social Services
XVIII. Underserved Communities

Phase Three: Focus Groups and Key Informant Interviews.
The third phase of the stakeholder planning process was designed to ensure diversity and representation of underserved and unserved communities with an emphasis on individuals and groups who were unlikely to participate in regional meetings and other conventional stakeholder forums. Consisting of 38 individuals, the focus groups and key informant interviews addressed the concerns of the following under-represented groups:

XIX. Transition-Age Youth
XX. Native Americans
XXI. Latinx/Spanish-speaking Individuals
XXII. Members of the Oaxacan community
XXIII. Members of the LGBTQ community
XXIV. Victims of Crime

Phase Four: Survey and Response
During the three regional stakeholder forums, attendees discussed and ranked PEI priority populations and community mental health needs. An online survey solicited further stakeholder input, including suggested programs and interventions. The survey was based on the priorities, recommendations and information gathered from the interviews, focus groups and regional forums. Approximately 700 stakeholders were invited to complete the survey, which was also available in hard copy and in Spanish upon request. Hard copies of the survey and postage-paid return envelopes were distributed at a meeting of the countywide CFMAC. 138 responses were received.

Phase Five: Draft and Final Plan
After synthesizing the multiple and diverse sources of stakeholder input previously described, a draft plan was developed and feedback was solicited and integrated into the final approved plan.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI’s priority/targeted populations).

The Oaxaqueño/Indigenous community is an invisible community with unmet needs. There are approximately 25,000 indigenous Mexicans in Santa Barbara County, and the Department employs one staff person that is trilingual, speaking Mixtec, English, and Spanish. More tri-lingual staff is necessary in order to provide minimal mental health services to the Oaxaqueño/Indigenous community.

The LGBTQ population was not assessed in the CSS plan. Suicide risk for Transition Age Youth and Adults was a key concern for the LGBTQ population, and the Department had not previously recognized this group as an underserved group. As a result, the PEI plan has remedied the oversight by designating one community mental health worker be designated specifically to serve the LGBTQ population.

III. Identified strategies/objectives/actions/timelines

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.
Community Support Services (CSS) Strategies

- Use natural healing practices and ceremonies as recognized by enrollees, their families, and communities.
- Develop an advisory body consisting primarily of clients and family members to provide advice and feedback on program functioning and development, and include representatives from culturally and ethnically diverse and underserved communities.
- Promote community engagement by providing educational forums and developing natural community settings to be welcoming and safe to people in recovery, including outreach to ethnically and culturally diverse communities.
- Provide cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities that proactively reach children who may have emotional and/or behavioral disorders, and provide easy and immediate access to mental health services when needed.
- Deploy integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments that are strength-based and focused on engagement of the transition-age youth and provide gender and culture-specific assessments as in the DSM-IV-R cultural formulation.
- Hire staff consistent with racial/ethnic composition of clients and emphasizing cultural competence including bilingual and bicultural staff.
- Promote the inclusion of representatives of diverse ethnic and cultural communities in the planning and management of peer-run Recovery Learning Centers in each region of the County.

Work Education and Training (WET) Strategies

- The WET plan identifies key strategies which includes the incorporation of cultural competence and language capacity in the workforce.
- Develop an Internship Program designed to: 1) afford interested consumers and family members an opportunity to participate in the consumer/family training program; 2) provide supervision and training in Spanish; 3) develop training opportunities for Oaxacan/Indigenous and Native American communities.
- Develop a strategy to increase the workforce of direct service staff persons who are bilingual and bicultural to serve Spanish speaking communities.
- Increase the capacity of law enforcement to better manage crisis situations with individuals experiencing severe mental illness by providing Crisis Intervention Training which includes components including cultural competence for different ethnic groups as well as the consumer and family culture.

Prevention and Early Intervention (PEI) Strategies

- Conduct outreach and education which includes community engagement, case management and linkages, and cultural wellness practices for persons at risk of serious
mental illness and their families in the Latinx, Oaxacan, LGBTQ and Native American communities countywide.

- Offer prevention and early intervention services in community health clinics throughout the Santa Barbara County to maximize access for culturally and ethnically underserved communities, including the Latinx community, by reducing the barriers of transportation and stigma.

- Provide in-home support, health, and development screening, parent education and skills training, infant/parent psychotherapy, advocacy, resources and referrals, postpartum support groups, and further outreach.

- Focus on providing prevention and early intervention services to children and transition-age youth from underserved cultural and ethnic communities.

- Provide crisis services to school-based support and early detection and intervention teams for TAY. The population served countywide is underserved at risk children and TAY whose ages range from 15-25.

List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:

II. Medi-Cal population
III. 200% of poverty population
IV. MHSA/CSS population
V. PEI priority population(s) selected by the county, from the six PEI priority populations

II. Medi-Cal Population

- Outreach to the Spanish speaking community has been identified as a priority of the Department. It has been recognized that more bilingual and bicultural staff are required in the areas where there is a larger Spanish speaking community base, such as Guadalupe and Santa Maria.

- The indigent population needs services, despite the lack of Medi-Cal eligibility. The Department has made a commitment to serve the neediest of the indigent population via MHSA programs.

III. 200% FPL Population

- Serve 20% more of the Latinx population in Spanish.

- Increase bilingual and bicultural staffing levels in the entire system of care.

- Require reporting be 100% complete, to include ethnicity and language preferred.

- Review services and programs on a quarterly basis to ensure they are culturally competent and that the number of bilingual and bicultural staff hired is consistent with the projected targets.
• Monitor the number of bilingual and bicultural clients served by bilingual and bicultural staff to ensure appropriate utilization.

• Review services for each age group and assess cultural competence for each program.

• Track ethnicity, primary language spoken, and language in which their service was received.

IV. MHSA/CSS Population

• Ten programs were developed as a result of the CSS stakeholder process to maximize cost-effectiveness and quality of services; one program was eliminated and two were expanded.

• The LGTBQ, Oaxaqueño, and Native American populations were not considerably represented during the CSS planning stages. During the PEI research and planning process, these communities were represented and programs were developed to serve this population.

V. PEI priority population(s) selected by the county, from the six PEI priority populations

• All priority populations were identified during the PEI stakeholder process as being important. Populations identified as being unserved and underserved included the Native American, Oaxaqueño and LGTBQ communities.

• The community health educator (Promotora) project will place individuals in the Oaxacan, Latinx, Native American, and LGBTQ communities to provide outreach, support and referrals to programs and services to enhance resiliency, decrease stigma, and connect the identified underserved populations to community services.

• Within each local community clinic, mental health representatives will provide the new PEI program to strengthen preventive mental health services in community clinics countywide, which is designed to increase access to underserved communities by offering services in convenient and non-stigmatizing locations.

