Sonoma County Department of Health Services
Behavioral Health Division
Cultural Competency Plan 2024

Send Word and PDF to MCBHD-CCPR@dhcs.ca.gov by December 31, 2024.

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CHECKLIST OF THE 2010 CULTURAL COMPETENCY PLAN REQUIREMENTS CRITERIA

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Criterion 1: Commitment to Cultural Competence

Sonoma County's Department of Health Services, Behavioral Health Division (DHS-BHD), is committed to meeting the cultural and linguistic needs of our community, for individuals from all racial, ethnic, cultural, and linguistic backgrounds, not just to attain individual health outcomes but also to ensure health equity for the thousands of community members seeking services. This endeavor is reflected in our mission, philosophy, policies, and procedures throughout our mental health system.

Most importantly, DHS-BHD develops data-informed strategic plans based on community engagement and client utilization. The identification of behavioral health disparities, vulnerable populations, emerging trends, and barriers to services is an ongoing quality improvement plan that involves a complex process of examining systemwide data, seeking consumer satisfaction and feedback, assuring regulatory compliance, and balancing budgets.

Holding true to Mental Health Services Act (MHSA) values, our system is driven by clients and family members, focused on wellness and resilience, and philosophically aligned with the belief that recovery is possible. Providing culturally responsive and linguistically appropriate services is central to these values.

I. County Mental Health System commitment to cultural competence. The county shall have the following available on site during the compliance review

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

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policies and Procedure Manuals;
5. Other Key Documents (Public reports, such as the Annual Quality Improvement Work Plans and corresponding Evaluations by fiscal year)

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

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

MHSA/BHSA has provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations. Sonoma County continues to expand the inclusion of consumers, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. Consequently,

Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate mental health system of care. At the foundation for the development of this system of care, Sonoma County continues to be driven by the following MHSA Guiding Principles:

- **Community collaboration:** Individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural responsiveness:** Adopting behaviors, attitudes, and policies that enable providers to work effectively in cross-cultural situations.
- **Client and family driven system of care:** Adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Focus on wellness, including recovery and resilience:** People diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities.
- **Integrated service experiences:** Services for clients and families are seamless; clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

DHS-BHD has established a system and structure for a community-engaged planning process as a basis for developing the Three-Year Program and Expenditure Plans and inclusive actions taken under MHSA governance. This structure is anchored with an MHSA Steering Committee and includes the Cultural Responsiveness Committee, the Community Program Planning (CPP) Process Workgroup, and the Mental Health Board. Furthermore, additional outreach and engagement is made through related but independent community committees and advisory councils, such as First 5 Sonoma County and Health Action Sonoma County. The California Code of Regulations, Title 9, states that counties must ensure that stakeholders reflecting the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity, have the opportunity to participate in the CPP process (CCR § 3300).

The commitment to an open and inclusive process is seeded throughout the MHSA committees that are convened by Sonoma County DHS-BHD. The following guiding principles are adhered to in membership and practice:

- Inclusive and representative
- Transparent and easy for all participants to understand
- Collaborative and in partnership with consumers, families, and the community
- Broad participation from diverse groups throughout Sonoma County within a safe space for expression of diverse perspectives
- Culturally responsive

The most recent draft of the Sonoma County MHSA FY2024-2025 Annual Plan Update with FY2022-2023 Program Report contains the CSS Program Plan and Community Program Planning Process (CPPP) to date.

B. A one-page description addressing the county's current involvement

efforts and level of inclusion with the above identified underserved communities on the advisory committee.

As noted in the section preceding, DHS-BHD works with stakeholders through established MHSA Steering Committee, Cultural Responsiveness Committee, and the Community Program Planning Workgroup. In addition, DHS-BHD has had various ad hoc interactions with the peer community, community at-large, industry groups such as Health Action Sonoma, law enforcement, First 5, and other coalitions throughout the year. DHS-BHD has consciously monitored the representation of committee stake holders against the county's demographic make-up. The following chart provides an overview of stakeholder engagement opportunities that have been instituted into regular practice.

Committee/Board	Open, appointed or elected	Composition of members	Number of seats	Meeting Frequency
MHSA Stakeholders	Open to the public	Consumers and family members nonprofit providers of health, social services, criminal justice, education; Contractors and providers of the health department and behavioral health division; interested members of the public.	Undefined	Bi-annually
MHSA Steering Committee	Application and selection process managed by the MHSA Coordinator and Department of Health Services, Behavioral Health Division administration	Members represent the following: · Clients · Families of clients · Providers of mental health, substance use, and social services · Persons with disabilities · Education field · Health care · Law enforcement · Veterans and/or representatives · College-age youth · Other advocates · Individuals from diverse cultural and ethnic groups	20-25 seats	Quarterly
Community Program Planning Workgroup	Combination of voluntary and appointed	MHSA Steering Committee members, Stakeholders	4-8 members	Monthly or as determined by members
Equity Steering Committee	Appointed	Sonoma County Behavioral Health Division employees, and a Department of Health Services equity liaison, who have extensive foundational training in anti-racism and equity through the Sonoma County and Department of Health Services offices of equity	7 members	Monthly or as determined by members

Cultural Responsiveness Committee (on hold, restarting soon)	Combination of voluntary and appointed	Contractors, Mental Health Board, Individuals and/or family members of individuals with lived experience, Equity Steering Committee members, MHSA Steering Committee members, Stakeholders, BHD staff	Up to 20 members	Quarterly or as determined by members
Life Worth Living Coalition (Suicide Prevention)	Combination of voluntary and appointed	Contractors, individuals and/or family members with lived experience, BHD staff, law enforcement, educational organizations, public health, and members of other organizations and fields as needed	Currently 18 members	Monthly or as determined by members
Peer Advisory Council	Voluntary	Individuals with lived experience; BHD director; BHD Cultural Responsiveness, Inclusion & Training Coordinator	Currently 10 members	Monthly or as determined by members
Mental Health Board	Appointed by Board of Supervisors	Member of the public vested in mental health services. Fifty percent of the Board membership shall be consumers or the family members of consumers who are receiving or have received mental health services. At least 20% of the total membership shall be consumers and at least 20% shall be family members of consumers.	16 members: 3 representatives for each of the 5 county districts and one Supervisor	Monthly, third Tuesday at 5:00 p.m. Check calendar.
Board of Supervisors	Elected		5 district representatives	Weekly on Tuesday at 8:30 a.m.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

Description of the Stakeholder Community Planning Process (CPP)

Over the years, Sonoma County has refined the system and structure for the Mental Health Services Act (MHSA) Community Program Planning Process (CPPP) as a basis for developing the Three-Year Program and Expenditure Plans, Annual Plan Updates, and other MHSA initiatives including Innovation proposals. This structure is anchored by the MHSA Steering Committee and adheres to the California Code of Regulations (CCR) § 3200.270 and CCR § 3200.300 to ensure that stakeholders reflect the diversity of the county's demographics, including but not limited to geographic location, age, gender, and race/ethnicity. The CPPP also utilizes the Community Program Planning (CPP) Workgroup, Department of Health Services,

Cultural Responsiveness Committee, Mental Health Board, Board of Supervisors, individuals with lived experience, family members, contractors, mental health providers, community committees, and all other stakeholders.

Stakeholder groups include:

- MHSA Steering Committee
- Mental Health Board
- CPP Workgroup
- MHSA Contractors
- Life Worth Living Suicide Prevention Alliance
- Board of Supervisors
- Individuals with lived experience and their loved ones
- Department of Health Services

A powerful force leading CPPP is the Community Program Planning (CPP) Workgroup, a subcommittee of the MHSA Steering Committee. The CPP Workgroup is comprised of MHSA Steering Committee members and other stakeholders from the community at-large. When the CPP Workgroup was established in 2020, it was determined that the purpose of the Workgroup is to support community engagement of local stakeholders to obtain input on the development of the county's MHSA Three-year plans and Annual Updates. More specifically, the CPP Workgroup established the following goals:

1. Expand the community's knowledge of the public mental health system, specifically MHSA funded programs and services.
2. Strengthen community partnerships and relationships with diverse representation.
3. Expand and strengthen partnership and relationships with consumers and family members.
4. Increase the engagement of community representatives in existing and emerging CPP opportunities.

CPP Workgroup Members

Name	Organization
Kimi Barbosa	Positive Images
Dory Escobar	Community Health Consultant
Fabiola Espinoza	MHSA Analyst, Behavioral Health Division
Jeane Erlenborn	Education
Saskia Garcia	Sonoma Connect
Angelina Gutierrez	Sonoma County Indian Health Project
Michael Johnson	Mental Health Board
Julie Kawahara	MHSA Consultant
Erika Klohe	Buckelew
Melissa Ladrech	MHSA Coordinator, Behavioral Health Division
Stephanie Manieri	Latino Service Providers
Meghan Murphy	Buckelew
Iridian Onofre	Senior Office Assistant, Behavioral Health Division
Michael Reynolds	Mental Health Board, West County Community Services
Michele Rogers	Early Learning Insitute

Tina Rogers	CPP Listening Sessions Co-Facilitator
KT Swan	Buckelew
Lee Turner	Community Baptist Church

The CPP Workgroup was aware that most of the stakeholder input was from current clients, individuals, and organizations that were already involved with the Behavioral Health Division. The Workgroup wanted to expand the stakeholders to include voices that MHSA hadn't heard from in the past. In 2022, the CPP Workgroup decided to conduct Listening Sessions with diverse populations that have been historically unserved and underserved.

CPP Listening Sessions Project Phases:

1. Identify priority populations for listening sessions countywide
2. Engage listening session co-facilitators representative of priority populations
3. Engage representatives of priority populations and provide listening session training for co-facilitators
4. Conduct countywide listening sessions
5. Analyze information gathered from the communities
6. Produce annual report, including recommendations for future action

The workgroup selected 16 populations to find out more about their perceptions of local mental health support and services, what services are available, and what is still needed.

FY 2022-2023

- African-American/Black
- Asian American/Pacific Islander
- Latinx Youth (immigrant & US-born)
- Latinx Adults (immigrant) – Sonoma Valley
- Latinx Adults (immigrant) – Cloverdale
- Latinx Adults (low-wage earners) – Guerneville
- LGBTQIA
- Older Adults

FY 2023-2024

- African-American/Black Youth
- Agricultural Workers
- Asian American/Pacific Islander Youth
- Indigenous (central County)
- Indigenous (coastal)
- People with Physical Disabilities
- Transitional Age Youth
- Unhoused Adults

Within these populations, individuals and organizations were identified by Dory Escobar, the Listening Session consultant. The consultant and CPP Workgroup members identified co-facilitators for the selected populations. Once the seventeen co-facilitators were identified, they participated in an orientation and a comprehensive

training. The co-facilitators are compensated with a stipend for attending trainings, doing outreach, and conducting the listening sessions.

Qualitative data was captured through transcripts of the audio recordings of the listening sessions, along with co-facilitator notes. A review of the transcripts revealed emerging themes in each listen session, as well as themes that were common to several or all the groups. A simple thematic table was composed for each listening session, followed by identification of common themes. As a community-based participatory project, the engagement of community representatives to serve as listening session co-facilitators was key.

Key Takeaways

- Themes found across culturally specific listening sessions include:
  - Culturally aware and relevant services
  - Cultural norms and stigma
  - Increased mental health concerns including isolation, depression, and stress
  - Intergenerational trauma
  - Racism and discrimination
  - Formal and informal peer support

- Facilitators who are representative of the listening session participants are at increased risk of experiencing and conflating primary and secondary trauma and need ongoing support.
- Social isolation, stress, anxiety, and depression increased in recent years in all populations represented in the project. Participants identified the pandemic, fires, interpersonal violence, racism, and recent political divisiveness as contributing factors.
- There is a need for greater access to services before the mental health concerns become a crisis, not only prevention, but widely available early intervention services for all income levels.
- Intergenerational trauma is experienced in diverse populations in Sonoma County and is discussed or addressed to varying degrees and in different ways.
- Culturally relevant peer support is critical, in some cases increased since the start of the pandemic and needs to be supported and expanded.
- Decentralized (beyond Santa Rosa) and more culturally aware and relevant services and providers are needed to increase access and utilization by diverse populations.
- Regardless of population, services need to be provided by organizations and individuals who are welcoming; authentically interested in and respectful of people's concerns, experiences, and perspectives; nonjudgmental; empathic; compassionate; and trustworthy.
- In some cases, participants stated there are no services available in their community or in their preferred language when, in fact, there are. Regardless of that fact, their perception is of great importance and indicates a need for improved culturally aware and relevant outreach, education, and information about services and how to access them.

Recommendations for Further Action

- Provide support to trusted community-based organizations to sustain safe spaces like these listening sessions in the community.
- Support cultural groups/organizations to build upon existing resources.
- Organize some listening sessions with even more focused, specific cultural groups to promote greater affinity to build emotional and social safety and to encourage participation.
- Continue to support capacity building within Sonoma County's diverse cultural populations to facilitate dialogue about mental health and institutionalize their voice and influence within the MHSA system, structures, and processes.
- Provide community education about intergenerational trauma and engage community representatives to provide more information.
- Improve and increase culturally aware and relevant outreach, education, and information about services and how to access them.
- Ensure that mental health services are not only linguistically appropriate but also culturally appropriate for the diversity within populations served.
- Expand facilitators' training on understanding the difference and interaction between primary and secondary traumatization.

Progress on Recommendations

Based on the recommendations of the listening sessions, the division is working on two initiatives:

Mini Grants

The division is planning on investing $325,000 in mini grants with technical and administrative support from California Mental Health Authority (CalMHSA). CalMHSA assists county behavioral health departments in administering grants to local organizations for providing mental health early intervention services to their communities. These Time-Limited Community Driven Early Intervention grants can help to improve access to early intervention programs, linkages to mental health resources, and culturally relevant healing and wellness activities to unserved and underserved groups.

Interactive Digital Resource Map

The division is developing an interactive and bilingual behavioral health and basic needs resource map. The map will be posted on the division's website, and the map can also be printed out with a QR code that connects to the online map.

Innovation Projects Focused on Underserved Populations

Several innovation projects funded through MHSA in Sonoma County have a specific focus on engagement with underserved populations.

Organization	Project	Focus & Funding
On the Move / VOICES in partnership with La Plaza, Humanidad, Raizes Collective, Latino Service Providers, and North Bay Organizing Project	Nuestra Cultura Cura Social Innovations Lab	Community defined practices for mental health in the Latino/x community. A total of $736,584 MHSA funding is being allocated for the three-year Innovation project.
Early Learning Institute	Instructions Not Included, Dads Matter	Screening and supporting new parents, inclusive of non-birth parent (fathers and partners). A total of $689,860 MHSA funding is being allocated for the three-year Innovation project.
DHS-BHD, Felton, and Behavioral Health Outcomes Data Services (BHODS)	Crossroads to Hope	Expanding access to community mental health, substance use disorder, and trauma treatment as an alternative to incarceration, by developing facility space for both housing and service delivery to individuals who are being diverted to the community from the County jail. A total of $560,379 is allocated for three fiscal years.
Sonoma County Human Services Department	Collaborative Care Enhanced Recovery Project (CCERP)	Case management for older adults 50+ years with an emphasis on Spanish speaking population. A total of $998,558 MHSA funding is being allocated for the three-year Innovation project.
First 5 Sonoma County	New Parent TLC	Training gatekeepers to refer new parents, with a specific focus on LGBTQ+ parents and Spanish speakers. A total of $394,586 MHSA funding is being allocated for the three-year Innovation project.

Peer Advisory Council

Our Peer Advisory Council is a new committee, which has met for about eighteen months. Designed to increase peer access to the Behavioral Health Director, the committee is facilitated by the Cultural Responsiveness, Inclusion & Training Coordinator. We are "moving at the speed of trust," working to repair and rebuild institutional relationships that have been strained in the past, and we are incorporating values of participatory decision-making to move against typical hierarchical structures that can impede relationships. We have worked over the past year and a half to define mission, membership, authority, and scope, recognizing that the voices of people with lived experience should be central in our planning of behavioral health treatment services. We are currently working on setting up an organizational structure that will support the council's mission.

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

Sonoma County's title for this position is Cultural Responsiveness, Inclusion, and

Training Coordinator. This position reports to and has direct access to the Behavioral Health Director regarding issues related to the racial, ethnic, cultural, and linguistic populations within the county and the DHS-BHD workforce.

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

The Cultural Responsiveness, Inclusion, and Training Coordinator position is held by Lisa Nosal, LMFT. She is responsible for ensuring behavioral health services are provided in a culturally appropriate and responsive manner to the diversity of our clientele. This involves participation in several cross-cutting areas in DHS-BHD. That includes:

- **Policy Development:** ensuring division policies are nondiscriminatory and inclusive.
- **Workforce, Education, and Training:** developing a workforce pipeline to diversify the incoming behavioral health workforce that includes participation in the development of strategies related to recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current DHS-BHD workforce is appropriately attending to the needs of our diverse clientele.
- **Program Design and Development:** participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- **Leadership Development:** Strengthening management, administrative, and other staff performance.
- **Department Coordination:** Participation in the Sonoma County Department of Health Services Equity Circle.

Sonoma County DHS-BHD uses the California Behavioral Health Directors Association (CBHDA) April 2016 *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services* as the basis for the implementation of CC-ESM responsibilities.

In addition, the Behavioral Health Division identified priority areas that have been driving the cultural competency goals for the division.

Goal	Details	Activities
I. Restart the Cultural Responsiveness Committee (CRC)	The monthly CRC meetings were suspended pending new leadership, the hire of the CRIT Coordinator, and the establishment and training of the DHS Equity Circle.	The BHD Equity Steering Committee has solicited applications from a wide range of community stakeholders as well as DHS and BHD staff. Applications will be reviewed in December 2024 and January 2025, with the goal of reconvening the committee in spring 2025.
II. Create a Trauma-Informed Division	A trauma-informed system requires a foundation in cultural humility and equity. By creating structures that emphasize equity, resiliency, collaboration, safety, empowerment, and an understanding of the effects of trauma and stress, BHD will create and maintain better conditions for fostering diversity, equity, inclusion, and belonging for both staff and clients.	Working with Trauma Transformed, a Bay Area clearinghouse that promotes and trains trauma-informed systems, BHD is providing staff training, leadership learning, organizational assessment, and transformation of policies, practices, and protocols.
III. Oversee a staff training program to reduce racial, ethnic, cultural, and linguistic mental health disparities and on the topics identified in the last staff Cultural Competence survey.	15 hours of all-staff training in calendar year 2024 has been devoted explicitly to cultural responsiveness and cultural humility trainings. In 2025, as part of the County of Sonoma's Racial Equity Action Plan, a four-hour Racial Equity Foundations training will be open staff at all levels, not just managerial. Additionally, Quality Management staff for Behavioral Health will receive six hours of training in Anti-Racist Results-Based Accountability. With the adoption of the	All-staff training explicitly focused on cultural responsiveness have included: • Cultural Humility • Anti-Racism • Working with LGBTQIA+ Clients Staff training with major components of cultural responsiveness include: • Harm Reduction monthly case consultations • Trauma Informed Leadership

	Relias Learning Management System, BHD staff have on-demand access to dozens of courses covering a wide variety of cultural competence and cultural humility topics.	
IV. Institute strategies to diversify and support a diverse behavioral health workforce at all levels of DHS-BHD.	Conduct pipeline activities to both encourage behavioral health career pathways and to support promotional opportunities. Implement recruitment, hiring, development, support, and retention strategies that support workforce diversification.	Continue the division's Trauma Informed Leadership Team to identify and address barriers to retention and trauma-informed systems. Using Trauma Transformed principles and systems and additional training from The Management Center and other equity-forward organizations, increase management and supervisory capacity for supporting a diverse workforce. As part of both BHD leadership and the DHS Equity Circle, work with both groups to create an inaugural Health Equity Plan for the department to guide and support ongoing work for diversity, equity, inclusion, and belonging for both staff and clients. Work with QI, HR, and other internal stakeholders to coordinate division and department efforts on recruitment and retention.

V. Implement strategies to support increasing services to the Latinx/Latine community	Work with the Quality Improvement Manager to increase Latinx/ Latine access to specialty mental health services. Identify supports to improve services from a cultural perspective and experience.	Attend regional and statewide CC/ESM meetings for TA exchange on strategies and best practices. Reconvene the Cultural Responsiveness Committee with a broader coalition to address the community's behavioral health needs across the continuum of care. Participate in the Community Health Assessment – Community Health Implementation Plan (CHA-CHIP) implementation process to identify and address community needs beyond the scope of the County Behavioral Health Division.
VI. Responsible for development and implementation of Cultural Competency Plan (CCP) for DHS- BHD	Review and develop the planning, policy, compliance, and evaluation of system and services to affect change and improvement to equity measures.	Attend Quality Improvement Committee (QIC), and MHSA Steering Committee to assist in development of a culturally responsive division and recommend actions for policy and practice adaptations. Work with DHS Office of Equity to develop and implement a Health Equity Steering Plan for the department.

IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:

1. Budget amount allocated for Interpreter and translation services

For FY2023-2024, Sonoma County BHD budgeted $357,973 for interpreter and translation services.

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities

Specific allocations in the FY 2024-25 budget for the Sonoma County Behavioral Health Division, to reduce disparities and increase equity system-wide.

Budget Allocation Description	FY24-25
Cultural Responsiveness, Inclusion & Training Coordination	$444,723
Support staff	$79,825
West County Community Services – Peer Education and Training	$147,926
DHS-BHD Workforce Education & Training Activities	$500,000
WET Annual Planning	$15,426
WET Administration	$78,773

3. Budget amount allocated towards outreach, community engagement and prevention to racial and ethnic county-identified target populations

Priority Population	Organization(s)	FY 24-25
Latinx/e	Latino Service Providers	$113,533
Latinx/e	La Luz	$35,206
Latinx/e	Innovation: New Parent TLC	$169,377
Latinx/e	Collaborative Care Enhanced Recovery Project (CCERP)aka Unidos Por Nuestro Bienestar	$71,558
Native Americans	Sonoma County Indian Health Project (Prevention)	$42,443
Native Americans	Sonoma County Indian Health Project (Outreach)	$85,988
Black/African-Americans	Community Baptist Church Collaborative	$127,327

4. Budget for culturally appropriate mental health clinical services

Priority Population	Organization(s)	FY 24-25
Latinos/x	On the Move	$348,146
Latinos/x	La Luz	$48,618

5. If applicable, financial incentives for culturally and linguistically competent

providers, non-traditional providers, and/or natural healers.

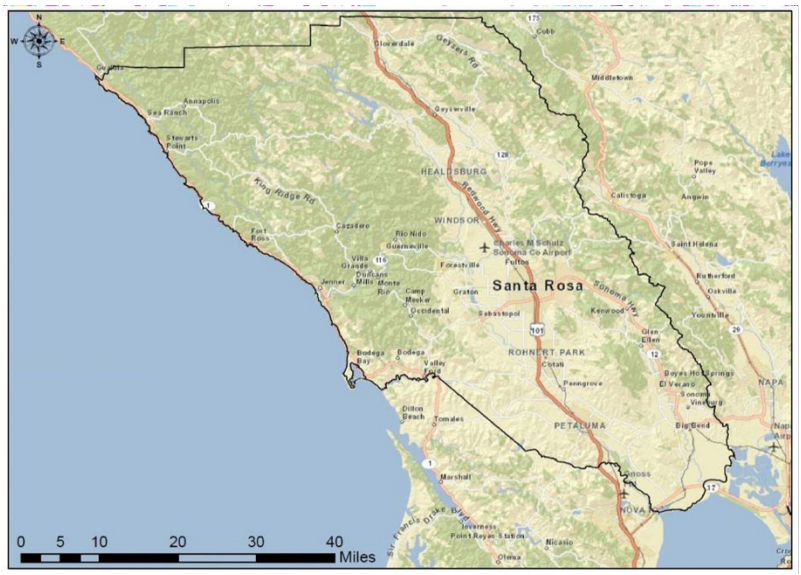
The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" (versus "basic"). The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

Criterion 2: Updated Assessment of Service Needs

A population assessment is necessary to identify the cultural and linguistic needs of the County and to determine/confirm emerging population(s) of need. This assessment is also critical in designing and planning for the provision of culturally responsive and effective mental health services.

I. General Population

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



Sonoma County, located within the San Francisco Bay Area about 50 miles north of San Francisco, has an estimated population of 481,8123, which is a decrease of 1.4% since the confirmed census count of 2020.[1] A medium-sized, urban-rural county of 1,576 square miles and 76 miles of Pacific Ocean coastline, Sonoma County is known for its Mediterranean climate that supports an agricultural industry including vineyards producing world-class wine. The county's major industries include healthcare, retail, and manufacturing.[2] The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.

Santa Rosa is the county's most populous city, with 177,181 residents, or over one-third of county residents. Santa Rosa is the county seat and the location of DHS-BHD's main campus. Beyond Santa Rosa, the main population centers are Petaluma (population 58,652) and Rohnert Park (population 44,326) to the south, and Windsor (population 25,789) to the north.[3] Sonoma County is geographically dispersed with limited public transportation and bicycle and pedestrian infrastructure, which can

[1] US Census, Sonoma County, California. https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia/PST045222
[2] DataUSA: Sonoma County, CA. https://datausa.io/profile/geo/sonoma-county-ca
[3] US Census Bureau, 2022 estimates.

create challenges for individuals living in more rural areas and those without a personal vehicle.

In 2022, 60.6% of residents identified as White, non-Hispanic, with 28.9% identifying as Hispanic or Latinx/e, the county's largest and fastest growing minority population.[4] The county's poverty rates vary significantly by ethnicity, with disparities affecting the Latinx/Latine community in particular. While Hispanic or Latinx/e residents represent almost 30% of the population, this group accounted for 40% of Sonoma County's Medi-Cal beneficiaries in 2021.[5]

Sonoma County is home to an estimated 27,000 undocumented residents. Of these residents, 12,000 or 44% are estimated to speak English less than "very well," suggesting possible linguistic isolation for this population.[6] Individuals who are undocumented and/or linguistically isolated experience unique challenges accessing medical, transportation, and social services.

The county is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the Lytton Band of Pomo Indians. Native Americans make up 2.3% of the county's total population[7] and about 1% of Medi-Cal beneficiaries. According to the US Census, in 2022 the Asian-American population composed 5.4% of the total population and African-American/Blacks were 2.2%.

Finally, Sonoma County is aging. The 65+ age group was the fastest growing between 2010 and 2021, increasing from 14% to 21.9% (55.5% growth). The share of population that is zero to four years old decreased from 5.8% in 2010 to 4.65 in 2022 as did the five- to nine-year-old population, from 19% to 16.5% for the same years.[8] This data trend has serious implications for service delivery needs for the elderly and economic impacts for school districts. The intersectionality of race, age, economics, language, and gender have deep implications on access to housing, services, and healthcare.

Sonoma County's median household income has increased to $99,266 (US Census Bureau, est. 2022), and the percentage of county residents living in poverty has decreased slightly from 9.1% to 8.9% in the past year. The unemployment rate has ticked up a bit in the past year, reported at 4.2% in March 2024 by the Labor Market Information Division, California Employment Development Department. In 2021, 61.4%

[4] 5 USA Facts, Our Changing Population: Sonoma County, California. https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county/
[5] California Department of Health Care Services (2018). Medi-Cal Enrollees and Beneficiaries. https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx
[6] Profile of the Unauthorized Population, Sonoma County, CA. Migration Policy Institute. https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6097
[7] USAFacts, Our Changing Population: Sonoma County, California, https://usafacts.org/data/topics/peoplesociety/population-and-demographics/our-changing-population/state/california/county/sonoma-county
[8] Ibid.

of the housing units in Sonoma County were occupied by their owner.[9] The remaining 38.6% of the population has encountered increasing rents over the past five years. Overall, median asking rents in Sonoma County have increased by 20% between 2021 and 2023.[10] This rent burden disproportionately impacts Black and Latino/x/e residents.

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

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

1. The county's Medi-Cal population

In calendar year 2022, the number of people eligible for Medi-Cal in Sonoma County was reported at 138,617, according the FY2023-24 External Quality Report.[11] The report states that 3,052 beneficiaries were served by the Mental Health Plan; the overall penetration rate is low, however, at 2.2%, compared to the statewide average of 3.96%.

