San Mateo County Behavioral Health and Recovery Services
Office of Diversity and Equity

Cultural Competence Plan 2018

Contents

Introduction

San Mateo County Behavioral Health and Recovery Services (BHRS) continues to deepen its efforts to develop a culturally responsive and inclusive system in support of the behavioral health and recovery needs of San Mateo County's increasingly diverse population. Through the BHRS Office of Diversity and Equity (ODE), we have laid a strong foundation and legitimacy within our system for deepening the meanings and manifestations of cultural humility and inclusion in partnership with diverse stakeholders and communities. ODE staff have been leading this work through 1) the community-oriented Health Equity Initiatives and the Diversity and Equity Council (Cultural Competence Committee); 2) facilitating BHRS' process to Multicultural Organization Development; 3) championing the adoption of the broader County Health racial equity framework; and 4) development of a health equity focused Theory of Change framework for ODE.

An independent consultant was hired to engage stakeholder in preparation of BHRS' Cultural Competence Plan Update. Engagement methods included online surveys, listening sessions, world café's and one-on-one interviews. Participants were asked for feedback and perspective on ODE's cultural competence investments and strategies as well as their impacts and effectiveness. The following activities and reports informed the plan:

- Cultural Competence Planning Stakeholder Engagement survey (responses: 72)
- Two Listening Session with the Diversity and Equity Council and ODE Team
- Two Cultural Competence Plan World Cafes with Current and Former HEI Co-Chairs
- ODE Theory of Change sessions with community stakeholders
- Health Equity Initiatives 10-Year Impact Report
- Mental Health Services Act Three-Year Plan
- Cultural Competency Plan Assessments and Alcohol and Other Drug Audits

San Mateo County

Located on the San Francisco Peninsula, San Mateo County is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The 2016 population estimated by the U.S. Census Bureau was 764,797. The median age of San Mateo County residents is 39.3 years[1]; 6 percent of the population was under 5 years old, 21.2 percent were under 18 and 15 percent were 65 or older[2]. An estimated 34.6% of San Mateo County residents were foreign born, and this is among one of the highest percentages for foreign-born residents in the Bay Area Region. Projections for 2020 suggest that the biggest changes will be an increase in the senior population (5 % increase), Hispanic/Latino population (3.3% increase), and Asian population (1.9% increase).

[1] 2010 Census
[2] 2015 Census estimates

Criterion 1: Commitment to Cultural Competence

Criterion 1: Provide documents on how the county intends to serve the community appropriately.

a. Mission statement and goals.
b. Policies, Procedures & Practices Related to Cultural and Linguistic Competence (i.e. Hearing-Impaired MH Access, Language Interpreters, Service Area Advisory Committees, Bilingual Bonus, and Employee Trainings Minimum Standards).

County of San Mateo Commitment

The County of San Mateo Shared Vision 2025 reflects the goals and priorities for the San Mateo county community as a whole. The five community outcomes that were identified pave the way for a healthy, prosperous, liveable, environmentally conscious, collaborative community. The BHRS Cultural Competence Plan directly ties into the healthy community goal where the vision is that neighborhoods are safe and provide residents with access to quality health care and seamless services.

On August 8, 2017, the County Board of Supervisors adopted the Diversity and Inclusion (D&I) Initiative, a multi-year process and opportunity for the County to take a strategic approach toward advancing diversity and inclusion goals. This process has included learning, identifying shared goals and priorities, gathering and assessing information and workforce data, identifying barriers and needs, reviewing hiring and recruitment practices, and making recommendations. BHRS is participating in the County D&I Taskforce, convened to offer departments the opportunity to provide input and assist in making recommendations and action plans to identify and advance shared D&I goals.

BHRS Vision, Mission and Values

The following statements were developed out of a dialogue involving consumers, family members, community members, staff and providers sharing their hopes for the Behavioral Health and Recovery Services (BHRS) Division. The members of the BHRS community agree to support the Vision, Mission and Values, and to strive to demonstrate our commitment to these concepts within our individual and collective responsibilities.

The Vision: We envision safer communities for all where individuals may realize a meaningful life and the challenges of mental health and/or substance use are addressed in a respectful, compassionate, holistic and effective manner. Inclusion and equity are valued and central to our work. Our diverse communities are honored and strengthened because of our differences.

The Mission: We provide prevention, treatment and recovery services to inspire hope, resiliency and connection with others to enhance the lives of those affected by mental health and/or substance use challenges. We are dedicated to advancing health and social equity for all people in San Mateo County and for all communities. We are committed to being an organization that values inclusion and equity for all.

**The Vision and Mission statements were recently revised as part of our Multicultural Organization Development work to more explicitly state our commitment to diversity and inclusion. The Values below will also be revised.*

Our Values

Person and Family Centered: We promote culturally responsive person-and-family centered recovery.

Potential: We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery

Power: The people, families and communities we serve and the members of our workforce guide the care we provide and shape policies and practices.

Partnerships: We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity

Performance: We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and additions and to promote the health of the individuals, families and communities we serve.

The Office of Diversity and Equity

The Office of Diversity and Equity (ODE) is a 15-staff unit within the San Mateo County BHRS division that advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo County. The Director of ODE serves as the statewide required role of Cultural Competence/Ethnic Services Manager (CC/ESM) and participates in the County Behavioral Health Directors Association, Cultural Competency Equity and Social Justice Committee to support and learn best and promising practices in the field and stay connected to Statewide efforts. ODE leadership staff also include the Mental Health Services Act (MHSA) statewide roles of MHSA Coordinator and Workforce Education and Training (WET) Coordinator. ODE is funded primarily through MHSA to advance MHSA priorities of cultural competence, reducing ethnic/racial disparities, prevention of serious mental illness and suicide, access and linkage to treatment, stigma and discrimination reduction and outreach for recognizing the signs and symptoms of mental illness. ODE also receives funding from a local half-cent sales tax, Measure K in San Mateo County.

In the Spring of 2017, an ODE Theory of Change process as a critical step to creating a shared understanding of how various activities in ODE contribute to the long-term goal for BHRS' efforts to promote equity, cultural humility and inclusion, investing in this process.

Long-term Goal: In collaboration with and for communities, advance health equity in behavioral health outcomes of marginalized communities by influencing systems change and prioritizing lived-experience.

Pathways: Based on the beliefs that 1) advancing health equity is a key strategy to prevention of mental health and substance use issues; 2) overall systems need redesign to address inequities where individual, institutional and structural biases are addressed; 3) lived-experience matters; and 4) a value-based approach centering cultural humility, inclusion, social justice, community collaboration and focus on wellness, recovery and resilience are necessary; four ODE pathways were identified.

As a result of the engagement in Theory of Change, ODE will now invest more in strategies that address social determinants of behavioral health outcomes. While culturally sensitive health education and awareness campaigns continue to be important strategies to decreasing stigma an important barrier to accessing behavioral health services for marginalized communities, getting to the root causes of inequities such as systemic and community biases and lack of social supports need to be prioritized to truly move forward towards health equity.

Policies, Procedures & Practices

Recently, BHRS adopted **Policy 18-01: Cultural Humility, Equity and Inclusion Framework**. The policy is intended to inform on existing and ongoing organizational efforts to embrace diversity, improve quality, and eliminate health disparities that align with the **National Standards for Cultural and Linguistically Appropriate Services (CLAS)**.

BHRS abides by the County's **Bilingual Salary Differential Allowance Policy** for non-supervisory employees required to use a second langauge critical to day-to-day operations and the **Americans with Disability Act (ADA) Policies and Procedures** to incorporate universal.

CLAS related policies and practices are listed below under the relevant CLAS standard.

Principle Standard (CLAS Standard 1)

- **BHRS Policy 18-01: Cultural Humility, Equity and Inclusion Framework** - BHRS is committed to providing effective, equitable, and welcoming behavioral health and

compassionate recovery services that are responsive to individuals' cultural health beliefs and practices.

Governance, Leadership and Workforce (CLAS Standards 2-4)

- **BHRS Policy 92-03: Affirmative Action** - BHRS is an equal opportunity employer committed to fair and equitable selection procedures and practices.
- **BHRS Policy 08-01: Welcoming Framework** - BHRS, including management, staff, and providers, is committed to creating and sustaining a welcoming environment designed to support recovery and resiliency for those seeking services and their families.
- **BHRS Policy 14-02: Family Inclusion Policy** - BHRS is fully committed to involve family members of clients/consumers to the fullest possible involvement to encourage active, culturally responsive partnership with the family, the consumer/client and clinical staff within all levels of the division.
- **Staff Training and Recruitment** - BHRS Workforce, Education, and Training (WET) programming provides education/training and workforce development opportunities to San Mateo County behavioral health staff, clients/consumers, and family members. WET aims to create and sustain a diverse, culturally responsive, and clinically effective workforce that provides the best possible care for our communities.

Communication and Language Assistance (CLAS Standards 5-8)

- **BHRS Policy 99-01: Services to Clients in Primary or Preferred Language** - states that there shall be enough staff at all mandated key points of contact who are proficient in speaking and reading in the target primary languages.
- **Health System Policy A-25: Client's Right to Language Services Notification** – Limited-English Proficient (LEP) clients will be informed in their primary language that they have the right to language assistance and that services are available free of charge.
- **Health System Policy A-26: No Use of Minors for Intepretation** - Staff will discourage LEP clients from using friends or family members and will not allow minors to interpret.
- **BHRS Policy 05-01: Translation of Written Materials** - procedures for translation of written materials ensures information provided to consumers will be faithful to the intent of the document, contextually accurate, free from any errors, and culturally appropriate and understandable to all readers.
- **BHRS Interpreter Training** - BHRS ensures the County Health interpreter services contractors are trained in cultural competency and behavioral health context.

Engagement, Continuous Improvement and Accountability (CLAS Standards 9-15)

- **Mental Health Policy 97-03 Committee Structure** – identifies advisory committees which have been established for BHRS priorities, which include to enhance diversity in staff and respect for diversity in service.
- **Cultural Competency Plan Requirement for Contractors** - BHRS contractors that provide client services include a cultural competency requirement in their contract.
- **External Quality Review Organizations (EQRO) BHRS Quality Improvement Work Plan** for CLAS includes the following:
    - "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.
    - All staff with direct client contact will accurately report client's "Preferred Language" including American Sign Language or aids like braille or TTY/TDD using the drop down language option in electronic healthcare records (Avatar) progress notes. Trends will be determined and identified as "emerging languages"
    - All staff will complete mandatory training on cultural humility.
    - All staff with direct client contact will appropriately ask client's sexual orientation and gender identity questions (SOGI).
- **Data Collection of Sexual Orientation and Gender Identity (SOGI) and Race Ethnicity and Language (REAL)** - standardizing how information is collected in the electronic health records for sexual orientation, gender identity, sex, preferred name and personal pronoun. Training and technical assistance will be provided to staff. Similar efforts will be undertaken to standardize and disaggregate race and ethnicity data.
- **BHRS Policy: 14-03: Selection of Evidence-Based and Community Defined Practices**- defines a process for selection and evaluation of proposed practices that facilitates broad based and consistent evaluation of these proposals, is inclusive of a broad range of multi-cultural practices and places importance on reducing disparities in access to care.

Criterion 2: Updated Assessment of Service Needs

Criterion 2: Describe the population assessment, assessment data and disparity concerns regarding access to mental health care.

a. General population by race, ethnicity, age, and gender
   - Charts or countywide ethnic break down
   - EQRO data, EQRO penetration rate, MEDS file Data, US Census data, TAY pop and MHSA population assessment

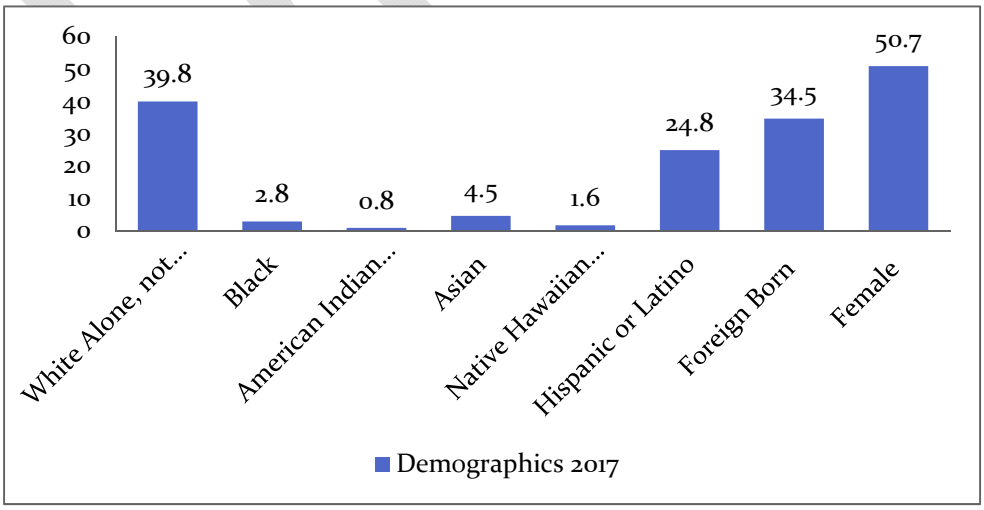
b. List of threshold languages

General Population Overview

San Mateo County has a total estimated population of 764,797[3]. Additionally, an estimated 34.6% of San Mateo County residents were foreign born, and this is among one of the highest percentages for foreign-born residents in the Bay Area Region.

The median age of San Mateo County residents was 39.3 years compared to the state's median age of 35.2 years. Portola Valley had the highest median age of 51.3 years while East Palo Alto a much less affluent and much more diverse community had the lowest at 28.1 years.

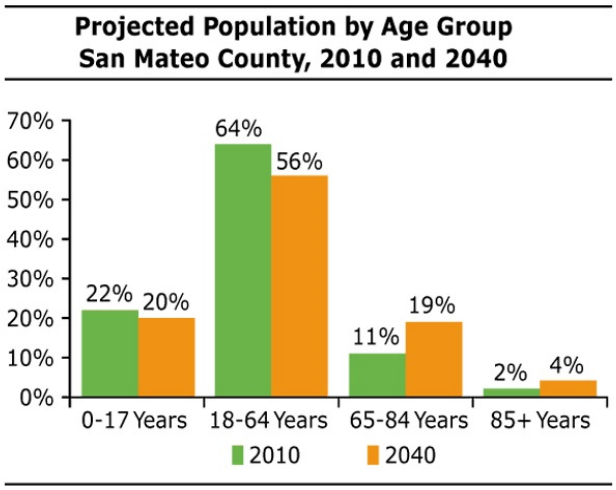
As the County's population continues to shift, the racial and ethnic composition continues to grow in diversity. Race and Hispanic Origin data shows White alone, who are not Hispanic or Latino, holding the largest percentage of County residents as of the July 1, 2016, U.S. Census estimate, with 39.8 percent, a decrease of 2.5 percent since April 1, 2010. Asian alone is the second largest racial subpopulation, with 28.9 percent, an increase of 4.1 percent since 2010. Hispanic or Latino numbers follow closely, with 24.8 percent, a decrease of .6 percent since 2010. Black or African American alone remained stable at 2.8 percent. Native Hawaiian and Other Pacific Islander alone grew to 1.6%, up .2 percent since 2010, and American Indian and Alaska Native alone grew to .8 percent, up .2 percent since 2010.



