BUTTE COUNTY
CULTURAL COMPETENCE PLAN
2018

Butte County

BEHAVIORAL HEALTH

Contents

Criterion 1: Commitment to Cultural Competence

County Mental Health System commitment to cultural competence

Butte County Department of Behavioral Health's (BCDBH) procedures and practices reflect the Department's commitment to recognize and value racial, ethnic, and cultural diversity within the county mental health system. The Department has a solid foundation of honoring diversity in program design and implementation.

BCDBH recognizes that cultures within race/ethnicity and culture within the community can be diverse and fluid. A person's beliefs, norms, values and language affect how they perceive and experience the world. There is considerable diversity within and across races, ethnicities, and cultural heritages. Other cultures and subcultures often exist within larger cultures. As such, BCDBH strives to address the behavioral health needs of prominent cultural groups that encircle race/ethnicity in our community through culturally competent practices.

Developing cultural competence is an ongoing process that begins with cultural awareness and a commitment to understanding the role that culture plays in behavioral health services. This includes establishing and understanding our own organizational identity in order to develop and implement goals to strengthen access to quality service delivery.

BCDBH highlights our strong partnerships with community based organizations and the use of Community Defined Practices in disparate communities to reduce stigma, leading to increased access to mental health services and treatment throughout the county. Internally, BCDBH adapts service delivery based on understanding of cultural diversity through required and voluntary trainings. Programs and services are delivered in a way that reflects the culture and traditions of the people served.

Butte County Department of Behavioral Health values the rich diversity of our organization and aspires always to demonstrate respect for the uniqueness of each individual's beliefs, values, traditions, and behaviors.

We encourage each contribution to the establishment of an open, inclusive environment that supports and empowers our employees.

Our commitment to diversity includes both the development of a diverse workforce and the delivery of culturally competent care to our clients.

The first step to providing culturally competent care is to embrace our own diversity – to celebrate, enhance, and learn from it. Our diversity is also our strength.

BUTTE COUNTY BEHAVIORAL HEALTH
CULTURAL COMPETENCE WEBSITE

County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system.

Mental Health Services Act

The Mental Health Services Act (MHSA) community and stakeholder input processes have regularly provided the opportunity for the department to engage with unserved and underserved populations and/or their care providers in Butte County. Community meetings are held across the County at locations where translators are available upon request to ensure that individuals with Limited English Proficiency can participate. In addition, focus groups are conducted to obtain input from our unserved and underserved populations. African American, LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and other Gender/Sexual minorities), Latinx, Hmong, older adults, and consumers from various programs participated. The Cultural Competence Manager and other leadership staff are in attendance during these focus groups. Through this process, MHSA has been instrumental in providing resources for honoring diversity in program design and implementation. MHSA specifically funds several programs that were specially designed for diverse populations, and/or were implemented in communities and at sites where diverse populations may access services. Those programs are as follow:

The Sixth Street Center: provides services to homeless youth between the ages of 14-24 in Chico, California. A large percentage of those youth have been in foster care; many of the youth have had traumatic experiences with families, friends, schools, and other community support systems which have caused them to be wary of accessing services. Thus, a major focus of the program is trust building. Youth initially contact the center to utilize shower facilities, access computers, use laundry services, and get food. Groups, classes, and workshops are offered focusing on development of independent living skills, youth leadership opportunities, and healthy use of leisure time. 6th Street clinicians provide therapy services on site. If a youth is in need of medication or has mental health symptoms requiring a higher level of care, a referral to Butte County Behavioral Health is completed. 6th Street staff and BCDBH work closely to coordinate care and assist the youth towards wellness and recovery.

African American Family and Cultural Center: integrates African American culture into services that focus on early detection, prevention, and awareness of mental health issues. These services include: outreach to families, increase access and linkage to medical care, reducing stigma associated with mental illness and reducing discrimination against people living with mental illness.

Live Spot programs in Oroville and Gridley: provides prevention services to students from high schools with ethnic populations. The Gridley and Oroville Live Spot & Prevention program provides hope and reassurance, as well as a safe place for young people after school when they need support and supervision. The Live Spot offers youth led, youth developed programming, workshops, vocational/job opportunities, mentoring, supportive services and events. The Live Spot employs young people to develop, implement and evaluate Live Spot services. Young people are the primary partners at The Live Spot and are recruited to plan and implement all facets of youth activity at the center, from co-facilitating solution focused group meetings to being trained as youth evaluators.

National Alliance for Mental Illness (NAMI): NAMI Butte County implements mental health awareness, education, support and advocacy programs to support the culture surrounding consumers of mental health services. This NAMI developed structured program embraces an anti-stigma approach which includes creating a forum by which individuals with mental illness share their personal experiences in diverse locations across the county, as well as family-to-family supports.

Passages: The Older Adult Suicide Prevention and Education Program seeks to establish a network of information, services, and supports throughout the county designed with the unique needs of older adults in mind. The program works to reduce stigma around issues of mental illness and treatment,

promote recognition and early intervention for in regards to challenges to mental health, decrease the incidence of psychological crisis, and improve suicide prevention efforts.

Promotores: provides services to the Latino population in the Gridley community and to Latinos and Hmong populations at two specific apartment complexes in Chico. The Latino and Hmong Promotores program is designed to provide strength-based, wellness-focused services and support which includes outreach/ education, mental health consultation and early intervention services building on individual and family strengths. Vital to this strategy is the involvement of mental health consultants—*promotores*—who are local residents trained as community health promoters and community liaisons.

Stonewall Alliance: The LGBTQI+ Suicide Prevention and Education Program provides suicide prevention, education, and outreach services throughout Butte County to gay, lesbian, bisexual, transgender, queer and intersex (LGBTQI+) youth and young adults, as well as their families, friends, allies and institutions, organizations, service providers and educational facilities.

Strengthening Families: provides a comprehensive approach to increasing skills and knowledge for parents/care givers and children, which are critical to healthy behaviors and relationships. The SFP is a science based program spanning 14 sessions, which increase life skills for parents/guardians, families and children. This program ends with a graduation for the parents/guardians and children who complete the program. Each session includes the Center for Disease Control (CDC)'s core components of effective evidence based parenting programs including: parent and child practice time in the family sessions, learning positive interactions, communication, and effective discipline.

Wellness and Recovery Centers: There are three Wellness and Recovery Centers located throughout Butte County. These centers are consumer driven and emphasize recovery oriented activities including peer support, socialization opportunities, life skill groups, reintegration into the community, employment services, and medication support. There is an on-site clinician to help consumers run their own groups and provide limited mental health support. At one location there is a warm line, staffed by trained consumers to provide non-crisis assistance to consumers needing support after hours.

Zoosiab: Originally an Innovation program (approved June 2010), designed specifically for the Hmong population. The Zoosiab Program is a community-based program serving Hmong elders who have experienced historical trauma often associated with the Vietnam War. It combines Western and traditional cultural practices to decrease the negative impacts of stress, isolation, stigmatization, depression and trauma.

Workforce and Translation Services

BCDBH is committed to developing a culturally and linguistically competent behavioral health workforce throughout our system of care. The department strives to employ a workforce that reflects the cultural identities of our consumers to ensure effective service delivery. BCDBH actively recruits for Spanish and Hmong language clinicians, counselors, and interns. Additionally, BCDBH offers a bilingual pay differential pending verification of the employee's language or communication skill ability. Key BCDBH staff in Gridley are bilingual and bicultural employees who are embedded in the community and actively involved in such community activities as soccer, church, cultural events, etc. The Promotores program in Gridley and Chico provides outreach to the Latino and Hmong communities with staff from those communities who are bilingual and bicultural.

Translation services, written and oral, are available through a number of contracted translation service providers if there are no BCDBH bilingual staff available. Staff may also connect individuals to Language Line Solutions if there is a language barrier and bilingual staff are not available, as dictated in Policy and Procedure BCDBH – 089. Standardized procedures are used for contacting Language Line Solutions for interpretation when required for Limited English Proficient (LEP) clients who are on the telephone or in the office. Please see Criterion 7 for a more comprehensive description of our translation services.

Organizational Assessment for Cultural Competency

Working in collaboration with the Cultural Competency Committee (CCC), BCDBH implemented an organizational cultural competency assessment of the Butte County Behavioral Health system in 2018. The analysis of this assessment guides the development of future strategies, trainings and recruitment practices for BCDBH. Implementation of an organizational assessment strengthens our commitment to sustaining a culturally competent system by providing review of our agency from the staff and consumer perspective. Cultural competence requires agency leaders to make an ongoing commitment to fact-finding in order to determine whether individuals of diverse backgrounds are served fairly and capably by their agencies. Analysis of this assessment is found in Criterion 3 and in the entire assessment is found in the Appendix.

A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

BCDBH endeavors to create and enhance a culturally diverse, client and family driven, mental health workforce capable of meeting the needs of our diverse communities. This is accomplished through a commitment to training mental health staff and community partners in evidence-based, promising, emerging and community-defined mental health practices. BCDBH offers free cultural competency trainings via the eLearning platform, Relias, and through quarterly Grand Rounds trainings which include presentations from various cultural perspectives. Examples of Grand Rounds trainings have included *Cultural Awareness In The African American Community From A Mental Health Perspective* provided by the local African American Family and Cultural Center, and *Latino Cultural Training* provided by Promotores.

Additionally, BCDBH has successfully used MHSA Prevention and Early Intervention (PEI) funds to provide skill development and strengthen community organizations in order to increase the ability to effectively serve our diverse communities. The community organizations that are funded by PEI directly impact and address disparity in mental health access and outcomes. These programs are included in the list above, beginning on page 2.
Supporting and maintaining the Cultural Competency Committee (CCC) has been beneficial in preserving relationships with community organizations. These strong relationships allow for effective networking and promotion of cultural events between agencies. BCDBH welcomes diverse perspectives and representatives to the Committee and provides staff support for the group.

In working with contracted community based organizations BCDBH is committed to ensuring that culturally competent practices are followed. Efforts to accomplish this goal include:

- All contracts include a separate cultural competence statement and the inclusion of all five fundamental concepts of MHSA, which specifically sites cultural competence.
- Contract providers are required to be members of the Cultural Competency Committee (CCC) and the Quality Improvement Committee (QIC).
- Contract providers participate in the process of developing the plan and implementation of the BCDBH Organizational Cultural Assessment.
- Our MHSA PEI programs are specifically designed to meet the needs of our culturally diverse populations. Our PEI contracts mandate the hiring of local and culturally competent staff (e.g., African American Family & Culture Center, Zoosiab, Promotores)
- Supporting our contracted agencies to leverage funding for program expansion.
    - In 2016, Zoosiab was awarded a grant from the California Reducing Disparities Project (CRDP): Phase Two. The CRDP focuses on achieving mental health equity for 5 population

groups recognized as being most adversely affected by disparities: African American, Asian and Pacific Islander, Latino, LGBTQI+ and Native American. The award of this five year grant will allow for Zoosiab demonstrate the effectiveness of their program model at a statewide level.

Each county has a designated Cultural Competence Manager responsible for cultural competence.

The County has an identified Cultural Competence Manager (CCM) whose role also aligns as the MHSA Coordinator. Cultural competency is one of the five fundamental guiding principles in the MHSA and the transformation and strengthening of cultural competency practices is embedded within each of those roles. The responsibilities, roles, and duties of the CCM are as follows:

- Member of the BCDBH Executive Team who reports directly to the Director.
- Regularly participates in the Cultural Competency, Social Equity and Justice Committee (CCSEJC), a sub-committee of California Behavioral Health Directors Association (CBHDA).
- Superior Region liaison for CCSEJC.
- Member of the BCDBH Quality Improvement Committee (QIC), reports to QIC on Cultural Competency Committee activities and recommendations.
- Regularly advocates for services that meet the needs of the diverse and unserved/underserved populations as evidenced in the approved MHSA plans.
- Coordinates the BCDBH Cultural Competency Committee.
- Consistently takes steps to strengthen relationships between BCDBH and the diverse unserved and underserved populations in Butte County.
- Serves as a liaison with the Behavioral Health Board and provides monthly reports at board meetings on issues related to MHSA and Cultural Competency.

In addition, the CCM attends workshops and conferences sponsored by state entities, such CBHDA and California Institute for Behavioral Health Solutions (CIBHS). CCM participates in the Cultural Competency, Equity and Social Justice Committee, a subcommittee of CBHDA, quarterly meetings and conference calls. The CCM is actively pursuing the integration of the *Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities*, a guideline developed by CBHDA on how to integrate National Culturally and Linguistically Appropriate Service (CLAS) standards. CLAS standards are intended to advance healthy equity, improve quality, and help eliminate health care disparities.

Identify budget resources targeted for culturally competent activities.

The following **programs** are specifically funded services to culturally diverse groups:

- African American Family and Cultural Center
- Promotores
- Stonewall Alliance- LGBTQI+ Suicide Prevention and Education Program
- Zoosiab- Historical Trauma & Hmong Elders

The following **services** are provided in a culturally appropriate manner and have percentages of participants who are members of Butte County's diverse populations:

- Live Spot Gridley
- Live Spot Oroville
- Stepping Stones- Perinatal program
- Youth Intensive Programs

- Interpreters/Translators (including the 24 hour language line)
- Compensation for culturally and linguistically competent providers and non-traditional providers/healers

Financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers include the County's bilingual staff pay differential. BCDBH encourages contract providers to provide financial incentives for their bilingual staff members. The below figure depicts programs that serve with culturally diverse populations and their allocated funding streams.