DMC-ODS-Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Disparities

Veterans Population
The Veterans Treatment Court (VTC) of Santa Barbara County was established in Santa Maria in 2011, in Santa Barbara in 2012 and in Lompoc in 2016 with the goal of serving justice-involved military veterans struggling with addiction, serious mental illness, and/or co-occurring disorders. VTC promotes sobriety, recovery and stability through a coordinated response that involves cooperation and collaboration with the traditional partners found in drug and mental health courts, in addition to the U.S. Department of Veterans Affairs health care networks, the Veterans Benefits Administration, and volunteer veteran mentors and veterans family support organizations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. SBIRT is at schools and other venues frequented by adolescents.
Strengthening Families Treatment Program (SFP)

SFP is an evidence-based parenting and family skills training program which increases family resilience, parent/child bonding, and monitoring; and reduces risk factors for behavioral, emotional, academic, and social problems in children 7-17 years old in underserved minority populations to avoid or remediate substance use problems.

IV. Additional strategies/objectives/actions/timelines and lessons learned

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI.

Improved tracking of the language in which the service was provided will contribute to a greater understanding of whether the bilingual and bicultural staffing requirements are providing services in a cultural and linguistically competent manner. Revising the training plan to include the identified unserved and underserved communities such as the Oaxaqueños, LGBTQ, Disabled, etc., will increase understanding and skills to address the needs of underserved populations.

Obtaining the Youth Perspective

Santa Barbara County’s Department of Behavioral Wellness is committed to support innovative transformational change throughout Santa Barbara’s public mental health system. In efforts to diversify the community planning process through engagement with leadership at all levels, Santa Barbara hosted the Youth Innovation Lab at University of California at Santa Barbara with partnership of the Mental Health Oversight and Accountability Commission expanding multicultural stakeholder advocacy. The Youth Innovation Lab was designed to support the inclusion of youth perspective with a focus on partnership with school and community leadership serving as Adult Allies. Santa Barbara’s Youth Leaders were a diverse group of five transitioned-aged youth some of which identified as LGBTQ+ and some of which identify as Mixteco that were able to bring light to the disparities within the two underserved populations- LGBTQ+ and Mixteco with mental health needs within the K-12 public education system.

The youth infused voice and vision project development process for the project focused on three goals: (1) identify mental health challenges facing youth, (2) identify potential solutions to those challenges, and (3) support the presentation of solutions to county leaders for innovation investment.

In response to the preventive mental health needs of LGBTQ+ youth(s) in the public educational school system with mental health needs, the project development process identified the following challenges facing LGBTQ+ youth(s):

- Youth leaders identified that practices requiring parent involvement for mental health services pertaining to LGBTQ+ youth can hinder the youth’s opportunity to disclose their personal gender identity prior to full knowledge and comfortability which may affect their mental health.
o Solutions that were identified:

- Implementing mandatory LGBTQ+ cultural sensitivity trainings for all school staff including after-school staff;
- Ensuring that LGBTQ+ support groups such as Parents and Families of Lesbian and Gay (PFLAG) were included throughout school resources and in counseling offices and shared with parents of LGBTQ+ families;
- Working with school officials to ensure that LGBTQ+ youth were able to access information pertaining to specific laws that protect LGBTQ+ community members that are minors- specific laws can include and educate on name change accessibility and gender form change that is protected and respected throughout education system.

o In response to mental health needs of Mixteco youth(s) in the public educational school system, the project development process identified the following challenges facing Mixteco youth(s); Youth leaders identified that practices that require language assistance, including testing, need to be treated as a priority, because youths that do not come from homes that culturally read and write as a form of communication may be at a disadvantage - as the youths may not have adequate support services at home causing increased levels of stress and anxiety.

  ▪ Solutions that were identified were:
    1. Creating study zones that include YouTube video access to allow for students to conduct research in a supportive environment;
    2. Increase communication efforts with parents through active community outreach that teaches families about Department of Education mandatory school testing to ensure that families are empowered with knowledge of the educational system that their children are exposed to;
    3. Support on-going Mixteco language mental health translation services at school and/or community centers to bridge the therapeutic communication gap that exists within the Mixteco community.

o With the information gathered through key informants in the process, action items will be brought to the Department’s action team meetings by the county staff involved with the event.

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county’s implementation efforts (i.e. timelines, milestones, etc.).

The following is a list of current and future strategies, objectives, and actions (some in progress and others to be initiated) to be completed within and by FY 2022.
• Enhance services to the Latinx population by increasing bilingual and bicultural staffing requirements throughout the mental health system and alcohol and drug system.

• Establish a measurement tool to assess programs and services’ cultural competence.

• Establish target that 50% of clients whose preferred language is not English are served only by bilingual and bicultural staff instead of via interpretation services.

• Ensure 100% reporting by Behavioral Wellness programs and contract agencies.

• Enhance IT capability to track ethnicity, language preferred, and language service provided, if interpretation services used and if provided by another clinician, non-clinician, friend, or language line.

• Analyze and report outcomes with an emphasis on the requirements for the Cultural Competence Plan to the Department’s Administration, Behavioral Wellness Commission, Consumer and Family Advisory Committee, Latinx Advisory Committee, and the Cultural Competency and Diversity Action Team on a quarterly basis.

• Continue to provide departmental cultural competency trainings and create a series of cultural competency trainings in Relias Training Management System. (See Cultural Competency Training Plan)
  o Key Indicator of success will be:
    ▪ A series of five or more cultural competency trainings will be added in the Relias Training Management System
    ▪ 100% Compliance with annual Cultural Competency Trainings

• Monitoring Language Assistance Services—See the Language Assistance Plan
  o Key indicators are listed in the Plan

• Continue to establish a Peer Support Specialist Career Ladder
  o Key indicator of success will be:
    ▪ Job classifications that start at an entry level with job advancement
      • Health Navigator
      • Peer Support Specialist
      • Senior Peer Support Specialist

• Continue to monitor accuracy of translation and field test client informing materials to ensure documents are culturally and linguistically appropriate
  o Key indicators of success will be:
    ▪ Establishment of Translation Review Committee
    ▪ All translated documents reviewed and tracked
    ▪ All translated documents will be field tested by consumers/family members

• Provide cultural competency trainings to staff and contract providers to increase cultural awareness, cultural knowledge, and cultural humility in order to be culturally responsive and work effectively with consumers of diverse cultures.
  o Key indicators will be:
• Pre/Post Testing Outcomes
• Assessment of Training Needs Survey to be developed

• The Organized Delivery System (ODS) plan’s programs and services will be culturally competent.
  o Key indicators will be:
    ▪ Contract monitoring

• Quarterly bilingual and bicultural staffing level reports will be presented to the Leadership Team.
  o Key indicator will be:
    ▪ Hire cultural/bicultural staff consistent with racial/ethnic composition of consumers.

• Acknowledge and celebrate cultural holidays.
  o Key indicator will be:
    ▪ The department will post to inform staff of cultural holidays.
    ▪ Department will participate in a cultural holiday as deemed appropriate to do so and does not disrupt client care and services.

• Increased access to services for clients with limited English proficiency.
  o Key indicator will be:
    ▪ Increase penetration rate

• Knowledge and distribution of Cultural Competence Plan
  o Key indicator will be:
    ▪ Cultural Competency Plan posted on the website
    ▪ Cultural Competency Plan discussed in action teams and clinic lead meetings

• Develop and define process for clients to access free non-emergency medical transportation for medical appointments. Key indicators of success will be:
  o Reduction of appointment no-shows
  o Qualitative process improvement measured by indication on client satisfaction survey results.