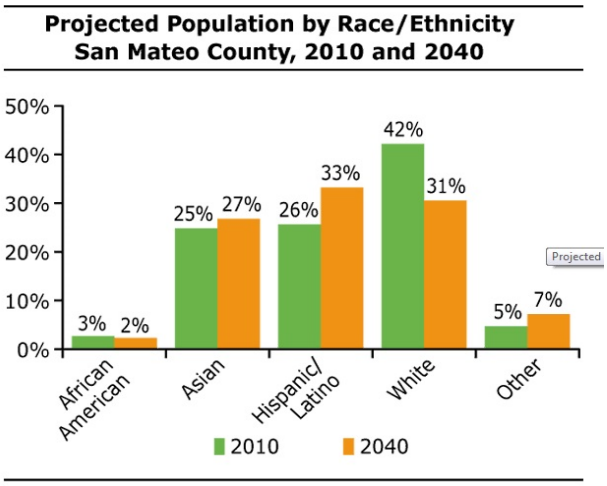
[3] U.S. Census Bureau, 2012-2016 American Community Survey 5-year Estimates

Demographic Projections

By 2040, San Mateo County's White population is projected to decrease as a proportion of the total population by 11%[4]. The Latino community is projected to increase by 7% (from 26% to 33% in 2040). San Mateo County's Asian population is also projected to increase but only by 2% (from 26% to 28% in 2040). Native Hawaiian and Other Pacific Islander population size is anticipated to double in size (from 1% to 2% in 2040). (Source: Sustainable San Mateo). Additionally, the projected population by age group shows that the share of residents 65 and older is projected to almost double. This data points to the increased need to focus on making services relevant and accessible to the Hispanic/Latino, Asian, and older adult population.



Data Source: State of California, Department of Finance



Data Source: State of California, Department of Finance

Sexual Orientation and Gender Identity

Demographic data on sexual orientation and gender identity (SOGI) is scarce. Data sources collect SOGI variables and not the full spectrum of data. The California Health Interview Survey from UCLA, collects annual data via telephone on four levels of sexual orientation.

Sexual Orientation	San Mateo	California
Straight, heterosexual	95.9%	93.3%
Gay, lesbian	2.4%	2.1%
Bisexual	1.4%	2.9%
Not sexual/celibate/none/other	.4%	1.7%

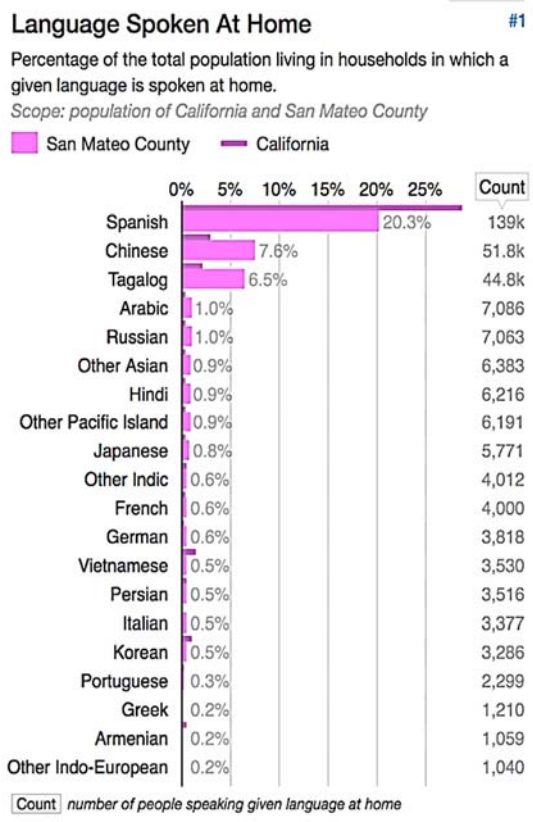
The San Mateo County Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Commission is California's first county commission focused on the needs to the LGBTQ Community. The Commission's Data Work Group developed a comprehensive needs assessment that will shed light on the needs of LGBTQ people who live and work in San Mateo County and will inform future policy recommendations of the commission.

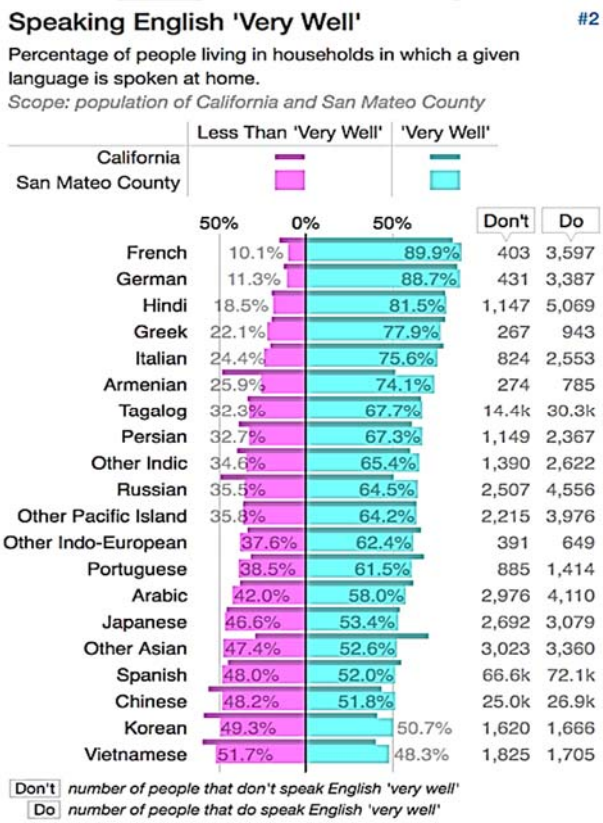
[4] sustainablesanmateo.org

Threshold Languages

According to census data, 46.3% of individuals age five and older served speak a language other than English at home. San Mateo County's threshold languages were English, Chinese, Spanish, and Tagalog. The Health System has also identified Russian and Tongan as priority languages based on a growing number of clients served. Based on BHRS language services requests, Burmese and Arabic may be emerging languages (and communities) in San Mateo County.

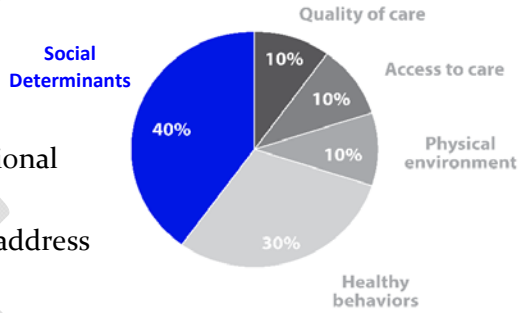
In 2015, the percentage of the total population in San Mateo County living in households in which Spanish was spoken at home was 20.3% or around 139,000 of San Mateo County's population. For those living in households where Chinese was spoken at home, the percentage was 7.6% (which is higher than for California as a whole), or around 51,800. Tagalog – the third non-English threshold language for San Mateo County – was spoken by approximately 7.6% of the population, also higher than the percentage for California as a whole. 48% of people living in households where Spanish is spoken, 48.2% of people living in Chinese speaking households, and 32.3% of people living in Tagalog speaking households speak English less than "very well."





Social Determinants of Health and Racial Equity

Social inequalities are associated with risk factors for behavioral health disorders.[5] For example, the lack of safe and affordable housing is one of the most powerful barriers to recovery. Access to social and economic opportunities; resources and supports, quality education; safe workplaces; clean water, food, and air; and social and community interactions and relationships all impact health. Who lives in neighborhoods that have decent opportunities and resources is determined by government institutional policies and practices. Whether intentionally or not, these often discriminate by race.[6] It is critical that we consider strategies that address social and racial inequities.



San Mateo County Racial Equity Data

Housing

- Housing costs have increased nearly 70% in just 5 years.
- 37% of Blacks, Latinos, Native Americans and Pacific Islanders own the homes they live in, while 67% of Whites own their homes. [6]

Education

- 92% of White students graduated high school compared to 85% of Pacific Islander, 80% of Latino and 77% of Black students. [7]

Economic Stability

- 5% of Whites live below poverty, compared to 10% Pacific Islanders, 13% Latinos, 14% Black and 19% Native Americans.[6]
- Latinos and Blacks are roughly 3x more likely than Whites to live below the minimum income necessary to cover a family's basic needs.[8]

Healthcare Access

- Latinos, Native Americans, and Pacific Islanders are all roughly 4x as likely to be uninsured as Whites. [6]

Community Context

- In 2015, 15 of 16 elected officials were White, 1 was Asian. [6]
- Blacks are over 20x more likely to be incarcerated than Whites; Native Americans are about 15x more likely, Latinos are 3x more likely. [6]

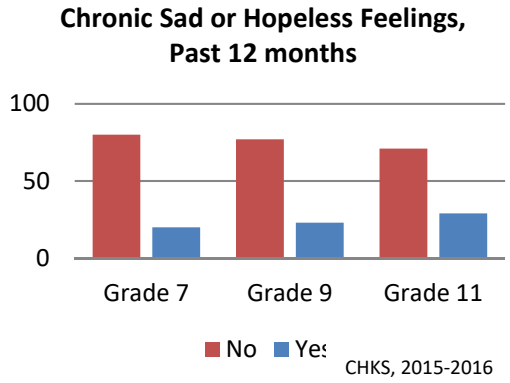
[5] Allen J1, et al. "Social determinants of mental health." *Int Rev Psychiatry. 2014* Aug;26(4):392-407.
[6] centerforsocialinclusion.org/our-work/what-is-racial-equity/
[7] Advancement Project California; RACE COUNTS, racecounts.org, 2017.
[8] Insight Center for Community Economic Development, Self-Sufficiency Standard, insightcced.org, 2018.

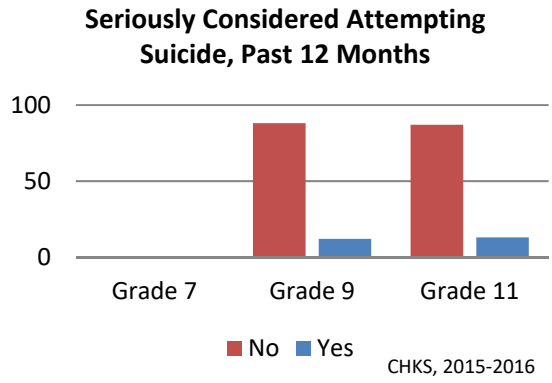
Mental Health Indicators

Through California and San Mateo County administered population health surveys we are able to learn about respondents' experiences with mental health and substance use. According to the 2017 California Health Interview Survey, in San Mateo County.

- 21.4% of adults **needed help** for emotional/mental health problems or use of alcohol/drugs; this increased from 10.7%
- 2.9% of adults likely have had **serious psychological distress** during the past year; this increased from 3.2%
- 8.5% of adults seriously thought about **committing suicide**; this increased from 8.2%

The California Healthy Kids Survey asks teens in grade 7,9 and 11 about chronic sadness or hopelessness as well as suicide attempts in the past 12 months.





According to the San Mateo County Health and Quality of Life Survey:

- Depression is more common among Latinos, low income residents, and those with a high school education or less.
- Those living below the 200% poverty thresholds express the highest average number of **days of poor mental health** per month (3.2 days, versus 1.8 days).
    - In addition, averages are higher among women, residents under 65, Latinos and residents in the South County region.
- Residents of San Mateo County were asked to evaluate the **ease of access** to each of the four specific types of healthcare and they were most critical of the access to mental health services, 36.3% rate this as fair/poor. Evaluations were significantly worse than found in 1998 and 2001 but statistically similar to 2004 and 2008 findings.

According to the San Mateo County 2016 Community Health Needs Assessment:

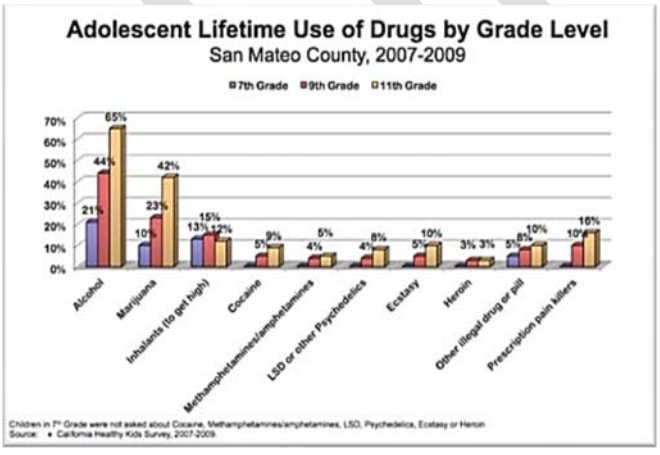
- Suicide was the 10th leading cause of death in 2013 (54 deaths); 9th in 2010 (70 deaths).
- The percentage of surveyed county adults reporting a history of mental or emotional problems is trending up, from 5% in 1998 to 8% in 2013.
- Similarly, in 2013, the percentages of county adults reporting they had sought help for mental or emotional problem was the highest of all years surveyed (29%).

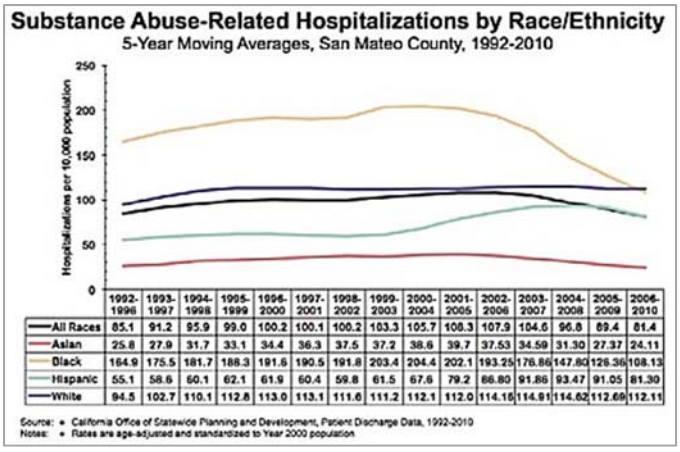
Substance Use

Substance use and its related problems are among society's most pervasive health and social concerns. Use of drugs, such as heroin, marijuana, cocaine, and methamphetamine are associated with severe consequences, including injury, illness, disability and death.[9] Additionally, drug users run a high risk of contracting gonorrhea, syphilis, hepatitis, tuberculosis and HIV. The stigma around substance abuse often prevents individuals from seeking treatment. In San Mateo County:

- Overall drug use among adolescents in 7th, 9th and 11th grade showed a correlation with age. 65% of 11th grade students have tried alcohol and 42% have tried marijuana. [9]
- Binge drinking has been rising among young adult males (aged 18-24), from 24% in 1998 to 39% in 2013 and 13.5% of adults were binge drinkers.
- Substance abuse-related hospitalizations in the county overall peaked in 2001-2005 and has been declining since, which seems mainly driven by a steady reduction in rates for African Americans (204 to 108 per 100,000). Rates rose for Latinos (55 to 81 per 100,000).
- More than 4 in 10 San Mateo adults (43.8%) would not know where to access treatment for a drug-related problem if needed for themselves or a family member.[9] This is higher among seniors, adults without a college education, lower-income adults, Asians/Pacific Islanders, Hispanics, and regionally on the Coastside.