Sonoma County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	13,034	73	0.56%	1.15%	1.82%
Ages 6-17	32,175	862	2.68%	4.80%	5.65%
Ages 18-20	7,720	192	2.49%	3.47%	3.97%
Ages 21-64	72,938	1,717	2.35%	3.60%	4.03%
Ages 65+	12,752	208	1.63%	1.98%	1.86%
Total	**138,617**	**3,052**	**2.20%**	**3.49%**	**3.96%**

[9] Ibid.
[10] State of Housing in Sonoma County, Generation Housing, 2023.
[11] FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review, Sonoma Final Report. Behavioral Health Concepts, Inc. February 2024. https://caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202023-2024%20Reports/MHP%20Reports/Sonoma%20MHP%20FY%202023-24%20Final%20Report%20EC%20051524.pdf

Sonoma MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	2,181	91	4.17%	7.08%
Asian/Pacific Islander	4,200	48	1.14%	1.91%
Hispanic/Latino	54,332	651	1.20%	3.51%
Native American	1,336	31	2.32%	5.94%
Other	39,502	939	2.38%	3.57%
White	37,068	1,292	3.49%	5.45%

Sonoma County's sole identified threshold language continues to be Spanish, with 33.3% of unduplicated Medi-Cal enrollees in Sonoma County declaring Spanish as their primary language.

Language	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
English	84,554	64.7%
Spanish	43,478	33.3%
Other/Unknown	2,633	2%
Total	130,665	100%

2. The county's client utilization data

Figures obtained from the Sonoma County Behavioral Health Quality Improvement team:

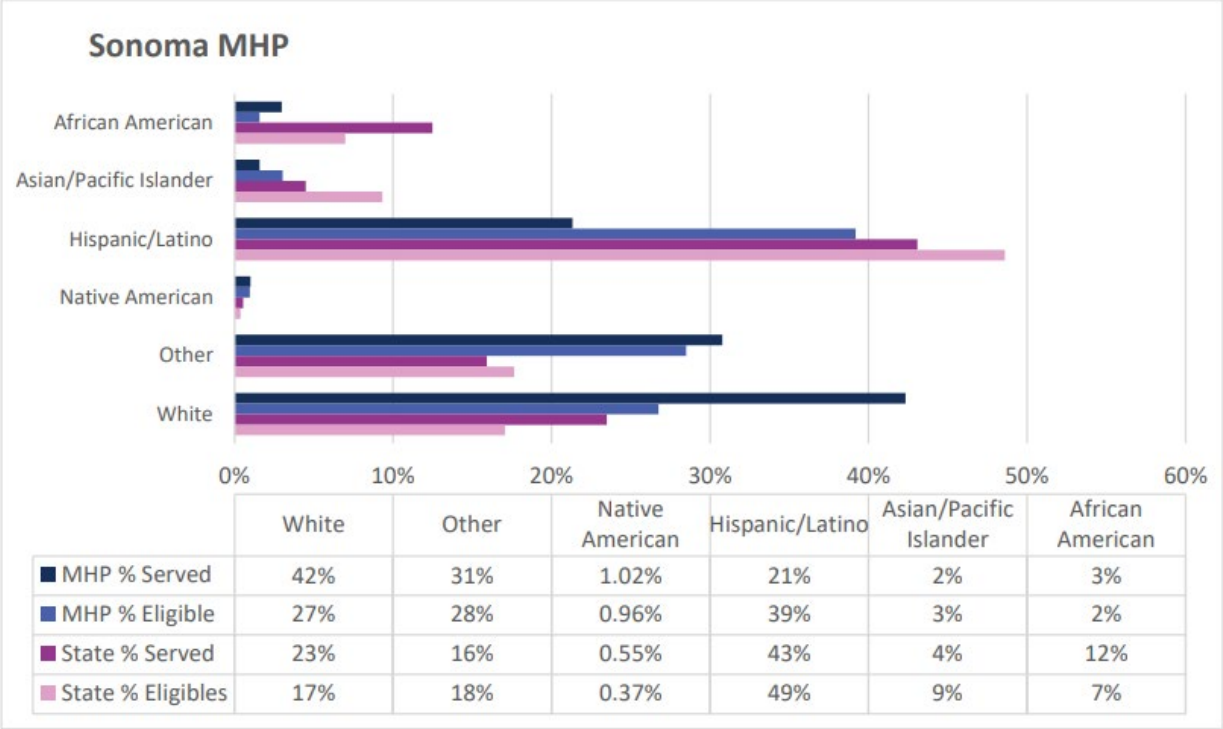
FY 23-24 DEMOGRAPHICS MHP BENEFICIARIES SERVED

AGE	UNIQUE BENEFICIARIES	PERCENT
Youth (0-17)	887	23.16%
TAY (18-25)	515	13.45%
Adult (26+)	2,428	63.39%
RACE		
Asian/Pacific Islander	73	1.19%
Black/African-American	185	4.83%
Native American/Alaskan Native	112	2.92%
Other Race	760	19.84%
Unknown	831	21.70%
White	1,869	48.80%
ETHNICITY		
Latinx	948	24.75%
Non-Latinx	2,121	55.38%
Unknown	761	19.87%
GENDER		
Female	1,777	46.40%
Male	1,933	50.47%
Transgender	51	1.33%
Unknown	69	1.80%
GRAND TOTAL	**3,830**	**100%**

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

a narrative discussion of the data. Data must support the analysis.

Race/Ethnicity
From the Sonoma MHP EQRO Final Report for FY 2023-24:



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	42%	31%	1.02%	21%	2%	3%
MHP % Eligible	27%	28%	0.96%	39%	3%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

Threshold Language of Sonoma MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	400	13.87%
Threshold language source: Open Data per BHIN 20-070		

While the penetration rate is lower than statewide averages in every category, it is most disproportionate to the eligible population for Latinx/e (34.2% of the statewide rate) and Native American (39.1% of the statewide rate) beneficiaries. The MHP believes that the Other category includes a substantial number of Latinx/e clients, a category that often overlaps greatly with Native American populations. The EQRO report states, "They [BHD] have been reducing the number of Other/Not Specified members in the EHR records to provide better tracking of services by ethnicity, though this data is not reflected in the Medi-Cal eligibility files." In fact, Sonoma County data analysis in 2023 shows a much smaller percentage of clients with "Other" racial identity than the EQRO report (22% vs. 32%), with only 5.15% falling into the "unknown" category of Latinx versus non-Latinx.

Age
From the Sonoma MHP EQRO Final Report for Fiscal Year 2023-2024:

Sonoma County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	13,034	73	0.56%	1.15%	1.82%
Ages 6-17	32,175	862	2.68%	4.80%	5.65%
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Ages 65+	12,752	208	1.63%	1.98%	1.86%
Total	**138,617**	**3,052**	**2.20%**	**3.49%**	**3.96%**

While Sonoma County shows a lower penetration rate in all categories than the statewide average, the difference is fairly uniform across all age categories. The outlier for underserved populations is the 0-5 age range. This gap points to a need to continue strengthening our relationships with prenatal and perinatal healthcare providers and supports.

Interestingly, the least disproportionate gaps are in the ages 18-20 and ages 65+ populations, two populations that tend to be at high risk for mental health concerns and behaviors. This points to strengths in coalition-building with community partners and in service delivery on which we can continue to build.

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

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

The following tables are made available by the CA Department of Health Care Services. These tables demonstrate mental health and alcohol and other drug prevalence estimates. These tables are available to all California counties. To review the complete report, follow the following link:

https://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

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

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition All Ages									
	Total Population			Household Population			Households below 200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Total Population	**22,264**	**472,102**	**4.72**	**21,152**	**460,234**	**4.6**	**8,858**	**105,332**	**8.41**
Youth Age 0-17									
Youth total	**7,471**	**105,202**	**7.1**	**7,330**	**104,184**	**7.04**	**2,553**	**29,326**	**8.71**
AGE									
00-05	2,549	35,226	7.23	2,525	34,988	7.22	982	11,292	8.7
06-11	2,385	33,920	7.03	2,382	33,892	7.03	839	9,625	8.71
12-17	2,537	36,056	7.04	2,424	35,304	6.87	732	8,409	8.71
GENDER									
Male	3,859	54,119	7.13	3,753	53,383	7.03	1,274	14,524	8.77
Female	3,612	51,083	7.07	3,578	50,801	7.04	1,279	14,802	8.64
ETHNICITY									
White-NH	3,601	53,810	6.69	3,562	53,496	6.66	748	8,570	8.73
African Am-NH	134	1,714	7.81	125	1,643	7.61	63	702	9.04
Asian-NH	272	3,886	7.01	270	3,867	6.99	92	1,073	8.6
Pacific I-NH	19	257	7.24	19	257	7.24	6	69	8.83
Native-NH	62	847	7.3	60	838	7.19	22	241	9.12
Other-NH	0	0	0	0	0	0	0	0	0
Multi-NH	302	4,264	7.09	297	4,238	7.01	84	955	8.82
Hispanic	3,081	40,425	7.62	2,997	39,845	7.52	1,537	17,716	8.68
POVERTY LEVEL									
Below 100%	1,042	10,415	10	1,035	10,354	10	1,035	10,354	10
100%-199%	1,520	19,004	8	1,518	18,973	8	1,518	18,973	8
200%-299%	1,443	20,616	7	1,443	20,616	7	0	0	0

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition All Ages									
	Total Population			Household Population			Households below 200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
300%+ pov	3,135	52,256	6	3,135	52,256	6	0	0	0
Undefined	330	2,911	11.35	199	1,985	10	0	0	0
RESIDENCE									
Household	7,330	104,184	7.04	7,330	104,184	7.04	2,553	29,326	8.71
Institution	79	393	20	0	0	0	0	0	0
Group quarters	62	625	9.89	0	0	0	0	0	0
Adult 18+									
Adult Total	**14,794**	**366,900**	**4.03**	**13,822**	**356,050**	**3.88**	**6,305**	**76,006**	**8.3**
AGE									
18-20	397	19,100	2.08	304	16,620	1.83	172	5,374	3.2
21-24	1,096	24,706	4.44	1,040	23,880	4.35	646	9,005	7.17
25-34	3,467	60,725	5.71	3,248	59,244	5.48	1,612	15,730	10.25
35-44	3,496	59,582	5.87	3,325	58,425	5.69	1,437	11,862	12.12
45-54	3,405	73,595	4.63	3,270	72,508	4.51	1,253	10,669	11.75
55-64	1,816	64,709	2.81	1,745	63,942	2.73	707	9,261	7.63
65+	1,116	64,482	1.73	889	61,430	1.45	477	14,104	3.38
GENDER									
Male	5,958	180,273	3.3	5,468	174,358	3.14	2,331	34,176	6.82
Female	8,836	186,627	4.73	8,354	181,692	4.6	3,974	41,830	9.5
ETHNICITY									
White-NH	10,461	265,920	3.93	9,774	258,892	3.78	3,869	42,589	9.08
African Am-NH	281	5,452	5.16	240	5,046	4.75	140	1,446	9.66
Asian-NH	242	14,109	1.72	225	13,797	1.63	100	2,850	3.49
Pacific I-NH	15	739	2.04	15	734	2.01	7	151	4.47

According to the data cited above, non-Hispanic Native Americans, African-Americans, and multi-racial populations are disproportionately represented in estimated need. This data is supported by Sonoma County's capacity assessments and identification of priority populations.

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

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

The utilization by Medi-Cal beneficiaries by age, race, ethnicity, and gender for Fiscal Year 2023-2024 are below. Geographic analysis was completed for the previous fiscal year and is included for reference.

FY 23-24 DEMOGRAPHICS MHP BENEFICIARIES SERVED

AGE	UNIQUE BENEFICIARIES	PERCENT
Youth (0-17)	887	23.16%
TAY (18-25)	515	13.45%
Adult (26+)	2,428	63.39%
RACE		
Asian/Pacific Islander	73	1.19%
Black/African-American	185	4.83%
Native American/Alaskan Native	112	2.92%
Other Race	760	19.84%
Unknown	831	21.70%
White	1,869	48.80%
ETHNICITY		
Latinx	948	24.75%
Non-Latinx	2,121	55.38%
Unknown	761	19.87%
GENDER		
Female	1,777	46.40%
Male	1,933	50.47%
Transgender	51	1.33%
Unknown	69	1.80%
GRAND TOTAL	**3,830**	**100%**

GEOGRAPHIC LOCATION OF MHP BENEFICIARIES SERVED FY22-23

North 7.04%

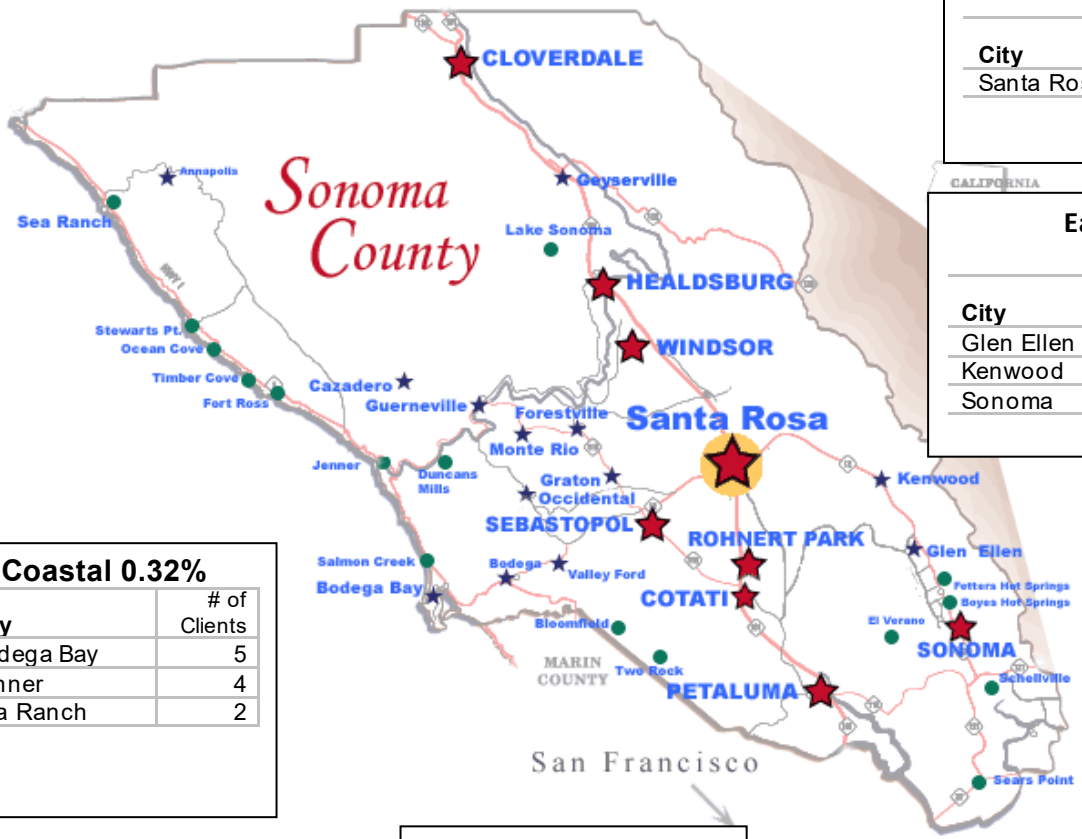
City	# of Clients
Cloverdale	71
Fulton	3
Geyserville	9
Healdsburg	58
Windsor	102

Central 58.08%

City	# of Clients
Santa Rosa	2006

East 4.63%

City	# of Clients
Glen Ellen	14
Kenwood	4
Sonoma	142



Coastal 0.32%

City	# of Clients
Bodega Bay	5
Jenner	4
Sea Ranch	2

West County 6.20%

City	# of Clients
Camp Meeker	1
Cazadero	2
Forestville	26
Graton	2
Guerneville	62
Monte Rio	8
Occidental	2
Rio Nido	3
Sebastopol	108

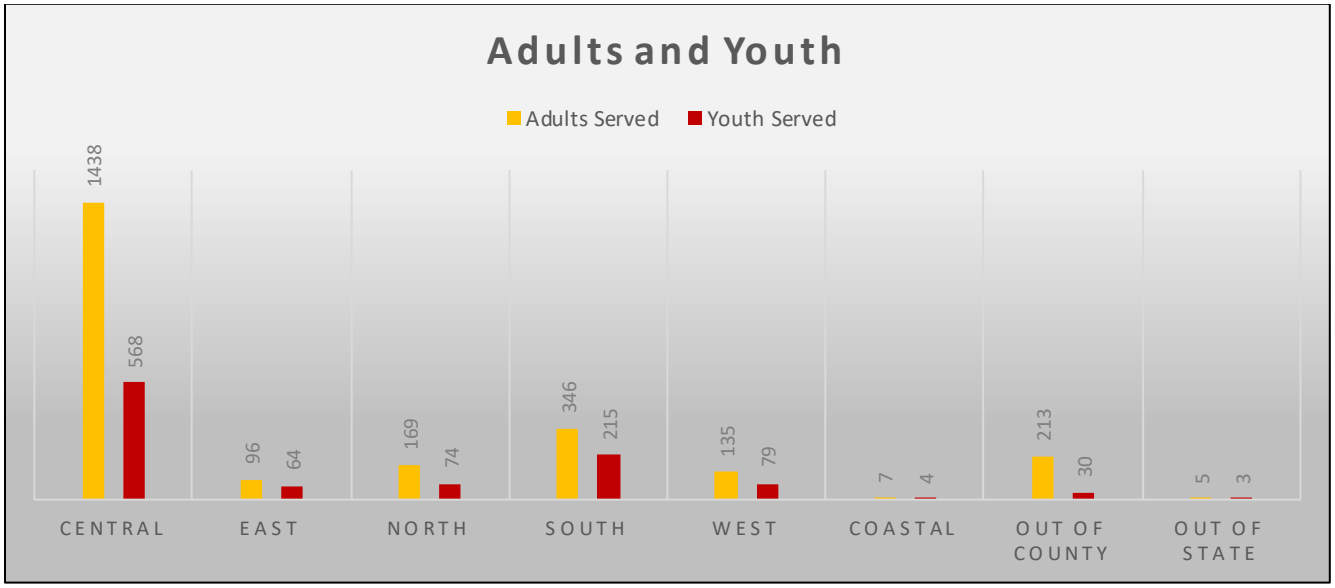
South 16.21%

City	# of Clients
Cotati	52
Penngrove	18
Petaluma	244
Rohnert Park	247

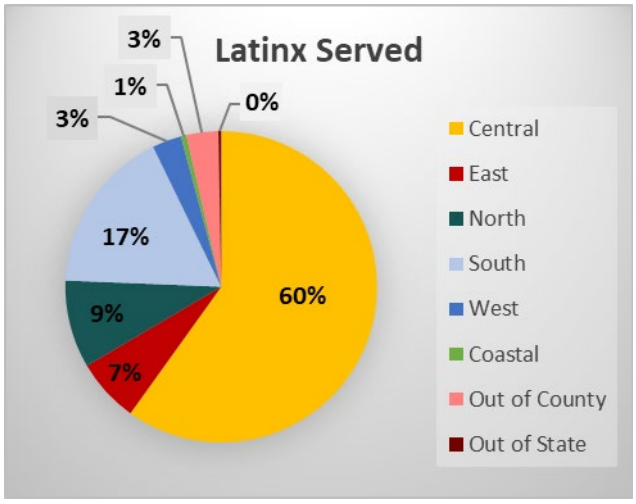
Out of County 7.27%

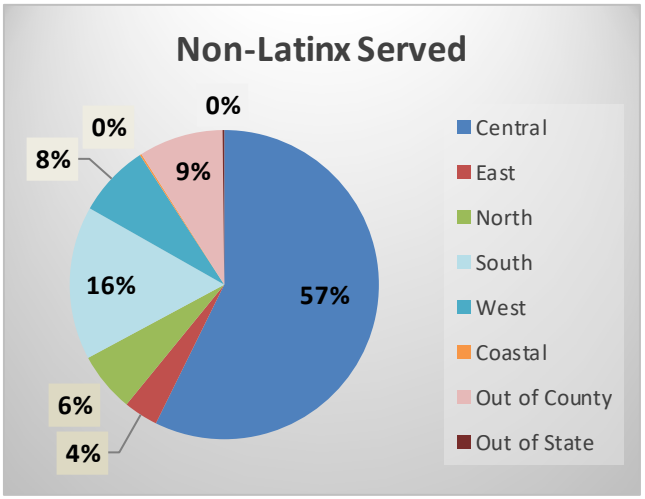
City	# of Clients
Out of County	243
Out of State	8

AGE GROUP MHP BENEFICIARIES BY REGION OF RESIDENCE FY22-23



ETHNICITY OF MHP BENEFICIARIES BY REGION OF RESIDENCE FY22-23





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

The ethnicity analysis of beneficiaries served revealed a growing trend seen in previous years. Latinx/Latine clients are significantly more likely to be served in the Youth System of Care; approximately 51% of the youth served in FY21-22 identified as Latinx, versus 22% for adults. Regarding recent years' growth in youth services, the majority of that growth (68%) was attributed to increases in Latinx/Latine youth served. In FY20-21, 417 Latinx/Latine youth were served, whereas a total of 525 Latinx/Latine youth were served in FY21-22. Finally, in terms of region of residence, Latinx/Latine beneficiaries are less likely to live in the West County area, and somewhat more likely to live in the East, North, and Central/Santa Rosa areas.

The 2023 MHSA Capacity Assessment Report found that in fiscal year 2021-2022, 3,484 unique individuals were served by Sonoma County BHD, with a total of 2,378 clients served by Adult and Older Adult Services, 1,154 clients served by Youth and Family Services, and 65 clients served by TAY services. The racial and ethnic makeup of clients was similar to that of the county, with a majority of clients identifying as White and about a quarter identifying as Hispanic/Latinx. Most clients were between the ages of 26 and 59, and the majority were diagnosed with psychotic disorders and mood disorders, including schizophrenia, bipolar disorder, anxiety disorders, depressive disorders, and trauma-related disorders. Almost half of all clients entered the system through the Access Teams and crisis services, and after entry, most clients utilized outpatient services. Analysis of client demographics across programs identified certain groups being over- and/or under-represented in the system of care. Notably, Latinx/Latine adult clients were underrepresented in the adult system, while Latinx/Latine youth were over-represented in the youth system of care, specifically within general outpatient programs and youth justice services, compared to the Medi-Cal–eligible population of Sonoma County. Other groups, such as Black and Native American clients, were also found to be overrepresented in locked residential programs.

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

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

Most recently, the MHSA Work Plan Summaries for the Integrated Plan for PEI have prioritized the following populations:

- Latinx/Latine people
- African-Americans
- Native Americans
- LGBTQIA+ youth and Older Adults
- 0-5 year olds and their caregivers

These culturally underserved groups were identified and validated through a variety of data sources, including the 2019 Sonoma County Capacity Assessment and FY 2020-23 MHSA Three-year Program and Expenditure Plan; 2018-2020 EQRO data reports; documented meetings with stakeholders, MHSA Steering Committee, Mental Health Board and Health Action Chapters.

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

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

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

The FY 2020-2023 MHSA Three-Year Planning Process and preceding Capacity Assessment validated the populations most at-risk and in need of PEI services:

- Latinx/Latine communities
- Native Americans
- African/Black Americans
- LGBTQIA+ communities

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

Latinx/e Communities
The division has had a low Latinx/Latine penetration rate in clinical services for the past several years. BHD is working toward increasing both access to mental health services for Latinx/Latine clients and on improving the cultural responsiveness of services for Latinx/Latine clients.

While the County offers behavioral health services for the Latinx/Latine community, targeted opportunities were limited. Recent listening sessions, conducted as part of the MHSA Community Program Planning process, identified the following concerns from Sonoma County Latinx/Latine populations:

- Culturally aware and relevant services
- Access to services
- Increased mental health concerns
- Increased bullying of children and youth
- Multi-generational families and their needs
- Youth service needs, increased depression/anxiety/stress among youth
- Need for more sensitive providers
- Racism and discrimination
- Need for formal and informal (e.g., peer) support
- Housing and homelessness
- Cultural taboos and stigma
- Education about mental health
- Need for geographically diverse services
- Need for community connectedness
- Need for more school-based services
- Intergenerational trauma
- Migration-based trauma

Native American Communities
The Native American population has access to the Sonoma County Indian Health Project (SCIHP), a Community Health Center that provides behavioral health, medical, dental, and other wellness-related services predominantly to Native Americans in Sonoma. However, SCIHP is underutilized, likely due to mental illness stigma within the target population and limited culturally specific programs in remote geographic areas. Data shows an overrepresentation of Native American individuals in County crisis services, as the majority of Native American consumers went to the Crisis Stabilization Unit in fiscal years 2018-2019. As mentioned previously, Native American consumers were also overrepresented in locked long-term residential treatment. In fiscal year 2018-2019 they made up 7% of program episodes compared to only 2% of the MHSA population.

MHSA listening sessions with Indigenous groups in central Sonoma County and coastal Sonoma County are planned so that work may continue on identifying and then addressing barriers and challenges, and building on community strengths.

African-American/Black Communities
While the Sonoma County MHP served African-American/Black clients at a higher rate than their representation in the Medi-Cal membership for the county, there is concern that Black clients are most often seen in locked or crisis settings.

The recent MHSA listening session with African-American/Black communities identified the following areas of concern regarding mental wellness and mental healthcare:

- Need for more personalized and person-centered care
- Need for more African-American/Black providers
- Amplifying effects of racism and ableism
- Need for connecting spiritual health and mental health
- Need for increased outreach to compensate for stigma against mental healthcare
- Desire for healthy activities for youth as preventative measures
- Intergenerational trauma and need for trauma-informed care
- Need for more community conversations about wellness and cultural resilience
- Perinatal mental health support
- Improved access to treatment and prevention services
- Increased peer support, formal and informal
- Specific resources for African-American/Black foster youth and former foster youth
- Effects of racism and discrimination
- Need for decentralized services that serve people in their own communities

LGBTQIA+ Communities
A recent survey conducted by a local nonprofit, Positive Images, focused on learning more from the community of LGBTQIA+ youth (14-18 years old) and young adults (18-30 years old). The sample of over 100 respondents reported that up to 24% were nonbinary or transgender. This population continues to report that they are challenged

with finding both healthcare and mental health services that support them in their identity and in meeting their health needs. Sixty-eight percent of the respondents reported that they had utilized mental health services in the past year. Furthermore, this population reported that 79% had received a diagnosis of depression, 77% of anxiety, 41% of PTSD, and 26% of ADD/ADHD. The most striking finding was that 25% had called the suicide hotline at least once in their life, and 4% had called more than three times in their life.

Sonoma County Consumer Perception Surveys have shown that the number of other-gender respondents increased significantly and dramatically for youth over the past few years. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year. While the finding corresponds to Positive Image's survey results, the increase indicates that trans and gender-expansive behavioral health clients are either more comfortable disclosing their gender identity to their mental healthcare providers or that more people from this community are seeking behavioral healthcare services with DHS-BHD.

A recent MHSA listening session for LGBTQIA+ people in Sonoma County identified the following concerns for this community:

- Lack of culturally aware and relevant services, including fear of misgendering
- Need for both formal and informal (e.g., peer) support
- Need for community connectedness
- Need for increased and improved outreach and information
- Expanded mental health services
- Need for more sensitive, prepared providers
- Stigma and discrimination
- Increased stressors (natural disasters, national and local politics, Covid)
- Need for improved access to services beyond crisis services
- Housing and homelessness
- Physical activity and its relationship to mental wellbeing
- Depression and suicidal ideation

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

OVERALL STRATEGIES

DHS Health Equity Action Plan and Sonoma County Racial Equity Action Plan
In July 2024, the Sonoma County Board of Supervisors passed the Sonoma County Racial Equity Action Plan (see Appendix C). The goal of the plan is for all County staff, especially staff of color, to feel a sense of belonging and be supported to achieve their career goals within the County organization. The plan identifies two major barriers to achieving this goal:

- County management is not representative of the racial demographics of Sonoma County.
- Staff of color report disproportionate dissatisfaction levels with management practices.

And identifies three "hot roots," or causes, underlying these barriers:

- There are few mechanisms supporting managers in hiring and promoting qualified staff members of color to leadership levels.
- Management practices do not reflect sufficient capacity, skill sets, and/or interest to contribute to the empowerment of staff, especially staff of color.
- The County system values productivity over the impact that working conditions have on people, especially staff of color.

To achieve the goal of all staff feeling a sense of belonging and being supported in their career goals, the plan identifies three main strategies:

- Strategy 1: County creates capacity for equity work and expands pipelines for hiring and career advancement.

- Strategy 2: County offers support and creates accountability for management at all levels to develop an understanding of racial equity

- Strategy 3: County invests in data collection and reporting systems to drive change that is responsive to staff experiences.

Sub-strategies focus on creating and funding equity positions; examining and rewriting job descriptions to remove artificial barriers; providing racial equity trainings to managers and including those competencies in their evaluations; providing disaggregated data on recruitment, hiring, promotions, and turnover rates; conducting yearly staff satisfaction surveys; and rolling out Anti-Racist Results-Based Accountability trainings.

The Department of Health Services has subsequently drafted a Health Equity Action Plan, based on the model of the countywide Racial Equity Action Plan, to particularize goals to this department. The plan is not yet finalized.