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

Measures and Monitoring
• The Department monitors compliance via quarterly reports which are required of all community-based organizations.

• Oversight committees, which include the Consumer and Family Member Action Team, the Behavioral Wellness Commission, the Quality Improvement Committee, and the Cultural Competency and Diversity Action Team will review all outcome reports, the reviews of which will be reported by the Department on a quarterly basis.

• The Department expects to have 100% reporting compliance by December 2022, and will include data on ethnicity of clients, served, language of services, etc.
CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

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

The county shall include the following in the CCPR Modification (2010):

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

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

The Cultural Competency and Diversity Action Team (CCDAT) has been developed and is committed to ongoing staff development in the areas of cultural competence, consumer recovery, and best practice approaches to support recovery and resiliency, in order to promote the inclusion and representation of underserved/unserved communities. The main goals of the CCDAT are to advocate for culturally competent services, provide guidance and recommendations regarding outreach to underserved, unserved, and inappropriately served communities, and reduce mental health disparities for racially, ethnically, and culturally diverse communities.

The Cultural Competency and Diversity Action Team (CCDAT) exists to ensure the Department fully embraces and implements the behaviors, attitudes, and values that define cultural and linguistic diversity.

As per the CCDAT Charter, “the major goals of [the CCDAT] are to advocate for culturally competent services, outreach to underserved, unserved, and inappropriately served communities and reducing mental health disparities for racially, ethnically, and culturally diverse communities. To ensure accountability for the provision and maintenance of such care and services, the action team is prepared to work with all relevant parties to develop and implement empirically sound and culturally appropriate evaluation instruments and procedures.”

Additionally, the Department’s “Cultural and Linguistic Competency” policy establishes the CCDAT as a key advisory group that participates in the overall planning, MHSA Community Planning Process, implementation and delivery of services. This may include submission of recommendations to management- and executive-level staff, transmission of concerns to
Leadership and the Director, Quality Improvement Committee, and to the Mental Health Services Act (MHSA) coordinator.

A CCDAT summary report is presented quarterly at the Department’s Quality Improvement Committee (QIC).

Future annual updates will include agenda and meetings minutes, demonstrating integration of cultural competence throughout the system.

Reports will be developed that detail progress towards goals and objectives, reviews, and recommendations to programs and Directors, along with a summary of hiring and retention, outreach and engagement, and training initiatives.

To ensure accountability for the provision of such care and services, the CCDAT is prepared to work with all relevant parties to develop and implement empirically sound and culturally appropriate policies, procedures, and practices. The committee meets the second Friday of each month from 9:30AM to 11:00AM and all meetings are open to the public. Video teleconferencing and interpretation is available upon request.

The CCDAT thrives on the inclusivity and the collective partnership of Department staff, providers, community partners, advisory groups, consumers, and their families. All meetings are open to the public and widely publicized in multiple mediums, including mass distribution emails, the Director’s monthly report, and online on the Department’s website. Additionally, the Ethnic Service and Diversity Manager actively recruits individuals throughout the county to create a diverse network of representatives within the CCDAT. The Department’s policy, “Cultural and Linguistic Competency”, formally establishes and recognizes the CCDAT as an essential component to service planning and delivery.
List of current Cultural Competency and Diversity Action Team Membership

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Company</th>
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<tbody>
<tr>
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CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR Modification (2010):

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

   1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.
   2. How cultural competence has been embedded into all trainings.
   3. A report list of annual trainings for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

B. Annual cultural competence trainings topics shall include, but not be limited to the following:
   1. Cultural Formulation:
   2. Multicultural Knowledge;
   3. Cultural Sensitivity;
   4. Cultural Awareness; and
   5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
   6. Interpreter Training in Mental Health Settings
   7. Training Staff in the Use of Mental Health Interpreters.

1. The Department projects that approximately 445 Behavioral Wellness staff will need to be trained annually based on 2019 staffing levels. (See 3-Year Cultural Competency Training Plan, Exhibit 1)
2. Per policy, upon hire all staff attend cultural competence training.
3. Required trainings will be offered online via the Relias Learning platform and live trainings. The department utilizes “Relias Training Management Platform”, to assign,
track and report trainings quickly and efficiently. Cultural competency trainings are announced annually via email with reminders sent periodically.

Department staff must complete required cultural competency trainings by June 30 of every year. Noncompliance reports are generated and sent to the respective supervisor/manager to follow-up. The Department’s Ethnic Services and Diversity Manager and Chief of Compliance assist with ensuring completion of all trainings. In those cases in which trainings are not completed by the deadline, staff may be barred from continuing work/services until all trainings are complete.

All training curricula within this plan address cultural competence issues. Annual cultural competence trainings topics shall include (as stated in the CCPR), but not limited to the following:

- Cultural Formulation
- Multicultural Knowledge
- Cultural Sensitivity
- Cultural Awareness and
- Social/Cultural Diversity) Diverse cultural groups, LGBTQ, Social Economic Status, Elderly, Disabilities, etc.)
- Interpreter Training in Mental Health Settings
- Training Staff in the Use of Mental Health Interpreters

The following are Cultural Competence Trainings recommended by the CCDAT:

- Health disparities
- Local issues and national trends in regard how to appropriately service diverse communities that are impacted by local/national trends
- Consumer and family culture
- Native American
- Members of the military
- Latinx
- Oaxaqueño/Mixtec community
- Working with the Limited English Proficient Community
- Disability awareness
- Use of interpretation in a Mental Setting
- Training staff on process in accessing language services
- Having a Subject Matter Expert to train on the Americans with Disabilities Act and discuss the intersectionality of physical disabilities and mental health services barriers
- Sensitivity training-Disabilities
- LGBTQ
- Sexual Assault/rape victims/cultural considerations that impact mental health treatment
- Self-awareness
- Eating disorders
- Implicit bias
- Library resources
- Culture of poverty
- Spirituality/Integration mental health
- Latinx population
- Network Providers—can we contract with them specialties

List of Cultural Competence Trainings that have been offered by the Department:

### Cultural Competence Training Schedule 2016

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A highlight of a Cultural Competency Training created by the Department in calendar year 2018:

The *Mixtec Culture and Mental Health Training* was created by the Department of Behavioral Wellness in response to requests for information on how to better engage with this under-served population. It is estimated that Santa Barbara County is home to approximately 18,000 to 30,000 Mixtec Indian migrants, primarily from the states of Oaxaca, Puebla and Guerrero in Mexico, living and working primarily in the Santa Maria Valley within the agricultural sector. The training examines ways to adapt treatment to suit the cultural needs of a Mixteco-speaking client and their families. Running approximately 40 minutes, the training is available on the Department’s online eLearning platform Relias free of charge.

The *Mixtec Culture and Mental Health Training* is narrated by Enrique Bautista, who is of Mixtec heritage and serves as a Patient Rights Advocate at the Department of Behavioral Wellness, and developed by the Department’s Cultural Competency and Diversity Action Team across several rounds of revision. The content draws on resources and guidance from the Ventura-based advocacy group MICOP (Mixteco Indigena Community Organizing Project), members of the county’s Mixtec community, and community partner organizations working with the Mixtec population in primary, dental and mental health care settings.

