California Department of Mental Health Cultural Competency Plan Requirements

COVER SHEET

Due December 31, 2022, to:

Department of Health Care Services (DHCS) via email: MCBHD.CCPR@dhcs.gov

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FY 2021/2022 UPDATE: Monterey County Cultural Competency Plan Requirements

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CRITERION I:

COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The County shall include the following in the Culture Competency Plan Requirement Report:

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

Monterey County FY 21/22 Cultural Competency Plan Requirement Report (CCPR) is written to satisfy the requirements under the Mental Health Services Act and the Medi-Cal Wavier. A full copy of Monterey County Behavioral Health (MCBH) Bureau's culturally relevant policies and procedures can be found HERE. MCBH will have the documents outlined below during the site compliance review.

The County shall include the following during the on-site during the compliance review:

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

i. Mission Statement
ii. Statements of Philosophy
iii. Strategic Plans
iv. Policy and Procedure Manuals
v. Human Resource Training and Recruitment Policies
vi. Contract Requirements
vii. Other Key Documents

II. County Recognition, Value and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within System.

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

The County shall include the following in the CCPR:

A. A description not to exceed two pages of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Community Program Planning Process for the Mental Health Services Act

The primary mechanism for obtaining diverse input to local mental health planning processes and services occurs on an annual basis during the Community Program Planning Process (CPPP) for the Mental Health Services Act (MHSA). For the MHSA annual update for FY 22/23, which covers the reporting period for this CCPR, MCBH contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. The purpose of this needs assessment was to collect primary data from community members and providers about the current mental and behavioral health issues in Monterey County and to gather suggestions for improving access to care and services and reducing health disparities.

Between November 2021 and January 2022, online surveys and focus groups were used for data collection. The two surveys, a Provider Survey (n=276) and a Community Member Survey (n=200), were administered throughout the community. Each instrument was designed to gather perspectives on the current state of mental and behavioral health services and needs in Monterey County. Seven focus groups (n=56) were conducted in December 2021 and January 2022. Ten focus groups were scheduled; two had no participants and one had to be cancelled due to COVID-19 staff outages.

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A list of community organizations was developed in a purposeful way to reflect a diverse set of voices within the community. To accommodate a population that did not have access to technology or were uncomfortable using it, one focus group was held with the community members at the host site and the facilitator joined virtually. Two focus groups were conducted in Spanish, and one in English and Spanish using a translator.

The results indicate that community members and providers identify the major mental and behavioral health issues as anxiety, chronic stress, depression, alcohol/substance use, and trauma. The major contributing factors to mental and behavioral health issues were reported as homelessness; financial stress, unemployment, or lack of job opportunities; stressful childhood experiences; COVID-19; and stigma and discrimination. For availability of services, the population identified by the highest percentage of providers as being available but insufficient to meet the need was among persons who are low-income. Focus group participants shared concerns about long wait lists and the affordability of services. Community members noted the biggest barriers to services is the cost of services; providers identified it as a lack of knowledge about available services and services for Indigenous language speakers. Focus group participants made comments about both issues being barriers as well as stigma. Providers noted many strengths of the County's Behavioral Health services, such having services available in different languages, telehealth, dedicated and helpful staff, collaboration with other agencies, and targeting underserved populations.

The recommendations included a need for stigma reduction education and campaigns, more providers, more services available in different languages, additional promotion about how to connect to services, and a central source for service information. MCBH provides services to many people in need, including underserved populations. There is a need to improve access to services and reduce barriers. COVID-19 has impacted the community in many ways and hence the need for services appears to have increased, especially in areas such an anxiety. MCBH will need to leverage resources and continue to work with partners to meet this increased need. View the complete Community Needs Assessment in English HERE and in Spanish HERE.

Outreach and Engagement for Communities with Mental Health Disparities

In FY 21/22, MCBH released a Request for Proposals (RFP) for Culturally Specific Prevention and Early Intervention Services with the intention of creating a continuum of support for vulnerable and historically underserved populations

including: Latinos, African Americans, Black and LGBTQ+ individuals. MCBH encouraged providers to include in their proposals *Promotores*, Community Health Workers and/or Peers that are representative of diverse populations as an effective strategy in connecting with community members, engaging, and effectively supporting historically marginalized populations to access mental health care and other resources.

As a result of the RFP, MCBH awarded 5 multi-year contracts in FY 21/22 for a total of $768,817 to community-based programs and these contracts continued in FY 22/23. Each program has provided Culturally Specific Outreach and Engagement specific to a racial, ethnic, or cultural group that has been historically underserved. Programming includes a) social marketing campaigns, b) community presentations, c) outreach events, and d) other promotional activities to engage historically underserved populations in mental healthcare and in programming to support their health and wellness. Holistic wellness activities that reduce isolation, promote resilience, recovery and social connectedness for each cultural group has been provided by several contractors depending on the population of focus.

Under these contracts, the specific communities that have been served include African Americans, Black, Hispanic, Latinx, and LGBTQ+ youth. A specific landing page highlighting available Behavioral Health resources for these communities has been developed and can be found in English with the URL www.Wellness4Us.org and in Spanish with the URL www.BienestarParaTi.org. In addition, the contractor that developed this landing page engaged in a Narrowcast Campaign which is a media and outreach strategy that places targeted messages in community venues within neighborhoods. This placement allows individuals from the intended audience to be exposed to materials in places they visit frequently and trust. The multi-month campaign targeted underserved neighborhoods in Monterey County and placed materials in venues including public libraries, Community Centers, Medical Offices, Counseling Centers, Hair & Barber Salons, Laundry Mats, Restaurants, Smoke Shops, and more. Materials included bilingual brochures, posters and countertop displays referring people to the landing pages noted earlier. Additional outreach strategies to promote awareness included hosting booths at two large community events and partnership with radio stations.

An update on these and other efforts funded under the Mental Health Services Act Prevention and Early Intervention (PEI) funding will be included in the MHSA Prevention and Early Intervention FY 2021-22 Evaluation Report which will be

produced in accordance with the MHSA PEI regulations and timeline. This information will be available under the MHSA section of the MCBH website found HERE or upon request.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

Committees & Commissions:

Cultural Relevancy and Humility Committee

During FY 21/22, MCBH facilitated the Cultural Relevancy and Humility Committee (CRHC), (the MCBH Cultural Competency Committee for mental health and substance use disorders) in 9 out of 12 months. This Committee includes community members, clients, family members of clients, providers and MCBH staff with the focus of providing MCBH with guidance and input to address racial and ethnic disparities and to ensure Behavioral Health programs and services are culturally relevant to Monterey County residents. More on this Committee will be discussed in Criterion 4.

Behavioral Health Commission

MCBH has a collaborative relationship with the Behavioral Health Commission (BHC) which serves as the body to review budget, policy, reports and plans that shape MCBH activities and reports, including those under the MHSA. Commissioners have a range of backgrounds including consumers, family of consumers and community partners. CRHC members regularly attend the BHC meetings and give voice to issues that are impacting Monterey County residents. Information on the Behavioral Health Commission may be found HERE.

Recovery Task Force

MCBH participates in the Recovery Task Force which is a peer run committee under the auspices of a local non-profit Interim, Inc. The Recovery Task Force has a vision of "A compassionate world without stigma." and a mission that "Together we promote equality of all individuals with regards to their whole health, self-expression, and quality of care, recognizing all

people have an equal voice." This dynamic committee works on the following goals: 1.) Develop a stronger consumer voice within the Mental Health County System to meet these needs; 2.) Increase consumer accessibility of mental health services; and 3.) Increase consumer participation in the program development of mental health services. MCBH's Deputy Director of the Adult System of Care is a standing member and additional MCBH key staff such as the Prevention Manager/Ethnic Services Manager, and Quality Improvement staff regularly attend the meetings and work in collaboration with the committee on peer identified projects, outreach, and community events. RTF members are involved with planning for the CPPP and are invited to participate in surveys and focus groups to provide input that will guide planning of programs and services.

Substance Use Disorder Committees:

Preventing Alcohol Related Trauma in Salinas (PARTS)

MCBH helped establish Preventing Alcohol Related Trauma in Salinas (PARTS) and in Seaside in 1992. The mission of this committee is to prevent alcohol- related injuries and fatalities, prevent youth access to alcohol and drugs and the initiated use of alcohol, tobacco and other drugs in the city of Salinas. Regular and active partners in this Coalition: MCBH, Community Members, Parents, Youth Groups and Organizations, Law Enforcement such as Alcohol Beverage Control, California Highway Patrol, Monterey County Probation, Salinas Police Department, Natividad Medical Center, City of Salinas, Community Alliance for Safety and Peace, Monterey County Department of Social Services, Alliance on Aging, OMNI Resource Center, Alcoholics Anonymous, Sun Street Centers, and Salinas City Council. PARTS has been an integral part of the community feedback for substance use disorder services. PARTS members are encouraged to participate in the CPPP which guides planning for Behavioral Health programs and services.

Monterey County Prescribe Safe Initiative

The Monterey County Prescribe Safe Initiative, a multi-organizational collaborative of more than 35 local businesses and agencies has been addressing the opioid addiction problem since 2014. Prescribe Safe works to improve safety of prescription drugs, reduce inappropriate prescribing of pain medications and sedatives, increase access to treatment for addiction and to teach the public and medical professionals about the protentional dangers of prescription drug addiction.

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Prescribe Safe Monterey County partners with MCBH and the Monterey County Health Department to provide education on safe prescribing practices, naloxone distribution and Medication-Assist Treatment best practices.

Monterey Integrated Systems Transformation Initiative Project (MISTI)

The vision of the Monterey Integrated Systems Transformation Initiative (MISTI) is for MCBH to work in partnership with people with lived experience, provider organizations, and other stakeholders to develop a system of care that is welcoming, recovery/resiliency oriented, and integrated to be better matched to the needs and hopes of people in Monterey County with co-occurring Mental Health (MH) and Substance Use Disorders (SUD), as well as other complex health and human service needs. Currently, The Medical Director and Deputy Director of Quality are leading a monthly steering committee with the guidance of Dr. Ken Minkoff and Dr. Chris Cline of ZiaPartners. The Steering Committee is being formally empowered by MCBH to represent the partnership that will plan and guide this integration. It includes leadership representatives from various divisions within MCBH, leadership of MH and SUD provider agencies, Federally Qualified Health Center leadership representation, representation from people with lived experience, and other partners. As this project progresses, we will also be identifying a cohort of front line "change agent" to help energize the process of change, and representatives of the change agent group will eventually join the Steering Committee as well.

Racial and Cultural Community Organizations:

In FY 21/22, MCBH was purposeful in connecting with underserved and unserved communities in Monterey County regions. It has also increased visibility of its bilingual and bicultural staff at South County communities (such as Gonzales, Greenfield, Soledad, and King City), and therefore, has increased the personal connection between community and MCBH staff.

MCBH has actively collaborated with the Center for Community Advocacy (CCA), which is a community organization that works to provide education and legal supports for farm workers and other low-income working families with a focus on housing and health related issues. CCA has a contract with MCBH to provide outreach and education on mental health to the farm working community and Spanish speaking individuals and families through their *Promotores* program. CCA provided training and recommendations to MCBH staff on ways to effectively engage monolingual Spanish speaking individuals in

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Behavioral Health treatment and addressed cultural elements that can impact a clinical relationship with the goal of improving outcomes for this population. In FY 21/22, the contract with CCA was expanded to include additional *Promotores* and clinical support so that community members could receive streamlined mental health services.

MCBH also has a contract with The Village Project Inc. (TVPI), a local non-profit who specializes in serving the African American, and Black communities. TVPI has had Outreach and Engagement as a component of its overall contract with MCBH for the past 13 years. Outreach and Engagement activities, over the years, have involved presentations in churches, schools, cultural and community organizations, civil rights organizations such as the Monterey County Branch of the NAACP and the Monterey, North County and Salinas Councils of LULAC and appearances on local radio shows and local news shows. The staple of the Outreach and Engagement Program component is the organization's appearance in the community and the trust the community has in the organization. TVPI is consistently invited by low-income housing complexes to set up display tables and speak to tenants, most of whom are people of color, about TVPI's mental health programs and services. Likewise, tenant associations have also had staff from the organization be guest speakers at tenant association meetings to talk about the organization's programs and services. In FY 21/22, the contract with TVPI was expanded to provide a broader array of mental health and related services to the African American and Black communities in Monterey County.

To better address and prevent Substance Use Disorders, MCBH has worked with Sun Street Centers (SSC) Prevention Department, which is a community-based agency actively working with diverse community members and youth in Monterey County for many years. Sun Street Centers Prevention Department provides a variety of services to community members and their families, to increase awareness and promote action toward resolving community health problems related to drug and alcohol abuse. Services are provided throughout Monterey County, including historically underserved communities such as North and South County, this includes the following:

Life Skills Training: Botvin Life Skills Training provided by prevention staff to promote healthy alternatives to risky behaviors through activities designed to teach students about necessary skills to resist peer pressure to smoke, drink and use drugs, learn how to effectively cope with anxiety, help students develop self-esteem and confidence, and increase knowledge of immediate consequences of substance abuse.

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Preventing Alcohol Related Trauma and Substance Abuse (P.A.R.T.S): The mission of this program is to prevent alcohol-related injuries and fatalities, prevent youth access to alcohol and drugs and the initiated use of alcohol, tobacco and other drugs. Coalition meetings take place throughout the calendar year via zoom and in-person.

Safe Teens Empowerment Project (STEPS): Provided in Salinas, Peninsula and South County. A drug and alcohol peer-to-peer mentoring after school program involving students who serve as community service volunteers representing local high schools. Youth lead campaigns/projects during the past year include Alcohol Awareness, Prevention Awareness, Gateway 0Drug Trainings.

Special Events & Collaboratives during FY 21/22: During FY 21/22, Sun Street Centers Prevention Department staff:

- Collaborated with Monterey County Supervisor Christopher Lopez, City of Soledad and City of King to facilitate a Town Hall Meeting focusing on educating the community about the prevalence of opioid use and fentanyl in Monterey County.
- Established partnership with South County law enforcement agencies and Monterey County Prescribe Safe to help facilitate overdose incident-mapping throughout South County cities.
- Since 2011, SSC prevention staff have partnered with the Gonzales Police Department to facilitate bi-annual take back prescription drug day in the City of Gonzales.

C. A narrative description, not to exceed two pages, discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

MCBH offers a variety of trainings to partners through a diverse provider collaborative effort with the aim of skill development and strengthening community organizations. Below is a list of trainings offered by MCBH and contract providers.

Training provided by MCBH:

Crisis Intervention Training for Law Enforcement and First Responders is provided by Behavioral Health experienced clinical staff for law enforcement, other emergency services personnel and public service staff on various aspects of mental health and crises de-escalation. By taking this 40-hour training, participants learn how mental health conditions can impact a person's

behavior and presentation, especially in traumatic situations. This has been critical in providing law enforcement and other key personnel who interact with community members with knowledge and skills to better understand and address individuals who are experiencing mental health challenges and crises. MCBH's goal is to provide law enforcement and other key personnel with tools that can be used to de-escalate situations and help resolve issues using non-confrontational approaches in community settings, specifically with individuals that may be experiencing a mental health related break/psychosis/condition.

Critical Incident Stress Management Training is an evidence-based model that was originally developed as a strategy to help emergency personnel debrief and process work related traumas that can potentially impact their mental health and wellbeing. It is currently utilized with a broader range of individuals to help them cope with traumatic events. MCBH provides regular training to emergency personnel, school personnel, MCBH staff and contract providers in this model and helps organizations to develop their own internal teams who can assist in providing psycho-educational supports and debriefings.

LGBTQ+ Cultural Competency Training Series continued in FY 21/22 as part of an effort to develop comprehensive affirmative care for LGBTQ+ youth and their families. The series was open to educators, community members, staff from community-based agencies and MCBH staff. The purpose of the series was to increase knowledge, understanding and skills related to providing culturally reflective and affirmative care for LGBTQ+ individuals. Topics included LGBTQ+ Best Practices, Understanding the Rights of LGBTQ+ Youth, LGBTQ+ Health 101: A Medical Perspective, Documenting Sexual Orientation and Gender Identity in Electronic Health Records, Increasing Family Acceptance for LGBTQ+ Youth, and Supporting Trans and Gender Expansive Youth. All courses offered in FY 21/22 will be listed in Criterion 5.
Clinical Training and Other Relevant Trainings are offered to all contract providers, which includes community organizations, through an online portal, NeoGov Learn. More on these trainings will be discussed in Criterion 5.

