# ANNUAL UPDATE

# *Cultural Responsivity Plan*

*Fiscal Year 2019-2020*

## *Solano County Behavioral Health*

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# Introduction

## *Purpose*

Solano County Behavioral Health (SCBH) is committed to equity, diversity, and inclusion. Our services aim to empower all community members throughout their journey towards wellness and recovery. It is also of equal importance for us to improve access to quality care for underserved and underrepresented ethnic and minority populations who have been historically marginalized by health care systems.

SCBH continues to strengthen its efforts to develop a culturally and linguistically responsive inclusive system of care in support of the behavioral health and recovery needs of our increasingly diverse population. Although our county is rich in its diversity, significant inequities continue to persistent. This annual update is intended to serve as our plan to meet the cultural and linguistic needs of all our community members. We continue to work directly with the underserved, underrepresented, and marginalized communities using the nationally recognized Culturally and Linguistically Appropriate Services (CLAS) standards https://www.thinkculturalhealth.hhs.gov/. The CLAS standards are utilized by health care providers as the benchmark for evaluation and are aligned with the U.S. Department of Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2010) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity by providing clear plans and strategies to guide efforts to improve cultural and linguistic responsiveness. The SCBH Mental Health Plan (MHP) has multiple initiatives and leverages several funding sources to carry out its mission towards equity. This report provides updates about the culturally responsive strategies implemented by SCBH during Fiscal Year (FY) 2018/19, recent data and demographic changes in our county, and updates on planning, community engagement and strategies being implemented to address disparities during FY2019/20.

## *County Demographics*

Our County[1] is rich in its variety of cultures and landscape. It is home to one of the nation's most diverse cities within its borders (Vallejo). We are located approximately 45 miles northeast of San Francisco and 45 miles southwest of Sacramento. The County includes 675.4 square miles of rural land area. As of 2019, the census[2] has estimated that our population has grown to 446,610 with an 11.5% poverty rate[3] – 49.7% of the population is male and 50.3% of the population is female. The largest demographic[3] living in poverty are Females 25 - 34, followed by Females 35 - 44 and then Males 18 – 24. Currently, 37.6%% of our county residents identify as White, 28.4% as Latino/Hispanic, 14.2% as Asian/Pacific Islander, and 14.2% as Black/African American.

*IN 2014, SOLANO COUNTY WAS RANKED AS THE 5TH MOST RACIALLY DIVERSE COUNTY IN THE UNITED STATES.*

[1] https://www.theatlantic.com/national/archive/2014/04/mapping-racial-diversity-by-county/361388/
[2] https://www.census.gov/quickfacts/solanocountycalifornia
[3] https://datausa.io/profile/geo/solano-county-ca/#economy

**Citizenship:** Approximately 91.2% of Solano residents are US citizens, lower than the national average of 93%.
**Foreign Born Birthplace:** As of 2017[3], 19.6% of Solano County, CA residents were born outside of the country. In 2015, the most common birthplace for the foreign-born residents of California was Mexico, the natural country of 4.32 million California residents, followed by Philippines with 878,605 and China with 555,855. At 52,641, Filipinos in the County making up 12% of the population, Solano County has the largest percentage Filipino population of any County in all the United States.

| Language Spoken at Home | Percent of Total Population |
|---|---|
| Speak only English | 70.3 |
| Speak Spanish | 16.6 |
| Speak Asian or Pacific Island Languages | 10.1 |
| Speak Other Indo-European Languages | 2.4 |
| Speak Other Languages | 0.5 |

# *Goals for FY2019/20*

The document provides data and information related to how these goals came to be- including present and future efforts with the Cultural Competence Committees and SCBH staff and leadership:

**Goal 1: Community Empowerment** – Create opportunities for individuals with lived experience, families, community members, staff and key stakeholders to engage in decisions that impact their lives.

- **Strategy 1:** Establish monthly committee meetings as recommended by the California Pan-Ethnic Health Network (CPEHN).
- **Strategy 2:** Post committee membership form online and enhance partnerships with key stakeholders from our local communities.
- **Strategy 3:** Create opportunities for genuine shared decision making with community via subcommittees.
- **Strategy 4:** Continue to gather community feedback related to the MHSA Innovation ICCTM QI action plans by engaging the community via community forums and focus groups.

**Goal 2: Policy & Systems Change** – Influence organizational level policies and institutional changes across Solano County agencies to positively impact behavioral health outcomes.

- **Strategy 1:** Implement QI Action Plans developed by stakeholders from the MHSA Innovation ICCTM Project.
- **Strategy 2:** Establish specific performance and disparities reduction goals and develop a protocol for monitoring this as recommended by CPEHN.
- **Strategy 3:** Assess, prioritize and implement the national Culturally and Linguistically Appropriate Services (CLAS) Standards across the department and contracted agencies.

- **Strategy 4:** Develop a plan to address areas of improvement identified in the CLAS organizational assessment (Standards 3, 4, 5, 7, 8 & 9). See Appendix C for more information.

**Goal 3: Improve Access to Language Assistance**– Ensure all staff—both County and contractor—have been adequately trained to utilize interpreter and/or translation services.

- **Strategy 1:** Provide BHIT training for all providers and front desk reception staff under the MHP.
- **Strategy 2:** Develop a process to ensure that all new staff receive training on how to access Language Link during the onboarding process.
- **Strategy 3:** Develop a process to better track and analyze data related to the use of Language Link.

# Criterion 1: Commitment to Culturally & Linguistically Appropriate Services

## *SCBH Vision, Mission and Values*

### Vision

Individuals of all ages will receive support to optimize their best development, increase their resiliency and recover from mental illness and substance use disorders.

### Mission

SCBH seeks to provide mental health and substance use supports in Solano County that are person centered, safe, effective, efficient, timely and equitable, that are supported by friends and community, that promote wellness/recovery, and that fully incorporate shared decision making between consumers, family members and providers.

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

It is also worth noting that SCBH and its Cultural Competency Committee is focused on effectively serving our County's diverse population by understanding and respecting the value cultural differences play in providing quality services.

### Overarching Principles

- Care is provided to promote self-defined recovery, family and child resiliency as well as positive development of each person served.
- Care is provided in a culturally and linguistically responsive way with sensitivity to and awareness of the person's self-identified culture, race, ethnicity, language preference, age, gender identity, sexual orientation, disability, religious/spiritual beliefs and socio-economic status.
- There are no disparities for individuals or groups of individuals in accessibility, availability or quality of mental health services provided.

### Dedicated Role: Ethnic Services Coordinator

As part of our commitment to equity, diversity, and CLAS standards, Solano County has a dedicated staff member who oversees the Cultural Responsivity Plan and other efforts. Solano has established the role of Ethnic Services Coordinator for several years. In 2019 due to staff changes, the Behavioral Health Director Sandra Sinz, LCSW, appointed a new staff, Eugene Durrah, LCSW, as the SCBH Mental Health Plan's (MHP) new Ethnic Services Coordinator (ESC). Each county is mandated by the state to appoint a representative who is responsible for the oversight of the MHPs efforts towards equity and addressing the needs of underrepresented and marginalized communities. As such the ESC role leads the Cultural Competency Committee; participates in program planning, policy development including hiring practices, and reviews of grievances related to disparities; sits on various advisory groups/task forces; monitors data related outcomes for racially, ethnically and culturally diverse populations; and is responsible for developing and monitoring the Cultural Responsivity Plan.

# Criterion 2: Assessment of Service Needs

## *Social Determinants*

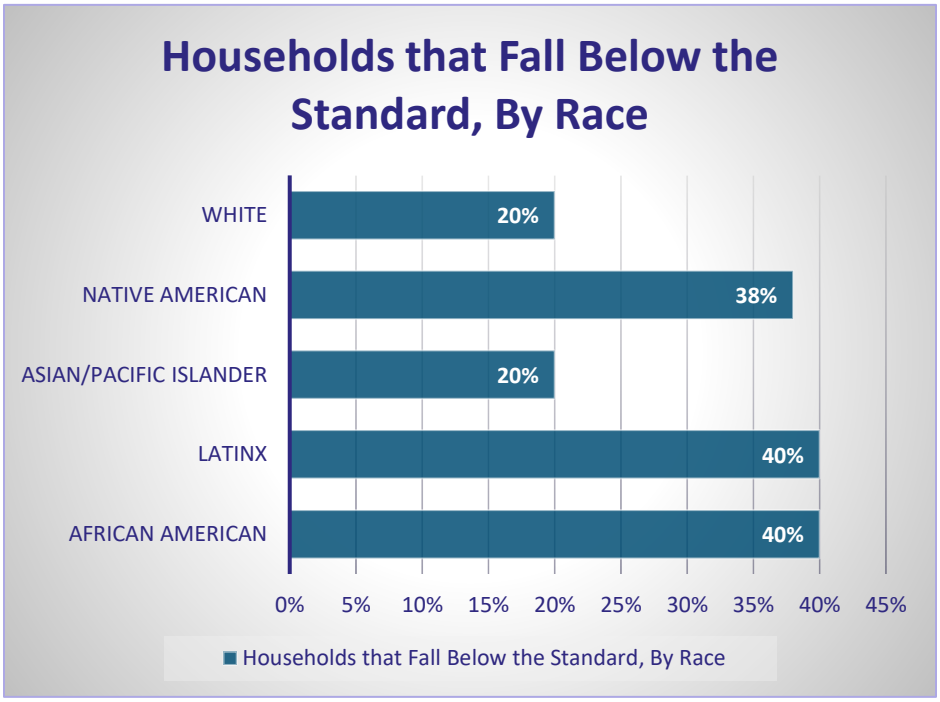
Solano County is one of the most racially diverse counties in the nation. 55% identify as people of color and 30% speak a language other than English at home[4]. 44% of businesses are owned by people of color, and 39% are owned by women[5]. Solano County has a flourishing seed industry and 42 registered organic farms[6]. Solano County is home to 6 colleges and university and 6 adult education programs and schools[7]. The 5 Keys program, focused on providing employment and education services to formerly incarcerated adults, is available in 3 cities[8]. Solano county maintains and operates 1,262 acres of parks, agriculture land and open space[9]. Residents have access to 115 smoke-free city parks[10]. Although many community members are thriving in our county, there are significant inequities we must address.


### Self Sufficiency

*Table - California Self Sufficiency Standard Fact Sheet, Solano County Key Facts[11]*

[4] Racially diverse: 2018 Most racially diverse counties in America. https://www.niche.com.
[5] Business: American Community Survey, 2012 Survey of Businesses, Table 1200CSA01.
[6] Seed Industry/farm: Solano County 2017 crop and livestock report, Solano County Dept of Agriculture.
[7] Colleges/Universities: Solano County, SolanoCounty.com/about/living
[8] 5 Keys Program: Solano Workforce Development Board.
[9] Solano-owned parks: Solano County, SolanoCounty.com/about/county/fact_n_figures.asp
[10] VibeSolano based on parks located in cities with smoke-free park ordinance.
[11] https://insightcced.org/wp-content/uploads/2018/04/SolanoCounty-FactSheet-FINAL.pdf

The 2018 California Self-Sufficiency Fact Sheet identifies "self-sufficiency" as the minimum income necessary to cover an individual or family's basic expenses such as housing, food, health care, child care, transportation, and taxes – without public or private assistance. Although this county is extremely diverse there are significant racial disparities. As of 2018, nearly 40% of African Americans, Latinx, and Native Americans did not earn enough income to cover their basic needs which is double the amount for the Asian/Pacific Islander and White families here in Solano County. These disparities reflect the many barriers different groups experience in our communities.




## Housing

- In comparison to White families (68%), Latino/Hispanic (52%) and Black/African American (43%) are significantly less likely to own their homes.[12]
- Black/African American families with children under 5 years are the most housing cost burdened racial/ethnic group in Solano County.[13]
- African Americans and Native Americans are overrepresented in the homeless population, which may be an indicates they may be suffering from disproportionate rates of homelessness. [14]

According to the Homeless Point in Time (PIT) count[15] for 2019, the number of homeless individuals is 1,151 (0.25%) where 39% (452) individuals are chronically homeless. Approximately 39% are white, 37% Black, 14% multiracial, and 5% are American Indian/Alaska Natives- 16% identify as Hispanic/Latinx. At least 14% of those counted report having been in the foster care system at some point. Related to health conditions, 29% report psychiatric/emotional conditions and 22% drug or alcohol abuse on top of other chronic conditions. All of these are contributing to difficulties affording, obtaining and maintaining safe, affordable housing and being closely monitored by the Solano Continuum of Care for homeless services. The "Neighbors Helping Neighbors: Forward Together", 5-Year Regional Strategic Plan to Respond to Homelessness in Solano County, is available here.