The training itself is structured with the following topics as sections:

- A historical introduction;
- What the Mixtec population is like today within California;
- Mixtec culture, and how it influences the way individuals understand mental health;
- Stigma surrounding mental health conditions and treatment;
- Barriers for Mixteco-speaking clients trying to access services;
- Spirituality, which has an important role in wellness and recovery; and
- New culturally-adapted ways to approach treatment and services.

**Live Trainings offered in 2018:**

1) Sexual Orientation/ Gender Identity, May 15 (2.5 Hours)
2) Sexual Orientation/Gender Identity, May 16 (2.5 Hours)
3) Sexual Orientation/Gender Identity, June 4 (2.5 Hours)
4) Implicit Bias, August 23 (3.5 Hours)
5) Implicit Bias, Sept. 5 (3.5 Hours)
6) Transition to Independent Process (2 Day for TAY Staff) October
7) Trauma Informed Care Foundations Training, Nov. 1 (6 Hours)
8) 5150, Nov. 20 (6 Hours)
9) Trauma-Informed Care: Trauma and Substance Abuse, Dec. 6 (6 Hours)

**Trainings that have been scheduled for calendar year 2019**

1) LGBTQ 101, Jan. 30 (2.5 Hours)
2) LGBTQ 101, March 5 (2.5 Hours)
3) Quarterly Peer Forum: Best Approaches to Career Advancement, March 14 (1 Hour)
4) Peer Support 101 and Recovery 101, March 25 (1 Day)
5) Trauma-Informed Care: Trauma and PTSD, March 28
6) Community Resilience Model Training, April 10 (1 Day)
7) Community Resilience Model Training, April 17, (1 Day)
8) WRAP I Training, April 29 and 30 (2 Days)
9) WRAP I Training, May 1 and 2 (2 Days)
10) Trauma Informed Care: Trauma and Eating Disorders, May 16 (6 Hours)
11) Implicit Bias Training, June 3, Buellton, (2.5 Hours)
12) Implicit Bias Training, June 25 (2.5 Hours)
13) Self-care and Stress Management, June 24 (1 Day)
14) Peer Forum - Effective Communication: How to Communicate with all Levels of Management, June 20 (2 Hours)
15) Implicit Bias 102, July 25, (4 Hours)
16) Surviving and Thriving, July 31, (7 Hours)
17) Cultural Humility in Working with Diverse Families in Community-Based Mental Health Settings, Aug 1 and 29 (2 Hours)
18) Trauma Resilience Model Training, Sept. 3-5 (23 Hours)
19) Peer Forum - Dealing with Conflict: How to Effectively Manage Perceived Conflict in the Workplace, September 19 (2 Hours)
20) Beneficiary Concerns, Sept. 19 (2 Hours)
21) Beneficiary Concerns, Oct. 28 (2 Hours)
22) Co-Occurring Disorders, Nov. 5 (5 Hours)
23) Motivational Interviewing, Nov. 13 (4 Hours)
24) Transition to Independent Process, Dec. 3rd and 4 (12 Hours)
Upcoming Cultural Competency Trainings Scheduled for 2020

1) Training Staff in the Use of a Healthcare Interpreter (Jan. 15, 2020 and February 19, 2020)
2) WRAP II, Jan. 13 - 17 (35 Hours)
3) Bridges Out of Poverty, Feb. 6 (7 Hours)
4) Trauma and Homelessness, Feb. 25 (6 Hours)
5) SCRP Conference, March 17 and 18 (12 Hours)

Relevance and Effectiveness of all Cultural Competence Trainings

Cultural competence trainings are an excellent tool for skill development and practice, which in turn, is a necessary step in reducing ethnic and cultural disparities. All key players in the public mental health system, including administrators, County and contracted staff, community leaders, and clients need to be educated about the needs, beliefs and strengths of culturally and ethnically underserved communities. As awareness is expanded, individuals become more supportive and compassionate of efforts to increase inclusion. For example:

- The training about Mixtec Culture and Perspective on Mental Health Training highlighted how non-Spanish-speaking groups are culturally and linguistically isolated even from the larger related community; in this case, the Latinx community. Language and cultural barriers require unique outreach strategies for the Oaxacan community in Santa Barbara County. The lack of a written language presents additional challenges and relies heavily on audio/visual media methods of communication (i.e. radio, video, social media, broadcast television).

- Client and family culture trainings have vividly illustrated the challenges faced by consumers and their families. As clients and family members tell their stories, often with great passion and emotion, they personalize issues related to mental health. This experience has a positive impact on mental health and law enforcement professionals who attend the trainings.

- Our Spotlight Training is going to focus on our community diversities. We will provide information that will help the community expand their knowledge base and stimulate further understanding. Educating staff about the significant diversities in our communities will improve engagement, compassion, and ultimately create a working and trusting relationship between staff and consumer. We will focus on the Mixtec, Native American, and LGBTQ communities. We will be able to demonstrate how the diversity and cultural changes in our communities are positive. While promoting positive relationships of compassion and sense of trust, more knowledge of each other will lead to further engagement of our diverse communities with mental health services.

With a robust schedule of cultural competence trainings addressing our numerous diverse communities, our staff and clinician self-awareness practices, and our ethical and compassionate engagement, Behavioral Wellness is committed to the expansion of our knowledge base and skills, and thus increasing the likelihood of enriching the mental health service delivery system and ensuring greater access for unserved, underserved, and marginalized members of our community.
II. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

A. Evidence of an annual training on Client Culture that includes a client’s personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent’s and/or caretaker’s personal experiences with the following:
1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency.

Behavioral Wellness Staff were assigned the Mental Health Consumer and Family Culture online training electives through the Department’s eLearning Training platform. Within the eLearning system, staff are able to choose between six different electives that satisfy their Client Culture training requirement. Three of the offered trainings focus on individual consumer experiences with mental health and accessing services within the public mental health system, whereas three of the offered trainings focus on consumers and their family’s experiences with mental health and accessing services within the public mental health system. Trainings are done through various cultural lenses so staff are able to understand and witness the different experiences with mental health and accessing services within the public mental health system faced by the Department’s consumers and their families.

Staff are assigned the Mental Health Consumer Culture: Recovery Stories training in Relias. The training will consist of:

- Introduction video which discusses why it is important for staff to learn about the various experiences of the populations served with mental illness, and what “recovery” means. This portion of the training will feature video interviews of peers and consumers within the mental health system.

- Training: Part 1
  - Includes four client video narratives of their individual experiences with mental illness. Included are associated quizzes to ensure trainees are learning and understanding.

- Training: Part 2
  - Consists of a SAMHSA flyer which defines recovery, and provides trainees with the principles of recovery. Included is an associated quiz to ensure trainees are learning and understanding the essential material.
CRITERION 6: COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

The County shall include the following in the CCPR Modification (2010)

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. Rational: Will give ability to improve penetration rates and eliminate disparities.
B. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.
C. Share lessons learned on efforts in rolling out county WET implementation efforts.
D. Identify county technical assistance needs.