Figure 1.1

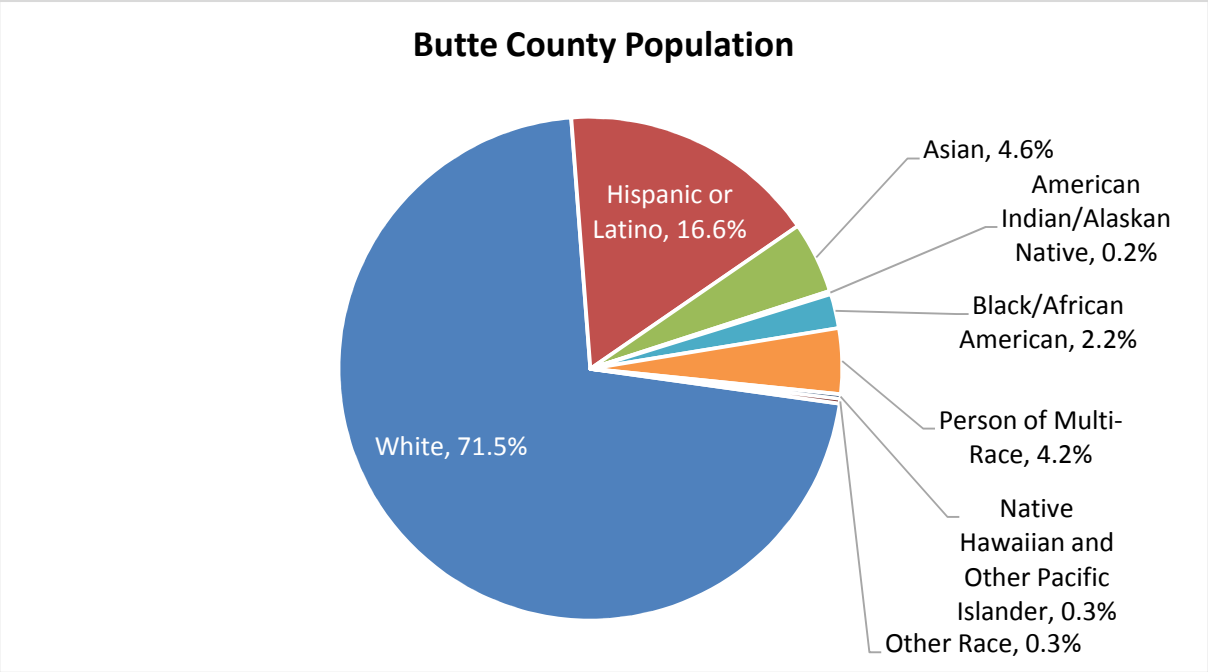
Funding	MHSA Component	Program
MHSA /Medi-Cal/ Realignment	Community Services and Support	Support, Employment, Assistance, Recovery, Community, Housing (SEARCH)
MHSA /Medi-Cal/ Realignment	Community Services and Support	Youth Intensive Program
Medi-Cal/Realignment	N/A	Translation
SAPT-Perinatal/Realignment	N/A	Stepping Stones
MHSA	Prevention Early Intervention	African American Family & Cultural Center
MHSA	Prevention Early Intervention	Promotores
MHSA	Prevention Early Intervention	Stonewall: LGBTQI+
MHSA /Medi-Cal	Prevention Early Intervention	Hmong Elder Program
MHSA /SAMHSA MHBG/STOP	Prevention Early Intervention	Live Spots - Gridley & Oroville
MHSA	Prevention Early Intervention	National Alliance for Mental Illness
MHSA	Workforce Education and Training	Cultural Competency Training

Criterion 2: Updated Assessment of Service Needs

General Population

Butte County is located in Northern California, about one hundred miles north of the state capital of Sacramento. Butte encompasses 1,677 square miles, of which 1,636 square miles is land and 41 square miles (2.4 percent) is water. This rural county holds an estimated population of 229,294 or 134 persons per square mile, approximately 39 percent of whom live within the borders of the City of Chico[1]. Much of the population is spread into agricultural land, foothills, and mountainous terrain.

Figure 2.1: Butte County Population Data by Race/Ethnicity, 2016



Individuals who self-identify as White (not Hispanic or Latino) comprise 71.5% of the County's population followed by Hispanic or Latino, Asian, American Indian/Alaska Native and African American/Black; persons of multi-races included 4.2% of the population. The age and sex distribution in Butte County was available in 2016 through the United States Census Bureau *American Community Survey*[2], which releases new datasets annually. The data is presented in Tables 2.1 and 2.2:

Table 2.1: Butte County Population Data, 2016

Sex	Estimate	Percent
Male	110,926	49.5%
Female	112,951	50.5%
Total Population	223,877	100%

Table 2.2: Butte County Population Data, 2016

Age	Estimate	Percent
Under 15 years	37,564	16.8%
15 to 24 years	41,918	18.7%
25 to 59 years	91,820	41.0%
60 years and over	52,575	23.5%
Total Population	223,877	100%

[1] US Census Bureau
[2] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Butte County Cultural Context

The following narrative was provided by members of the Cultural Competency Committee in 2017. Representatives from a culture or those who worked closely with an identified culture were asked to describe the unique characteristics or challenges that exist in Butte County for this culture.

Racial/Ethnic groups

American Indian/Alaskan Native

The 2016 United States Census Bureau *American Community Survey* reports that 2.4% of individuals in Butte County self-reported their race to be American Indian/Alaskan Native. As of July 2017, BCDBH was actively serving 191 individuals who self-reported as Native American, which comprised of 3.6% of all clients open to services.

Native Americans indigenous to the area are primarily Maidu, with sizable numbers of Wintu, Pomo, and Miwok. Many are unaffiliated with a Rancheria (a problem in California caused by federal tribal termination policies), and hold no voting power on the Rancherias. There are approximately 8,000 Native Americans living in the area. Of those about half are from local tribes. According to the 2016 U.S. Census, 1.1% of the population of Butte County is Native American, located mostly in the Oroville area. This census estimate is thought to be a low statistic for many reasons including that many Native Americans are being reported as Hispanic due to surnames. Among the four Rancherias in the area, the population distribution is as follows: Berry Creek Rancheria: 304; Mooretown Rancheria: 1,170; Enterprise Rancheria: 395; and, Chico Rancheria: 321 (Individual Rancheria data, 2003).

Research shows higher rates of related behavioral health concerns for Native Americans, including high occurrence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases across Indian Country, which continue to have a profound effect on individuals, families, and communities[3]. According to the Centers for Disease Control and Prevention (CDC), suicide disproportionately affects Native Americans and is the second leading cause of death for those between the ages of 10 to 34 (2013). The suicide rate among Native American adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000) (CDC 2013).

Hmong American

Hmong is the third largest minority group in Laos who came to the United State as refugees in the mid 1970's after fifteen years of service side by side with the United Stated Central Intelligence Agency (CIA) in Laos. This war is known as the "Secrete War" in Laos. Hmong refugees came to the United State of America after the fall of Saigon, from the middle of 1975's to early 1980's as the first wave, and late 90's and 2005 as the last waves of Hmong Refugees from the refugee camps in Thailand. Hmong believes in animism, which is the belief that human beings and everything have souls and spirits. Hmong believed that when a Hmong person is sick, his or her souls and spirits are no longer with the body. The shaman is the first contact person and his job is to bring harmony to the individual, their family, and their community by performing various rituals in communication with the souls or spirits and bring them back to the body.

[3] Indian Health Service. "American Indian/Alaska Native Behavioral Health Briefing Book." Rockville, MD: U.S. Department of Health and Human Services, Division of Behavioral Health, Office of Clinical and Preventive Services, August 2011.

In the early 1980's Hmong moved to Butte County with a few Hmong in Chico and Oroville. In the late 90's to now, many Hmong families are moving to Butte County. Butte County is home for more than nine thousand Hmong because of the natural beauty and farming similarities to where they came from the mountains of Laos. Hmong still practice their cultural traditions and belief at home. For example, if member of the family is sick, herbal medication is the first form of treatment, and if that does not help, a shaman will be called to do a ritual. If the ritual does not treat the sick family member, then the last resort is taking the sick person to see a doctor or seek Western treatment.

Latino American

Latino Americans comprise about 16% of the Butte County population. While the vast majority of residents are originally from Mexico, there are Latino Americans in Butte County that are also from many countries in Central and South America. Latino Americans live throughout Butte County, though the majority of people live in Gridley. Gridley is the fourth smallest of Butte County cities with its primary economy based on the local agricultural business. "La familia" and "la comunidad" (family and community) are central for the Latino culture's wellness, which includes its language (Spanish or Indian dialect), traditions, folklores/mythology, music, food, and religious or spiritual affiliation: all are fundamental for family norms to be transmitted from one generation to the next. Latino families needing services, however, are predominately from family systems that are culturally broken, have ceased to bond or prosper due to assimilation/acculturation, experience severe trauma via violence in the home, have strict male patriarchy via *machismo*, ongoing immigration legal issues, and traumatic deportation histories. Although migration experiences to the U.S. may be similar, each family has its own story that often reflects an ongoing generational trauma and can be an extremely painful experience. Situations leading to U.S. immigration include poverty, political persecution, drug cartel wars, hope of a better future for their children, and limited job opportunities within countries of origin. When Latino families experience mental health, drug and substance abuse issues, and/or the presence of gang influences/violence within the home, it often creates ongoing shame and embarrassment for individuals, ostracism from their religious community, and the fracturing of the family system.

African American

African Americans are about two percent of the population in Butte County and are primarily living in the cities of Oroville and Chico, with the greater concentration occurring in Oroville. Most African Americans in Butte County live in poverty and have insufficient healthcare. Infant mortality among African Americans in the County is more than twice that of other ethnic groups (8.8 per 1000 births) and about one in 20 of their children are living in out-of-home placements. Most African American community members in Butte County are descendants of Africans who were forcibly removed from their homeland and enslaved in America. Sadly, the forced separation of family members in slavery continued in a new form under Jim Crow laws and Black Codes. In Butte County, many African American families came due to assurances of good jobs associated with building the Oroville Dam, with the state promising that much of the economic boom of this project would be directed to Butte County. Unfortunately, this economic boom did not materialize, and the African American families that moved to this county for employment and benefits of the project were left without local jobs. Many leaders and gifted members of the community have moved for higher paying jobs in other areas resulting in disconnecting families and/or poverty. Many local African American families have for generations been subject to trauma, had disrupted family life, and struggled with poverty. The experience of perceived racial discrimination leads to lower levels of mastery, and higher levels of psychological distress. Many males respond to trauma and other stressors through

aggressive and angry behavior towards self and others and/or using drugs. With the immense difficulties of coping and racial profiling, many of these males in the community were criminalized.

Cultural Groups

In addition to the four distinct racial/ethnic groups in Butte County, the agency also recognizes that there are cultural groups in Butte County that hold shared beliefs, attitudes, knowledge, practices, and behaviors. The BCDBH Cultural Competence Committee has identified six cultural groups that are important to understating the population of Butte County.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersexual and Other Sexuality, Gender or Sex Identities (LGBTQI+)

Over the past 15 years, research has suggested that adolescence can continue into the third decade of life. As those of us who work with adolescents and their families can attest, getting there is half the battle. And while adolescence is a period of increased stress and excitement for a majority of youth, some definitely have more of a struggle on their hands than others. Numerous studies report on the high percentage of LGBTQI+ youth that feel isolated from peers and additional feelings of isolation, and difficulties caused by their parents' rejection due to their sexual orientation. As a result of their families' rejection, as many as 26% of LGBTQI+ youth feel forced to leave home.

Schools often unwittingly or by complicity reinforce that it is not healthy or safe to be gay, lesbian, or bisexual. A study at Lincoln-Sudbury Regional High School in Boston revealed that 97% of the student body reported hearing anti-gay comments on campus. Such disparaging and often prejudicial remarks are often ignored or, even worse, tacitly encouraged by faculty and administration. Over the last two decades, research findings have pointed to disproportionately high rates of suicidal behavior among LGBTQI+ adolescents and young adults. Suicide attempts in this population have been linked to a variety of factors including lack of support, family problems, violence/ victimization, and mental health problems, notably depression and substance abuse or dependency. One study found that when compared to their heterosexual peers, LGBTQI+ youth are:

- Over five times more likely to have attempted suicide in the past year.
- Over three times more likely to miss school in the past month because of feeling unsafe.
- Over three times more likely to have been injured or threatened with a weapon at school.

Parents' attitudes and behaviors toward their gay, lesbian, and bisexual offspring are key determinants of their children's risks of suicide, substance abuse, and depression, according to a new study (December 2009) published in the journal *Pediatrics*. The study in *Pediatrics* found that rejection by one or both parents and/or efforts to change sexual orientation were significantly associated with higher risks of suicide and poorer health outcomes among this population.

Lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection. It is important to note that stigma associated with homosexuality and gender identity causes many affected individuals to be wary of “governmental” service providers, and of receiving

services at typical governmental offices. The mental health field especially has a long history of institutionalize homophobia which is in of itself a barrier to treatment for LGBTQI+ community.

Trust is a most significant factor for the LGBTQI+ populations and the effort to reach out with trusted community liaisons will lead to improved prevention efforts and lessen the risk of suicide, depression, and other risky behaviors.