## Education

As the charts below illustrate, there are also significant disparities within our educational system as demonstrated by the graduation and suspension rates by race/ethnicity. African American, Pacific Islander, Native American and

[12] Source: American Community Survey, 2013-2017 5-year estimate, Table B25003
[13] Source: American Community Survey, 2013-2017 5-year estimate, Table B25003
[14] Dates refer to the date of the 2018 Housing Inventory Count (January 24, 2018) and the date prior to the 2019 Point-in-Time Count (January 22, 2019).
[15] http://www.capsolanojpa.org/

Hispanic/Latino Students are suspended at significantly higher rates in comparison to other students. Consequently, Pacific Islander, African American, Hispanic/Latino, and Native American/Alaskan Natives experience lower graduation rates as a result.

## *2018-19 Four-Year Adjusted Cohort Graduation Rate*

**Cohort Outcome Period:** For the calculation of the four-year ACGR, the period for determining cohort inclusion is 07/01/Year1 – 06/30/Year4; however, the period for determining cohort outcomes is 07/01/Year1 – 08/15/Year4. This provides LEAs with additional time to report summer graduates. All cohort graduation requirements, including the awarding of the diploma, must be completed by the end of the cohort outcome period (August 15).

**Cohort Students:** The four-year cohort is based on the number of students who enter grade 9 for the first time adjusted by adding into the cohort any student who transfers in later during grade 9 or during the next three years and subtracting any student from the cohort who transfers out, emigrates to another country, transfers to a prison or juvenile facility, or dies during that same period.

| Race / Ethnicity | Cohort Students | Regular HS Diploma Graduates | Cohort Graduation Rate | Graduates Meeting UC/CSU Requirements | Graduates Earning a Seal of Biliteracy | Graduates Earning a Golden State Seal Merit Diploma |
|---|---|---|---|---|---|---|
| African American | 767 | 603 | 78.6% | 177 | 6 | 45 |
| American Indian or Alaska Native | 31 | 24 | 77.4% | 14 | 2 | 4 |
| Asian | 199 | 185 | 93.0% | 121 | 25 | 80 |
| Filipino | 526 | 501 | 95.2% | 301 | 38 | 146 |
| Hispanic or Latino | 1,775 | 1,424 | 80.2% | 523 | 127 | 187 |
| Pacific Islander | 56 | 48 | 85.7% | 20 | 3 | 4 |
| White | 1,208 | 1,074 | 88.9% | 523 | 54 | 252 |
| Two or More Races | 297 | 275 | 92.6% | 127 | 16 | 70 |
| Not Reported | 21 | 11 | 52.4% | 5 | 0 | 1 |

## *2018-19 Suspension Rate[16] - Disaggregated by Ethnicity*

| Ethnicity | Cumulative Enrollment | Total Suspensions | Unduplicated Count of Students Suspended | Suspension Rate | Percent of Students Suspended with One Suspension | Percent of Students Suspended with Multiple Suspensions |
|---|---|---|---|---|---|---|
| African American | 9,503 | 2,585 | 1,336 | 14.1% | 59.1% | 40.9% |
| American Indian or Alaska Native | 286 | 31 | 14 | 4.9% | 35.7% | 64.3% |
| Asian | 2,546 | 83 | 63 | 2.5% | 79.4% | 20.6% |
| Filipino | 5,584 | 155 | 113 | 2.0% | 77.9% | 22.1% |
| Hispanic or Latino | 26,172 | 2,245 | 1,318 | 5.0% | 66.8% | 33.2% |
| Pacific Islander | 748 | 71 | 44 | 5.9% | 70.5% | 29.5% |
| White | 15,905 | 1,059 | 608 | 3.8% | 68.3% | 31.7% |
| Two or More Races | 4,972 | 401 | 257 | 5.2% | 71.6% | 28.4% |
| Not Reported | 424 | 29 | 24 | 5.7% | 83.3% | 16.7% |

## *2018-19 Expulsion Rate*

| Ethnicity | Cumulative Enrollment | Total Expulsions | Unduplicated Count of Students Expelled | Expulsion Rate |
|---|---|---|---|---|
| African American | 9,503 | 42 | 41 | 0.43% |
| American Indian or Alaska Native | 286 | 1 | 1 | 0.35% |
| Asian | 2,546 | 1 | 1 | 0.04% |
| Filipino | 5,584 | 4 | 3 | 0.05% |
| Hispanic or Latino | 26,172 | 13 | 12 | 0.05% |
| Pacific Islander | 748 | 3 | 3 | 0.40% |
| White | 15,905 | 7 | 7 | 0.04% |
| Two or More Races | 4,972 | 6 | 6 | 0.12% |
| Not Reported | 424 | 1 | 1 | 0.24% |

[16] https://dq.cde.ca.gov/dataquest/dqCensus/DisSuspRate.aspx?year=2018-19&agglevel=County&cds=48#collapseTwo

# *Mental Health Indicators*

Although Solano County data is not readily available, the American Psychiatric Association[17] highlights the following mental health disparities:

- Only one in three African Americans who need mental health care receives it.
- Hispanics are more likely to report poor communication with their health provider.
- Compared with men, women are twice as likely to experience PTSD.
- Only 8% of Asian Americans seek mental health care compared with 18% of the general population.
- White Americans are more likely to die by suicide than people of any other ethnic/racial group.
- LGBTQ individuals are more than twice as likely as heterosexual men and women to have a mental health disorder in their lifetime.
- American Indian/Alaskan Native children and adolescents have the highest rates of lifetime major depressive episodes.
- Existing data show high rates of adjustment disorder experienced by Muslim Americans seeking MH treatment.

# *Consumer Surveys – Cultural & Linguistic Responsiveness*

SCBH continues to implement the quarterly consumer service verification survey which includes questions measuring cultural and linguistic responsiveness by asking consumers about their experiences with our system of care. SCBH collected 1,390 surveys during FY2018/19. Although there were relatively small numbers of dissatisfaction with our system of care, the data indicates SCBH can still make improvements regarding linguistic support (interpretation services) and in respect towards consumers' race/ethnicity, religion/spirituality and sexuality/gender identity. The following charts summarize consumers responses to the service verification survey that are implemented quarterly which include both county and contractor agencies.

## *Quarter 1*

| Service Verification Agregate Data by Quarter<br>FY 2018/2019 | Review Period:<br># of Surveys: | Qtr. 1<br>499 | |
|---|---|---|---|
| **Question** | **Yes, definitely** | **Yes, somewhat** | **No** |
| **1. Did the staff explain things in a way that was easy to understand?** | 95% | 4% | 1% |
| **2. Did the staff listen carefully to you?** | 95% | 3% | 1% |
| **3. Did the staff show respect for what you had to say?** | 96% | 3% | 1% |
| **4. Did you feel the staff was respectful of your race/ethnicity?** | 97% | 2% | 1% |
| **5. Did you feel the staff was respectful of your religion/spirituality?** | 95% | 3% | 2% |
| **6. Did you feel the staff was respectful of your sexual orientation/gender identity?** | 95% | 3% | 3% |
| | **Yes** | **No, but I'd like one** | **I don't need one** |
| **7. Was an interpreter/bi-lingual staff provided?** | 14% | 2% | 84% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **8. Did the interpreter/bi-lingual staff meet your needs?** | 96% | 3% | 1% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **9. Do you feel better?** | 64% | 29% | 7% |
| **10. Would you recommend our services to others?** | 80% | 11% | 10% |

[17] https://www.psychiatry.org/psychiatrists/cultural-competency/mental-health-disparities

## *Quarter 2*

| Service Verification Agregate Data by Quarter FY 2018/2019 | Review Period: | Qtr. 2 | |
|---|---|---|---|
| | # of Surveys: | 247 | |
| **Question** | **Yes, definitely** | **Yes, somewhat** | **No** |
| **1. Did the staff explain things in a way that was easy to understand?** | 94% | 5% | 0% |
| **2. Did the staff listen carefully to you?** | 96% | 4% | 0% |
| **3. Did the staff show respect for what you had to say?** | 97% | 3% | 0% |
| **4. Did you feel the staff was respectful of your race/ethnicity?** | 96% | 3% | 0% |
| **5. Did you feel the staff was respectful of your religion/spirituality?** | 94% | 4% | 2% |
| **6. Did you feel the staff was respectful of your sexual orientation/gender identity?** | 96% | 3% | 2% |
| | **Yes** | **No, but I'd like one** | **I don't need one** |
| **7. Was an interpreter/bi-lingual staff provided?** | 20% | 2% | 78% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **8. Did the interpreter/bi-lingual staff meet your needs?** | 88% | 2% | 10% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **9. Do you feel better?** | 71% | 23% | 6% |
| **10. Would you recommend our services to others?** | 86% | 9% | 4% |

## *Quarter 3*

| Service Verification Agregate Data by Quarter FY 2018/2019 | Review Period: | Qtr. 3 | |
|---|---|---|---|
| | # of Surveys: | 548 | |
| **Question** | **Yes, definitely** | **Yes, somewhat** | **No** |
| **1. Did the staff explain things in a way that was easy to understand?** | 95% | 3% | 1% |
| **2. Did the staff listen carefully to you?** | 96% | 3% | 1% |
| **3. Did the staff show respect for what you had to say?** | 96% | 2% | 2% |
| **4. Did you feel the staff was respectful of your race/ethnicity?** | 97% | 1% | 1% |
| **5. Did you feel the staff was respectful of your religion/spirituality?** | 95% | 3% | 2% |
| **6. Did you feel the staff was respectful of your sexual orientation/gender identity?** | 96% | 2% | 3% |
| | **Yes** | **No, but I'd like one** | **I don't need one** |
| **7. Was an interpreter/bi-lingual staff provided?** | 11% | 2% | 87% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **8. Did the interpreter/bi-lingual staff meet your needs?** | 87% | 5% | 8% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **9. Do you feel better?** | 66% | 22% | 12% |
| **10. Would you recommend our services to others?** | 78% | 12% | 11% |

*Quarter 4*

| Service Verification Agregate Data by Quarter FY 2018/2019 | Review Period: | Qtr. 4 | |
|---|---|---|---|
| | # of Surveys: | 96 | |
| **Question** | **Yes, definitely** | **Yes, somewhat** | **No** |
| **1. Did the staff explain things in a way that was easy to understand?** | 95% | 4% | 1% |
| **2. Did the staff listen carefully to you?** | 97% | 2% | 1% |
| **3. Did the staff show respect for what you had to say?** | 97% | 2% | 1% |
| **4. Did you feel the staff was respectful of your race/ethnicity?** | 97% | 2% | 1% |
| **5. Did you feel the staff was respectful of your religion/spirituality?** | 97% | 2% | 1% |
| **6. Did you feel the staff was respectful of your sexual orientation/gender identity?** | 97% | 2% | 1% |
| | **Yes** | **No, but I'd like one** | **I don't need one** |
| **7. Was an interpreter/bi-lingual staff provided?** | 20% | 1% | 79% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **8. Did the interpreter/bi-lingual staff meet your needs?** | 89% | 0% | 11% |
| | **Yes, definitely** | **Yes, somewhat** | **No** |
| **9. Do you feel better?** | 63% | 32% | 5% |
| **10. Would you recommend our services to others?** | 85% | 6% | 8% |

## *Specialty Mental Health Service Penetration Rates*

In California, penetration rates are another tool used to identify disparities. The state uses this method to highlight disparities and identify gaps in access to Mental Health treatment. Penetration rates are calculated by taking the total number of individuals who receive a Specialty Mental Health Services (SMHS) or Early and Periodic Screening Diagnostic and Treatment (EPSDT) service through County MHPs in a FY and dividing that by the total number of Medi-Cal eligible individuals for that FY. Penetration rates essentially assess how a county serves its community by racial and ethnic demographics.

As an MHP SCBH is required to serve individuals who have serious mental health conditions and have Medi-Cal insurance, or are uninsured. Individuals whose mental health condition are more “mild/moderate” are referred to their managed care plan, which is Partnership Health Plan in Solano County who then sub-contracts with Beacon to serve the mild-to-moderate population. It is also noteworthy that Solano County is unique in that we are one of two counties that has a Kaiser carve out situation whereby Partnership Health Plan contracts with Kaiser to provide services for a portion of the seriously mentally ill (SMI) population. Additionally, SCBH does leverage Mental Health Services Act (MHSA) prevention and early intervention (PEI) funding to provide services and supports for the mild-to-moderate population.