Training funded by MCBH provided by contractors:

The Epicenter provided training on LGBTQ+ Best Practices designed for service providers, and community members to understand the mental health needs of Monterey County's LGBTQ+ communities.

Suicide Prevention Services of the Central Coast provided online trainings in English and Spanish regarding suicide awareness and prevention.

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The Village Project Inc. provided the Lucille Hralima Mental Health Education Series. The series consists of monthly presentations about mental health from the perspectives of different ethnic/cultural groups. They were well attended and rated highly by attendees. In addition, the Village Project, Inc., since its inception, has trained its clinical staff in identifying general risk factors in clients and potential clients with special attention paid to identifying these factors in people of color. Exacerbated by race-related stressors, those who are members of groups who have been historical victims and survivors of oppression, discrimination, and racism, carry intergenerational trauma, depression and anxiety, which gets passed from one generation to the next and further exacerbated by the Pandemic and ongoing acts if racism done through acts of macro- and micro-aggressions. Clinical work will often not realize positive results unless a clinician addresses the issue of the role of racism in the lives and the mental health of these clients.

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

Sadly, what was shared in the prior CCPR continued to be relevant in FY 21/22, with impacts of the COVID-19 pandemic disproportionately impacting communities of color and continued institutional and structural racism in the medical/health care system that perpetuates these inequities. Our country is continuing to reckon with racial injustice and violence directed at communities of color from law enforcement and inequality in the legal system while there have been some attempts to address systemic issues in various local and state level policing and law enforcement jurisdictions.

As a provider of public Behavioral Health Care that is part of a larger bureaucratic system, MCBH has begun to examine the role of institutional and structural racism that impacts racial and ethnic disparities that exist in our Behavioral Health Care delivery system and how this impacts staff of color employed at MCBH. Concerted attention and effort have been applied in this area and strategic work has begun to conceptualize a more diverse an equitable Behavioral Health Care organization. It will take an ongoing dedication of resources and a strategic plan that is overseen by our Quality Improvement department to have a truly comprehensive approach to diversity, equity and inclusion that will result in substantive changes. MCBH will continue to monitor and report out on these efforts over the next FY.

MCBH continues to recognize the shortage of mental health professionals and sees an opportunity to leverage community resources that exist in the Community Health Workers/*Promotores* workforce that has developed during the pandemic to address COVID-19 related issues in our County. Also, with the passing of SB 803 which will establishes Peer

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Specialists as providers of increased specialty mental health services, MCBH has an opportunity to increase much needed mental health supports in our County. Partnering with diverse community members will be critical in these endeavors and MCBH will build on progress made in this area over the next FY.

E. Identify County technical assistance needs.

The needs identified in last FY21/22 continued to be present and MCBH would appreciate responsiveness from DHCS in the following areas:

1.) MCBH would benefit from technical assistance to develop functional processes to transform our behavioral health delivery system to address racial and ethnic disparities.

2.) MCBH, contract providers and community members would also benefit from training and technical assistance related to the Peer Specialist role and function in a behavioral health care delivery system.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

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

The county shall include the following in the CCPR:

A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

MCBH has a full-time position dedicated to the CC/ESM and this position was vacant in FY 21/22 due to a hiring freeze instituted by the Health Department of Monterey County. MCBH did hire an individual to fill the position in July 2022. Dana Edgull, LCSW, served as the CC/ESM in FY 21/22 and has been in this role since 2019. Ms. Edgull has prior experience with

developing culturally responsive programs and services in her role as Project Director for a Federal System of Care grant where one of the primary goals was to assist MCBH under the Children's System of Care to improve efforts around cultural competency. Ms. Edgull has close relationships with community members and contract providers who represent historically marginalized populations, and she is committed to helping MCBH further its efforts on addressing racial and ethnic disparities. Ms. Edgull will supervise the CC/ESM and will continue to be involved with assisting MCBH to address disparities and improve equitable service delivery to Monterey County residents along with Jessica Mora Ramirez who assumed the CC/ESM role in July 2022.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

The Cultural Competency Coordinator carries the duties and responsibilities supporting the implementation, maintenance, and evaluation of how cultural competence is reflected in the Mental Health and Substance Use Disorder services that MCBH and contract providers deliver. This position represents Monterey County on California's Mental Health Directors Association Ethnic Services Committee and facilitates Monterey County's Cultural Competence Committee. These committees ensure that behavioral health services meet the needs of all individuals who seek such services, and that culture, language, and ethnicity are reviewed and considered to provide high-quality service. MCBH understands that with the implementation of Specialty Mental Health Services, Drug Medi-Cal Organized Delivery System (DMC-ODS) and the MHSA, the state requires this classification to ensure that each County is monitoring and evaluating behavioral health services in accordance with the Cultural Competence Plan. The CC/ESM serves to identify areas requiring improved service capacity, aid partner agencies with cultural competency plans, and provide consultation to better improve those plans. The position is essential in meeting the increased needs and demands of MCBH programs, seeking to implement quality behavioral health services in a culturally diverse and sensitive manner.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

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In MCBH's FY 21/22 budget there was $2,472,818 allocated for cultural competence activities. Details are described below in the following section.

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

i. Interpreter and translation services
ii. Reduction of racial, ethnic, cultural and linguistic mental health disparities
iii. Outreach to racial and ethnic county-identified target populations
iv. Culturally appropriate mental health services
v. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers

The cultural competency FY 21/22 funds were spent on the items below.

Interpreter and Translation Services ($157,000)

- Interpretation is provided to clients when there is a need to ensure effective communication is occurring in their Behavioral Health treatment
- Interpretation to ensure language accessibility for the following ongoing meetings: Cultural Relevancy and Humility Committee meetings, Behavioral Health Commission meetings, Mental Health Services Act Community Program Planning Process, MC HOPES suicide prevention coalition. Interpretation is provided at other bilingual meeting and community outreach events.
- Translation services for MHSA and other MCBH documents
- Utilization of interpretation services that include indigenous languages, such as *Mixteco* and *Triqui*, with the Natividad Medical Foundation

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Training and Consultation to Reduce Disparities ($110,000)

- Cultural Competency training for MCBH staff at all levels of organization and consultation regarding Cultural Relevancy and Humility Committee.
- MCBH conducted and Organizational Assessment on Racial Equity through a contract with the Eikenberg Institute which was facilitated by Dr. Ken Hardy as the Principal Investigator.

Reduction of Mental Health Disparities ($193,000)

- Contract with University of Southern California (USC) bilingual therapists and psychiatrists were expanded to fill in workforce language capacity gaps utilizing telemedicine

Outreach and Culturally Appropriate Services for Underserved Racial and Ethnic Communities ($2,012,818)

The contract providers identified below are culture-specific agencies with the aim to engage under resourced and historically underserved populations experiencing mental health service needs. Each organization's program/project combines outreach, education, as well as educational materials on common mental health diagnoses, such as depression and anxiety, plus information on coping skills, self-care and resources for seeking additional mental health services, as needed.

i. The Village Project provides supports and therapeutic services to Blacks and African Americans
ii. The Center for Community Advocacy provides community outreach and education on mental health through the *Promotoras* program to monolingual Spanish-speaking communities, focusing on agricultural workers
iii. *Pajaro* Valley Prevention and Student Assistance's (PVPSA) mission is to improve the quality of life for students and families of the greater *Pajaro* Valley by providing health education, mental health and substance use services, and by advocating for public policies that promote the wellbeing of the community. PVPSA serves primarily Latino students and families in North Monterey County which is an underserved region of the County.
iv. Community Human Services (CHS) is a local non-profit that addresses underlying conditions or root causes of personal, family and community problems, including addiction, domestic violence, mental illness, emotional health, homelessness, child abuse. In FY 21/22, CHS received additional MHSA funding to provide culturally relevant short

term therapeutic services to individuals who do not have insurance and to develop a social marketing and outreach campaign to reach historically underserved racial and ethnic communities, along with LGBTQ+ folks.

v. Partners for Peace is a community agency that provides Culturally Relevant Parenting classes, and they were awarded a contract to expand programs to reach historically underserved communities, focusing on South Monterey County and Spanish speaking families and families who speak Indigenous languages, such as *Triqui*.

vi. The Epicenter is a community-based agency that exists to empower at risk and system involved youth ages 16-24 to flourish by connecting them to community resources that provide opportunities for equity and hope. The Epicenter also serves LGBTQ+ youth and communities through Our *Gente,* a multi-faceted project that includes community and agency trainings, weekly support groups for youth ages 16-24, and community events all steered by the Queer & Trans Youth Collective. Our *Gente* offers a safer space for lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual youth living in Monterey County.

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The county shall include the following in the CCPR:

A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.

Table 2.1 Monterey County, California	Population	Percent of Population group
Total:	439,035	
Hispanic or Latino	265,321	60%
Not Hispanic or Latino	173,714	40%
Population of one race:	159,594	36%
White alone	120,077	75%
Black or African American alone	9,051	6%
American Indian and Alaska Native alone	1,314	1%
Asian alone	25,123	16%
Native Hawaiian and Other Pacific Islander alone	1,859	1%
Some Other Race alone	2,170	1%
Population of two or more races:	14,120	3%
Population of two races:	12,786	91%
White; Black or African American	1,556	11%
White; American Indian and Alaska Native	2,458	17%
White; Asian	4,742	34%
White; Native Hawaiian and Other Pacific Islander	390	3%
White; Some Other Race	1,929	14%

Black or African American; American Indian and Alaska Native	126	1%
Black or African American; Asian	497	4%
Black or African American; Native Hawaiian and Other Pacific Islander	74	1%
Black or African American; Some Other Race	85	1%
American Indian and Alaska Native; Asian	62	0%
American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	16	0%
American Indian and Alaska Native; Some Other Race	34	0%
Asian; Native Hawaiian and Other Pacific Islander	665	5%
Asian; Some Other Race	83	1%
Native Hawaiian and Other Pacific Islander; Some Other Race	69	0%
Population of three races:	1,185	0%
White; Black or African American; American Indian and Alaska Native	194	16%
White; Black or African American; Asian	281	24%
White; Black or African American; Native Hawaiian and Other Pacific Islander	34	3%
White; Black or African American; Some Other Race	21	2%
White; American Indian and Alaska Native; Asian	190	16%
White; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	14	1%

White; American Indian and Alaska Native; Some Other Race	14	1%
White; Asian; Native Hawaiian and Other Pacific Islander	316	27%
White; Asian; Some Other Race	18	2%
White; Native Hawaiian and Other Pacific Islander; Some Other Race	6	1%
Black or African American; American Indian and Alaska Native; Asian	47	4%
Black or African American; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	3	0%
Black or African American; American Indian and Alaska Native; Some Other Race	2	0%
Black or African American; Asian; Native Hawaiian and Other Pacific Islander	27	2%
Black or African American; Asian; Some Other Race	3	0%
Black or African American; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%
American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander	11	1%
American Indian and Alaska Native; Asian; Some Other Race	0	0%

American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%
Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	4	0%
Population of four races:	121	0%
White; Black or African American; American Indian and Alaska Native; Asian	40	33%
White; Black or African American; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	9	7%
White; Black or African American; American Indian and Alaska Native; Some Other Race	15	12%
White; Black or African American; Asian; Native Hawaiian and Other Pacific Islander	26	21%
White; Black or African American; Asian; Some Other Race	9	7%
White; Black or African American; Native Hawaiian and Other Pacific Islander; Some Other Race	2	2%
White; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander	11	9%
White; American Indian and Alaska Native; Asian; Some Other Race	1	1%
White; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%

White; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	3	2%
Black or African American; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander	0	0%
Black or African American; American Indian and Alaska Native; Asian; Some Other Race	1	1%
Black or African American; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%
Black or African American; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	4	3%
American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%
Population of five races:	24	0%
White; Black or African American; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander	17	100%
White; Black or African American; American Indian and Alaska Native; Asian; Some Other Race	5	29%
White; Black or African American; American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander; Some Other Race	1	6%
White; Black or African American; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	1	6%
White; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%

Black or African American; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	0	0%
Population of six races:	4	0%
White; Black or African American; American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander; Some Other Race	4	100%

Source: US Census Bureau, 2020 American Community Survey Decennial Census estimate. Located at: Monterey County Census Bureau Table 2020

[Cont.] Table 2.1 Monterey County, California Race/Ethnicity Breakdowns FY2021	Population Estimate for 2021	Percentage
Total population	428,441	100.00%
Hispanic or Latino (of any race) (200-299)	243,894	56.93%
American Indian and Alaska Native alone or in combination with one or more other races (300, A01-Z99) & (100-299) or (300, A01-Z99) or (400-999)	7,889	1.84%
Asian; Native Hawaiian and Other Pacific Islander	688	0.16%
Some other race alone or in combination with one or more other races	58,844	13.73%
American Indian and Alaska Native alone or in combination with one or more other races, Hispanic or Latino	4,082	0.95%

Chinese (except Taiwanese) alone or in any combination (410-411) & (100-299) or (300, A01-Z99) or (400-999)	3,030	0.71%
Mexican American Indian tribal grouping alone (V84-W66)	572	0.13%
Micronesian alone or in any combination (520-529, 531-541) & (100-299) or (300, A01-Z99) or (400-999)	993	0.23%
Black or African American alone	11,947	2.79%
Two races without Some Other Race	10,802	2.52%
Black or African American in combination with one or more other races	3,819	0.89%
Chinese alone or in any combination (410-419) & (100-299) or (300, A01-Z99) or (400-999)	3,074	0.72%
Some Other Race alone, Hispanic or Latino	54,161	12.64%
White; Some other race	2,305	0.54%
White alone or in combination with one or more other races, not Hispanic or Latino	143,034	33.38%
Asian alone or in combination with one or more other races, not Hispanic or Latino	30,527	7.13%
American Indian and Alaska Native in combination with one or more other races	4,587	1.07%

Filipino alone or in any combination (420-421) & (100-299) or (300, A01-Z99) or (400-999)	15,357	3.58%
Central American (excludes Mexican) (221-230)	7,259	1.69%
Three or more races with Some Other Race	1,898	0.44%
Vietnamese alone or in any combination (450-459) & (100-299) or (300, A01-Z99) or (400-999)	2,356	0.55%
Spaniard (200-209)	1,645	0.38%
White; Black or African American	2,008	0.47%
Mexican (210-220)	227,551	53.11%
Two or more races, not Hispanic or Latino	9,648	2.25%
American Indian and Alaska Native alone, Hispanic or Latino	2,070	0.48%
Guamanian or Chamorro alone or in any combination (520-522) & (100-299) or (300, A01-Z99) or (400-999)	854	0.20%
Salvadoran (226)	4,915	1.15%
White alone, Hispanic or Latino	179,056	41.79%
Two races with Some Other Race	3,598	0.84%
Asian alone, Hispanic or Latino	852	0.20%
White in combination with one or more other races	13,316	3.11%

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

American Indian and Alaska Native alone (300, A01-Z99)	3,302	0.77%
American Indian alone	1,799	0.42%
American Indian and Alaska Native alone or in combination with one or more other races, not Hispanic or Latino	3,807	0.89%
Asian; Some other race	626	0.15%
Black or African American alone or in combination with one or more other races, not Hispanic or Latino	13,770	3.21%
Two or More Races, Hispanic or Latino	6,650	1.55%
White alone or in combination with one or more other races	327,393	76.41%
Chinese alone (410-419)	2,316	0.54%
Asian alone or in combination with one or more other races (400-499) & (100-299) or (300, A01-Z99) or (400-999)	33,199	7.75%
Black or African American alone, not Hispanic or Latino	10,981	2.56%
White alone or in combination with one or more other races, Hispanic or Latino	184,359	43.03%
Asian alone (400-499)	26,075	6.09%
Korean alone (440-441)	2,392	0.56%
Vietnamese alone (450-459)	2,197	0.51%
Native Hawaiian and Other Pacific Islander alone (500-599)	2,101	0.49%