Input from focus groups and key informants conducted for the San Mateo County 2016 Community Health Needs Assessment revealed that there is limited mental health care and substance abuse treatment options, as well as inadequate insurance coverage for behavioral health.[10] Community members noted the level of stigma associated with behavioral health issues may make it harder for individuals to seek and obtain help, and that these individuals are often discriminated against in their communities and healthcare/service settings.



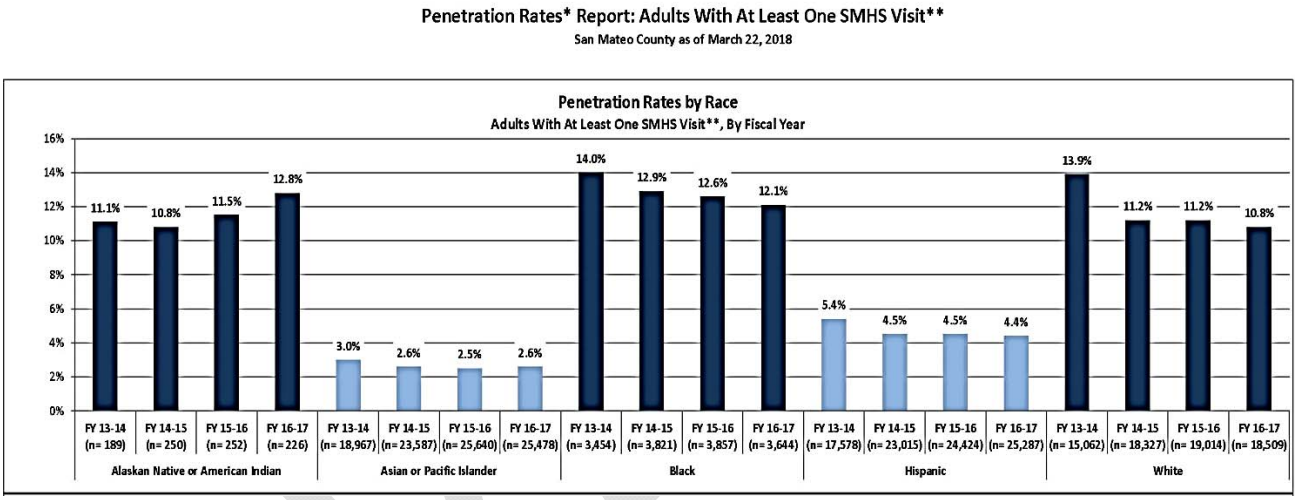


[9] 2013 Community Health Needs Assessment: Health and Quality of Life in San Mateo County
[10] 2016 Community Health Needs Assessment: Kaiser Foundation Hospital

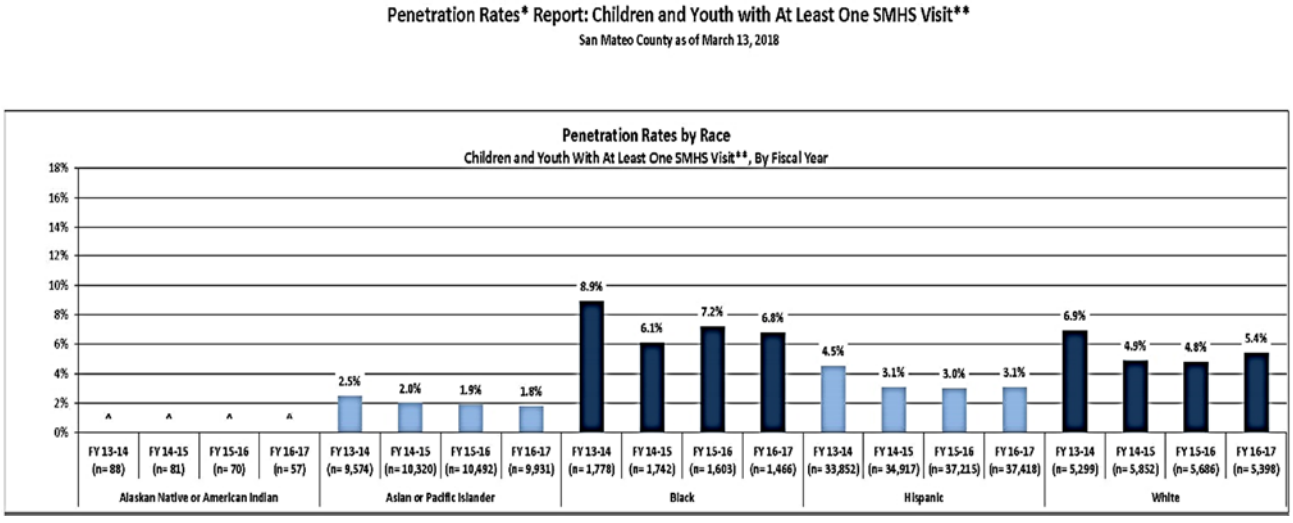
Penetration Rates

Penetration rates are calculated by taking the total number of individuals who receive SMHS in a Fiscal Year (FY) and dividing that by the total number of Medi-Cal eligible adults for that FY. The BHRS SMHS Performance Dashboard provides data for Fiscal Years 2012-2013 to through 2015-2016. [11] The data measures used for each fiscal year are derived from the annual External Quality Review Organization (EQRO) report. Penetration rates across the board seem to be declining for adults and children and youth with at least one SMHS visit. Penetration rates are the lowest for the Asian or Pacific Islander racial group followed by Hispanic.

Adults With At Least One SMHS Visit



Children and Youth With At Least One SMHS Visit



[11] San Mateo County Health: Behavioral Health & Recovery Services Dashboards

BHRS Open Clients by Race and Ethnicity FY 2016-17 (as of February 1, 2017)

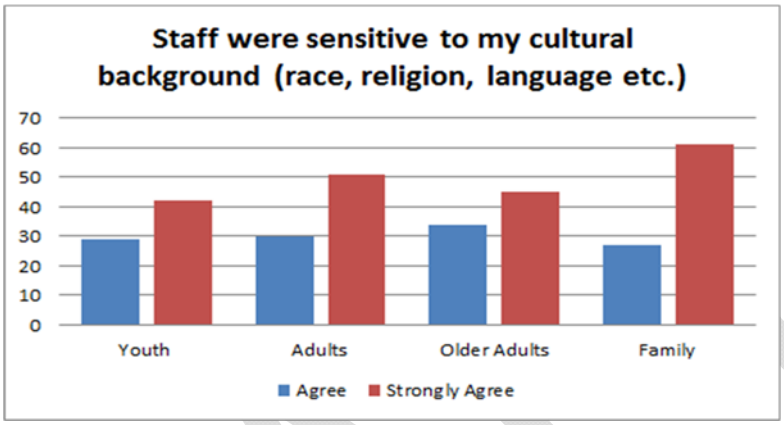
14,347 clients were open in BHRS service system as of February 1, 2017. This number includes any client who had an open episode at that time. Clients were counted in multiple race groups if they indicated belonging to multiple races.

The largest number of open clients (36.73%, or 5271 clients) did not indicate their race, or their race was unknown or not recorded.

Race	Count	Percent of Open Clients (14,347 total open clients)
Unknown/Not Reported	**5039**	**35.12%**
No Race Recorded	**194**	**1.35%**
Client declined to state	**38**	**0.26%**
Hispanic or Latino	**3345**	**23.31%**
Mexican/Mexican American	88	0.61%
Other Hispanic	81	0.56%
Puerto Rican	8	0.06%
Cuban	3	0.02%
White or Caucasian	**4214**	**29.37%**
Black or African American	**1007**	**7.02%**
Asian	**1143**	**7.97%**
Other Asian	111	0.77%
Other Asian or Pacific Islander	1	0.01%
Filipino	547	3.81%
Chinese	254	1.77%
Asian Indian	69	0.48%
Japanese	57	0.40%
Vietnamese	44	0.31%
Korean	29	0.20%
Laotian	16	0.11%
Cambodian	14	0.10%
Amerasian	1	0.01%
Native Hawaiian and Other Pacific	**223**	**1.55%**
Other Pacific Islander	88	0.61%
Tongan	48	0.33%
Samoan	37	0.26%
Guamanian	26	0.18%
Native Hawaiian	24	0.17%
American Indian or Alaska Native	**160**	**1.12%**
Mixed Race	**101**	**0.70%**

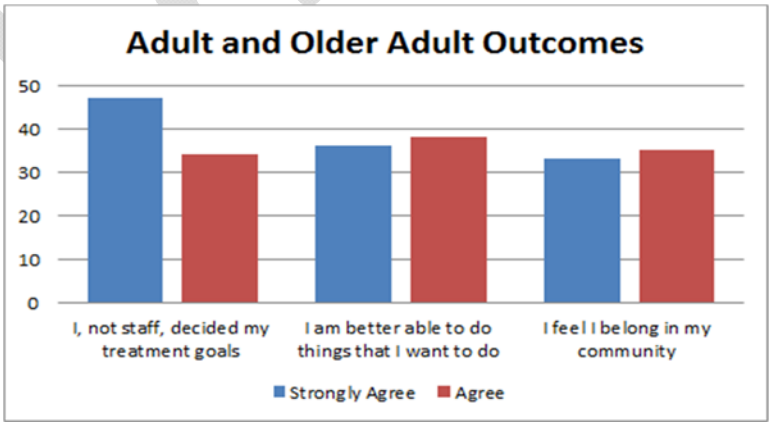
Client Surveys – Cultural Responsiveness & Recovery Principles

BHRS gathers performance outcome results via survey twice a year via the California Department of Health Care Services MHSIP Consumer Survey. One of the questions on the survey states "staff were sensitive to my cultural background (race, religion, language etc.)" This survey was given to adult, family, youth and older adult consumers. The results show that for each group, the majority of the consumers strongly agreed or agreed that staff was sensitive to their cultural background while they received services.



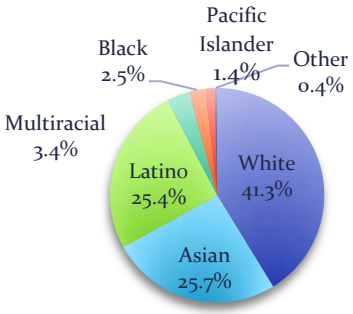
BHRS uses a Strength Based Recovery model where the goal is to improve lives rather than to treat illness. This person focused model is person-focused, and the outcomes include empowerment, hope, self-advocacy, choice, self-identified goals, healing and control of symptoms. As we evaluate our programs, we are prioritizing evaluation methods that capture recovery indicators that are complemented by traditional evaluation indicators of symptoms.

The California Department of Health Care Services MHSIP Consumer survey for adults and older adults, reference recovery in three questions that state, as a direct result of services I received: "I, not staff, decided on my treatment goals" " I feel I belong in my community" and " I am better able to do things that I want to do."



Health Equity Initiatives Needs Assessments

Health Equity Initiatives (HEIs) were created through the Office of Diversity and Equity to address access and quality of care issues among underserved, unserved, and inappropriately served communities representing ethnic and cultural communities that have been historically marginalized. HEIs conducted brief needs assessments using mixed methods. The results enable us to tailor our services and identify gaps in access and quality.



San Mateo County Population by Race

Pacific Islander (PI) Community: there is a scarcity of data for the PI community because Asian and Pacific Islanders are often aggregated into one category. Ethnicities commonly reported include Tongan, Samoan, Fijian and Chamorro.

- The highest concentration of PI reside in the city of East Palo Alto.
- 20% of PIs live in poverty and 28% of the PI community are low income.
- The average age of death for PI is 61 years, which is the lowest among all racial groups.
- PI's have one of the highest rates of uninsured at 20%.
- Barriers to healthcare utilization were identified as high cost, missing work, fear associated with immigration, lack of inclusion when accessing services, language barriers, negative experiences with healthcare professionals and the need for providers to be culturally and linguistically competent.

Arab Community: Forum discussions with Arab leaders from the Bay Area were conducted. Arab Americans represent many different nationalities the largest from Lebanon, Egypt, and Iraq.

- Population estimates for Arab-Americans (based on city data for Daly City 1,824, Redwood City 580, and San Mateo 1,536) is .5% of the population or 3,940.[12]
- San Mateo County has the 5th largest number of Arab Americans in CA.
- There was a 66% increase in BHRS requests for Arab language interpreters (2010 to 2013).
- Some of the priority needs identified by stakeholders were PTSD from war, torture and displacement, paranoia, anger issues, depression and drug abuse.
- Additional needs include trauma informed services which acknowledge the political climate for the Arab-American experience, understanding of generational differences, and materials that are translated and designed by the community.
- Barriers for accessing mental health services were identified as denial, stigma and lack of providers that are culturally competent. Additional concerns were around confidentiality, privacy, language access, lack of awareness of services, and religious beliefs.
- Outreach needs to include building rapport and talking more personally to individuals.

[12] US Census 2010 & American Community Survey 2011

Latino Community: the Latino community is growing in San Mateo County and is projected to increase by 7% (from 26% to 33% by 2040). [4] The most common Latino ethnicities include Mexican and Central American (Salvadorian and Guatemalan).

- Latinos are 3x more likely than Whites to live below the minimum income necessary to cover a family's basic needs.
- Latinos are 4x as likely to be uninsured as Whites.
- Latinos are 3x more likely to be incarcerated than Whites.
- More outreach is needed for Latinos in the coast from Half Moon Bay to Pescadero.
- Barriers to for accessing care include immigration status and fear of being deported. This fear also translates to the children of immigrants who have been found to be afraid either all or most of the time, and whose symptoms are closely linked to PTSD.
- There is a need for culturally and linguistically competent care.

African American/Black Community: the African American community makes up 2.5% of San Mateo County population or 18,352 and primarily reside in East Palo Alto and San Mateo.

- 92% of White students graduated high school compared 77% of Black students. [13]
- Blacks are over 20x more likely to be incarcerated than Whites.
- A needs assessment revealed the need for having culturally appropriate services.
- There is a need for more African American clinicians in the field and more clinicians who are able to discuss and understand African American culture. The need to put forth a stronger effort to recruit and foster a welcoming environment for retention.
- African Americans need support meeting basic needs such as housing, food and jobs.
- Additionally, despite the # of African Americans working for county reflects the overall population, there is a lack of African American staff at management and senior levels.
- A desire to partner with community-based organizations to help increase County staff competence in working with the African American community was also expressed.