A review of the penetration rates shows whether the number of beneficiaries served is keeping pace with the averages in other similar sized counties. The chart below provides information regarding local penetration rates for beneficiaries who access the County Mental Health system of care. This will not include beneficiaries access services through Beacon, Kaiser or MHSA PEI funded programs.

*Fiscal Year 2018-2019**

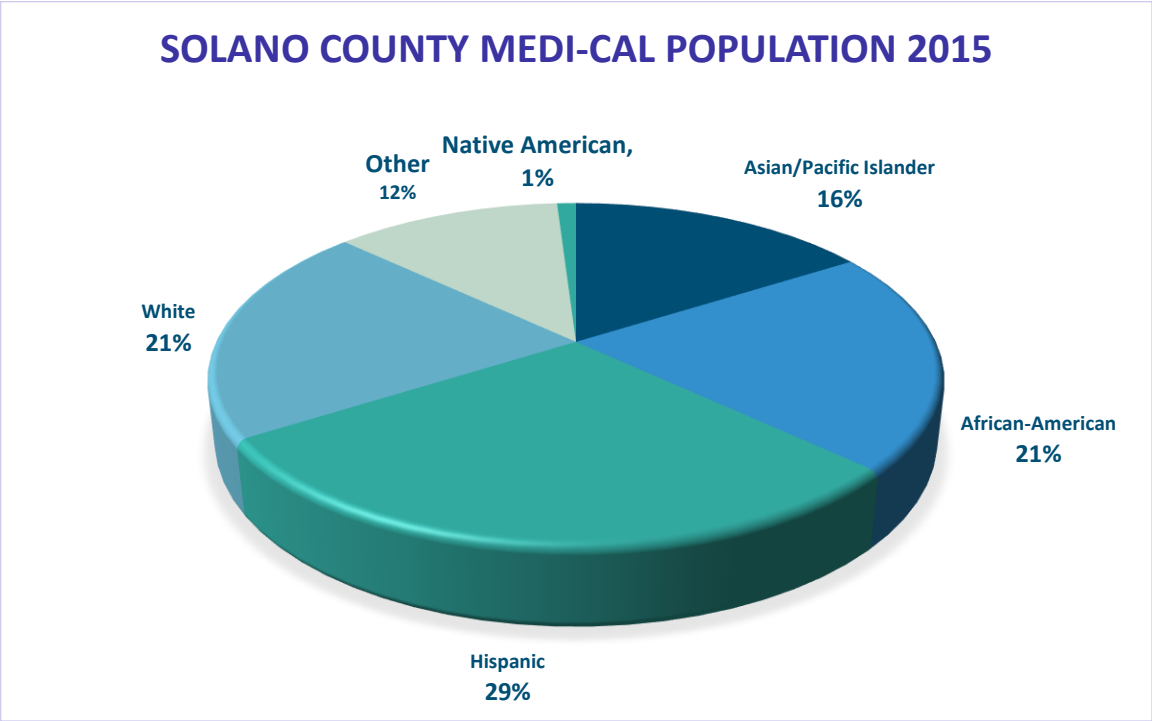
| Race/Ethnicity | Solano County | Medium County |
|---|---|---|
| White | 5.90% | 6.08% |
| Hispanic | 2.26% | 2.88% |
| African American | 4.59% | 6.44% |
| Asian/Pacific Islander | 1.88% | 2.41% |
| Native American | 8.45% | 6.25% |

Solano County has historically underserved its Hispanic and Asian/Pacific Islander populations which is largely Filipino in Solano County, and more recently the African American population in comparison to averages of other similar sized medium counties. It is widely known that we are also underserving the LGBTQ community. Although Native Americans are one of the smallest minority groups in the county, they are among the highest utilizers of specialty mental health services which is one indicator of the many challenges indigenous groups continue to experience. In addition, these communities are also underrepresented in our workforce.

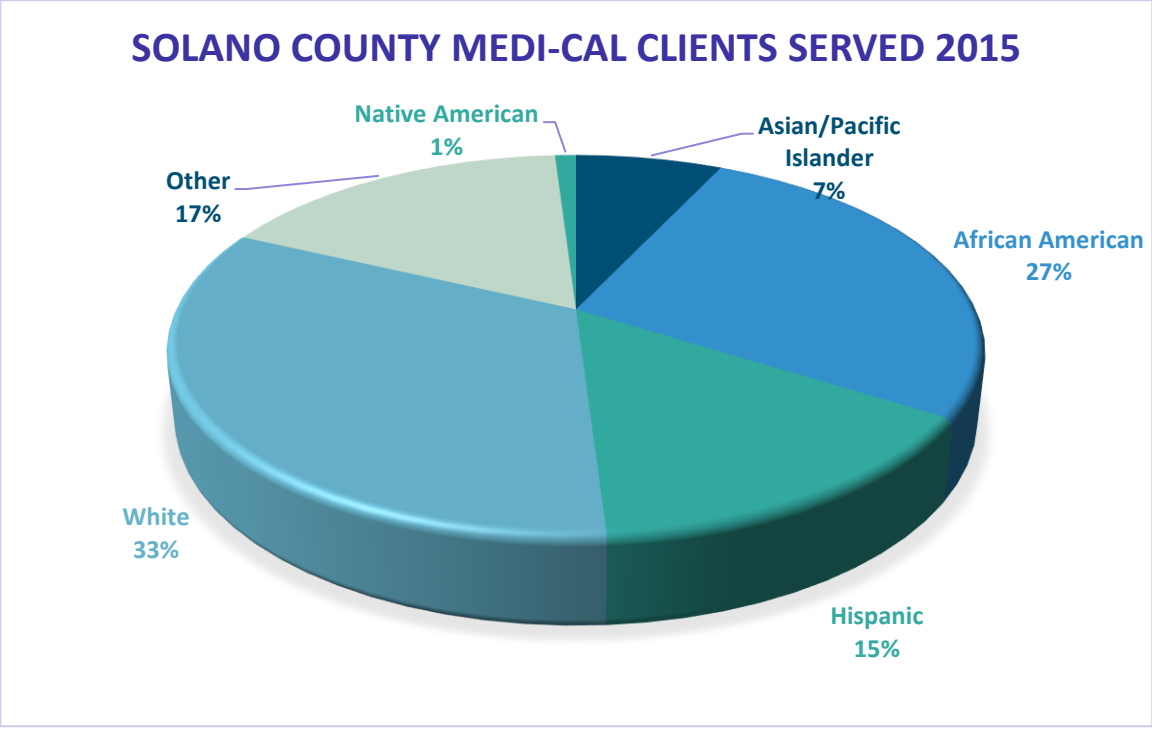
**CLAS Standard 12:** Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

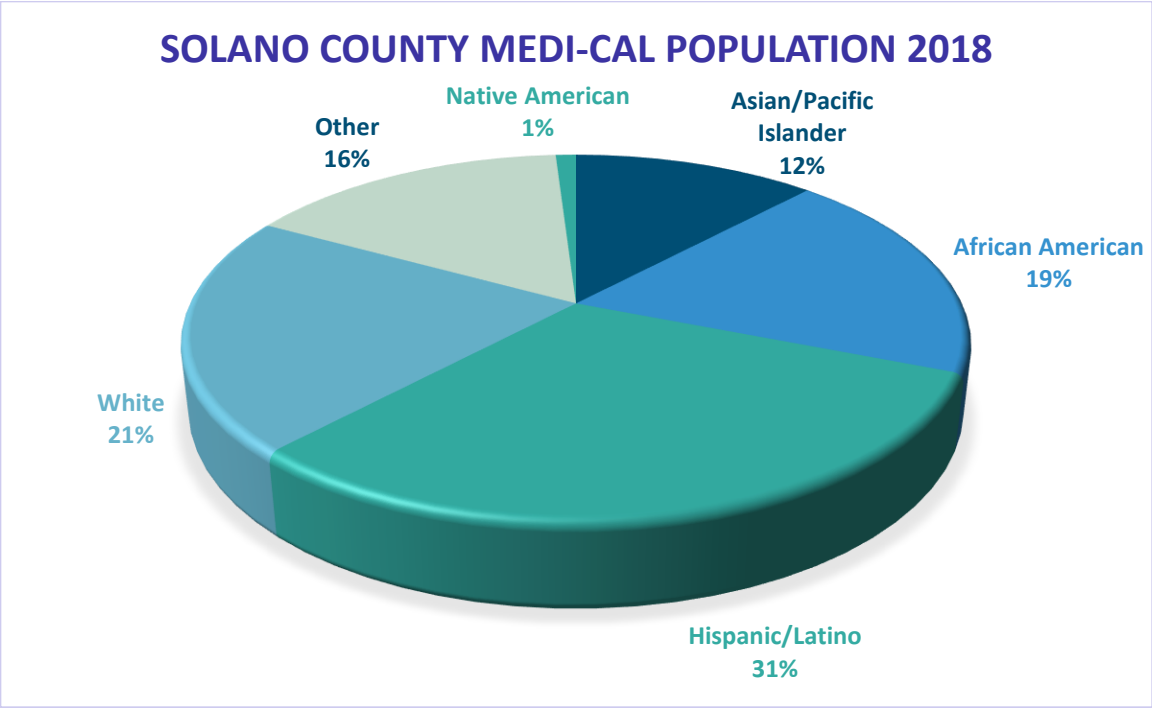
## *Solano Medi-Cal Eligible Population*

The following charts show for the comparison years, the number of individuals on Medi-Cal followed by the number of individuals who received mental health services through the County MHP, as reflected in the specialty mental health claims. Beacon and MHSA PEI services are not reflected in the County data, where the target population shows functional impairment that is more “moderate/severe.”

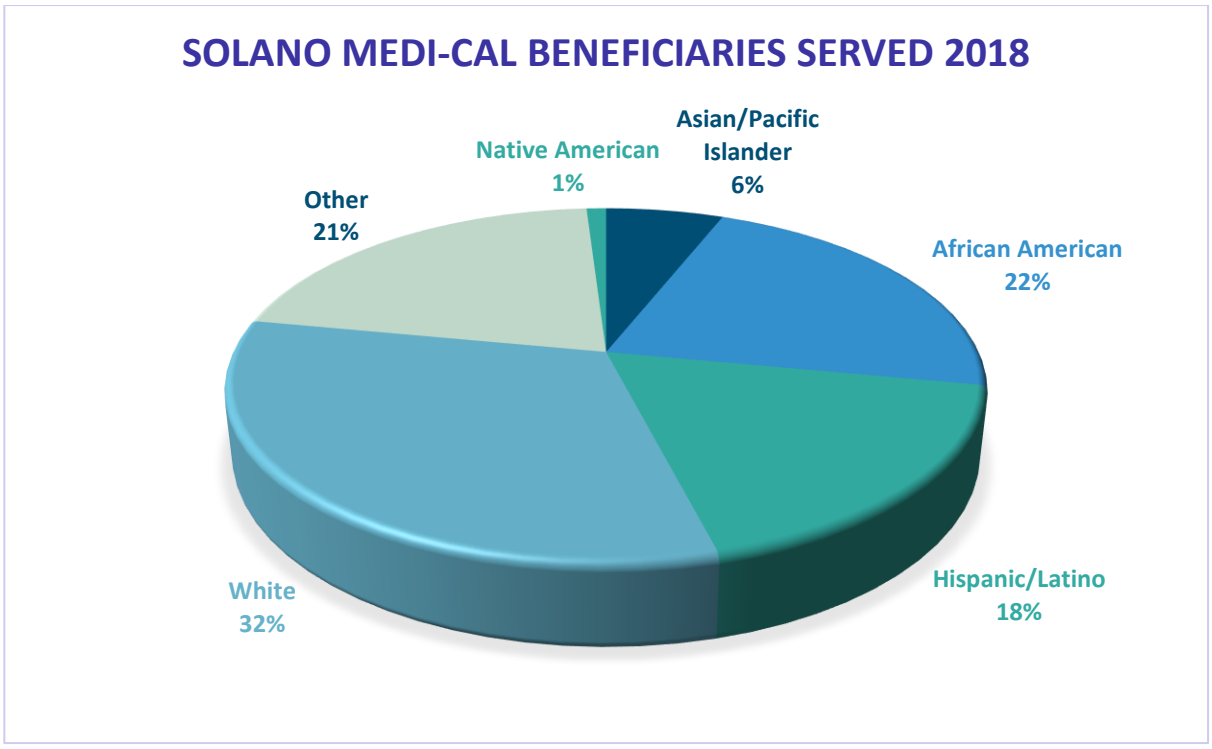



In 2015 the above chart shows the Medi-Cal population which was 93,325. The percentages of each race/ethnicity group are noted in the chart as well as the number of people it represents. While the Latino population represented 29% of the Medi-Cal population it was 15% of our clients served. Similarly, Asian/Pacific Islanders (largely Filipino) represented 16% of the Medi-Cal population but 7% of the clients served. The white population is disproportionately higher in the population of clients served.