Black or African American alone or in combination with one or more other races	15,766	3.68%
American Indian alone or in any combination	4,837	1.13%
Chinese (except Taiwanese) alone (410-411)	2,284	0.53%
Filipino alone (420-421)	11,993	2.80%
Two or more races	16,298	3.80%
South American (231-249)	1,400	0.33%
Some other race alone or in combination with one or more other races, not Hispanic or Latino	963	0.22%
Three or more races without Some Other Race	1,293	0.30%
Puerto Rican (260-269)	2,289	0.53%
Native Hawaiian and Other Pacific Islander alone, not Hispanic or Latino	1,962	0.46%
Black or African American alone, Hispanic or Latino	966	0.23%
Asian in combination with one or more other races	7,124	1.66%
White alone	314,077	73.31%
Cherokee tribal grouping alone or in any combination (B21-B39) & (100-299) or (300, A01-Z99) or (400-999)	1,505	0.35%

Asian alone or in combination with one or more other races, Hispanic or Latino	2,672	0.62%
Some other race alone	54,641	12.75%
Native Hawaiian and Other Pacific Islander in combination with one or more other races	1,661	0.39%
Guatemalan (222)	882	0.21%
Asian Indian alone or in any combination (400-401) & (100-299) or (300, A01-Z99) or (400-999)	2,653	0.62%
Polynesian alone (500-519)	1,079	0.25%
White; Asian	4,095	0.96%
Some other race in combination with one or more other races	4203	0.98%
Korean alone or in any combination (440-441) & (100-299) or (300, A01-Z99) or (400-999)	3,051	0.71%
Polynesian alone or in any combination (500-519) & (100-299) or (300, A01-Z99) or (400-999)	1,909	0.45%
American Indian and Alaska Native alone, not Hispanic or Latino	1,232	0.29%
Black or African American alone or in combination with one or more other races, Hispanic or Latino	1,996	0.47%
Japanese alone or in any combination (430-439) & (100-299) or (300, A01-Z99) or (400-999)	4,949	1.16%

Native Hawaiian and Other Pacific Islander alone or in combination with one or more other races, not Hispanic or Latino	3,285	0.77%
Mexican American Indian tribal grouping alone or in any combination (V84-W66) & (100-299) or (300, A01-Z99) or (400-999)	1,114	0.26%
White; American Indian and Alaska Native	2,948	0.69%
Some Other Race alone or in combination with one or more other races, Hispanic or Latino	57,881	13.51%
Asian Indian alone (400-401)	2,349	0.55%
Native Hawaiian and Other Pacific Islander alone or in combination with one or more other races (500-599) & (100-299) or (300, A01-Z99) or (400-999)	3,762	0.88%
Japanese alone (430-439)	3,128	0.73%
White alone, not Hispanic or Latino	135,021	31.51%
Native Hawaiian alone or in any combination (500-503) & (100-299) or (300, A01-Z99) or (400-999)	1,021	0.24%
Asian alone, not Hispanic or Latino	25,223	5.89%

Source: US Census Bureau: Census Race & Ethnicity Table FY21 Monterey County

Table 2.1 above shows 2020-21 Racial estimates for Monterey County. It is reported that 60% of our residents are Hispanic or Latino with an ethnic break-down of 53% Mexican, 0.53% Puerto Rican, 2% Central American (excludes Mexican),14% Guatemalan, and 14% as some other race alone, Hispanic or Latino group, 40% identified as Not Hispanic or Latino, 70% White alone, 6% Black or African American alone, 0.1% American Indian and Alaska Native alone, 16% Asian alone, 0.1% Native Hawaiian and Other Pacific Islander

alone, 0.1% Some Other race alone, 3% Two or More Races, 91% Population of two races, and 0% for Populations of three, four, five and six races.

Table 2.2: Monterey County Language Spoken 5 years of age and over FY 2020-21 estimates:						
	Overall		Speaks English only or "very well"		Speaks English less than "very well"	
	Estimate	Percentage	Estimate	Percentage	Estimate	Percentage
Population 5 years and over	408,838	(X)	305,336	74.7	103,502	25.3
Speak only English	182,447	44.60	(X)	(X)	(X)	(X)
Speak a language other than English	226,391	55.4	122,889	54.3	103,502	45.7
SPEAK A LANGUAGE OTHER THAN ENGLISH						
Spanish	199,900	48.9	106,526	53.3	93,374	46.7
5 to 17 years old	49,940	12.2	38,068	76.2	11,872	23.8
18 to 64 years old	133,622	32.7	62,650	46.9	70,972	53.1
65 years old and over	16,338	4.0	5,808	35.5	10,530	64.5
Other Indo-European languages	9,783	2.4	6,105	62.4	3,678	37.6
5 to 17 years old	982	0.2	599	61.0	383	39.0
18 to 64 years old	6,138	1.5	4,700	76.6	1,438	23.4
65 years old and over	2,663	0.7	806	30.3	1,857	69.7

Asian and Pacific Island languages	13,488	3.3	8,573	63.6	4,915	36.4
5 to 17 years old	946	0.2	737	77.9	209	22.1
18 to 64 years old	9,102	2.2	6,180	67.9	2,922	32.1
65 years old and over	3440	0.8	1,656	48.1	1,784	51.9
Other languages	3220	0.8	1,685	52.3	1,535	47.7
5 to 17 years old	546	0.1	285	52.2	261	47.8
18 to 64 years old	2,580	0.6	1,314	50.9	1,266	49.1

Table 2.2 above shows an estimate of languages spoken in Monterey County for FY 2020-21. An estimate of 75% speak English only or "very well", and 25% of those residents speak English less than "very well". Additionally, across age groups within the languages of Spanish, Indo-European, Asian Pacific Islander, and other languages; a variation of 54 % speak English only or "very well" and 46% speak English less than "very well".

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

The county shall include the following in the CCPR:

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

The following tables [2.3-2.4] below are a breakdown of Medi-Cal Enrollees and MCBH beneficiaries served by Race/Ethnicity, Age and Region for FY 21/22 & FY20/21 for a comparison of Monterey County.

1. The County's Medi-Cal population

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

Table 2.3: Monterey County Behavioral Health Medi-Cal Client data FY 2021-22		
Number of Clients Served (N=8260)	Mental Health 6909	Substance Use Disorder 1351
Clients served by Age category		
Average Age	26 years old	38 years old
0-5 years	4%	N/A
6-15 years	28%	1%
16-25 years	24%	12%
26-59 years	41%	82%
60+ years	3%	5%
Clients served by Gender		
Female	55.2%	40.5%
Male	44.5%	59.5%
Transgender	0.2%	0%
Unknown	0.1%	0%
Clients served by Preferred spoken language		

English Language Preference	78%	94%
Spanish Language Preference	17%	5%
Other Language	5%	1%
Clients served by Race/ethnicity		
Hispanic/Latino	46%	47%
White	14%	29%
African American	3%	4%
Asian/Pacific Islander	2%	3%
American Indian	1%	1%
Other	34%	16%
Clients served by region of residence		
Salinas Valley	47%	51%
South County	24%	11%
North County	9%	9%
Coastal Region	19%	27%

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

2. The county's client utilization data -see table 2.4 below

Table 2.4		Monterey Medi-Cal Enrollees and MCBH Beneficiaries Served in FY1 21/22 by Race/Ethnicity			Monterey Medi-Cal Enrollees and MCBH Beneficiaries Served in FY 20/21 by Race/Ethnicity		
		% Enrolled in Medi- Cal	*% Served at MCMCBH*	*Service Utilization Differences*	*% Enrolled in Medi- Cal*	*% Served at MCBH*	*Service Utilization Differences*
Race/ Ethnicity	*White*	10%	16%	7%	10%	18%	8%
	Hispanic	69%	46%	-23%	77%	57%	-20%
	African American	1%	4%	2%	1%	4%	2%
	Asian/PI	3%	2%	-1%	3%	3%	0%
	Native American	0%	1%	1%	0.1%	1%	1%
	Other	2%	31%	29%	9%	19%	9%
Age	*0-5 yrs.*	12%	3%	-9%	11%	4%	-7%
	5-15 yrs.	24%	24%	0%	22%	23%	1%
	16-25 yrs.	17%	22%	5%	17%	23%	6%
	26-59 yrs.	36%	47%	11%	39%	46%	7%
	60+ yrs.	11%	4%	-7%	11%	4%	-7%

Region	*Salinas*	47%	48%	1%	50%	48%	-2%
	South County	19%	22%	3%	19%	22%	3%
	North County	12%	9%	-3%	12%	9%	-3%
	Coastal	20%	20%	0%	17%	19%	2%
	Other	2%	1%	-1%	2%	2%	0%

The total is not a direct sum of the averages above it. The averages are calculated separately. Source: Monterey County Behavioral Health, Avatar Data FY 2021-22, FY 2020-21 data. ***Note: Objectives for these defined disparities will be identified in Criterion 3, Section III***

Table 2.5 Gaps in service utilization at MCBH among Medi-Cal eligible clients by Age-group, Region of residence, Race/ethnicity, Gender, Preferred spoken language of clients FY 2021-22						
Age group	0-5 yrs.	6-15 yrs.	16-25 yrs.	26-59 yrs.	60+ yrs.	Overall
Region of Residence						
Coastal	2.31	-1.25	-9.79	-11.81	-21.1	0.37
North County	3.98	-3.16	-1.66	0.03	1.02	-2.55
Other	-0.17	-0.75	-2.76	-3.85	-0.63	-1.46
Salinas Valley	-3.5	-3.63	3.71	11.43	17.12	0.77
South	-2.62	8.77	10.49	4.2	3.57	2.87
Race/Ethnicity						
White	1.41	2.17	0.39	-0.62	-7	6.64
Hispanic	-42.46	-35.89	-13.99	-8.48	8.9	-22.85
African American	1.11	1.13	-1.21	2	3.56	2.19
Asian/Pacific Islander	1.64	-0.26	-6	-3.9	-6.49	-0.63
American Indian	-0.05	0.51	0.49	0.82	1.32	0.65
Other	62.37	41.11	28.56	19.49	12.96	28.98
Declined to answer	-24.04	-8.77	-8.23	-9.31	-13.26	-14.98
Gender						

Female	-11.75	4.38	-1.15	-6.83	-0.89	0.61
Male	10.61	-4.69	0.66	6.75	0.89	-0.86
Transgender	0	0.21	0.38	0.06	0	0.15
Unknown	1.14	0.1	0.05	0.03	0	0.08
Preferred spoken language						
American Sign Language	0	0	0.11	-0.12	0	0
Arabic	-0.05	-0.03	-0.26	-0.86	-0.33	-0.18
Cambodian	0	-0.05	0	0	-0.33	-0.04
Cantonese	0	0	-0.39	0.03	0	-0.01
English	15.62	33	42.61	30.5	1.18	32.98
Farsi	0	0	0	-0.32	-0.33	-0.06
Italian	0	0	0	-0.12	0	-0.02
Korean	0	0	-0.39	-0.12	-0.33	-0.06
Mandarin	0	0	-0.39	-0.12	-0.66	-0.08
Other Non-English	0.36	0.07	0.27	-0.24	-0.66	0.07
Russian	0	0	0	-0.12	-0.66	-0.06
Spanish	-21.19	-36.13	-44.74	-30.6	-0.77	-35.76
Tagalog	-0.02	-0.05	0.05	-0.37	-0.33	-0.06
Vietnamese	0	-0.05	-0.72	-0.5	-0.72	-0.17
Unknown	5.27	3.23	3.86	2.89	3.63	3.39

**Service Gap is defined as the difference in percentage distribution of BH clients and percentage distribution of average Medi-Cal enrollees in the same fiscal year.*

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

MCBH served about 8,260 Medi-Cal eligible beneficiaries in fiscal year 2021-22 (FY 21/22). Table 2.3 provides the socio-demographic data of all the beneficiaries served in FY 2021-22 based on their primary diagnosis groups-Mental health disorders and substance use disorders.

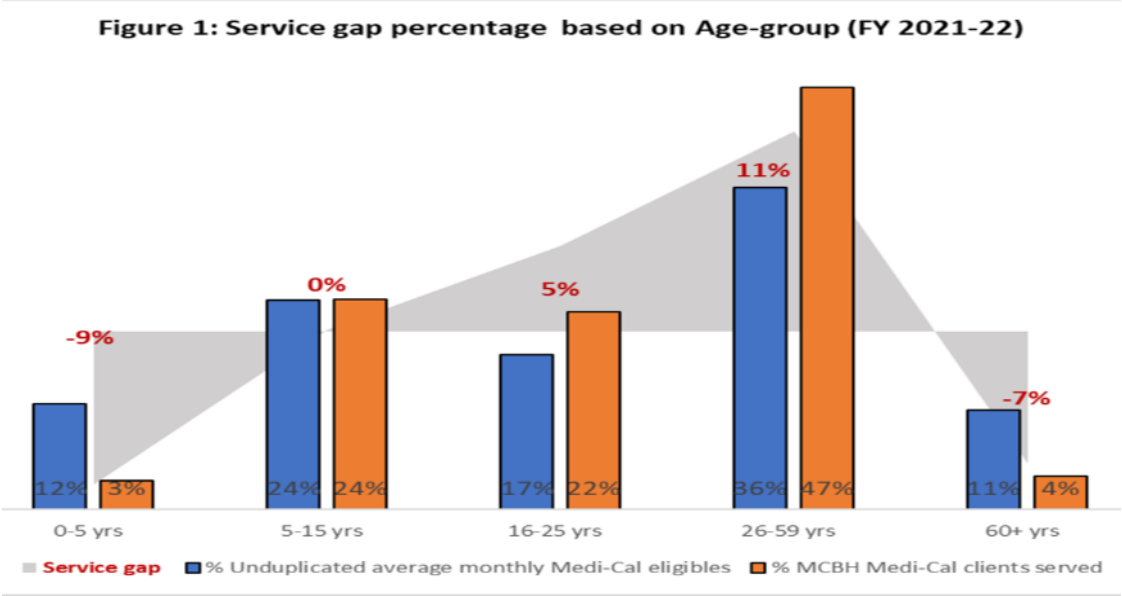
CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

Age distribution:

The average age of Medi-Cal beneficiaries served in MCBH is 28 years. The percentage age-group distribution in FY 21/22 when compared to that of the Medi-Cal eligible population of Monterey County showed gaps in services to individuals under 5 years old and above 60 years old. (**Figure 1**). The average age of Hispanic/Latino beneficiaries is significantly lower than the average age of White beneficiaries by 10 years. There was no significant difference in the mean service value among different age-groups.

Figure 1: Service gap percentage based on Age-group (FY 2021-22)



**Service Gap is defined as the difference in percentage distribution of BH beneficiaries served and percentage distribution of Medi-Cal enrollees in the same fiscal year.*

The following data reports service utilization by age groups:

Under 5 years age-group:

- Total number of beneficiaries served: 263

- Female MCBH Beneficiaries percentage: 40%
- Female beneficiaries under-utilize MCBH services by 12 percentage points
- Preferred spoken language among MCBH Beneficiaries: 31% Spanish and 63% English
- Spanish-speaking beneficiaries under-utilize the MCBH services by 21 percentage points
- Percentage of Hispanic/Latino MCBH Beneficiaries: 28%
- Hispanic/Latino population under-utilize the MCBH services by 42 percentage points
- Salinas Valley Region and South County region under-utilize the MCBH services by 4% and 3%, respectively
- The mean service value per client is $95,994.15

6-15 years age-group:

- Total number of beneficiaries served: 1948
- Female MCBH Beneficiaries percentage: 53%
- Under-serving Male beneficiaries by 5 percentage point
- Preferred spoken language among MCBH Beneficiaries: 21% Spanish and 76% English
- Under-serving Spanish-speaking beneficiaries by 35 percentage points
- Percentage of Hispanic/Latino MCBH Beneficiaries: 47%
- Under-serving the Hispanic/Latino population by 36 percentage points
- Under-serving the Salinas Valley and North County Regions by 4% and 3%, respectively
- The mean service value per client is $95,028.62

16-25 years age-group:

- Total number of beneficiaries served: 1835
- Female MCBH Beneficiaries percentage: 55%
- Under-serving Female beneficiaries by 1 percentage points
- Preferred spoken language among MCBH Beneficiaries: 10% Spanish and 86% English
- Under-serving Spanish-speaking beneficiaries by 45 percentage points

- Percentage of Hispanic/Latino MCBH Beneficiaries: 56%
- Under-serving the Hispanic/Latino population by 14 percentage points
- Under-serving the Coastal Region and North County region by 10% and 2%, respectively
- The mean service value per client is $84991.25

26-59 years age-group:

- Total number of beneficiaries served: 3911
- Female MCBH Beneficiaries percentage: 52%
- Under-serving Female beneficiaries by 7 percentage point
- Preferred spoken language among MCBH Beneficiaries: 13% Spanish and 83% English
- Under-serving Spanish-speaking beneficiaries by 31 percentage points
- Percentage of Hispanic/Latino MCBH Beneficiaries: 44%
- Under-serving the Hispanic/Latino population by 8 percentage points
- Under-serving the Coastal region by 12%
- The mean service value per client is $98991.31

60+ years age-group:

- Total number of beneficiaries served: 303
- Female MCBH Beneficiaries percentage: 53%
- No significant service gap differences by gender
- Preferred spoken language among MCBH Beneficiaries: 17% Spanish and 77% English
- No significant service gap differences by spoken language
- Percentage of Hispanic/Latino MCBH Beneficiaries: 29%
- Under-serving the White/Caucasian and Asian/Pacific Islander population by 7%
- Under-serving the Coastal regions by 21%
- The mean service value per client is $116045.6

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

GENDER:

Approximately 53% of our beneficiaries are Females. The mean service value and mean service utilization among Medi-Cal beneficiaries was significantly lower among female beneficiaries compared to male beneficiaries in FY 21/22. The service utilization data suggests that the female beneficiaries are engaged more in the short-term care via Access to treatment programs and more male beneficiaries were enrolled in the high-cost long term care.