While these documents are "inward facing" and focus on employee experience, not client experience, they do so because we cannot serve clients equitably if we are not treating our staff equitably and if staff of color are unable to serve clients with dignity and respect. The Racial Equity Action Plan and the forthcoming Health Equity Action Plan are therefore powerful tools in organizational self-reflection that will help us better serve our clients.

Cultural Responsiveness & Humility Trainings

In March 2024, WET funds were used to host a six-hour training by nationally acclaimed DEI trainer Gloria Morrow, Ph.D., called "Building Beloved Community through Cultural Humility." The training was open to MHP, SUD, and CBO staff. This training introduced the integration of two powerful concepts, "Building the Beloved Community" and

"Cultural Humility" as a strategy for preparing the environment for providing culturally responsive services and helping marginalized clients to heal from racism-related trauma. As staff members are sometimes not working in culturally safe and nurturing environments, this training aimed to help staff by sharing strategies for them to engage in culturally responsive behaviors to create a healthy environment for their co-workers and clients. Finally, service providers are often exposed to secondary trauma when working with traumatized clients, especially those who have experienced racial trauma. The training also included a section on teaching staff the basic steps for practicing self-compassion to help them to better take care of their clients while taking better care of themselves.

Learning objectives included:

- Identifying at least three (3) ways that racism-related trauma impacts the mental, physical, and spiritual well-being of marginalized clients.
- Listing at least three (3) principles of the Beloved Community, and its rationale for effectively meeting the overall health and well-being of those you serve, especially those from marginalized communities.
- Listing at least three (3) threats to building the beloved community.
- Identifying at least three (3) components of cultural humility and its role in building the beloved community.
- Identifying at least three (3) strategies for becoming culturally humble.
- Identifying at least three (3) strategies for Building the Beloved Community through Cultural Humility.
- Listing three (3) ways staff can become more culturally responsive in creating an environment that embodies the principles of diversity, equity, and inclusion.
- Identifying at least five (5) strategies for staff to practice self-compassion.

In April and May 2024, the BHD Equity Steering Committee organized a series of two three-hour division-wide trainings on anti-racism, adapted from the County of Sonoma Racial Equity Foundations training. This training had otherwise been available only to managerial staff, and the Behavioral Health Division was proud to pilot it as a training for staff at all levels. The committee further added behavioral-health specific information and resources to further tailor it to the division. This Racial Equity Foundations training provided an introduction to racial equity, antiracism, and related foundational concepts. Participants developed a shared understanding of core concepts; a shared understanding of the historic and ongoing role of government in upholding structural racism; clarity regarding how racial inequities are experienced by Sonoma County employees and residents; a shared understanding of the Racial Equity and Social Justice pillar of the County's 5-year Strategic Plan; our role and expectations as public servants and healing professionals; and an understanding of how racial equity efforts advance trauma-informed and healing-centered care. Learning objectives included:

- You will be able to identify at least two ways our roles as public servants and our accountability to the "racial equity and social justice" pillar of Sonoma County guide our work.
- You will be able to name strength-based, person-centered and relational practices.
- You will be able to identify how culture is prevention and how a sense of

belonging is a protective factor in trauma theory.
- You will be able to identify ways to use a racial equity lens on our intakes, safety and safety support plans, mental status exam forms, and procedures.
- You will be able to identify at least two ways our roles as public servants and our accountability to the "racial equity and social justice" pillar of Sonoma County guide our work.

CULTURALLY SPECIFIC STRATEGIES

Latinx/Latine Community

Latino Service Providers
Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and the social service sectors. LSP currently comprises over 1,600 members from neighborhood and community groups, mental health programs, public and private health service providers, education, law enforcement, immigration and naturalization agencies, social service agencies, community-based organizations, city and county governments, criminal justice systems, and the business community. The mission of LSP is to serve and strengthen Latinx families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

In 2021, Prevention & Early Intervention (PEI) MHSA funds were opened to public bid to identify new approaches for prevention and early intervention for Latinx/Latine community members. Funding was shifted to support bilingual/bicultural Youth Promotores who provide education and resources to youth and adults in school and community settings. This model was initially funded and evaluated utilizing State MHSA funding administered by the Office of Health Equity, California Department of Health Services. In addition, PEI funding was allocated to a Latinx/Latine-serving organization in Sonoma Valley, reaching a geographical population in the eastern region of the county that was previously underserved.

In the 2022-2023 fiscal year, LSP maintained their commitment to serving the Youth and the community. The Youth Promotor team achieved significant milestones by recruiting and onboarding over 60 students from across Sonoma County. The Youth Promotor Internship Program aimed to actively involve the Latinx community in addressing health-related issues in the county and inspire the next generation of community health workers. These young advocates consistently engaged with the Latinx community, providing resources and information in a culturally and linguistically responsive manner. Collaborating with Youth Promotor students, the Community Engagement Team attended over 40 events, reaching out to the community. They also expanded their impact through 49 e-newsletters, offering free or low-cost resources to Sonoma County residents. The 2023 Stomp the Stigma event, organized by LSP Youth Promotor Students, saw the participation of over 150 individuals, successfully raising awareness about mental health through activities curated by the students. Latino Service Providers' unwavering commitment, coupled with dynamic leadership and the collaborative efforts of the Youth Promotor team, ensured a year of significant impact. As they continue to bridge gaps, foster community engagement, and promote mental health awareness,

LSP remains a vital force in enhancing the well-being of Sonoma County residents.

Nuestra Cultura Cura
In the fall of 2019, the County started to collaborate on a new MHSA Innovation Project, *Nuestra Cultura Cura*: A community-based Social Innovations Lab. The County has worked closely with local CBOs On the Move and La Plaza Latinx for this project, which specifically focuses on the unique cultural needs of the Latinx/Latine community surrounding mental health, as a means to raise awareness, reduce stigma, and increase access to mental health support.

La Plaza is set apart from traditional mental health programs by pairing clinical, therapy-based services with traditional mental health practices and cultural experiences that empower the Latinx/Latine community to recognize their own ability to heal. By providing a welcoming cultural approach, La Plaza creates a bridge for Latinx/Latine community members to access clinical services when needed. As a specific Innovations project, the *Nuestra Cultura Cura* Social Innovations Lab and its prototype strategies will create and promote a welcoming setting that will reduce mental health stigma, create appropriate, culturally based wellness activities, and provide a bridge to a variety of mental health resources. This Innovation Project was initiated in FY 2022-23 and has continued into this year.

La Luz
MHSA PEI funding also goes to La Luz Center's "Your Community, Your Health / Tu Comunidad, Tu Salud," which addresses the mental health needs of the Sonoma Valley Latino/x/e community by working to reduce risk factors for developing a potentially serious mental illness, build protective factors, and improve timely access to mental health services. The program is designed to prevent the onset of stress, anxiety, and depression through education and wrap-around model. In FY22-23, "Your Community, Your Health / Tu Comunidad, Tu Salud" served 331 total clients, had 1,324 total encounters, outreached to approximately 4,501 people, and referred 181 families to mental health services.

La Clinica LatinX, YFS Bilingual Latinx Empowerment Group, and Spanish-Speaking Clinical Consultation Group
A grassroots effort of BHD Youth and Family Services (YFS) staff, La Clinica LatinX currently provides a dedicated space for any Latinx/e YFS staff to see Latinx/e YFS clients. This space provides an atmosphere that is welcoming, culturally engaging, and comfortable for Latinx/e clients and families. The goal is to grow La Clinica LatinX over time, and plans are underway to increase outreach to let the community know about the existence of La Clinica. In addition, staff are working with the Quality Assessment and Performance Improvement team to monitor usage of La Clinica and hope to use data to advocate for dedicated resources for expansion of La Clinica in the future.

The clinic provides bicultural/bilingual individual and family therapy, coaching, psychiatric rehabilitation, and youth and parent support groups. The clinic aims to improve and increase access to mental health services, wellbeing, and self-determination to the Latinx/e community.

Since the clinic's launch in August 2024, 33 YFS clients have been served face-to-face

in the clinic space, and staff have signed into the clinic 177 times to provide face-to-face or telehealth services.

While La Clinica LatinX is too new to analyze client outcomes, which are generally measured every six months for YFS clients using the Child Assessment of Needs and Strengths (CANS), the MHP's Quality Improvement team is working closely with YFS staff to gather data and plans to complete further analysis in 2025.

In addition to the clinic, YFS staff have started the YFS Bilingual Latinx Empowerment Group, to value, support, and encourage bilingual Latinx/e staff. Working closely with Quality Improvement staff, this group has developed a 13-question client perception survey designed to mirror the annual Consumer Perception Survey. The survey includes questions from each domain of the CPS survey, with staff feedback incorporated to tailor the questions to the local Latinx/e community. Once the survey format is finalized, the survey responses will be used to measure community perception at the time of intake and over the course of treatment.

YFS staff have also started two monthly Spanish-speaking consultation groups, one for clinicians and one for Senior Client Support Specialists, with the goal of improving client care by supporting clinical staff to provide culturally and linguistically appropriate therapeutic interventions and services in Spanish.

African-American/Black Community

The Community Baptist Church Collaborative goals are to increase awareness of mental health issues and resources in the broader community and specifically within the African-American community. Community Baptist Church Collaborative addresses the associated risk factors of stigma, inadequate information regarding mental health issues, lack of trust for mainstream services, and lack of acceptable mental health service for the African-American community in Sonoma County with the following programs:

- The Village Project and Saturday Academy are weekly programs for children ages 7 to 11 (Village Project) and 12 to 18 (Saturday Academy) that use faith-based curriculum focusing on character building and resiliency. Topics include perseverance, leadership, and African-American history and representation in the Bible, as well as physical and mental health topics. Many youth also receive additional support through mentoring and tutoring.
- Safe Harbor Project provides events and activities to increase wellbeing, reduce stress, and increase community building using music, sound, and vibro-acoustic techniques. In addition, Safe Harbor Project provides significant outreach concerning mental health to African-American and other residents. Safe Harbor Project launched a 24/7 internet radio station (KSHP Mood Music) with music intended to increase wellbeing, public service announcements, interviews, speakers, and other mental health related information. Once in-person programs are viable, SHP will continue KSHP; host at least four large events each year at African-American cultural events, health and wellness fairs, and other venues; and provide music and programing.
- Mental Health Training and Speaker Series hosts four events each year to

reduce stigma, increase mental health awareness and appropriate help-seeking, and increase the cultural competency of the mental health system. The agency's staff, leaders, mentors, and volunteers attend theses trainings, as well as others interested in the wellbeing of the African-American community. Events will include QPR training regarding suicide prevention, the annual African-American Mental Health Conference, annual Martin Luther King celebration, and annual Juneteenth festival of which Safe Harbor Project is a sponsor.

Native American Community

Sonoma County Indian Health Project's Gathering of Native Americans Program offers presentations and workshops, trainings, gatherings, and cultural events that bring together the Native community with a focus on cultural strengths and behavioral health wellness. The purpose of the Gathering of Native Americans (GONA) and curriculum is to reduce mental health disparities in local Native American communities by increasing access to mental health services by:

- Mental health stigma reduction and decreasing suicide through community-based awareness campaigns and education (utilizing community wellness gatherings and community outreach). The GONA focuses on the following four themes: belonging, mastery, interdependence, and generosity.
- Providing GONA events that support healing, encourage and guide community discussion about mental wellness, and help communities build capacity for Native Americans who are at risk.

LGBTQIA+ Youth Community

Positive Images is an agency in Sonoma County serving the unique needs of lesbian, gay, bisexual, transgender, queer, intersex, asexual, and otherwise marginalized gender/sexual identified populations, with an emphasis on identities and individuals at the margins. Their LGBTQIA+ Community Center hosts multiple weekly support groups, a youth leadership development program, mentorship opportunities, an LGBTQIA+ Library, resource and referral station, and a Transformation Station. Positive Images offers a warm, welcoming, and affirming environment for young people to explore their individual identities, develop leadership skills, and contribute to the collective community. Positive Images staff lead LGBTQIA+ Cultural Competency Trainings and presentations that educate the greater community focusing on human connection, compassion, and inclusion.

Positive Images envisions a Sonoma County where all LGBTQIA+ people are valued, compassionate community members, creating a just society.

In 2024, WET funding went toward hosting an all-staff training for Sonoma County MHP, SUD, and CBO staff on "LGBTQ+ Diversity, Equity, and Inclusion for Healthcare Providers" by Equality California in June 2024. This training was geared toward service providers, staff, and organizations looking to provide inclusive, equitable, and affirming care to LGBTQ+ people. The training promoted LGBTQ+ acceptance and offered participants a range of tools to better identify and serve the needs of the LGBTQ+ community. It also emphasizes the intersections of sexual orientation, gender identity,

race, and class, and walked through data and best practices related to LGBTQ+ health and wellbeing, understanding and evaluating risks for LGBTQ+ people, and implementing safe and inclusive practices that protect the wellbeing of this vulnerable population, using a harm-reduction framework. Objectives of the training were for service providers to be able to:

- explain the importance of affirmative, patient-centered care for LGBTQ+ people
- implement what they have learned and apply that to various workplace situations
- distinguish between and understand the major terminology around LGBTQ+ experience and identity
- understand the difference between gender, sex, and sexuality
- understand multiple ways to provide affirmative care
- identify ways the organization can improve in regards to LGBTQ+ issues
- understand the importance of using a harm reduction framework

Additionally, a grassroots initiative started in July 2024 by a Behavioral Health Clinician, who has since been promoted to a Health Program Manager, has been a monthly case consultation group for providers working with transgender, non-binary, and gender-expansive clients.

The group offers a chance to "come ask general questions, share your experience and knowledge, brainstorm ideas, find community resources, and deepen your understanding" of the trans community.

Older Adult Collaborative

The Older Adult Collaborative (OAC) is the primary senior services agencies in Sonoma County and is led by the Sonoma County Human Services Department, Adult & Aging Services Division. The community-based, non-profit members serving older adults in their respective communities are:

- Council on Aging (COA)
- Petaluma People Services (PPSC)
- West County Community Services (WCCS)

The OAC utilizes Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), a prevention and early intervention evidence-based model, to reduce depression and suicide among older adults throughout Sonoma County by:

- Administration of a depression screening by both licensed experienced professionals and peers/volunteers who are supervised by licensed professionals; and
- Referral of case-managed clients to counseling and psychotherapy for those older adults identified as at risk for depression.

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

DHS-BHD uses a community driven Continuous Quality Improvement (CQI) model as part of our community planning process. Continuous Quality Improvement is the complete process of identifying, describing, and analyzing strengths and problems, and then testing, implementing, learning from, and revising solutions. Sonoma County BHD staff and managers monitor performance outcomes with contractors, working with them to make necessary adjustments in real time, in the effort to realize more effective programs, services, and activities.

Sonoma County is also moving to implement Anti-Racist Results-Based Accountability (AR-RBA) training for contracted and staff quality improvement and director-level staff, supported by a more in-depth AR-RBA training for DHS Equity Circle members. The department hopes that AR-RBA's focus on "targeted universalism" can further reduce racial, ethnic, and other disparities.

Cultural Responsiveness Survey

Every three years, a division-wide Cultural Responsiveness (CR) Survey is conducted to identify disparities, assess cultural responsiveness needs of the staff and provide insight into future training and system planning (reflected in the Workforce Education and Training Plan) for DHS-BHD. Three levels of staff are requested to take the survey to address differing scopes of work and interactions with the communities served: Management, Clinical, and Administrative staff.

The following standardized tools are used to collect information:

- California Brief Multicultural Competence Scale (CBMCS)
- Contra Costa County Mental Health Division Cultural Competency Assessment Tool
- Sonoma County Mental Health Administrative Staff Cultural Assessment Tool

The last survey was completed in December 2020 and included only selected behavioral health staff and contractors, not just from those providing services in specialty mental health, but along the mental health services continuum—prevention, early intervention, treatment, and recovery—not specifically focused on staff of the Mental Health Plan. It also does not include substance use disorders staff or contractors. While this survey does provide DHS-BHD with some information, it does not reflect an accurate picture of

the behavioral health division staff as a whole nor can the data be compared with previous surveys.

In December 2020, an email was sent out inviting behavioral health staff, contractors, and community members to participate in the CR Survey. A link to a survey monkey was sent in the email and the survey closed in February 2021. (No survey was conducted in 2023 or 2024; the survey will be repeated in 2025.) Below reflects the characteristics and responses from that survey:

- 165 individuals responded
- 64.6% or 104 respondents identified Sonoma County Department of Health Service Behavioral Health Division as their place of work, specifically:

ANSWER CHOICES	RESPONSES	
Adult Services	26.83%	44
YFS/FASST/TAY Services	20.12%	33
Crisis/Outreach Services	13.41%	22
BH Administration	9.15%	15
Not Applicable	30.49%	50
TOTAL		164

- 35.40% or 57 respondents identified as contract service provider of DHS-BHD.
- 74.55% stated they were White, and 11.73% reported they were of Hispanic or Latino ethnicity.
- Only 1.82% stated they spoke Spanish as a primary language.
- 8.59% stated they were bisexual, 5.52% stated they were gay or lesbian, and 3.68% stated they were queer.
- 33.33% stated they had lived experience with mental health challenges.
- 62.11% were clinicians, 26.71% were management, and 11.18% were administrative support.
- Survey questions regarding working with a non-English speaking client varied from 76% feeling that they knew what to do if a caller (on phone) speaks a language different than theirs to only 52% stating they had training on how to use translation services and could access translation services from their work station.
- Only 42.5% reported feeling confident that they could get interpreter support within 15 minutes of recognizing client need.
- Regarding a level of awareness about multicultural issues, a higher percentage of survey respondents reported they had awareness of racial challenges in society (96.7%) and institutional barriers that affected their clients (98%).
- However, the more specific the questions were regarding diverse groups (LGBTQ+, seniors) and the intersectionality of groups (low-income vs. high income Puerto Ricans), the lower the confidence level staff had regarding their knowledge and ability to work effectively with those groups.
- There was a significant recognition that the organization's staffing did not represent the populations of the broader geographic community being served. Only 22% felt that the organization represented the community, and 39% felt that the organization did not.

- Survey respondents felt less confident that the overall service delivery system was effective in providing culturally appropriate and linguistically proficient mental health services to the ethnic, racial, and cultural groups served.
- Although not necessarily representative of all staff, the overall sentiment of survey respondents indicated that ongoing cultural training, discussions, and refining practices is warranted to better serve Sonoma County residents.

Capacity Assessment Report

The Sonoma County MHSA Capacity Assessment Report released in 2023 made the following recommendations:

- Improve the transition of clients out of the Crisis Stabilization Unit (CSU) into less-intensive services, to reduce the amount of time that clients stay in the CSU and to provide clients with a better environment for recovery.
- Increase capacity for non-crisis services, including outpatient therapy, to reduce wait times for appointments and help prevent clients from escalating needs that may turn into crises. Increased capacity for non-crisis services may also help alleviate overstays in the CSU by providing clients who have been stabilized with more options for appropriate levels of follow-up care.
- Continue to integrate peer providers into the system of care. Services provided by peer providers and those with lived experience are highly valued by the community, serve a large number of clients, and may help reduce the burden of services on other cadres of providers.
- Invest in a sustainable workforce, exploring strategies for better recruitment and retention of staff that can alleviate the high levels of staff turnover and understaffing, which impact service availability.
- Explore the reasons behind over- and under-representation of specific populations in mental health services and in justice-related services to better understand possible service gaps and bias in the treatment of mental illness.

Consumer Perception Survey

While results for the 2024 Consumer Perception Survey are not yet available, results from the May 2023 survey are. Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations. Section 3530.40 of Title 9 of the California Code of Regulations requires that semi-annual surveys be conducted (May and November). However, beginning in 2020, the Department of Health Care Services (DHCS) cancelled one of the survey periods due to the implementation of a system shift in submission processes.

DHCS has contracted with the University of California Los Angeles (UCLA) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There are a total of four surveys for consumer populations:

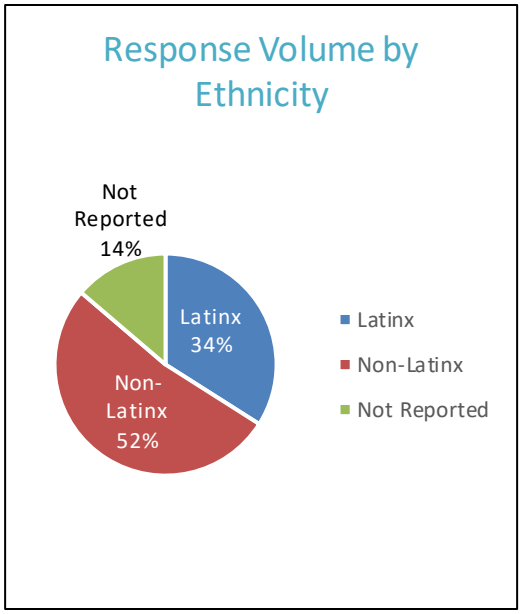
- Adults
- Older Adults
- Youth
- Family/Parents of Youth

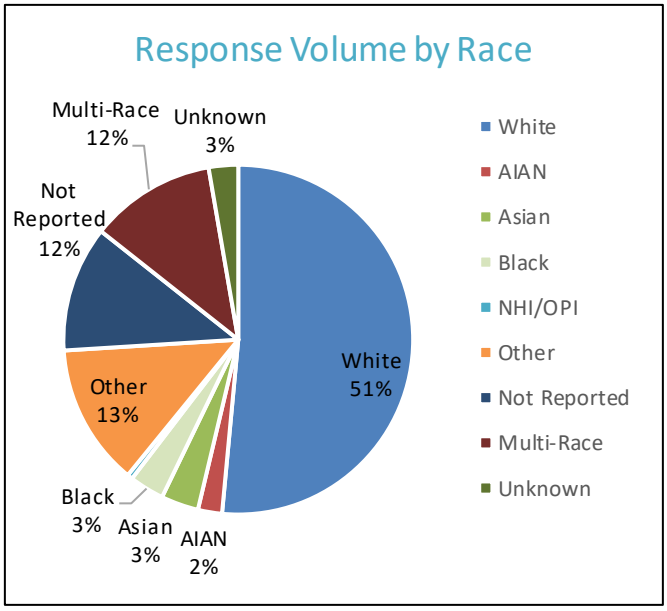
The surveys contain items in the form of statements that consumers rate. These responses are aggregated into the following categories:

Adults and Older Adults	Youth and Family
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Quality and Appropriateness	Perception of Outcomes of Services
Perception of Outcomes of Services	Perception of Social Connectedness
Perception of Social Connectedness	Perception of Cultural Sensitivity
Perception of Functioning	Perception of Functioning

The table below details consumer participation in Sonoma County for calendar year 2023.

Consumer Population	Items Scored	Survey Participants
Older Adult	36	31
Adult	36	217
Youth	26	66
Family / Parents of Youth	26	90





Overall, 404 Consumer Perception Surveys were collected in calendar year 2023. In some cases, there were relatively small numbers of consumers who

self-categorized in certain ethnic or racial categories (e.g. Native American, Asian/PI, African-American). As such, the small number of responses limit the generalizability of findings based on racial, ethnic, and gender analysis. This is especially true for the youth, family, and older adult surveys given the lower sample size in those group.

Satisfaction with services varied between the four population groups surveyed. For adults, satisfaction increased across all domains relative to the previous year. Given the large sample size of adult respondents (n=160), this finding is a substantive one. One possible explanation for the increase in satisfaction could be related to the network's return to more in-person service offerings starting in 2022.

Of all four groups analyzed, youth had lowest overall satisfaction scores. Youths and families experienced two years of declining general satisfaction rates, which was most pronounced in both the outcome and perception of functioning domains. Ratings on satisfaction with social connectedness continued to decrease for youth; they were, however, slightly better for families. A promising strength for both youth and families, evident in three years' worth of satisfaction data, pertains to consistently high satisfaction with the cultural appropriateness of youth services. Youth and families consistently score this among the highest domains.

The analysis of satisfaction by gender, ethnicity, and race is complicated by low sample sizes in all but the adult groups. Several observations are worth making, however. First, the number of other-gender respondents increased significantly and dramatically for youth. Approximately 25% of all youth surveys were completed by youth who identified as "other" gender, a 300% increase over the previous year.

Finally, a complex and somewhat contradictory finding relates to satisfaction for mixed-race or multi-racial beneficiaries. Satisfaction scores tended to be below the minimum satisfaction threshold for mixed race adults and youth. By contrast, in parents/families who identified their children as mixed race, satisfaction scores were higher. Furthermore, while mixed race clients had low satisfaction scores generally, they showed high satisfaction with the cultural appropriateness of services. This pattern suggests that while consumers find staff respectful of their cultural identity, the program or service model itself may be less effective in meeting the needs of this group.

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

Despite the challenges faced by the County over the past several years (budget crisis, firestorms, COVID), BHD has managed to gain ground on re-establishing the MHSA Steering Committee and corresponding community engagement in community planning,

relevant committees, and changes in cultural responsiveness of service delivery in PEI, WET, CSS, and Medi-Cal. This community engagement is the primary key that ensures diverse experiences and perspectives shape processes and decision-making.

Furthermore, engaging community members provides for a level of accountability and momentum that could not be achieved if the County were working in isolation. Adopting a Community-Based Participatory Research practice is challenging but rewarding and sustainable. For example, it may not be possible for BHD to hire a workforce that is equally representative of the community in gender, ethnicity, age, or life experience, but engaging a diverse community constituency to serve in various capacities within the mental health system is an achievable goal.

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

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

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

Due to an extended staff vacancy in the Ethnic Services Manager (now the Cultural Responsiveness, Inclusion & Training Coordinator) role, as well as DHS structural changes in creating a DHS Office of Equity and then recruiting and training a DHS Equity Circle, the BHD Cultural Responsiveness Committee had been placed on hold in an effort to ensure that when it restarts, the committee aligns with and can leverage and build on the work done at the department and county levels.

A Sonoma County Office of Equity was established in August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity. The champions in the Department of Health Services, called the DHS Equity Circle, began initial training and planning with DHS leadership to create a Health Equity Action Plan, which was presented to DHS leadership in November 2024 and is awaiting final approval. This plan focuses both on serving the community and on creating workplace conditions in which diverse employees can thrive.

While these structural changes have been taking place, the equity champions within the Behavioral Health Division have formed the Behavioral Health Equity Steering Committee, which began meeting monthly in the summer of 2023.

The BHD Equity Steering Committee comprises four Behavioral Health employees and one liaison from the DHS Office of Equity. The Cultural Responsiveness, Inclusion & Training Coordinator chairs the committee. The group membership is 40% Latinx/Latine, 20% White, 40% mixed race. The committee includes members who are immigrants and members who identify as part of the LGBTQIA+ community. The committee contains both direct-service providers and administrative staff, from multiple job classifications.

The BHD Equity Steering Committee reports to the DHS Equity Circle and DHS Office of Equity, and, as Chair, the Cultural Responsiveness, Inclusion & Training Coordinator reports to the Behavioral Health Division Director. In 2024, this committee organized a series of division-wide trainings on anti-racism, adapted from the County of Sonoma Racial Equity Foundations training. This training had otherwise been available only to managerial staff, and the Behavioral Health Division was proud to pilot it as a training for staff at all levels. The committee further added behavioral-health specific information

and resources to further tailor it to the division.

The committee also focused on imagining a revamped Cultural Responsiveness Committee, deciding to extend invitations beyond existing MHSA contractors and Medi-Cal Specialty Mental Health providers in order to more fully represent the continuum of care for mental health services in Sonoma County. Feedback from the MHSA Community Program Planning process, the Sonoma County Community Health Assessment and Improvement Plan process, and the newly published Sonoma County Agenda for Action from Health Action Together all indicate that while Specialty Mental Health Services are obviously needed, there is a wider sense from the community that "no services are available" at any acuity level. We have received applications for the committee from a wide range of community providers, advocates, and other stakeholders, and we look forward to finding creative and sustainable ways to move forward.

Quality Improvement Committee (QIC)
The Cultural Responsiveness, Inclusion & Training Coordinator regularly attends the monthly Quality Improvement Committee (QIC) meetings. The purpose of QIC is to oversee and be involved in quality improvement activities including policy issues, reviewing and evaluating results of QI activities, instituting needed QI actions, and following up on QI processes. The areas of responsibility for the QIC are to monitor and review consumer relations/outcomes, develop and review the annual QI work plan, review data and work plan activities, and monitor performance improvement projects.

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

The Cultural Responsiveness, Inclusion & Training Coordinator attends QIC, MHSA Steering Committee, and MHSA CPP Workgroup. She facilitates the BHD Equity Steering Committee and will facilitate the Cultural Responsiveness Committee (CRC). She will be kept appraised of the MHSA planning processes.