In 2018, the Medi-Cal population increased to 120,092, an impact from the Affordable Care Act. All populations grew except the Asian/Pacific Islander group; therefore, their percentage of the population decreased. In 2018, there were 25% more clients served than in 2015, showing increases across all populations. The biggest increase is in the Latino population which increased by 49% (567 clients in 2015 to 843 clients in 2018). The Latino population now represents 18% of the client population compared to 15% in 2015. The increase in the Asian/Pacific Islander population is more modest at 12% (247 clients in 2015 and 276 clients in 2018), despite the total Medi-Cal eligible population staying about the same.



# *MHSA Community Engagement*

During FY2019/20 SCBH engaged community stakeholders in the MHSA Community Program Planning (CPP) process which included six (6) meetings across the county attended by 165 participants with representation from consumers; family members; mental health, substance use disorder and physical health providers; law enforcement, local educational agencies; veterans; faith-based communities; and representation from the County's unserved/underserved Latino, Filipino and LGBTQ communities. During each meeting there were activities to solicit feedback from stakeholders regarding gaps in the system of care and recommended areas to focus on, including how to better serve underserved and marginalized communities. The following are the top 3-4 priorities identified for each of the special populations:

**LGBTQ+ Community**

1. Training and education on working with LGBTQ community
2. Safe spaces for LGBTQ individuals
3. LGBTQ friendly shelters/housing

**Latino Community**

1. Increase diverse staff to meet needs of Latino consumers
2. Increase access to employment services using the Individual Placement and Support (IPS) employment model with a cultural lens
3. Integration of spirituality in services and outreach efforts through partnerships with faith communities
4. Perinatal/post-partum mental health services for Latino parents

**Filipino Community**

1. Increase diverse staff to meet needs of Filipino consumers
5. Increase access to employment services using the Individual Placement and Support (IPS) employment model with a cultural lens
6. Integration of spirituality in services and outreach efforts through partnerships with faith communities

**African American Community**

1. Increase diverse staff especially male African American therapists
2. Increase access to employment services using the Individual Placement and Support (IPS) employment model with a cultural lens
3. Increase training on best practices for working with African American community
4. Address trauma and depression due to interactions with law enforcement

**Native American Community**

1. Consider a specific SCBH Liaison for the Native American community
2. Increase access to employment services using the Individual Placement and Support (IPS) employment model with a cultural lens
3. Increase diverse staff to meet needs of Native American consumers

SCBH in partnership with the MHSA Steering Committee will explore increasing funding for existing programs that are serving the special populations and/or implement new initiatives to address the identified needs.

# Criterion 3: Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

## *MHP Equity Initiatives and Programs*

SCBH has several initiatives and/or programs that are focused on improving access to services for unserved/underserved communities and developing programming that is culturally and linguistically responsive to better address healthcare disparities. These initiatives include:

- **The Hispanic Outreach and Latino Access (HOLA) initiative**, implemented in 2014, consists of a half-time licensed mental health clinician funded by MHSA who conducts outreach with schools, health clinics, churches, local migrant camps and other key stakeholders on behalf of SCBH to reduce mental health stigma within the Latino community in an effort to increase access and utilization of county behavioral health services.
- The **KAAGAPAY "Reliable Companion" Filipino outreach initiative,** implemented in 2015 consists of a half-time licensed mental health clinician funded by MHSA who conducts outreach with health providers, libraries and other key stakeholders on behalf of SCBH to reduce mental health stigma within the Filipino community in an effort to increase access and utilization of behavioral health services.

- Since 2015 MHSA prevention and early intervention (PEI) funds have been used to implement the **African American Faith-Based Initiative (AAFBI) Mental Health Friendly Communities (MHFC) project**, which is delivered by three consultants, funded by MHSA, and includes training for faith leaders on the signs and symptoms of mental health, support for faith communities to build internal support systems to address mental health needs of congregants, and training for providers on how to better engage consumers from the African American community. Additionally, there is a mini-grant program whereby African American faith communities are awarded small grants to facilitate events and/or support groups focused on stigma reduction and suicide prevention.
- Starting in 2015 MHSA PEI funds have been used to fund a LBGTQ Outreach and Access program. Currently SCBH contracts with the **Solano Pride Center, a local LGBTQ organization** to provide education for the community, social and support group activities, and brief counseling. Starting in FY2018/19 the program began providing the "Welcoming Schools" training for our local schools to create safe spaces in schools for LGBTQ youth.

- In order to support the **Native American Community**, during FY2018/19, a SCBH Clinician, funded by MHSA under the Wellness and Recovery Unit, began to provide a women's "Talking Circle" group for women who identified as Native American in partnership with the local TANF office. Additionally, during FY2018/19 SCBH used MHSA PEI funds to sponsor and cohosted with the local TANF office, a Native American Forum in order to provide training for behavioral health providers in best practices when working with indigenous people.
- Over the course of the last several years SCBH has developed processes to **collect data related to LGBTQ status**. During FY2016/17 SCBH created fields in the electronic health record (EHR) to collect "gender assigned at birth", "current gender identity", and "sexual orientation". In December of 2017 SCBH launched a data collection process to collect the abovementioned data points for all consumers who were already opened to the MHP. In May of 2018 a workgroup was convened with representatives from the Children's system of care to revise and update the demographic collection tool used for parents/caretakers of minor consumers as well as the self-reporting tool used at intake to gather information from parents/caretakers on medical, developmental, substance use history, and presenting problem (symptoms and behavior). The workgroup also developed a youth self-reporting tool to capture the youth's own perspective on gender identity, sexual orientation, and overall functioning. These self-reporting tools will be used at intake and at the annual assessment going forward.

**Standard 11:** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

## *MHSA Innovation Project*

SCBH has implemented several strategies to address and reduce health disparities including a comprehensive **5-year MHSA funded Innovation project called the *Interdisciplinary Collaboration and Cultural Transformation Model* (ICCTM).** The County has partnered with the University of California, Davis (UCD) – Center for Reducing Health Disparities (CRHD) to implement this project which aims to increase culturally and linguistically appropriate services for County-specific unserved and underserved populations with low behavioral health service utilization rates: the Latino, Filipino, and LGBTQ communities as identified in 2015 when the Innovation Plan was developed. The project includes the creation of a region-specific curriculum incorporating the CLAS standards with the local community's perspective on culturally competent practices that should be integrated into the current local behavioral health system to increase access and utilization for the target populations.

**Phase I** of the project included UCD conducting a comprehensive health assessment of our community and behavioral health system of care which included: key informant interviews, focus groups, community forums, and organizational surveys to gather information regarding the needs of the three target communities. UCD collated all the information gathered during the health assessment into three different narrative reports, one for each target community; Latino, Filipino, and LGBTQ. These reports can be found in English, Spanish and Tagalog on the SCBH website . Additionally, during Phase I, quantitative data from the County's electronic health record was used to develop a baseline regarding access and penetration rates for the three target communities.

**Phase II** of the ICCTM project included the facilitation of a CLAS Training for three cohorts of up to 30 people each. The cohorts included partners from different sectors including county and community-based behavioral health providers, law enforcement, education, health services, child welfare, the legal system, businesses, consumers,

family members and specific representation from the three target communities. The cohorts received more in-depth training on a specialized curriculum that incorporated the CLAS standards and the findings of the local health assessment. Each cohort designed quality improvement (QI) action plans to improve the behavioral health system of care's response and support of our diverse community. Following the training the cohorts received up to 5 months of coaching from the UCD team and SCBH to further refine the QI action plans to ready them for implementation. Additionally, three local community-based organizations representing each of the three target communities were identified and sub-contracted by UCD to help facilitate ongoing community engagement to obtain feedback regarding the QI action plans and the overall progress of the project.

**Phase III** of the project involves the ongoing implementation of the QI action plans and evaluation. A total of ten (10) comprehensive QI action plans were developed and transitioned to the County in June of 2019. UCD provided a comprehensive report covering each of the QI action plans. This report can be found on the SCBH website here. The QI action plans are focused on workforce development, training, and community engagement. Several of the QI action plans have already begun to be implemented and the remaining plans will be implemented during FY2019/20.

For the purposes of this report a brief summary and updates will be provided for each of the ten (10) QI action plans:

- **Mental Health Education** – Develop workshop(s) on various topics related to mental health for youth and create a system to help faith leaders undergo mental health training needed to help their members seek services.
    - Update: This QI action plan is pending implementation. SCBH is leveraging several existing partnerships with local faith centers and faith collaboratives across the county to recruit faith leaders to participate in train-the-trainer sessions for several curriculums (Mental Health First Aid (MHFA), safeTALK, Applied Suicide Intervention Skills Training (ASIST) which we will be bringing to county in spring of 2020. Additionally, the QI workgroup developed a curriculum that could be used to train youth and SCBH will work with existing faith partners to schedule several trainings across county.

- **TRUe Care Promoter** – Create a mental health "Roadmap" and peer navigator system (TRUe Care promoters) to assist individuals through accessing services from start to finish.
    - Update: This QI action plan is pending implementation. SCBH is working with a graphic designer to develop the "Roadmap" which will be available in English, Spanish and Tagalog. The tool will also be made available on SCBH's website and will be interactive. In regard to the recommendation from the QI action plan group to have a peer navigator system, SCBH is exploring whether existing Peer Support Specialists could be tasked with activities related to navigation. Additionally, Solano County Health and Social Services (H&SS) is developing a navigator system which may include positions related to helping consumers navigate and access the H&SS system of care which includes Behavioral Health.

- **Taking CLAS to the Streets** – This plan is focused on launching wellness center/rooms with a cultural lens on school campuses across Solano County, both K-12 and adult education sites. The initial goal was to open five (5) pilot wellness centers with a plan to expand these if funding was available. This project is being funded by MHSA and grants that the Solano County Office of Education (SCOE) received.

Update: This QI action plan has been implemented. Between September and December of 2019 five (5) pilot wellness centers opened at three (3) elementary schools, an alternative education site and an adult education site. Twenty (20) more school wellness centers will be opened between January-June 2020. SCBH and SCOE have partnered to develop the criteria for school sites to receive funding, including criteria related to cultural competency training to address racial and linguistic equity as well as ensuring equity and safety for LGBTQ+ students.

- **LGBTQ Ethnic Visibility** – Create culturally and linguistically appropriate signage to increase visibility of individuals who identify as LGBTQ and either the Latino or Filipino community. Several focus groups were held with members of the Latinx and Filipinx communities to design signage.
    - Update: This QI action plan is pending implementation. SCBH is working with a graphic designer to develop signage. To date eight (8) signs have been created and will be distributed throughout the community in 2020.

- **Bridging the Gap –** Create a "wellness brand" that will be recognized throughout Solano County and expand on outreach efforts to non-health related events held in Solano County. The QI action team requested to have uniform outreach kits developed that could be used by SCBH and contractor staff when engaging the community.
    - Update: pending implementation. SCBH is working with a graphic designer to develop materials that will be included in the outreach kits.

- **CLAS Gap Finders –** This QI action plan recommended developing a unit dedicated to monitoring and addressing gaps in the MHP regarding compliance with CLAS standards. Given challenges with getting new positions approved SCBH is utilizing existing staff and the Cultural Competency Committee to assist with monitoring our efforts towards full implementation of the CLAS standards and are using other strategies to identify gaps.
    - Update: partially implemented. In October of 2019 SCBH did complete a CLAS Organizational Assessment to identify areas for improvement within our organization. Starting in FY2019/20 SCBH inserted language in all of our contracts to require SCBH funded agencies to develop their own Cultural Responsivity Plans with drafts due December 31, 2019. The ESC and members of the SCBH team have provided templates for plans and technical assistance for vendors.