Chinese Community: The Asian community makes up 25.7% of the San Mateo County population or 189,837. Chinese community primarily resides in Daly City and San Mateo. Unfortunately, data is often not disaggregated and includes two large threshold language communities, Chinese and Filipino. Other common Asian ethnicities among San Mateo County clients include Asian Indian, Japanese, Vietnamese, Korean, Laotian and Cambodian.

- Barriers for accessing behavioral health continues to be language-related for those with limited English speaking proficiency and lack of bilingual/bicultural therapists.
- An identified need is also insufficient services for Chinese youth and older adults, specifically for prevention and early intervention. For the engagement of older adults a stigma reduction intervention is necessary and assisting people in their homes.
- Recruitment of Chinese speaking consumers and family members to assist in the promotion of mental health and access to BHRS.

[13] Advancement Project California; RACE COUNTS, racecounts.org, 2017.

Filipino Community: According to the 2010 Census, Filipinos made up 11% of the San Mateo County population or 80,349. Unfortunately, data for Filipinos is often not disaggregated from Asian. Daly City has the highest concentration of Filipino Americans of any municipality in the United States; Filipino Americans comprise 35% of the city's population.

- Among this community 70% speak their native language at home instead of English, 23% are Limited English proficiency and 9% live in linguistically isolated households. In 2015, there were 47,333 native Tagalog speakers living in San Mateo County.
- And identified need is teens accessing services as 45.5% are at risk for depression and only 8.6% have received psychological/emotional counseling in the past year.
- Barriers to accessing behavioral healthcare include linguistically and culturally competent services including more Filipino providers, psychiatrists, therapists and case workers, more flexibility of appointments and family treatment, stigma, denial and embarrassment are major barriers to care among Filipinos of all age groups, and distrust of social and mental health services and concerns about being involved with a government service.
- There is a perception of high cost and a belief of addressing problems within the family.
- There is also a lack of knowledge when it comes to resources that are available. For those that find a point of entry, the system continues to be confusing and difficult to navigate.

Native American Community: According to the 2010 Census, American Indian and Alaskan Native made up 0.5% of the San Mateo County population or 3,306. In San Mateo County:

- 19% Native Americans live below poverty, compared to 5% of Whites.
- Native Americans are all roughly 4x as likely to be uninsured as Whites.
- Native Americans are about 15x more likely to be incarcerated than Whites.
- The Native and Indigenous People Initiative (an HEI) is planning to conduct a needs assessment in the near future to support relevant strategies for this community.

LGBTQ+ Community: Demographic data on sexual orientation and gender identity (SOGI) is scarce. Not one data source collects the full spectrum of SOGI. According to the California Health Interview Survey from UCLA, gay/lesbian make up 2.4%, bisexual 1.4% of the San Mateo County population. Priority needs identified include:

- Outreach efforts to engage LGBTQ+ communities, produce educational materials that is tailored to the community, assess and address gaps in care through data collection and policy recommendations.
- Staff continue to be afraid or “uncomfortable” to ask SOGI questions, clinicians are unsure of what to do with the information, and there are few resources in San Mateo County for this community.
- Youth engagement since youth from this community experience high levels of school victimization, that can lead to substance use, suicidality and sexual risk behaviors when compared to heterosexual youth.

Criterion 3: Strategies and Efforts to Reduce Racial, Ethnic, Cultural and Linguistic Mental Health Disparities

Criterion 3: Provide the mechanisms and processes used for the systematic collection of baseline data, on-going info about groups served

a. Planning, tracking and assessment of cultural competence

Systematic Collection of Baseline Data, Tracking and Assessment

The Office of Diversity and Equity (ODE) was originally developed as a BHRS strategic initiative to promote cultural humility and address health disparities, health inequities and stigma in the areas of mental health and alcohol and other drugs. There are a variety of mechanisms and processes for the systematic collection of baseline data, and ongoing information about the groups that are served.

ODE Indicators, Demographic Data and Satisfaction Surveys

ODE has identified 5 impact indicators based on our Theory of Change frameworks, mission, values and strategies. All ODE programs and activities will have standardized satisfaction and evaluation questions to inform the impact on any relevant key indicators. Additionally, ODE collects demographics of participants for every event that is hosted and funded through our office. This process enables the staff to recognize groups that are being served, those underserved and those that may not be served at all. The demographic survey, see Appendix A, was developed in partnership with our Health Equity Initiatives to ensure culturally appropriate identity categories across race, ethnicities, and sexual orientation and gender identity. Following is a draft sample event survey that incorporates both the indicators and satisfaction-type questions.

1. Self-Empowerment - enhanced sense of control and ownership of the decisions that affect your life
2. Community Advocacy- increased ability of a community (including clients and family members) to influence decisions and practices of our behavioral health system
3. Cultural Humility - heightened self-awareness of community members' culture impacting their behavioral health outcomes and/or heightened responsiveness of behavioral health programs and services for diverse cultural communities served
4. Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social and cultural barriers.
5. Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions

Health Equity Initiative Event Evaluation – DRAFT TEMPLATE

As a result of attending this event, please share how much you agree or disagree with these statements (circle one number for each question).

						
		Strongly Agree	**Sort of Agree**	**Neither Agree or Disagree**	**Sort of Disagree**	**Strongly Disagree**
a.	*I am satisfied with this event.*	5	4	3	2	1
b.	*I feel this event was sensitive to my cultural backgrounds.*					
c.	*I know where to go for mental health and substance use services.*	5	4	3	2	1
d.	*I would seek mental health and/or substance use services for yourself or a loved one if needed.*	5	4	3	2	1
e.	*My attitude about mental health has changed positively.*	5	4	3	2	1
f.	*My attitude about substance abuse has changed positively.*	5	4	3	2	1
g.	*I feel more confident in promoting my own mental wellness.*	5	4	3	2	1
h.	*I feel more confident in promoting the mental wellness of my community.*	5	4	3	2	1

Contractor Requirements

In 2012, ODE developed benchmark criteria and introduced the Cultural Competence Plan requirement within the contract terms of contracted providers. This requirement aligns with federal and state guidelines specifically the U.S. Office of Minority Health Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) and the California Department of Health Care Services (DHCS) Welfare & Institutions Codes (WIC) 14684(h).

ODE has received 84 plans from contracted providers and has seen significant improvement in two areas: 1) agencies of developing a cultural competence committee where cultural and linguistic competence issues can be discussed and 2) in increasing services in clients' threshold languages which includes translating important health related material into service area threshold languages. The plans also provide a sense of our contractors' efforts, successes, needs and challenges in implementing CLAS strategies.

ODE is committed to changing misconceptions of cultural competency planning as merely an administrative requirement or compliance issue and instead move toward improvements to the greater system to support contractors to meet these standards. Following are additional recommendations, based on a recent comprehensive assessment of plans submitted to-date and key interviews with staff, reviewers and contractors:

1. Improve and reinforce system-wide communication.
    - Strengthen communication between the Diversity and Equity Council (DEC), Quality Improvement Committee (QIC), and BHRS Leadership to influence policy development and resource availability that supports cultural competence planning and implementation.
    - Increase communication and collaboration between ODE and Alcohol and Other Drug (AOD) teams, which review Cultural Competence Plans of contract providers, for timely feedback and addressing contractor needs.
    - Ensure information is funneling from QIC and BHRS leadership to contract providers (for example, a May 2016 Memo regarding the opportunity to budget for language access services was not received by all contract providers).
    - Utilize DEC as a central hub for CLAS information sharing.

2. Language access services to be specifically included in BHRS contracts
    - Provide more support in attaining and setting up contracts with vendors, standardizing the work done with Hope House by their AOD contract analyst.
    - Requiring language accesses costs be specified in contractor budgets and tracking of language requests.

3. Have cultural competence trainings more readily available contractors, contract analysts and managers
    - Have specific training on CLAS, its importance, legality, and application. Make this available not only to contractors and their staff, but contract analysts and contract managers.
    - Offer trainings in webinar format to increase participation and decrease staff time away from work.

4. Strengthen uniform collection of data across all providers
    - Provide contractors with community assessment information for their geographic area, in order for them to make informed decisions on how to implement CLAS for the specific communities they serve.
    - Collect the same demographic information from all contractors, to begin looking at data trends that indicate countywide CLAS advancement.

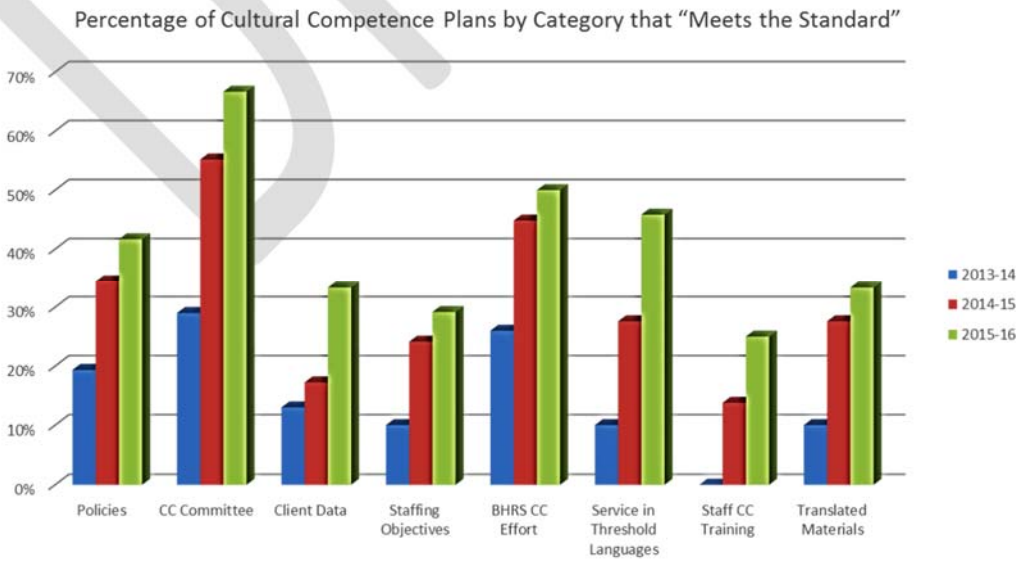
5. Conduct "willingness or readiness" assessment to identify specific cultural barriers at organization level, to implementing CLAS
    - Provide an assessment or survey for all front-line staff that are directly in charge of implementing CLAS, to identify any other barriers (logistical or interpersonal) that may impede success with CCP.

Summary of Successes 2013 – 2016

- **80%** of plans requested have been received.
- **40% increase** in agencies developing a cultural competency committee where leadership and line staff consensually discuss and plan cultural competence issues.
- **36% increase** in agencies providing service in clients' threshold languages.
- **28% increase** of agencies meeting the standard overall in each category.
- **25% increase** within agencies translated important health related material into the service area threshold languages.

Areas of Improvement 2013 – 2016

- **60%** of contractors have not met the criteria to implement policies and practices that promote cultural competence in responsive services, education and training, language, staff recruiting and retention, etc.
- **71%** of contractors have not met the criteria to develop a plan for staffing objectives to recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.
- **75%** of contractors have not met the criteria to ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services.



Between November 2016 and January 2017, Alcohol and Other Drugs (AOD) team conducted site visits to track and assess the culturally and linguistically appropriate services standards of AOD contracts. Site visits with 12 treatment provider agencies were conducted and each visit was 1.5 to 2.5 hours and included agency staff as determined by the agency and was guided by the CLAS standard site visit review tool. Following each visit, a letter containing feedback and recommendations was submitted to the agency. This assessment revealed system-wide gaps in complying with CLAS standards and BHRS cultural competency requirements. However, these visits were designed to discuss these gaps and work towards quality improvement, ensure compliance, and support contract providers.

1.) Language Access: Identified barriers to offering adequate language services (i.e. cost, confusion about requirements, best practices and standards, etc.)
    - 92% of providers did not have a policy, protocol, or procedure for language access
    - 83% of providers did not have a contract with an interpreter, language line, or translation service and therefore had not adequate method of providing language access to clients whose preferred language was not English. Various providers reported using non-clinical methods which violate confidentiality. Interpretation services were given by non-clinical staff, peers, and family, and written translation by Google translate and non-clinical staff. The majority of staff expressed not being aware of language access requirement.
    - No systematic way in which language preference is collected and tracked
    - Providers expressed they are not able to retain or hire enough bilingual staff within clinical or counseling positions. The percent of providers with one or more bilingual staff members in San Mateo County threshold languages included:
        - Spanish: 80%
        - Tagalog: 30%
        - Mandarin: 10%
        - Cantonese 10%

      However, these numbers include *any* bilingual staff, which means that counted within these numbers are staff that are not trained to work with clients. Data for bilingual clinical or counselor staff is not currently being tracked.

    - The majority of providers do not have materials in language other than English. Clients sign legal documents in English even if they do not understand English including, but not limited to, treatment plans, client rights, fee scale, etc.

2.) Training:
    - The majority of providers demonstrated a lack of knowledge in how to effectively implement CLAS standards. For example, some agencies assess client and community needs by "attending a Community Services Area meeting" or collecting demographics at intake." However, few providers were actually able to describe

how they utilize data available to them to effectively assess the needs of community in which they deliver services.

- Providers expressed needing more training on data outcome assessment. Less than half of providers regularly review demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes to inform service delivery.

3.) AOD monitoring practices: Creating an internal structure/system that supports monitoring CLAS and cultural competency will enable AOD staff to more effectively assist providers to meet CLAS standards

- Several programs have shown little improvement in meeting CLAS standards over the last 3-5 years. IN fact, many providers have, year after year, continued to submit the same cultural competence plan with few changes/edits suggesting current monitoring and/ or QI practices are not effective.
- Analysts express confusion about monitoring procedures related to CLAS standards. For example, there has been confusion as to whom the cultural competence plans are to be submitted, how they are to be reviewed and what standards providers are to be held to. There is a need for more clarity around standards as they relate to CLAS' this includes technical assistance from the state.

4.) Serving the LGBTQ+ Community:

- The majority of providers did not ask sexual orientation or gender identity (SOGI) demographic questions of their clients, staff or Board of Directors.
- No providers had a policy around serving transgender or gender nonconforming clients. No providers operated outside of a gender binary.
- Many providers lacked LGBTQ 101 knowledge and expressed discomfort at LGBTQ related topics, and reinforced harmful stereotypes about the LGBTQ community.