Criterion 5: Culturally Competent Training Activities

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

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

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

The overall goal of division-wide staff development trainings for fiscal year 23-24 was to establish solid clinical frameworks for evidence-based practices that will improve client outcomes, increase staff efficacy and sustainability, and build foundational skills and mindsets on which BHD can build going forward.

Trainings in cultural humility, equity and anti-racism, and working with trans and gender-expansive populations were offered for all clinical staff, and open to contracted staff, in the spring and summer of 2024. Most of the trainings were recorded so that staff who were not available on the day of the live training, including new staff, could access the trainings later through our on-demand learning management system. (One training was not recorded, at the trainer's request, given that it involved a great deal of sharing about participants' own experiences.)

Relevant trainings so far scheduled for 2025 include a peer-provider–led training on collaborative care, Trauma-Informed Systems 101 (of which equity is a foundational pillar), and Working with BIPOC Clients.

Additionally, the County of Sonoma Office of Equity will open its Racial Equity Foundations training to all staff, not just managers, starting in January 2025, as part of the countywide Racial Equity Action Plan implementation. Quality Management staff in Behavioral Health will also be trained in Anti-Racist Results-Based Accountability (AR-RBA) in order to help lead the roll-out of AR-RBA in the division.

How cultural competence has been embedded into all trainings.

All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation. The staff-development training series for fiscal year 23-24 is explicitly focused on important foundational skills for cultural responsiveness.

2. A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental

Health Board and Commissions; and Community- based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

DATE	TITLE	LENGTH (HOURS)	PRESENTER(S)	AUDIENCE
1/17/2024	Drugs 101 (Harm Reduction)	3	Maurice Byrd, LMFT	BHD & CBO staff
1/30/2024	Assessing & Managing Suicide Risk	6	Serina Sanchez, LMFT	BHD clinical supervisors
3/7/2024	Building the Beloved Community through Cultural Humility	6	Gloria Morrow, Ph.D.	BHD & CBO staff
4/4/2024	Racial Equity 101, Part 1	3	Sonoma County Office of Equity Core Team	BHD staff
5/2/24	Racial Equity 101, Part 2	3	BHD Equity Steering Committee	BHD staff
6/6/24	LGTBQ+ Diversity, Equity, and Inclusion for Healthcare Providers	3	Equality California	BHD & CBO staff
4/2024 – 6/2025	Harm Reduction Monthly Case Consultation Groups	1.5 each month; 22.5 total	Maurice Byrd, LMFT	Whole Person Care and Integrated Recovery Teams
8/15/2024	Care, Safety, and Impact: Protecting from Harm, Considering Involuntary Admission, and Complying with Mandated Reporting in California	3	Lisa Wenninger, Ph.D.	BHD & CBO staff

10/17/2024	Hoarding 101 (Harm-Reduction Approach)	3.5	Dr. Jose Antonio Aguilar and Dr. Danielle Schlichter	BHD & CBO staff
11/2024 & 12/2024	Hoarding Monthly Case Consultation Groups	1 each, 2 total	Dr. Jose Antonio Aguilar and Dr. Danielle Schlichter	Integrated Recovery Team
11/21/2024	Understanding Consent, Confidentiality & Parental Collaboration: Law & Ethics of Working with Minors in California	3	Lisa Wenninger, Ph.D.	BHD & CBO staff

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

Workforce, Education, and Training Plan (WET)

DHS-BHD endeavors to provide a comprehensive workforce education and training program that supports diversity, equity, and inclusion and has both staff training and professional development opportunities available to all staff. WET programming provides workforce training and development opportunities for DHS-BHD staff, contractors, providers, clients/consumers, and family members. Through system-wide workforce training and development initiatives, WET aims to create and sustain a diverse, culturally responsive, and clinically effective workforce that provides the best possible care for Sonoma County communities.

Through the Clinical Practice Guidelines developed for the MHP and DMC-ODS, the principles of cultural humility are cultural awareness will be embedded in the foundational work of the organization. The division's Clinical Practice Guidelines, including available trainings via the Sonoma County learning management system, are below.

Cultural Responsiveness & Humility Trainings

In March 2024, WET funds were used to host a six-hour training by nationally acclaimed

DEI trainer Gloria Morrow, Ph.D., called “Building Beloved Community through Cultural Humility.” The training was open to MHP, SUD, and CBO staff. This training introduced the integration of two powerful concepts, “Building the Beloved Community” and “Cultural Humility” as a strategy for preparing the environment for providing culturally responsive services and helping marginalized clients to heal from racism-related trauma. As staff members are sometimes not working in culturally safe and nurturing environments, this training aimed to help staff by sharing strategies for them to engage in culturally responsive behaviors to create a healthy environment for their co-workers and clients. Finally, service providers are often exposed to secondary trauma when working with traumatized clients, especially those who have experienced racial trauma. The training also included a section on teaching staff the basic steps for practicing self-compassion to help them to better take care of their clients while taking better care of themselves.

Learning objectives included:

- Identifying at least three (3) ways that racism-related trauma impacts the mental, physical, and spiritual well-being of marginalized clients.
- Listing at least three (3) principles of the Beloved Community, and its rationale for effectively meeting the overall health and well-being of those you serve, especially those from marginalized communities.
- Listing at least three (3) threats to building the beloved community.
- Identifying at least three (3) components of cultural humility and its role in building the beloved community.
- Identifying at least three (3) strategies for becoming culturally humble.
- Identifying at least three (3) strategies for Building the Beloved Community through Cultural Humility.
- Listing three (3) ways staff can become more culturally responsive in creating an environment that embodies the principles of diversity, equity, and inclusion.
- Identifying at least five (5) strategies for staff to practice self-compassion.

In April and May 2024, the BHD Equity Steering Committee organized a series of two three-hour division-wide trainings on anti-racism, adapted from the County of Sonoma Racial Equity Foundations training. This training had otherwise been available only to managerial staff, and the Behavioral Health Division was proud to pilot it as a training for staff at all levels. The committee further added behavioral-health specific information and resources to further tailor it to the division. This Racial Equity Foundations training provided an introduction to racial equity, antiracism, and related foundational concepts. Participants developed a shared understanding of core concepts; a shared understanding of the historic and ongoing role of government in upholding structural racism; clarity regarding how racial inequities are experienced by Sonoma County employees and residents; a shared understanding of the Racial Equity and Social Justice pillar of the County’s 5-year Strategic Plan; our role and expectations as public servants and healing professionals; and an understanding of how racial equity efforts advance trauma-informed and healing-centered care. Learning objectives included:

- You will be able to identify at least two ways our roles as public servants and our accountability to the “racial equity and social justice” pillar of Sonoma County guide our work.

- You will be able to name strength-based, person-centered and relational practices.
- You will be able to identify how culture is prevention and how a sense of belonging is a protective factor in trauma theory.
- You will be able to identify ways to use a racial equity lens on our intakes, safety and safety support plans, mental status exam forms, and procedures.
- You will be able to identify at least two ways our roles as public servants and our accountability to the "racial equity and social justice" pillar of Sonoma County guide our work.

Clinical Practice Guidelines

The overall goal of these clinical practice guidelines is to establish solid clinical frameworks for evidence-based and community-defined mental healthcare practices that will improve client outcomes, increase clinical efficacy and sustainability, and build foundational skills and mindsets that allow client-centered work grounded in evidence-based practice.

These clinical foundations are mutually complementary and can (and should) be used in conjunction with each other. These overarching frameworks allow provider to tailor individual interventions and treatment plans to the client's needs, while still working within guidelines that provide direction on clinical techniques, case conceptualization, and desired outcomes.

Sonoma County supports and expects the use of:

- Trauma-Informed Care
- Harm Reduction
- Cultural Humility & Cultural Responsiveness
- Recovery-Oriented Person-Centered Treatment

Trauma-Informed Care

Goal

To provide services and an environment in which clients and providers experience safety, trust, support, collaboration, empowerment, and equity.

Definition

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) says that Trauma-Informed Care in behavioral healthcare settings "includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services."

Principles

Core Principle	Explanation
Safety	Throughout the organization, clients and staff feel physically and psychologically safe.
Trustworthiness & Transparency	Decisions are made with transparency, consistency, respect, and fairness so as to build and maintain trust.
Peer Support	Individuals with lived experiences of trauma are integrated into the organization and viewed as integral to client care.
Collaboration & Mutuality	Power differences between staff and clients and among organizational staff are leveled to support shared decision-making.
Empowerment	Client and staff strengths are recognized, built on, and validated, including a belief in resilience and the ability to heal from trauma.
Cultural Humility & Responsiveness	Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical systemic trauma are recognized and addressed.

Treatment Principles for Providers and Organizations

1. **Promote Trauma Awareness and Understanding.** Recognize the prevalence of trauma and its possible role in your client's life.

2. **Recognize That Trauma-Related Symptoms and Behaviors Originate from Adapting to Traumatic Experiences.** View your client's responses to the impact of trauma as adaptive—regard the client's presenting difficulties, behaviors, and emotions as responses to surviving trauma.

3. **View Trauma in the Context of the Client's Environment.** Consider the context in which the trauma(s) occurred.

4. **Minimize the Risk of Retraumatization or Replicating Prior Trauma.** Take practical steps to reexamine treatment strategies, program procedures, and organizational polices that could cause distress or mirror common characteristics of traumatic experiences.

5. **Create a Safe Environment.** Be responsive in adapting the treatment environment to establish and support the client's sense of physical and emotional safety.

6. **Identify Recovery from Trauma as a Primary Goal.** Remember that your client is less likely to experience recovery in the long run if treatment for mental and substance use disorders does not address the role of trauma.

7. **Support Control, Choice, and Autonomy.** Create opportunities for empowerment; doing so may help reinforce your client's sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions.

8. **Create Collaborative Relationships and Opportunities for Participation**. Remember to shift the perspective from, "We, the providers, know best" to the more collaborative, "Together, we can find solutions." Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued.

9. **Familiarize the Client with Trauma-Informed Services.** Explain the value and type of trauma-related questions that may be asked as part of the intake process, educate clients about trauma to help normalize traumatic stress reactions, and discuss the rationale behind specific interventions.

10. **Incorporate Universal Routine Screenings for Trauma.** Universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence on a client's interactions and engagement with services. As stated above, explain the value and type of trauma-related questions that may be asked, and inform clients how this information could be useful in their treatment. You may also invite clients to complete such screenings on their own or with trusted support people and then share the information with you if they choose.

11. **View Trauma Through a Sociocultural Lens**. Understand that culture influences the interpretation and meaning of traumatic events and the acceptability of symptoms, support, and help-seeking behaviors.

12. **Use a Strengths-Focused Perspective: Promote Resilience.** Focus on the client's strengths. Shift the focus from, "What is wrong with you?" to, "What has happened to you? What has worked for you?"

13. **Foster Trauma-Resistant Skills.** Focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence.

14. **Show Organizational and Administrative Commitment to Trauma-Informed Care.**

15. **Develop Strategies To Address Secondary Trauma and Promote Self-Care**. Remember that the demands of providing care to trauma survivors cannot be ignored; secondary trauma is a normal occupational hazard for behavioral health service providers.

16. **Provide Hope—Recovery Is Possible.**

Where To Learn More

- "Trauma Informed Systems 101" through Trauma Transformed's learning management platform
- Relias Courses
    - A Client's Experience of Trauma-Informed Care
    - Addressing Behavioral Health Needs of Veterans
    - Addressing Racial Trauma in Behavioral Health

    - Addressing Trauma and Stressor Related Disorders
    - An Introduction to Trauma-Informed Care
    - An Overview of Trauma Disorders in Adults for Paraprofessionals
    - An Overview of Trauma-Informed Care for Non-Clinical Staff
    - Assessing and Screening for Suicide Risk
    - Assessment and Intervention for Trauma in Early Childhood (0-4)
    - Behavioral Health Leaders: Implementing Trauma-Informed Leadership
    - Disaster Behavioral Health: Public Health Emergencies, Trauma, and Resilience
    - Effective Intervention in the Aftermath of a Suicide
    - Engaging Family Members in Crisis Planning
    - Impact of Psychological and Physical Trauma
    - Implementation of Trauma-Informed Care Systems
    - Overview of How Behavioral Health Disorders are Impacted by Trauma
    - Self-Care Strategies for Frontline Professionals
    - The Influence of Trauma on Substance Use
    - Trauma-Informed Care Delivery for Clinicians and Peer Support Specialists
    - Traumatic Stress Disorders in Children and Adolescents
    - Treating Posttraumatic Stress Disorder
    - Understanding Trauma in Early Childhood (0-4)
    - Understanding Trauma-Informed Care
    - Working More Effectively with LGBTQ+ Children and Youth
    - Working with Children and Adolescents Exposed to Violence and Disasters
- "Trauma-Informed Care in Behavioral Health Services" from SAMHSA: https://store.samhsa.gov/product/tip-57-trauma-informed-care-behavioral-health-services/sma14-4816
- "Trauma-Informed Care in Behavioral Health Services KAP Keys for Clinicians" from SAMHSA: https://store.samhsa.gov/sites/default/files/sma15-4420.pdf

Evidence to Support Its Use
The United States Substance Abuse and Mental Health Services Administration (SAMHSA) includes Trauma-Informed Care in Behavioral Health Services as a Treatment Improvement Protocol (TIP), which are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements, and are considered a consensus on best practices.

Harm Reduction

Goal
To support clients in reduce substance use and other risky activities

Definition
SAMHSA says that “harm reduction is an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives. Harm reduction is a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy. Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of people who use drugs, especially those in underserved communities, in these strategies and the practices that flow from them.”

Principles
Core Principles

1. **Harm Reduction is led by people who use drugs (PWUD) and with lived experience of drug use.** Work is led by PWUD and those with lived and living experience of drug use. Harm reduction interventions that are evidence based have been innovated and largely implemented by PWUD. Through shared decision-making, people with lived experience are empowered to take an active role in the engagement process and have better outcomes. Put simply, the effectiveness of harm reduction programs is based on the buy-in and leadership of the people they seek to serve.

2. **Harm Reduction embraces the inherent value of people.** All individuals have inherent value and are treated with dignity, respect, and positive regard. Harm reduction initiatives, programs, and services are trauma informed, and never patronize nor pathologize PWUD, nor their communities. They acknowledge that substance use happens, and the reasons a person uses drugs are nuanced and complex. This includes people who use drugs to alleviate symptoms of an existing medical condition.

3. **Harm Reduction commits to deep community engagement and community building.** All communities that are impacted by systemic harms are leading and directing program planning, implementation, and evaluation. Funding agencies and funded programs support and sustain community cultural practices, and value community wisdom and expertise. Agencies and programs develop through community-led initiatives focused on geographically specific, culturally based models that integrate language revitalization, cultural programming, and Indigenous care with dominant-society healthcare approaches.

4. **Harm reduction promotes equity, rights, and reparative social justice.** All aspects of the work incorporate an awareness of (and actively work to eliminate) inequity related to race, class, language, sexual orientation, and gender-based power differentials. Pro-health and pro-social practices that have worked well for specific cultural and/or geographic communities are aligned with organizing and mobilizing, providing direct services, and supporting mutual aid among PWUD.

5. **Harm reduction offers the most accessible and noncoercive support.** All harm reduction services have the lowest requirements for access. Participation in services is always voluntary, self-directed, and free from threats, force, and the concept of compliance. Any data collection requires informed consent and participants should not be denied services for not providing information.

6. **Harm reduction focuses on any positive change, as defined by the person.** All harm reduction services are driven by person-centered positive change in the individual's quality of life. Harm reduction initiatives, programs, and services recognize that positive change means moving towards more connectedness to the community, family, and a more healthful state, as the individual defines it. There are many pathways to wellness; substance use recovery is only one of them. Abstinence is neither required nor discouraged.

Treatment Principles

- **Respect autonomy.** Each individual is different. It is important to meet people where they are, and for people to lead their own individual journey. Harm reduction approaches, initiatives, programs, and services value and support the dignity, personal freedom, autonomy, self-determination, voice, and decision making of PWUD.

- **Practice acceptance and hospitality.** Love, trust, and connection are important in harm reduction work. Harm reduction approaches and services hold space for people who are at greatest risk for marginalization and discrimination. These elements emphasize trusting relationships and meaningful connections and understand that this is an important way to motivate people to find personal success and to feel less isolated.

- **Provide support.** Harm reduction approaches, initiatives, programs, and services provide information and support without judgment, in a manner that is non-punitive, compassionate, humanistic, and empathetic. Peer-led services enhance and support individual positive change and recovery; and peer-led leadership leads to better outcomes.

- **Connect with community.** Positive connections with community, including family members (biological or chosen) are an important part of well-being. Community members often assist loved ones with safety, risk reduction, or overdose response. When possible, harm reduction initiatives, programs, and services support families in expanding and deepening their strategies for love and support; and include families in services, with the explicit permission of the individual.

- **Provide many pathways to well-being across the continuum of health and social care.** Harm reduction can and should happen across the full continuum of health and social care, meeting whole-person health and social needs. In networking with other providers, harm reduction services work to build relationships and trust with health and social care partners that embrace

supporting principles. To help achieve this, organizations practicing harm reduction utilize education and encourage policies that facilitate interconnectedness between all parties.

- **Value practice-based evidence and on-the-ground experience.** Structural racism and other forms of discrimination have limited the development and inclusion of research on what works in underserved communities. Harm reduction initiatives, programs, and services understand these limitations and use community wisdom and practice-based evidence as additional sources of knowledge.

- **Cultivate relationships.** Relationships are of central importance to harm reduction. Harm reduction approaches, initiatives, programs, and services are relational, not transactional, and work to establish and support quality relationships between individuals, families, and communities.

- **Assist, not direct.** Harm reduction approaches, initiatives, programs, and services support people on their journey towards positive change, as they define it. Support is based on what PWUD identify as their needs and goals (not what programs think they need), offering people tools to thrive.

- **Promote safety.** Harm reduction approaches, initiatives, programs, and services actively promote safety as defined by the people they serve. These efforts also acknowledge the impact that law enforcement can have on PWUD (particularly in historically criminalized and marginalized communities) and provide services accordingly.

- **Engage first.** Each community has different cultural strengths, resources, challenges, and needs. Harm reduction approaches, initiatives, programs, and services are grounded in the most impacted and marginalized communities. It is important that meaningful engagement and shared decision making begins in the design phase of programming. Equally important is bringing to the table as many individuals and organizations as possible who understand harm reduction and who have meaningful relationships with the affected communities.

- **Prioritize listening.** Each community has its own unique story that can be the foundation for harm reduction work. When we listen deeply, we learn what matters. Harm reductionists engage in active listening — the act of inviting people to express themselves completely, recognizing the listener's inherent biases, with the intent to fully absorb and process what the speaker is saying.

- **Work toward systems change.** Harm reduction approaches, initiatives, programs, and services recognize that trauma; social determinants of health, such as access to healthcare, housing, and employment; inequitable policies; lack of prevention and early intervention strategies; and social support have all had a responsibility in systemic harm.

Where To Learn More

- Relias Courses
  - Harm Reduction in Substance Use
  - Biopsychosocial Model of Substance-Related and Addictive Disorders
  - Assessment and Treatment of Methamphetamine Use Disorder (includes both harm reduction and cognitive-behavioral approaches)
- Harm Reduction Framework from SAMHSA: https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf
- National Harm Reduction Coalition Online Training Institute: https://harmreduction.org/our-work/training-capacity-building/online-training-institute/

Evidence to Support Its Use

At the federal level, the Biden-Harris Administration has identified harm reduction as a federal drug policy priority. SAMHSA describes harm reduction as "an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives." Harm-reduction strategies are shown to substantially reduce HIV and Hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment. In line with this, harm reduction is one of the four strategic priorities of the U.S. Department of Health and Human Services (HHS) Overdose Prevention Strategy. At the state level, the harm-reduction framework is required by our MHSA Full-Service Partnerships, as described by the *Full Service Partnership Tool Kit*. Skills in harm-reduction therapy are also a required part of licensure as a mental-health therapist in California; clinical interventions to reduce harm are a required competency for Marriage and Family Therapist and Clinical Social Worker licensure. Providing support and training in harm-reduction therapy is therefore a supervisory ethical requirement for our system of care.

Harm-reduction therapy is supported at the federal and state level as the standard of care for clients who have issues with substance use.

Cultural Humility & Cultural Responsiveness

Goal

To meet the principal CLAS standard of providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Definition

"Cultural humility involves an ongoing process of self-exploration and self-critique combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are," according to Katherine Yeager and Susan Bauer-Wu, who brought the concept forward in 2013.

The National Association of Social Workers "promotes and supports the

implementation of cultural and linguistic competence at three intersecting levels: the individual, institutional, and societal. Cultural competence requires social workers to examine their own cultural backgrounds and identities while seeking out the necessary knowledge, skills, and values that can enhance the delivery of services to people with varying cultural experiences associated with their race, ethnicity, gender, class, sexual orientation, religion, age, or disability [or other cultural factors]."

Principles

Core Principles

1. The focus of cultural competence, in practice, has historically been on individual providers. However, counselors will not be able to sustain culturally responsive treatment without their organization's commitment to support and allocate resources to promote these practices.
2. An understanding of race, ethnicity, and culture (including one's own) is necessary to appreciate the diversity of human dynamics and to treat all clients effectively.
3. Incorporating cultural competence into treatment improves therapeutic decision-making and offers alternative ways to define and plan a treatment program that is firmly directed toward progress and recovery—as defined by both the counselor and the client.
4. Consideration of culture is important at all levels of operation—individual, programmatic, and organizational—across behavioral health treatment settings. It is also important at every treatment phase: outreach, initial contact, screening, assessment, placement, treatment, and continuing care and recovery support.
5. Achieving cultural competence in an organization requires the participation of racially and ethnically diverse groups and underserved populations in the development and implementation of culturally responsive practices, program structure and design, treatment strategies and approaches, and staff professional development.
6. Public advocacy of culturally responsive practices can increase trust among the community, agency, and staff. The community is thus empowered with a voice in organizational operations.

Treatment Competencies

Cultural responsiveness is not a discrete skill set or set of knowledge but requires ongoing self-evaluation on the part of the provider. Culturally responsive providers are aware of their own cultural groups and of their values, assumptions, and biases regarding other cultural groups, and they strive to understand how these factors affect their ability to provide culturally effective services to clients.

Culturally responsive providers develop and use the following skills:

- Self-Knowledge, including
    - Awareness of one's own cultural background
    - Understanding the process by which racial, ethnic, and cultural identity develops
    - How one's own cultural worldview influences interactions both inside and outside of providing services
    - Awareness of one's own stereotypes, prejudices, and history

    - Understanding of the impact of a provider's role and status within the client-provider relationship
- Knowledge of Other Cultural Groups, including
    - Communication patterns
    - Values
    - Gender roles
    - Clinical presentations of distress
    - Counseling expectations
    - Behavioral norms and expectations in and outside the counseling session (e.g., touching, greetings, gift-giving, level of formality between counselor and client)
- Cultural Knowledge of Behavioral Health

Treatment Skills

To provide culturally responsive care, providers need to:

- Develop a positive attitude toward learning about multiple cultural groups.
- Invest in ongoing learning and the pursuit of culturally congruent skills.
- Demonstrate commitment to cultural competence by behaviors that reflect attitudes of:
    - Respect
    - Acceptance
    - Sensitivity
    - Commitment to equality
    - Openness
    - Humility
    - Flexibility
- Frame issues and provide interventions in culturally appropriate ways.

Where To Learn More

- Relias Courses
    - A Multicultural Approach to Recovery-Oriented Practice
    - An Overview of the Social Determinants of Health
    - Cultural Awareness and Humility
    - Cultural Competence and Healthcare
    - Cultural Competence for Supervisors
    - Cultural Considerations Related to Suicide
    - Cultural Diversity and the Older Adult
    - Cultural Humility and Implicit Bias in Behavioral Health
    - DEI: An Introduction to Multicultural Care
    - DEI: Multicultural Care for the Clinician
    - DEI: Multicultural Care for the Organization
    - Diversity, Equity, and Inclusion for the Healthcare Employee
    - Implicit Bias for the Healthcare Professional
    - Implicit Bias in Healthcare
    - Improving Behavioral Health Equity: Children, Adolescents, and Emerging Adults
    - Improving Behavioral Health Equity: Immigrant and Refugee Populations
    - Improving Behavioral Health Equity: Individuals Living in Rural or

Remote Communities
    - Improving Behavioral Health Equity: Individuals Living in Poverty
    - Improving Behavioral Health Equity: Individuals with Asian American Identities
    - Improving Behavioral Health Equity: Individuals with Black or African-American Identities
    - Improving Behavioral Health Equity: Individuals with Hispanic and Latine Identities
    - Improving Behavioral Health Equity: Individuals with Intellectual or Developmental Disabilities
    - Improving Behavioral Health Equity: Individuals with Marginalized Ethnic Identities
    - Improving Behavioral Health Equity: Individuals with Physical Disabilities
    - Improving Behavioral Health Equity: Individuals with Tribal, Indigenous, or Native Identities
    - Improving Behavioral Health Equity: People Who Are LGBTQ+
    - Improving Behavioral Health Equity: People Who Are Transgender and Nonbinary
    - Improving Behavioral Health Equity: Spiritual and Religious Diversity
    - Improving Behavioral Health Equity: Veterans
    - Improving Behavioral Health Equity: Women
    - Influence of Culture on Care in Behavioral Health for Paraprofessionals
    - Introduction to Cultural Variations in Behavioral Health for Paraprofessionals
    - Overcoming Barriers to LGBTQ+ Affirming Behavioral Health Services
    - Psychotherapy Skills: Addressing Cultural Differences with Humility
    - Racial Equity 101, Part 1
    - Racial Equity 101, Part 2
    - Strategies and Skills for Behavioral Health Interpreters
    - Substance Use Treatment and Relapse Prevention for Marginalized Populations
    - Understanding and Minimizing Cultural Bias for Paraprofessionals
    - Working More Effectively with LGBTQ+ Children and Youth
    - Your Role in Workplace Diversity
- "Standards and Indicators for Cultural Competence in Social Work Practice," from NASW: https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-and-Indicators-for-Cultural-Competence-in-Social-Work-Practice
- "Improving Cultural Competence: TIP 59" from SAMHSA: https://store.samhsa.gov/sites/default/files/sma14-4849.pdf
- "Improving Cultural Competence Quick Guide for Clinicians" from SAMHSA: https://store.samhsa.gov/sites/default/files/sma16-4931.pdf

Evidence to Support Its Use

Culturally responsive care is required through our contract with DHCS and are monitored during Triennial audits. Using the framework of cultural humility decenters the idea of "normal populations" and "marginalized populations" and allows us all to examine our experiences, identities, and beliefs so that we may better develop

partnerships with others.

Recovery-Oriented Person-Centered Treatment

Goal
To support individuals improving their health and wellness, living a self-directed life, and striving to reach their full potential.

Definition
SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" and identifies four major dimensions that support a life in recovery: health, home, purpose, and community.

Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery. A person's recovery is built on their strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members.

The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

The Four Major Dimensions of Recovery are:

- Health: Overcoming or managing one's disease(s) or symptoms and for everyone in recovery making informed, healthy choices that support physical and emotional well-being.
- Home: Having a stable and safe place to live.
- Purpose: Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community: Having relationships and social networks that provide support, friendship, love, and hope

Principles

- **Informed Consent.** A foundational principle in all healthcare and required by medical law and ethics, informed consent involves patient agreement to treatment including the provider's full disclosure of all pertinent information. This includes disclosure of the risks and benefits of treatments, options and choices for treatment approaches, the patient's role in treatment, their right to refuse treatment and a clear appreciation and understanding by the patient of the facts, implications, and consequences of an action.

- **Person-Centered Planning.** Moving beyond treatment or care planning, person-centered planning is a set of collaborative approaches to assist an individual to plan their services and supports by identifying their self-defined,

individualized goals. Person-centered planning is directed by the person to discover and act on what is important to their values, preferences, relationships, and other factors that respect their chosen pathways to recovery. It is driven by the individual receiving care, with whomever they choose, which may include family members, friends, advocates, or others to develop a plan based on community living and improved quality of life.

- **Shared Decision Making.** Shared decision-making builds on informed consent, whereby the person and provider are acknowledged for their expertise with both contributing to the medical decision-making process. In this approach, providers explain treatment options and alternatives and help the patient choose the option that best aligns with the person's preferences as well as their unique cultural and personal beliefs. Choices are then included in the person-centered plan. Shared decision-making aids can assist the patient to work with the provider to choose the best treatment option.

- **Relationship Building.** Effective recovery-oriented and trauma-informed services and treatment are based on respectful and trusted relationships that meaningfully establish a therapeutic alliance that can lead to healing and problem solving. Developing effective relationships requires engaging with the person to understand the "story" of their journey, their strengths, values, preferences, family, and social factors.

- **Respectful Communication.** The foundation of effective working relationships is honest and trust-based communication. By their communications and actions, providers should demonstrate that they value and respect the individual being served. Jargon should be avoided as well as judgmental and authoritative approaches.