- **Cultural Game Changers** – Create CLAS appropriate strategies for recruitment and hiring and recruit a diverse workforce through pipeline strategies.
    - Update: partially implemented- The action plan team and SCBH all understand that this QI action plan will be implemented in phases over several years due to the interfacing with Human Resources and civil services laws. The QI action plan team did develop an inclusion statement that is now incorporated into all SCBH job postings:

      *Solano County Behavioral Health is committed to equity, diversity, and inclusion. Our services aim to empower all community members throughout their journey towards wellness and recovery. It is also of equal importance for us to improve access to quality care for underserved and under-represented ethnic and minority populations who have been historically marginalized by health care systems. We value the importance of employing staff who possess valuable life experiences and expertise to ensure our workforce is culturally and linguistically responsive and leverages diversity to foster innovation and positive outcomes for the people we serve.*

**CLAS Standard 3:** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

In addition to the Inclusion Statement, SCBH is exploring changes to the job descriptions for all behavioral health specific classifications and will be convening a special workgroup to develop specific interview questions pulling for cultural and linguistic competencies during the hiring process. SCBH now has an ongoing bilingual (Spanish and Tagalog) clinician position posted continuously to identify bilingual candidates more easily when any Clinician positions come available. In regard to the pipeline component of this QI plan, in April of 2019 SCBH partnered with CIBHS to hold our 2nd annual high school pipeline event with three (3) high schools in Fairfield. The event was a success and SCBH plans to continue to facilitate a large event annually alternating in the different regions of the County. Additionally, SCBH has allocated MHSA workforce education and training (WET) funds for stipends for college interns who represent diverse communities.

- **ISeeU –** Develop recommendations for improved cultural and linguistic competency and customer service trainings for mental health front desk reception staff and improve clinic spaces to be more welcoming to consumers from diverse communities.
    - Update: This QI action plan is pending implementation. SCBH is working in partnership with UC Davis CRHD to develop a framework of a specialized training curriculum for front desk reception staff that will then be vetted by front desk staff.

- **Culturally Responsive Supervision –** Train supervisors to perform culturally sensitive supervision and to provide appropriate support and mentoring to their multilingual and multicultural staff and consumers.
    - Update: This QI action plan has been implemented. SCBH entered into a contract with Dr. Kenneth Hardy, an internationally recognized trainer on topics related cultural responsivity—specifically the connection between trauma and oppression—to provide training for supervisors under the MHP. Dr. Hardy provided two 8hr trainings, one in February and one in June of 2019 for county and contractor clinical supervisors who directly supervise staff providing direct services. In addition to the trainings Dr. Hardy provided consultation for identified leaders who then led monthly consultation groups for training participants during the months between the first and second training to help support applying skills learned to further sustain learning. This model was very well received, therefore SCBH will be funding another supervisor training cohort during FY2019/20 and are contracting with Dr. Hardy to provide trainings for staff at all levels.

- **Cultural Humility Champions –** Develop a framework for culture-specific trainings for clinical and non-clinical staff to better understand the populations they are serving and develop recommendations for general training requirements for staff.

    Update: This QI action plan is pending implementation. SCBH plans to leverage an existing team of providers—both county and CBO—who have been working on developing culturally responsive trainings to carry out the mission of this QI action plan.

During FY2018/19 UC Davis CRHD, in partnership with CBO partners, facilitated three (3) community forums, one for each target population Latino, Filipino, and LGBTQ to update the community on the ICCTM project and to solicit

feedback on the QI action plans. Furthermore, as SCBH begins to implement components from the QI action plans, particularly those that involve developing materials for community outreach efforts will be made to solicit feedback from community members from the three target populations through focus groups and existing partnerships with CBOs serving these communities.

## *Policy Changes*

To further promote a system that is culturally responsive and equitable, SCBH has inserted language into all our Requests for Proposals (RFPs) to pull for information related to each prospective agency's efforts towards equity and cultural responsivity. Additionally, starting in FY2017/18 SCBH began to insert more formal language into contracts with behavioral health vendors to require annual cultural competency training for all staff at every level, a requirement to use the CLAS standards as a guide in policy and program development, and an emphasis on the provision of linguistically appropriate services.

**CLAS Standard 2:** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

As mentioned previously starting FY2019/20 SCBH inserted a requirement into all our contracts for vendors to develop their own agency Cultural Responsivity Plans. In July of 2019 a training was held for key staff from each contract agency to better orient them to the CLAS standards, share expectations regarding the content of the plans, and to communicate how the County will support them by providing sample plans and technical assistance. Over the course of the next six months the ESC, County contract managers and the Cultural Competency Committee will work collaboratively with our vendors to assist them in finalizing their agency plans.

## *Equity Collaborations & Partnerships*

The SCBH ESC and other clinical staff participate in an Equity Collaborative with all Solano County H&SS Divisions, i.e. Public Health, Health Services, Administration, Child Welfare, Employment & Eligibility, and other County Departments including General Services, libraries, First 5 Solano, Probation, etc. The Equity Collaborative meets on a quarterly basis and its mission is to foster diversity and inclusion through education, advocacy, policy and systems change throughout Solano County. The Equity Collaborative was developed by H&SS staff who participate in a nationwide network called the Government Alliance on Race and Equity (GARE), which supports local jurisdictions to determine and implement strategies to address inequities experienced within our communities.

Several SCBH staff members are part of the H&SS Community Action for Racial Equity (CARE) Team which is a group comprised of individuals from H&SS Divisions (Public Health, E&E, Health Services, Behavioral Health, etc.). The CARE Team leads the H&SS Department's racial equity efforts which includes the provision of the Advancing Race Equity (ARE) training, training on the use of a Race Equity Tool intended to be used in developing policies, practices and contracting, and organizing caucuses to enhance learning regarding marginalized and underserved communities in Solano County. Additionally, starting in FY2018/19 the CARE Team began to hold caucuses for three (3) target populations: the Latino, African American and the Asian/Pacific Islander communities. There caucuses are attended by H&SS staff—including Behavioral Health staff—who are assisting in identifying the needs of these communities,

developing strategies to better serve the communities and to develop a more inclusive workforce across the H&SS Department.

# Criterion 4: Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System

## *Cultural Competency Committee*

SCBH has an active Cultural Competency Committee that meets quarterly and is led the ESC. The Committee is comprised of county and contractor staff, a peer specialist, consumers, community members and other key stakeholders. The Cultural Competence Committee is not only a state requirement but a vital component of the system of care. SCBH makes every effort to ensure committee participants reflect the demographic profile of our diverse community which includes representatives from the Latino, Asian-American, African American, Native American and LGBTQ communities.

Committee members provide feedback and guidance related to the MHP's implementation of the CLAS standards, provide input for the annual cultural responsivity plan update, formulate and monitor procedures that evaluate the implementation and effectiveness of the MHP's Cultural Responsivity Plan in developing culturally responsive services and practices (Substance Abuse and Mental Health Services Administration, 2014). During FY2018/19 several sub-committees were held which addressed our system's linguistic needs, community outreach efforts for underserved communities, and culturally responsive trainings. Additionally, the quarterly committee meetings were held in locations throughout the county including Vallejo, Vacaville, Fairfield and Rio Vista and efforts were made to invite community members from those communities in order to gather stakeholder feedback regarding efforts related to addressing disparities within the SCBH system of care.

During FY2019/20 the Committee will transition to a monthly meeting format and efforts are being made to recruit new members to include behavioral health providers representing SCBH funded contractors, consumers, family members and SCBH partners. The Cultural Competency Committee developed a new membership form which can be seen in Appendix B. This form was developed to help garner more consistent committee participation and to establish a more formal membership process.

Several initiatives monitored by the Cultural Competency Committee are also reported out to the MHP through the Quality Improvement Committee which meets quarterly and is comprised of county and CBO behavioral health providers and peers representing the consumer voice.

# Criterion 5: Cultural Humility Trainings

## *SCBH Training Efforts*

**Standard 4:** Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

- During FY 18/19 all County staff—including non-clinical staff—were trained in ***"Advancing Race Equity" (ARE)*** developed by the **Government Alliance on Race Equity (GARE).** For more information please use the following link https://www.racialequityalliance.org/about/. Solano County H&SS staff—including SCBH staff—have been trained as ARE trainers, and therefore we were able to train our entire division. The ARE training is being built into the 40hour Crisis Intervention Team (CIT) training that SCBH is developing in partnership with Fairfield Police Department and NAMI Solano. Additionally, the ARE training was made available to the leadership of a local school district who has had racial tensions on school campuses. Due to a strong relationship SCBH has with local law enforcement, the Solano County Office of Education (SCOE) and local school districts we were able to offer train-the-trainer slots for the ARE training to 3 Fairfield Police Department officers, 1 Sheriff Deputy, 1 representative from SCOE and 1 representative from a local school district. Additionally, 2 additional SCBH staff were trained as trainers. By increasing the number of trainers across sectors the hope is that we can offer this training to all our behavioral health contractors, other law enforcement departments and all school districts.
- All SCBH staff were trained in "***Gender Diversity – The Transgender Experience***" during FY2018/19.
- In March of 2019 SCBH hosted, in partnership with Solano Pride Center and #Out4MentalHealth a state funded organization, both an "***Ally Training"*** and "***How to Support LGBTQ Youth Training"*** for staff and administrators from local schools. The trainings were specific to school environments with the target audience being teachers, school counselors and school administrators. Staff from Solano Pride will be trained as trainers in both abovementioned training curriculums which will position them to continue to provide these trainings for all Solano County schools.
- In March of 2019 SCBH funded and co-hosted in partnership with Solano TANF, **"A Path Towards Healing: Native American Forum"**, which provided insight into the historical trauma experienced by the community as well as best practices when working with Native American consumers.
- In August of 2019 SCBH provided **Behavioral Health Interpreter Training (BHIT)** for both bilingual and English-speaking staff on the use of interpreters.
- In October of 2019 a 3-day **Tulong (Help), Alalay (Assistance), and Gabay (Guidance)**, (**TAG) mental health intervention training** was held for local Filipino community members in Solano County. The development of this training curriculum was a result of a grassroots approach that educates civil society to identify warning signs and symptoms of the most common mental health problems, to triage any actively suicidal person and connect them to professional help. TAG follows the simple format of Psychological First Aid by the WHO and the Disaster Crisis Intervention program done in San Francisco, Kamalayan (Youth Crisis Intervention Program for Filipino students). The training included one day of the basics and two days of a train-the-trainer model to prepare training participants to conduct the TAG training in order to raise awareness in their own communities.

- During FY2017/18 a train-the-trainer cohort was identified and trained to provide Cultural Competency (CC) 101 and CC 102 trainings which had been developed by UC Davis CRHD in support of the ICCTM MHSA Innovation Project. Since that time the cohort—now called the Diversity and Social Justice Trainers—have developed a more comprehensive "***Diversity and Social Justice Training"*** which is an introduction training that is now available on-line at **https://vimeo.com/374531348**.


This training will be required for all staff in 2020 and will include discussions during team meetings and additional resources such as implicit bias test, videos, and articles staff can utilize to support their cultural and linguistic responsiveness efforts. The training is intended is intended to introduce staff to SCBH's culturally responsive strategies, provide an overview of human diversity and disparities and provide a foundational understanding and shared language around core concepts for social justice education. This training will be available to county and contractor behavioral health staff. See Appendix A to view discussion questions, pre/post evaluation, and additional resource guide for staff. In addition to this initial training, the Diversity and Social Justice Trainer cohort will be developing additional in-person and on-line trainings to address disparities and to assist staff in better serving underserved and marginalized communities. This is the trainer cohort that will assist with implementing the Cultural Humility Champions QI action plan that was developed through the MHSA ICCTM Innovation project.

# Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining

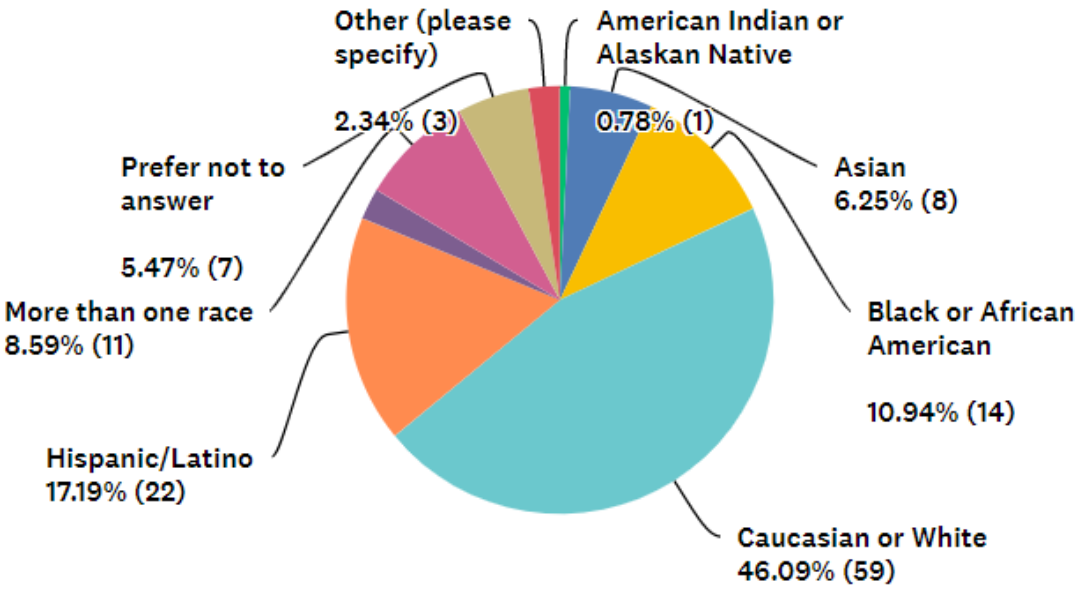
## *Workforce Equity Survey*

Over the past 3 years, SCBH has administered a "Workforce Equity" survey to monitor and evaluate the demographics of our workforce, participation in cultural humility trainings, job satisfaction, and attitudes towards equity and inclusivity efforts. The FY2019/20 "Workforce Equity" survey was administered in October of 2019 and yielded 129 responses. The results show that:

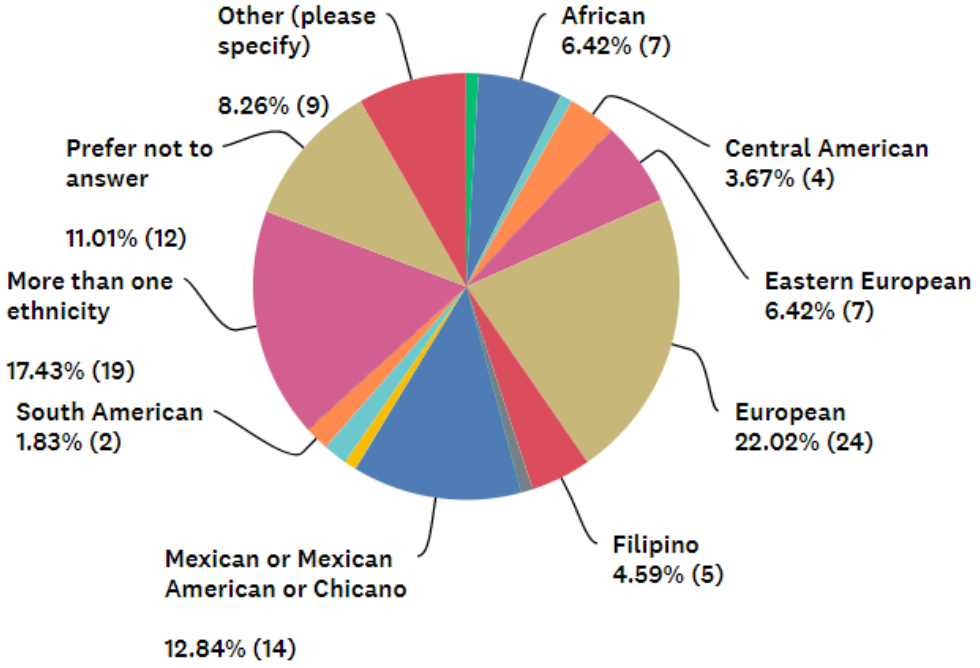
- 81% total respondents reported receiving Cultural Responsivity training in the past year

- 12% are certified bilingual county employees (89% Spanish and 11% Tagalog), while 25% of the contractor providers identified as bilingual (100% Spanish and 0 Tagalog).

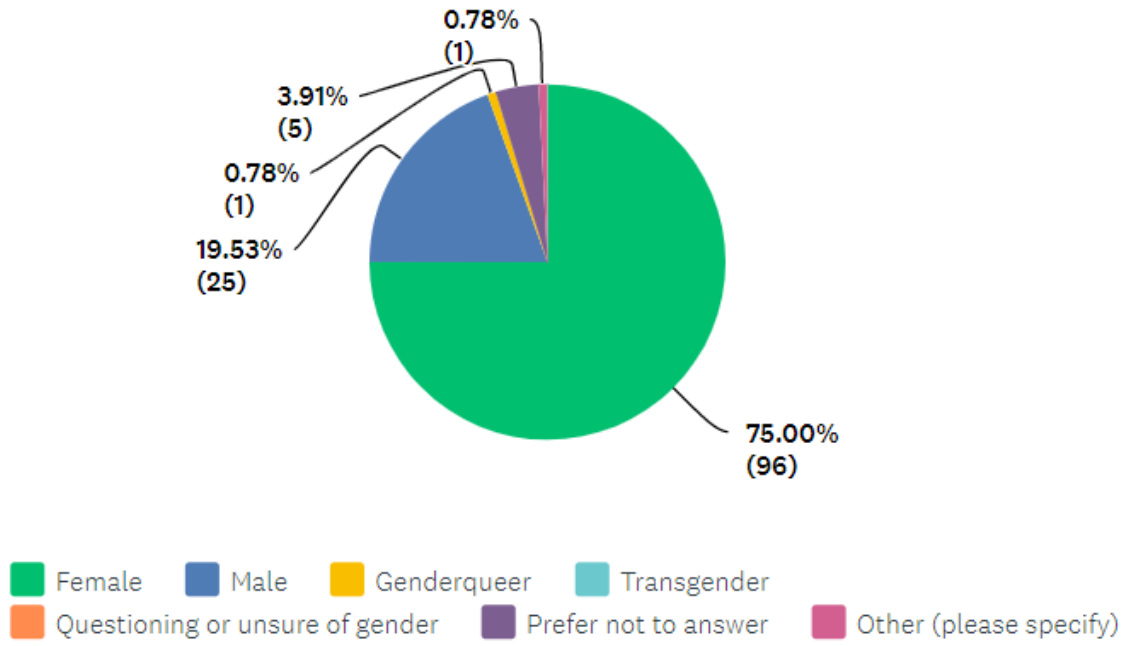
## Race



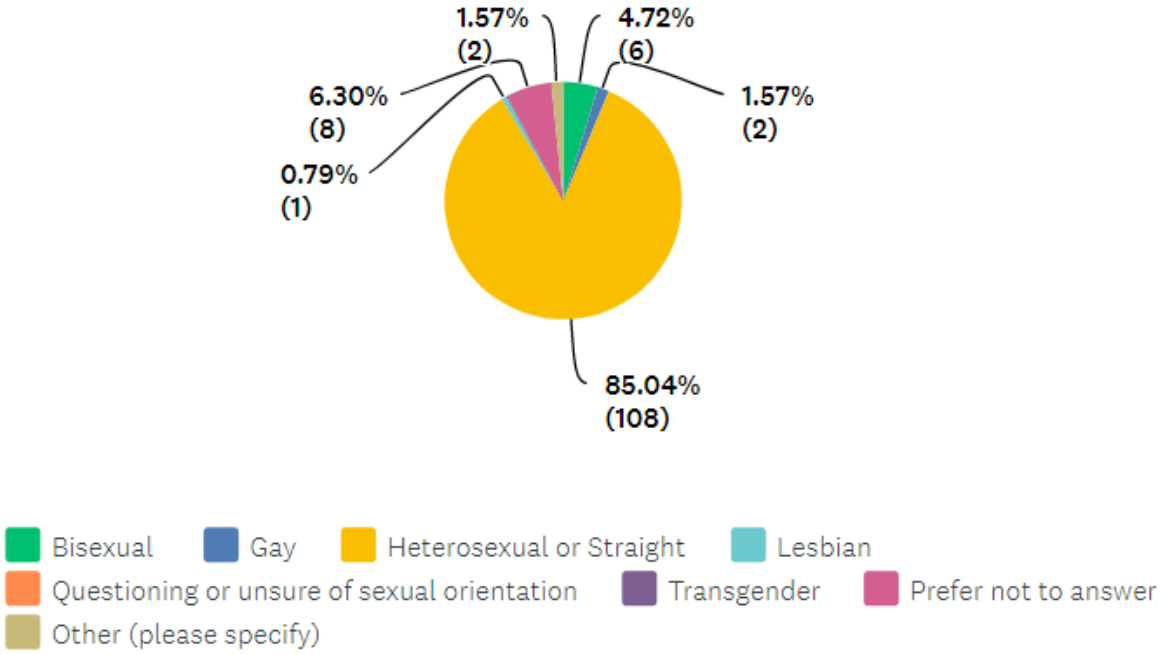

## Ethnicity



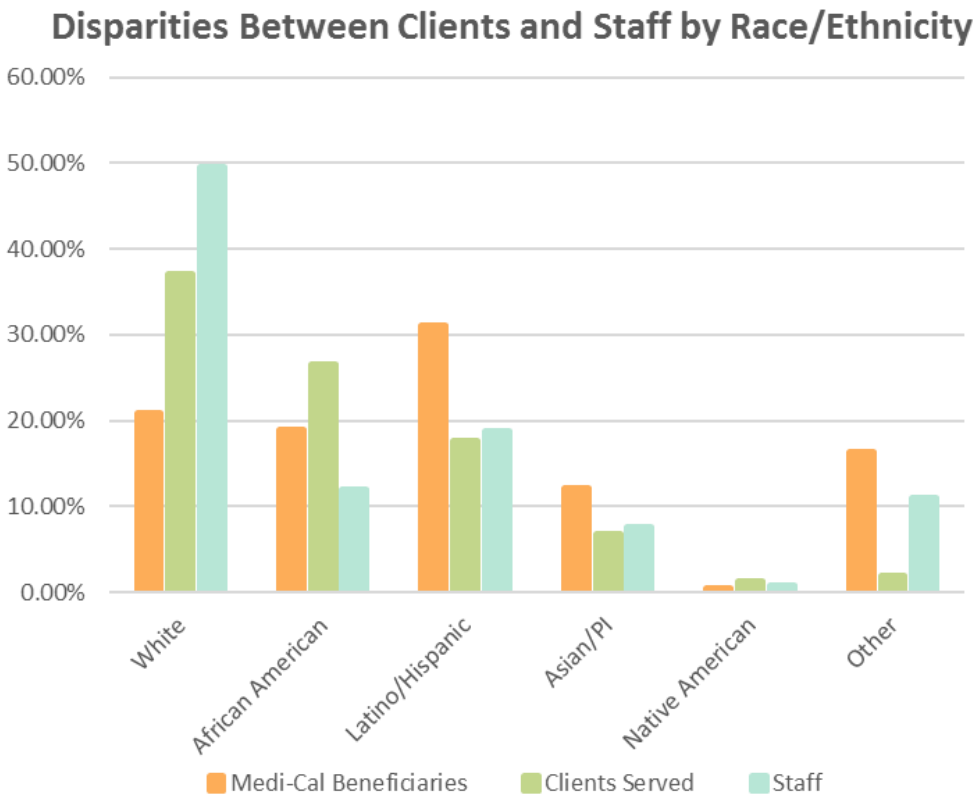

## Gender Identity




## Sexual Orientation



Furthermore, the chart below shows a disparity between eligible Medi-Cal population (those that receive the Medi-Cal insurance benefit), current beneficiaries served by the MHP, and our current County/contractor staff.




The above chart highlights some of the inequities that exist within our system of care. Inferences can be made regarding eligible beneficiaries who might not be receiving culturally and linguistically responsive engagement as well as necessary treatment due to outreach by staff who do not represent their culture. We have identified significant disparities within the African-American/Black, Asian/Pacific Islander (Predominantly Filipino), Latino/Hispanic, and Native American communities. SCBH hires quality, bi-lingual staff whenever possible – a workforce challenge generally experienced statewide. There has been a historical shortage of applicants who speak Spanish and Tagalog, our top two non-English languages. Solano County consists of many rural towns such as Rio Vista, Dixon and others which often include residents identified as foreign born or other language speakers. Many of the people in these communities and throughout other prominent areas of our county have difficulties with securing basic needs such as housing, transportation, access to healthcare services, and have limited education related to the needs and benefits of behavioral health treatment. These areas are critical for SCBH outreach and engagement efforts for some of our most vulnerable populations.