RACE/ETHNICITY:

46% of the Medi-Cal eligible MCBH beneficiaries were Hispanic/Latino in FY 21/22. MCBH is under-serving the Hispanic/Latino population by 23% and Asian / Pacific Islander population by 1%. This gap has widened by 9% for Hispanic/Latino Medi-Cal beneficiaries since FY 18/19. The age-adjusted mean service value and mean service utilization among Hispanic/Latino Medi-Cal beneficiaries are 33% and 50% lower than those availed by Caucasian/ White beneficiaries.

PREFERRED SPOKEN BENEFICIARIES' LANGUAGE:

15 percent of beneficiaries indicated they prefer Spanish as their Preferred spoken language. We have observed a service gap of about 26% among Spanish speaking beneficiaries. In FY 19/20, 95% of the beneficiaries were matched to clinicians who spoke/understood the beneficiaries' language. Compared to English speaking beneficiaries, the Spanish speaking beneficiaries had 47% lower (approximately $3,900) average cost of service per beneficiaries and other non-English speakers had 73% lower (approximately $6,000) average cost of service per beneficiaries. There was also significant lower number of services among Spanish and other non-English speakers, compared to English speaking beneficiaries.

REGION OF BENEFICIARIES' RESIDENCE:

The county boundary is geographically divided into 4 different regions- Salinas Valley, South County, North County and Coastal Region. About 48% of our beneficiaries come from Salinas Valley Region, 22% from South County, 20% from Coastal Region and 9% from North County. Service gap has widened in Salinas valley region by 3% and in North County region by 2% in the last 3 years.

Compared to those who reside in Salinas Valley region, the South County residents received lower service value as well as average count of service per beneficiaries. Those residing in Coastal Region, received higher services as well as high-cost services per beneficiaries in FY 21/22.

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

(Please note that this information is posted at the DMH website at http://www.dmh.ca.gov/News/Reports_and_Data/default.asp.)

The county shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

Table 2.6: Percentage of Monterey County Residents Uninsured by Income Level in 2014*		
Federal Poverty Line (FPL)	Percentage	
Income levels	*Monterey County*	*California*
All income level	*21.70*	*17.30*
At or below 138% FPL	*33.90*	*30.40*
At or below 200% FPL	*33.30*	*29.90*
At or below 250% FPL	*31.80*	*28.70*
At or below 400% FPL	*27.90*	*24.60*

Average FPL between 138% and 400%	*24.5*	*21.3*

**Note: Most current year for data. Source: Open Data Network. Retrieved HERE*

Table 2.7: Percentage of Medi-Cal Eligible and Uninsured					
	Mental Health N=13150 *	Substance Use Disorder N=1,608 *	Monterey County N= 439,035 **	California N=37,551,064 **	United States N=309,082,272 **
Medi-Cal	72%	85%	44.4%	33.4%	20.75%
Uninsured	6%	3%	20.9%	16.7%	14.2%
Medicare B	19%				

*Source: *Monterey County Behavioral Health, Data Driven Decisions, D3, FY21/22.*

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

FY 21/22, 13,150 individuals were served in Behavioral Health programs of which 72% had Medi-Cal as their primary insurance, 19% had Medicare B, 4% had private insurance and 6% were uninsured. (see Table 2.7 above). Additionally, Substance Use Disorder programs served 1,608 individuals out of which 85% of the individuals who were served identified Medi-Cal as their primary insurance, 1% private insurance, and 3% uninsured (see Table 2.7 above). While MCBH currently does not have a system to distinguish between beneficiaries who fall under the 200% FPL compared to those who do not, there are about one-third of Monterey County residents living at or below 200% FPL and about one quarter living at or below 400% FPL, therefore there is a strong probability that MCBH is a safety net for residents living at or under the poverty level (at any level). FY 2020 for Monterey County data suggest 67.1% of residents were at or above 200% the Federal Poverty Level (FPL), compared to 70.6% of CA residents. Source . Comparing across the four poverty level lines of 138%-400%, data suggests, that on average Monterey County residents are about 3% higher in each category compared to that of the State. HERE. The total poverty rate in Monterey County is 12%, with 18.4% of all children in Monterey County living below the poverty level. Source. On January 31, 2019, the latest Monterey County Homeless Census conducted by Applied Survey Research found there are approximately 2,422 individuals who are homeless in the County Source.

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

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

The county shall include the following in the CCPR:

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.

[See Tables 2.8-2.9]

Table 2.8 Monterey County Mental Health Services Act (MHSA)		
Community Services & Supports (CSS) FY 2021-22		
CSS Strategy	**Program**	**# Clients**
CSS-01 Early Childhood and Family Stability FSP	**CS Family Preservation**	**7**
	CS Salinas Home Partners	**13**
	CS Family Reunification FSP	**9**
	Kinship Adoption FSP Seneca	**40**
	Kinship Center Seneca First Five Trauma	**2**
	Kinship Center Seneca FSP King City Outpatient	**37**
CSS-02 Dual Diagnosis FSP	**DTH Integrated Co-occurring Disorder FSP**	**106**
	DTH Santa Lucia FSP	**15**
CSS-04 Transition Age Youth FSP	**CS MHSA TIP AVANZA FSP**	**231**
CSS-05 Adults with SMI FSP	**Interim Assertive Community Treatment**	**61**
CSS-06 Older Adults FSP	**AS Older Adult FSP**	**10**
	Drake House MHSA FSP	**26**

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

CSS-07 **Access Regional Services**	**Access Programs**	**5656**
CSS-08 **Early Childhood Mental Health**	**CS Secure Families**	**12**
	DTH MCSTART	**21**
	DTH MCSTART 6-11	**21**
	DTH MCSTART 6-11 DSES	**1**
CSS-10 **Supported Services to Adults with SMI**	**Supported housing for Mentally ill**	**549**
	Interim Wellness Navigator - Marina	18
	Interim Wellness Navigator - Salinas	31
CSS-11 Dual Diagnosis Services	Interim Co-occurring Integrated Care	91
CSS-13 Justice-Involved FSP	AS Creating New Choices FSP	10
	CS JJ CALA (Juvenile Mental Health Court)	16
	CS JJ Juvenile Sex Offender Response Team	33
	JJ Silver star resource	119
CSS-14 and CSS-15 Homeless Services & Supports FSP	Homeless Outreach & Treatment	113
	Lupine Gardens Supported Housing	24
CSS-16 Responsive Crisis Interventions	CS Archer Child Advocacy Center	301
	Mobile Crisis (county operated services)	64
TOTAL		7683

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

Table 2.9 Monterey County Mental Health Services Act (MHSA)Community Services and Support FY 2021-22	
Race/Ethnicity	% Of Total
African American/Black	3%
Asian/Pacific Islander	2%
Hispanic/Latino	39%
Caucasian/White	16%
Other than specified	41%
Gender	% of Total
Female	60%
Male	40%
Language Preference	% of Total
English	76%
Spanish	16%
Other	9%
Region of Residence	% of Total
Coastal	19%
North County	9%
Salinas Valley	24%
South County	47%
Other Region	1%
Insurance	% of Total
Medi-Cal	16%
Medicare Part B	8%
Private Insurance	7%
Self-Pay	16%
Others	1%
Unknown	53%

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

B. Provide an analysis of disparities as identified in the above summary.

In FY 21/22, 7,683 individuals were served in our MHSA Community Services & Supports programs. Overall, 39% clients were Hispanic/Latino, 60% were Female, 76% preferred English as their language and how to receive services, and 47% were residents of our South County region. More investigation needs to be done to understand the racial and ethnic identity of individuals who self-identify as "Other that specified" race or ethnicity as this has grown over time and was 41% in this reporting period. At the time of entry into services, 16% of clients were enrolled in Medi-Cal; 7% had private insurance and 8% were covered by Medicare Part B; and 16% used self-pay option as they were probably uninsured. Our Access Regional Services, consisting of county-operated clinics in King City, Marina, Salinas, and Soledad as well as services provided by community-based agencies, served 7,683 clients. 74% of all CSS program clients belonged to Access Regional Services.

V. Prevention and Early Intervention (PEI) Plan:

The process used to identify the PEI priority populations

The county shall include the following in the CCPR:

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

i. Underserved cultural populations
ii. Individuals experiencing onset of serious psychiatric illness
iii. Children/youth in stressed families
iv. Trauma-exposed
v. Children/youth at risk of school failure
vi. Children/youth at risk or experience juvenile justice involvement

CRITERION II:

UPDATED ASSESSMENT OF SERVICE NEEDS

MCBH is following the recommendations of the Mental Health Services Oversight and Accountability Commission (MHSOAC) to implement services that promote wellness, foster health, and prevent the suffering that can result from an untreated mental illness. The current organizing framework from the MHSOAC includes the following service categories:

i. Prevention
ii. Early Intervention
iii. Stigma and discrimination reduction
iv. Recognizing early signs of mental illness
v. Promoting greater access and linkage to treatment
vi. Suicide prevention

All programs employ strategies for promoting access and linkage to treatment, improving timely access to services for underserved populations, and utilizing non-stigmatizing and non-discriminatory practices. These categories and strategies align with Mental Health Services Oversight and Accountability Commission (MHSOAC) requirements of 2018 and can be found HERE. Based on data for Monterey County as described throughout Criterion 2, in FY21/22 MCBH prioritized two underserved populations as priority populations for PEI funded programs and services: 1) Medi-Cal eligible Latinos and 2) all residents living in the Northern Region of Monterey County. Other priority populations include transition age and college age youth, older adults, African Americans, individuals who are at risk of suicide, individuals who are experiencing early psychosis disorders and reducing childhood exposures to trauma in alignment with SB 1004 which identifies priority populations for PEI. MCBH PEI funded programs have been developed to address disparities in these specific populations and can be referenced in the MHSA FY 21-23 Three-year Program and Expenditure Plan found HERE

CRITERION III:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. List the target populations with disparities your county identified in Medi-Cal and all MHSA components (CSS, WET, and PEI)

The county shall include the following in the CCPR:

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

i. Medi-Cal population
ii. Community Services Support (CSS) population. Full-Service Partnership population
iii. Workforce, Education, and Training (WET) population; Target to grow a multicultural workforce
iv. Prevention and Early Intervention (PEI) priority populations: These population are county identified from the six PEI priority populations

When examining disparities in the Medi-Cal population based upon race, ethnicity and age (see Tables 2.4-2.5), we find disparities in numbers of Latinx individuals served in every age group with Latinx individuals between the ages of 5 and under having the largest disparate gap of 42%, followed by 6-15 36%, 16-25 age range had a disparate gap of 14%, Latinx individuals ages 26-29 had a disparate gap of 8 %, and individuals age 60+ in the Asian/Pacific Islander population had a disparate gap of 7%. To fully understand who is being served and how this impacts service gaps, MCBH needs to better understand the racial and/or ethnic identity of individuals who select "Other" as their racial and/or ethnic identity, as 31% of Medi-Cal beneficiaries served in MCBH and/or contracted services selected "Other". It is recommended that our Quality Improvement department develop a strategy to accurately obtain this information in a client-centered and trauma-informed approach so that MCBH can better understand where service gaps exist and develop targeted strategies to address these gaps.

Regarding regional equity, MCBH breaks down the Medi-Cal population by race, ethnicity and region, as part of aligning services with the needs of this population. Medi-Cal beneficiaries eligible for mental health services are primarily Latinx, located predominately in the Salinas Valley region of Monterey County. 47% of the Medi-Cal population resides in the Salinas Valley, 20% in the Coastal Region, 12% in the North County region, 19% in the South County region, and 2% in other areas.

CRITERION III:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

Monterey County Behavioral Health has served Medi-Cal beneficiaries in the Salinas Valley at 48%, South County at 22%, the Coastal Area at 20% and lastly, North County at 9% with a services gap of –3%. Table 3.1 below shows that MCBH has made improvements in decreasing the disparate service provision that has historically occurred in the South County region and highlights the disparate service provision in FY 21/22 for the North County region.

Table 3.1: Monterey Medi-Cal Enrollees and MCBH Beneficiaries Served in FY21/22 by Region

Region	% Enrolled in Medi- Cal	% Served at MCBH	Service Gap
Salinas	47%	48%	1%
South County	19%	22%	3%
North County	12%	9%	-3%
Coastal	20%	20%	0%

Workforce, Education, and Training (WET) population; Target to grow a multicultural workforce

Monterey County Behavioral Health (MCBH) has exhausted the initial allocation of WET and submitted the workforce assessment in prior CCPR. MCBH transferred funding from CSS, as allowed in regulations, to address WET needs beginning in FY 19/20. MCBH also participates in the regional WET partnerships. For reference, the FY 2020/21 - FY 2022/23 MHSA 3-YEAR PROGRAM & EXPENDITURE PLAN can be found HERE. The MCBH has a full-time training manager who oversees efforts to grow our multicultural

workforce, retention, and training efforts for our staff and to the extent that we have capacity, our contract providers. This will be more fully described in Criterion(s) 5 and 6.

Prevention and Early Intervention (PEI) priority populations: These population are county identified from the six PEI priority populations

MCBH is following the recommendations of the Mental Health Services Oversight and Accountability Commission (MHSOAC) to implement services that promote wellness, foster health, and prevent the suffering that can result from an untreated mental illness. The current organizing framework from the MHSOAC includes the following service categories: 1) Prevention, 2) Early Intervention, 3) Stigma and discrimination reduction, 4) Recognizing early signs of mental illness, and 5) Promoting greater access and linkage to treatment and 6) Suicide prevention. All programs employ strategies for promoting access and linkage to treatment, improving timely access to services for underserved populations, and utilizing non-stigmatizing and non-discriminatory practices.

Individuals who are not likely to seek services because of ethnicity, race, sexual orientation or stigma represent unserved or underserved cultural populations. As noted previously due to disparities and inequities, in Monterey County the priority populations include Spanish-speaking Latinos and individuals residing in North Monterey County. Other priority populations include transition age and college age youth, older adults, African Americans, individuals who are at risk of suicide, individuals who are experiencing early psychosis disorders and reducing childhood exposures to trauma in alignment with SB 1004 which identifies priority populations for PEI. MCBH PEI funded programs have been developed to address disparities in these specific populations and can be referenced in the MHSA FY 21-23 Three-year Program and Expenditure Plan found HERE.

II. Identified disparities (within target populations)

The county shall include the following in the CCPR:

List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET and PEI's priority/target populations)

CRITERION III:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

Upon reviewing the data, it is recommended that MCBH focus on disparities that exist within populations based upon region of residence in [North County], ages' [0-5, and 60+, year-olds], race and ethnicity Hispanic (Latinx) as discussed above. *Ref 2.4

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

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

i. Medi-Cal population
ii. 200% of poverty population
iii. MHSA/CSS population
iv. PEI priority population(s)

MCBH's focus is to improve racial and regional health equity for Monterey County residents. Strategies to reduce disparities are consistent across priority populations and categories identified in Criterion 3, III A & B. The Health Department and stakeholder efforts have focused on expanding Medi-Cal coverage for eligible Monterey County residents. The expansion of coverage creates additional eligible beneficiaries; giving MCBH access to serve even more individuals. Some of the strategies designed to engage and serve this population, along with Monterey County residents in need of Behavioral Health care, are stated below.