Older Adult

In Butte County, approximately 22% of the population is over the age of 59, compared to the statewide proportion of 18%. Older adults are at considerably higher risk for mental illness, particularly depression. According to national statistics, they are the most likely individuals to successfully complete suicide. A key finding of Enloe Medical Center, the primary hospital in Butte County, found that 29% of adults in this area had depression lasting two years or more, particularly, people aged 65 and older (2007 Community Health Survey, Enloe Medical Center). Many older adults have chronic health conditions that contribute to signs and symptoms of mental illness, e.g. diabetes and stroke are very closely correlated to depression in older adults. In fact, the 2007 Community Health Survey shows that in Butte County 3.2% of adults suffer from or have been diagnosed with cerebrovascular disease (stroke), a rate higher than the statewide figure of 2.4%. More than 18% of adults older than age 65 have diabetes (Centers for Disease Control and Prevention). Butte County has a higher rate of this disease in adults (10.5%) than the state proportion of 7.1%.

It is acknowledged that in Butte County, the incidence of mental illness and severe emotional distress among older clients is high; older adult have presented with symptoms/diagnoses of depression, bipolar disorder, complicated grief/loss, anxiety, PTSD (post-traumatic stress disorder), panic disorders, psychotic disorders, medication misuse, overuse and mismanagement; and obsessive-compulsive disorder. Furthermore, older adults who are experiencing initial symptoms of substantial emotional distress are not accessing mental health services in proportion to their numbers. These older adults are facing profound and unremitting sadness, grief/loss, social isolation, fear, and physical symptoms. They frequently do not know the cause of these symptoms, or that the proper early intervention treatment of older adults is generally successful. They may believe and accept that the nature of being old is to be sad: that depression is a "normal" part of aging. They often express the sentiment that these feelings are "their fault" and that they need to "pick themselves up by the bootstraps" if they want to feel better. If they have had treatment that did not include thorough education, support, and follow-up, then they may believe that treatment, in general, doesn't work. Consequently, they may not seek help or disclose symptoms after that failed intervention.

The result of the lack of early identification and appropriate in-home intervention and services are substantial and include escalation of symptoms, institutional placement, self-harm, and suicide.

Veterans

The total number of Veterans documented in Butte County for 2010-2014 was 17,116.[4] The total number of individuals that self-identified as Veteran served by BCDBH for the Fiscal Year of 2013-14 BCDBH was 240. According to the RAND Center for Military Health Policy Research, 20% of the vets who served in either Iraq or Afghanistan suffer from either major depression or post-traumatic stress disorder and only

[4] https://www.census.gov/quickfacts/table/PST045214/06007

about ½ of veterans who need mental health services will receive them. Veteran mental health services are critical to recovery, however, veterans face barriers to treatment which includes the following[5]:

- Personal embarrassment about service related mental disabilities
- Long wait times to receive mental health treatment
- Shame over needing to seek mental health treatment
- Fear of being seen as weak
- Stigma associated with mental health issues
- A lack of understanding or lack of awareness about mental health problems and treatment options
- Logistical problems, such as long travel distances in order to receive this type of care
- Concerns over the veteran mental health treatment offered by the VA
- Demographic barriers and false perceptions based on these demographics such as age or gender

Foster Care

Analysis of data from the 2011-2012 National Survey of Children's Health revealed that children who had been in foster care were seven times as likely to experience depression, six times as likely to exhibit behavioral problems, five times as likely to feel anxiety, three times as likely to have attention deficit disorder, hearing impairments, and vision issues, and twice as likely to suffer from learning disabilities, developmental delays, asthma, obesity, and speech problems[6]. Factors contributing to the mental and behavioral health of children and youth in foster care includes the history of complex trauma, frequently changing situations and transitions, broken family relationships, inconsistent and inadequate access to mental health services and the over-prescription of psychotropic medications.[7]

As of July 2015, children under age 21 in foster care per 1,000 population was 5.8 in California and 10.1 in Butte County[8]. As of January 2018, Butte County has 572 children in foster care placement, 59.09 percent (338) of whom are age 0-10. During Fiscal Year 2017-2018, Butte County BCDBH served 341 youth who were identified as having active child welfare cases. Adversity in childhood has been shown to be a predictor of future negative health outcomes, including emotional and mental health issues. Adverse childhood experiences (ACEs) are reliable indicators of physical health and cognitive functioning in adulthood. As of a 2013 study performed by the Center for Youth Wellness, Butte County has the highest prevalence of residents living with one or more ACEs in California at 76.5 percent of residents, with 30.3 percent having experienced four or more ACEs. These high rates of trauma contribute to many of the physical and mental health issues observed in Butte County. According to research, neurological functioning is acutely affected by childhood trauma, causing alterations in the child's brain that may stimulate the development of maladaptive coping skills later in life. A likely correlation witnessed in Butte County, these physiological modifications can be passed on and present themselves in the next generation.

Homeless

An estimated 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or substance use disorders. Additionally, California has the highest

[5] https://nvf.org/veteran-mental-health-facts-statistics/
[6] https://psychcentral.com/news/2016/10/18/foster-children-at-risk-for-physical-mental-health-issues/111294.html
[7] http://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx
[8] KidsData.org 2018

number of homeless than any other state.[9] The homeless population have barriers to mental health treatment which includes, but is not limited to, transportation, lack of resources, stigma, family support, ability to access insurance, and negotiating systems.

Consistently since 2008, the adult homeless population in Butte County has reported that the number one cause of their homeless status is job loss/lack of employment and/or other financial reasons. Family problems and eviction are also cited as primary reasons. For both unaccompanied and transition-aged youth, being kicked out of the family home, running away, or family violence are the primary reasons for homelessness.

Being homeless is a very traumatic experience. On a physical level, those experiencing homelessness are at elevated risk for communicable disease, chronic illness, and being victims of violence. Psychologically, they are more likely to experience poor mental health and to develop substance-related and addictive disorders due to their attempt to survive in high stress, unhealthy and dangerous environments. The dynamic is even worse for those persons who already had a behavioral health condition when they became homeless. In addition, those who are homeless are often marginalized, isolated and discriminated against by society, compounding their trauma. It is estimated that the mortality rate for homeless persons may be up to 9 times greater than for the general population.

Consumer and Consumer Employment

Cultures within mental health communities can be defined around diagnosis, symptoms, and treatment. For example, Bipolar Support Communities or Asperger's Support Communities can arise based on diagnosis and explicit symptoms. On the other hand, communities can develop based on treatment communities, i.e. support programs offered by BCDBH or other community mental health programs may promote identification and interactions between members of this community.

Because mental illness is present in all ethnicities and social groups, it is important to identify and address the intersection of mental illness and other social groups:

- Race/Ethnicity
- Language
- LGBTQI+
- Veterans
- Children in and emerging from foster care
- Culture of Poverty

Butte County has been a leader in consumer/peer employment since 2006. Subcontractor NVCSS (Northern Valley Talk Line/Iversen Center) employs 25 peer staff from part to full time, in every job classification. BCDBH employs peer staff for several departments (Computer Labs, Crisis, the HUB). Peer staff have been able to access better job opportunities, i.e. case manager, medical records tech, and supervisor after their entry into peer based services. Peer staff have also left employment to pursue education at the BA and MSW levels.

MEDI-CAL population service needs

As reported by the California External Quality Review Organization (CalEQRO), the average number of Medi-Cal enrollees per month in 2017 for Butte County was 84,600. Of that population, there were 7,128 beneficiaries served annually by BCDBH. Tables 2.3-2.6 show the demographic break down of the Medi-Cal

[9] https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf

population by race/ethnicity, age group, gender, and eligibility category. CalEQRO data represents clients receiving mental health services and does not include clients receiving substance abuse disorder services.

Table 2.3: Butte County Medi-Cal Population for Calendar Year 2017

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY17 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
White	50,806	4,825
Hispanic	15,522	826
African-American	2,185	241
Asian/Pacific Islander	5,091	186
Native American	1,486	99
Other	9,510	951

Table 2.4: Butte County Medi-Cal Population for Calendar Year 2017

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY17 by Age		
Age	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
0-5	9,214	255
6-17	17,407	2,156
18-59	47,291	4,169
60 +	10,687	548

Table 2.5: Butte County Medi-Cal Population for Calendar Year 2017

Butte County Medi-Cal Enrollees and Beneficiaries Served in CY17 by Eligibility Categories		
Categories	Average Monthly Medi-Cal Enrollees	Annual Count of Beneficiaries Served
Disabled	11,536	2,303
Foster Care	684	308
Other Child	19,567	1,800
Family Adult	16,984	779
Other Adult	6,396	130

The following figures show BCDBH penetration rates by demographics compared to statewide penetration rates as reported by CalEQRO. The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count.

Figure 2.2: Penetration Rates for Calendar Year 2017

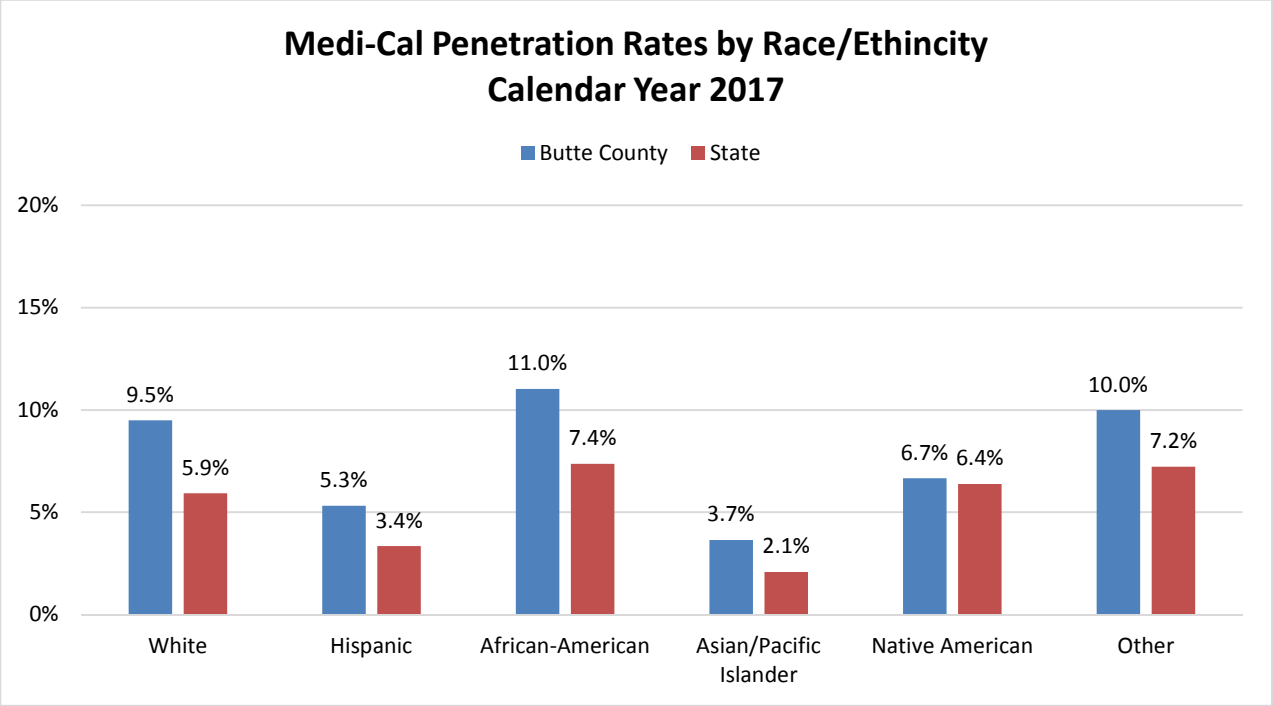
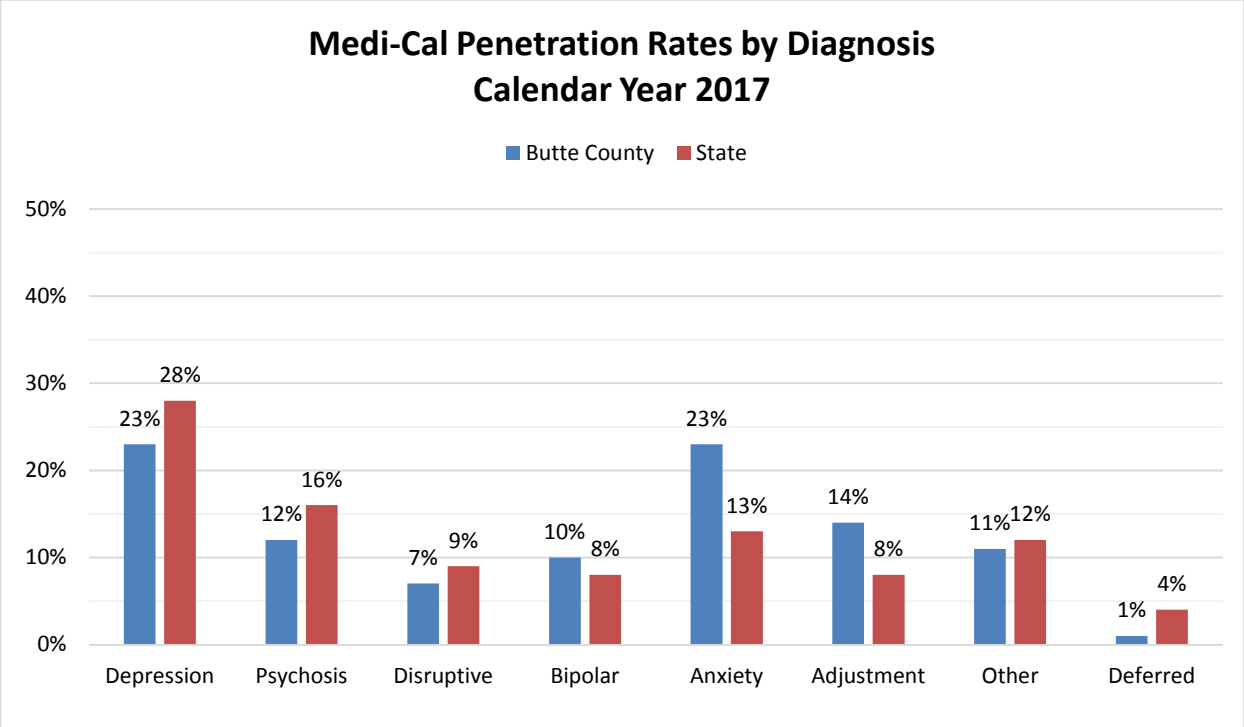


Figure 2.3: Penetration Rates for Calendar Year 2017



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

The client demographic data is collected at admission. This data is collected through Avatar, the Electronic Health Record that is used exclusively by BCDBH staff. The number of distinct clients that obtained mental health and substance use disorder services during the fiscal year 2016-2017 is 9,409. Based on the Butte MHP CalEQRO 2017 Report, there are 84,729 Medi-Cal recipients in the County with an overall penetration rate of 9%. Of that population, there were 7,128 beneficiaries served annually by BCDBH. This data indicates that the majority of the population we serve are enrolled in Medi-Cal.