Workforce Education and Training (WET)

The goal of the Workforce Education and Training (WET) component is to develop a diverse workforce supporting the continuum of CSS, PEI, CFTN and Innovation. More specifically, WET addresses the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, provides client and family driven mental health services, and adheres to wellness, recovery, and resilience values.

Additionally, consumers and families and/or caregivers may be given training to help others by providing skills to promote wellness and other positive mental health outcomes. As a MHSA component, the system of care relies on the ability for all concerned to work collaboratively in order to deliver consumer- and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent, responsive, relevant, and include the perspectives, perceptions, and expertise of consumers and their families and/or caregivers.

The Department is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations. There is significant strength in the Department’s mental health workforce in regard to the employment of consumer and family members peer staff throughout the system. Also, CBO contractors have been successful in recruiting peer staff.

Summary of Targets Reached to Grow a Multicultural Workforce in Rolling Out County WET Planning and Implementation Efforts.

Limited goals have been developed through the WET Plan to grow a multicultural workforce because the focus is primarily on consumer and family member entry level peer training opportunities.
The Workforce Education and Training (WET) funding component was conceived to be time-limited; it is not a continuous source of funding like CSS, PEI and Innovation. To maximize the use of WET funding, we transferred many of the functions to the entire system of care including peer staff in outpatient clinics, capacity of our contract providers to hire peers and have trainings for staff, and creation of the Client and Family Member Advisory Committee (CFMAC) which has been meeting for at least 16 years. The remaining ongoing budgeted activities are supported by a transfer from Community Support Services (CSS) funding to WET to maintain the Consumer Empowerment Manager and Peer Employment activities.

As a result of the State reversion calculations, part of the Peer Empowerment Manager position and twelve part-time employment opportunities for graduates of the WET Peer Specialist Training as Peer Expert Pool staff will be funded by WET through FY 19-20 and sustained by a transfer from CSS. Peer recovery specialists, peer navigators, and peer expert pool for special projects are examples of strategies used in FY 18-19. In Spring of 2018, a special project hiring plan for peers was promoted during the MHSA Stakeholder process and other community venues. Resumes have been received, and continue to be submitted, and two special projects were assigned to assist in work skill development for peers seeking workforce growth.

One of these special projects is the MHSA Innovation Help@Hand Project-Santa Barbara. This project is committed to growing a multicultural workforce through development of a culturally and linguistically responsive Technology Peer Career Ladder. The Career Ladder is made up of peer preferred positions which include a Bilingual Project Manager – Health Care Coordinator, a Bilingual Outreach Coordinator – Behavioral Wellness Case Worker, two Multicultural Recovery Assistants – Peer Recovery Specialists, and twelve Diverse Extra Help Recovery Assistants - Peer Recovery Specialists to assist with multi-faceted peer needs in each of the three geographic regions throughout the Santa Barbara County: Santa Maria, Lompoc, and Santa Barbara. Consumer-led Community Engagement Workshops with interpretation services are available monthly, and serve to develop materials that ease the complexity of modern language, ensuring accessibility to services are reached in a more equitable manner.

In addition, in FY 18-19 a Training Coordinator started in Behavioral Wellness and created training opportunities for all peer employees and contract staff. Trainings included: Peer Support 101, Recovery, WRAP Plans, and Resume and Hiring Tips. All supervisors were assigned training in Behavioral Wellness Ethics, Boundaries, and Confidentiality.

The Department held the first Peer Employee Forum in March 2018 to seek input on the technological suite innovations project, using modern technology to connect individuals in the community; including peer linkages and digital chats. The Peers requested more regular meetings, which the Department scheduled on a quarterly basis through FY 18-19 and setting new goals for FY 19-20. In March 2019, staff attended the Southern Counties Regional Partnership (SCRP) Workforce Conference in Pomona, California. The Department acts as the fiscal agent for this project and staff assist in the coordination and preparation of the conference on behalf of ten Southern California counties. Included as part of the conference was a workshop addressing Onboarding Peers, Recovery, and Core Competencies for Peer Employees.
Ongoing Efforts

The Department is focused on ensuring the availability of adequate bilingual Spanish-speaking staff in key regions of the County with larger Latinx consumer numbers. Recruitment and retention challenges are impacted by Santa Barbara County’s high cost of living.

The MHSA workforce assessment was last completed by the Department in 2009. Data may not correctly reflect the current workforce as a number of new positions were established in recent years to respond to increasing demand.

Rolling out the WET plan is a complex, multidimensional task that focuses on developing an internship program to provide consumers and family members an opportunity to participate in newly developed peer training, to address shortages in the mental health field and to build skills for entry or re-entry into the workforce. The department has hired an experienced WET Coordinator who will be working with the Cultural Competency and Ethnic Services Manager to assess the workforce and provide a comprehensive workforce analysis to identify any disparities and improve penetration rates. However, a department-wide language survey is conducted annually to determine how many staff members within the Department are bilingual and bicultural. Survey results will be compared with client demographic data to calculate workforce needs.

Criterion 5 Exhibit:

1. 3-Year Cultural Competency Training Plan
CRITERION 7: LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.
   1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.
   2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the identified populations.
   3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

Currently, 20.5% of the Department’s staff of 443 are bilingual. Bilingual and bicultural staffing is a mandatory reporting element for CBOs and is tracked quarterly to ensure compliance with contract requirements.

Additionally, the Department’s Human Resources Division has been involved as a critical participant in the implementation of MHSA programs and is playing a key role in developing a bilingual and bicultural workforce to meet the needs of the identified population.

On the Santa Barbara County jobs website, all Behavioral Wellness job postings encourage bilingual and bicultural individuals to apply, and advertise the availability of a bilingual allowance. For those candidates who indicate on the employment application that they are bilingual in Spanish, management and leadership staff ask interview questions in Spanish to identify the candidate’s general level of fluency. At hire, bilingual employees are encouraged to complete a bilingual fluency exam offered by the Language Line Academy. Successful completion of fluency testing qualifies employees for a bilingual allowance (currently $57.69 per pay period). Employees are tested through an oral interview conducted entirely in the tested language. All testing is completed and rated by Language Line Academy.

As of this report, 20.5% of the Department’s bilingual staff receives a bilingual allowance every pay period. Efforts are underway to encourage remaining bilingual staff to complete a fluency exam.

Dedicated Resources for Interpreter Services

The National Latinx Behavioral Health Association (NLBHA), in partnership with the South California Regional Partnership (SCRP), provided Santa Barbara County a 3-day Mental Health Interpreter Training and 1-day Provider Training in March 2016. Trainings were open to all department and community based organization (CBO) staff. The 3-day training series focused on
the role of the interpreter within the therapeutic relationship, common clinical diagnosis and mental health terms, developing technical interpretation skills, and boundaries and limitations. The 1-day Provider Training educated staff on how to appropriately and effectively utilize interpreter services. Seventeen Department and CBO staff completed the Interpreter Training and received a certificate of completion. Nine employees participated in the Provider Training.