- **Trauma-Informed.** Effective care seeks to recognize and respond to trauma experienced by those being served. Trauma is often a common precursor to mental health and substance use conditions. Interventions such as seclusion and restraint can break trust, are often unsafe and, in fact, can re-traumatize individuals seeking help. Trauma-informed care seeks to provide a care environment that focuses on safety and trust.

- **Least Restrictive.** The *L.C. vs. Olmstead* U.S. Supreme Court decision stipulated that people with disabilities, including those with behavioral health conditions, have a right to a life in the community. Recovery-oriented care promotes individuals to pursue independence and community integration. Institutional and coercive care are to be avoided whenever possible and individuals and families are provided with the services needed to live in home and community-based settings.

- **Engagement.** Engaging the person and their chosen supporters, or family into care and recovery are key for people starting and maintaining their journeys of healing. Peer and family support can assist recovery by providing hope and role models who demonstrate that recovery is possible. Peer support includes being consistently and compassionately present with and for

the person and believing in their capacity for recovery. Developing respectful, trust-based relationships is critical to creating an environment in which the person can talk openly and honestly to activate recovery. Other approaches such as motivational interviewing can be helpful.

- **Resilience and Strengths-Based.** Care providers must identify and build on the strengths, skills, resources, and knowledge of the person being served and their families. This includes recognizing and valuing the resilience of people to manage and persevere in the face of major life challenges.

- **Culturally Centered.** Understanding culture is critical in promoting effective healing practices for individuals, families, and communities. Providers must practice cultural humility and learn about the history, beliefs, language, practices, and values of those they serve. Care delivery should be congruent with and build on the person's cultural preferences.

- **Wellness Focused and Whole Person Care.** Recovery is holistic and integrative of the multiple options for a person's life that promote healing and wellness. This includes a focus on the 4 pillars that support recovery: health, home, purpose, and community, as well as the 8 dimensions of wellness: emotional, physical, occupational, social, spiritual, intellectual, environmental, and financial.

- **Harm Reduction.** Care providers must meet individuals "where they are" and promote practices that can assist an individual in their present situation based on their needs and preferences. This includes providing harm reduction services to help save lives.

- **Peer and Family Support.** Peer and family support are essential to recovery-oriented care. Having shared lived experience: peers and families can provide authentic mutual support, systems navigation, education, and more. Peer support specialists work with care providers (or not) to promote whole person care. Providers should understand, recognize, and respect the roles and responsibilities of peers to work with peer provided recovery support services.

- **Recovery-Oriented System of Care.** A Recovery -Oriented Systems of Care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve recovery and improve wellness, and quality of life for those served.

Where To Learn More

- Relias Courses
  - A Multicultural Approach to Recovery-Oriented Practice
  - Approaches to Person-Centered Planning in Behavioral Health
  - Etiology, Symptoms, and Recovery-Focused Interventions for Schizophrenia
  - Peer Support in Substance Use Recovery

- Recovery Principles and Practices in Behavioral Health Treatment
- Recovery-Oriented Community Inclusion and Social Determinants of Health
- Self-Advocacy and Recovery for Persons with Mental Health Disorders
- Supporting Persons with Serious Mental Illness toward Recovery
- Understanding Psychosocial Rehabilitation and Recovery-Oriented Practice

- "Recovery-Oriented, Person-Centered Behavioral Treatment" from SAMHSA: https://store.samhsa.gov/sites/default/files/recovery-oriented-fact-sheet-pep24-08-003.pdf
- Peer Recovery Center of Excellence: https://peerrecoverynow.org/
- National Empowerment Center: https://power2u.org/

Evidence to Support Its Use
An editorial in *The Psychiatrist*, published by Cambridge University Press in 2018, reviewed several studies on the effectiveness of empowerment and the recovery model. They conclude, "The recovery model refers both to subjective experiences of optimism, empowerment and interpersonal support, and to the creation of positive, recovery-oriented services. Optimism about outcome from schizophrenia is supported by the research data. One of the most robust findings in schizophrenia research is that a substantial proportion of those with the illness will recover completely and many more will regain good social functioning. Much recent research suggests that working helps people recover from schizophrenia and advances in vocational rehabilitation have made this more feasible. A growing body of research supports the concept that empowerment is an important component of the recovery process and that user-driven services and a focus on reducing internalized stigma are valuable in empowering the person with schizophrenia and improving the outcome from illness."

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

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

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

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency

Sonoma County BHD is in the planning process for a training in February 2025 on client culture, organized and presented by leaders in the county peer provider community. As the division continues to rebuild its relationship with the local peer provider community, as detailed under the section the Peer Advisory Council, BHD remains committed in

following the lead of these community members on needed training content and to assume their expertise in assessing and delivering it.

Required trainings held in the past were responsive to both staff surveys and input from community providers. Peer panels and Latinx/Latine focused staff development has been a mainstay of the annual training plan(s). Moving forward, DHS-BHD will use multiple strategies to ensure staff receive trainings that will continue to include bringing together all staff via Zoom or in person. With the Relias learning management system, staff have access to trainings that are tailored specifically for their job, or to particular client populations, making cultural responsiveness training more relevant to their particular work.

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

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

The Sonoma County DHS-BHD Workforce Education and Training (WET) plan seeks to realize some of the Organizational Excellence and Racial Equity and Social Justice goals of the Sonoma County Board of Supervisors approved a Five-Year Strategic Plan (2021-26), with specific focus on the goals of:

- Fostering an organizational culture in DHS-BHD that supports the commitment to achieving racial equity
- Implementing strategies to diversify the behavioral health workforce to ensure representation the behavioral health workforce reflect the County demographics at all levels of the organization
- Becoming an employer of choice with a diverse workforce that reflects our community and with a positive work culture that results in engaged and developed employees

Specifically, DHS-BHD is using MHSA funds to develop and implement a WET program designed to enhance the public behavioral health workforce with programs and activities that shall address workforce shortages and deficits to:

1. Conduct outreach, recruit, hire, employ, train and develop, retain, and create promotional opportunities for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of behavioral health service consumers seeking to work in the public behavioral health system.
2. Recruit, hire, employ, train, and create promotional opportunities for people with lived experience and their family members in DHS-BHD.
3. Educate the public behavioral health system workforce on incorporating culturally responsive, clinically appropriate evidence-based and community-defined practices that align with the general standards for the implementation of State Drug Medi-Cal and the Mental Health Plan.

Trauma-Informed Systems Transformation

A significant investment in workforce retention is our Trauma-Informed Systems Transformation project. This project is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and these values will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work.

A 2022 DHS workforce survey found that having a sense of belonging in the department was significantly less for employees of color than for White employees. In December of 2023, BHD launched an organizational assessment (Tools for Trauma-Informed

Worklife, or TTIW) to help identify, and then target, areas of concern for employees regarding organizational culture. While overall employees rated the division high in understanding cultural responsiveness and humility, further listening sessions demonstrated that employees of color did not share this view. Additionally, the assessment found that BHD had room for improvement in the areas of collaboration and empowerment and for staff's sense of safety and stability.

Given the continued disparity between White employees' job satisfaction and sense of belonging and that of employees of color, we are assuming that these other areas identified (collaboration & empowerment and safety & stability) are likewise disproportionately affecting staff of color. Our Trauma-Informed Systems Transformation initiative, therefore, is working to improve our workplace culture for all, especially for BIPOC employees.

As part of this systems transformation, BHD partnered with Trauma Transformed, the only regional center and clearinghouse in the Bay Area dedicated to promoting a trauma-informed system of care. BHD and Trauma Transformed have provided training in "Trauma Informed Systems 101" to 77% of our staff, through in-person, virtual, and recorded trainings, and BHD is working to provide this training on-demand to staff in calendar years 2025 and 2026. Trauma Transformed administered the Tools for a Trauma Informed Worklife (TTIW) organizational assessment, which had a 62% completion rate. Additionally, BHD sponsored two cohorts of a "Leadership Learning Community" training series for division management, which were six monthly two-hour sessions on trauma-informed leadership. As equity is considered one of the six "pillars" of trauma-informed systems, all of this work incorporated, explicitly and/or foundationally, equity, especially racial equity.

Once the TTIW organizational assessment was complete, BHD worked with Trauma Transformed to create a Trauma-Informed Leadership Team (TILT), which is a cross-divisional group of "trauma-informed champions" who are meeting monthly. Applications were open to everyone, and the finalized TILT was a cross-sectional team in terms of job classifications, race and gender, and populations served. The CRIT Coordinator and Behavioral Health Division Director are both heavily involved in the TILT, ensuring that the group's insights are transmitted to leadership. The TILT used data from both the TTIW and the 2022 DHS workforce survey to develop goals for division input. The identified priorities fell into broad categories of racial equity and inclusion, collaborative decision-making, and staff retention more broadly. DHS is asking our Board of Supervisors to extend our contract with Trauma Transformed for another two years to continue this work.

Sonoma County Racial Equity Action Plan and DHS Health Equity Action Plan
A significant development worth noting is the establishment of a countywide Office of Equity on August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity; the champions within the Behavioral Health Division constitute the Behavioral Health Equity Steering Committee, which began meeting in the summer of 2023.

As mentioned previously, in July 2024, the Sonoma County Board of Supervisors passed the Sonoma County Racial Equity Action Plan. The goal of the plan is for all County staff, especially staff of color, to feel a sense of belonging and be supported to achieve their career goals within the County organization. To achieve this goal, the plan identifies three main strategies:

- Strategy 1: County creates capacity for equity work and expands pipelines for hiring and career advancement.

- Strategy 2: County offers support and creates accountability for management at all levels to develop an understanding of racial equity

- Strategy 3: County invests in data collection and reporting systems to drive change that is responsive to staff experiences.

Sub-strategies focus on creating and funding equity positions; examining and rewriting job descriptions to remove artificial barriers; providing racial equity trainings to managers and including those competencies in their evaluations; providing disaggregated data on recruitment, hiring, promotions, and turnover rates; conducting yearly staff satisfaction surveys; and rolling out Anti-Racist Results-Based Accountability trainings.

The Department of Health Services has subsequently drafted a Health Equity Action Plan, based on the model of the countywide Racial Equity Action Plan, to particularize goals to this department. The department plan was presented to DHS leadership in November 2024 and is awaiting final approval. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

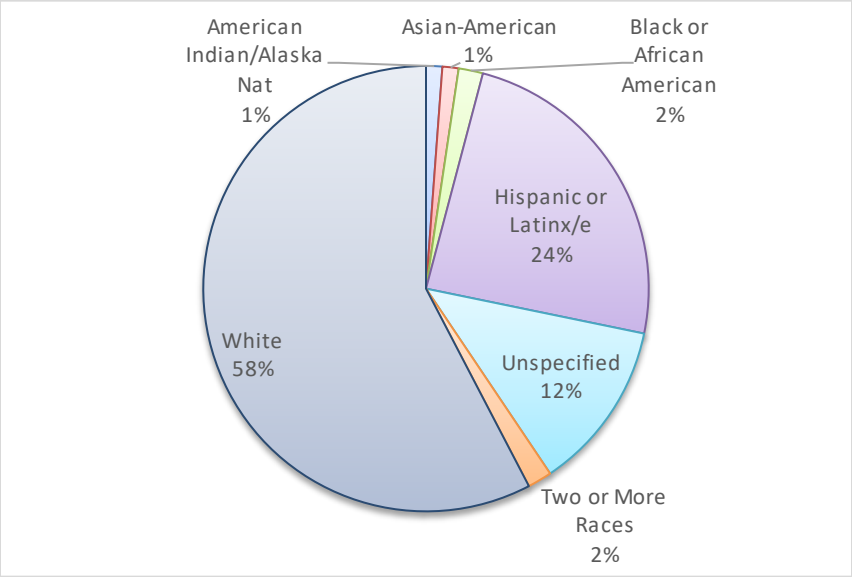
YFS Bilingual Latinx Empowerment Group
Grass-roots efforts to support staff of color have also started. Youth and Family Services (YFS) staff have started the YFS Bilingual Latinx Empowerment Group, to value, support, and encourage bilingual Latinx/e staff. The group is explicitly focused on staff retention and in creating a sense of belonging and community for bilingual Latinx/e staff. Meetings are facilitated in Spanish, and group members facilitate networking, provide mentoring, and offer a space to share experiences, debrief, and process trauma within the workplace.

Current Behavioral Health Workforce Demographics
The Sonoma County Five-Year Strategic Plan provides the context for its departments to inform policies and projects to prioritize over the next five years. Sonoma County chose to focus a strategic pillar on Racial Equity and Social Justice. The Board states, “Sonoma County’s collective well-being and prosperity are impacted by significant racial inequities. By focusing on racial equity and social justice within the Strategic Plan, the Board of Supervisors can begin to institutionalize equity and address disparate impacts on people of color both internally and as an organization and in the community.” Data shows that the greatest disparities occur along racial and socio-economic lines. If Sonoma County wants to start closing those gaps, we have to start there. Research and best practices nationally show that successful equity programs begin with a focus on

race. This sort of "targeted universalism" allows the development of a framework that centers the people most likely to be affected by disparities in ways that have been shown to improve conditions for people in all categories, including sexual orientation and gender.

Sonoma County Human Resources provided the information about DHS-BHD's current workforce in the tables below. There are 340 employees.

Race and Ethnicity	BH Workforce		Sonoma County	
	#	%	Residents[12]	Medi-Cal Population
American Indian/Alaska Native	4	1.18%	2.3%	**1%**
Asian American	4	1.18%	5.4%	**3.1%**
Native Hawaiian and Pacific Islander	0	0%		
Black or African-American	6	1.76%	2.2%	**1.6%**
Hispanic or Latinx/Latine	82	24.12%	28.9%	**40%**
White	196	57.65%	85.7%	**27.7%**
White (alone, not Hispanic or Latinx)	-	-	60.6%	-
Two or More Races	6	1.76%	4.4%	-
Unspecified/Not Reported	**42**	**12.35%**	-	**26.7%**

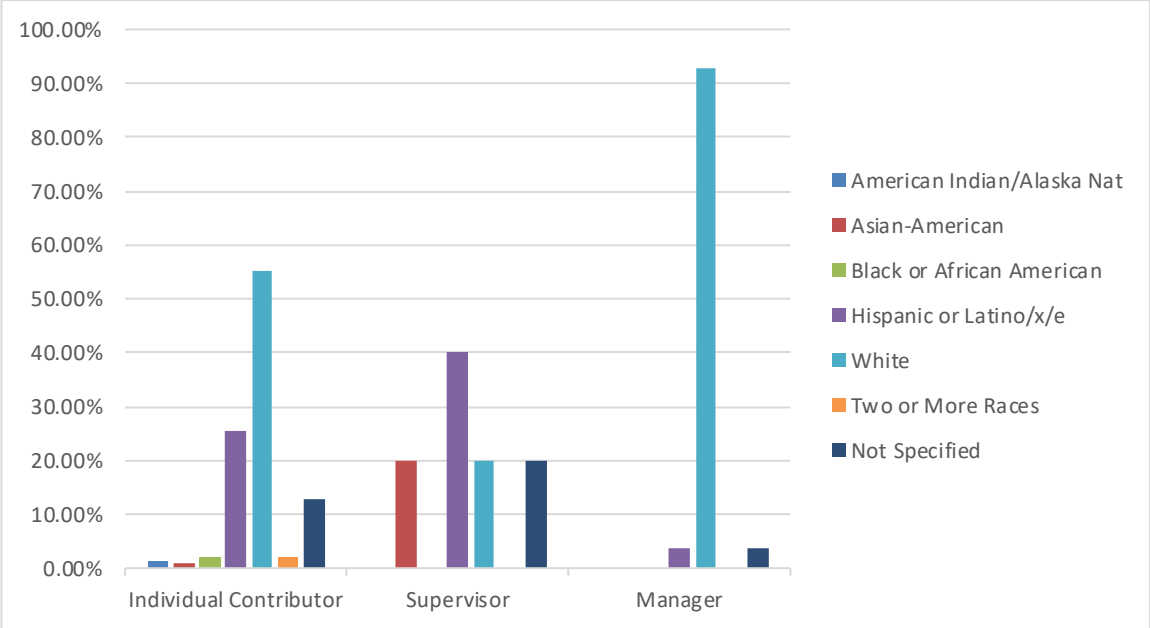


Data from these two charts indicates that while the division's Hispanic/Latinx/Latine workforce is becoming close to representational for Sonoma County as a whole, it remains underrepresented as compared to Medi-Cal eligibility. The Asian-American, Pacific Islander, and Native Hawaiian workforce is also underrepresented. Reducing the disparity in representation continues to be a high priority in staff recruitment for the division, as well as the County as a whole.

[12] 2022 U.S. Census

Behavioral Health Workforce by Job Class and Race/Ethnicity
When presented by reporting level, the racial and ethnic disparities in the Sonoma County Behavioral Health workforce become starker. Based on the most recent data (December 2024) from the Sonoma County Human Resources Department, White employees are 92.59% of the 27 total managers in the division, with only 3.7% Latinx/Latine and 3.70% unspecified. These numbers have gotten more disproportionate since the 2023 data. While Latinx/Latine and Asian employees each constitute 40% and 20% of the supervisors in the division, respectively, please note that there are only five supervisor-level positions in total.

Reporting Level	American Indian / Alaska Native	Asian-American	Black/African-American	Hispanic or Latinx / Latine	White	Two or More Races	Not Specified
Individual Contributor	1.30%	0.97%	1.95%	25.65%	55.19%	1.95%	12.99%
Supervisor	0%	20%	0%	40%	20%	0%	20%
Manager	0%	0%	0%	3.70%	92.59%	0%	3.70%



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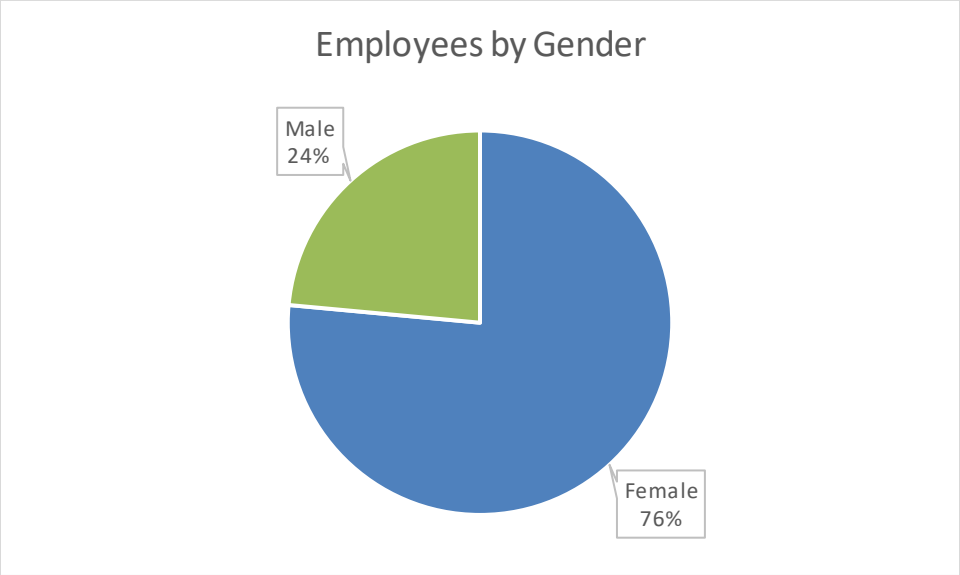
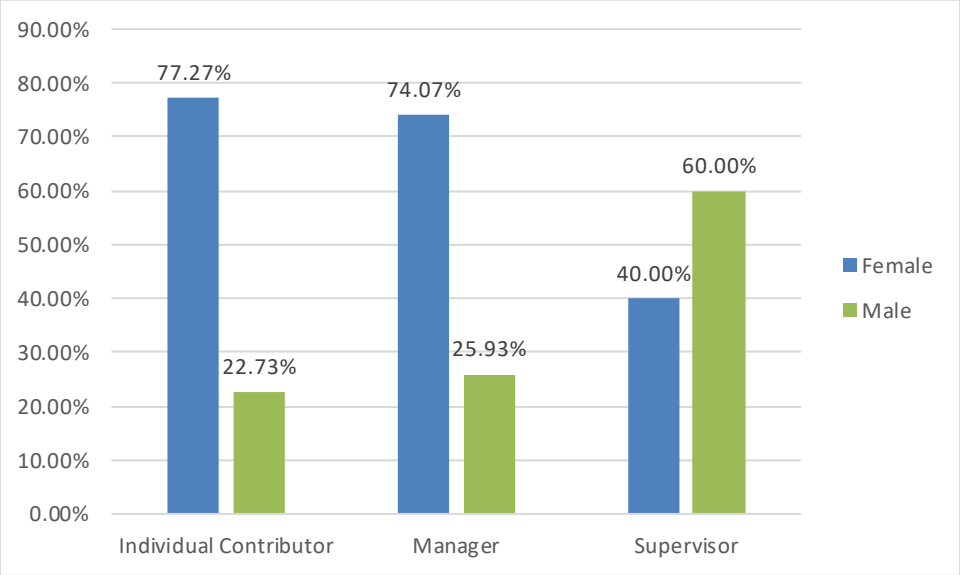
Gender
Upon hire, the County asks gender identity of its incoming staff. Unfortunately, the County only provides two categories, male and female as options.

Sonoma County's Behavioral Health Division workforce is 24% male and 76% female, reflecting overall gender trends in the behavioral health workforce. In looking at reporting levels, they are almost identical for individual contributors and managers to the gender make-up of the workplace overall. (While the supervisor percentages show a

flipped gender breakdown, please note that there are only five supervisors in the division.)





Sexual Orientation and Gender Expression

Gary Gates, a researcher at UCLAs Williams Institute, a think tank on sexual-orientation law, who based his findings on data from the US Census Bureau's 2008 American Community Survey, reported that the Santa Rosa Metropolitan Area ("in effect Sonoma County") was second "most gay" population in the nation, with 7.63 gay couples per

1,000 households, a rate 56 percent greater than the national average.[13] Unfortunately, information about sexual orientation is not a category collected of new hires into the workforce of Sonoma County, nor is this information collected for Medi-Cal beneficiaries or consistently for DHS-BHD clients.

People who identify as lesbian, gay, bisexual, transgender, intersex, asexual, or otherwise queer often face social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion, and family rejection. Because of these stressors, people in the LGBTQIA+ communities are at risk for various behavioral health issues. A National Institute of Health study further found that although sexual orientation discrimination alone was not significantly associated with substance use disorders, sexual orientation discrimination in combination with racial/ethnic or gender discrimination—and racial/ethnic discrimination alone—was associated with greater odds of substance use.[14]

O'Brien et al, in "Mapping the Road to Equity: The Annual State of LGBTQ Communities Report, 2018," report that according to town hall meetings in California, a sizable proportion of therapists are not adequately trained or even willing to serve trans clients, and several trans people spoke of their difficulties in finding therapists who could provide the much-needed quality support.[15] This discomfort points to the need both for more training and also for recruiting LGBTQIA+, specifically trans, therapists.

Recruitment and Hiring

Data regarding the current behavioral health workforce demonstrates the ongoing need to diversify is urgent and necessary. Over the previous years, BHD engaged in many efforts to diversify its workforce through innovative recruitment strategies including educational and employment pipeline opportunities. Previous outreach efforts of Latinx/Latine individuals into the behavioral health division workforce included a contract with a local non-profit, Latino Service Providers (LSP). The current contract with LSP provides for support and training of bilingual Youth Promotores in mental health. Many of these young adults expressed interest in pursuing a career in behavioral health, and in fiscal years 2021-2022 through 2024-2025, BHD has hosted interns from LSP in the MHSA coordinator's office and on the mental health treatment teams.

As part of the implementation of the County of Sonoma Racial Equity Action Plan passed by the Board of Supervisors in summer 2024, the county Human Resources department, in coordination with the county Office of Equity, will conduct an assessment of County job descriptions and hiring practices and engage in a codesign process to remove barriers and elevate the value of lived experience. This process will include developing a plan for evaluating job classifications and descriptions and through an anti-

[13] Out4MentalHealth Sonoma County Mental Health Fact Sheet. https://californialgbtqhealth.org/wp-content/uploads/2021/06/Sonoma-Task-Force-Fact-Sheet-Final-1.pdf

[14] Sean Esteban McCabe, PhD, MSW, Wendy B. Bostwick, PhD, MPH, Tonda L. Hughes, PhD, RN, Brady T. West, MA, and Carol J. Boyd, PhD, MSN The Relationship Between Discrimination and Substance Use Disorders Among Lesbians, Gay, and Bisexual Adults in the United States, American Journal of Public Health; 2010 October; 100(10): 1946–1952.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2937001/

[15] O'Brien, R.P., Walker, P.M., Poteet, S.L., McAllister-Wallner, A., & Taylor, M. (2018). Mapping the road to equity: The annual state of LGBTQ communities, 2018. Sacramento, CA: #Out4MentalHealth Project.

racist lens and identifying additional anti-racist hiring practices to pilot within departments.

The Division will continue to coordinate with the County and Health Services Department Human Resources to identify best practices[16] for successful recruitment of a diverse workforce, with special attention to bilingual Spanish-speaking, bicultural Latinx/Latine individuals.

Hiring

Current data for the Behavioral Health workforce demographics demonstrates a significant shortage of bilingual Spanish speaking, bicultural Latinx/Latine workforce in comparison to the number of bilingual Spanish speaking, bicultural Latinx/Latine Medi-Cal beneficiaries in Sonoma County. As a specialty provider, and in keeping with the Sonoma County Board of Supervisor's Five-Year Strategic Plan, it is vital that DHS-BHD implement strategies to diversify the behavioral health workforce to ensure the behavioral health workforce reflects the County demographics at all levels of the organization.

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DHCS for the Workforce Education and Training (WET) component. **Rationale:** Will ensure continuity across the County Mental Health System.

The Workforce Education and Training program supports the mission of the Sonoma County Behavioral Health Division to promote recovery and wellness of Sonoma County residents. BHD embraces a recovery philosophy that promotes the ability of people with mental illness and/or substance use disorders to live meaningful lives in communities of their choosing, while striving to achieve their full potential. The principles of a recovery-focused system include:

- Self-direction
- Individualized and person-centered care
- Empowerment and shared decision-making
- Holistic approach that encompasses mind, body, spirit, and community
- Focus on strengths
- Prioritizing peer support
- Focus on respect, responsibility, and hope

BHD fosters a collaborative approach by partnering with clients, consumers, family members, and the community to provide high quality, culturally responsive services.

Workforce Education and Training goals are:

- To provide staff with high quality education and training that promotes and endorses the mission of the Behavioral Health Division
- To contribute to the development and maintenance of a culturally responsive workforce, including individuals with client and family member experience who

[16] GEM. (December 7, 2021). Think Diversity is a "Pipeline Problem"? Look to Your Process Instead. [Blog Post] Retrieved from https://www.gem.com/blog/diversity-hiring-pipeline-problem

are capable of providing client- and family-driven services that promote wellness, recovery, and resilience
- To teach and promote evidence-based and community-defined practices leading to measurable, values-driven outcomes in support of the Quality Improvement Workplan for the Behavioral Health Division
- To encourage career development and increase job satisfaction by supporting the growth and advancement of a skillful workforce
- To create and promote community outreach and training opportunities that encourage community stakeholder collaborations and facilitate forums for discussion and education around locally relevant behavioral health topics and needs

In response to the QI Work plan and the Cultural Competence Plan, the Staff Development Training Series provides annual trainings on a core set of skills to support staff in refining and using skills in trauma-informed care and systems, harm reduction, cultural humility and responsiveness, and recovery-oriented person-centered approaches.

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

The WET Plan assessment agrees with known shortages of Spanish-speaking, culturally diverse providers, particularly Latinx/Latine staff to help match our Medi-Cal client base demographics. In addition, the plan calls for increasing the number of people with lived experience in the public mental health system workforce.

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

Workforce, Education and Training (WET) Plan for FY 23-26
The goal of the WET component is to develop and retain a diverse, engaged, and clinically excellent workforce. Our WET program provides training for staff and contracted agencies to promote culturally responsive and clinically appropriate interventions to promote community wellness and staff development. At the end of 2022, the Division hired an Ethnic Services, Inclusion, and Training Coordinator (now the Cultural Responsiveness, Inclusion & Training Coordinator) to oversee this mission. The Sonoma County Behavioral Health Cultural Responsiveness, Inclusion & Training Coordinator position is responsible for ensuring behavioral health services are provided in a culturally responsive manner to the diversity of our clientele, and that our diverse staff are supported and respected in their work. This oversight involves participation in a number of cross-cutting areas in the division including:

- **Policy Development:** ensuring division policies are nondiscriminatory and inclusive.
- **Workforce, Education, and Training:** diversifying the incoming behavioral

health workforce and supporting its ability to care for diverse clients, including developing strategies for recruitment, hiring, on-boarding, training, support, and retention practices and ensuring the current behavioral health workforce is appropriately attending to the needs of our diverse clientele.