# *Workforce Demographic Comparison: 2017-2019*

Please see the demographic characteristics of SCBH's workforce from 2017 to 2019. Although the data is limited due to the lack of full participation from county and contractor staff, it summarizes some of the diversity within our workforce as well as the need for more adequate representation from some of our underserved and underrepresented populations. Data is displayed below however, it is important to highlight some key findings:

- It is 0.45 times more likely that individuals are openly identifying as gay or lesbian compared to 2018
- There is a significant difference in the prevalence of those having received cultural competency training in the past year.

- Whereas there were significant differences across years in sex/gender identification among contracted partner/CBO staff, sex/gender identification did not differ across years in SCBH staff

*Table 3a.* Language and Certification Characteristics of Bilingual Behavioral Health Workforce in Solano County from 2017 to 2019

| | 2017 | 2018 | 2019 | *P* |
|---|---|---|---|---|
| | N (%) | N (%) | N (%) | value |
| **Total Participants:** | 98 (100.0) | 51 (100.0) | 36 (100.0) | N/A |
| **Speak Spanish** | | | | |
| Yes | 62 (63.3) | 35 (68.6) | 25 (69.4) | .714 |
| No | 36 (36.7) | 16 (31.4) | 11 (30.6) | |
| **Speak Tagalog** | | | | |
| Yes | 6 (6.1) | 7 (13.7) | 3 (8.3) | .292 |
| No | 92 (93.9) | 44 (86.3) | 33 (91.7) | |
| **Speak Other Language** | | | | |
| Yes | 33 (33.7) | 14 (27.5) | 12 (33.3) | .726 |
| No | 65 (66.3) | 37 (72.5) | 24 (66.7) | |
| **Received Interpreter Training** | | | | |
| Yes | 9 (9.2) | 4 (7.8) | 15 (41.7) | **<.001** |
| No | 66 (67.3) | 40 (78.4) | 13 (36.1) | |
| **Compensated Bilingual Staff** | | | | |
| Yes | 36 (36.7) | 16 (31.4) | 12 (33.3) | .795 |
| No | 62 (63.3) | 35 (68.6) | 24 (66.7) | |

*Note.* Percentages may not add up to 100 due to missing responses

*Table 3b.* Language and Certification Trends in Bilingual Behavioral Health Workforce in Solano County from 2017 to 2019

| | Odds Ratio (95% Confidence Interval) | *P* value |
|---|---|---|
| **Speak Spanish** | | |
| Yes vs. No | 1.17 (0.79, 1.73) | .441 |
| **Speak Tagalog** | | |
| Yes vs. No | 1.29 (0.69, 2.41) | .432 |
| **Speak Other Language** | | |
| Yes vs. No | 0.95 (0.64, 1.41) | .805 |
| **Received Interpreter Training** | | |
| Yes vs. No | 2.92 (1.68, 5.07) | **<.001** |
| **Compensated Bilingual Staff** | | |
| Yes vs. No | 0.90 (0.61, 1.34) | .614 |

*Note.* ^values may be omitted due to insufficient cell sizes

*Table 1a.* Demographic Characteristics of Behavioral Health Workforce in Solano County from 2017 to 2019

| | 2017 | 2018 | 2019 | *P* |
|---|---|---|---|---|
| | N (%) | N (%) | N (%) | value |
| **Total Participants:** | 274 (100.0) | 177 (100.0) | 128 (100.0) | N/A |
| **Agency** | | | | |
| SCBH | 119 (43.4) | 80 (45.2) | 72 (56.2) | **<.001** |
| Contracted Partner | 144 (52.6) | 92 (52.0) | 39 (30.5) | |
| **Age Group** | | | | |
| 16-25 years | 6 (2.2) | 5 (2.8) | 2 (1.6) | .291 |
| 26-59 years | 212 (77.4) | 151 (85.3) | 102 (79.7) | |
| 60-84 years | 44 (16.1) | 20 (11.3) | 19 (14.8) | |
| 85+ years | 2 (0.7) | 0 (0.0) | 0 (0.0) | |
| **Race/Ethnicity** | | | | |
| White or Caucasian | 123 (44.9) | 79 (44.6) | 60 (46.9) | .970 |
| Black or African American | 31 (11.3) | 21 (11.9) | 14 (10.9) | |
| Hispanic or Latino | 39 (14.2) | 27 (15.3) | 22 (17.2) | |
| Asian or Pacific Islander Filipino American | 14 (5.11) | 10 (5.6) | 5 (3.9) | |
| Asian or Pacific Islander Non-Filipino American | 17 (6.2) | 8 (4.5) | 7 (5.5) | |
| American Indian or Alaskan Native | 2 (0.7) | 1 (0.6) | 1 (0.8) | |
| Other race/ethnicity | 3 (1.1) | 2 (1.1) | 1 (0.8) | |
| More than one race/ethnicity | 31 (11.3) | 25 (14.1) | 10 (7.8) | |
| **Sex/Gender Identity** | | | | |
| Male | 46 (16.8) | 22 (12.4) | 25 (19.5) | .437 |
| Female | 219 (79.9) | 147 (83.1) | 95 (74.2) | |
| Transgender | 2 (0.7) | 2 (1.1) | 0 (0.0) | |
| Genderqueer | 0 (0.0) | 0 (0.0) | 1 (0.8) | |
| Other sex/gender identity | 1 (0.4) | 1 (0.6) | 1 (0.8) | |
| **Sexual Orientation** | | | | |
| Heterosexual | 219 (79.9) | 153 (86.4) | 107 (83.6) | **.013** |
| Gay or Lesbian | 14 (5.1) | 0 (0.0) | 3 (2.3) | |
| Bisexual | 15 (5.5) | 9 (5.1) | 6 (4.7) | |
| Queer | 0 (0.0) | 3 (1.7) | 0 (0.0) | |
| Questioning | 3 (1.1) | 1 (0.6) | 0 (0.0) | |
| Other sexual orientation | 2 (0.7) | 0 (0.0) | 2 (1.6) | |

*Note.* Percentages may not add up to 100 due to missing responses

# Criterion 7: Communication and Language Assistance

## *Linguistic Initiatives*

The threshold language in Solano County is Spanish and Tagalog is a sub-threshold language. SCBH continues to contract with Language Link to assist with linguistic needs including translating documents and interpreter services—both in person and phone. Language Link is frequently offered to consumers during initial calls to the Access line and during outpatient treatment. In January of 2020 SCBH will expand the contract H&SS has with Language Link, vendor for interpreter services, to allow our behavioral health contractors to utilize our service for uniformity and to be able track the utilization of interpreter/translation services to better track the linguistic needs of our community.

In August 2019, a Behavioral Health Interpreter Training (BHIT) for bilingual staff will be offered and is focused on supporting bilingual staff in learning behavioral health terminology (both in Spanish the threshold language and Tagalog which is a sub-threshold language), learning how to hold the role of interpreter when asked to support English speaking colleagues, and learning laws and ethics related to the provision of interpreting services. Additionally, a BHIT session was held for monolingual English-speaking staff on best practices related to using interpreter services. During FY2019/20 several more rounds of Behavioral Health Interpreter Training (BHIT) for English speaking staff will be offered with a focus on teaching providers how to appropriately utilize interpreters, how to understand laws and ethics related to the provision of linguistically appropriate services, and how to access the County's interpreter services. One session will be dedicated to supporting front desk reception staff in the use of interpreter services.

**CLAS Standard 5:** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

**CLAS Standard 6:** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

**CLAS Standard 7:** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

**CLAS Standard 8:** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

During FY2017/18 and FY2018/19 SCBH leveraged Mental Health Block Grant (MHBG) first episode psychosis (FEP) funding to enable U.C. Davis – Behavioral Health Center of Excellence, who is the contractor who supports the local early psychosis treatment program, to translate materials used in treatment. The translated materials were made available for first-episode consumers and their families for the threshold language of Spanish to improve access to care for diverse populations. In addition to the translation of the materials, the County funded U.C. Davis to provide specialized training and support for the implementation of the newly translated materials with the program direct service staff. These translated materials are now being used in the Sacramento County early psychosis program and will be shared with other Counties in California.

# Criterion 8: Engagement, Continuous Improvement, and Accountability

## *CLAS Organizational Assessment Report*

In partnership with the UC Davis Center for Reducing Health Care Disparities, SCBH senior leadership (BH Director, Adult Administrator, Senior Manager and Ethnic Services Coordinator) completed the CLAS Organizational Assessment during this FY which is a tool that evaluates an organization's implementation of the 15 National Standards for Culturally and Linguistically Appropriate Services (CLAS). This assessment was adapted from the Communication Climate Assessment Tool by Matthew Wynia and colleagues. It has been endorsed by the US Department of Health & Human Services' Office of Minority Health as well as the National Quality Forum. The assessment pulls for information related to efforts made within the last six (6) months. After completing the assessment, UC Davis provided SCBH a detailed report which highlighted some of the county's strengths and areas for improvement. The following pages provide an overview of findings from the assessment.

**Standard 10:** Conduct ongoing assessments of the organizations CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

## *Strengths*

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| **CLAS Standard 1:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. | Over the past 6 months: SCBH has taken steps to create a more welcoming environment for consumers, to promote a more consumer-centered environment and made effective communication with diverse populations a priority. |
| **CLAS Standard 2:** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. | Over the past 6 months: SCBH'S mission, vision, and strategic plan illustrates our commitment to culturally and linguistically appropriate care; and senior leaders have allocated resources annually to meet the cultural and linguistic needs of its consumers. |
| **CLAS Standard 6:** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. | In each clinic lobby—both county and contractor—there is signage that informs consumers about the availability of no-cost language assistance. SCBH plans to enhance efforts to ensure consumers are better informed of the availability of language assistance services. |
| **CLAS Standard 10:** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. | During the past 6 months: Senior leaders have conducted routine self-assessment/audit of organizational policies, procedures, and practices to evaluate its implementation of the CLAS Standards; SCBH sought feedback from consumers and the community on how the organization can improve its delivery of culturally and linguistically appropriate services through the MHSA CPP process and |

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| | the ICCTM MHSA Innovation project; utilized the results of organizational self-assessments to revise its policies and practice to better provide culturally and linguistically appropriate services. In addition, during the past 6 months, supervisors have asked for staff suggestions on how to improve communication within the organization and used staff feedback to improve communication within the organization. |
| **CLAS Standard 11:** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. | SCBH has an organizational policy and practices in place to document a consumer's race/ethnicity, language preference, need for interpreters, desire and motivation to learn, cultural/religious beliefs, emotional barriers, cognitive barriers, physical limitations and need for transportation assistance. |
| **CLAS Standard 12:** Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. | SCBH has routinely assessed the needs and assets of its service community through the MHSA CPP process and in partnership with local community and advocacy groups to collect information about new and emerging populations. During the past 6 months, SCBH has used community needs and assets data to evaluate the accessibility of health services within the community, generated profile reports of its various service community populations, identify and report on potential disparities in care or services to community leaders and stakeholders, improve delivery of culturally and linguistically appropriate services and inform staff about resources for consumers that are available in the community. Furthermore, UC Davis CRHD will continue to work in partnership with SCBH to evaluate the effectiveness of the ICCTM MHSA Innovation project. |
| **CLAS Standard 13:** Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. | During the past 6 months: SCBH has implemented written plans for developing relationships with consumer communities it serves, charged several individuals to conduct outreach and maintain ties to community partners and unserved/underserved communities, worked to build alliances and coalitions between different community partners to improve the delivery of culturally and linguistically appropriate services, shared data and findings with community partners to improve service delivery and involved community representations in its planning processes. SCBH has worked with community partners to co-locate staff or provide presentations to educate consumers on how to access social services and available care, to promote health literacy, to educate adults and youth about mental health, schools to educate students about mental health careers, schools to establish volunteer |