Client utilization rate for Butte County Medi-Cal is higher than the statewide averages for each of its comparable populations. This is portrayed above, in Figure 2.2, which shows the utilization rate of Butte County residents who have Medi-Cal. Penetration rates for Butte County exceed State averages for each racial/ethnic group. The following table demonstrates the percentage that Butte County exceeds statewide averages, ranked from highest to lowest.

Table 2.7: Butte County Medi-Cal Rates Exceeding Statewide Averages

Butte County Medi-Cal Penetration Rates Ranked by percentage they exceed statewide average	
White	3.6%
African American	3.6%
Other	2.8%
Hispanic	1.9%
Asian/Pacific Islander	1.6%
Native American	.3%

The Native American penetration rate just barely exceeds state average by .3%, while other groups, such as White and African-American exceed by 3.6%.

These client utilization rates do not reflect that some cultural groups are at higher risk for behavioral health issues and therefore will have a higher need for services. The factors that may dictate a higher need for services are groups that have experienced historical trauma or those whose cultural norms and teachings often influence beliefs about the origins and nature of mental illness. Groups who experience historical trauma experience cumulative emotional and psychological wounding of an individual or generation caused by a traumatic experience or event. Groups who suffer from historical trauma include Native Americans, African Americans, immigrants, and families living in poverty. Stakeholders from these groups substantiate that there are many unmet service needs in their communities, in particular, culture-based services that are congruent with cultural traditions.

Butte County penetration rates for Asian/Pacific Islander and Native American are identified as the smallest percentages that exceed statewide rates. These are cultural groups who have potential for an increased need for services due to their historical trauma; Native Americans experienced trauma through violent colonization, assimilation policies, and Asian/Pacific Islander trauma from the Vietnam War and forced migration.

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

Butte County is considered a low-income county. Approximately 19.5 percent of persons in Butte County meet or fall below the federal poverty line, compared to 14.3 percent in the State of California and 12.7 percent nationally (US Census Bureau 2017). The lower socio-economic status of many Butte County residents is often generational and many families are freighted down with other social and economic burdens that appear at higher rates in lower income households: unemployment, financial instability, food insecurity, mental health issues, and substance abuse and dependence. Butte County's unemployment rate was 5.7 in 2017, compared to California at 4.2 percent (Bureau of Labor Statistics 2018).

Individuals at or below 200% of poverty without Medi-Cal are much less likely to receive services at BCDBH than their Medi-Cal counterparts (3.7% vs. 9.14%). This difference pertains to the core target population of BCDBH: 1) BCDBH is the provider for people with Medi-Cal, and 2) Butte County focuses on the severely impaired who are more likely to be on long-term disability and have Medi-Cal. BCDBH does serve individuals who do not have any insurance, and those are most likely individuals who fall below the poverty line.

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

List the target populations with disparities your county identified by MHSA components.

Community Services & Supports (CS&S)

- Homeless/at-risk of homelessness
- Foster youth

The CS&S portion of the MHSA Plan provides a framework for providing services that fall into two categories; Crisis Intensive Services and Consumer Education, Employment and Wellness programs. These categories address the populations at-risk for homelessness, individuals in crisis, foster care youth and those who live with serious mental illness symptoms. The CS&S component includes programs throughout the entire crisis continuum of care, three peer-run wellness centers, housing assistance various vocational programs, full-service partnership services (youth, TAY and adult) and intensive case management services to homeless and at-risk of homeless youth and adults.

Prevention Early Intervention (PEI)

- African American
- Hmong
- Latino
- Native American
- LGBTQ+

BCDBH designed a process for collecting and analyzing data for the PEI Community Workgroup to study and determine priority populations and service needs. The workgroup reviewed six sources of community input, and data were gathered between September 2007 and March 2008 included: survey, community meetings, targeted focus groups, additional written input from staff and the community, census data, and Butte County Behavioral Health service data. The 32 member community workgroup identified seven local needs for PEI services, matched them with the PEI State priority populations. The group subsequently recommended the development of specific services and programs, and this ultimately became the approved MHSA plan. Butte County has implemented projects that reach a wide array of geographical, age, and cultural populations within our county. Projects include prevention and early intervention for youth, transitional aged youth, adults, and older adults. The African American, Latino, Hmong, and LGBTQI+ communities receive specialized PEI services. All programs include elements to address suicide prevention and the reduction of stigma and discrimination.

Workforce Education & Training (WET)

- Bicultural staff
- Consumer/family member staff

Findings from the BCDBH Staff Organization Assessment reflect the staff's desire for increased diversity in the local public mental health workforce. Specifically, individuals who are bicultural and are native speakers of Spanish and Hmong language remain difficult to recruit/retain.

Identified disparities

In preparing the Cultural Competency Plan, disparities were identified throughout the various Criterion:

Criterion 2: The Butte County penetration rate for Native Americans just barely exceeds state average by .3%, while other groups, such as White and African-American exceed by 3.6%.

These client utilization rates do not reflect that some cultural groups are at higher risk for behavioral health issues and therefore will have a higher need for services. The factors that may dictate a higher need for services are groups that have experienced historical trauma or those whose cultural norms and teachings often influence beliefs about the origins and nature of mental illness. Groups who experience historical trauma experience cumulative emotional and psychological wounding of an individual or generation caused by a traumatic experience or event. Groups who suffer from historical trauma include Native Americans, African Americans, immigrants, and families living in poverty. Stakeholders from these groups substantiate that there are many unmet service needs in their communities, in particular, culture-based services that are congruent with cultural traditions.

Butte County penetration rates for Asian/Pacific Islander and Native American are identified as the smallest percentages that exceed statewide rates. These are cultural groups who have potential for an increased need for services due to their historical trauma; Native Americans experienced trauma through violent colonization, assimilation policies, and Asian/Pacific Islander trauma from the Vietnam War and forced migration.

Criterion 6: Our existing staff demographics do not represent our service population, with Caucasian (White) staff at 78.8% compared to our consumer population percentage of 73.0%. The ethnic community that is least represented is the Hispanic/Latino population where our Latino staff are only 9.0% yet Latino ethnicity is 14.6% of our service population. After closer inspection of the data collection processes that go into identifying staff demographics, it was determined that there is an opportunity to change our process to portray a better reflection of staff demographics. For example, the choices available for race/ethnicity selection are very small, especially when comparing with the options available to our consumers. The Butte County Human Resources Department provides all County departments with methods to collect staff demographic data. Additionally, neither the department, nor the County, collect information on the numbers of LGBTQI+ staff that are 'out' at work and can therefore provide expertise regarding the LGBTQ+ community to both staff and consumers.

Criterion 7: Butte County recognizes the Department's need for bilingual language skills or specialized communication skills to improve consumer experience and reduce cultural/linguistic disparities. Thus, BCDBH continues to implement Personnel Rule 11.15 Bilingual Pay Differential (found in the Appendix). Bilingual pay differential is intended to be an incentive for bilingual staff to utilize their skills and for departments to leverage resources. This rule requires verification of language and communication skills as defined and administered by the Butte County Human Resources Department. BCDBH is currently working with County Human Resources to allow for development of an internal (department level) certification process. BCDBH asserts that language certification in health and human services is more complex and requires a more sophisticated certification process than is currently in place for the County. A more sophisticated certification process may dictate an increased need for training and support of individuals who are certified. The enhancement of support and training for our staff was also defined by our leadership team via the Translation Survey (Appendix).

Organizational Assessment Findings

To further identify opportunities to enhance Cultural Competency at BCDBH, the department engaged in an Organization Assessment for Cultural Competency in 2018. The results were reviewed with the Cultural Competency Committee and strategies were identified through the committee for the department to implement through 2021. For more information about the history of this Assessment, please review Criterion 4: Client/Family Member/Community Committee. Those results of this survey were also shared with the Executive Management Team.

The following analysis was completed by the BCDBH Systems Performance, Research and Evaluation Unit. The surveys were distributed to consumers and staff to gain qualitative data about the agency's Cultural Competency. They were mostly comprised of multiple choice questions, with the option to provide further commentary at the end. The demographic requirements match PEI data requirements. The comprehensive results for the staff and consumer surveys can be found in the Appendix.

Consumer Survey: There were 322 consumer surveys completed.

STRENGTHS

- 91% *strongly agree* or *agree* that "I feel respected, supported, and understood at this agency."
- 88% of consumers have not experienced any unfair or biased treatment because of personal characteristics.
- 79% *strongly agree* or *agree* that adequate "Information and Resources [are] Provided by this Agency."
- 76% *strongly agree* or *agree* that "This agency has served me in a culturally sensitive manner."
- 67% *strongly agree* that "When I come into the office for services, I am greeted with respect."

CHALLENGES/OPPORTUNITIES

- 28% *strongly disagreed*, *disagreed*, *doesn't know* or finds it *not applicable* that "I am bothered less by my symptoms."
- 24% *don't know* if or found it *not applicable* that "I was asked about my cultural needs and preferences in a way that was comfortable for me."; while those who identified as Genderqueer agreed the least with it.
- 16% *disagreed* that or *don't know* if "I was asked about my and my family's strengths as well as our needs."

Staff Survey: There were 219 staff surveys completed.

STRENGTHS

- 92% *strongly agree* or *agree* that "My agency has policies against discrimination and harassment."
- 88% *strongly agree* or *agree* that "The agency's vision statement, and policies and procedures reflect a commitment to serving clients/families of different cultural backgrounds."
- 67% *strongly agree* or *agree* that "Staff understand and respect the communication and other behavioral implications of different client cultures."
- 63% *strongly agree* or *agree* that "The cultural diversity of clients currently served by my agency is reflective of the cultural diversity of persons most in need of services in the broader community."
- 53% *strongly agree* or *agree* with the "Respect, Support and Understanding of this Agency."

CHALLENGES/OPPORTUNITIES

- On average 58% of staff *don't know* about "Leadership Values" concerning board members.

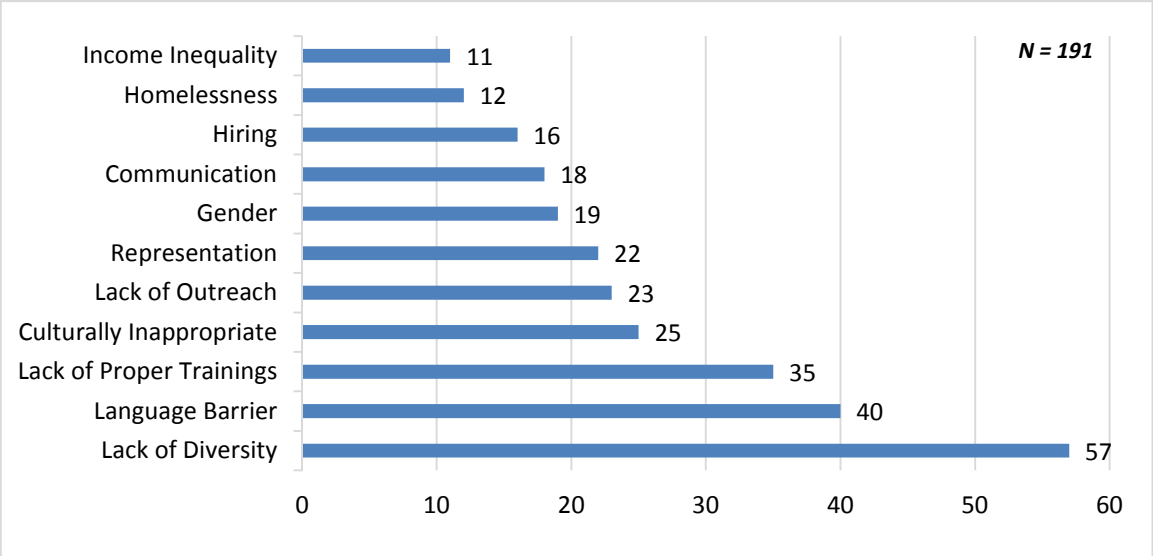
- On average, 42% of staff *don't know* about our agency's "Leadership Values," in general.
- On average, 36% of staff *don't know* about our agency's "Community Outreach," in general.
- 32% *don't know* if "My agency addresses cultural tensions that arise, both within the organization and within the broader community."
- 27% *disagree* or *strongly disagree* that "My agency provides adequate training regarding the cultures of the clients served, staff, community, and the interaction among them."