- **Program Design and Development:** participation in program design and development to control for bias and ensure equity and cultural relevance in service provision.
- **Leadership Development:** Strengthening management and administrative performance

Workforce, Education, and Training Activities

The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients.

The Cultural Responsiveness, Inclusion & Training Coordinator manages training programs and community events to further DHS-BHD's goals in the following Domains: System Level Support, Career Pathways and Pipeline Program, Staff Skill Development, and Workforce Diversification.

Domain	Programs/events/goals
System Level Support	• Accreditation (BRN, CAMFT, CCAPP)
Career Pathways	• Pipeline Programs • Career & Internship Fairs
Staff Skill Development	• Staff Development Trainings

System Level Support

Accreditation

The division will continue to maintain accreditation through the Board of Registered Nursing (BRN), the California Association of Marriage and Family Therapists (CAMFT) and California Consortium of Addiction Programs and Professionals (CCAPP) for the license types listed below, and provides Continuing Education (CE) credit for these license types:

BRN

- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Registered Nurse (RN)
- Public Health Nurse (PHN)
- Nurse Practitioner (NP)

- Psychiatric Nurse Practitioner (PNP)

CAMFT

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Educational Psychologist (LEP)

CCAP

- Registered Alcohol Drug Technician (RADT)
- Certified Alcohol Drug Counselor I (CADC-I)
- Certified Alcohol Drug Counselor II (CADC-II)
- Licensed Advanced Alcohol Drug Counselor (LAADC)
- Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Graduate School Students & Pre-Licensed Clinicians
The Cultural Responsiveness, Inclusion & Training Coordinator will continue the Internship and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This includes a Group Clinical Supervision and Educational Outreach Events.

Currently, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation for pre-licensed clinicians. We hope to expand and formalize our trainee/intern/field placement program for FY25-26, with additional paid grad school internships.

The division has benefited greatly from the CalMHSA contract with Motivo, an online supervision platform. BHD has historically struggled to attract Licensed Clinical Social Workers (LCSWs), and we have only a few in supervisory roles. It was difficult, therefore, to provide the required supervision for Associate Social Workers (ASWs) and students in Master of Social Work (MSW) programs. Through Motivo, BHD has been able to arrange LCSW supervision for both ASWs and MSW students.

This arrangement has been of particular benefit to several employees in Senior Client Support Specialist/Rehab Specialist roles who are pursuing their MSW degrees through online programs. Many have been able to fulfill their graduate school field placement requirements through BHD, either on their assigned team or through arrangements with other teams, and to receive their required clinical supervision with a Motivo LCSW. Once they graduate, they will be eligible to apply for our Clinician Intern/Registered Clinician job classification.

In 2012, BHD made a strategic decision to make systemic changes to its job classification and management structure as a recruitment strategy. This strategy set BHD aside from other organizations, making BHD a desirable place to work for newly graduated behavioral health clinicians. The strategy involved creating new job

classification of Behavioral Health Clinical Intern positions for individuals to practice clinical work while gaining the supervised experience necessary to sit for the licensing exam. BHD also created the Clinical Specialist position to ensure oversight and accountability for the work of the Behavioral Health Clinician job classification.

Individuals who possess a graduate degree in counseling and/or social work, are registered with the CA Board of Behavioral Science Examiners, and need to gain the mandatory hours of qualifying supervised professional experience in order to take and pass the requisite law and ethics exam can be hired as Behavioral Health Clinical Interns. The Behavioral Health Clinical Interns practice under the licensure of their Clinical Supervisor. Once the Behavioral Health Clinician Intern completes their clinical hours, any other prerequisites, takes and passes their licensing exam, and is in good employment standing, they receive and automatic promotion to a Behavioral Health Clinician. The Behavioral Health Clinical Intern has three years to complete all prerequisites to obtain licensure.

For the future, BHD is also looking into creating mechanisms to allow people graduates from master's-level counseling and social work programs to apply and begin working while waiting for their BBS registration number, creating even more of a ladder for new graduates.

This structure has historically been successful to recruit bicultural and bilingual staff, as it provides paid work while staff are pursuing their graduate degrees and clinical licensure. Supervision through Motivo also allows a greater diversity in supervision, allowing staff of color and staff who are bilingual to seek out supervision that supports their experience and skills.

In addition to individual supervision through Motivo and the division's Clinical Specialists, the Cultural Responsiveness, Inclusion & Training Coordinator, who is a licensed Marriage and Family Therapist (LMFT), with the assistance of Clinical Specialists from the Quality Assessment & Performance Improvement (QAPI) team, facilitate multiple clinical supervision groups each week, with a focus not only on clinical feedback on current cases but also exam preparation. This structure allows the Cultural Responsiveness, Inclusion & Training Coordinator to have weekly contact with line staff and to stay abreast of pain points for them in their work.

Clinical Supervision & Professional Development
The Cultural Responsiveness, Inclusion & Training Coordinator also facilitates or co-facilitates monthly meetings with the division's Senior Client Support Specialists (one for the Youth and Family Services section and one for the Adult and Acute/Forensic section), with the Clinical Specialists providing clinical supervision, and with the Peer Support Specialists working in the Crisis Stabilization Unit. These meetings allow the identified group time and space to develop skills, build relationships, and advance their professional development. They also, similar to the clinical supervision groups, allow the Cultural Responsiveness, Inclusion & Training Coordinator to have regular contact with the staff providing services to clients. Through these meetings, the Cultural Responsiveness, Inclusion & Training Coordinator has been able to successfully raise issues to leadership that staff had felt uncomfortable bringing up through their own management chain, and to work toward resolving systemic issues that were interfering with employees' ability to thrive in the

division.

Peer Support Services Specialists
Sonoma County BHD is slowly working to creating permanent positions for peer specialists and for Medi-Cal Certified Peer Support Services Specialists. Currently, there are two peer specialist roles in the Crisis Stabilization Unit, who are working in our existing Client Support Specialist classification. With the expansion of the Mobile Support Team, BHD was able to hire peers into allocated Senior Client Support Specialist roles. While neither setting allows for the billing and claiming of Peer Support Services CPT codes, as they are bundled services, BHD is excited to support peer expertise in these roles.

Telecare Sonoma ACT, a Community-Based Organization working in the MHP network and providing assertive community treatment, has asked to add Medi-Cal Certified Peer Support Services Specialists to its contract. Several contractors for residential and acute placements have also expanded their peer services for those settings.

Of note, West County Community Services (WCCS), a Sonoma County non-profit with programs including peer-run centers, senior services, employment, housing, youth programs, behavioral health, and crisis counseling services and which offers a peer support specialist certification training, was recently certified by DHCS as a trainer for Medi-Cal Certified Peer Support Services Specialist training. WCCS is the first organization in Sonoma County to achieve that designation, and BHD is excited to continue working with them to place peers in the system of care.

Workforce, Education, and Training Activities
The goal of our Workforce, Education, and Training (WET) Activities is to create and maintain a robust comprehensive training program, including evidence-based clinical practices and culturally responsive frameworks, to make Sonoma County Behavioral Health an attractive place to work and to promote wellness and meaning for our diverse clients. To better support these goals, WET hopes to add a full-time clinical specialist role to support this program in the future.

WET Activities	Trainings
Comprehensive Training Program	• Harm Reduction Therapy for People Who Use Substances • Motivational Interviewing • CBT & Harm Reduction for People with Hoarding Behaviors • Trauma-Informed Care • Trauma-Informed Systems • Client Autonomy • Confidentiality
Culturally Responsive Practices	• Collaborative Care • Cultural Humility • Working with BIPOC Clients

Online On-Demand Trainings	• Relias Learning Management System

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

- BHD has lost a number of bilingual staff over the past several years and is challenged by the competition among the county's healthcare system.
- BHD leadership must support managers to attend to recruiting, interviewing, hiring, onboarding, training, and developing and supporting strategies that promote diversity in the workforce needs to attend to its hiring practice as well.
- BHD leadership will need to incorporate lessons and strategies from the Sonoma County Racial Equity Action Plan and forthcoming DHS Health Equity Action Plan, which have been developed in deep community with employees of color, to address systemic issues identified as barriers to a successfully thriving diverse workforce.

E. Identify county technical assistance needs.

DHS-BHD does not have any identified TA needs at this time.

Criterion 7: Language Capacity

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

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

Continuous efforts are made by the County to recruit and retain bilingual staff to more accurately reflect the diversity of Sonoma County, specifically focused on the Latinx/Latine and Spanish-speaking community. A significant development worth noting is the establishment of a countywide Office of Equity on August 20, 2020, followed by the establishment of a Department of Health Services Office of Equity in May 2022. Each office also created a core team of equity champions across its administrative division who have received and continue to receive extensive training in antiracism and equity; the champions within the Behavioral Health Division constitute the Behavioral Health Equity Steering Committee, which began meeting in the summer of 2023. The champions in the Department of Health Services, called the DHS Equity Circle, have also completed an extensive Anti-Racist Results-Based Accountability process to draft a Health Equity Action Plan, which was presented to DHS leadership in November 2024 and is awaiting final approval. This plan will focus both on serving the community and on creating workplace conditions in which diverse employees can thrive.

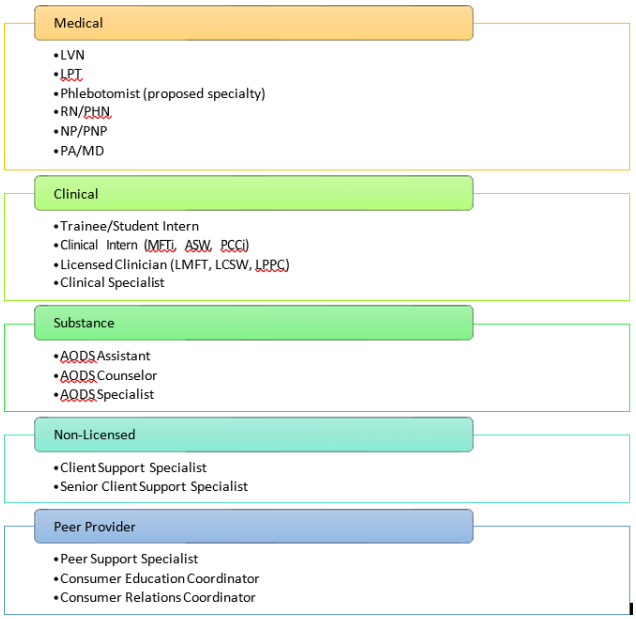
While not explicitly focused on bilingual capacity, BHD's Trauma-Informed Systems Transformation project, discussed above, is focused on improving workplace culture, specifically by focusing on management and leadership and developing their skills in leading a diverse, supportive, trauma-informed workplace. Cultural humility and responsiveness is one of the pillars of a trauma-informed system, and will be foundational to all parts of this systems improvement. The Cultural Responsiveness, Inclusion & Training Coordinator is the main coordinator for this effort, further ensuring integration, rather than competition, between trauma-informed changes and equity work.

The County of Sonoma has personnel policies that provide for a differential pay increase above the employee's base hourly rate if the position requires at least 10% of the employee's work time to be used in a bilingual English/Spanish capacity. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

As of the most recent data provided by Sonoma County Human Resources, there are 72 bilingual employees in BHD, staffing the three categories of Management, Administrative, and Clinical.

Career Ladders

The Cultural Responsiveness, Inclusion & Training Coordinator will support the development of promotional opportunities with career tracks to support a Grow-Your-Own Model from entry-level intern/student through supervision and management. This includes formalizing an Internship & Traineeship program, expanding the Peer-Provider program, providing clinical support to pre-licensed and paraprofessional staff, and providing management-level training and support.



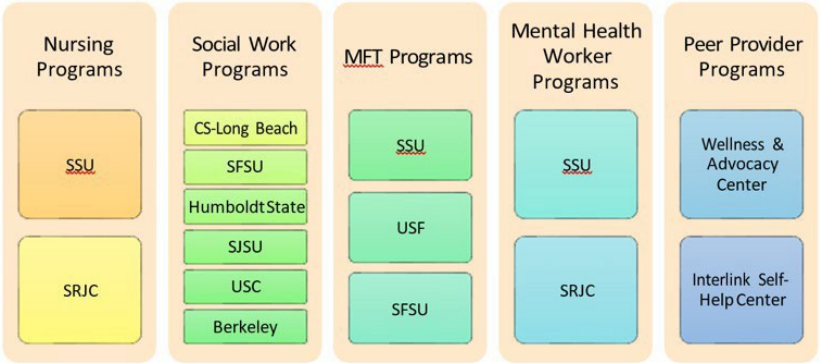
Internships & Pipeline Programs

To increase and diversify the clinical workforce, BHD works with local universities to assist staff in obtaining clinical licensure and to develop pipeline programs with participating post-secondary schools and universities. The purpose of the pipeline program is to cultivate interest in healthcare careers, particularly in hard-to-fill areas with high-risk, underserved populations. Additionally, the pipeline program preserves diversity in the workforce and reduces health disparities for the consumers.

BHD has worked with West County Community Services to create internship opportunities for peers completing their peer support specialist training program, and the organization is eager to continue partnering with WCCS now that they have been awarded training certification by DHCS.

Career & Internship Fairs

The Cultural Responsiveness, Inclusion & Training Coordinator, in coordination with Sonoma County Human Resources, engages in outreach through internship and career fairs at Santa Rosa Junior College, Sonoma State University, and University of San Francisco.



As part of a push to reduce our staff vacancy rate, Sonoma County held its first ever Behavioral Health Job Fair on site in November 2023, which resulted in five job offers for clinical staff and four people being hired.

Community Health Workers and Pro Promotores

Community health workers and *promotores* (CHW/Ps) have been part of the health care landscape in the United States for decades. Payers and providers increasingly recognize their essential role in supporting people with complex medical and social and

behavioral health needs. The roles that CHW/Ps fill vary widely, including helping individuals navigate the complicated health care system, connecting them to resources to address their social needs, and accompanying them to visits with health providers. Whatever role they play, the work of CHW/Ps is characterized by a deep connection to their community and the lived experience that they share with their clients. They can draw on their knowledge of available resources and the social networks that define their communities, bridging geographic and cultural gaps between the health care system and consumers. CHW/Ps' shared life experience can provide an essential human connection between health care providers and the patients they serve. The Behavioral Health Division is interested in engaging CHP/Ps to build and diversify its behavioral health workforce.

The Health Planning, Policy, and Evaluation (HPPE) Division of the Department of Health Services has created a team of Community Health Workers, who are rotating through DHS divisions. The HPPE CHW team supports capacity-building for individual DHS programs to better serve underrepresented communities. A CHW can be assigned to an individual DHS program for one or two days a week, for a period of three to five months, as scope of work permits. The CHWs have completed programmatic assignments with the Behavioral Health FASST team, Behavioral Health Adult Services, Public Health Field Nursing programs, and the Homelessness team at Eliza's Village and Mickey Zane Place.

The HPPE CHW team also conducts door-to-door outreach, tabling at community events, and outreach at food distribution sites. In August 2024, they provided information to over 810 community members about DHS programs and services. Feedback received from community members during this period included recurring comments about the need for more information regarding mental health resources, shelter, and affordable housing. The team distributed information on healthy eating and active living, Medi-Cal renewal information, mental health and suicide prevention resources, extreme heat event resources, lead prevention education, Mobile Support Team flyers, and dental education.

Latino Service Providers (LSP) is a non-profit organization in Sonoma County that works with community partners to exchange information to increase awareness of available resources, build access to programs and services, enhance interagency communication, and promote development within the Latinx/Latine community. LSP's Youth Promotor Internship program seeks to address the mental health inequities in the Latinx/Latine community by meaningfully engaging Latinx/Latine youth in issues related to mental health in the Latinx/Latine community by training youth as community health workers in hopes of inspiring them to seek a career in public behavioral health. LSP has trained over 150 youth promotores and retained alumni over the years.

BHD is in its third year of hosting LSP pro promotor interns, who have worked with both administrative and clinical staff to learn about how mental health services are provided in county settings.

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

As of December 2024, the Behavioral Health Division (BHD) had the following positions filled by bilingual Spanish-speaking staff in the following job classifications. The total of 72 positions shows an increase of 38% since reporting totals last year.

Position	Basic (Conversational)	Fluent (Speak, Read, Write)	Total
Account Clerk II	1	2	3
AODS Assistant I		1	1
AODS Counselor I		1	1
AODS Counselor II		4	4
AODS Intake Interviewer	1	1	2
AODS Specialist		1	1
Clinical Specialist	1	1	2
Clinician	3	5	8
Clinician Intern		7	7
Health Program Manager	2	1	3
Licensed Vocational Nurse II		1	1
Nurse Practitioner/Physician's Asst	1		1
Office Assistant II		3	3
Psychiatric Nurse (RN)	1		1
Senior Client Support Specialist	4	13	17
Senior Office Assistant	6	10	16
Social Services Worker III	1		1
GRAND TOTAL	**21**	**51**	**72**

3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to the staffing referenced above, BHD uses Language Link for spoken languages and Communique for American Sign Language. We do not have dedicated interpreter positions on staff.

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

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

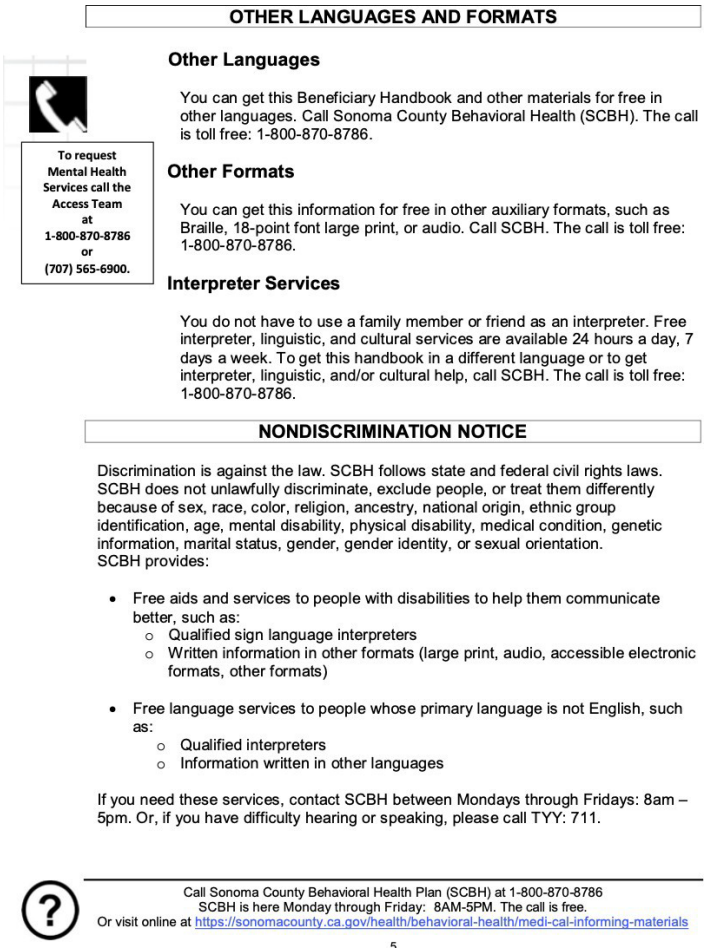
1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

Within the BHD Beneficiary Handbook, Sonoma County has an acknowledgement of

nondiscrimination and a corresponding policy addressing access to services in languages other than English and formats that are accessible to people with different abilities. The BHD policy is to use a bilingual staff member to provide interpretation services whenever needed. Sonoma County BHD has a 24-hour phone line that is answered by a live person. If bilingual staff are unavailable, BHD uses other resources to provide interpretation. These other resources include:

- CTS Language Link
- CA RELAY TDD

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



OTHER LANGUAGES AND FORMATS

To request Mental Health Services call the Access Team at 1-800-870-8786 or (707) 565-6900.

Other Languages

You can get this Beneficiary Handbook and other materials for free in other languages. Call Sonoma County Behavioral Health (SCBH). The call is toll free: 1-800-870-8786.

Other Formats

You can get this information for free in other auxiliary formats, such as Braille, 18-point font large print, or audio. Call SCBH. The call is toll free: 1-800-870-8786.

Interpreter Services

You do not have to use a family member or friend as an interpreter. Free interpreter, linguistic, and cultural services are available 24 hours a day, 7 days a week. To get this handbook in a different language or to get interpreter, linguistic, and/or cultural help, call SCBH. The call is toll free: 1-800-870-8786.

NONDISCRIMINATION NOTICE

Discrimination is against the law. SCBH follows state and federal civil rights laws. SCBH does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
SCBH provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact SCBH between Mondays through Fridays: 8am – 5pm. Or, if you have difficulty hearing or speaking, please call TYY: 711.

Call Sonoma County Behavioral Health Plan (SCBH) at 1-800-870-8786
SCBH is here Monday through Friday: 8AM-5PM. The call is free.
Or visit online at https://sonomacounty.ca.gov/health/behavioral-health/medi-cal-informing-materials

5

Sonoma BHD does not solely rely on language lines, though that is one tool to support access to individuals who have limited English proficiency. In addition, BHD has interpreter services on contract and is always seeking to hire a diverse multilingual staff to serve the community. Since the beginning of the Covid-19 pandemic, staff providing telehealth services have expanded their use of video language conferencing.

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

Sonoma County BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (see Attachment A), provides the protocols to implement language access at no cost, 24 hours a day, seven days a week.

Furthermore, multilingual signage is provided at all BHD county lobbies and at the entryways to contracted providers.

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

Contained in the Sonoma County Mental Health Plan Beneficiary Handbooks provided to all consumers/beneficiaries is a multilingual notice informing them of their right to access services in their primary language, free of charge. This notice is located on the first two pages of the handbook.

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

The Sonoma MHP EQRO Final Report for Fiscal Year 2023-24 shows that nearly one in seven beneficiaries served in the MHP speak Spanish.

Threshold Language of Sonoma MHP Medi-Cal Members Served in CY 2022

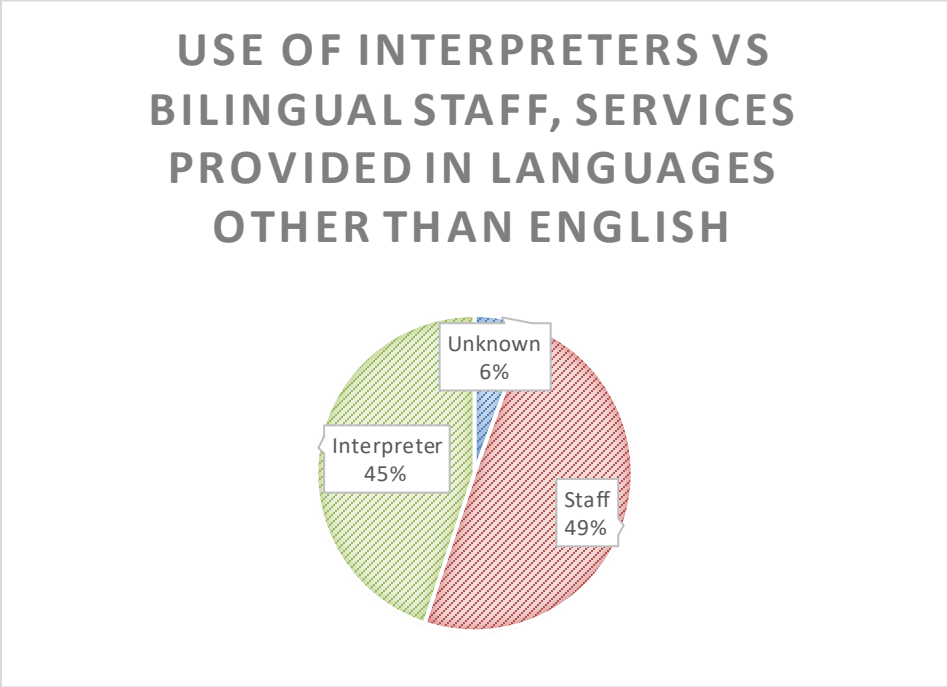
Threshold Language	# of Members Served	% of Members Served
Spanish	400	13.87%
Threshold language source: Open Data per BHIN 20-070		

Data from Sonoma County's electronic health record, Smartcare, shows the following services provided in languages other than English between December 1, 2023, and November 30, 2024:

Language	Unknown	Staff	Interpreter	Total
American Sign Language (ASL)	3		4	7
Chinese - Cantonese		2		2
Farsi		5		5
French			5	5
Hebrew			1	1
Lao			2	2
Other		3	30	33
Russian	1		1	2
Samoan		1	1	2
Spanish	188	1669	1478	3335
Thai		1		1
Turkish			5	5
Vietnamese			11	11
Unknown / Not Reported		15		15

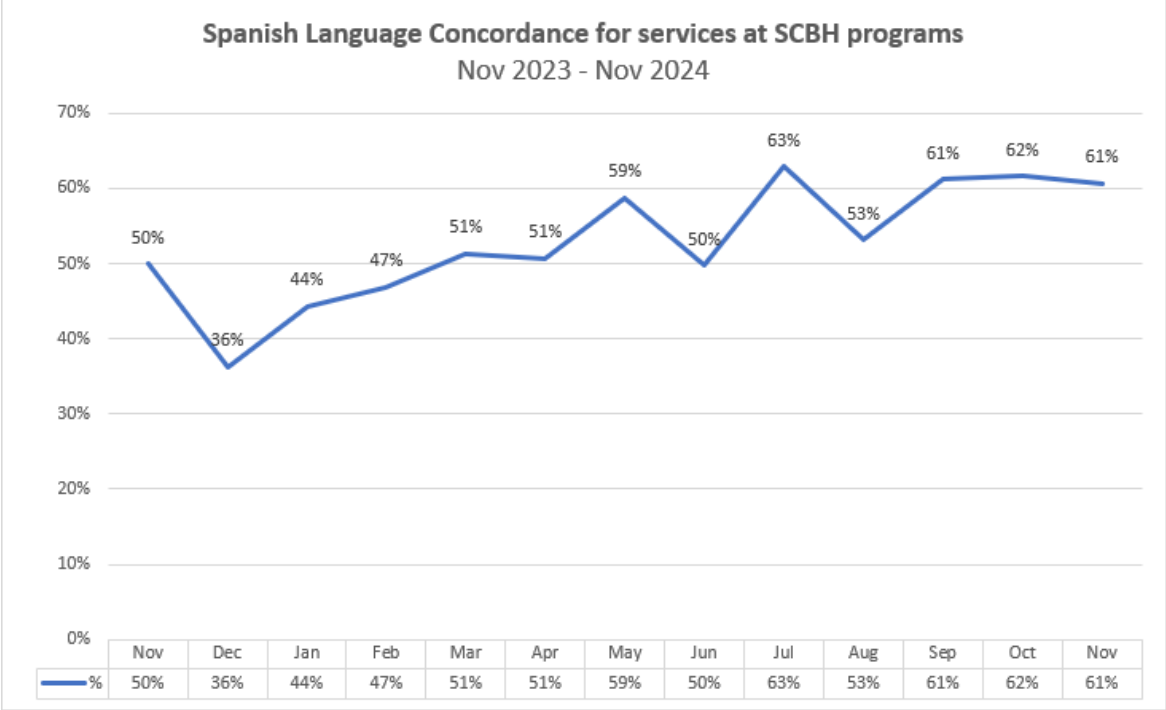
Grand Total	**192**	**1696**	**1538**	**3426**

This data shows that interpreters were used 45% of the time and that staff provided services in the client's preferred language 49% of the time (with 6% unknown) for all services documented in the electronic health record for that twelve-month period.



Data in the previous Cultural Competency Plan showed 1022 services provided in languages other than English. While the data used for that report came from the MHP's previous electronic health record and contained slightly different parameters, thus making direct comparison inexact, the data does indicate that services provided in languages other than English increased a great deal over the last few years.

Sonoma County MHP has also looked at Spanish language concordance, or whether services provided in Spanish used bilingual staff or outside interpreters. Over the course of 2024, the MHP has seen close to a 15% improvement, or 37 additional services each month, on Spanish language concordance.



Of note, Smartcare, the semi-statewide electronic health record, which was adopted by Sonoma County in FY 2023-2024, did not originally allow to providers to indicate what language a service was provided in or whether the provider was able to speak that language themselves. That functionality was added later, and the MHP suspects that services are being provided by staff in the client's preferred language but not captured when they are entered in the client's chart. More work will be done to ensure data is being recorded correctly.

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

As noted, the semi-statewide electronic health record adopted by the MHP through CalMHSA did not originally capture data about language used or whether the staff spoke the language in which the service was provided. Ongoing efforts are needed to ensure that such data is captured correctly.