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| | or internship program opportunities in mental health services and faith organizations to advance mental health. |
| **CLAS Standard 14:** Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. | During the past 6 months: Staff have communicated with one another respectfully, effectively to ensure high quality care, shown that they care about communicating effectively with diverse populations, communicated well with consumers over the phone, known whom to call if they had a problem or suggestion and spoken openly with supervisors about any miscommunications; SCBH has implemented steps to enhance the grievance resolution process for consumers, to ensure that the process is culturally and linguistically appropriate, tracked communication-related complaints and designated a point of contact for community members to provide complaints and feedback. |
| **CLAS Standard 15:** Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public. | During the past 6 months: SCBH has informed community members about its efforts to implement the CLAS standards through the ICCTM Innovation project in addition to efforts to promote wellness in their neighborhoods and strategized with community partners on how to report on its progress towards making services more culturally and linguistically appropriate; through the MHSA CPP process, community forums held by UC Davis CRHD, and the Cultural Competency Committee SCBH has provided opportunities to engage the community to share progress towards making services more culturally and linguistically appropriate. |

# *Areas for Improvement*

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| **CLAS Standard 3:** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. | Over the past 6 months: SCBH senior leaders have not closely monitored the retention of staff that provide high quality culturally competent services. SCBH senior leaders recognize that efforts need to be made to strengthen our intern program to establish diverse candidate pools by recruiting employees through minority professional fairs, job boards, publications, and other specialized media networks. For five years MHSA workforce education and training (WET) funds have been allocated to internship stipends, however the stipends have been under-utilized. Starting in FY2019/20 one staff person has been assigned to take on a leadership role to recruit interns. Additionally, the Cultural Game Changers QI action plan through the |

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| | ICCTM project includes a pipeline component including working with local high schools to raise awareness of career paths within Behavioral Health. |
| **CLAS Standard 4:** Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. | While efforts have been made to increase cultural competency training, SCBH senior leadership is aware that additional efforts need to be made to provide staff with adequate training on how to ask consumers about their health care values and beliefs, how to ask about their racial/ethnic background in a culturally appropriate way, the impact of miscommunication on consumer safety or ways to check whether consumers understand instructions. The Culturally Responsive Supervision QI action plan through the ICCTM project involved training for Supervisors to provide support for staff to provide culturally responsive services. There are plans to provide a number of trainings related to cultural and linguistic responsivity during FY2019/20. |
| **CLAS Standard 5:** Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. | SCBH has identified a need to train staff to be more intentional in determining if consumers need assistance in filing out organizational forms and determining whether consumers need an interpreter. While staff throughout the system of care have had adequate training in how to utilize Language Link, the vendor for interpreter services, senior leadership recognize that trainings in use of interpreters and how to access Language Link needs to be offered to all staff as a mandatory training and be available for onboarding all new staff. Several trainings related to language assistance were offered in FY2018/19 and more sessions are planned for FY2019/20 Additionally, the Language Link service will be made available for contractors. While SCBH is provided data related to the utilization of Language Link efforts need to be made to analyze this data particularly related to how long individuals waited for interpreters. |
| **CLAS Standard 7:** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. | SCBH has historically not routinely assessed the competence and skills of its bilingual staff or contracted interpreters. In August of 2019 a BHIT training was held for bilingual staff and a component of the training was an evaluation of linguistic competency. The findings of this evaluation will be used to train and support bilingual staff to improve competencies. SCBH will work with our interpreter vendor to better gather information related to their internal assessment of linguistic competencies of their staff. |

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| **CLAS Standard 8:** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. | Over the past 6 months: SCBH has not distributed user-friendly guides on community resources to consumers (materials in alternative formats for individuals with varying sensory, developmental, cognitive, or other access needs…such as printed guides for those with limited internet access), posted culturally and linguistically appropriate signage in its service area or sought feedback from the community about whether its media materials were culturally and linguistically appropriate. While the majority of consumer forms have been translated into Spanish there were some forms identified that had not been translated. Since that time these forms have been translated and efforts are being made to monitor the translation of forms more closely. During FY2019/20 SCBH will have all consumer forms translated into the sub-threshold language of Tagalog using MHSA Innovation funding. Peer Support Specialists co-located in adult clinics are offering support for consumers to complete forms that are long and may be difficult to complete without assistance. |
| **CLAS Standard 9:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations. | SCBH leadership acknowledges that it would like to improve its signs, maps and interpretation services. SCBH has not established a process for evaluating how well it meets written goals for effective communication. |

# Appendices

## *Appendix A: Diversity and Social Justice Training Resources*

### DIVERSITY AND SOCIAL JUSTICE TRAINING ADDITIONAL RESOURCES

Please feel free to utilize the links below to learn more about the various social justice topics addressed throughout this training. This content can be utilized to help facilitate ongoing discussions with hopes of normalizing such conversations and promoting an inclusive environment.

**Videos:**

- The Model Minority Myth is a pervasive stereotype of Asian Americans in the United States. The stereotype continues to have a harmful effect on both individuals and Asian American communities.
- Stella Young's Ted Talk on ableism which highlights society's habit of viewing disabled people as inspiration.
- This video provides various perspectives on the different types of Microaggressions and the impacts they have on people of marginalized communities.

**Tests:**

- Project Implicit helps individuals discover their implicit associations about race, gender, sexual orientation, transgender people, and topics related to mental health. Click here to learn more.

**Readings:**

- Mass Shootings and Mental Illness: Click here
- Reflections on cultural humility: Click here

**References:**


- Adams, M. (2018). Reading for Diversity and Social Justice (4th ed.). New York, NY: Taylor & Francis.
- Mental Health Disparities: Diverse Populations. (n.d.). Retrieved July 24, 2019, from https://www.psychiatry.org/psychiatrists/cultural-competency/mental-health-disparities
- National Institute on Drug Abuse. (2019, January 29). Overdose Death Rates. Retrieved July 24, 2019, from https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

# DIVERSITY AND SOCIAL JUSTICE TRAINING
# POST TRAINING DISCUSSION GUIDE

The following questions can be used as a guide immediately after viewing the video presentation to help facilitate conversations during team meetings and/or during individual supervision for new staff who are onboarding to behavioral health. When facilitating such conversations, it is often helpful to reflect on some of your personal experiences especially if these are not normal conversations for your team/staff. You do NOT need to ask every question listed below but feel free to use these questions as a guide while you facilitate this discussion.

**Recommended Discussion Prompts:**

1.) What are your initial thoughts after watching this video? Was there anything that resonated with you about any of the topics reviewed?
2.) Why is it important for Behavioral Health staff to understand these core concepts of social justice education and the inequities different groups continue to experience in society?
3.) Is there anyone willing to share any personal experiences that stand out for you that made you especially aware of a privileged or disadvantaged identity? **(As a facilitator, it helps to model first if the group is unwilling to share)**
4.) One of the quotes shared in the training came from a community member who stated, “Staff should treat clients as human beings rather than assume they are potentially violent. I have had no violent history and have never hurt anyone, yet staff assumed I would become violent.” What are things we can do as a system and individually to help prevent people from feeling this way about our services?
5.) What are some of common stereotypes about people experiencing severe mental illness?
6.) What are ways we can help change this narrative?
7.) As we learned in the video, microaggressions are the everyday verbal or nonverbal insults that cause harm to target groups such as clinicians stating “That’s not my job” when asked to do clerical task or “You’re not like the other back people I know. You speak so well.” Have you ever observed or overheard a microaggression in the workplace, your neighborhoods, schools, or families?
8.) Have you tried to interrupt a microaggression? Can you provide an example of interrupting a microaggression successfully? **(Microaggressions can be directed towards staff and community members so having a discussion amongst your team can help staff address any issues that may arise in the future especially since cultural humility is a lifelong journey for all of us)**

Date:

# Pre-Evaluation Survey

| True or false: mark with an "x" next to each statement to select if it is true or if it is false. | | |
|---|---|---|
| **TRUE** | **FALSE** | **STATEMENT** |
| | | **People with serious mental illness contribute to about 3% of all violent crimes.** |
| | | **Compared with men, women are twice as likely to experience PTSD.** |
| | | **In 2018, nearly 40% of African Americans, Latinx, and Native Americans did not earn enough income to cover their basic needs in Solano County.** |
| | | **People of color, religious minorities, women, and members of the LGBTQ community live under constant threats of violence in our society.** |
| | | **Individuals with disabilities are the largest minority group in the world.** |
| | | **Implicit bias can impact our thoughts and decisions we make about people and groups based on their characteristics (i.e. race, ethnicity, religion, etc.)** |

Date:

# Post Evaluation Survey

| True or false: mark with an "x" next to each statement to select if it is true or if it is false. | | |
|---|---|---|
| **TRUE** | **FALSE** | **STATEMENT** |
| | | **People with serious mental illness contribute to about 3% of all violent crimes.** |
| | | **Compared with men, women are twice as likely to experience PTSD.** |
| | | **In 2018, nearly 40% of African Americans, Latinx, and Native Americans did not earn enough income to cover their basic needs in Solano County.** |
| | | **People of color, religious minorities, women, and members of the LGBTQ community live under constant threats of violence in our society.** |
| | | **Individuals with disabilities are the largest minority group in the world.** |
| | | **Implicit bias can impact our thoughts and decisions we make about people and groups based on their characteristics (i.e. race, ethnicity, religion, etc.)** |

| Place an "x" in the appropriate column that reflects your response to the statements | | | | | |
|---|---|---|---|---|---|
| **Statements** | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
| **I am more aware of the disparities different groups experience in Solano County including access to quality behavioral health services.** | | | | | |
| **I learned something new from this training.** | | | | | |
| **I feel more comfortable having conversations about social justice at work.** | | | | | |
| **I would recommend other colleagues to attend this training.** | | | | | |
| **The PowerPoint presentation and training materials were clear and understandable.** | | | | | |
| **The instructors were clear and explained topics thoroughly.** | | | | | |

**Any additional comments?**

# *Appendix B: Cultural Competency Committee Participation Agreement*

Dear Potential Committee Member:

The Solano County Behavioral Health (SCBH) Cultural Competency Committee is facilitated by the Ethnic Services Coordinator Eugene Durrah. The committee is comprised of representatives from County departments, community-based organizations and other key stakeholders who are committed to producing equitable health outcomes for Solano County residents.

The mission of the Cultural Competency Committee is to focus on effectively serving our County's diverse population by understanding and respecting the value cultural differences play in providing quality mental health services to our community. Committee members oversee the organizations self-assessment process, develop the cultural responsivity plan, formulate and monitor procedures that evaluate the implementation and effectiveness of the organization's plan in developing culturally responsive services and practices.

To fulfill our goal of having adequate representation from our diverse community, we continue to recruit new members who will be able to dedicate time and efforts to the cause. ***We are looking for individuals that are able to commit to attending monthly meetings and/or sending a representative on their behalf when unable to attend, and who are able to commit additional time to attend sub-committees that are assigned to work on specific projects or to be contributors in regard to reviewing documents that are being developed.*** If you are still interested in participating in the County's health equity related activities but are unable to make the commitment to participating on this Committee, please note that there will be opportunities to provide your support through attending stakeholder meetings, community survey's, etc.

Thank you for your consideration in joining the Cultural Competency Committee and your dedication to health equity within Solano County. Please complete the Participation Commitment Form on the following page which covers the specific time commitment you can agree to at this time. Also, please note that for individuals that are representing organizations we are asking that you review this letter and the Participation Commitment Form with your supervisor to secure approval to participate in the Committee meetings and other projects as they come up.

Regards,

*Eugene Durrah, LCSW*
MHSA Clinical Supervisor/Ethnic Services Coordinator
Solano County Behavioral Health
Phone: 707-784-4931 (Office)
Email: EADurrah@solanocounty.com

# Participation Commitment

| | |
|---|---|
| Name: | |
| Position: | |
| Agency (if applicable): | |
| Email: | |
| Phone #: | |
| Direct Supervisor: | |
| Direct Supervisor's Email: | |
| Direct Supervisors Phone #: | |

In the space provided below, please provide a brief statement regarding what interests you, or motivates you to participate in the Solano County Cultural Competency Committee.

Please mark the level of participation you estimate you or your employee can commit to:

| | | |
|---|---|---|
| Larger Committee (2.5 hrs per month) | Attend the monthly meeting two and half hour meeting. The time commitment includes estimated travel time as needed. | ☐ |
| Larger Committee & Ad Hoc Sub-Committees (~ 6 hrs per month) | Attend the monthly meetings and additional sub-committees as needed to work on specific initiatives. The time commitment includes estimated travel time as needed. | ☐ |

_____

New Committee Member Signature Date

_____

Direct Supervisor Signature Date