In addition to these in-house resources, the Department contracts with Language Line, Ortiz-Schneider, Inc. for Translation and Interpretation, Independent Living Resources Center, Inc., and American Sign Language Services. Language Line services are available over the phone 24/7 in over 240 languages from a pool of 8,000 professional interpreters. Ortiz-Schneider Translation and Interpretation is a local company based in Santa Barbara that provides in-person interpreters in a variety of languages common to the area, including Spanish, Mixteco and other Indigenous Mexican languages, and Tagalog.

The total annual amount of dedicated resources for contracted interpreter and translation services:
- FY17/18 - $148,036.71
- FY18/19 - $276,055.56
II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The county shall include the following in the CCPR Modification (2010):

A. Evidence of policies, procedures, and practices in place for meeting clients’ language needs, including the following:
   1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Services, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.
   2. **Least preferable are language lines.** Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.
   3. Description of protocol used for implementing language access through the county’s 24-hour phone line with statewide toll-free access including staff training protocol.

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

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

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

E. Identify county technical assistance needs.

The Department has policies and procedures in place and implemented for a 24-hour access phone line (aka the “Access Line”) and is available to all individuals, including people who require linguistic accommodations and TDD/TTY/California Relay Service for the hearing impaired.

These policies include:

- 24/7 Toll-Free Telephone Access
- Mental Health Plan – Visually and Hearing Impaired and Beneficiaries with Limited Reading Ability
- Accessing a Welcoming and Integrated System of Care and Recovery

Interpretation equipment is available for meetings and other events as needed. With the centralization of the Access Line within the Quality Care Management (QCM) division, an Access Screener training was developed addressing language access and how to use the Language Line. The Access Screener resource packet also includes a call script, Language Line procedures, and
instructions on how to make a three-way conference call. The Ethnic Services and Diversity Manager provides training on Language Line usage as needed.

**Evidence that clients are informed in writing in their primary language of their rights to language assistance services. Including posting of this right.**

Throughout clinics and programs, signs are posted in reception areas and consultation rooms informing clients of language assistance services. All signage is available in English and Spanish. For other languages, a Language ID Poster (Exhibit 1) is displayed in the lobby or at reception desk. Instructions in the top 20 common languages state: “Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.” This signage can easily assist a client in self-identifying their language by simply pointing.

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

At first contact, the Department collects demographic information from the client, including primary and preferred language. This information may be documented on the Pre-consumer Access form used by Access Line Screeners (Exhibit 2) or within ShareCare during the client’s intake and assessment.

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

Providing appropriate accommodation can be highly complex. Santa Barbara County is rich in cultural diversity, and with this richness comes a variety of language needs. The most complicating factor is the various dialects for any given cultural/linguistic preference. The Department has learned it is not sufficient to simply have bilingual capacity in Santa Barbara County’s threshold language. The Department has had to understand the variety of dialects and attempt to meet the challenge of ensuring interpretation and translation of materials will accommodate those dialects as needed. Additionally, the Department has learned it takes a great deal of human and financial resources to meet the bilingual needs of a community such as Santa Barbara County.

The primary challenges faced by the Department have been in finding alternatives to the Language Line and in having fully certified interpreter services available due to resource and financial limitations. However, over the past 3-6 years the Department has focused efforts on recruiting and hiring bilingual and bicultural staff in key positions who can communicate with clients in their primary language. Additionally, steps have been taken to ensure all clinical staff members remain aware of the availability of the face-to-face interpreter services and Language Line as a resource, and they use it consistently as necessary. The Department has practices in place to ensure beneficiary material is always available and easily accessed in both English and Spanish at all service sites.

Another challenge had been providing interpretation at various stakeholder meetings and processes. MHSA funds were utilized to purchase interpretation equipment in order to provide non-intrusive interpretation and improve stakeholder and consumer participation in meetings, trainings, and other processes.

The Department is investigating upgrading the Language Line use from telephone only to video conferencing. In order to do so, the Department would require the installation of a sufficient number of webcams to ensure the video conferencing for interpretation services is of acceptable
quality. The Department continues to research this method of providing interpreting services to ensure it is culturally competent to do so.

### III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact

The county shall include the following in the CCPR Modification (2010):

A. Evidence of availability interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.
B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.
C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.
D. Evidence that the counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

The Department ensures no individual or family suffers due to language or cultural barriers to care by providing culturally-sensitive interpretation services utilizing County certified bilingual and bicultural staff or a contracted interpreter.

As mentioned previously, consumers are informed of language assistance services provided by our clinics and programs.

Beneficiary Rights and Responsibility material is posted and available in English and Spanish in all Behavioral Wellness clinics, provider organizations, and service areas.

During the intake process, clients are asked to identify their language preference, which is then documented in the client file.

Language Assistance contractors provide documented evidence of interpreter competence and continuing training in providing interpretation services.
IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact

The county shall include the following CCPR Modification (2010):

A. Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to cultural and linguistically appropriate services.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:
   1. Prohibiting the expectation that family members provide interpreter services;
   2. A client may choose to use a family member or a friend as an interpreter after being informed of the availability of free interpreter services; and
   3. Minor children should not be used as interpreters.

The Department has implemented policies, procedures, and dedicated financial resources to demonstrate its commitment to ensure language assistance services are available in order to remove barriers to access care and meet the needs for its English Limited Proficient consumers and their family members which adhere to, and comply with the Title VI of the Civil Rights Act of 1964. (Exhibit 1: Cultural Competency Plan – Language Access Plan 2019-2022.)
V. Required translated documents, forms, signage, and client informing materials

The county shall have the following available for review during compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
   1. Member service handbook or brochure;
   2. General correspondence;
   3. Beneficiary problem, resolution, grievance, and fair hearing materials;
   4. Beneficiary satisfaction surveys
   5. Informed Consent for Medication form;
   6. Confidentiality and Release of Information form;
   7. Service orientation for clients;
   8. Mental health education materials, and
B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the client’s preferred language.
C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results
D. Report mechanism for ensuring accuracy of translated materials in terms of both language and culture.
E. Report mechanism for ensuring translated materials are at an appropriate reading level (6th grade)

The Department has met this criterion by offering standard beneficiary information in English and Spanish. At entry to services, and annually, clients are provided with information in English and Spanish services offered to them, general welcome and correspondence, new client orientation, beneficiary rights, problem resolution processes and forms, release of information form, informed consent for medication form, discharge criteria and process, compliance hotline, informative mental health materials, state fair hearings and privacy practices and advance directives.

Availability of materials in waiting rooms is also monitored for all the Department clinic sites and community-based organizations in the provider network.

The Department monitors the distribution and availability of these materials through Patient’s Rights Advocates checking clinics and service areas whenever they are at said clinics and service areas.

The Department’s assessment form includes a section for the documentation of consumer services that were provided in their preferred language.

The Consumer Perception Survey conducted by the Department is available in the Spanish and other languages, including Tagalog, Vietnamese, and Hmong. As summary reports become available, the Department will analyze the outcomes and make recommended improvements.

Currently, the Cultural Competence and Ethnic Services Manager receives requests for translation of documents. The documents are sent to the certified translation contractor who
possesses documented evidence of competence in translation of documents. In addition, to ensure accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing) the Cultural Competence and Ethnic Services Manager reviews the document and convenes the newly formed Translation Review Committee to review the accuracy of the translation. This area continues to be researched to find the best and most efficient method of determining accuracy and readability of translated materials at the 6th grade reading level of all Department produced documents.