The goal of maintaining bilingual staffing is challenged by the fact that the BHD is in direct competition for a bilingual workforce with other health systems such as Kaiser Permanente, Sutter Health, St. Joseph's Health, and the community clinics throughout Sonoma County. Bilingual staff has also reported feeling unsupported, especially as they are often dealing most directly with the effects of lack of local resources on vulnerable communities of which they are a part. BHD is hopeful that the work detailed in the staff retention section of this report, including the Sonoma County Racial Equity Action Plan, will improve these staff members' experience in the workplace.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

At this time, there are no technical assistance needs identified.

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

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

As noted in earlier in this document, Sonoma County DHS-BHD Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (Attachment A), provides the protocols to implement language access at no cost, 24 hours, seven days a week. In addition, information for all language access is found on the first pages of the Beneficiary Handbook given to all consumers. Finally, as stated in Mental Health Policy MHP-21, "Required Informing Materials and Translation of written Documents" (Rev. 5-20-19), posters are required to be prominently displayed in the lobbies of BHD offices and posted by contractors providing mental health services to Medi- Cal beneficiaries. (See Attachment B).

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

As seen in Criterion 7, II.C. above, 3426 clinical services in language other than English were provided and documented between December 1, 2023, and November 30, 2024.

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

As of December 2024, BHD had 72 positions filled by bilingual Spanish-speaking staff. Because the competition for attracting and retaining skilled workers has increased significantly, particularly for health professionals and for bilingual candidates, Sonoma County provides bilingual pay to certified bilingual staff working in specific, bilingual designated positions. In order to receive this premium, staff must meet the established job qualifications and also meet the County's bilingual certification requirements. This differential was recently split into two levels, with additional pay added for employees who tested as "fluent" in Spanish. The current policy states that the employee shall be entitled to an additional $1.15 per hour for basic bilingual skills and an additional $1.50 per hour for fluent bilingual skills.

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

Bilingual skill testing is conducted by Sonoma County Human Resources (HR). The following process is used to test bilingual (English/Spanish) skills:

- The Department Head or Designee determines the level of proficiency (basic/fluent) required to perform the duties of the position:
    - Basic: the ability to verbally communicate in English and Spanish effectively, conversationally proficient. The individual will speak only, and work will be limited to providing verbal information to clients and to the public. They will not translate text or transcribe verbal communications.
        - Example: an Office Assistant or Receptionist primarily assists the public by answering questions, such as the location of another building, the restroom, locating an appropriate form, etc.
    - Fluent: the ability to speak, read, write, and translate between English and Spanish, at a highly proficient level. Translation is defined as the process of translating words or text from one language into another. This level is used for positions where employees may have a higher degree of interaction with and responsibility to the public or clients.
        - Example: a Social Service Worker primarily assigned to work in a courtroom setting, in which their clients need verbal information translated from English to Spanish.
- The Department submits a certified/complete Bilingual Proficiency Exam Request Form to HR.
- HR schedules the individual(s) for the next available exam session.
    - "No Shows" and last-minute cancellations will not be automatically rescheduled.
- HR tests the examinee(s) at the level requested by the Department.
    - Basic: This exam has 7 work-related exam questions. Exam Raters may allow some mixed language use and can simplify the questions to aid the examinee in understanding and responding to the questions. Speech may not be grammatically correct. The Raters will assess the examinee's ability to understand and use a common vocabulary, handle day-to-day verbal communication, and determine whether the examinee can be easily understood by a monolingual person.
    - Fluent: This exam has 3 sections: conversational, oral reading/translation, and a writing performance exercise. At this highly proficient level, the examinee is expected to fully comprehend and correspond in both English and Spanish. With the understanding that specialized terms in their area of responsibility will be learned on the job, Exam Raters assess the examinee's command of language to determine their ability to perform the duties of the position.
- Within approximately one week of the exam:
    - If the candidate has passed the exam, HR will send exam results to the examinee, HR Liaison, and Payroll Clerk. This formal notice is viable for the duration of the examinees' employment with the County of Sonoma and should be placed in their personnel file.

- If the candidate has failed the exam, HR will notify the HR Liaison and Payroll Clerk to discuss applicable next steps. After that conversation has occurred HR will send results to the examinee, HR Liaison, and Payroll Clerk.

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

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

As noted earlier, the Beneficiary Handbook and corresponding policies clearly provide for language access through bilingual staffing, language interpreters, or the Language Line (last resort) for all aspects of the continuum of care. In addition, materials translated into the threshold language of Spanish are available to all staff.

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

The MHP maintains a policy to ensure that all client and MHP contact providers link non-English speaking clients to culturally and linguistically competent mental specialty mental health services regardless of language spoken. Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters" (see Attachment A), explains the process.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and
3. Minor children should not be used as interpreters.

Sonoma County's Mental Health Policy MHP-8, "Linking Non-English-Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters," clearly states the three policy positions above. Please see Attachment A.

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

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

1. Member service handbook or brochure;
2. General correspondence;

3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

As noted previously, Spanish is the only threshold language for Sonoma County. The Mental Health Plan Member Service Handbook is published in English and Spanish and kept on file for regular review, updating, and access by staff on a common computer drive. Forms, including Informed Consent and Release of Information, are generated through the semi-statewide electronic health record, SmartCare, and are available in Spanish. In addition, consumers/beneficiaries can access all documents in English and Spanish on the County's website:

https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials

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

The BHD Mental Health Program Audits include verification of the following standards:

- Based on the documentation as a whole, is there evidence that treatment is high quality, person centered, culturally responsive, and aligned with client needs?
- For clients whose primary language is something other than English, is there evidence of informing materials provided to client in primary language or documented evidence that informing materials were explained to client in primary language with acknowledgement of understanding?

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

Each year in May, the Consumer Perception Survey is administered by UCLA. The survey is offered in English and Spanish. The survey is a state-issued and -controlled survey, and BHD cannot change labels, age categories, or wording of questions. The BHD Quality Improvement team shares the results of the survey to the Quality Improvement Committee (QIC). QIC has recommended sharing the survey results with the community via posts at program sites, and BHD hopes to do so in both English and Spanish in the future.

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

The standard practice for Sonoma County BHD is to have translated documents proofread by at least two bilingual staff to ensure accuracy and accessibility.

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

To monitor readability and access for those needing an appropriate reading level, documents are proofread by utilizing Word options in the software to show readability statistics. This application will provide a Felsch-Kincaid Grade Level for the selected content.

Criterion 8: Adaptation of Services

I. Client driven/operated recovery and wellness programs

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

Sonoma County is seeking to build on four client-driven/operated recovery and wellness programs provided under the auspices of West County Community Services:

- Wellness and Advocacy Center, Santa Rosa
- Interlink Self-Help Center, Santa Rosa
- Petaluma Peer Recovery Program, Petaluma
- Russian River Empowerment Center, Guerneville

In addition, Positive Images, a MHSA PEI funded program for the LGBTQIA+ community, uses a peer-based and peer-led socio-educational model with support groups, social activities, community education, and activism.

II. Responsiveness of mental health services

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

As required, Sonoma County provides a Provider Directory to all new clients, which has descriptive information regarding types of services available, populations served, and/or linguistic capabilities. DHS-BHD develops contracts with a number of community-based organizations who provide non-traditional mental health services.

The following chart illustrates the contractors and their focus in working with specific populations that are traditionally underserved.

Agency / Population Focus	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
Latino Service Providers/ Latinx		X	X	X
Sonoma County Indian Health Project/ Native Americans		X	X	X

Positive Images / LGBTQIA+		X	X	X
Community Baptist Church Collaborative / African-Americans		X	X	X
Santa Rosa Community Health Centers/ Communities of Color		X	X	X
Alliance Health Center/ Latinx	X	X	X	X
West County Health Services/ LGBTQII		X	X	X
Alexander Valley Health Center/Latinx	X	X		

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

DHS-BHD provides each beneficiary/consumer with the DHCS required Guide to Medi-Cal Mental Health Services in either English or Spanish. Also, both documents can be found on the County's website:

https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials

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

DHS-BHD Mental Health Policy MHP-21, "Required Informing Materials and Translation of Written Documents," states that DHS-BHD and its contracted providers will provide to all beneficiaries written informing materials that are critical to obtaining Specialty Mental Health Services at the first face- to-face contact and/or upon request. In addition, informing materials will be displayed in the lobbies of all County-owned/operated programs and contract provider programs. (See Attachment B.)

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas

BHD's Access team is located within the main Behavioral Health Campus at The Lakes business complex in Santa Rosa. Clinical services, including crisis and peer services, are co-located and centralized to provide easier access. In addition, a main bus line has a stop in front of BHD complex. This Behavioral Health Campus is located in the southern section of Santa Rosa and is close to the heart of the Latinx/Latine community, known as Roseland, where many Medi-Cal beneficiaries reside. This area is also accessible to many parts of Sonoma County given its proximity to the major highways. DHS-BHD also maintains clinics in the outlying areas of Sonoma, Petaluma, Guerneville, and Cloverdale to provide easier access for clients living in the east, south, west, and north areas of the county.

Since the Covid pandemic in 2020, BHD has also expanded the use of virtual clinical services to augment in-person services, which can help alleviate transportation issues.

Hours of operations are generally 8am to 5pm, Monday through Friday. The five Full Service Partnerships provide services to clients beyond those hours, as needed, including weekends. We also have several options for after-hours services. Optum provides after-hours phone coverage to provide information and referrals, and our screening team is generally available until 7pm on weekdays. Our Crisis Stabilization Unit, our crisis phone line, and our Mobile Support Team provide services 24 hours a day, seven days a week.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs)

All County-owned and -rented facilities have access for people with disabilities. Many locations have upgraded their waiting rooms to be more client-centered, culturally inclusive, and inviting.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

As part of the MHSA planning process, in order to provide more services to the Latinx/Latine population, it was decided to co-locate services as much as possible with the community health centers (FQHCs and Sonoma County Indian Health Project). In addition, BHD has a variety of community-based nonprofits that provide an array of prevention, early intervention, and clinical services in locations that are

accessible to the populations intended to be served and in an appropriate cultural setting.

III. Quality Assurance

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

A grievance can be filed either orally or in writing at any time by contacting any DHS-BHD staff member or by completing form BHD 406. All grievances will be forwarded by DHS-BHD staff to the Grievance Coordinator prior to the end of the next business day following the filing of the grievance. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance.

The Grievance Coordinator will resolve each grievance as expeditiously as the beneficiary's health condition requires, not to exceed 30 calendar days from the day DHS-BHD receives the grievance. "Resolved" means that DHS-BHD has reached a decision with respect to the beneficiary's grievance and notified the beneficiary, or their authorized representative, of the resolution of the grievance.

When resolving Discrimination grievances the Grievance Coordinator will (in addition to what is identified above) do the following:

- DHS-BHD will not require a beneficiary to file a Discrimination Grievance with DHS-BHD before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office of Civil Rights.
- Within 10 calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the DHS-BHD Grievance Coordinator will submit specific required documentation to the office of civil rights.

All beneficiaries are informed of the Client Grievance process through the following informing materials located at DHS-BHD provider sites:

- The Beneficiary Handbook
- Client Rights flyer, and
- Client Rights and Grievance/Appeal Process and Form.

Attachment A

COUNTY OF SONOMA

DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 11/25/2002 REVISION DATE: 03/02/2020 APPROVED BY: _____ Behavioral Health Services Director	POLICY NO: MHP - 08 POLICY NAME: **Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters** REFERENCE/AUTHORITY: 1. MHP Contract, Exhibit A, Attachment I, MHP Contract, Attachment 11, Item 3 2. CCR 1810.410 3. DMH Information Notice 10-17

POLICY:

The Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD), Mental Health Plan (MHP) maintains a policy to ensure that all beneficiaries and MHP contracted providers are informed about specialty mental health services (SMHS) offered by the MHP and have procedures in place to link Non-English speaking beneficiaries to culturally and linguistically competent providers.

Beneficiaries will have access to culturally and linguistically competent staff or interpreters at all key points of contact and in all DHS-BHD programs. All oral interpretation and sign language services will be provided free of charge to all MHP beneficiaries.

It is the policy of the MHP to use a DHS-BHD county-certified bilingual staff member who speaks the primary language of the person seeking treatment whenever possible. It is expected that DHS-BHD programs will assist each other in this regard to provide essential language services whenever possible. Furthermore, it is the policy to not use family members to interpret for the beneficiary, or for the beneficiary to interpret for the family; except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services.

PROCEDURE:

I. Definitions

A. **Beneficiary:** Individuals who receive SMHS provided by the MHP.

B. **Key points of contact:** Common points of access to SMHS from the MHP, including but not limited to the MHP's 24-hour toll-free line, the Beneficiary Grievance and Appeals Process, MHP contract providers, or any other central access locations established by the MHP.

C. **Threshold language:** A language that has been identified as the primary language, as indicated on the Medi-Cal eligibility Data System (MEDS) of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

II. Standards for Linking Non-English Speaking Beneficiaries to SMHS

A. Key points of contact, such as the Access Team, Crisis Stabilization Unit (and other MHP program locations, will have posted a notice in English and Spanish that beneficiaries have a right to free language assistance services, including sign language services, and how to access these services. Beneficiaries with LEP are informed of these rights and how to access services by the use of interpreters.

B. A statewide toll-free telephone number will be available 24 hours a day, 7 days a week, with language capability in all languages spoken by beneficiaries of the County.

C. For beneficiaries who are deaf or hearing-impaired, a telephone communication device for the deaf (TTY machine) will be used [TTY: 711].

D. See ***MHP – 21 Required Informing Materials and Translation of Written Documents*** policy for requirements concerning written document formatting, translation, and threshold languages.

III. Use of Bilingual Staff and Interpreters

A. When there is no clinical staff member who can speak the beneficiary's preferred language, it is the policy of the MHP to use county-certified, bilingual staff as interpreters to assist beneficiaries and staff in providing mental health services for those beneficiaries who do not speak English, or have LEP capability.

B. Whenever possible, and when practical, attempts should be made to use County-certified, bilingual clinical staff for clinical services. This is especially important when providing an initial assessment, discontinuing a 5150 detention, or for evaluating any high-risk situations, including homicide or suicide ideation.

C. If county-certified, bilingual clinical staff are not available, County-certified, bilingual clerical staff may be used.

D. Telephone calls: When it has been determined that a caller needs an interpreter, the staff receiving the call should make all efforts to find either a County-certified bilingual staff member in their program with the necessary language skills, or use the SCBH designated language line vendor to request a telephone interpreter for interpretive services (see attached instructions).

E. Face-to-Face interviews: When setting up a face-to-face meeting with a beneficiary, it is incumbent upon the staff to ascertain the need for an interpreter, and arrange for one prior to the meeting. This includes beneficiaries who are deaf/hearing-impaired and need sign-language interpretative services. Allow sufficient time for the meeting to ensure adequate interpretation. Medication services appointments are to be extended for additional time to ensure a thorough clinical assessment.

F. If the staff member involved with the beneficiary does not speak the beneficiary's preferred language, then the staff member should consult with their Health Program Manager (HPM) regarding the use of another County-certified bilingual team member who does speak the beneficiary's preferred language to either provide the service, or to provide interpretation.

G. If there is no other county-certified bilingual staff member available within that team, then it is permissible to seek help from DHS-BHD staff from outside of that team. Staff should inform their HPM of their need.

H. The HPM may contact another HPM to request the use of County-certified bilingual staff supervised by this HPM.

I. The requesting HPM should make a determination as to the level of service needed, and should be as specific as possible regarding:
   1. The acuity of the situation (e.g. emergency vs: urgent vs. regular appointment)
   2. The type of service necessary (clinical vs. administrative)
   3. The nature of the relationship requested (e.g. clinical or administrative)

J. If no county-certified bilingual staff member is available to provide interpretive services, then a MHP designated vendor for interpretive services may be used to assist in providing the service. (see attached list of vendors.)

K. If using a contracted vendor, it is advisable to give them as much notice of the meeting as possible.

IV. Use of an Interpreter when conducting a Face-to-Face Interview

A. Pre-Interview and Interview

   1. Staff should instruct interpreter as to the nature of the meeting prior to the

interview. Review topics to be covered and any potentially sensitive topics;

2. Provide for additional length of session time;

3. Review seating arrangements. Whenever possible, the interpreter should sit (slightly behind and to the side of the beneficiary);

4. The interpreter should interpret everything spoken by either party;

5. Staff should instruct the beneficiary "do not say anything that you do not want to be interpreted";

6. The interpreter should always ask for clarification from the clinician and the beneficiary if something is not clear;

7. Pay attention to nonverbal cues and impact of culture.

B. Post-Interview

1. Review session to see if there are any areas of concern that were not discussed or any areas that may still be unclear;

2. Clarify cultural factors, beliefs, behaviors that could influence assessment and diagnosis;

3. Discuss issues that may have been difficult or problematic for the interpreter;

4. Discuss planning for future sessions as appropriate.

C. Family Member Interpretation

1. A family member shall not be allowed to interpret for the beneficiary, nor should the beneficiary be allowed to interpret for or to the family:

2. Except at the request of the beneficiary, and only when the beneficiary has been informed of the availability of free interpreter services and declines these services;

3. The reasons for using a family member to interpret must be documented in the progress note, including the offer to utilize free interpreter services and the beneficiary's decline of such services.

4. Minor children should not be used as interpreters.

5. Family members shall never be used to interpret when evaluating someone to discontinue a 5150 detention, or for evaluation of any high risk situation, including evaluation of suicidal or homicidal ideation.

V. Documentation and Claiming for Services

A. Documentation of a beneficiary's preferred language other than English must be entered in the Initial Assessment and in the individual Progress Note, and whether the service provided was in a language other than English and if so, whether an interpreter was used.

1. If an interpreter is used, the Progress Note should include who provided the interpretation, and what language was spoken. If the staff member conducted the session in a different language, the Progress Note should reflect what language was spoken.

2. Documentation that interpreter services are offered to the beneficiary and the beneficiary's response to the offer is documented in the Progress Note.

B. The staff member providing interpretative services does not claim for interpretative services. For example, if a county-certified, bilingual staff member provides interpretative services for beneficiary at the request of another staff member, only the requesting staff member is allowed to claim for services provided.

C. Translation and Interpretative services are non-reimbursable and cannot be claimed to Medi-Cal.

SCBH FORMS:

1. MHS 403 Free Language Assistance Poster (English & Spanish)
2. Behavioral Health Services Staff Available for Bilingual Interpretation List
3. http://sc-intranet/dhs/bh-policies.htm

ATTACHMENTS:

1. Instruction sheet: How to Request Interpretation Services with CTS Language Link
2. CTS Account Number Codes by SCBH PROGRAM list
3. Communique ASL Interpreter Request Form

Attachment B

COUNTY OF SONOMA

DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 03/31/2017	POLICY NO: MHP-21
REVISION DATE: 05/20/2019	POLICY NAME: **Required Informing Materials and Translation of Written Documents**
APPROVED BY: _____ Behavioral Health Services Director	REFERENCE/AUTHORITY: 1. Code of Federal Regulations, Title 42, §438.10 2. Code of Federal Regulations, Title 45, §92.8 3. California Code of Regulations, Title 9, Chapter 11, §1810.360 and §1810.410 4. Department of Health Care Services (DHCS), Mental Health Substance Use Disorders Services Information Notice NO.: 18-020 and 18-043 5. DHCS-Sonoma County Behavioral Health Mental Health Plan Contract 17-94619 6. 81 Federal Register Volume 81, Issue 96 31375, Nondiscrimination in Health Programs and Activities

POLICY:

The Sonoma County Behavioral Health Division (SCBH) and its contracted providers will provide to all Medi-Cal beneficiaries served by the Sonoma County Mental Health Plan (MHP) written informing materials that are critical to obtaining Specialty Mental Health Services (SMHS). Informing materials will be provided to Medi-Cal beneficiaries at the first face-to-face contact and upon request. Additionally, informing materials will be displayed in the lobbies of all MHP county-owned/operated programs and contracted provider programs. Electronic versions of informing materials will be available on the SCBH website.

Informing materials will be available in Sonoma County's threshold languages and upon request, alternative formats will be available to beneficiaries at no cost and in a format that the beneficiary can easily understand. Upon request, oral and alternative interpretation of informing materials will be provided; this includes the availability of auxiliary aids and services, such as TTY/TDY and American Sign Language. Language Assistance Taglines and a Non-Discrimination Notice shall be included in all informing materials, and posted in MHP county-owned/operated programs and contracted provider programs.

Definitions:
Sonoma County's *threshold languages* are English and Spanish. This means that these languages have been identified as the primary language of either 3,000 Medi-Cal beneficiaries or 5% of the beneficiary population, whichever is lower, in the County geographic area. Thus, all written informing materials are available in English and Spanish.

Informing materials include, but are not limited to, program literature that is critical to assisting

beneficiaries in accessing mental health services, explain the beneficiary problem resolution and fair hearing process, and identify beneficiary rights and protections.

Alternative formats for written materials include, but are not limited to, large print or oral interpretation/audio format. The MHP readily has large print formats available and other formats (e.g., audio, braille) will be provided upon request.

Language Assistance Taglines is a notification explaining the availability of written or oral translation and includes the toll-free and TTY/TDY telephone number of the MHP's customer service unit. This notification is written in English, large-print (18-point font), and the top 16 non-English languages spoken by individuals with Limited English Proficiency.

Non-Discrimination Notice is a notification that the MHP must comply with non-discrimination and accessibility requirements.

PROCEDURE:

I. Informing Materials Provided to all Medi-Cal Beneficiaries

The following documents must be provided to beneficiaries at the first face-to-face contact with them and upon request:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County MHP Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form*-with County addressed envelope
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
F. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)

NOTE: An acknowledgement of receipt must be obtained from all beneficiaries who are offered the identified informing materials (Use MHS 115–Consent for Treatment).

II. Informing Materials Postings for Medi-Cal Provider Lobbies

The following documents must be readily available in the lobbies of all Medi-Cal certified provider sites:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County Mental Health Plan Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)

G. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
F. *Free Language Assistance Services* (Taglines)
G. *Point to Your Language*
H. *Consumer Notification of Licensing Boards*
I. *Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
J. *Request for Change of Service Provider*
K. *Non-Discrimination Notice*

III. Translation of Written Materials

SCBH staff and contractors will provide to Medi-Cal beneficiaries, informing materials in Sonoma County's threshold languages (English and Spanish) and in Large print (18-point font) format.

When applicable, SCBH staff will also ensure that other SCBH documents are translated into threshold languages, or provided in alternative formats upon request. For this purpose, SCBH contracts with a language interpretation and translation service (See policy *MHP 08-Linking Non-English Speaking Beneficiaries to Mental Health Services and Use of Interpreters*).

A. Requests for written translation of formal SCBH documents are to be e-mailed to the Mental Health Plan Quality Assurance Manager (MHP-QA Manager) for review and authorization.

    i. Less formal document translation, such as a single letter to a client during the course of treatment, may be translated by SCBH bilingual staff without going through the MHP-QA Manager (SCBH maintains a list of bilingual staff).

        a. In these cases, review of the document by at least one other bilingual staff person is recommended before distribution of the document.

B. Either the contracted language service or the identified bilingual staff person provides translation into Latin American Spanish, the type of Spanish that is most relevant to the County's Spanish-speaking clients.

C. To ensure both accuracy of translation and cultural appropriateness, upon receipt of a translated document, the MHP-QA Manager will request review of the document by at least one bilingual SCBH staff member, who will notify the MHP-QA Manager of any recommended edits.

    i. Any edits will be made by Quality Assurance (QA) staff before the document is released for use by SCBH and/or MHP contracted provider.

D. With previously published SCBH documents, if an error in translation is identified; if content is deemed culturally insensitive for any reason; or if a document must be adapted to be accessible to persons with limited reading proficiency, the MHP-QA Manger will make necessary modifications/edits by adhering to the abovementioned review and approval process prior to re-release of the document.

E. When a revised document becomes available, QA staff will inform all applicable SCBH staff and/or MHP contracted providers of the change and request that any outdated documents be discarded and replaced by the revised version.

   i. QA staff will save the current document in a shared folder on the SCBH network for all staff to access and archive the outdated document.

   ii. QA staff will update the SCBH website with the revised document.

FORMS/BROCHURES:

1. *Guide to Medi-Cal Mental Health Services Handbook*
2. *Sonoma County Mental Health Plan Provider Directory*
3. *HIPAA Provider's Notice of County Privacy Practices*
4. *MHS 406-Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
5. *MHS 157-Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
6. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
7. *MHS 162-Free Language Assistance Services* (Taglines)
8. *Point to Your Language*
9. *MHS 402-Consumer Notification of Licensing Boards*
10. *MHS 400-Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
11. *MHS 109-Request for Change of Service Provider*
12. *MHS 158-Non-Discrimination Notice*
13. *MHS 115*-Consent for Treatment

ATTACHMENTS:

1. Medi-Cal Informing Materials available online at:
   http://www.sonoma-county.org/health/publications/medi-calinforming.asp

Attachment C

Equity First Consulting LLC
info@equityfirstconsulting.com
www.equityfirstconsulting.com
April 12, 2024

OFFICE OF EQUITY
COUNTY OF SONOMA

Racial Equity Action Plan

Prepared for:
The County of Sonoma

Prepared by:
Equity First Consulting, LLC
The County of Sonoma Office of Equity
The County of Sonoma Core Team Steering Committee

Table of Contents

Land Acknowledgement

Sonoma County and the County of Sonoma are located within the ancestral, traditional, and contemporary land relationships of the Kashia Pomo and Southern Pomo, Wappo, and Coast Miwok Tribal Nations, which include the federally recognized Cloverdale Rancheria of Pomo Indians, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, and Lytton Rancheria of California.

The Office of Equity has not adopted a land acknowledgement yet. We recognize that unless there is direction and subsequent allocation of resources for the County of Sonoma, as an institution, to authentically engage with Tribal Nations and members, a land acknowledgement standing alone cannot replace the need for the creation of collaborative and meaningful relationships founded on respect, reciprocity, shared values and agreements, and a deep understanding of Tribal history and sovereignty, grounded in actions intended to heal past and present harm.

Acknowledgements

The Office of Equity, the Core Team Steering Committee, and Equity First Consulting worked in a partnership based in reciprocity, trust, mutual accountability, and solidarity to shine a light of loving focus on the experience, wisdom, and solutions of staff of color within the County of Sonoma. The team holds a tremendous amount of gratitude for everyone who supported and continues to support this effort.

Action Plan Development Team

- Current & Former Steering Committee members
    - Shawntel Reece, Human Services Department
    - Jo McKay, Human Services Department
    - Michelle Revecho, Human Services Department
    - Audrianna Jones, Community Development Commission
    - Leslie Lew, Agricultural Prese and Open Space District
    - Lauren Reed, Department on Health Services
    - Nora Mallonee-Brand, Department of Health Services
    - Christel Querijero, County Administrator's Office
    - Ryan Pedrotti, Sonoma Water Agency

    - Anna Yip, County Administrator's Office (former member)
    - Denia Candela, Department of Health Services (former member)
    - Victoria Willard, Human Resources Department (former member)
    - Oscar Chavez, Human Services Department (former member)
- County Department Heads and their department staff, particularly the Central Human Resources Department, the County Administrator's Office, the Department of Health Services, and the Human Services Department.
- Community based leaders' group

County of Sonoma Board of Supervisors

- Supervisor Susan Gorin, District 1,
- Supervisor David Rabbitt, District 2
- Supervisor Chris Coursey, District 3
- Supervisor James Gore, District 4
- Supervisor Lynda Hopkins, District 5

County of Sonoma Office of Equity

- Alegría De La Cruz, Founding Director
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- Pilar Garibay, Administrative Assistant
- Lorraine Sekito, Racial Equity Accountability Analyst

Consultant Team

- Equity First Consulting
- Equity and Results

County of Sonoma Staff

- Core Team 1.0
- Focus group participants and survey respondents
- Department Action Plan Liaisons
- County Administrator Projects, Grants and Special Projects Team
- All of the equity champions within all County departments

Executive Summary

In the summer of 2020, the County of Sonoma Board of Supervisors created the County of Office of Equity, taking a meaningful step to recognize and celebrate our local government's powerful role in unseating racial inequity in our communities and within our internal systems. This decision was grounded on the work that led to the creation of the Racial Equity and Social Justice Pillar of the County's 5-year Strategic Plan, which was adopted in 2021, with the goal to "achieve racial equity in County service provision and ensure a workforce reflective of the community we serve." The pillar is made up of specific goals and objectives that will lead to normalizing, organizing, and operationalizing (Bernabei, 2017; Rudiger, 2021) a new way of seeing our challenges, conducting analysis, and implementing new policies to achieve this goal.