COMMENTS

Additionally, staff were asking to respond to the following questions:

- List the five most important diversity-related issues currently facing the agency.
- List three steps the agency could take to enhance its cultural competence.

Phrases most mentioned in comments:



Note: There could be multiple mentions in one comment.

Identified strategies

Criterion 2: Increase the Butte County penetration rates for Asian/Pacific Islander and Native American. These are cultural groups who have potential for an increased need for services due to their historical trauma; Native Americans experienced trauma through violent colonization, assimilation policies, and Asian/Pacific Islander trauma from the Vietnam War and forced migration.

Criterion 6: BCDBH Human Resources department has agreed to partner with the Cultural Competency Committee to implement changes that would allow for a larger dictionary of race and ethnicity for staff to choose from.

Criterion 7: BCDBH is currently working with County Human Resources toward implementing an updated certification process. A more sophisticated certification process may dictate an increased need for training and support of individuals who are certified. BCDBH is currently exploring these options and how to best move forward with training and supporting, and therefore potentially recruiting current staff to apply for the bilingual pay differential.

Cultural Competency Committee Recommendations

The California Reducing Disparities Project: Strategic Plan to Reduce Mental Health Disparities was developed to represent the voice of the unserved, underserved and inappropriately served communities involved in California's public mental health system. This Strategic Plan was developed in between 2012-2015 by the California Pan-Ethnic Health Network and released in 2018. The five CRDP populations – African American, Latino, Native American, Asian and Pacific Islander, and Lesbian, Gay, Bisexual and Transgender – have historically been challenged in obtaining optimal mental health, despite a mental health system that's expected to provide adequate and appropriate services to all persons, regardless of our race, ethnicity, nativity, gender, age, sexual orientation, or gender identity. In addition, many communities remain underserved, such as the homeless, Limited English Proficient, persons with disabilities, immigrants and refugees, and those living in rural areas.

The Committee is interested in implementing some strategies from the CRDP strategic plan, which provides community-driven direction to transform California's public mental health system and reduce disparities in racial, ethnic, and LGBTQ communities. It identifies strategies to improve access, services, and outcomes for unserved, underserved, and inappropriately served populations. These recommended actions are organized into overarching themes, goals, and strategies. The four overarching themes must be addressed at the state, county, and local levels. The five goals will move us toward a system where all communities are afforded quality, accessible, and culturally and linguistically appropriate services. The goals are accompanied by 27 strategies that provide specific recommendations for moving forward. This will be explored further in 2019.

More specific strategies have been identified by the Committee through the analysis of our Organization Assessment for Cultural Competency. The staff survey identified phrases that were used the most in the comments section:

1. Lack of Diversity
2. Language Barrier
3. Lack of Proper Trainings

Table 3.0

Strategy/Project	***Description***	***Actions***
Increase number of bilingual, bicultural staff	Recruit for staff whose heritage language is Hmong or Spanish. Continue to increase the number of African American, Native American, Latino, Hmong, LGBTQI+, staff members.	Recruit for Hmong and Spanish speaking staff. Consider including language in job specifications around diverse communities. When possible, hire local staff from the community that is being served.
Increase the competency of the procedure used to capture	The choices available for race/ethnicity selection for our staff members are very small, especially when comparing with the options available in Avatar for our consumers.	Work with BCDBH Human Resources department to implement changes that would allow for a larger dictionary of

Strategy/Project	***Description***	***Actions***
demographics BCDBH staff	We currently do not collect demographic data related to the LGBTQI+ community.	demographics for staff to choose from.
Develop environments at BCDBH and contract providers that allow LGBTQI+ staff to feel safe in coming out at work.	Increase numbers of LGBTQI+ staff that are 'out' at work and can therefore provide expertise regarding the LGBTQ+ community to both staff and consumers.	Discuss with staff members how to increase safety level for LGBTQI+ staff members at work. Identify strategies to implement and monitor implementation progress.
Have a process in place to ensure that interpreters are trained and monitored for language competence	Ensure that staff who are receiving bilingual pay and/or contracted for translated services have been trained in or have experience in the mental health field. Translator/Interpreter Service Evaluation is used to monitor individuals on their skills and ability to cooperate with staff and consumers.	The Cultural Competency Manager will initiate an evaluation of how to implement this process.
Provide training and education to department staff about Native American, African American, Hmong, Latino, LGBTQ+ communities.	Provide access to Cultural Competency Trainings to staff and providers	Grand Rounds trainings are relaunching in 2018 through coordination from the Cultural Competency Committee. Develop workgroup to design and implement cultural competency academy.
Offer training and education to tribal communities about MH, substance abuse, and co-occurring disorders, including outreach.	Offer partnership and training to local tribal communities.	Develop partnership to identify methods of training and outreach regarding co-occurring disorders in the Native American Population. Identify action steps to take regarding training and outreach.

The overall cultural competence strategy is to incorporate cultural proficiency within the department and its programs through specific strategies. These current strategies are continuing to be utilized:

- Training for staff on LGBTQI+ issues, sensitivity and ally training
- Targeted outreach to homeless individuals
- Cultural trainings provided by local community based organizations
- Program Managers to attend Cultural Proficient Professional trainings
- Strengthening support for bilingual/bicultural staff

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

The annual Cultural Competence Plan will be reviewed by the Cultural Competency Committee and the Leadership Team on a regular basis. The strategies identified above will be implemented through 2021, until the next organization Assessment for Cultural Competency is completed. The following table illustrates the plan for monitoring implementation of strategies to reduce disparities.

Table 3.7

	Frequency	***Method***
Cultural Competency Manager	On-going	
Quality Improvement Committee (QIC)	Quarterly	Cultural Competence Manger will report to the QIC on Committee activities and the status of initiatives and strategies
Cultural Competency Committee	Quarterly	Review strategies to reduce mental health disparities during committee meetings and make recommendations regarding progress on current initiatives
BCDBH Leadership Team	Quarterly	Cultural Competence Manger will report on Committee activities and the status of initiatives and strategies

Criterion 4: Client/Family Member/Community Committee

The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

The Cultural Competency Committee (CCC) includes various community members, cultural organizations, and BCDBH staff. The CCC is designed to include representatives from local racial, ethnic, and cultural groups to ensure an accurate representation of the diversity in Butte County and the client's the MHP serves. The CCC reviews the representative positions on annual basis to ensure that the CCC is an accurate and robust depiction of the local population. Recruitment for representatives is on-going, and positions are filled as they are vacated.

The CCC is a branch of the BCDBH Quality Improvement Committee (QIC). The Cultural Competency Manager updates the QIC on a quarterly basis on the Committees activities and recommendations the Committee has for the department. These recommendations are born out of the Organizational Assessment for Cultural Competency and participation in the input and review of the Cultural Competency Plan (CCP).

Current Representation	
African American Cultural Center*	Homeless Shelter
BCDBH Cultural Competency Coordinator	Latino/a--Spanish Speaker
BCDBH Systems Performance Unit Analyst	LGBTQ+
BCDBH Training Coordinator	Native American/Tribal
BCDBH Patient's Rights Advocate	Older Adult
Consumer/Wellness Center	Public Health Department
Family Member/NAMI	Substance Use Disorder
Foster Care Advocate	Veterans Services Officer (open)
Hmong Cultural Center	Youth, Homeless

**Co-chair*

At a minimum, committee meetings take place quarterly. However, when working on large projects the committee has, and will, meet monthly. The committee's current long term goals are to assist in updating the Cultural Competence Plan based on the new state guidelines, guide the department as an updated mental health workforce Cultural Competence Assessment is completed, and actively participate in policy and grant review to confirm culturally appropriate considerations. Short term goals include supporting and coordinating Grand Rounds cultural trainings. Committee members have agreed to provide free cultural trainings on a quarterly basis to internal staff, contracted staff and other community stakeholders. In 2017, the Committee established a mission statement:

"The Cultural Competence Committee works to enhance the behavioral health system of care by reducing behavioral healthcare disparities through collaborating with diverse populations and sharing diverse perspectives. This committee takes ownership of promoting cultural understanding and appreciation through education, advisement, and recommendations of culturally sensitive policies and practices to our community. This committee strives to recognize personal and social biases and to consciously build respectful interactions."

General practice for retaining culturally/linguistically members in the Cultural Competency Committee is to maintain a membership that includes various cultural/linguistic backgrounds that reflect the makeup of the County, which includes a mix of community members, contract providers, and BCDBH staff members. The balance of the Cultural Competency Committee is assessed on an ongoing basis and when needed new members are identified to fill gaps. Additionally, Cultural Competency representation is required for contract providers to ensure that the community partners who are culturally and linguistically diverse are included on the CCC. In 2018, it was decided that the Committee would benefit from a co-chair that was a community member, and not a staff member. The Director from the African American Family and Cultural Center was nominated and confirmed as the Committee Co-Chair for 2019.

Organization Assessment for Cultural Competency

History

The CCC identified and contributed to a cultural competency assessment of the Butte County behavioral health workforce in 2009. The CCC was clear that participation from BCDBH and BCDBH contract providers was essential. Another key desire was to have input from all levels, consumers, volunteers, line staff, supervisor/manager, and administration. The CCC reviewed several different cultural competency assessment tools and recommended that BCDBH use the Greenbook Assessment. The goal of this tool is to be able to identify specific areas in which the workforce is doing well and areas that would benefit from training and education. In July 2010 the cultural competence assessment took place. The assessment was available in English, Spanish, and Hmong.

In 2014, the BCDBH identified a need for an updated Organizational Assessment. The CCC reviewed questions and methods previously used and provided input and feedback on the assessment. There were two versions of the assessment developed using the Greenbook Assessment tool and structure of the 2010 Assessment. BCDBH tried to model the previous assessment as much as possible to allow for patterns or changes in responses to be determined. In 2015, the staff and consumer surveys were distributed via email and paper copy to all internal and contracted staff and paper copies were provided to clients. There were 188 responses from staff and 66 consumers surveys returned.

Current

In 2018, BCDBH facilitated another Organizational Assessment for Cultural Competency. There was increased participation this time around, with 219 staff responses and 313 consumer surveys completed. The Committee reviewed the assessment tools and supported the implementation of this Assessment. The results of this assessment can be found in Criterion 3 and the Appendix. The Committee was scheduled to review the results of this Organizational Assessment in November 2018, but due to a wildfire that destroyed the town of Paradise, and other surrounding communities, the

committee meeting was not held until January 2019. Strategies to increase the department's overall Cultural Competency were formulated and will be shared with the leadership team and the QIC in February. Those strategies can be found in Criterion 3.

Cultural Competency Plan

The CCC continues to provide active input into the Cultural Competency Plan (CCP) by reviewing for accuracy and providing accurate cultural context. In 2017, committee representatives from a culture or those who worked closely with an identified culture were asked to describe the unique characteristics or challenges that exist in Butte County for this culture. This was then imbedded in Criterion 2: Updated Assessment of Service Needs.

The committee is utilized to evaluate existing strategies and recommend new strategies (Criterion 3) to address issues of disparity and cultural competence, using the results of the 2018 Organizational Assessment. These recommendations are reported to the QIC and included in the Cultural Competency Plan. Additionally, all members of the CCC have the opportunity to review the draft Plan and to make recommendations prior to submission to the state.

Other Contributions

The Committee continues to be a part of the Annual Community Input process for all MHSA Program Expenditures and Plan Updates. This entails reviewing the plan and providing feedback on programs and new Innovation concepts.

The Committee is interested in incorporating the *California Reducing Disparities Project: Strategic Plan to Reduce Mental Health Disparities* into the BCDBH system of care. This plan has been reviewed and Committee Meetings and there is much interest from the Committee to explore the community driven direction to reduce disparities in the racial, ethnic and LGBTQ communities.

The CCC contributed insightful feedback on the *New Employee Orientation: Cultural Competency* initiative that was launched in 2017. This enhanced initiative will train all new employees on Cultural Competency; state and federal requirements, the population we serve, language capacity, and the agency's commitment to building culturally competency through knowledge, awareness, and sensitivity. This presentation can be found in Appendix.

Meeting minutes, agendas, and sign-in sheets from recent Cultural Competency Committee meetings can be found in the Appendix.

Criterion 5: Culturally Competent Training Activities

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

The Department's Cultural Competency Manager, Cultural Competency Committee, and Training Coordinator collaborate in the development and application of culturally competent trainings to ensure that all staff have receive at least one annual culturally competent training (BCDBH Policy and Procedure 68, found in the Appendix).