Exhibit 1:

All documents below support Criterion 7

1. Beneficiary Brochure Mental Health Plan Services (English & Spanish)
2. Cultural Competency Questionnaire
3. Discharge Process
4. ADP Grievance Form (English & Spanish)
5. Advance Directives Form (English & Spanish)
6. Appeal Form (English & Spanish)
7. CARES Facts (English & Spanish)
8. Compliance Hotline (English & Spanish)
9. Mental Health Plan Grievance Form (English & Spanish)
10. Medi-Cal Mental Health Services (English & Spanish)
11. Mental Health Plan Services (English & Spanish)
12. Mental Illness Information (English & Spanish)
13. Privacy Practices (English & Spanish)
14. PTSD Information (English & Spanish)
15. Request for Second Opinion Form (English & Spanish)
16. Release of Information (ROI) Form (English & Spanish)
17. Schizophrenia Information (English & Spanish)
18. Services for Mental Health (English & Spanish)
19. Informed consent for Medications (English & Spanish)
20. State Fair Hearing (English & Spanish)
21. Welcome to Behavioral Wellness (English & Spanish)
22. Customer Satisfaction Survey – ADULT (English & Spanish)
23. Customer Satisfaction Survey – OLDER ADULT (English & Spanish)
26. New Client Orientation - Welcoming PowerPoint (English & Spanish)
27. Language Line Flowchart
28. Language Line Poster – Top 20 Common Languages
29. Pre-consumer Access Form
CRITERION 8: ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

A. List and describe the county’s/agency’s client-driven/operated recovery and wellness programs.

Mental Wellness Centers

There are mental wellness centers (Recovery Learning centers) throughout all three regions of the County of Santa Barbara. The centers are peer run and serve the adults who are recovering from mental illness and are at risk of homelessness, incarceration, or increasing severity of mental health issues.

The goal of the peer staff and RLCs is to create a vital network of peer-run supports and services to build bridges to local communities and engage in natural community support. The RLCs are also supported by Mental Health Services Act (MHSA) funds to provide technology access to participants. These include computer access and technology training and classes. There are currently three RLCs throughout the County. Each are located at pre-existing housing developments that include MHSA-funded units, including Garden Street Apartments in Santa Barbara, Home Base on G in Lompoc, and Rancho Hermosa in Santa Maria.

The Partners in Hope MHSA CSS program promote wellness and recovery through peer support activities in Santa Barbara County. The Partners in Hope Program is a peer-run program providing peer support services to consumers and family members, with the integration of three Peer Recovery Specialists, and three Family Advocates with Transitions Mental Health Association (TMH) and the Mental Health Association (MHA).

Recovery Learning Communities are located in Santa Maria, Lompoc, and Santa Barbara are centers where consumers and family members can access information and resources for care and services in Santa Barbara County. Consumers and their family members can also learn more about a self-help wellness recovery approach to their own treatment.

Partners in Hope has integrated Peer Recovery Specialists and can promote and model recovery from their personal experience, as well as from training in respected curriculums on best practices for mental health recovery. The Department has hired one bilingual and bicultural staff member and has now made it a requirement to have at least one bilingual and bicultural staff member in the Santa Maria Peer Specialist position; given the majority of the population is Latinx. Peer Recovery Specialists and Family Advocates conduct groups in all three regions of the County. In addition, Partners in Hope has two Peer Recovery Specialists with AOD experience and also conduct groups.

MHSA Innovation Project: Help@Hand Project:

Help@Hand Project is a multi-county and city collaboration which is supported through Mental Health Services Act Innovations funding. In Santa Barbara, the culturally diverse peer-run project empowers consumers to engage in self-care practices through the use of technology. These
practices increase the wellness perspective through the education of wellness technology in a cultural and linguistically appropriate manner while learning wellness practices.

The project engages peers to run community workshops throughout the county teaching technology basics to our consumers. Workshops have been held throughout the county in our Recovery Learning Communities (RLCs) located in Santa Maria, Lompoc, and Santa Barbara. Engagement with RLCs ensures the project is interfacing with recipients of drop-in services. Engagement also includes regional colleges and universities allowing the project to meet the diversified needs of Transitioned-Aged Youth receiving mental health services there.

Locations for Help@Hand Project community workshops are thought through carefully with the diverse voices from the Department’s Cultural Competence and Diversity Action Team, and with the input from the Consumer and Family Member Action Team. This ensures the project reaches the most vulnerable of diverse groups in the Spanish, Mixteco, LGBTQ, elderly, and consumer-based communities within the project’s three identified populations:

1) Transitioned Aged Youth enrolled in colleges and universities
2) Recipients of crisis mental health services
3) Geographically isolated communities

Consumer facilitated holistic whole-person care Mindfulness Meditations are held monthly in each region to ensure human connection is not lost while also teaching clients how to use technology applications. Community mental wellness events are planned collaboratively with community-based organizations to expand community partnerships throughout the county within the innovation Help@Hand five-year plan.

The Help@Hand project in Santa Barbara is ensuring effective communication and language access is met through increasing multilingual technology knowledge in the areas of phone/tablet/computer use, data security and privacy, and email creation/password storage for consumer and family members throughout the county.

Diversity is ensured through the implementation of peer-led Technology Workshops that are held in geographically isolated regions of the county which have been measured through diversity data efforts conducted in the development of the plan. The three geographically isolated regions within our plan are:

1) Guadalupe 2) New Cuyama 3) Carpinteria

Accessibility efforts continue with the work in creating culturally sensitive materials such as an all-in-one bilingual bookmark which includes a QR code connecting clients to the Behavioral Wellness website and the Behavioral Wellness Department ACCESS information line which eases the needs of our illiterate and visually impaired communities.
Delivering Help@Hand services to these unserved and underserved populations ensure the project is reducing disparities in their access of services.

DMC-ODS Treatment Providers adapt all evidence-based practices models to cultures being served, this includes Motivational Interviewing and Cognitive Behavioral Therapy.

II. Responsiveness of mental health services

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

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (counties may include a) Evidence of community information and education plan or polices that enable Medi-Cal beneficiaries to access specialty mental health services; or b) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services programs (e.g. number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)

D. Evidence that the county has assessed factors and developed plans to facilitate the ease which culturally and linguistically diverse population can obtain services. Such factors should:
   1. Location, Transportation, hours of operation, or other relevant areas;
   2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g. posters, magazines, décor, signs); and
   3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and/or partners

When serving a multi-cultural community, it is vital to be mindful that the intervention being provided is reflective of the client’s culture, beliefs, and background. The community being served by the Department calls for actively utilizing a multicultural approach in creating culturally inclusive approaches and incorporate the cultural dimensions of our clients into the care provided. Beginning with assessment, moving into treatment (i.e. counseling, groups, case management), and into community outreach, our team of Behavioral Wellness professionals create mindful and intentional methods of engaging our youth, adults, and seniors into care that reflects the uniqueness of who they are; their identity matters. These approaches strengthen client retention, consumer self-report greater satisfaction with services, and builds mutual trust compassion in the relationship between the consumer, their families, and Department
staff. These approaches include our commitment to the primary cultures we serve including the Latinx, Mixtec, Native American, LGBTQ, and Indigenous communities.