The key recommendations for addressing the cultural competence gaps observed with the contracts held by BHRS and AOD are:

- Providing a monetary incentive (deliverable-based contracting) to submit the annual cultural competency by the September 30 deadline
- Explore revising organizational structure for managing contractor obligations.
- Increase opportunities for training and technical assistance for BHRS staff involved in contract modeling
- Reimbursement for Language Services Memo- to address the gap in language services and assure the contract agencies that the county will reimburse their use of language services.
- Provide specific language guidance for substance use providers around language access standards, policies and best practices including:
    - Ensuring that language access is written into each budget and reimbursed
    - Enforcing best practices such as translating all client facing documents into the 4 threshold languages

    - Creating contracts with interpreter, language ling and translation services
    - Providing bilingual pay to attract and retain bilingual staff
    - Creating a Language Access Policy and training all staff
    - Enforce state requirement of using in-person interpreters for group sessions and language line or interpreter services for individual sessions
    - Support providers in conducting community assessments in their specific geographical locations
- Trainings
    - Train staff on how to implement CLAS standards and quality improvement processes
    - Train AOD staff on how to effectively monitor CLAS standards
    - Enforce 8 hour cultural competency requirement among staff
- Evaluate progress across programs yearly and utilize findings to inform training needs, monitoring and other QI practices
- Ensure standardization of demographic questions using BHRS SOGI questions, enforcing training of all staff
- Create a policy on best practices when working with transgender and gender non-conforming clients

Goals, Strategies and Activities

The last full Cultural Competence Plan was submitted to the State in 2010. To-date we have not received final updated criteria for County plans. See Appendix B for the FY 17-18 update on previous Cultural Competence Plan strategies and activities. The current BHRS Cultural Competence Plan goals, strategies and activities are organized based on ODE's Theory of Change pathways and incorporate the comprehensive stakeholder engagement process, needs assessment and data and learning from 10 years of addressing cultural competence in San Mateo County.

Goal 1: Workforce Development and Transformation - Expand on Workforce Development and transformation that prioritizes cultural humility, inclusion and equitable quality care.

- **Strategy 1:** Deepen BHRS' commitment to diversity, cultural humility and inclusion principles through a Multicultural Organizational Development (MCOD) process.
- **Strategy 2:** Implement a systemic approach to Workforce Education and Training.
    1) Provide training to introduce and initiate dialogue and individual-level culture shifts related to cultural humility, trauma-informed care, co-occurring informed and other integrated care, evidence-based practices, lived experience and client/family members integration, self-care, and other BHRS transformation goals
    2) Establish policies, leadership engagement and quality improvement focus to sustain the transformation goals.
- **Strategy 3:** Create pathways for individuals with lived experience in behavioral health careers and meaningful participation

1.) Provide trainings for and by consumers and family members on various behavioral health, wellness and recovery topics
2.) Create new career pathways and expand existing efforts for clients and family members in the workforce

- **Strategy 4:** Promote behavioral health careers and other strategies to recruit, hire and retain diverse staff
    1) Attract prospective candidates to hard-to-fill positions
    2) Increase diversity of staff to reflect the service population
    3) Promote the behavioral health field in academic training institutions
    4) Promote interest among and provide opportunities for youth

Activities and programs that support the Workforce Development and Transformation:

- **Multicultural Organizational Development (MCOD)** is an organizational change framework focused on building BHRS capacity to advance equity, diversity and inclusion principles in the workplace. BHRS focused on internal capacity development to work effectively and respectfully with diverse cultural, linguistic, and social backgrounds. To accomplish this goal, BHRS is using four levels of organizational change which include; personal, inter-personal, cultural, institutional and structural/systemic. An MCOD Action Plan was developed, see Appendix C, and includes goals, strategies and shorter-term activities and tasks. The MCOD Action Plan will be reviewed, evaluated and updated annually. One of the accomplishments so far of this strategy has been the BHRS Mentoring program which launched in 2018. This program pairs mentees and mentors within the health system to provide professional development and advise for up to 6 months.
- **Government Alliance on Race and Equity (GARE)** is a national network of government working to achieve racial equity and advance opportunities for all. Racial equity is critically important to getting different outcomes in our communities and our goal extends beyond closing the gaps. To advance equity we must focus not only on individual programs, but also on policy and institutional strategies that are driving the production of inequities. Our first step as part of the GARE cohort is to develop and implement a racial equity training for our supervisors and managers. The Race, Health and Equity training will be implemented across the health system as a mandatory requirement in 2019. Following the supervisor and manager trainings we will be focusing on training all the staff of the health system.
- **Behavioral Health Career Pathways Programs** aim to recruit, hire, support, and retain diverse staff in behavioral health careers. The components include:
    i. Attract prospective candidates to hard to fill positions (including child/adolescent psychiatrists, psychiatric mental health nurses, and promotores/navigators) by addressing application barriers and providing incentives. BHRS participated in the Mental Health Loan Assumption Program which provides loan forgiveness for BHRS and contractor staff.

BHRS also participated in the Behavioral Health Resources Forums which influence human resources practices and priorities towards hiring staff who reflect the community being served

ii. Promote mental health/behavioral health field in academic institutions in order to attract individuals to the public mental health system. This includes the Intern/Trainee Program which consists of BHRS partnering with graduate schools in the Bay Area to provide education, training and clinical experience for their students at various county worksites.

iii. Create new career pathways and expand existing efforts for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the county system. This includes the Lived Experience Education Workgroup/Lived Experience Academy which prepared clients/consumers and family members for workforce entry, advocacy, and participation on committees and commissions etc. Additionally, the BHRS New-Hire Orientation is designed to help new staff understand how BHRS works and connects to other agencies and departments.

iv. Increase diversity of staff to better reflect our client population and retain diverse staff. This includes the Cultural Competency Stipend Internship Program which supports behavioral health graduate students who contribute to cultural humility/responsiveness of BHRS through linguistic capability, cultural identity or experience working with special populations in San Mateo County.

- BHRS required trainings include Working Effectively with Interpreters in Behavioral Health Settings and Cultural Humility 101. Employee Training Minimum Standards require that each BHRS employee complete 20 hours of training per year.

Goal 2: Community Empowerment - Create opportunities for individuals with lived experience, families and community members to engage in decisions that impact their lives.

- **Strategy 1:** Recruit, train, hire and support mental health clients and family members at all levels of the mental health workforce.
- **Strategy 2:** Create, support and enhance existing programs that build community empowerment and capacity building for mental health recovery and skills training.
- **Strategy 3:** Create opportunities for genuine shared decision making with community

Activities and programs that support the Community Empowerment:

- **Health Equity Initiatives (HEIs)** were created to address access and quality of care issues among underserved, unserved, and inappropriately served communities. There are eight HEIs representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino Collaborative; Native American Initiative; Pacific Islander Initiative; PRIDE Initiative; and the Spirituality Initiative.

- **Alcohol and Other Drug Prevention Partnerships** exist throughout San Mateo County. These partnerships are community-based and acting locally to identify and address community-level conditions that promote or encourage underage alcohol use and to reduce the harmful consequences of alcohol and other drug use. The partnerships include the North County Prevention Partnership, One East Palo Alto: Substance Abuse Prevention Coalition, Peninsula Conflict Resolution Center: North Central San Mateo Prevention Partnership, Puente De La Costa Sur: South Coast Prevention Partnership, Redwood City 2020: Alcohol And Other Drugs Prevention Partnership, San Mateo County Health System: Alcohol & Other Drug Services, and Youth Leadership Institute: Coastside Prevention Partnership

- **Office of Consumer and Family Affairs (OCFA) Peer and Consumer Family Partners Program** is designed to support employment of consumer/client and family partners with lived experience within the county behavioral health system of care, which recognizes the special contributions and perspectives of consumers/family members and aids in case management as well as peer support. Peer Support Workers and Family Partners provide a very special type of direct service and support to BHRS consumers/clients: they bring the unique support that comes from the perspective of those experiencing recovery, either in their own personal lives, or as relatives of someone personally affected. They know firsthand the challenges of living with and recovering from a behavioral health diagnosis, and work collaboratively with our clients based on that shared experience. There are 17 Peer Support Workers in the BHRS Adult System of Care and 11 Family Partners throughout BHRS representing diverse cultural and linguistic experiences including bicultural and bilingual Spanish and Tongan, as well as English speaking African American.

- **The Lived Experience Education Workgroup (LEEW)/Lived Experience Academy** are overseen by OCFA in partnership with the BHRS Workforce Education and Training Coordinator. The primary purpose of LEEW is to identify and engage lived experience clients, consumers, and family members to prepare for workforce entry, advocacy roles, committee and commission participation, and other empowering activities. This group consists of BHRS and contractor staff, lived experience staff, clients/consumers, and family members. The LEEW plans, facilitates, and oversees the *Lived Experience Academy* (LEA), which trains clients/consumers and family members with behavioral health lived experience to share their stories as a tool for self-empowerment, stigma reduction, and education of others about behavioral health problems. Graduates then become part of the Lived Experience Academy Speakers' Bureau and are paid $35 per hour to speak at BHRS trainings and events around San Mateo County. Their participation greatly enhances BHRS trainings and events and provides staff and the community greater understanding of clients/consumers with behavioral health concerns.

- **The Parent Project®** is a free, 12-week course for anyone who cares for a child or adolescent. The classes meet for three hours each week. Parents learn parenting skills and get information about resources and other support available in their communities. Parents/caregivers learn and practice skills such as appropriate ways to discipline;

preventing or stopping alcohol, drug and tobacco use; improving communication skills; improving grades and school attendance; dealing with unhealthy and/or dangerous behaviors in teens; strengthening family relationships.

- **Health Ambassador Program** was developed as a response to feedback from the graduates of the Parent Project© who wanted to continue learning about how to appropriately respond behavioral health issues and get involved within their communities and the broader BHRS decision-making processes. After completion of the Parent Project, individuals continue to increase their skills and knowledge in behavioral health and substance use related topics by completing public education programs such as Mental Health First Aid (MHFA) certification training, the 12-week NAMI Family to Family program, the Applied Suicide Intervention Skills Training (ASIST), and/or a Wellness Recovery Action Plan (WRAP) workshop. Health Ambassadors are also encouraged to become advocates in Stigma-Free San Mateo and be part of the BHRS Health Equity Initiatives. In this work, individuals engage in outreach, education and dialogue with members of our communities to reach our goal of a stigma free County. Becoming a Health Ambassador can potentially lead to opportunities to work and volunteer amongst other dedicated individuals; teach both youth and adult courses in their community; assist in identifying unmet needs in their community and help create change; or become a Community worker/Family Partner.

- **Storytelling Program** emphasizes the use of personal stories as a means to draw communal attention to mental health and wellness. While reducing stigma and broadening the definition of recovery, workshops consider social factors such as racism, discrimination, and poverty. Participants are asked to share their stories through words, photos, drawings, personal mementos, and even music. The stories shared have been both personal and powerful, creating a sense of connection, and for others, they've been transforming. ODE continues this powerful storytelling work with Digital Storytelling and Photovoice. ODE partners with community-based organizations, schools, faith-based organizations, correctional institutions, and other sectors of the community to offer these storytelling opportunities. These stories help shed light on important social issues including stigma and empower others with lived experience to share their stories.

- **Outreach Workers** (also known as promotores/health navigators) connect with and facilitate access for marginalized populations through culturally and language appropriate outreach and education and providing linkage and warm hand-off of individuals to services. Outreach Workers are usually members of the communities within which they outreach to. They speak the same language, come from the same community and share life experiences with the community members they serve. Outreach Workers use a variety of methods to make contact with the community. From group gatherings in individuals' homes to large community meetings, and make

direct contact with target audiences, warm hand-offs and convey crucial information to provide community support and access to services. ODE's Outreach Worker efforts include two positions within ODE supporting the Pacific Islander and LGBTQ+ communities and two Outreach Collaboratives. The East Palo Alto Partnership for Behavioral Health Outreach employs Outreach Workers within the Latino, African American, Pacific Islander and LGBTQ communities. The North County Outreach Collaborative employs Outreach Workers within the Chinese, Filipino, Latino, Pacific Islander and LGBTQ communities**.**

- **GARE Racial Equity Tool** is being piloted by the health system and will be used to operationalize equity. This tool is designed to integrate explicit consideration of racial equity and the communities most impacted by inequities in decisions including policies, practices, programs, and budgets.

- **MHSA Community Program Planning (CPP) Process** engages in ongoing community input opportunities. MHSA CPP includes training, outreach and involvement in planning activities, implementation, evaluation and decisions, of clients and family members, broad-based providers of social services, veterans, alcohol and other drugs, healthcare and other interests. In the most recent CPP process, there were over 270 participants in the sessions across the County with 37% identifying as clients/consumers and family members. Two additional prioritization sessions were conducted in the high need communities of East Palo Alto and the Coastside.

Goal 3: Strategic Partnerships - Strengthen and create new meaningful partnerships in the community to maximize reach and impact on equitable behavioral health outcomes.

- **Strategy 1:** Create and sustain partnerships that build on shared lived experience, cultural identities, and/or geographical service areas
- **Strategy 2:** Create programs and partnerships that advance an effective model of integration of mental health, physical health, and substance abuse services.
- **Strategy 3:** Create and enhance partnerships with key non-traditional stakeholders.
- **Strategy 4:** Develop a communication plan focused on the impact and urgency of behavioral health equity work to strengthen community, including non-traditional partners, buy-in and engagement in the work.

Activities and programs that support the Strategic Partnership:

- **Power mapping** will allow us to conceptualize the necessary partnerships and efforts and visually map out relationships between people, organizations, and institutions involved in equity work to better understand the value of these relationships

- **Diversity and Equity Council (DEC)** and the **Health Equity Initiatives** (described in Goal 2 above) are made up of BHRS staff, contracted providers, community leaders and members and work to ensure that topics concerning diversity, health disparities,

and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the state-mandated Cultural Competence Committee.

- **Alcohol and Other Drug Prevention Partnerships** (described in Goal 2 above)
- **Peer Recovery Collaborative** is comprised of peer operated programs focused on education and community outreach to meet individuals where they are in their recovery journey. The collaborative is made up of Heart and Soul, Voices of Recovery and California Clubhouse, they continue to be strong partners working with BHRS an have sponsored the Peer and Family Member Summit.
- **Partnerships with San Mateo Medical Center FQHCs** allow for collaboration with FQHC's to identify patients presenting for healthcare services that have significant needs for mental health services. Ravenswood FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.
- **Primary Care Interface** focuses on identifying persons in need of behavioral health services in the primary care settings, thus connecting people to needed services. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary.
- **Total Wellness** is a collaborative peer-based care model integrating primary care with behavioral health coordinated by nurse care managers. This promotes one coordinated client care plan including behavioral health, physical health, and wellness goals
- **Outreach Collaboratives** (Described in Goal 2 above) are based on the key model of community-based organization collaboration. Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy and, offering ongoing presence and opportunities for community members to engage in services.
- **The Pride Center:** LGBTQ+ individuals are at increased risk for mental health disorders given their experience with stress related to subtle or overt acts of homophobia, biphobia, and transphobia, and as such, need access to service providers and resources that are reflective and sensitive of their experiences and needs. The Center is a collaboration of multiple agencies that will work to provide support to high-risk LGBTQ+ individuals through peer-based supports, with the goal of becoming a centralized resource for mental health services. The Center promotes interagency

collaboration, coordination, and communication, which will lead to increased access to mental health services among LGBTQQI individuals, and ultimately, improved mental health outcomes.

Goal 4: Policy & Systems Change - Influence organizational level policies and institutional changes across San Mateo County agencies to positively impact behavioral health outcomes.