The Committee developed and implemented providing quarterly "Grand Rounds Cultural Training" to all Behavioral Health staff and contracted staff in 2018 and will continue these trainings quarterly. In addition to these trainings, our electronic learning system, "Relias", has several cultural training offerings that are available to all staff at all times. We have implemented a tracking system that ensures that all staff must take at least one hour of culturally competence training, either a live training or through a Relias. These selections in Relias include the following:

- Addressing Substance Use in Military and Veteran Populations
- Advocacy and Multicultural Care
- Behavioral Health Services and the LGBTQ+ Community
- Best Practices for Working with LGBTQ Children and Youth
- Caring for LGBT Residents in California Nursing Facilities
- Common Mental Health Conditions in Veterans
- Cultural Awareness and the Older Adult
- Cultural Competence
- Cultural Competence and Sensitivity in the LGBTQ Community
- Cultural Dimensions of Relapse Prevention
- Cultural Diversity
- Cultural Issues in Treatment for Paraprofessionals
- Groundwork for Multicultural Care
- Human Trafficking: Forced Labor
- Human Trafficking: Sexual Exploitation
- Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans
- Information & Referral for Military Service Members and Their Families
- Infusion of Culturally Responsive Practices
- Military Cultural Competence
- Substance Use Disorder Treatment and the LGBTQ Community
- Working Effectively with Gender and Sexual Minorities
- Working with the Homeless: An Overview

As appropriate, the MHSA fundamental concepts are embedded into all trainings. During the planning process, the trainer reviewed the MHSA fundamental concepts, and incorporated relevant elements into the curriculum**.** Please see the Appendix for the reported list of annual trainings for staff.

The Cultural Competency Committee is dedicated to organizing and providing comprehensive trainings representing the diverse racial and ethnic populations in Butte County including Latino, Hmong, Native American, and African American families; as well as socially and culturally diverse groups such as

LGBTQI+, older adult, transitional aged youth, the homeless population, veterans and foster care youth. These trainings are open to the entire Butte County workforce, including contracted staff. The trainings have been well attended and include the following topics:

- LGBTQ Ally Training
- How to Support LGBTQ Youth
- LGBTQ Awareness, Sensitivity & Competency Training
- African American Family Cultural Center - Cultural Awareness in the African American Community from a Mental Health Perspective
- Hmong Cultural Center – Recognizing Mental Health Issues In The Hmong Elder Community
- Trans GNC Week Training: Medical, Mental & Social Health
- Military Cultural Awareness and Clinical Implications
- Health Equity & Cultural Agility Training
- Creating LGBTQ Affirming Youth Services
- LGBTQ+ Stonewall Alliance Cultural Competency Training
- Culturally Proficient Professional

Additionally, BCDBH has demonstrated a strong support of the client culture through a variety of trainings. BCDBH currently has an initiative to become a Trauma-Informed organization and there have been trainings provided for an introduction to Trauma-Informed Systems trainings to provide the base knowledge and shared language around the subject of Trauma. These trainings have been the foundational trainings and there will be more trainings that will develop upon this foundational training over the remainder of the 1819 fiscal year, continuing on through the next fiscal year and annually to keep our staff "Trauma-Informed". This training helps our workforce become more culturally sensitive to our peers, as well as the clients we serve by providing a better foundational understanding of their backgrounds and how an individual's actions can affect another person's reaction.

BCDBH is working with community members on the Cultural Competency Committee to continue providing quarterly culturally and socially competent trainings to our staff. This will be developing into more trainings throughout the year as training opportunities are needed to ensure staff are receiving adequate exposure trainings that represent our demographic population that we serve.

BCDBH continues to collaborate with BJ North and our own staff members, including lead WRAP Facilitators Tony Stefanetti and Jessica Wood, in providing an introductory two-day Copeland's Certified Wellness Recovery Action Plan (WRAP) training and a five-day Copeland's Certified Wellness Recovery Action Plan (WRAP) facilitator training to Butte County staff, which included many of our Peer Advocate staff, and community partners. The goal of providing this training was to develop a cadre of consumers who are able to lead WRAP groups and help consumers complete WRAP plans. This collaborative has broadened WRAP resources in the region by offering at least one annual train the trainer workshop, at least one facilitator refresher class, and at least one three-day WRAP Seminar I course for our staff and community partners. Placing emphasis on WRAP plans has highlighted their effectiveness and increased their use and success throughout BCDBH.

Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

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

Butte County Department of Behavioral Health (BCDBH) is committed to developing a culturally and linguistically competent behavioral health workforce throughout our system of care. The department strives to employ a workforce that reflects the cultural identities of our consumers to ensure effective service delivery. BCDBH actively recruits for Spanish and Hmong language clinicians, counselors, and interns. BCDBH offers a bilingual pay differential pending verification of the employee's language or communication skill ability. Key BCDBH staff in Gridley are bilingual and bicultural employees who are embedded in the community and actively involved in such community activities as soccer, church, cultural events, etc. The Promotores program in Gridley and Chico provides outreach to the Latino and Hmong communities with staff from those communities who are bilingual and bicultural.

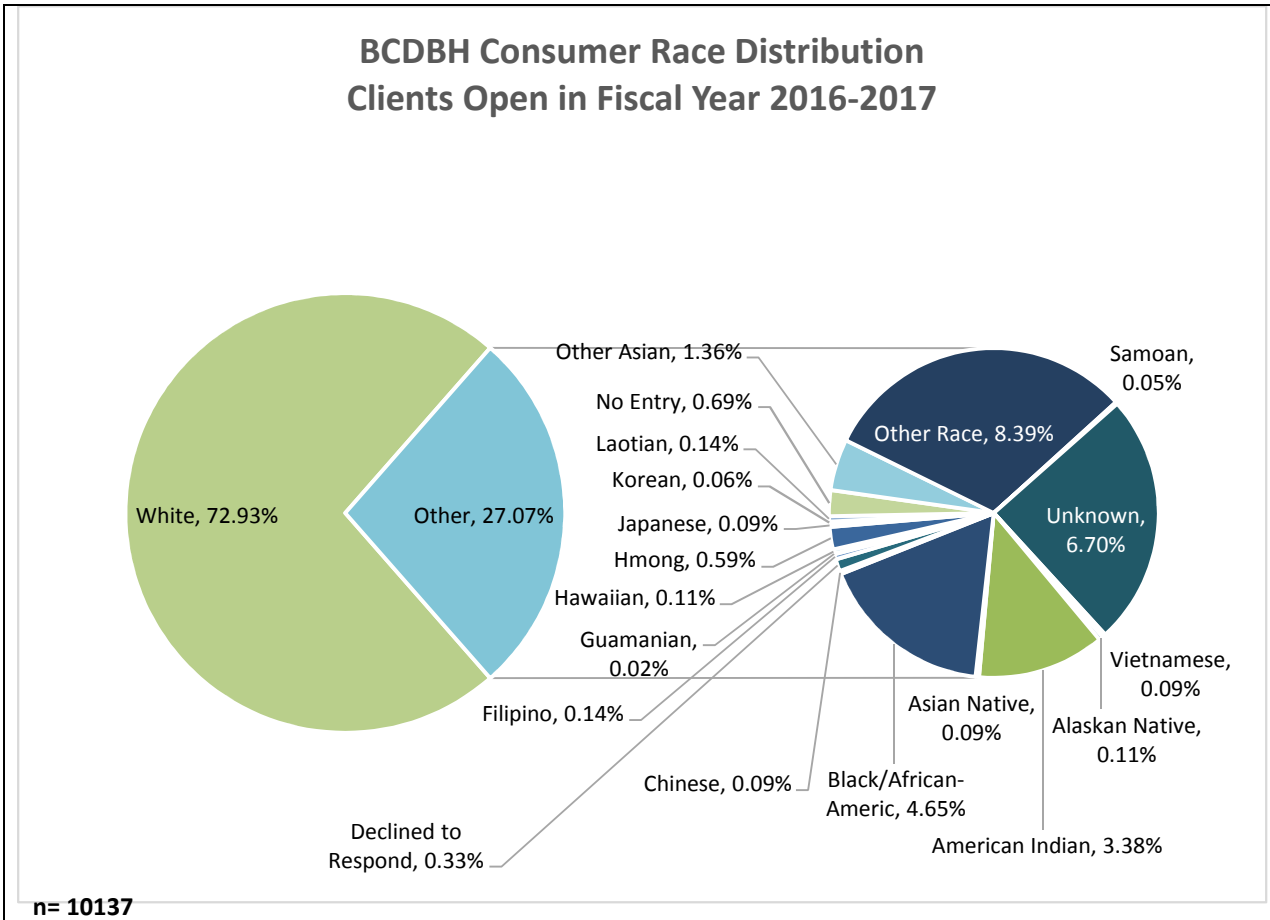
Our MHSA funded community based contractors have focused on underserved communities and has improved both the workforce race/ethnicity comparability and the penetration rates in serving these communities. Hmong and Spanish speaking staff are available in Chico, Oroville, and through Crisis Services. A major obstacle has been recruiting and retaining psychiatrists, family nurse practitioners, and nurses, as well as licensed Hmong, African American, Native American, and Latino staff. It is worth noting that as of December 2016, California ranks number one[10] in the country for Mental Health Care Health Professional Shortages Area (HPSA). "The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that, in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For mental health, the population to provider ratio must be at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community)." When considering the implications of this data point, in addition to the need for a diverse population of mental health care providers one can determine the high challenge for meeting the need for hiring and retaining culturally and linguistically competent staff.

Data

The charts and tables below depict the distribution of race and ethnicity for BCDBH consumers and race for BCDBH staff.

[10]http://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Mental%20Health%20Care%20HPSA%20Designations%22,%22sort%22:%22desc%22%7D

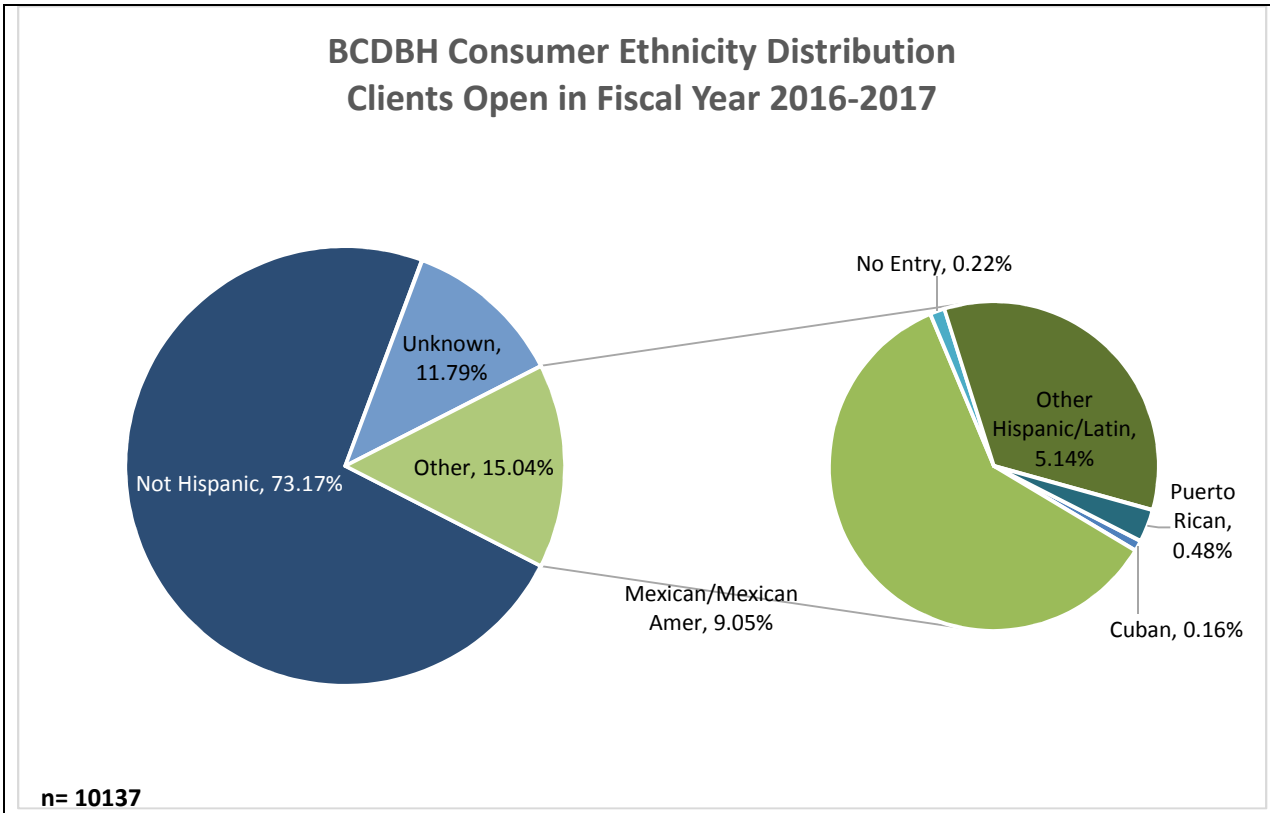
Table 6.0



n= 10137

Race			
White/European American	7393	Hmong	60
Alaskan Native	11	Japanese	9
American Indian	343	Korean	6
Asian Native	9	Laotian	14
Black/African American	471	No Entry	70
Chinese	9	Other Asian	138
Declined to Respond	33	Other Race	851
Filipino	14	Samoan	5
Guamanian	2	Unknown	679
Hawai'ian	11	Vietnamese	9
		Total	**10137**