<u>Strategies to address regional disparities:</u>

- To target hard-to-reach areas of the County, such as the North and South County region, MCBH prioritized hiring staff for the South County region and MCBH increased use of Telehealth and offers space in the MCBH clinics for clients to utilize necessary technology and ensure privacy/confidentiality for therapeutic sessions. In FY 21/22, MCBH was not able to effectively address the regional disparity that continues to exist in North County, and this has been brought to the attention of MCBH leadership.

CRITERION III:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

- MCBH will examine capacity of current workforce to identify strategies for decreasing the disparity for North Monterey County residents and may utilize Telehealth as a strategy that has proven successful in assisting South County residents to access services.
- In FY 21/22 a community agency in North Monterey County, Pajaro Valley Prevention and Student Assistance (PVPSA), added an outreach coordinator through the contract with MCBH to increase engagement in services and develop culturally attuned communication strategies to help residents access mental health services.
- All four regional MCBH Access clinics have walk-in hours and people can receive same day services, although this has been modified as needed to meet health and safety guidelines due to the COVID-19 pandemic, all regional Access clinics remain open for walk-in services to address needs.

Strategies to increase access and engagement in services for Hispanics and Latinos

- MCBH has expanded contracts and maintained relationships with community organizations that employ *Promotoras* and Community Health Workers (CHWS). In FY 21/22, MCBH increased funding to community agencies using MHSA PEI dollars so they could develop culturally specific outreach materials and strategies for reaching historically underserved communities, including Hispanics and Latinos through a Request for Proposal (RFP). The RPF encouraged the usage of Peers (individuals with lived experience related to Behavioral Health), CHWS and *Promotoras.*
- MCBH continues to contract with Interim Inc. to provide comprehensive therapeutic services for Latinos living in the Salinas and South County regions through the Assertive Community Treatment (ACT) program for adults with Serious Mental Illness.

Strategies to address mental health needs of children, youth, and families:

- MCBH has hired additional staff to expand services to children/youth and their families in school settings in collaboration with school districts county-wide. This strategy reduces barriers to care including transportation, childcare, and scheduling for working parents/caregivers. These barriers disproportionately impact families with parents/caregivers who work in agriculture and in Monterey County agricultural workers are predominately Latino.
- MCBH entered contract with a community agency to provide a Mobile Response Team (MRT) for all children and youth in Monterey County who have Medi-Cal or are uninsured. The MRT provides 24/7 crisis counseling to the child/youth and their

caregiver(s) to stabilize crises and help maintain children/youth in the least restrictive environment. The child/youth and family are linked to appropriate mental health treatment as needed. Services are available in English and Spanish.

Strategies to address substance use disorder service needs:

- Substance-use-disorder services are available through the Drug Medi-Cal Organized Delivery System (DMC-ODS) and are integrated into MCBH's organizational structure through Access and contracted service providers.
- MCBH Children's System of Care is participating in the Effective Child Welfare and Justice Systems for Families Impacted by Opioid and/or Stimulant Use: A Learning Collaborative through California Department of Health Care Services Medication Assisted Treatment Expansion. By participating in this Learning Collaborative, Monterey County hopes to create an inter-agency strategic plan for an effective coordinated level of care system for substance use disorder treatment for youth and their families.
- The vision of the Monterey Integrated Systems Transformation Initiative (MISTI) is for MCBH to work in partnership with people with lived experience, provider organizations, and other stakeholders to develop a system of care that is welcoming, recovery/resiliency oriented, and integrated to be better matched to the needs and hopes of people in Monterey County with co-occurring MH and SUD, as well as other complex health and human service needs. Currently, The Medical Director and Deputy Director of Quality are leading a monthly steering committee with the guidance of Dr. Ken Minkoff and Dr. Chris Cline of ZiaPartners. The Steering Committee is being formally empowered by MCBH to represent the partnership that will plan and guide this integration. It includes leadership representatives from various divisions within MCBH, leadership of MH and SUD provider agencies, FQHC leadership representation, representation from people with lived experience, and other partners. As this project progresses, we will also be identifying a cohort of front line "change agent" to help energize the process of change, and representatives of the change agent group will eventually join the Steering Committee as well.

Strategies to provide comprehensive care for clients served in the Adult System of Care:

- MCBH has implemented a very successful system transformation known as Reaching Recovery and began this process in 2018. (For more on the implementation of this model, visit our Quality Improvement Website HERE.) In FY 20/21, MCBH transitioned clients served in Levels 1 and 2 of these models to be in Full-Service Partnerships so that clients needing higher levels of care would have access to "whatever it takes" to recover and live healthy lives with their mental health condition. This successful model continues to be implemented in FY 21/22.

CRITERION III:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

- To identify strategies for addressing disparities MCBH, utilizes the Community Program Planning Process (CPPP) for the Mental Health Services Ac (MHSA). MCBH conducted an in-depth CPPP for the development of the MHSA FY 21-23 Three-year Program and Expenditure Plan, and this is used as the foundation for informing the Bureau's strategies to address inequities and disparities. In addition, MCBH engages in an annual CPPP and the process for FY 21/22 was described in detail in Criterion 1.

MCBH utilized the feedback and input from the CPPP to develop strategies to reduce disparities and increase equity that make sense for diverse community residents. The MHSA funded programs have been developed to address disparities in priority populations that have been identified by the State and based upon local data for the CSS and PEI populations. These strategies can be referenced in the MHSA FY 21-23 Three-year Program and Expenditure Plan found HERE and updated strategies for the MHSA FY 2021/2022 Annual Update can be found HERE.

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

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. Note: New strategies must be related to the analysis completed in Criterion 2.

1. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, action, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medic-Cal, CSS, WET and PEI.

Through the MHSA Innovation (INN) component, MCBH continued to offer a funding opportunity for one-time projects designed to increase the engagement of Latino communities with our local mental health services system. For several years, health record data for Monterey County has indicated Latino communities to be the most underserved in our county. Extensive community feedback has indicated this may be due to current services not resonating with the various Latino ethnicities, languages and dialects, and cultural norms that exist across our large county. In response to this feedback, MCBH has obtained approval from the MHSOAC to utilize INN funding to support individuals and organizations across Monterey County to try out unique approaches to promoting mental health services in ways that better reach their Latino ethnicity, culture, language, city, neighborhood, etc. As a result, it is hoped that more culturally appropriate and impactful mental health service delivery and

communication methods will be uncovered. The first application period began in March 2019, the second occurred in December 2019, with a final application period was announced in the early Summer of 2020. However, due to the widespread COVID-19 pandemic, the final application period has been postponed. MCBH will provide a final evaluation report on this Innovative project upon project completion. Information on Monterey County's MHSA INN projects can be found HERE. In FY 2122, this MHSA INN project was concluded, and a final evaluation report will be provided once completed.

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

The County shall include the following in the CCPR:

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

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

- All the of the programs mentioned above and in prior Criterion are currently operational. It is MCBH's intention to support ongoing efforts to reduce disparities among the vulnerable and underserved communities in Monterey County and to expand access as resources allow.

MCBH's Quality Improvement department provides oversight and monitoring of data related to health equity and the Department of Health Care Services (DHCS) regulations pertaining to Medi-Cal beneficiaries.

MCBH's Quality Management statement is as follows:

Quality Management is a high priority in Monterey County. We value our community and the quality of service we provide. Quality Management is provided through a robust system comprised of multiple programs within our organization. Collectively, it is through these programs that we obtain information on quality of care, evaluation of current processes, and identification of areas for

improvement. Using data to inform decision, we can make the necessary changes to meet the needs of our community. Quality Management ensures to meet all state, federal, and local level regulatory requirements.

MCBH monitors data on an ongoing basis and produces an annual comprehensive report titled "Data Driven Decisions" (D3), with reports starting in FY 2011/12 that can be found HERE. The Quality Assurance Manager in partnership with MCBH's epidemiologist regularly reviews county data to inform Performance Improvement Projects and to monitor MCBH's progress on reducing disparities based upon priority populations identified above. Programs report results of activities, both direct and through outreach, in their quarterly reports for MHSA PEI funded programs. The MCBH was recently introduced to reports available through Microsoft Power BI that will assist the MCBH in tracking service provision and utilization, among other key factors. The Health Equity and Cultural Competency Coordinator will work closely with the Avatar information technology staff to develop culturally competent-related benchmarks for programs, to ensure that measurable objectives are monitored on a regular basis.

C. Identify County technical assistance needs.

The County would benefit from technical assistance in developing strategic plans to measure and monitor the effect of identified strategies, objectives, actions, and timelines for reducing disparities.

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

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

The county shall include the following in the CCPR

A. Briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role).

MCBH's committee that has fulfilled this role has been the Cultural Relevancy and Humility Committee (CRHC). The CRHC has been functioning for the past several years and has operated under the following mission statement: The mission of the CRHC is to support a holistic approach to bring equitable services to all community members in Monterey County through cultural humility awareness and education, with the end goal of all Monterey County residents having an equal opportunity to reach their full health potential.

In FY 19/20, MCBH began working with a consultant who has provided training in Monterey County on culturally and linguistically appropriate services (CLAS) in Behavioral Health, as well as participated in state and national efforts related to cultural competency, to engage in a process so that the CRHC could evolve and transition to a more diverse and robust committee that would lead MCBH in efforts to eliminate disparities. MCBH convened a Transition Team of MCBH staff, community members, clients and contract providers who met between the months of May-August 2020, along with the consultant, to examine the current organizational structure and the role of the CRHC in MCBH. Recommendations were made to increase diverse representation on the committee and to develop relationships with existing groups who represent the cultural and ethnic diversity of Monterey County. Additionally, MCBH committed to dedicating additional resources and staffing from Quality Assurance and MCBH leadership to assist with the development and implementation of a transparent and inclusive process for obtaining client, community, and staff input related to cultural competence planning, implementation, monitoring and evaluation.

In FY 20/21 the larger CRHC meetings resumed in October 2020 and continued in FY 21/22 where 9 meetings were held during this time. The meetings were held virtually using Zoom video conferencing. Interpretation was available for individuals who needed

assistance due to language needs as meetings are facilitated in English. The meetings were facilitated by Dana Edgull, who was the CC/ESM in FY 21/22.

The CRHC performed the following functions in FY 21/22:

- Provides input and recommendations to MCBH on practices, policies and procedures that impact Behavioral Health care provided to Monterey County residents by MCBH and contracted providers.
- Provides input and recommendations to MCBH on the Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) and on ongoing MHSA initiatives, such as Innovations planning and implementation.
- Provides recommendations to establish and implement a transparent and inclusive process for obtaining client/participant, community, and staff input related to cultural competence planning, implementation, monitoring and evaluation.
- Reviews county data on services and outcomes for Monterey County residents served by MCBH and contracted providers to identify racial and ethnic disparities, along with inequities based upon an individual's personal identity and life experiences.
- Provides recommendations to MCBH staff, including the Behavioral Health Director, to effectuate change to reduce and eliminate racial and ethnic disparities, along with inequities based upon an individual's personal identity and life experiences in Behavioral Health Care service delivery and client/participant outcomes. This includes the Training Plan for MCBH and contract providers.
- Policies, procedures, and practices that assure members of the Cultural Competence Committee with be reflective of the community, including County management level and line staff, clients and family members from ethnic, racial and cultural groups, providers, contractors and other members as necessary.

In the CCPR for FY 20/21, MCBH described a plan to convene a Steering Committee that would develop infrastructure and build relationships to support authentic community engagement and involvement with diverse community groups along with a timeline for implementation. Due to staffing and resource challenges, MCBH was not able to execute this plan. MCBH was able to conduct an organizational assessment on Racial Equity by Dr. Kenneth Hardy of the Eikenberg Institute in FY 21/22.

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

For the organizational assessment, the consultants from the Eikenberg Institute conducted 25 focus groups with a total of 47 participants between February and March of 2022. All Behavioral Health staff were invited to participate multiple times in the focus groups and the total number represents a small percentage of MCBH staff. It is unclear why the participation rates were so low and further investigation is warranted. The focus groups were comprised of a diverse range of staff, including Behavioral Health Director and Assistant Bureau Chief, the Medical Director, Deputy Directors, Managers, Supervisors, Administrative and Line Staff. The input and feedback collected during the focus groups was analyzed and synthesized into recurring themes and consultants' personal reflections. This, along with the verbatim responses from all participants and consultants' recommendations, was compiled into a resultant Race, Equity, and Inclusion Organizational Assessment Report which MCBH leadership received in May 2022. MCBH is currently prioritizing key themes from the report in a strategic plan to improve the organizational culture and create a more equitable and diverse Bureau.

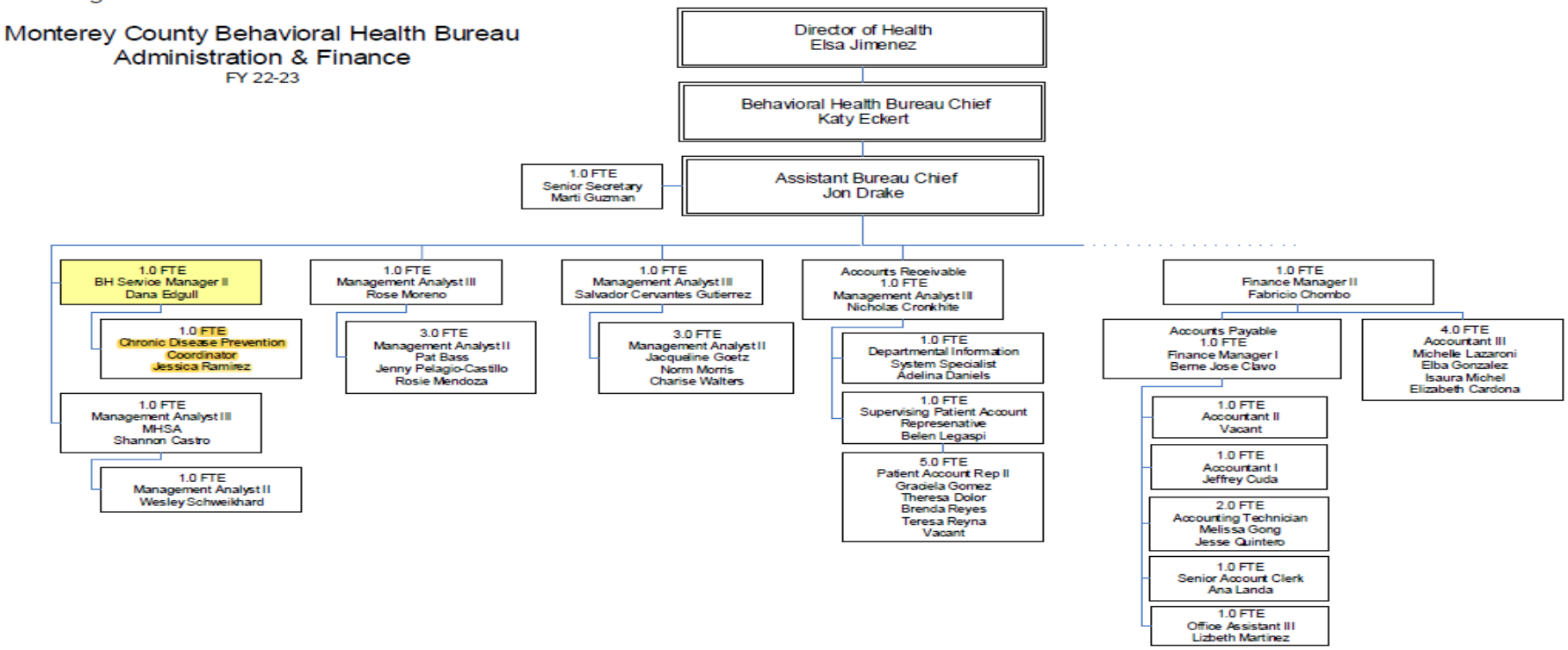
There are no formal policies or procedures related to membership for the CRHC. Currently contract providers who work with historically underserved communities are encouraged to participate in the CRHC, along with contract providers who are funded by MCBH to provide Behavioral Health Services, including Substance Use Disorders. Diverse representation on the committee is highly encouraged and the CC/ESM is continuously working to engage staff, community partners, consumers, family members and local activists to participate in the CRHC through presentations, 1:1 connection, and email campaigns.