- **Strategy 1:** Identify policies, practice, and systemic changes needed to become a genuinely multicultural organization.
- **Strategy 2:** Identify key outcome indicators for behavioral health equity including internal policies and practices.
- **Strategy 3:** Assess, prioritize and implement the National Culturally and Linguistically Appropriate Services (CLAS) Standards across the department and contracted agencies.

Activities and programs that support the Policy & Systems Change:

- **Multicultural Organization Development** (described in Goal 1 above)
- **Government Alliance on Racial Equity** (described in Goal 1 above)
- **Diversity and Inclusion (D&I) Taskforce** is comprised of representatives from cross-sector San Mateo County departments working to advance principles of workforce diversity. The Taskforce will 1) identify current challenges, needs, and priorities relating to D&I; 2) develop a coordinated approach to shared goals and priorities; 3) collect and review of workforce data such as D&I survey and department workforce demographic data to assess priorities, needs, and challenges; and 4) make informed recommendations and develop action plans to advance D&I goals.
- **Cultural and Linguistic Appropriate Services (CLAS) Implementation**
  i. **CLAS requirements in all contracts:** As described in Criterion 3, Contractor Requirements, in 2012 ODE developed benchmark criteria for all BHRS contractors that provide client services to develop and submit cultural competence plans that focus on improving quality of services and advancing health equity.
  ii. **Language Access Services** (discussed in more detail in Criterion 7) includes translating materials in threshold languages Spanish, Tagalog, Chinese (Mandarin and Cantonese), 24/7 language line that is available for over-the-phone interpretation services and a process for scheduling in-person language interpreters including ASL.

Criterion 4: County Mental Health System Client/Family Member

Criterion 4: Describe the exchange of information within different levels of the organization as well as between the organization and the community, target population, and partner organizations.

a. Policy and procedure regarding Cultural Competence Committee and how it reflects community, management and line staff
b. Organizational chart, list of cultural competence committee members and affiliation to cultural competence
c. Can include advisory committee(s) to the CCC

Diversity and Equity Council

The Diversity and Equity Council (DEC) works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the state-mandated Cultural Competence Committee. This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of the Office of Diversity and Equity. The DEC has been involved in many of the opportunities to bring discussions of cultural competence in our work through DEC members participating in various committees and focused efforts such as the Quality Improvement Committee and the roll-out of eClinical Care, training (sponsoring or hosting), facilitation and networking, and ODE's Health Equity Initiatives.

Mission, Vision & Objectives

The Council serves as an advisory board to assure San Mateo BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Membership in the DEC is open and encouraged to all. Members may include management, line staff, consumers/clients and family members, and community partners. Health Equity Initiative members attend DEC meetings. The DEC encourages participation of consumers/clients and family members by providing stipends or honorariums for ongoing participation. In the past few years, a couple of consumers have joined and participated, but due to scheduling issues only, their participation has wavered.

Diversity and Equity Council Attendance, FY 2016-17

Name	Agency/Affiliation	Email/Phone	Affiliation	Health
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Heather	Our Common	hbond@ocgworks.org	CBO	
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Claudia		csaggese@smcgov.org	BHRS Staff	
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Siavash		szohoori@smcgov.org	BHRS Staff	Office of

Health Equity Initiatives

The Health Equity Initiatives (HEIs) were created to address access and quality of care issues among underserved, unserved, and inappropriately served communities. HEI representatives attend the Diversity and Equity Council (DEC) to ensure cross-sharing and learning, bring forward concerns and issues from San Mateo County's most marginalized communities, and brainstorm systemic solutions. ODE provides oversight to eight HEIs representing specific ethnic and cultural communities that have been historically underserved: African American Community Initiative; Chinese Health Initiative; Filipino Mental Health Initiative; Latino Collaborative; Native American Initiative; Pacific Islander Initiative; PRIDE Initiative; and Spirituality Initiative. HEIs are comprised of San Mateo BHRS staff, community-based health and social service agencies, clients and their family members, and community members. The HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader. HEIs implement activities throughout San Mateo County that are intended to 1) decrease stigma; 2) educate and empower community members; 3) support wellness and recovery; 4) build culturally responsive services. One co-chair of each HEI attends the monthly DEC meeting. This enables and foster a space of collaboration, learning across agencies, and a space for training.

Summary of HEI Impact

- HEI's are integral partners in conducting meaningful and authentic community outreach and engagement
    - Each HEI has organized, conducted and hosted numerous events in the last 10 years and reached thousands of individuals.
- HEIs hold lived experience that allows them to more effectively address stigma-related issues specific to their population
    - Knowing how an individual's attitude towards mental health, substance abuse, and accessing services is shaped by their racial, ethnic, sexual, and gender identities allows HEI members to develop outreach materials, resources, and community events that reflect a nuanced understanding of stigma and barriers to accessing services.
- HEIs have been able to increase awareness of BHRS services among San Mateo County residents

    - Resources have been developed and designed in a culturally and linguistically appropriate manner that allows the HEIs to more readily disseminate information
    - Additionally, many of the events have served as opportunities to connect individuals with BHRS services
- HEI members strengthen the practice of other San Mateo BHRS staff and community-based agencies in order to better serve communities
    - HEI members share their own experiences, but also are cultural brokers on how to work with a specific community or population. Additionally, by remaining connected to community issues they can develop and resources that are responsive to changing needs.

Community-Informed Culturally Responsive Improvement Process

ODE is beginning to develop and pilot a community-informed process for making cultural responsive improvements to our system. It is intending to reinforce the role of the DEC and more meaningfully embed it in a feedback loop with the Quality Improvement Committee (QIC). This exchange of information between the DEC, the QIC, the HEIs and the Director will lead to cultural competence going beyond compliance and towards institutional transformation and continuous quality improvement of services. There were several recent observations, outlined below, that have led to the development of this proposed process.

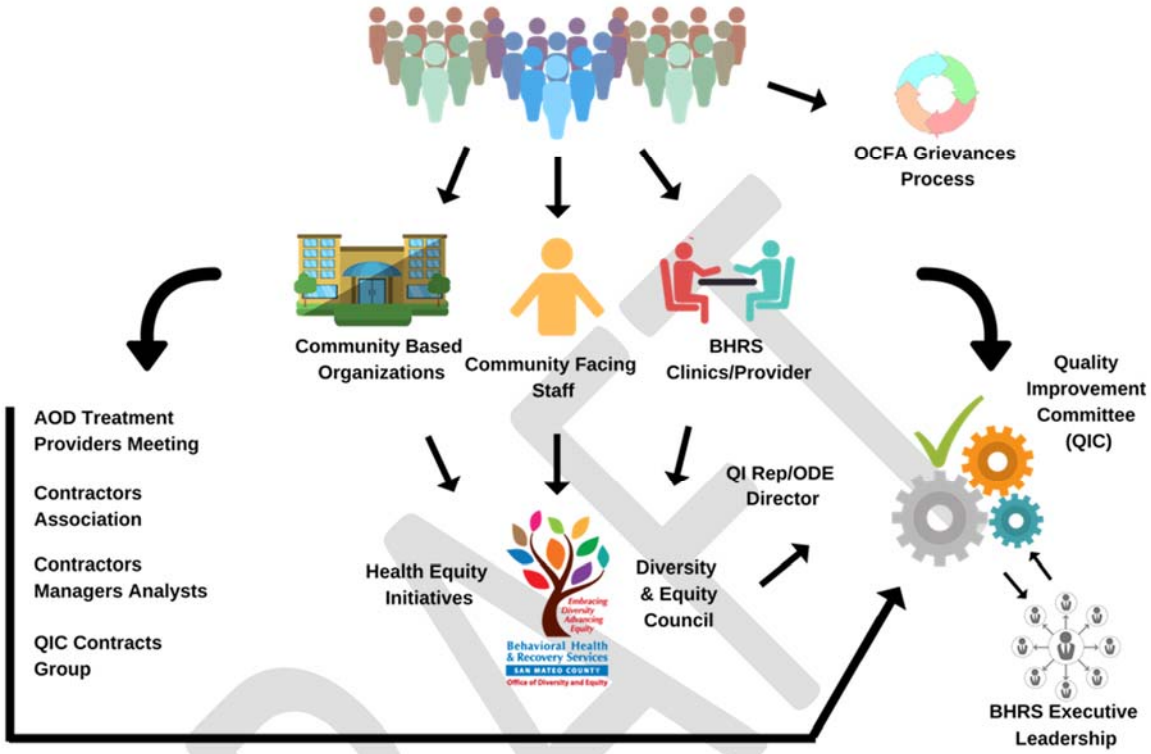
- BHRS Multicultural Organizational Development identified the need for developing a process for soliciting community feedback to better understand the strengths and needs of historically excluded groups. This is in alignment with the Government Alliance on Race and Equity framework for centering community in the decisions we make, which our broader County Health is engaged in.
- The Office of Consumer and Family Affair Grievances has a category for cultural responsiveness-related grievances, until recently this category has had no grievances. The recent grievance was related to limited availability of sign language interpreters.
- Comprehensive review of contractor's CLAS activities identified a need to move toward improvements to the greater system to support contractors to meet CLAS standards (vs. a focus on compliance).
- The recent **Policy 18-01: Cultural Humility, Equity and Inclusion Framework** identified the need to strengthen and formalize the Diversity and Equity council's role in influencing policies, procedures and practices of BHRS.
- Recent comprehensive community needs assessments in East Palo Alto and the Coastside have led to the identification of concerns and issues from some of San Mateo County's most marginalized communities.

The following diagram depicts a process for cultural responsiveness-related issues to have the space whether that's at ODE, at the Health Equity Initiatives (HEI) and/or the Diversity and

Equity Council (DEC) meetings to be considered, dialogued and communicated to the appropriate channel for resolution as appropriate. The process has the following implications:

- Community facing staff and providers are acknowledged as advocates within the system. We hire diverse staff to represent the communities we serve, provide bilingual skills and/or bicultural expertise but, the space to bring up issues and/or propose changes to practices, based on what they are hearing/learning from the communities they serve, is not formally in place.
- ODE HEI's and the DEC will provide the space for dialogue and problem-solving around issues as needed. Often, issues may be able to reach resolution at these spaces, given the network of providers and subject matter experts, or through a formal grievance with the Office of Family and Consumer Affairs.
- The DEC will bring forward issues that may require a change/creation of policy and make recommendations for quality improvement to the Quality Improvement Committee via the ODE Director and/or the QIC representative at the DEC.
- ODE staff, HEI/DEC representatives will have a heightened responsibility to bring forward issues.
- ODE will keep track of issues and their resolution and will be responsible for communicating back the resolution. When outside of ODE's scope, ODE will seek input on potential solutions from the community impacted to provide to the QIC or respective BHRS entity.
- ODE will present an annual report to DEC, QI and/or other community forum regarding the improvement process and use the data and opportunity to align priorities and strategies with the HEIs and DEC.
- ODE/DEC/HEIs will reach out to external stakeholders as needed, for cross sector collaboration and problem-solving.
- The DEC will play a primary role in bringing in case studies or topics to review and collaborate related to current socio-political events impacting the mental health of marginalized communities (e.g. deportation, gender x on identification cards, adding citizen status to the Census, etc.).

Community-Informed, Culturally Responsive Improvement Process



MCOD Strategy 2.A.2

Criterion 5: County Mental Health Plan

Culturally Competent Training Activities

Criterion 5: Describe the organizations efforts to ensure that staff, and service providers have requisite attitudes, knowledge, skills, ability to deliver culturally competent services

a. Narrative summary of steps taken to provide cultural competence trainings to staff in last 3 years
b. List of CCC goals, objectives, activities, trainings and learning series Analysis of effectiveness of CCC trainings such as pre/post test results

Trainings in the area of cultural humility are designed to increase the capacity of providers to recognize biases in the workplace and engage in authentic dialogues and learning about different cultures and in turn reduce health inequities in our community. The trainings provide instruction and protocols for providing culturally and linguistically appropriate services and increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities are made available to consumers, family members, providers, and those working and living in the community. Trainings are also used to help support key Health Equity Initiatives.

BHRS' Training Plan identified a number of components designed to address these issues, such as the use of the CA Multi-Cultural Scale to assess our system of services; trainings to increase the effective use of interpreters in service delivery; creation of a clinical consultation resource for providers working with Filipino consumers; addressing cultural issues when providing services to consumers suffering from co-occurring disorders and domestic violence.

Trainings were also used to help support key cultural disparity initiatives then underway as part of our work on reduction of disparities. The different cultural disparity initiatives then funded through CSS were focused on the following populations: Chinese; Filipino; Pacific Islander; African American; Latino; LGBTQQI. These initiatives later evolved into ODE's first formal Health Equity Initiatives (HEIs). The number of cultural humility trainings (including specific trainings like those conducted by the Pride Initiative and Spirituality Initiative) for FY 2016- FY 17 was 39 and it included:

- Cultural Humility System-Wide Trainings
- Cultural Humility Training of Trainers
- Culturally Responsive Clinical Supervision
- Working Effectively with Interpreters in a Behavioral Health Setting

Total investment in training for system transformation for 2014-17, which includes cultural competence training, was $205,450.00, which is 15.7% of the total WET investment. This investment category also grew as a portion of the total investment annually - 10% in FY 2014-15, 16% in FY 2015-16, and 20% in FY 2016-17.

Cultural Competence Training for FY2014-15 – FY2016-17 included the following:

Cultural Humility 101

In 2013-2014, Melanie Tervalon, MD, MPH conducted a large scale cultural humility training for behavioral health providers in San Mateo County to improve the cultural responsiveness of the system of care. Since then, BHRS has embraced cultural humility as one of its system-wide values. Dr. Tervalon developed a model of medical care of at Children's Hospital in Oakland that embodies cultural humility in the 1990s, and she now provides consultation and training on cultural humility for organizations and businesses across the U.S. In 2014-2015, she will conduct 2 large scale trainings and also a smaller, intensive 5-week train-the-trainer program. The train-the-trainer program is designed to teach participants how to effectively teach cultural humility in efforts to make this essential training more accessible to various groups and agencies in San Mateo county.

Working in Partnership with Family and Communities in September 2014 for BHRS and contract staff to improve the cultural responsiveness of our system of care. Seventy-four participants attended the training. This system-wide training was followed by an in-depth 6-week Training of Trainers (TOT) from November 2014-January 2015. The TOT included 9 BHRS and contract agency staff who applied for the training to learn to provide the training throughout our system of care for other staff. After receiving the training, these trainers provided 7 trainings throughout the system during that year

In our Spring 2017 WET Stakeholder Survey, cultural humility was identified consistently as a top training recommendation, with specific cultural humility-related topics identified for future focus, including:

- Training on cultural differences
- White privilege
- Systemic oppression
- Cultural humility and diversity conversations
- Multicultural trainings
- Social equity
- Cultural competence

In the survey, cultural competence (including cultural humility and responsiveness) ranked among the top five Foundational Knowledge areas for training, was identified as a Core Behavioral Health Competency and cultural humility was identified as a top priority.