The Department offers a variety of referral options to meet the cultural needs of consumers. Referrals are done via the ACCESS Team when appropriate for culturally and linguistically appropriate services (i.e. Spanish speaking network providers, LGBTQ resources, peer counseling, support groups, and various natural and community supports). Clinics and contractors refer, or offer culturally sensitive services, as well as research evidenced-based culture-specific programs to ensure availability of the most appropriate services within available resources and capacity.

**Cultural Adaptations and Improvements to Documentation Practices**

In 2018, members of the Department’s Cultural Competence and Diversity Action Team (CCDAT) guided the revision of several documentation templates, including the Comprehensive Assessment and Treatment Plan templates, to strengthen collection of culturally relevant information. A key focus this year was the integration of the American Psychiatric Association’s Cultural Formulation Interview (CFI) questions throughout the assessment. Posing these questions during an assessment enhance a mental health practitioner’s clinical understanding of the problem and functional impairments, potential sources of help, and expectations for services from the client’s cultural perspective. Below is a screenshot of a section of the template within the Department’s electronic health record system Clinician’s Gateway.

![Screenshot of documentation template](image)

The Department engages in a variety of outreach and engagement activities to inform the community of the availability of services. Presentations on the availability of services and access to care are frequently provided in community forums such as community centers, schools, churches, and during weekend events such as the Day of the Farm Worker; held annually in Santa Maria. Additionally, the Department disseminates written materials that advertise how to obtain services in Santa Barbara County and the availability of the Access Line in English and Spanish (**Criterion 1: Exhibit 26**).
The Santa Maria Adult and Children Clinic is located on Foster Road in Santa Maria. Peer Recovery Specialists provide rides to and from the clinic for groups if consumers schedule with the Peer Recover Specialists beforehand. The local bus transportation system stops at Foster Road and is connected throughout the city.

In Santa Barbara, the Recovery Learning Center (RLC) operates from a central downtown location accessible by multiple modes of transportation, including the local bus transportation system with a stop immediately in front the RLC. The Crisis Services walk-in clinic is also located in downtown Santa Barbara.

Lompoc clinics are centralized within the town, as it is a geographically small area, making navigation and transportation quick and efficient. The Adult and Outpatient Clinics, Assertive Community Treatment (ACT) program and the RLC are all located on or near the main thoroughfare in Lompoc.

All RLC programs operate during weekdays with varying hours:

- **Santa Barbara Recovery Learning Center**
  - 10:00AM to 4:00PM Monday, Wednesday, Thursday
  - 10:00AM to 7:00PM Tuesday
- **Santa Maria Recovery Learning Center**
  - 9:00AM to 5:00PM Tuesday, Wednesday, Friday
  - 11:00AM to 5:00PM Thursday
- **Lompoc Recovery Learning Center**
  - 10:00AM to 4:00PM Monday, Wednesday, Thursday
  - 10:00AM to 7:00PM Tuesday

Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds.

The County follows regulations for facilities to be ADA compliant and contractors are required to do the same.

Clinic and provider sites are warm, comfortable, and inviting to diverse cultural backgrounds. As part of an ongoing System’s Change effort, several Department clinics engaged in a lobby redesign project to promote welcoming environments. Clinic teams updated wall colors, furniture and art, including photos and drawings reflecting diverse cultural and ethnic backgrounds.

Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and/or partnerships.

The Department’s Santa Barbara programs are centralized on a main campus, along with Public Health and Social Services, and are safe, accessible, and well-lit. The Sheriff’s Department and the County Jail are in the near vicinity, offering a quick response (usually 3-5 minutes) to requests for assistance. Other programs, such the Recovery Learning Center, are located in community centers in the heart of downtown Santa Barbara.
In Lompoc, the majority of program sites are community based along the main thoroughfare; on Ocean Road. The sites are surrounded by shops, restaurants and neighborhoods.

The Santa Maria Adult and Children Outpatient clinic is located on Foster Road. The clinic is in close proximity to several other county entities, including a Sheriff’s substation, and the Food Bank of Santa Barbara County.

### III. Quality of Care: Contract Providers

A. Evidence of how a contractor’s ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

During the provider selection process, the Department accounts for the provider’s ability to provide culturally competent mental health services. Within the Mental Health Services Statement of Work for Contract Providers are several cultural competence requirements. These requirements include adherence to reporting requirements on ethnicity, race, and language of clients served, and staff training completion. (See Criterion 1: Exhibit 23)

### IV. Quality Assurance

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

The county shall include the following in the CCPR Modification (2010):

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

List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

The Behavioral Wellness Quality Improvement (QI) Program is a Department of Health Care Services (DHCS) Mental Health Plan and Drug Medi-Cal Organized Delivery System requirement. The QI Program coordinates performance-monitoring activities throughout the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), including:

- Service Delivery Capacity
- Accessibility of Services
• Timeliness of Services
• Beneficiary Satisfaction
• Service Delivery System Monitoring and Analysis
• Service Coordination with Physical Healthcare and Other Agencies
• Monitoring Provider Appeals
• Tracking and Resolution of Beneficiary Grievances, Appeals, Fair Hearings, and Provider Appeals
• Performance Improvement Projects
• Consumer and System Outcomes
• Utilization Management
• Credentialing

The above processes are further detailed in the Department’s Quality Improvement Plan. (Exhibit)

The Department’s Quality Improvement Committee (QIC) analyzes data quarterly to assess and address trends and patterns. However, the Department does not currently compare the general beneficiary population with ethnic beneficiaries. Beginning in 2017, the Ethnic Services and Diversity Manager became a standing member of QIC and will collaborate with the Quality Care Management (QCM) division to generate comparison rates.

**Cultural Competence Needs Assessment**

Another method by which the Department measures the quality of cultural and linguistic services is through a cultural competency needs assessment. In 2019, through funds coordinated by the Southern California Regional Partnership, the Department consulted with Dr. Jonathan Martinez with the California State University at Northridge (CSUN) to conduct a cultural competence needs assessment of the county-wide behavioral health system of care. The needs assessment comprised of a 15-20-minute online survey inquiring on organizational confidence in cultural adaptations for treatment and services, availability of trainings and language services, and capability to serve hard-to-reach, marginalized, and vulnerable populations including immigrants and refugees, individuals with physical, cognitive, and sensory disabilities, and older adults. Surveys were followed by focus groups with organizational providers to gain deeper insights on cultural competence strengths and areas for improvement. The information obtained in the report was used to inform ongoing and future cultural competence initiatives at Santa Barbara County Department of Behavioral Wellness. (Exhibit 5)

**Exhibits for Criterion 8:**

1) Behavioral Health Services in Santa Barbara County (English & Spanish)
2) Access Flyer (English & Spanish)
3) Access Cards (English & Spanish)
4) Mental Health Statement of Work – Cultural Competence Excerpt
5) Santa Barbara County, Department of Behavioral Wellness Cultural Competency Needs Assessment Report