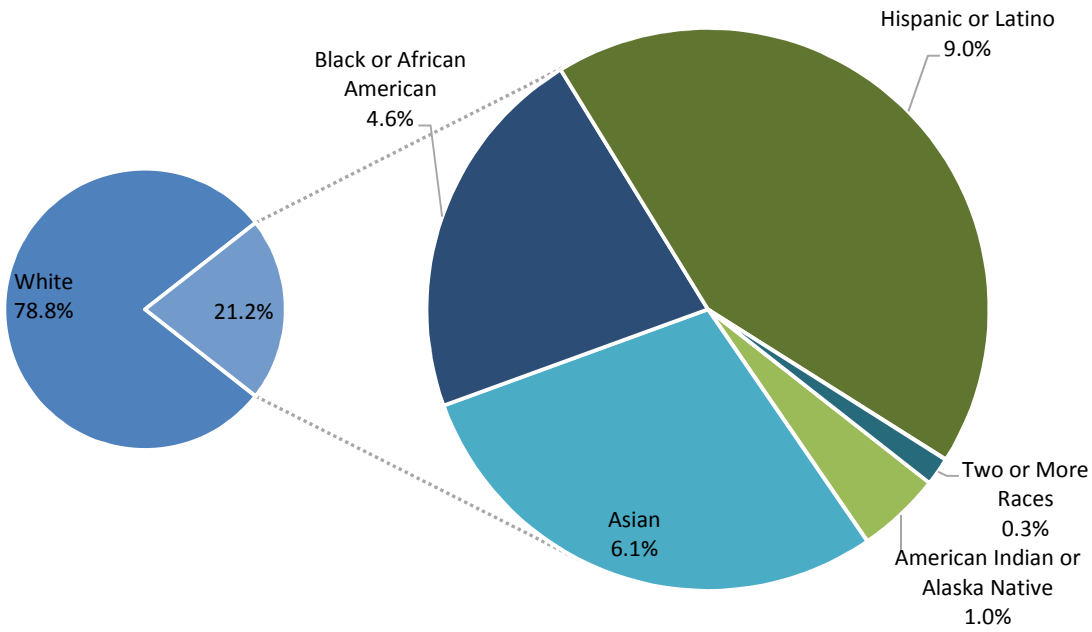
Table 6.1



Ethnicity			
Not Hispanic	7417	No Entry	22
Unknown	1195	Other/Hispanic/Latino	521
Cuban	16	Puerto Rican	49
Mexican/Mexican American	917	**Total**	**10137**

All consumer data is extracted from the BCDBH Electronic Health Record (Avatar).

Table 6.2



Race			
American Indian or Alaska Native	6	Hispanic or Latino	53
Asian	36	Two or More Races	2
Black or African American	27	White	462
		Total	**586**

The staff data is collected through PeopleTrack by the BCDBH Human Resource Department.

Analysis

Our existing staff demographics do not represent our service population, with Caucasian (White) staff at 78.8% compared to our consumer population percentage of 73.0%. The ethnic community that is least represented is the Hispanic/Latino population where our Latino staff are only 9.0% yet Latino ethnicity is 14.6% of our service population.

After closer inspection of the data collection processes that go into identifying staff demographics, it was determined that there is an opportunity to change our process to portray a better reflection of staff demographics. For example, the choices available for race/ethnicity selection are very small, especially when comparing with the options available to our consumers. The Butte County Human Resources Department provides all County departments with methods to collect staff demographic data. Additionally, neither the department, nor the County, collect information on the numbers of LGBTQI+ staff that are 'out' at work and can therefore provide expertise regarding the LGBTQ+ community to both staff and consumers. This project has been added to our Identified Strategies in Criterion Three.

MHSA: Workforce, Education, and Training

Peer/Family Member Employment

One strategy that has increased the multicultural nature of the workforce is designating positions that require consumer/family member experience. A variety of BCDBH and contract provider programs have employed this method including:, Wellness Centers, SEARCH, LGBTQI+ Suicide Prevention and Education Program (Stonewall), Promotores, African American Family and Cultural Center, Zoosiab: A Community Based Treatment for Historical Trauma to Help Hmong Elders, The Warm Line, and Passages Older Adult programs.

Workforce, Education and Training Coordinator

The WET Coordinator ensures that the five fundamental elements of MHSA (consumer and family driven, community collaboration, recovery/resiliency strength-based services, integrated services, and culturally competency) are embedded within all training events. The coordinator works with Behavioral Health staff and leadership to support planning, development and operation of a comprehensive workforce program that meets MHSA requirements and supports the development of our diverse workforce.

Job Specific Training

All Butte County organized trainings will incorporate the concepts of cultural competency/diversity, wellness, recovery and resiliency. Outcome measures will be used to ensure effectiveness and fiscal efficacy. Trainings will be offered to staff, contract providers and consumers and family members, as appropriate.

Regional Partnership: Distributed Learning

The state administered Superior Regional WET Partnership supports the planning, development, and implementation of a distance learning system. This program encourages the strengthening of curricula in Superior California to support wellness and recovery principles, and assure that mental health departments support and encourage career paths throughout the higher education system. This partnership has identified on-line training resources and county needs for those resources. The MHSA Coordinator participates in the development and work of the proposed Superior Regional WET Partnership. There is no cost for this initiative besides staffing time. Objectives include:

1. Increase the availability of information on regional education and employment activities
2. Increase the coordination of education programs available for regional students to pursue mental health employment
3. Provide a forum for the exchange of strategies and best practices for training, encouragement of mental health career paths

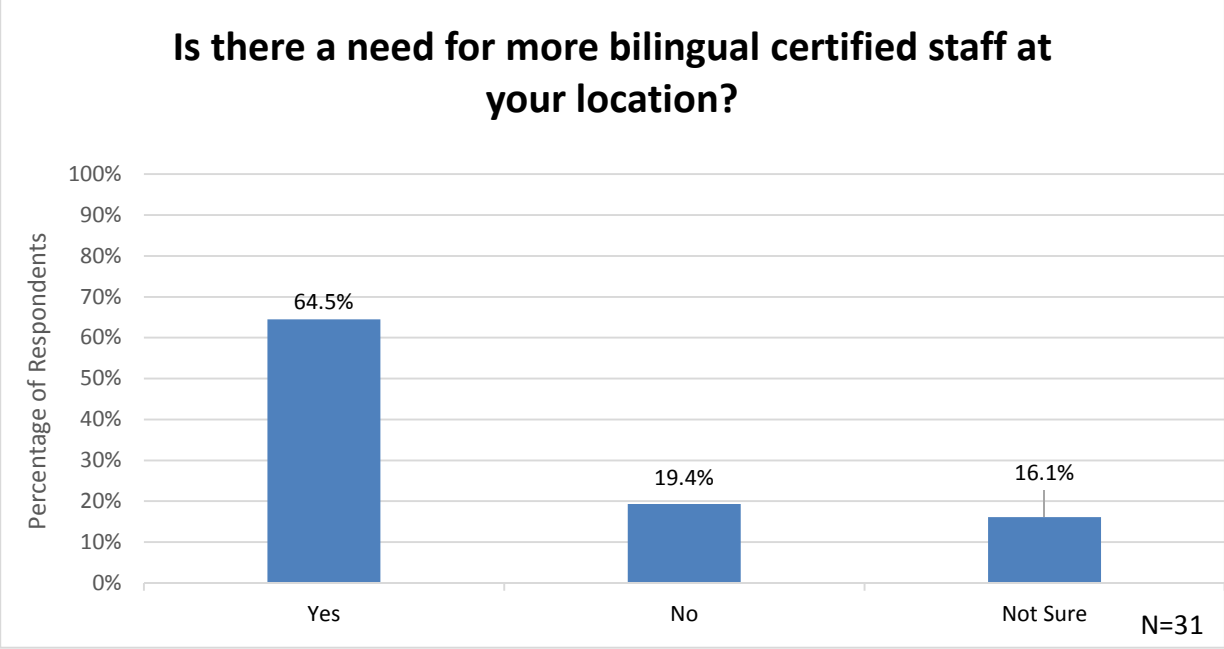
Criterion 7: Language Capacity

Increase bilingual workforce capacity: Evidence of dedicated resources and strategies BCDBH is undertaking to grow bilingual staff capacity.

The implementation of the Mental Health Services Act has given counties the opportunity and encouragement to increase linguistic capacity. Since its implementation, strategies have been created to overcome language barriers between staff and consumers, with the goal of further building bilingual capacity. While dedicating bilingual positions is not new, BCDBH continues to embed this idea into culturally competent programs. For example, the Promotores MHSA program dedicates a full time Behavioral Health Counselor to provide culturally and linguistically appropriate services including screening, assessment, and case management services. Currently there are 40 staff members that have been certified to receive the bilingual pay differential.

In September 2018, a Translation Survey was distributed to the BCDBH leadership team to serve as a needs assessment for increasing bilingual language capacity. The survey was completed by 31 individuals, who ranged from program managers, supervisors and assistant directors. The complete results of this survey can be found in the Appendix. As demonstrated in the following chart, approximately 65% of respondents agreed there is a need for increased bilingual certified providers at their service site locations. This was also reinforced in the 2018 Organizational Assessment.

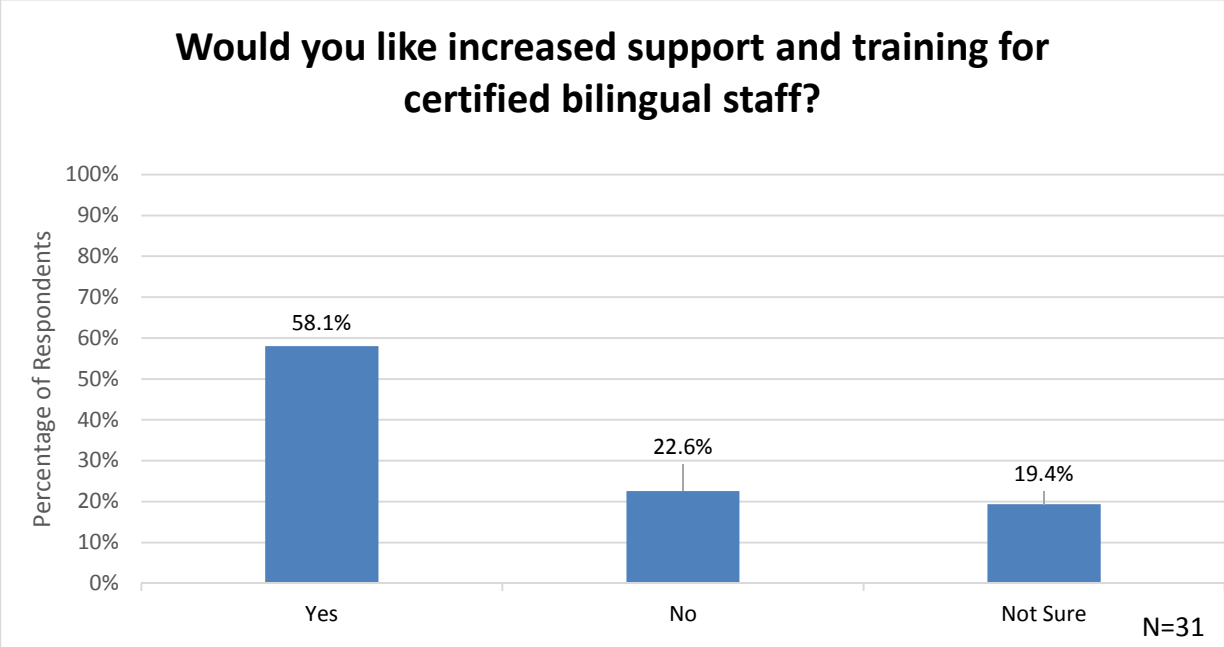
Figure 7.0: Translation Survey Results



Butte County recognizes the Department's need for bilingual language skills or specialized communication skills to improve consumer experience and reduce cultural/linguistic disparities. Thus, BCDBH continues to implement Personnel Rule 11.15 Bilingual Pay Differential (found in the Appendix). Bilingual pay differential is intended to be an incentive for bilingual staff to utilize their skills and for departments to leverage resources. This rule requires verification of language and communication skills as defined and administered by the Butte County Human Resources Department. BCDBH is currently

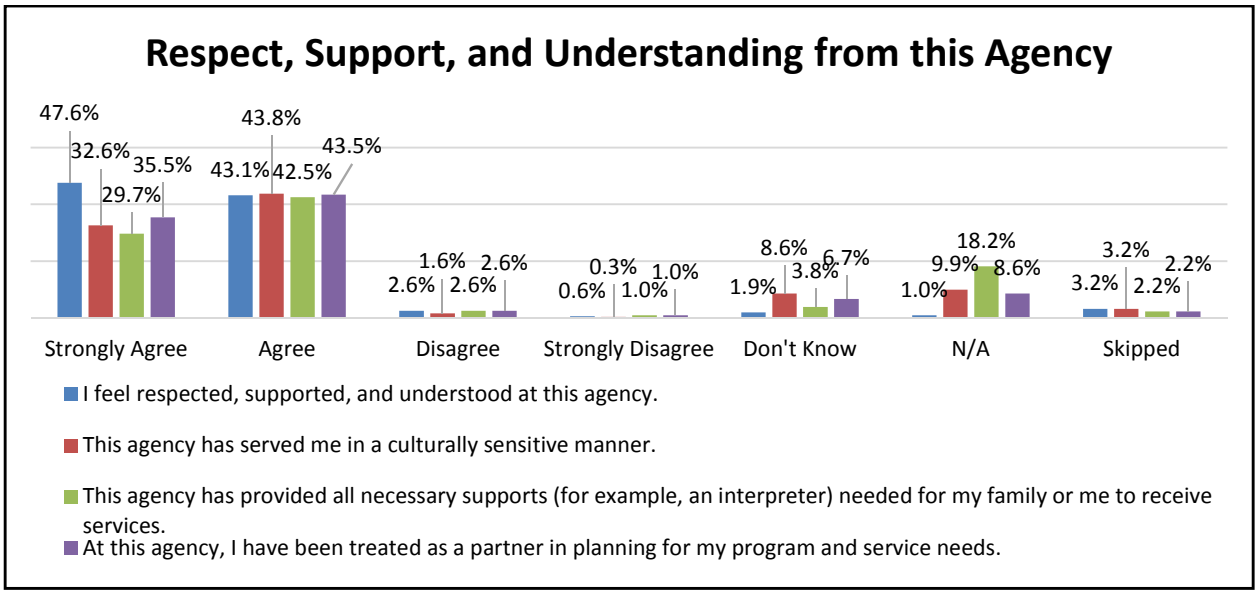
working with County Human Resources to allow for development of an internal (department level) certification process. BCDBH asserts that language certification in health and human services is more complex and requires a more sophisticated certification process than is currently in place for the County. A more sophisticated certification process may dictate an increased need for training and support of individuals who are certified. The enhancement of support and training for our staff was also defined by our leadership team via the Translation Survey (see figure 7.1 below). BCDBH is currently exploring these options and how to best move forward. These initiatives are included in our strategies that are explored in Criterion 3.