Working Effectively with Interpreters in a Behavioral Health Setting

This mandatory training aims to enhance the cultural competency and humility of BHRS staff as well as to help providers learn to effectively communicate with clients when they don't speak the client's language. The training was conducted once in 2013-2014. This training is typically well

attended, highly regarded, and is known to improve staff competence and knowledge on the appropriate use of interpreters. In 2013-2014, 52 people attended. The average pre-test score was 58% correct and the average post-test score was 80% correct; hence, the average increased by 22% from pre-to-post training. This mandatory training for direct service staff was offered twice in during 2014-2015. In October 2014, 43 people attended. And in May 2015, 27 people attended. The training was offered twice in 2015-2016 in October 2015 and May 2016.

Cultural Competence Trainings Addressing Specific Populations

The FY2014-17 WET Plan update was guided by a meaningful community stakeholder process, which included diverse groups of San Mateo County community members, clients/consumers and family members of behavioral health services, Behavioral Health and Recovery Services (BHRS) and contract agency staff (including peer and family positions), and Health Equity Initiatives. The input process consisted of 2 surveys, 14 meetings with specific stakeholder groups, and 2 community meetings that occurred between May 2014 and October 2014. Over 600 stakeholders participated in this input process. The chart below lists the forums by which information was collected. The data was analyzed in September and October 2014 in order to create the updated WET Plan.

The 2014-2017 WET Plan identified only 4 specific cultural communities for specific focus (Latino/ Hispanic, African American, Pacific Islanders, and Chinese). Since the FY2014-17 WET Plan, the cultural communities list has expanded to include more communities and cultures since our most recent plan. This can be seen as evidence that the workforce has gained a heightened appreciation for culture and community-specific trainings that help improve the quality of services. The 2017 WET Survey identified 10 cultural communities for focus (African American, Arab, Asian Americans, Black, Chinese, Filipino, Indigenous, Native American, Latina/a/x (including youth and families), and Pacific Islanders). Some responses indicate a special need for trainings that address the experiences of marginalized and newly immigrated communities.

The Health Equity Initiatives and workgroups took the lead in creating and/or sponsoring trainings on specific marginalized populations in San Mateo County in recent years. In January 2015, the Arab Community Workgroup organized a training on Working with the Arab and Arab-American Community presented by Hazem Hajaj. Thirty-four participants attended.

The African American Community Initiative sponsored a training for the African-American Community in San Mateo County on Mental Wellness: The Key to Complete Health in Celebration and Recognition of Black History month. Fifty-four participants attended.

The PRIDE Initiative and LGBTQ Commission co-sponsored a Transgender 101: Creating an Inclusive Community by Project Outlet in honor of International Transgender Visibility Day. The training was followed by a panel discussion from transgender individuals living in the Bay Area sharing their experiences and perspectives. Sixty-one participants attended.

Some of the cultural groups/populations that have been addressed with recent trainings include:

- *Working with Arab Americans*
- *Spirituality 101* and *102*
- *Mental Wellness: The Key to Complete Health (African American community focus), Transgender 101: Creating An Inclusive Community*
- *Working with Filipino Youth - Filipino Mental Health Initiative (FMHI)*
- *Trans 102: Beyond the Basics: Increasing Gender Competence and Cultural Humility, Trans 102: Seminar Series #1 - #5*
- *LGBTQ Youth 101, LGBTQ 102 for Clinicians*
- *Native American Mental Health*
- *Understanding Issues in the Queer Experience (UNIQUE)*
- *Addiction and the LGBTQIA Community*
- *Native American Mental Health: Historical Trauma and Healing Practices*
- *Cultural Awareness Training: Improving Cultural Sensitivity in Working with the Latino Population*

Other Examples:

Culturally Responsive Clinical Supervisions for Supervisors

- Culturally responsive supervision was identified as among the top training priorities by managers and supervisors in our Spring 2017 WET Stakeholder Survey. Leanna Lewis, LCSW conducted a culturally responsive clinical supervision training that was offered twice in June of 2016. This training focused on teaching supervisors how to use cultural humility and critical self-reflection to improve their supervision of their colleagues and to create a more collaborative and supportive work environment.

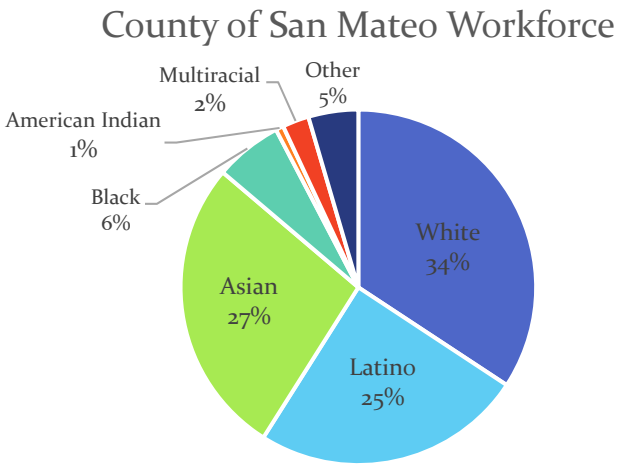
Criterion 6: County Mental Health Systems

Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

Criterion 6: Describe the extent to which the agency and its members participate in the community as well as what degree the community are actively engaged in agency activities.

a. MHSA workforce assessment (ie staffing classification and bilingual capability)
b. Analysis of workforce assessment and compare with general population (census, medical, poverty)
c. Summary of how we will target and grow a multicultural workforce in the future

Growing a multicultural workforce



Mental health career pathway programs – Multiple workgroup discussions concluded that strategies are necessary to address ongoing vacancies in positions which are difficult to fill. Strategies include:

• Attract prospective candidates to hard to fill positions via addressing barriers in the application process

- Attract prospective candidates to hard to fill positions through incentives

- Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system in general, and to hard to fill positions in particular
- Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in behavioral health.
- Increase diversity of staff to better reflect diversity of client population
- Retain diverse staff
- Expand existing efforts and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system
- Ongoing engagement and development of client and family workers

The following three objectives were established from the MHSA guidelines and the 2014 stakeholder process for the WET Plan Update in San Mateo County to promote behavioral health career pathways.

1) Attract prospective candidates to hard-to-fill positions and increase staff diversity

The state-funded Mental Health Loan Assumption Program (MHLAP) continued to be implemented in San Mateo County BHRS to address 1) attracting, hiring, and retaining staff in hard-to-fill positions and 2) increasing diversity of staff and retaining diverse staff. The MHLAP program provides student loan forgiveness for BHRS and contract staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or have experience working in underserved areas. Applicants receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation. The following chart shows the number of awards given out each year and an overall increase in awards and interest.

Fiscal Year	# of Awards
2008-09	2
2009-10	6
2010-11	9
2011-12	11
2012-13	17
2013-14	22
2014-15	17

2015-16	23
2016-17	16
2017-18*	23*
Total	146

*2017-18 numbers finalized after June 30, 2018

2) Promote the Behavioral Health Field

Intern/Trainee Programs (Clinical and ODE)

The BHRS clinical intern/trainee program provides clinical training opportunities each year at BHRS worksites throughout the county. BHRS partners and contracts with multiple graduate schools in the Bay Area and from other regions of the country to provide education, training, and clinical practice experiences for students. In 2014-2015, there were 41 BHRS interns and trainees placed at 15 different worksites throughout San Mateo County BHRS. The interns and trainees represented multiple professional disciplines including Alcohol and Other Drug certificate, doctoral psychology, MSW, MFT, and nurse practitioner students and interns. They received multiple training opportunities including a 2-day orientation that included sessions on crisis management, trauma-informed care, wellness and recovery, self-care, and health equity and a mid-year training on cultural humility. They each attended a weekly or biweekly regional didactic seminar at one of 4 sites. They were also invited to attend all of the system-wide trainings (listed earlier in this document). Nineteen of these trainees/interns received a $5,000 stipend as part of our Cultural Stipend Internship Program for their contributions to improving the cultural competence and cultural humility of our system of care (see full description below under Financial Incentives Programs).

The Office of Diversity and Equity (ODE) intern training program consists of college and graduate students who want experience in behavioral health careers through focusing on health equity and social justice work. In 2014-2015, ODE had 2 interns whose work focused on Prevention and Early Intervention initiatives including suicide prevention and stigma discrimination reduction related to behavioral health conditions. ODE interns receive a $5,000 stipend for their work.

3) Career Pathways and Ongoing Development for Clients/Consumers and Family Members

Lived Experience Academy

By way of the Lived Experience Academy, clients/consumers and family members were offered many different paid opportunities during the 2015-2016 fiscal year. Opportunities included participating in up to 3 annual trainings, opportunities to speak in front of an audience, and opportunities to provide support to BHRS events. An "event" was classified as one organized

program which could have included multiple clients/consumers and family members. An "opportunity" captured each client/consumer and family member paid to work an "event".

FY 2014-2015 Paid Opportunities for Clients/Consumers and Family Members:

- Number of Paid *Opportunities 126*
- Number of Paid *Events 21*
- Number of Paid *Speaking Opportunities 24*
- Number of Paid *Speaking Events 10*

Lived Experience Scholarship Program

The Lived Experience Scholarship program provides up to $500 in scholarship to individual behavioral health clients/consumers and/or family members to pursue their academic goals toward a behavioral health profession.

Other Projects to Enhance Workforce Retention and Development

BHRS New-Hire Orientation

The BHRS New-Hire Orientation was created and provided to new BHRS staff in fiscal year 2014-2015. The Orientation consisted of a series of five 2-hour sessions that took place over the course of 6 months. The goal was to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore the possibilities for career advancement, and to feel invested in and supported by BHRS as an organization. Thirty-five new employees who had been hired within the last year were invited to participate in the Orientation. The average number of attendees per session was 15. The session topics were as follows:

1. Orientation to What We Do at BHRS--guiding vision and mission of BHRS
2. BHRS Programs and Partnerships
3. Career Path and Professional Development Opportunities in BHRS
4. Who We Are Serving
5. Keys to Success at BHRS

BHRS Leadership College

The BHRS Leadership College provides an opportunity for BHRS staff to learn about facets critical to the successful operation of BHRS. The College supports staff in considering their career development goals and is part of a succession planning strategy. The information and experiences received from participation gives staff an understanding of key policy, fiscal, operational and planning responsibilities that BHRS executes as part of its business practices. In 2014-2015, 25

employees applied and participated in the college cohort. The BHRS College consists of 9-sessions. Staff are required to attend 6 of 9 sessions to graduate the College. In 2014-2015, 23 participants completed the college. They are eligible to make up missed sessions the next time the College is offered. The nine session topics were as follows:

1. Behavioral Health: History and Policy
2. Health System and Health Policy
3. County Governance and Administration
4. Quality Improvement, Performance Measurement, and Customer Service
5. LEAP Process and Institute
6. Finance and Budgeting
7. Servant Leadership
8. Community Partnerships, Requests for Proposals, and Contracting
9. BHRS Moves Toward the Future

Criterion 7: County Mental Health System Language Capacity

Criterion 7: Describe the delivery or facilitation of a variety of services offered equitably & appropriately to all cultural groups served.

a. Policy and procedure and practices in place for meting clients' language needs, including a 24/7 telephone line with statewide toll-free access that has linguistic capability to meet the threshold languages of the county.
b. Include the 24/7 telephone line, showing the total of number of non-English speaking callers being assisted.
c. Provide evidence that staff and interpreters are trained and monitored (i.e. Staff proficiency report)
d. Provide a summary of any efforts allocated toward language assistance to individuals who have limited English proficiency. This may include information found in the MHSA plan within the Community Service and Support and Prevention and Early Intervention programs.

The County of San Mateo increasing foreign-born population continues to be linguistically diverse. More than 46% of the County population five years of age and older spoke a language other than English at home; of this population, 45% spoke English less than "very well". California legislature requires DHCS to implement requirements for language group concentration standards through its contracts with Medi-Cal managed care counties. In addition, counties must ensure equal access to health care services for limited English proficient (LEP) members through the provision of high quality interpreter and linguistic services, and that translated written informing materials must be provided to all monolingual or LEP members that speak the languages identified by DHCS for the county service area.

On June 30, 2017 DHCS informed the County of San Mateo that according to the language group threshold standards, the county would be required to provide translated materials in Spanish, Tagalog, Chinese (Mandarin and Cantonese). In addition, our partners at the Health Plan of San Mateo identified Russian would also be included in the required languages. The Health System identified Tongan and Samoan as priority languages based on a growing number of clients served. and emerging languages as Arabic, Burmese, Hindi, and Portuguese.

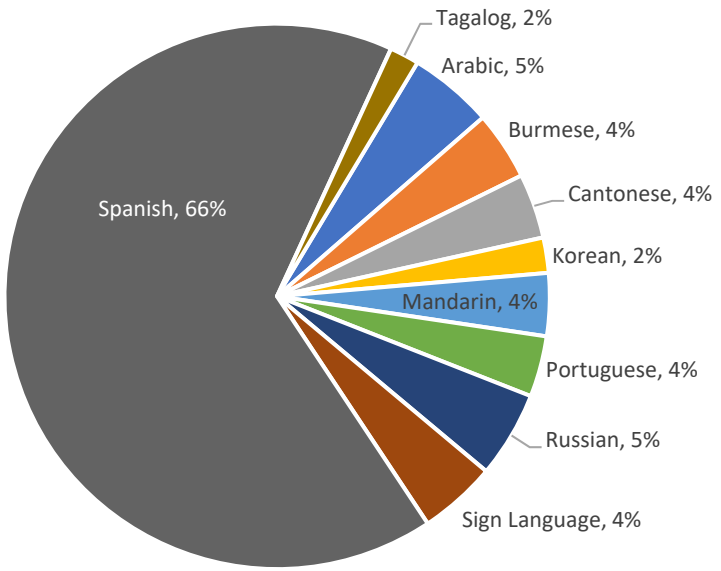
In compliance with federal and state regulations, the County of San Mateo Behavioral Health and Recovery Services (BHRS) Language Assistance Services (LAS) program provides health system staff with in-person and telephonic interpretations services and translation of written materials to enrollees and potential enrollees at no cost. In FY 2016-2017 the Health System saw 1,818 unique requests for in-person interpretation, x unique request for telephonic interpretation, and 119 unique requests for translation of written materials.