One of the key functions of CRHC members is to support the expansion of the committee to include representation of unrepresented cultures and ethnic groups, and to encourage others to join the group to include fresh insights from the community. The roster list in Table 4.1 is inclusive of consumer and family members, community organizations, stakeholders, MCBH and Health department staff. Ms. Edgull, the Ethnic Services Manager sends calendar invites with time and Zoom video conferencing link to participants to ensure meeting participation.

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

C: Organizational Chart



CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

D. Committee membership roster listing member affiliation if any:

Table 4.1 Cultural Relevancy and Humility Committee Roster		
Name	Organization	Affiliation or Role
Dana Edgull	MCBH	Ethnic Services Manager
Katy Eckert	MCBH	Behavioral Health Director
Lindsey O'Leary	MCBH	Quality Improvement Manager
Jill Walker	MCBH	Training Manager
Nivedita Meethan	MCBH	Epidemiologist
Yvette Carreon	MCBH	Access Team Supervisor
Luis Saldana-Ruiz	MCBH	Adult System of Care
Relindis Diaz	MCBH	Children's System of Care
Raquel Morris	MCBH	Adult System of Care
Adriana Furuzawa	Felton Institute	Early Psychosis Division Director
Jacob Agamo	The Epicenter	Our *Gente* Coordinator
Sam Gomez	The Epicenter	Program Coordinator
Norma Ahedo	Center for Community Advocacy	*Promotora*
Natalie Herendeen	Center for Community Advocacy	Executive Director
Robin McCrae	Community Human Services	Executive Director
Mel Mason	The Village Project	Executive Director
Regina Mason	The Village Project	
Justin Alnas	NAMI	Office Manager
Maria Gurrola	California State University Monterey Bay	Department Chair of the Social Work Department
Kontrena McPheter	OMNI Resource Center	Peer Outreach and Advocacy

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

II. The County has a Cultural Competence Committee, or other group with the responsibility for cultural competence, is integrated within the County Mental Health System.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures and practices that demonstrate the Cultural Competence Committee's activities including the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county

Members of the CRHC provide input to support the integration of cultural competence in the local Behavioral Health Care service delivery system. The Committee receives reports from the Quality Assurance/Quality Improvement (QI) Program on an annual basis and reviews data each fiscal year that includes numbers of individuals served by race & ethnicity, gender, and region to examine disparities based upon these demographics. Additionally, service trends, primary mental health and substance use disorder diagnoses, and hospitalization rates are reviewed.

Provides reports to Quality Assurance/Quality Improvement Program in the county:

QI team members are active CRHC members and regularly attend committee meetings. In these meetings, QI hears committee concerns and receives feedback as they share policy updates on QI activities. Ms. Edgull provides updates to the QI Committee as needed. Ms. Edgull is in regular contact with QI team members to report any committee members concerns or grievances.

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county

Members of the CRHC provide input to support the integration of cultural competence in the local Behavioral Health Care service delivery system. The Committee receives reports from the Quality Assurance/Quality Improvement (QI) Program on an annual basis and reviews data each fiscal year that includes numbers of individuals served by race & ethnicity, gender, and region to examine

disparities based upon these demographics. Additionally, service trends, primary mental health and substance use disorder diagnoses, and hospitalization rates are reviewed.

2. Provides reports to Quality Assurance/Quality Improvement Program in the county

QI team members are active CRHC members and regularly attend committee meetings. In these meetings, QI hears committee concerns and receives feedback as they share policy updates on QI activities. Ms. Edgull provides updates to the QI Committee as needed. Ms. Edgull is in regular contact with QI team members to report any committee members concerns or grievances.

3. Participates in overall planning and implementation of services at the county

During this past FY there were limited opportunities for the CRHC to be involved in the overall planning and implementation of services at the county. It is recommended by the CC/ESM that MCBH develop policies and procedures to ensure there is adequate opportunity with clear roles for the CRHC to be involved in planning and implementation of the Behavioral Health Care service delivery system. As MCBH is embarking on the implementation of California Advancing and Innovating Medi-Cal (CalAIM), we will look for ways the CRHC can be involved in the systemic transformation of the Medi-Cal Behavioral Health Delivery System.

4. Reporting requirements including directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director

The MCBH Director, Katherine Eckert, has been involved with CRHC meetings and hears concerns directly from the Committee. Ms. Edgull reports to the Assistant Bureau Chief and brings forward concerns identified by the Committee in regularly held meetings with the MCBH executive staff which includes Ms. Eckert. CRHC members attend the Behavioral Health Commission (BHC) meetings, which is comprised of executive BH staff. Concerns are brought forward during public comment to the BHC and key CRHC members discuss and report on Committee goals and progress.

5. Participate in and review county MHSA planning process

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

6. Participates in and reviews county MHSA stakeholder process
7. Participates in and reviews county MHSA plans for all MHSA components

For the MHSA annual update for FY 21/22, which covers the reporting period for this CCPR, MCBH contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. The purpose of this needs assessment was to collect primary data from community members and providers about the current mental and behavioral health issues in Monterey County and to gather suggestions for improving access to care and services and reducing health disparities.

CRHC members were recruited to participate in the CPPP for the Annual Update for the MHSA for FY 21/22 and assisted with planning and outreach for the CPPP. As was reported on in the CCPR for FY 20/21, MCBH posted a presentation that was reviewed by the CRHC to inform the public of the CPPP and included an audio version on the website. To review the audio/visual aid for the CPPP and the finalized Annual Update for FY 22 which describes the CPPP please go to our website HERE.

The CRHC receives updates on any significant MHSA changes over the course of the plan's timeline. All CRHC members can participate and provide feedback during the MHSA plan's development on an annual basis. They are also able to ask questions and are notified of significant changes to the MHSA. CRHC members are also encouraged to provide comments in oral or written form during the public comment period and are asked to invite other to do so as well.

1. Participates in and reviews client developed programs (wellness, recovery, and peer support programs)

In FY 21/22, the CRHC worked in partnership with The Recovery Task Force (RTF), which is a client run committee that focuses on reducing stigma related to mental health and promoting recovery, to implement a community awareness event during suicide awareness month and community outreach throughout the year. The CRHC has several members from RTF that represent the peer and client perspectives and they share updates on client centered programming for input and collaboration. The CRHC is recruiting

youth and family members to the CRHC and in FY 20/21 have added members from a youth run community agency, The Epicenter. The CRHC would like to expand its focus in this area for FY 22/23 and in future years.

2. Participates in revised CCPR (2010) development.

This is an area that is underdevelopment as MCBH is waiting to see the updated regulations that will be released from the Department of Health Care Services (DHCS).

A. Provide evidence that the Cultural Competence Committee participates in the above review process.

Once the DHCS releases updated regulations for the CCP, MCBH will involve the CCC or similar committee in developing a CCP for MCBH.

A. Annual Report of the Cultural Competence Committee's activities including:

1. Detailed discussion of the goals and objectives of the committee

Were the goals and objectives met?
If yes, explain why the county considers them successful?
If no, what are the next steps?

i. Reviews and recommendations to county programs and services
ii. Goal of cultural competence plans'
iii. Human resource report
iv. County organizational assessment
v. Training plans
vi. Other county actives, as necessary

CRITERION IV:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

As noted above, MCBH has had limited resources to dedicate to the CRHC. Beginning in FY 19/20, resources were diverted to operational functions to ensure MCBH could meet the critical needs of individuals and families with mental health needs. The County of Monterey has been in a hiring freeze due to fiscal concerns and the full-time position for the Ethnic Services Manage was vacant until July 2022. An annual report of the Cultural Competence Committee's activities is not available currently. Meeting agendas and minutes provide a record of the CRHC's activities for FY 21/22 and are posted on the MCBH Quality Improvement website.

In FY 21/22, MCBH contracted with The *Eikenberg* Institute and completed an organizational assessment on racial equity and inclusion for MCBH which was completed in May 2022. MCBH is using the findings and recommendations from this report to further equity focused work for the organization with a consultant, Miguel Gavaldon, who began working with a group of diverse staff in FY 22/23 representing various teams and positions in the organizational hierarchy. This work will culminate in November 2022 with an initial proposed plan to address prioritized areas from the organizational assessment on racial equity and inclusion.

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR:

A. The county shall develop a three-year training plan for required cultural competence training that includes the following:

1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.

MCBH requires that all 400 plus employees (i.e., clinical, clinical support, and administrative) take six hours of cultural competence training per year. Except for the Foundations in Cultural Humility course (formerly Foundations in Cultural Competence), which all employees are required to take once, employees can attend courses of their choice, offered, or approved by MCBH, to meet this requirement.

The Foundations in Cultural Humility course is a 6-hour, classroom-based course (now virtual), taught by Matthew R. Mock, Ph. D. The course support MCBH's ability to productively address challenges related to cultural differences and develop ways to turn often difficult dialogues into ones that are informative, instructive, and ultimately helpful for all involved.

MCBH also provides and tracks cultural competence training for clinical and clinical-support staff who work for MCBH contract agencies and bill Medi-Cal; contract provider employees include approximately another 200 individuals.

2. Steps the County will take to provide required cultural competence training to 100% of their staff over a three-year period.

MCBH's Training Manger has developed a cultural competence framework to guide the development and identification of training that qualifies for the 6-hour per year cultural competence requirement. Currently the focus is on classroom training; however, the Training Manager is developing a cultural competence consultation format that will support clinical service and also a way to track staff participate in community activities that expose them to the cultural values and traditions of our citizenry, which will also count toward the requirement.

The cultural competence framework focuses on three areas:

i. Humility

ii. Knowledge
iii. Practice/Skills

Compliance with the cultural competence requirement is managed using MCBH's learning management system, NeoGov Learn. Reports can be generated which track both MCBH and Contract staff attendance.

3. How cultural competence has been embedded into all trainings.

The Training Manager has been intentional in incorporating cultural competence in MCBH training standards. One way this occurs is to ensure that all instructors are aware of the cultural backgrounds represented in the Monterey County and the clients MCBH serves. Such information includes statistics about racial, linguistic, socio-economic status, and common mental health diagnoses in our communities. With this knowledge, instructors can tailor their presentations.

The Training Manager also encourages instructors who teach clinical interventions (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavior Therapy) to present research about the effectives of their intervention with various cultural groups, including Latinx individuals who make up a large portion of our community.

MCBH's efforts to imbed cultural competence into all trainings has not always been successful. In 2017, the Training Manger added a cultural competence item to the class evaluation: ***"Cultural issues were identified and discussed."*** Except for classes that focus on cultural competence, this item almost always receives the lowest evaluation score, and comes out neutral; participants neither agree nor disagree. ***MCBH could benefit from technical assistance to support embedding cultural competence into all trainings.***

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

1. Please report on the cultural competence trainings for staff. Please list training, staff and stakeholder attendance by function (if available, include if they are clients and/or family members):

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

[Table 5.1]

Date	Course Name	General Competence Focus	Cultural Competence Focus	Hours	Target Audience	Learners (Approx)	Lead Trainer
09/27/21	Foundations in Cultural Humility	Culturally Rooted Care	Humility	6	All Staff	11	Mock, M
12/13/21	Asian Americans: Strength & Resilience in Difficult Times	Culturally Rooted Care	Humility	3	Clinical Staff	15	Mock, M
01/24/22	Foundations in Cultural Humility	Culturally Rooted Care	Humility	6	All Staf	6	Mock, M
06/22/22	Foundations in Cultural Humility	Culturally Rooted Care	Humility	6	All Staff		Mock, M
08/16/21	Introduction to Public Behavioral Health	On Boarding	Humility	4	All Staff		Mock, M
08/19/21	Introduction to Public Behavioral Health	On Boarding	Humility	4	All Staff	5	Walker, J
10/14/21	Introduction to Public Behavioral Health	On Boarding	Humility	4	All Staff	4	Walker, J
01/31/22	Introduction to Public Behavioral Health	On Boarding	Humility	4	All Staff	4	Jones, L
06/06/22	Introduction to Public Behavioral Health	On Boarding	Humility	4	All Staff		Walker, .
10/18/21	Cultural Complexities in Engagement, Assessment & Diagnosis	Culturally Rooted Care	Knowledge	6	Clinical Staff	12	Mock, M
01/13/22	Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth	Culturally Rooted Care	Knowledge	3	Clinical Staff	13	Pacha, K.
02/10/22	Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth	Culturally Rooted Care	Knowledge	3	Al Staf	24	Pacha, K.
07/07/21	Progress Note Writing	Documentation	Knowledge	4	Clinical Staff	3	Jones, L
08/04/21	Universal Psychosocial Assessment	Documentation	Knowledge	4	Clinical Staff	7	Amerault, E
09/01/21	Treatment Planning	Documentation	Knowledge	4	Clinical Staff	22	Sudak, D
09/27/21	Treatment Planning	Documentation	Knowledge	4	Clinical Staff	10	Jones, L
10/06/21	Progress Note Writing	Documentation	Knowledge	4	Clinical Staff	15	Jones, L
11/03/21	Universal Psychosocial Assessment	Documentation	Knowledge	4	Clinical Staff	8	Jones, L
02/02/22	Universal Psychosocial Assessment	Documentation	Knowledge	4	Clinical Staff	7	Jones, L
03/02/22	Treatment Planning	Documentation	Knowledge	4	Clinical Staff	10	Jones, L
10/07/21	Mandated Reporting	Professionalism	Knowledge	3	Clinical Staff	44	Garrett, J
02/03/22	Annual Behavioral Health Legal Updates 2022	Professionalism	Knowledge	3	All Staf	27	Garrett, J
12/14/21	Human Trafficking & Our Community	Trauma Informed Care	Knowledge	3	All Staf	49	MCRCC
12/16/21	Human Trafficking & Our Community	Trauma Informed Care	Knowledge	3	All Staf	31	MCRCC
11/15/21	Working w/ Latinx When You Yourself Are Not Latinx	Culturally Rooted Care	Skill	3	Clinical Staff	13	Mock, M
02/10/22	Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth	Culturally Rooted Care	Skill	3	Al Staf	20	Pacha, K.
02/14/22	Cultural Complexities in Engagement, Assessment & Diagnosis	Culturally Rooted Care	Skill	6	Clinical Staff	9	Mock, M
03/24/22	What's Your Pronoun?	Culturally Rooted Care	Skill	3	Al Staf	16	Pacha, K.
04/07/22	Working with Trans & Gender Expansive Children 11 & Under	Culturally Rooted Care	Skill	3	Clinical Staff	8	Pacha, K.
04/14/22	Working with Trans & Gender Expansive Children 11 & Under	Culturally Rooted Care	Skill	3	Clinical Staff	11	Pacha, K.
06/10/22	72 hour Involuntary Holds: Authorization Course (5150/5585)	Safety	Skill	3	Clinical Staff		Walker, .

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

2. Annual Cultural Competence training topics shall include, but not be limited to the following:

i. Cultural Formulation.
ii. Multicultural Knowledge.
iii. Cultural Sensitivity.
iv. Cultural Awareness; and
v. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disability, etc.)
vi. Mental Health Interpreter Training
vii. Training staff in the use of mental health interpreters
viii. Training in the use of interpreters in the mental health setting

For four months in FY 21/22 (January through April 2022), the Training Manager met with the Cultural Relevance and Humility Committee (CRHC) to identify the cultural competence training focus for FY 22/23. Through the process of brainstorming, evaluating and decision making, the Committee came to a consensus that training should focus on "hosting a conversation;" the ability to talk with clients about diversity, equity and inclusion issues supports (3) Cultural Sensitivity.