Figure 7.1: Translation Survey Results



As we explore increasing our Bilingual Language capacity, it is important to look at the consumer perspective. The following figure provides the consumer response to the question, "This agency has provide all necessary supports (for example, an interpreter) needed for my family or me to receive services". With just 29.7% responding as Strongly Agree, it can be determined that our agency would benefit from increased interpreter services.

Figure 7.3: 2018 Organization Assessment Responses



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

BCDBH accommodates individuals that may be affected by linguistic barriers through the use of bilingual staff and/or interpreter & translation services. At the first point of contact, a client's preferred language is identified using the Determining Language Preference form (Appendix) and the client demographic information is gathered. Once the client's preferred language is identified, it is then documented in the client chart. Once an individual becomes a client of Specialty Mental Health Services, the offer and acceptance of interpreter services is documented in the client's Progress Notes. The client is then scheduled to receive services with a bilingual provider for future meetings. All of this information this information is tracked by the Systems Performance, Research and Evaluation team for further development and monitoring.

If bilingual staff are unavailable, staff are trained to utilize the Translator List provided by the Contracts Unit (Appendix). The department extends its invitation for Translators/Interpreters to all bilingual individuals in the community. If needed, a separate recruitment is sent out to maintain demand for threshold languages. This practice permitted BCDBH to pool a variety of linguists. During the past fiscal year the Translator/Interpreter List listed eight languages. A list of all bilingual certified staff (Appendix) is also available so clients may receive services that would match their cultural and linguistic needs.

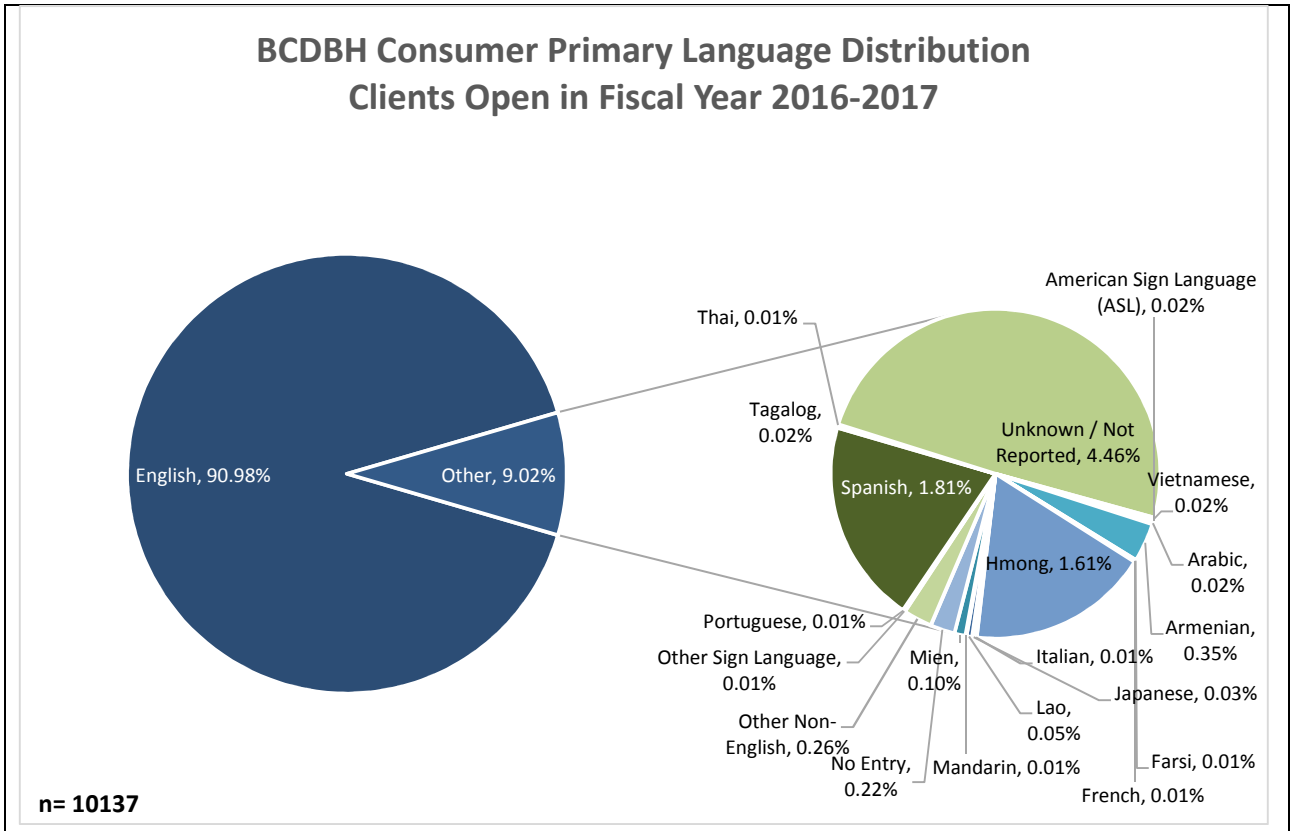
Clients and staff, as a last resort, may also utilize the Language Line Solutions service for interpretation if there is a language barrier as dictated in BCDBH Policy and Procedure 89 (Appendix). Language Line Solutions provides high quality phone and video translation services via highly trained and professional linguists in more than 240 languages 24 hours a day, 7 days a week. This resource is a quick, easy way to help provide quality service to our clients with Limited English Proficiency. Instructions on how to use Language Line Solutions and tips for working with telephone interpreters can be found in the Appendix. New staff orientation includes review of all policies and procedures, which incorporate instructions on accessing Language Line Solutions and California Relay Service systems. Policy and Procedure 92

(Appendix) also provides instruction to assist hearing-impaired individuals along with information on how to access the California Relay Service for TDD to Voice and for Voice to TDD.

Provide translated documents, forms, signage, and client informing materials in all threshold languages

As demonstrated in the following chart, English is the primary language for 90% of our consumer population. Spanish and Hmong are tied for the same rate of Primary Language distribution at 1.7%. While Spanish is the only language that meets the criteria to become a threshold language, BCDBH acknowledges that there is a similar need for Hmong translation and implements strategies as if Hmong is a threshold language.

Figure 7.2: Primary Language of Consumers



Primary Language of Consumers

English	9223	Mien	10
American Sign Language	2	No Entry	22
Arabic	2	Other Non-English	26
Armenian	35	Other Sign Language	1
Farsi	1	Portuguese	1
French	1	Spanish	183
Hmong	163	Tagalog	2
Italian	1	Thai	1

Japanese	3	Unknown	452
Lao	5	Vietnamese	2
Mandarin	1	**Total**	**10137**

BCDBH sites are provided a list of material in threshold languages to make available in their lobbies. The Mental Health Patients' Rights poster specifically states "You have the right: To services and information in a language you can understand and that is sensitive to cultural diversity and special needs". The Member Information brochure is another source of information for consumers, stating under Member Rights "Receive services that are culturally competent and sensitive to language and cultural differences."

Additionally, a Client Satisfaction Survey is available in all of our service site lobbies and on the BCDBH website. The survey is available in English, Spanish, and Hmong throughout the year. The outcomes can be found in the BCDBH Evaluation and Outcomes website[11]. Additionally, the annual MHSA Community Input flyers and surveys are translated into Spanish and the 2018 Organizational Cultural Assessment survey was translated into Spanish and Hmong.

[11] http://www.buttecounty.net/behavioralhealth/Evaluations-Outcomes-and-Survey-Data

Criterion 8: Adaptation of Services

Client driven/operated recovery and wellness programs

BCDBH has many programs which are client and family driven/operated. Client driven services is a guiding characteristic in the MHSA, and therefore, is incorporated in all of our MHSA service driven programs. The following program descriptions can be found on page 2:

- Wellness Centers
- The North Valley Talk Line
- The African American Family and Cultural Center
- Stonewall
- Live Spot
- National Alliance on Mental Illness (NAMI)
- Passages
- Promotores
- Zoosiab

Responsiveness of mental health services

The BCDBH Provider list provides a list of Medi-Cal providers contracted with BCDBH and what cultural/linguistic services they offer. The Member Information and Services Directory brochures notify clients of cultural and linguistic services that are available upon request. Additionally the county posts a notification in each of the clinics that translation services are available free of charge. Policy and Procedure BCDBH 207 mandates BCDBH provide and inform Medi-Cal beneficiaries of available services, which includes the Provider list and Guide to Medi-Cal Mental Health Services booklet. The booklet provides written information about available specialty mental health services.

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

BCDBH has made a concerted effort to provide community based services specifically designed for unserved and underserved populations. These programs are embedded in locations comfortable to diverse cultural populations. Great efforts have been made to design offices that are welcoming to the cultural groups served. Efforts continue to increase the level of multicultural staff members.

Quality of Care: Contract Providers

BCDBH contracts with Contract Providers (primarily Organizational Providers) include stipulations of mandatory cultural competency requirements including primary language needs, written materials, documentation, and outreach efforts. Monitoring for quality of services, including specific issues of Cultural Competency, occurs primarily - though not exclusively - within the activity of clinical record Utilization Review (UR) referred to at BCDBH as Quality Management. As defined in the Departments Annual Quality Improvement Plan, a group of licensed Clinical Supervisors reviews a random selection of client charts once a month, including records from contract providers. Included in utilization review the team monitors and measures compliance and efforts to reach cultural competency including notations of primary language, use of interpreters, etc. In addition, routine QI activities includes the analysis of language and ethnic make-up of contract provider caseloads in order to evaluate community needs to meet identified Departmental goals.

Quality Assurance

BCDBH has a variety of mechanisms in place to implement and evaluate Cultural Competencies issues within the areas of Quality Assurance/Improvement (QI/QA). Primary to meeting this need is inclusion of the Chair of the Cultural Competency Committee as a standing member of the Quality Improvement Committee. The QIC meets monthly with a standing agenda that addresses issues of Quality Service including access, patient's rights, etc. This forum allows for issues of cultural competency to be fully identified, addressed, and/or corrected - whether related to specific identified improvement activities, or identified problem areas brought to light by the Cultural Competency Committee or the office of Patient's Rights through complaints/grievances. As noted previously, the QIC also analyzes issue of cultural competency needs through data analysis of client caseloads with regard to geographic location of language needs, outreach efforts, etc.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for monitoring, assessing, and improving client care and service in the Butte County Specialty Mental Health Plan. The QIC recommends policy changes, reviews and evaluates the results of Quality Improvement (QI) activities, institutes needed QI actions, and ensures follow-up of QI processes. The licensed QI Coordinator is responsible for the clinical oversight of the QI process. The QIC meets monthly to monitor State Fair Hearings, Notice of Action (NOAs), Performance Improvement Projects, Beneficiary Grievances and Appeals, Cultural Competence Issues, Provider Information and Provider Grievances, Change of Provider Requests, Training, Timeliness of Consumer Access to services, and Crisis Line response.

QIC meeting minutes are kept in the QI folder on the DBH intranet and may be accessed electronically by all QI Committee members. Consumer confidentiality is protected at all times in the QIC minutes. The minutes reflect all QI deliberations, decisions, recommendations, and actions to insure that ongoing efforts are made to improve the quality of service provided by the department the QI Committee will establish yearly goals. The goals are selected by the QI Committee and may be directed toward improvement in any area of operation of the department. The following Department of Behavioral Health Committees and sub-groups report at the Quality Improvement Committee:

- Cultural Competence
- Quality Management Chart Review Committee
- Compliance Committee
- Authorization/Access
- Systems Performance, Research and Evaluation
- Organizational Providers
- Patient’s Rights Advocacy
- Training Coordinator