In-Person Interpretation

Between July 1, 2016 and June 30th, 2017 health system staff made 1,818 unique requests for in-person interpretation services in 23 different languages. Below are the number of requests for each language:

LANGUAGE	COUNT OF LANGUAGE	PERCENTAGE OF TOTAL
Spanish	1137	63%
Russian	88	5%
Arabic	86	5%
Sign Language	79	4%
Burmese	70	4%
Cantonese	66	4%
Mandarin	64	4%
Portuguese	62	3%
Korean	36	2%
Tagalog	30	2%
Vietnamese	26	1%
Mongolian	14	1%
Nepali	12	1%
Tongan	10	1%
Punjabi	10	1%
Japanese	6	<1%
Brazilian Portuguese	6	<1%
Farsi	5	<1%
Thai	4	<1%
Croatian	3	<1%
Turkish	2	<1%
Italian	1	<1%
Hindi	1	<1%
Total	**1818**	**100%**

Ten Most Requested Languages for In-Person Interpretation



Row Labels	Sum of Amount
Spanish	$110,433.75
Russian	$13,125.00
Arabic	$12,750.00
Sign Language	$12,660.00
Burmese	$11,034.54
Cantonese	$10,125.00
Mandarin	$9,712.50
Portuguese	$9,487.50
Korean	$5,400.00
Tagalog	$4,537.50
Vietnamese	$3,862.50
Mongolian	$2,100.00
Nepali	$1,912.50
Tongan	$1,500.00
Punjabi	$1,500.00
Japanese	$900.00
Brazilian Portuguese	$900.00
Farsi	$750.00
Thai	$487.50
Croatian	$450.00
Turkish	$412.50
Italian	$150.00
Hindi	$150.00
Grand Total	**$214,340.79**

Telephonic Interpretation

During FY16-17, the Health System contracted with a new telephonic interpretation servicer starting 3/1/17. Health Administration is in process to obtain the usage data for the previous telephonic interpretation contractor for 7/1/16 – 2/28/17. Health System staff made 1,358 requests for telephonic interpretation services. Below are the number of requests for each language during 3/1/17 – 6/30/17:

LANGUAGE	COUNT OF LANGUAGE	PERCENTAGE OF TOTAL
Spanish	738	54%
Chinese (Cantonese)	160	12%
Chinese (Mandarin)	102	8%
Portuguese (Brazil)	59	4%
Tagalog	54	4%
Russian	51	4%

Burmese	47	3%
Arabic	32	2%
Vietnamese	28	2%
Farsi	16	1%
Korean	14	1%
Punjabi	11	1%
Chinese (Other)	6	<1%
Thai	4	<1%
Japanese	4	<1%
Hindi	4	<1%
Turkish	3	<1%
Cambodian	3	<1%
Mongolian	2	<1%
Tongan	2	<1%
Nepali	2	<1%
Hungarian	2	<1%
Lao	2	<1%
Ilocano	1	<1%
Gujarati	1	<1%
Italian	1	<1%
Armenian	1	<1%
Moroccan (Arabic)	1	<1%
Samoan	1	<1%
Total	1	<1%
Shanghainese	1	<1%
Ukrainian	1	<1%
Georgian	1	<1%
Romanian	1	<1%
Igbo (Ibo)	1	<1%
Total	**1358**	**100%**

LANGUAGE	COUNT OF LANGUAGE	AMOUNT
Spanish	394	$4,447.16
Chinese Cantonese	36	$443.84
Portuguese (Brazil)	34	$292
Chinese Mandarin	21	$264.26
Russian	17	$194.18
Burmese	17	$139.43
Vietnamese	10	$95.63
Arabic	10	$79.57
Tagalog	8	$119.72
Farsi	8	$38.69
Korean	2	$16.06

Japanese	1	$23.36
Igbo (Ibo)	1	$2.92
Total	**559**	**$6,167.04**

Translation of Written Materials

Between July 1, 2016 and June 30th, 2017 health system staff made 119 unique requests for translation of written materials. Below are the number of requests by language and Health System division:

LANGUAGE	COUNT OF LANGUAGE	PERCENTAGE OF TOTAL
Spanish	42	35%
Chinese	22	18%
Tagalog	19	16%
English	18	15%
Tonga	6	5%
Samoan	4	3%
Arabic	3	3%
Hindi	1	1%
Brazilian Portuguese	1	1%
Igbo	1	1%
Korean	1	1%
Vietnamese	1	1%
Total	**119**	**100%**

Language specific programs:

- North and South Drop-in Centers (Discussed in Criterion 8)
- Older Adult System of Integrated Services (OASIS) (Discussed in Criterion 8)
- Senior Peer counseling Services (50% CSS; 50% PEI) (Discussed in Criterion 8)
- Peer Consumer and Family Partners (Discussed in Criterion 8)
- The California Clubhouse (Discussed in Criterion 8)
- The Barbara A. Mouton Multicultural Wellness Center (Discussed in Criterion 8)
- Health Ambassador Program (Discussed in Criterion 8)

Criterion 8: County Mental Health System Adaptation of Services

Criterion 8: List and brief description of county's client driven/operated recovery and wellness programs (ie centers, drop in centers, client-run programs etc.) and which of these programs are racially, ethnically, culturally, and linguistically specific

a) Describe beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve grievance and appeals

The San Mateo County Behavioral Health and Recovery Services, Office of Consumer and Family Affairs (OCFA) helps clients and family members become more empowered and aware of services and community resources available to support your treatment and recovery. Staff are culturally diverse peers and family members that consider all unique situations and circumstances, while listening with empathy, compassion and respect for your personal history and cultural values. OCFA staff help guide consumers/clients and family members through the Behavioral Health and Recovery Services (BHRS) system on how to get services and benefits for which they may be eligible; help obtain information about support and resources available, including wellness centers and peer-run organizations; and help resolve concerns or problems about individual rights relating to BHRS services received, including filing a grievance about services received from BHRS or providers.

Grievance and Appeal Process: Grievances include but are not limited to; the quality of care or services provided, for instance, if staff are rude or disrespectful; an individual feels staff did not respect their rights; services requested were not authorized and/or provided.

A decision is made within 90 calendar days of receiving a grievance. Information related the grievance may be provided in person, on the phone or in writing at any time during the process. Clients receive an acknowledgment letter and a resolution letter in clients' preferred language and are not discriminated against in any way for expressing a problem or filing a grievance. Clients may file an appeal if they do not agree with a grievance decision and appeals are decided within 30 days. Clients/consumers and family members are provided various ways to file a grievance or appeal including; calling OCFA to discuss or to set up a meeting (language support is provided as per policy); completed and mailed/faxed form or a letter to OCFA; calling the ACCESS Call Center; or in person where clients received services and staff will assist with forms and/or making calls. Decisions are made by people with the right skills and training to understand the clients' unique conditions or illness; people who read all the records, comments, or other information provided; people who were not involved in any earlier decision about the grievance or appeal. Clients have the right to provide testimony and may request copies, free of charge, of all documents in the case file, including medical records, other documents and any new or additional evidence considered, relied upon or generated in connection with the appeal of adverse benefit determination.

Edgewood Drop-In Centers, North and South: support wellness and recovery of clients and their families in the community. Provide opportunities for increased socialization, employment, education, resource sharing and self-advocacythese drop-in centers are a component of Edgewood Full Service Partnerships and provides basic needs and resources including: hot meals, hygiene supplies, laundry, bus tokens, Internet and phone access, clothes, and educational and peer support services to emerging adults between the ages of 18-25. These youths often have been impacted by substance abuse, homelessness, violence, and/or mental illness. Edgewood hopes to lay the groundwork for a trusting relationship through a welcoming approach and unconditional positive regard while serving the basic needs of emerging adults may increase the likelihood of individual engagement and later participation in additional supports and services.

Older Adult System of Integrated Services (OASIS): OASIS serves a client population that is aging, increasingly fragile and medically complex. OASIS clients come into the program with multiple co-occurring conditions related to physical health, cognitive impairment, substance use, functional limitations and social isolation in addition to their serious mental health conditions. This requires more hands-on case management support and assistance to enable these clients to remain living in a community based-setting. The case management provided also necessitates greater collaboration among the OASIS psychiatrists and primary care providers due to complex medical conditions and comorbid with their serious mental health conditions.

Senior Peer Counseling Services: provided by Peninsula Family Service, recruits and trains volunteers to serve homebound seniors with support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. The Senior Peer Counseling program has been expanded to include Chinese, Filipino and LGBT volunteers.

Peer Consumer and Family Partners: San Mateo County BHRS continues to support Peer Support Workers and Family Partners employed throughout the Youth and Adult Systems. These workers provide a very special type of direct service and support to BHRS consumers/clients: they bring the unique support that comes from the perspective of those experiencing recovery, either in their own personal lives, or as relatives of someone personally affected. They know firsthand the challenges of living with and recovering from a behavioral health diagnosis, and work collaboratively with our clients based on that shared experience.

The California Clubhouse: The California Clubhouse is a social and vocational rehabilitation program for adults who suffer from mental illness. The Clubhouse is a membership-based service that creates a community of support through collegial relationships committed to the vocational and social recovery. California Clubhouse assists, supports and empowers members (program participants) to achieve their goals of increased socialization, employment, education, independence and self-advocacy.

The Barbara A. Mouton Multicultural Wellness Center: is a new mental health facility and programmatic initiative resource for East Palo Alto (EPA) residents. Opened in June of 2009, The

Mouton Center is a place where consumers of mental health services and their family members can go to receive support, information, and be in community with each other. BHRS contracts with One East Palo Alto (OEPA) acts as lead agency for The Mouton Center, implementing all aspects of its development and operation. The Mouton Center and OEPA are supported by collaborative mental health initiatives currently with organizational partners including BHRS, the East Palo Alto Mental Health Advisory Group and the East Palo Alto Partnership for Mental Health Outreach.

Health Ambassador Program, Adult and Youth: Adult Health Ambassadors begin by graduating from the Parent Project - a 12-week course that teaches parents the skills to improve their relationship with their children as well as effective prevention and intervention strategies. After completion of the Parent Project, individuals continue to increase their skills and knowledge in behavioral health and substance use related topics by completing four of the eight public education programs offered by ODE. Individuals interested in broadening their skills on how to help people who have a mental illness or may be experiencing a mental health crisis are encouraged to attend an 8-hour Mental Health First Aid (MHFA) certification training, the 12-week NAMI Family to Family program, the Applied Suicide Intervention Skills Training (ASIST), and/or a Wellness Recovery Action Plan (WRAP) workshop. Health Ambassadors are also encouraged to become advocates in Stigma-Free San Mateo and be part of the BHRS Health Equity Initiatives. In this work, individuals engage in outreach, education and dialogue with members of our communities to reach our goal of a stigma free County.

The Health Ambassador Program-Youth (HAP-Y) is an Innovation program under the Mental Health Services Act (MHSA). HAP-Y engages, trains, and empowers TAY between the ages of 16 and 24 as Youth Ambassadors to promote awareness of mental health and increase the likelihood that young people will access needed mental health services. For this project, Youth Ambassadors receive psycho-educational training to build their own mental health knowledge and advocacy skills. Youth Ambassadors then engage in outreach and educational activities with other young people and deliver mental health presentations in the community.

Becoming a Health Ambassador has led to opportunities to work and volunteer in the field of or community outreach and peer support; teach both youth and adult courses in their community; assist in identifying unmet needs in their community and help create change.

The San Mateo County Pride Center: The Pride Center is an Innovation program under the MHSA. LGBTQQI individuals are at increased risk for mental health disorders given their experience with stress related to subtle or overt acts of homophobia, biphobia, and transphobia, and as such, need access to service providers and resources that are reflective and sensitive of their experiences and needs. The Center is a collaboration of multiple agencies that work to provide support to high-risk LGBTQQI individuals through peer-based supports, with the goal of becoming a centralized resource for mental health services. The Center promotes interagency collaboration, coordination, and communication, which will lead to increased access to mental health services among LGBTQQI individuals, and ultimately, improved mental health outcomes.

Heart and Soul, Inc., offers a complete package of services: self-help centers, outreach and advocacy activities, referrals to a variety of resources, and an internationally known anti-stigma speakers bureau. All of their activities are run solely by mental health consumers, and they are the only consumer-run organization in the state of California that is independently run by the consumers themselves. Heart and Soul, Inc., currently serves 200 to 300 consumers per week and is being used by other consumer organizations in the state as a role model for developing their own programs. Their anti-stigma program (Stamp Out Stigma) has trained organizations in other parts of the state and the United States to perform their own anti-stigma work.

Voices of Recovery (VOR) of San Mateo County: VOR is for people seeking and maintaining long-term recovery from their own addictions, and long-term recovery from being affected by other people's addictions. VOR is meant to be geographically convenient, culturally diverse and warmly welcoming to all people seeking recovery. Voices of Recovery will coordinate efforts already established and connect with alcohol and drug treatment providers; other recovery groups (12-Step and non-12-Step); faith-based organizations; alcohol and other drug studies students; organizations providing treatment, information and support for co-occurring/complex disorders and more as we discover them.

Wellness Recovery Action Plan (WRAP) Group. One of BHRS' Strategic Initiatives System of Care Enhancements and Supports Towards Wellness and Recovery strategies is "Recognize recovery is a lifelong process: Individualized planning (WRAP) for supports, self-help and resources that build a life worth living in the community."

NAMI San Mateo County – is dedicated to improving the quality of life for people with a mental illness and their families through support, education and advocacy.

NAMI Peer to Peer Education Program. In addition to providing education and support to families with a mentally ill member, NAMI also sponsors a Peer to Peer Education program for people with a mental illness. The Peer to Peer Education program provides a free, 9-week education class exclusively for mental health consumers in San Mateo County. The course is facilitated by trained mental health consumers. Course covers mental illnesses, stigma reduction, medications, recovery tools and activities. Consumers interested in taking the class should call the NAMI office and leave a message. The Peer to Peer coordinator will return calls.

The Lived Experience Education Workgroup (LEEW)/Lived Experience Academy (LEA): The primary purpose of the Lived Experience Education Workgroup (LEEW) is to identify and engage lived experience clients, consumers, and family members to prepare for workforce entry, advocacy roles, committee and commission participation, and other empowering activities. This group consists of BHRS and contractor staff, lived experience staff, clients/consumers, and family members. The LEEW plans, facilitates, and oversees the *Lived Experience Academy* (LEA), which trains clients/consumers and family members with behavioral health lived experience to share their stories as a tool for self-empowerment, stigma reduction, and education of others about behavioral health problems. Graduates then become part of the Lived Experience Academy

Speakers' Bureau and are paid $35 per hour to speak at BHRS trainings and events around San Mateo County. Their participation greatly enhances BHRS trainings and events and provides staff and the community greater understanding of clients/consumers with behavioral health concerns.

Outreach Collaboratives, North County Outreach Collaborative (NCOC) and East Palo Alto Behavioral Health Advisory Group (EPABHAG): The MHSA Outreach and Engagement strategy works to increase access and improve linkages to behavioral health services for underserved communities. BHRS has observed increases in representation of these communities in its service system since the outreach strategy was deployed. Community outreach collaboratives include NCOC and the EPAPBHO with each working to engage with particular underserved populations and communities. EPAPBHO focuses their outreach efforts on at-risk youth, transitional-aged youth (TAY), and underserved adults, with a specific focus on Latino, African American, Pacific Islander, and LGBTQ communities. While NCOC focuses their community engagement efforts on rural and/or ethnic communities, including Chinese, Filipino, Latino, Pacific Islander, and LGBTQ populations in the North County region of San Mateo.

The outreach collaboratives are intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; and linking residents to culturally and linguistically competent public health and social services.

Outreach Worker Program: The Office of Diversity and Equity employs community outreach workers to engage community, encourage participation in programming and continue targeted outreach to marginalized populations served in collaboration with the Health Equity Initiatives.