As is evident in Table 5.2 below, which outlines MCBH's cultural competency training topics, MCBH did not provide training in the use of interpretation training. ***MCBH could benefit from technical assistance to support interpreter training.***

[Table 5.2]

Course	Cultural Formulation	Multi- Cultural Knowledge	Cultural Sensitivity/ Awareness	Social/ Cultural Diversity	MH Interpreter Training	Use of MH Interpreters
Intro to Public Behavioral Health			X	X		
Foundations in Cultural Humility		X	X	X		

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

Cultural Complexities in Assessment, Dx & Engagement	X	X	X	X		
Working with Latinx Clients When You're Not Latinx			X	X		
Asian Americans: Strength & Resiliency in Difficult Times			X	X		
Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth: Knowledge		X	X	X		
Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth: Skills		X	X	X		
Working with Trans & Gender Expansive Children 11 & Under	X		X	X		
What's Your Pronoun?			X	X		
Community Interpretations			X		X	
72-hour Involuntary Holds: Authorization Course (5150/5585)						
Human Trafficking & Our Community		X	X	X		
Universal Psychosocial Assessment	X		X	X		
Treatment Planning	X		X	X		
Progress Note Writing						

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

			X	X		
Annual BH Legal Updates		X	X	X		
Mandated Reporting		X	X	X		

III. Relevance and effectiveness of all culture competence trainings.

The county shall include the following in the CCPR:

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

i. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities
ii. Results of pre/post-tests
iii. Summary report of evaluations
iv. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
v. County methodology/protocol for following up and ensuring staff, over time and well after they completed the training are utilizing the skills learned.

Rationale/Reducing Disparities

Course	Relevancy in Reducing Disparities
Intro to Public Behavioral Health	Demonstrate to new hires how MCBH's "values in action" support diversity, inclusion, and equity. Provide statistics re: disparities to educate and inspire action/support of BB equity plan
Foundations in Cultural Humility	Increase staff cultural humility and ability to value and respect differences.
Cultural Complexities in Assessment, Dx & Engagement	Help staff minimize misunderstanding of cultural norms with pathological behavior.

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

Working with Latinx Clients When You're Not Latinx	Teaches Non-Latinx clinicians how to more effectively work with clients of a different cultural background
Asian Americans: Strength & Resiliency in Difficult Times	Teaches Non-Asian clinicians how to more effectively work with clients of a different cultural background
Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth: Knowledge	Gives clinicians knowledge of how to more effectively work with religious parents who are struggling with their child's gender identity or sexual orientation
Increasing Family Acceptance Among Religious Caregivers of LGBTQ+ Youth: Skills	Gives clinicians skills to more effectively work with religious parents who are struggling with their child's gender identity or sexual orientation
Working with Trans & Gender Expansive Children 11 & Under	Gives clinicians skills to more effectively work with LGBTQ+ young children and their caregivers
What's Your Pronoun?	Supports cultural humility, knowledge, and skills to support use of accurate pronouns and sharing of their own pronouns
72-hour Involuntary Holds: Authorization Course (5150/5585)	Help staff minimize misunderstanding of cultural norms with pathological behavior
Community Interpretations	Provides knowledge and skills to improve interpretation skills.
Human Trafficking & Our Community	Increases awareness of cultural disparities with respect to human trafficking
Universal Psychosocial Assessment	Help staff minimize misunderstanding of cultural norms with pathological behavior integration into the diagnostic formulation.
Treatment Planning	Increase awareness of a culturally integrated treatment plan to support level of care.
Progress Note Writing	Increases knowledge and skills to more effectively develop and document behavioral health interventions.
Annual BH Legal Updates	Help staff minimize misunderstanding of cultural norms with pathological behavior

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

Mandated Reporting	Help staff minimize misunderstanding of cultural norms with pathological behavior. Provide statistics re: disparities to educate and inspire action/support of BB equity plan

Results of pre/posttests (Counties are encouraged to have a pre/post-test for all trainings)

Due to a lack of personnel, the Training Manager was not able to create pre and post tests for cultural competence trainings during FY 21/22. An analysis of 278 *Cultural Competency Foundations* matched self-report pre and post-tests, administered in FY 19/20, suggest a statistically significant increase across knowledge, awareness, skills, and commitment to cultural concepts presented in this course. Analysis indicates that paraprofessional with non- higher education degrees, reported a greater increase of knowledge, awareness, skills, and commitment compared to staff with undergraduate and/or graduate degrees.

Summary report of evaluations

Class evaluations for Cultural Competence trainings are consistently positive, as are all classes offered by MCBH. As mentioned above, MCBH is less successful in integrating cultural humility, competence, and responsiveness into its general course catalogue. Ratings of courses not listed above, in response to the item: ***"Cultural issues were identified and discussed"*** are most often "neutral" (neither "agrees" or "disagrees," suggesting MCBH has work to do to impend cultural competence into all its course.

Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings

This is another area of growth. MCBH is working to define Cultural Competency skills and then teach to and measure, beyond self-report. ***MCBH could benefit from technical assistance to support cultural competency skills assessment.***

County methodology/protocol for following up and ensuring staff, over time and well after they completed the training, are utilizing the skills learned

This is another area of growth. MCBH is working to define Cultural Competency skills and then teach to and measure, beyond self-report. ***MCBH could benefit from technical assistance to support cultural competency skills assessment.***

CRITERION V:

CULTURALLY COMPETENT TRAINING ACTIVITIES

IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

The county shall include the following in the CCPR:

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

The Success over Stigma (SOS) panel presents multiple times per year to new employees learning about work in public behavioral health. Presenters from SOS are all current or former consumers of behavioral health services and talk about their experience with past and current symptoms, functional impairment, and behavioral health services. They share their stories, including elements of their individual and familial culture, and make recommendations as to how new MCBH staff can engage, build relationships, and effectively work with people like them or in a similar situation. SOS is a program through one of our contract agencies, Interim Inc., that aims to reduce stigma surrounding mental illness by having individuals from the community share their stories of recovery and wellness.

B. The training plan must also include, for children, adolescents, and transition age youth, the parents' and/or caretaker's personal experience with the following:

i. Family focused treatment
ii. Navigating multiple agency services
iii. Resiliency

See answer to IV A. above.

CRITERION VI:

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

The county shall include the following in the CCPR:

A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.

MCBH has exhausted the initial allocation of WET and submitted the workforce assessment in prior report. MCBH transferred funding from CSS, as allowed in regulations, to address WET needs beginning in FY 19/20. MCBH also participates in the regional WET partnerships. For reference, the FY 2020/21 - FY 2022/23 MHSA 3-YEAR PROGRAM & EXPENDITURE PLAN can be found HERE.

B. Compare the WET Plan assessment data with the general population. Medi-Cal population, and 200% of poverty data

Table 6.1 MCBH Staff Race/Ethnicity	Count	Percentage
WHITE	107	28.01%
OTHER	4	1.05%
ASIAN	21	5.50%
HISPANIC	233	60.99%
BLACK	12	3.14%
AK NATIVE/AMER. IND.	5	1.31%
Total	382	100.00%

Table 6.1 reports data identifying MCBH workforce race and ethnicity. Looking at this data we can see that 60.99% of staff report to be Hispanic/Latino, which is reflective of Monterey County general population demographics. In Criterion 2, 2020 Racial

estimates for Monterey County were reported. It is reported that 60% of our residents are Hispanic, with an ethnic break-down of 54.8% Mexican, 0.5% Puerto Rican, 0.3% as Cuban and 3.7% as another Hispanic or Latino group. 42% identified as non-Latino, 29.1% White alone, 2.6% Black or African American, 0.1% American Indian and Alaska Native alone, 5.8% Asian alone, 0.2% Native Hawaiian and Other Pacific Islander alone, 0.2% Some Other race and 2.5% Two or More Races.

However, when looking at Medi-Cal beneficiaries, Hispanic/Latinos comprised 77% of enrolled individuals which is a higher percentage than reflected in MCBH staff. When looking at other racial and ethnic groups, MCBH staff has slightly higher representation of the following racial and ethnic groups: Black/African American (3.14% of MCBH staff compared to 1% of Medi-Cal beneficiaries), Asian/Pacific Islander (5.5% of MCBH staff compared to 3% of Medi-Cal beneficiaries) and Native American (1.31% of MCBH staff compared to 0.1% of Medi-Cal beneficiaries).

C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of the WET Plan submission to the State.

MCBH did not receive cultural consultant technical assistance.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

During Academic Year 21/22, MCBH provided seventeen (17) Master's Level students with a yearlong internship experience; nine (9) of these interns are bilingual (English and Spanish, MCBH threshold language).

MCBH, using $172,000 in MHSA funds, and matching $68,000 in MCBH funds, provided $15,000 to sixteen (16) MCBH employees providing in the Greater Bay Area (GBA) – MCBH Loan Repayment Program. Of these 16 employees, 5 are bilingual (English and Spanish speaking).

CRITERION VI:

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

MCBH, actively advertises open recruitments and works closely with County Health Department's HR to post job descriptions in various venues, including professional association job boards and employment sites, as well as the County website. Job openings are shared internally with staff and with community-based partners and local universities to attract local talent.

E. Share lessons learned on efforts in rolling out of County WET planning and implementation efforts

Developing an effective cultural competence training program requires a dedicated Training unit employee. This employee could also lead efforts to recruit and retain a diverse workforce, reflective of County of Monterey. This position currently does not exist in MCBH. In FY 22/23, MCBH's Training Unit will be rebranded as the Workforce Development unit.

F. Identify County Technical Assistance Needs

<u>MCBH would benefit from support with the following:</u>

1) Outcome Analysis

   MCBH would benefit from consultation regarding how to collect and analyze data related to the impact of cultural competence and other training. Results would inform training content, timing, frequency, etc.

2) Employee Demographics: Race, Gender

   MCBH is required to report out on these statistics; however, HR limits our ability to collect this data.

CRITERION VII:

COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The County shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

A partnership with California State University Monterey Bay (CSUMB) is in place to help build capacity and assist in providing education and training to bilingual students, who could potentially become employees of MCBH and contract providers. It should be noted that MCBH was instrumental through funding and collaborative partnership to establish the Master's in Social Work (MSW) program at CSUMB. The first cohort of MSW candidates graduated in Spring 2013 and since then the University has been graduating individuals who can apply to MCBH vacancies. The intent of the MSW program is to 'grow our own' by providing the opportunity for Monterey County residents to pursue advanced education in social work without having to commute to neighboring counties or sacrifice fulltime employment. The program's curriculum is focused on increasing student competence in serving the Hispanic/Latino community.

MCBH and Monterey County Health Department support CSUMB's Collaborative Health and Human Services (CHHS) bachelor's degree program, which offers concentrations in social work and community health. The program requires 240 field placement hours. Several bureaus within the Health Department, including MCBH, and several of our community partners offer field-placement opportunities for these students. The hands-on experience and engagement the students receive during placement help them become ready to work in our system and provides them introductory knowledge and skill set to effectively work within the community. Many of the students in this program are from Monterey County and are part of the vision to 'grow our own' as a large portion of the students are bilingual with a fair amount coming from families and households where they have dealt with immigration related issues.

CRITERION VII:

COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

For this reporting period the CSUMB MSW program had a Health Resources Services Administration (HRSA) grant to place student interns in rural communities in health care settings and MCBH has partnered with CSUMB to help place interns in MCBH clinics where appropriate.

The CRHC identified these partnerships as an opportunity given that many of MCBH's line staff have bilingual skills and currently serve the Hispanic/Latino Spanish-speaking community as case managers, behavioral health aides and support-group counselors. The CRHC recognizes that helping to build their capacity through education and training can help them become more competent providers and help the Bureau narrow the disparity gaps that currently exist.

MCBH continues to need to develop an orientation process for interpreters and bilingual staff to ensure an understanding of the basics of interpretation ethics and confidentiality. Moreover, MCBH needs to engage in research, via external experts, to ensure best practices for interpreter certification. Additional strategies include intentionally recruiting of bilingual and bicultural employees, bilingual pay for candidates that pass bilingual exam, and an annual stipend of $520.00 for bilingual staff after five (5) years of employment with MCBH.

1. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

Currently MCBH does not have a current MHSA WET plan, although as referenced in Criterions 5 and 6, has an extensive training plan that aims to increase staff skill and knowledge in providing linguistically and culturally appropriate Behavioral Health services to the community.

2. Total annual dedicated resource for interpreter services.

CRITERION VII:

COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

MCBH has allocated funding for vendors to provide interpretation including The Language Line, Media-locate, Natividad Medical Foundation, Indigenous Interpretation services, and utilizes additional entities who are contracted vendors with the Health Department of Monterey County.

The amount dedicated to interpretation for FY 21/22 was $ 157,000.

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The County shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.

Policy 451 Procedure 7 states: "24-hour service access (crisis services/inpatient psychiatric) to a toll-free line (888) 258-6029 to assist staff and consumers with translation services. Access services on outpatient accesses the County's or other local agencies (e.g., Defense Language Institute and translation services for deaf and blind) to assist the translation." Policy 451 can be found HERE.

MCBH clients can call 1-888-258-6029, referred to as the "Access Line", 24 hours a day, seven days a week. The call is answered by bilingual [English and Spanish] MCBH staff during 8:00 AM -5:00 PM with after business hours and on holidays calls are centrally answered by Crisis Support Services of Alameda County (additional information may be found https://www.crisissupport.org/). MCBH and Crisis Support Services provide TTD services for deaf and hearing-impaired callers and offer translation in 240 languages through the Language Line (described below). Detailed Policy information may be found on the QI website at MCBH Policies and Procedures.

CRITERION VII:

COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

To inform the public on the Access Line, it is featured prominently in bilingual MCBH communication materials and website (Click HERE for website) as well as shared at community meetings and presentations on how to access Behavioral Health services, which includes mental health and substance use disorder services.

2. Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.

If an individual comes into a clinic during a time when a bilingual, (English and Spanish), clinical staff is off-site or unavailable or requires assistance in languages other than English or Spanish, the on-site staff can request the assistance of Language Line and have the language and needs of the client addressed. MCBH staff are provided with Language Line instruction cards containing a MCBH identification number and instructions on process. The Language Line service staff will provide interpretation within a reasonable amount of time and explain the interpretation process to the individual and/or family, including reviewing confidentiality of information, via their services.

In addition, MCBH has access to the County's master agreement list of providers that have additional language service providers. For part of FY 21/22, MCBH utilized Indigenous Language Interpreters from Natividad Medical Foundation (NMF) http://interpretnmf.com/, to provide language access for individuals who speak an Indigenous language and NMF was able to provide in-person interpretation. After this agreement ended in early 2022, MCBH partnered with the Health Department to enter contract with *Centro Binacional para el Desarrollo Indígena Oaxaqueño* (CBDIO) in order to continue providing language access for individuals who speak an Indigenous language. MCBH was able to utilize this contract as of September of 2022.

3. Description of protocol used for implementing language access through the County's 24- hour phone line with statewide toll-free access.

As noted above, the MCBH has a toll-free number that is answered 24 hours a day seven days a week (1-888-258-6029). The call is answered by bilingual (English and Spanish) MCBH staff during 8:00 AM -5:00 PM with after business hours and holidays calls

centrally answered by Crisis Support Services of Alameda County (additional information found at https://www.crisissupport.org/). MCBH and Crisis Support Services provide TTD services for deaf and hearing-impaired callers and offer translation in 240 languages through the Language Line.

To inform the public on the Access Line, it is featured prominently in bilingual MCBH communication materials and website, as well as shared at community meetings and presentations on how to access Behavioral Health services which includes mental health and substance use disorder services.

Staff are trained on how to utilize the Language Line with instructions being available on our Quality Improvement website HERE, which also identifies how to access the Indigenous Language Interpreters noted above. When MCBH clinical staff receive a caller, whose language is unknown by clinical staff, then staff is instructed to contact the Language Line for assistance in determining the caller's language and collect the caller's telephone number to ensure follow up if the call is inadvertently disconnected before securing an interpreter. Policies and clinical documentation may be found at by clicking the following link HERE.

4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access to meet the client's linguistic capability.

During orientation, staff are provided information about interpretation resources and on how to use the Language Line which addresses how to use with the 24-hour phone line. Each employee receives a card provided by Language Line with instructions on calling and obtaining the appropriate interpreter.

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

Clients are informed of their rights to services in their preferred language, and their preference is recorded in the Electronic Medical Record (EMR) during initial assessments. Materials informing clients of the availability of interpretation services at no-cost to

them are provided during the initial visit. The MCBH Client Rights document given at intake outlines this as well. Every effort is made to provide services by bilingual staff directly, without use of an interpreter, but the client is still informed of the availability of interpretation services. Each Access Team has bilingual staff (English and Spanish) and materials in both languages. Additional language information about interpretation is available through materials provided by the Language Line. Posters and cards with information about interpretation services are displayed throughout the offices, so clients have access to information in their preferred language.

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

Use of interpreters is documented in the EMR, and the consumer's preference for services in their own language is noted in admission documents. Language used (other than English) to deliver a service, including when an interpreter or language line was used, is noted within the client health record via progress notes. Interpretation services provided by others are noted in billing invoices from contracted interpreters, including date, name, location and amount of time.

1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff

Bilingual staff are used when available, however the use of the Language Line has also been useful when assessing clients' needs and staff are not proficient in the client's language. The following lessons have been learned about providing services to persons with LEP:

- It is helpful to have a pre- and a post session with the interpreter and MCBH staff.
- It is important to train clinicians on how to utilize interpreters.
- It is beneficial to train interpreters about mental health services provided in our County and on behavioral health terminology.
- Interpreters should be neutral and someone the client does not know or have any prior relationship.

CRITERION VII:

COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

- MCBH needs to increase capacity for addressing language and communication needs for individuals who speak Indigenous languages.
- More bilingual staff are needed. MCBH supports County human resource efforts to increase bilingual staff.

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

MCBH is committed to providing services in the client's preferred language; however, bilingual personnel qualified to provide such services are limited in availability and highly sought after. Historically, this has been one of the reasons MCBH has partnered with community organizations mentioned throughout this plan to best meet the needs of the diverse populations it serves. Conflicting priorities and budget impacts make it difficult to dedicate adequate funds to provide high-level interpreter services in-person in a diversity of languages. Nonetheless, the MCBH understands local linguistic barriers and is working to address these in the best way possible.

E. Identify County technical assistance needs.

MCBH sees a need for technical assistance to most effectively identify languages spoken by callers, especially those who speak languages infrequently encountered in this County. Technical assistance also is needed to improve outreach to clients with LEP, including individuals who speak Indigenous Languages such as *Triqui* and *Mixteco*. It would be useful to receive training and implement strategies that go beyond language barriers to help engage clients who have low utilization rates of service.

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

The County shall include the following in the CCPR:

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

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MCBH has used in-person bilingual staff to assist and serve clients and is currently reexamining this practice. When there is a need to assist a client in a language that staff are not proficient in, staff may acquire services from the Language Line and Natividad Medical Center Foundation. Posters and cards with information about interpretation services are displayed throughout the offices so that clients have information in their preferred language. If bilingual staff are not present or available at the office when a client with language needs comes in, staff members contact the Language Line for assistance. Clinics have bilingual (English and Spanish) support staff on-site at each location. The Crisis Team staff at Natividad Medical Center Emergency Department have available interpreters for Hispanic/Latino and Filipino clients and their family members. Indigenous languages interpreters were available during the first half of FY 21/22 through the Natividad Medical Center's Foundation interpretation services.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

EMR documents, including Assessments and Services Plans, indicate the clients' preferred language. An acknowledgement of interpretation services is provided, and client response is recorded for requested interpretation services. The Consumer Handbook also provides information about availability of interpretation services at no-cost to client.

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

Each contractor is requested to review and sign a Cultural Competence Exhibit as part of their contract with the MCBH. The exhibit clearly identifies the need to provide availability of services in English and Spanish, and other languages as necessary during regular operating hours. The scope of work in the contract also includes expectation that services will be provided in the client's preferred language. Contract Monitors are expected to monitor availability of signage informing clients of their right to interpretation and linguistically appropriate service provision.

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To ensure that contractors are also providing support in a culturally and linguistically appropriate manner, MCBH is working towards increasing contractor's awareness of cultural and linguistic resources. MCBH will include the following statements to ensure interpreters are trained and monitored for language competence:

"Contractor shall ensure all personnel assigned to provide language-interpretive services meet all applicable licensing, certification, training and/or professional criteria during all periods of service provision. Interpreters shall demonstrate proficiency in English and non-English languages, possess knowledge of specialized terms used in the mental health field, and have clear understanding of interpreting ethics and practice."

"Contractor shall maintain files of language interpretation professional criteria of all assigned personnel, including contracted and subcontracted personnel. Contractor will maintain and make available personnel files of aforementioned professional criteria upon request of the County."

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing)

All Spanish bilingual staff are tested for language proficiency upon hire. Bilingual language exams include a Spanish-speaking conversation with a bilingual staff to assess fluency. Further training is provided to bilingual staff that are interested in being interpreters for psychiatric patient's needs.

IV. Provide services to all LEP clients not meeting the threshold languages criteria who encounter the mental health system at all points of contact.

The County shall include the following in the CCPR:

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COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

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

The threshold language for Monterey County is Spanish. Currently, the diversity in languages spoken in the community is beyond the public mental health workforce capacity. Our community is home to speakers of many other languages other than Spanish, such as Tagalog (2,280 individuals) and Korean (1,099 individuals). For legal purposes, Spanish is considered the only "significant" or "threshold" language. In addition, it is known that there is a large population of speakers of Mexican indigenous languages including Mixteco, *Triqui,* and *Chatino*, among others.

MCBH utilized the Indigenous Interpreting+, a program of Natividad Medical Foundation, to meet the linguistic needs of individuals the MCBH serves, such as Mixteco and *Triqui* in the first half of FY 21/22. After this agreement ended in early 2022, MCBH partnered with the Health Department to enter a contract with *Centro Binacional para el Desarrollo Indígena Oaxaqueño* (CBDIO) in order to continue providing language access for individuals who speak an Indigenous language. MCBH was able to utilize this contract as of September of 2022 and will continue to use this contract in the upcoming fiscal years.

MCBH staff have access to the Language Line interpreting services to support assessment, short-term group services, referral to ongoing services, referrals to contractor-provided services, or community services. Interpreting services directions may be found at the following link HERE.

Staff may receive additional guidance for LEP patients in MCBH's Guide to Medi-Cal Mental Health Services, available on MCBH county webpage at http://www.co.monterey.ca.us/home/showdocument?id=51480

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

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Monterey County's threshold language is Spanish, for non-English speakers that do not meet this criterion, MCBH staff work collaboratively with bilingual treatment team members and use the Language Line. MCBH has partnered with the Health Department to enter a contract with *Centro Binacional para el Desarrollo Indígena Oaxaqueño* (CBDIO) in order to continue providing language access for individuals who speak an Indigenous language. MCBH was able to utilize this contract as of September of 2022 and will continue to use this contract in the upcoming fiscal years.

In addition, MCBH staff will work with community resources to connect them to the appropriate resources.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

i. Prohibiting staff from expecting family members to provide interpreter services.
ii. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services
iii. Minor children should not be used as interpreters.

To ensure accurate translation follows Title VI of the Civil Rights Act of 1964, MCBH staff is prohibited from using family members and friends of MCBH clients to provide translation services, as well as clerical staff, except in unplanned circumstances.

MCBH Policy 451: Cultural and Linguistic Services states "…staff is prohibited from expecting family members and friends to provide translation. Only in unplanned situations will clinical staff utilize clerical staff for interpretation and translation services unless the consumer prefers a family member or friend to do the translation. Minor children are not to be used as interpreters."

When possible, Monterey County MCBH will assign staff who speak the same language as the client to the client's treatment team. Clients also may request a provider who is of their same ethic background or whom they feel can best understand their culture. Similar efforts will be offered regarding contractual providers.

If needed, an audio tape of the materials is provided and is available to consumers on this webpage: http://qi.mtyhd.org/index.php/home/printable-documents/ Click on "Medi-Cal Guide to Mental Health Services" to access the audio version.

V. Required translated documents, forms, signage and client informing materials.

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

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

i. Member service handbook or brochure
ii. General correspondence
iii. Beneficiary problem, resolution, grievance, and fair hearing materials
iv. Beneficiary satisfaction survey
v. Informed Consent for medication form
vi. Confidentiality and Release of information form
vii. Service orientation for clients
viii. Mental health education materials
ix. Evidence of appropriately distributed and utilized translated materials

MCBH Policy 452 specifies that information will be provided to clients in their language in an understandable written language. Materials are available to consumers in English and Spanish at: http://qi.mtyhd.org/index.php/home/printable-documents/ . Written material will be provided to the consumer in font size 14 (or larger upon request). Materials will be available during on site compliance visits.

B. Documented evidence in the clinical chart that clinical findings/reports are communicated in the clients' preferred language.

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The EMR documentation includes client's language of preference and documents provided to the client in their preferred language.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of results (e.g., back translation and culturally appropriate filed testing).

MCBH utilizes the state's satisfaction survey instruments to gather information from clients and family members about their level of satisfaction and beneficial outcomes from participation in services. Surveys are provided in the client's language of preference. Reports are developed by the department for distribution and review by the Quality Improvement Committee and the CRHC.

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

Materials are translated either by a contractor or bilingual staff and are subsequently reviewed by various bilingual staff, including Quality Improvement staff, to ensure accuracy. Some materials also are reviewed by the CRHC to ensure appropriate use of language and content. Recommendations from the CRHC are incorporated into final materials.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade) Source: Department of Health Services and Managed Risk Medical Insurance Boards.

Translated materials are reviewed by staff for content and clarity before finalization. The CRHC also provides feedback on reading level of materials and presentations upon request.

CRITERION VIII:

COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

The County shall include the following in the CCPR:

A. List and describe the county's agency's client driven/operated recovery and wellness programs.
The agencies below support MCBH mental and behavioral health client driven/recovery and wellness programs in the community.

Contract Provider Services:

The Epicenter: The Epicenter is Monterey County's first youth-led community center and is an innovative type of organization that is focused on personal connection and relationships. The center provides resources and leadership opportunities for youth, ages 16-24, especially those who are transitioning out of foster care and youth who have been involved with public agencies, such as Juvenile Probation. Services include information, referral and linkage to mental health and other supportive services, coaching and mentoring, training on life skills emphasizing employment and educational opportunities and development and sustainability of local volunteers. The Epicenter also offers support and empowerment services for LGBTQ+ youth through the Our *Gente* program and in this last FY, Our *Gente* staff partnered with MCBH to offer an educational series to help providers understand some of the important issues to consider when working with LGBTQ+ folks. Additional information can be found at their website at http://www.epicentermonterey.org/.

Interim Inc., OMNI Resource Center: The OMNI Resource Center provides outreach, prevention education, and peer support, which contribute to improvements in personal functioning through the development of social and independent living skills. Services are delivered by paid consumers/peers and volunteer staff, in English and Spanish, with administrative oversight from a nonprofit mental-health services organization (Interim, Inc.). Omni Resource Center services are offered by ethnically diverse staff who understand and celebrate cultural diversity. The services provided at the Omni Center are based on personal connection and self-determination, therefore ensuring each client may experience services that are suitable for their individual preferences. Integral values of the Omni Center are to value the diversity of the staff, designing services that are meant to meet the diverse cultures of the clients, and to keep the focus on the whole person. Services include wellness and recovery services, relapse prevention, healthy boundaries, whole health, and *"No Estás Solo"* (You are not Alone) support groups. Additional information may be found at http://www.interiminc.org/.

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COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

Another program operated by Interim Inc. that has been very successful in helping to destigmatize mental health and substance use disorders is Success over Stigma (SOS). SOS provides community presentations by individuals with lived experience with behavioral health conditions who share their personal stories exemplifying hope and recovery. SOS promotes peer and client involvement in advocating for public policies that empower people with psychiatric disabilities and provides peer consultation to service providers for strengthening local and state mental health services.

Contracted community programs at Interim Inc. are client-led and help to inform MCBH and infuse a client culture throughout the system, such as the Recovery Task Force (RTF). The RTF aims for 51% of meeting attendees to be current or former clients and/or individuals with lived experience with a mental health condition. This structure supports the client centered culture, where individuals can feel comfortable discussing gaps in the mental-health continuum and discuss innovative solutions to those issues. Their efforts help to improve services and programs for people with mental health challenges, with the goals of increasing access, decreasing duplication of services, and facilitating community-wide support of mental health recovery. Their meetings are attended by members of the MCBH's Quality Improvement (QI) team, Cultural Competency Coordinator and other MCBH staff who seek to inform and improve the mental health system by soliciting information and feedback about service access and program impact.

i. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.
ii. Briefly describe, from the list in 'A', those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

The Epicenter's central focus areas are LGBTQ+ youth and youth coming out of the foster care system and/or youth who have been involved with another public agency, as noted above. This is a youth-lead initiative and the services that are provided have been designed by youth for youth. The Epicenter also focuses on health and well-being for LGBTQ+ youth with programs such as Our *Gente,* a multi-faceted project that includes community and agency trainings by the Queer and Trans Youth Collective and provides a safe space for lesbian, gay, bisexual, queer and questioning, and asexual youth to come and talk, share, and explore their experiences with peers. The Epicenter fosters youth development and provides supports for youth leadership. Staff at the Epicenter come from diverse cultural and ethnic backgrounds that reflect the populations of Monterey County and the youth that are served in these programs have options to support their needs and personal preferences.

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Interim Inc. provides a variety of services and programs in Monterey County. As noted above, Interim Inc. supports the OMNI Resource Center self-help, wellness and recovery activities and services are available at no cost to interested adults and supports the RTF and SOS. Outreach services and specialized groups and activities are available for Spanish-speaking adults. Most staff and all volunteers at the Omni Center have personal experience with mental health issues and recovery. Interim Inc. also provides residential services for individuals with serious mental health conditions in the MCHOME, Soledad House, Lupine Gardens, Sunflower Gardens and Rockrose Gardens. These programs provide supportive housing for community members that are low income and have serious mental health conditions. The overarching goals of the programs are to maximize recovery or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhancing self- sufficiency. Staff at Interim reflect the diversity of Monterey County residents and individuals served in Interim programs have options to support their needs and personal preferences.

II. Responsiveness of mental health services

The County shall include the following in the CCPR:

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

In addition to the programs noted above, MCBH provides alternative options that accommodate monolingual Spanish speaking communities through contractors such as *Promotoras de Salud*, and the National Alliance on Mental Illness (NAMI) Connections, focusing on Latino outreach. The *Promotoras de Salud* program offers early psycho-educational services, limited individual/family services, and provide referrals for more specialized services in MCBH. The *Promotoras* (visit https://cca-viva.org/health/) utilize an evidence-based approach in their outreach into the community. *Promotoras* provide a bridge to services for the uninsured Latino immigrant community, by readily communicating in the threshold language of Spanish and having staff that understand on a personal level the experiences of Latino immigrants. The contract with CCA was expanded in this past fiscal year to include screening and referral to mental health services by a licensed therapist. In addition, specialized short-term mental health services are available for

Spanish speaking individuals and families in need of therapeutic support through Community Human Services. These counseling services were developed specifically for individuals who do not have insurance or are not documented.

The Village Project Inc. (TVPI) was founded to help meet the needs of the under-served African American community and currently provides early intervention mental health and prevention services to any individual or family in need, thereby increasing the availability of culturally competent services for communities of color. TVPI values providing services from one's cultural identify and sees this as paramount to the organization's mission. The work includes cultural-competence development, culturally relevant mental health training series and systematic-outreach activities. TVPI also provides individual and family counseling, parenting groups, and other prevention services. These services are available to all ages and for Medi-Cal beneficiaries. In addition, the contract with TVPI was increased in this last fiscal year to serve individuals without insurance along with increasing outreach in the community. Learn more about TVPI at their website HERE.

Pajaro Valley Prevention and Student Assistance's (PVPSA) mission is to improve the quality of life for students and families of the greater *Pajaro* Valley by providing health education, mental health and substance use services, and by advocating for public policies that promote the wellbeing of the community. PVPSA serves primarily Latino students and families in North Monterey County which is an underserved region of the County. MCBH has a contract with PVPSA to provide therapeutic services and in this last fiscal year the contract was expanded to include a system's navigator who can help connect individuals and families to care and services that are culturally relevant.

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

Information about each program is available on the MCBH website found HERE and in community announcements on social media. Availability of these programs will be included in the next printing of the member brochure. Member brochures are provided in every MCBH office and are available online.

C. Counties have policies, procedures and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

MCBH works to inform Medi-Cal beneficiaries about available programs and services with regular and ongoing participation in community-health fairs, presentations, workshops and trainings to increase awareness about Behavioral Health services, which

include Substance Use Disorder programs and services. In FY 20/21, MCBH dedicated resources to update and promote a community friendly website, www.mtyhd.org/BH, and has developed content in English and Spanish that informs Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. In addition, MCBH has increased its presence on social media channels advertising available behavioral health services and encouraging Monterey County residents to engage with MCBH to address their behavioral health needs.