Among the work that the Office of Equity has done to embed racial equity within County systems has been the creation and stewardship of Core Team 1.0, a learning community of equity champions from different County departments. Participants worked together for a year and a half to deepen their understanding of racial equity concepts and learn how to operationalize equity in their areas of expertise. While learning how to apply the Anti-Racist Results-Based Accountability (AR-RBA) methodology (Equity and Results, 2023), the Office of Equity and the Core Team 1.0 began to see patterns among Core Team members' experiences, the exit of leaders of color from the County workforce, and the lack of representation of staff of color in leadership positions (as documented by the data on the Central Human Resources Workforce Demographics dashboard).

Understanding the power of staff's own lived experiences as people of color in the face of these patterns, in 2023, the OOE convened a Steering Committee, made up of Core Team 1.0 members, to create a roadmap to operationalize the strategic guidance of the Racial Equity and Social Justice Strategic Plan pillar. The result is the County's first Racial Equity Action Plan (Action Plan), approved by the Board of Supervisors on May 17, 2024.

Key Questions Addressed by the Racial Equity Action Plan:

1. What are the conditions of well-being that we want County staff to experience?
2. What racial inequities exist within the internal infrastructure of the County that prevent these conditions from occurring?
3. Why do these racial inequities exist and persist?
4. What strategic actions can the County take to disrupt the roots of these inequities?

5. How can the County measure the efficacy of these strategic actions?

Snapshot of the Racial Equity Action Plan

The answers to these questions and the solutions to address them are reflected in the following snapshot of the Racial Equity Action Plan. The rest of this document will explain in more detail the process, methodology and implementation of the Action Plan.

COUNTY OF SONOMA RACIAL EQUITY ACTION PLAN SNAPSHOT

Goal	All County staff, especially staff of color, feel a sense of belonging and are supported to achieve their career goals within the County organization.		
Barriers	County management is not representative of the racial demographics of Sonoma County.	Staff of color report disproportionate dissatisfaction levels with management practices.	
Why	There are few mechanisms supporting managers in hiring and promoting qualified staff members of color to leadership levels.	Management practices do not reflect sufficient capacity, skill sets, and/or interest to contribute to the empowerment of staff, especially staff of color.	The County system values productivity over the impact that working conditions have on people, especially staff of color.
Recommended Strategies	County creates capacity for equity work and expands pipelines for hiring and career advancement.	County offers support and creates accountability for management at all levels to develop an understanding of racial equity principles and practices.	County invests in data collection and reporting systems to drive change that is responsive to staff experiences.
Accountability	• Percentage of staff hired and promoted into management positions	• Percentage of Department Heads, supervisors, and managers implementing anti-racist practices. • Percentage of staff who see management taking new kinds of actions in service of equity.	• Percentages of staff retention and turnover. • Percentage of staff who feel like the County is offering a positive space to support their work and well-being.

Part 1: Rationale

Why a Racial Equity Action Plan for Sonoma County?

Sonoma County's collective well-being and prosperity are impacted by significant inequities, and data shows that the greatest disparities occur along racial and socio-economic lines (Measure of America, 2021). Because racial inequities have been deeply rooted into government systems, policies, and practices, the County has a unique opportunity and responsibility to address these inequities by improving outcomes for County staff and community members who have experienced generational marginalization.

The County of Sonoma Board of Supervisors acknowledged and accepted the County's responsibility to unseat these racial inequities when they included a Racial Equity & Social Justice Pillar in the Sonoma County's Five-Year Strategic Plan. This strategic direction informs policies and projects and defines the core commitments that the County wishes to prioritize.

Building on this work, the Racial Equity Action Plan provides an intentional road map, made up of strategies, action steps, and accountability mechanisms focused on our internal systems, which 1) builds on equity work that is already happening within County departments, and 2) seeks to provide additional supports to further advance racial equity through enabling collaboration across County departments and consistency as an organization.

Our Approach to Research and Plan Development

Strengthening Equity by Starting from Within

Building a strong foundation starts from within (Equity in the Center, 2019; Nelson & Tyrell, 2015). This strategic approach recognizes that County staff are integral members of the Sonoma County community and represent the broad range of experiences and identities of the communities we serve. By establishing the foundations to advance racial equity work within our organization, we create a strong backbone for generating transformative change in the broader community in the following ways:

(1) Modeling and refining anti-racist leadership: The way we support the County workforce, especially staff and leadership of color, can serve as a model for how we

approach solutions to greater inequities experienced by Sonoma County communities, both by refining strategies internally before scaling externally, and by positioning co-leadership between communities of color and County leaders as a critical practice for change in Sonoma County.

(2) Creating more nuanced and contextualized policy recommendations: Research shows that greater diversity among leadership leads to more equity-driven decisions and policies (Cook & Glass, 2015). Creating the conditions for diverse leadership (which includes shifts in workplace culture and policies related to hiring, promotion, and advancement) will allow the County to shift policies and practices to better address the barriers that communities of color face with the solutions that will work for them.

(3) Creating capacity to connect with communities experiencing marginalization: One of the ways in which diversity in leadership positions can impact external policy is the ability to connect with members of the communities most impacted by systemic inequities who are outside of the County structure. The community engagement work sponsored by the County throughout 2023 showed that folks in these communities are better able to connect and engage with County staff and leaders who can use their bicultural and institutional knowledge to bridge the gap between the institution and the community (Sonoma County Office of Equity, 2024).

(4) Minimizing staff turnover: Public service is exhausting work for people from all backgrounds (Noblet & Rodwell, 2008; Ruble, 2022). Research (Humphrey, 2021; Manning, 2021; Ruble, 2022) and the data analyzed for this plan show that staff of color do more emotional labor (on top of their public service work) than their White peers in the County of Sonoma. This additional labor creates a less sustainable working environment, which increases burnout and the likelihood of staff turnover (Bloomberg, n.d.; Jeung et al, 2018). Additionally, research shows that turnover rates are lower for Black women when there are more Black women on their team (Linos, 2023). Creating the conditions for psychological safety at work has the opposite effect, minimizing burnout and turnover (Kerrissey et al, 2022; Lindzon, 2021), so that staff can thrive, and the County can get the desired return on investment from training, developing, and retaining staff. In other words, everybody wins.

Designing-to-the-Margins in Order to Expand the Center

This Action Plan recognizes that “the creation and perpetuation of racial inequities has been baked into government” (GARE, n.d.), and that institutions are not designed to capture or respond to community wisdom equitably (Gonzalez, 2021). Existing data demonstrates that the needs and wisdom of people of color in Sonoma County are still not

reflected in our work, staff or community outcomes (Sonoma County HR, 2023; Measure of America, 2021), despite best intentions. This is why this Action Plan focuses on systemic levers.

A Design-to-the-Margins framework centers the most impacted and marginalized community members in all stages of policy and program design, from imagination to implementation. This prioritization begins with race, and includes a range of intersecting identities, such as primary language, documentation status, wealth and income, gender, etc., which impact the extent to which people are likely to have equitable access to decision-making power and/or experience harm perpetuated at the systems level (Crenshaw, 1991; Crenshaw 2017; GARE, n.d.). The Design-to-the-Margins framework recognizes that the people who are "closest to the problem are closest to the solution" (Martin, 2017), and that the people living on the margins have a unique vantage point from which to envision and create, yet they are often simultaneously furthest from institutional power (hooks, 1984). By placing loving focus on historically marginalized communities and their perspectives, this framework seeks to create equitable outcomes from which the broader community can benefit.

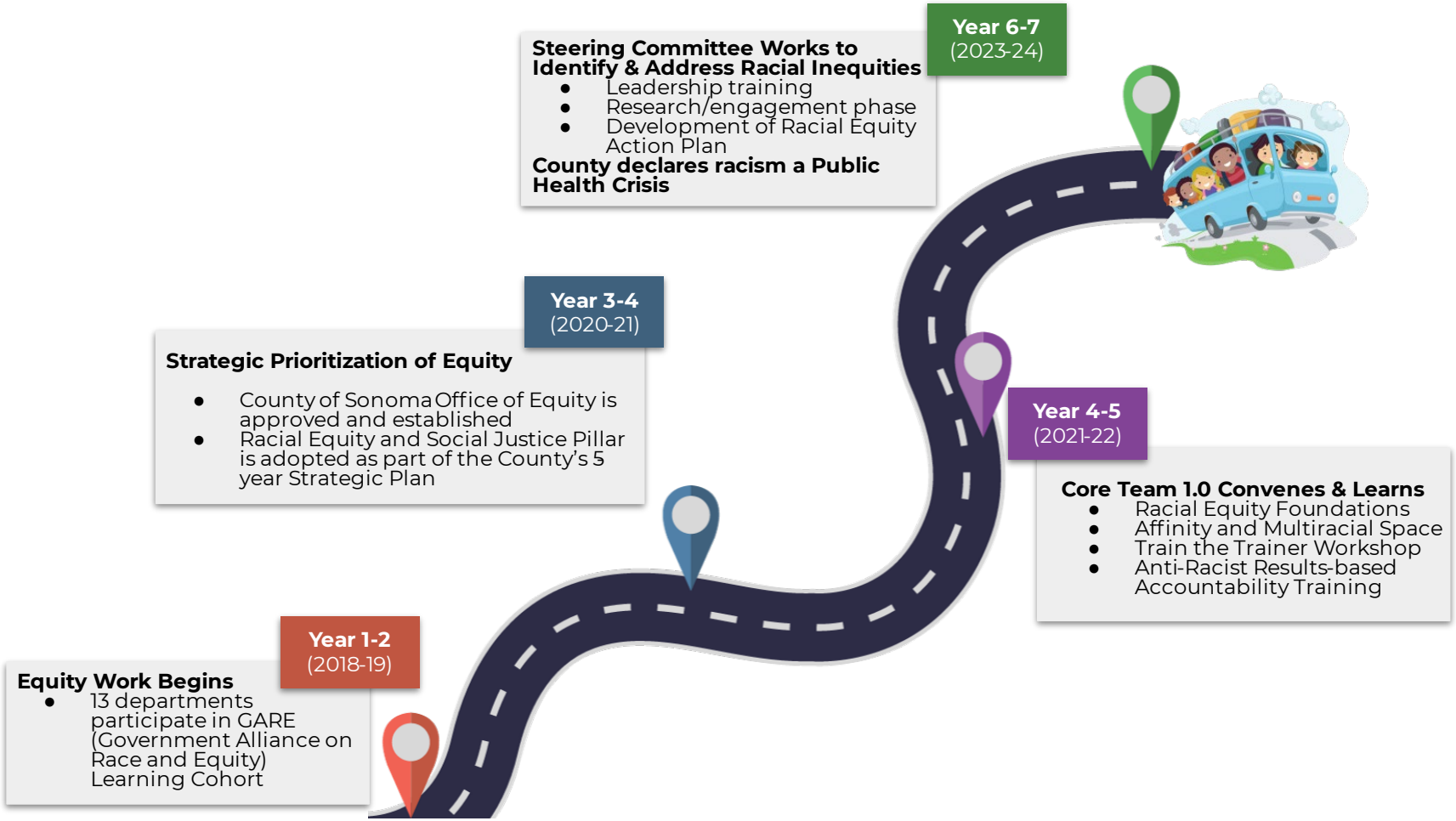
Applying the County of Sonoma's Theory of Change

Creating a world where daily processes and actions naturally generate equitable outcomes will require ongoing and intentional interventions. The Office of Equity follows the Government Alliance on Race and Equity (GARE) strategic approach to advance racial equity within County institutions by 1) normalizing, 2) organizing, and 3) operationalizing racial equity work (Bernabei, 2017; Rudiger, 2021).

Strategic Stages	**What this means**	**What this looks like at the County of Sonoma**
Normalize	• Use a racial equity framework • Operate with urgency and accountability	• Strategic Planning Pillar • Establishment of the OOE • County declaration of Racism as a Public Health Crisis
Organize	• Build organizational capacity	• Creation of Core Team 1.0 and Racial Equity Learning Program • Creation of the Core Team

	• Partner with other organizations and communities	Steering Committee • Cross-departmental alignment and coordination • Racial Equity 101 and Anti-racist Results-Based Accountability (AR-RBA) Trainings • Collaborations around the American Rescue Plan Act (ARPA) Community Resilience Programs
Operationalize	• Implement racial equity tools • Be data-driven	• Racial Equity Analyses for significant Board items • Anti-racist Results-Based Accountability (AR-RBA) Trainings • Development of a Racial Equity Action Plan (Action Plan)

Strategic Stages of Institutionalized Equity Work at the County of Sonoma



Part 2: Methodology

The process for developing this Racial Equity Action Plan was phased as follows:

Phase 0: Creating a Space Built on Trust, Reciprocity, and Accountability

Core Team 1.0 spent nearly a year working first in affinity space and then as a multi-racial group, developing a collective understanding of racial equity foundational principles and patterns and building the trust to step into brave spaces and lean into discomfort. Core Team 1.0 participants then had the option to participate in learning to (a) facilitate conversations about racial equity, and/or (b) use the Anti-Racist Results-Based Accountability (AR-RBA) methodology in their work, eventually creating a collective vision for eliminating racist outcomes in County systems.

In year two, communication went out to Core Team 1.0 members, inviting people who had the desire, capacity, and skills to apply to join the Core Team Steering Committee, which would be charged with creating a Racial Equity Action Plan for the County of Sonoma. The Office of Equity and consulting team were intentional about creating a space of trust, mutual accountability, and shared humanity for Steering Committee members. This team-building time and work became crucial to creating the conditions to launch into complex work in later stages.

The strategies engaged in this phase included:

- Prioritizing relationship- and community-building and repairing harm even in the face of urgency.
- Person-centered working spaces including deep check-ins to start meetings and reflection surveys at the end to help shape working spaces and relationships.
- Flexible working groups, including a mix of affinity and multiracial space and task-specific committees.
- Building capacity and identifying and removing barriers to meaningful participation

Phase 1: Research and Anti-Racist Results-Based Accountability

In the spirit of community engagement and to integrate and amplify the wisdom shared with the County of Sonoma in the past, the Steering Committee Research Team reviewed existing data from various reports, surveys, and demographic data sets to assess the state of race equity within the County of Sonoma. Steering Committee members then identified a list of key themes that emerged frequently and throughout the organization. Based on

this data, the Steering Committee collectively made the decision to focus further data collection and AR-RBA analysis efforts internally on the experience of County staff.

Antiracist Results-Based Accountability (AR-RBA) begins with impact and backs into solutions to ensure that solutions are selected with a focus on the root causes of the racial inequity. It requires organizations to deeply consider the answer to the question, how will we know that people are better off as a result of our work? (Equity and Results, 2023).

Using the Anti-Racist Results-Based Accountability (AR-RBA) methodology and completing a root-cause analysis, the Steering Committee developed an understanding of root causes of inequities impacting the County, identified why these inequities persisted, developed strategies that address the root causes, and performance and better-off measures that hold the County accountable to whether people, especially people of color, are truly better off because of them. The two major themes identified in this process were: 1) increasing the sense of belonging for County staff and 2) supporting career advancement for County staff, especially staff of color.

Phase 2: Engagement with County Staff and Community-Based Leaders

After the Research Team made significant progress on the AR-RBA analysis, the Engagement Team planned focus groups with staff, with the following goals: (1) to present the AR-RBA analysis results and gather perspectives on whether the proposed strategies resonated with staff and community-based leaders, (2) to gather more data to help expand strategies, and (3) to find out if anything was missing. Participants across County departments, job types, experiences, and racial identities shared their thoughts and experiences with the Steering Committee. All participants were provided with the strategies and terminology before the focus group, to allow for additional reflection time.

To recruit participants, the Steering Committee presented at a County of Sonoma Department Agency and Head Association (DAHA) meeting and asked department leaders for nominations for liaisons within each department, whose first assignment was to help select participants for the focus groups. The Steering Committee stressed the importance of hearing from both management (Supervisors/Managers/Division Directors) and front-facing staff in this process. With the support of departmental liaisons, at least two staff members from each department, representing those two categories, were invited to participate in the focus groups. Two meeting opportunities were offered for each job category to promote honest answers and a safe space for sharing. The Steering Committee

also invited the participation of Core Team members in Affinity groups (Black Affinity, Non-Black People of Color Affinity, White Affinity). During this engagement phase, 60 staff members participated in the focus groups. Relevant demographic information from focus group participants includes:

Racial Identity

Percentage	Racial Identity
40.70%	Hispanic or Latine/x
30.00%	White
9.30%	Asian
9.30%	Prefer to self-describe
7.40%	Native American/Indigenous Peoples/First Peoples (American Indian) or Alaska Native
7.40%	Black or African American
3.70%	Middle Eastern or North African
3.70%	Prefer not to say

Role within the County

Percentage	County Role
38.20%	Supervisor or Manager
30.90%	Front-facing staff, client-facing (ex: front desk/ receptionist, social worker, eligibility worker, community health worker, community engagement person, etc.)
14.50%	Administrative staff, non-client facing, non-managerial (ex: operations, financial, etc.)
10.90%	Executive Leadership (Department Head, Division Manager within a Department)

5.50%	Prefer to self-describe

The Steering Committee also held two focus groups, one in English and one Spanish, with community-based leaders to gather external community perspectives about the draft of the Racial Equity Action Plan. Community-based leaders responded to content and questions that were adapted from what was shared during the focus groups with staff.

Phase 3: Analysis of Engagement and Incorporation into the Draft Action Plan

After the focus groups, the engagement team analyzed the additional data obtained to find common themes and feedback around the presented strategies. The Writing Team incorporated the feedback and adapted the draft strategies in response to the data gathered during the focus group process.

Phase 4: Strategy, Reflection, and Assessment of Capacity and Needs

Once the draft Action Plan strategies were revised to include data from the focus groups, the Steering Community Strategy Team held reflection sessions with staff in the Spring of 2024 to ensure that wisdom shared was accurately reflected in the revised strategies, as well as to understand what would be needed to set the Action Plan up for success. The Strategy Team facilitated two reflection sessions with prior focus group invitees, including breakouts by race affinity and management level, which had a total of 33 participants. They also sought feedback on the Action Plan from the County Administrator, the Central Human Resources Director, County Counsel, and additionally gave presentations to the Safety Net Collaborative, the Department Head and Agency Association, and offered all Department Heads an optional 1:1 meeting to discuss the Action Plan. Finally, the Office of Equity held board briefings with the Board of Supervisors in advance of the Board presentation. The Strategy Team also met with community members engaged in the prior focus groups to follow up and present the draft Racial Equity Action Plan.

Phase 5: Finalizing the Racial Equity Action Plan

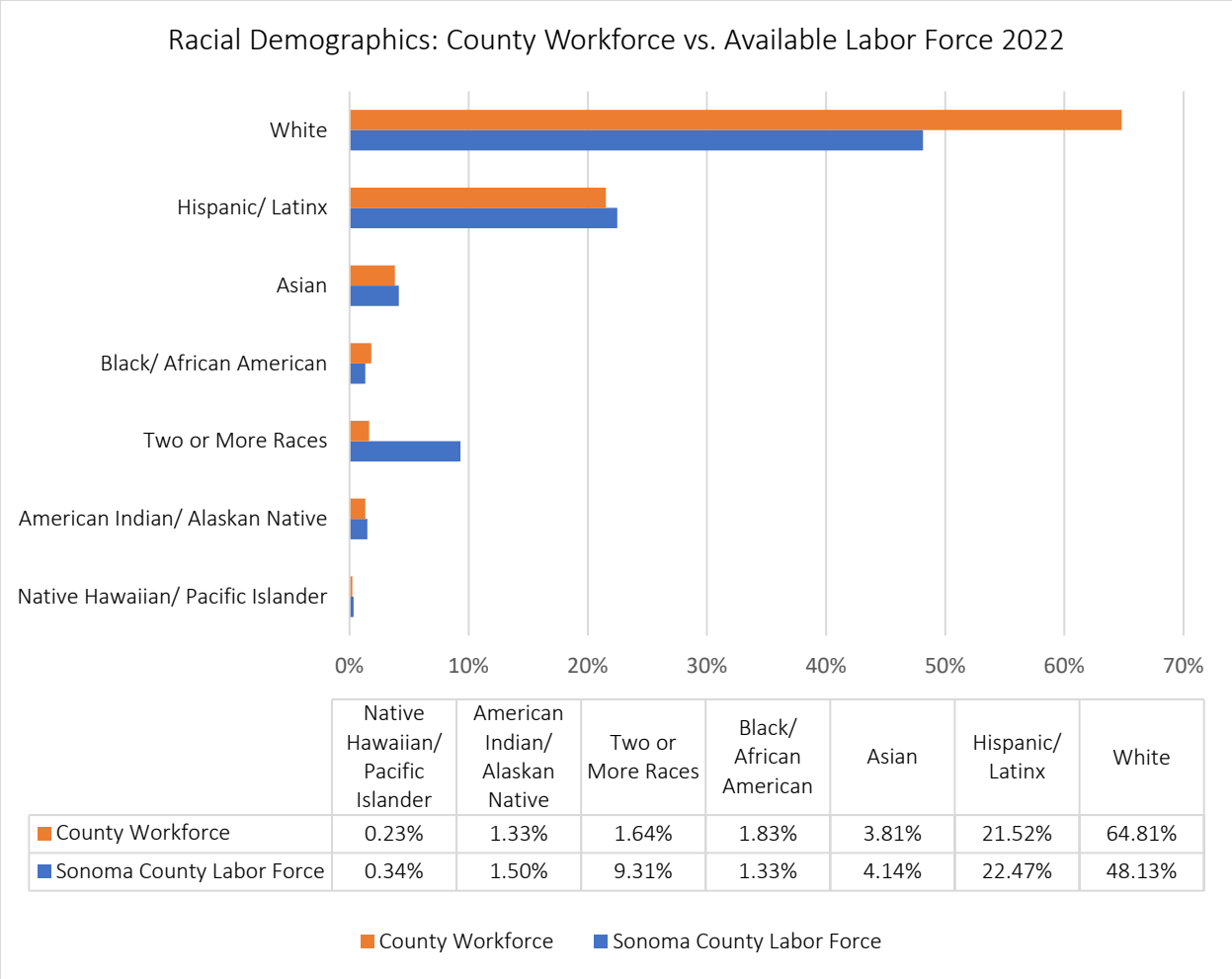
In Phase 5, the Steering Committee revised the Action Plan's strategies according to the feedback received during the Reflection Sessions and finalized this document. In May of 2024 the Board of Sonoma County Board of Supervisors approved the Draft Racial Equity Action Plan and directed staff to implement the strategies in the Action Plan.

Part 3: Internal Indicators

The initial research phase of the Racial Equity Action Planning process identified two major internal indictors or Barriers, each of which was supported by the engagement phase. While many factors contribute to these outcomes, the research team used the Anti-Racist Results-Based Accountability (AR-RBA) root cause analysis to identify what are known as Hot Roots of inequities, which are (1) race-explicit levers, (2) within the purview of the County to shift, and (3) if disrupted, could have an outsized impact on the County's structural dynamics and change racial outcomes for the better.

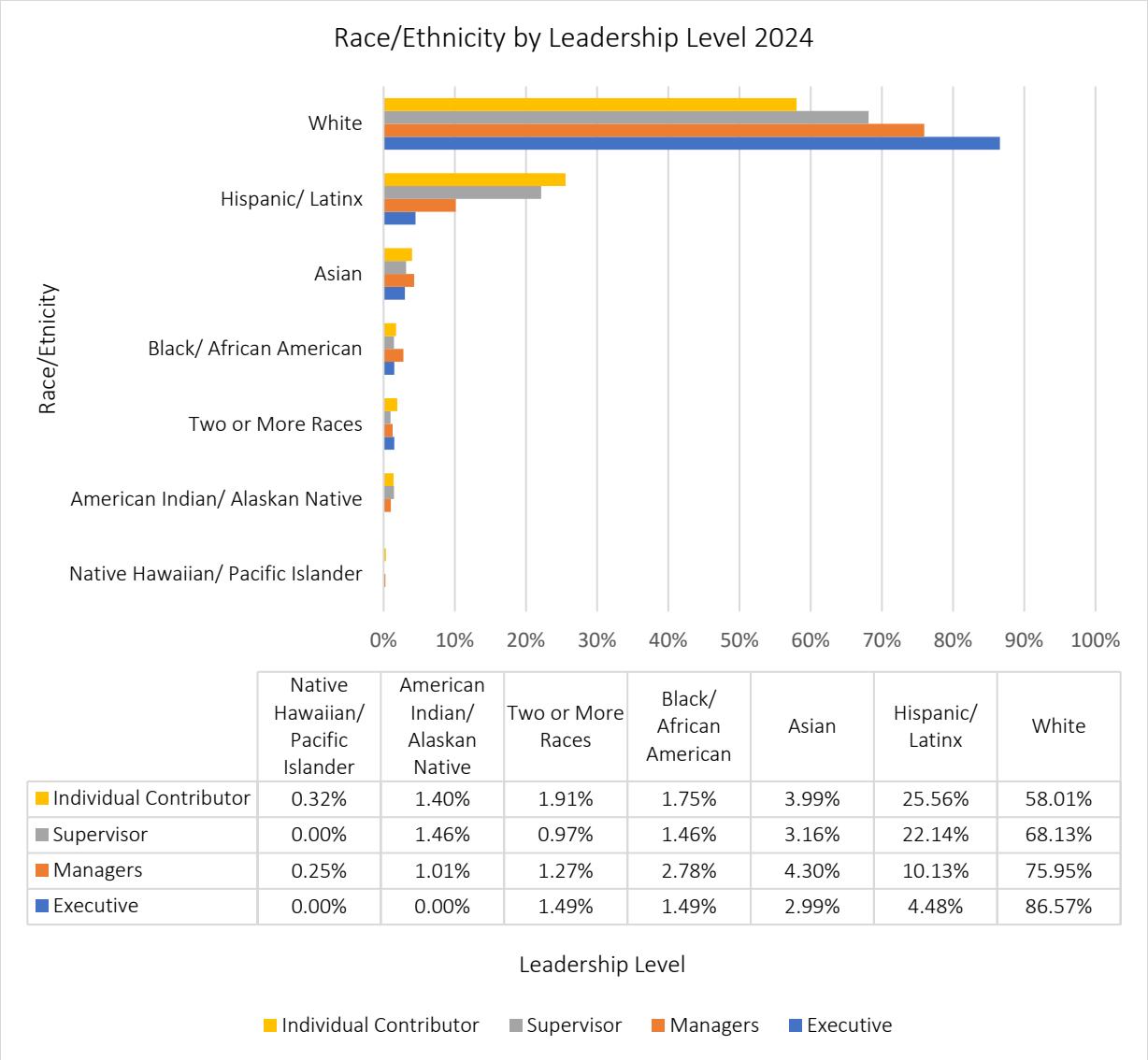
Internal Indicator (Barrier) 1: County Management is not representative of the racial demographics of Sonoma County.

Data from the County of Sonoma Workforce Demographics Dashboard from 2022 shows White employees are overrepresented in great numbers in the County of Sonoma workforce compared to the available labor force, while most other racial/ethnic groups remain underrepresented.



	Native Hawaiian/ Pacific Islander	American Indian/ Alaskan Native	Two or More Races	Black/ African American	Asian	Hispanic/ Latinx	White
County Workforce	0.23%	1.33%	1.64%	1.83%	3.81%	21.52%	64.81%
Sonoma County Labor Force	0.34%	1.50%	9.31%	1.33%	4.14%	22.47%	48.13%

This trend worsens higher up the organizational hierarchy, with the percentage of White people on staff rising (and conversely, the percentage of people of color decreasing) at each leadership tier.



	Native Hawaiian/ Pacific Islander	American Indian/ Alaskan Native	Two or More Races	Black/ African American	Asian	Hispanic/ Latinx	White
Individual Contributor	0.32%	1.40%	1.91%	1.75%	3.99%	25.56%	58.01%
Supervisor	0.00%	1.46%	0.97%	1.46%	3.16%	22.14%	68.13%
Managers	0.25%	1.01%	1.27%	2.78%	4.30%	10.13%	75.95%
Executive	0.00%	0.00%	1.49%	1.49%	2.99%	4.48%	86.57%

Hot Root (Why): There are few mechanisms supporting managers in hiring and promoting qualified staff members of color to leadership levels.

Staff surveys across County departments show that staff of color do not have equitable access to career advancement pathways, including opportunities to join leadership development programs, gain experience with assignments that expand staff's current skill level or expertise, informal leadership opportunities, and opportunities to advance within their department upon completion of professional development programs. Staff of color report having to work twice as hard to feel valued at work and are less likely than their White counterparts to report that diversity, equity, and inclusion (DEI) work is valued or sufficiently staffed or resourced in their department.

Staff, in particular staff of color, have also reported patterns of "ingroup bias," where County managers, the majority of whom are White, tend to favor candidates or staff who are similar to them. Studies on supervisor favoritism suggest that these instances create costly outcomes to the organization and among staff, including "negative emotions toward the organization, less loyalty to the company, less job satisfaction, stronger intentions to quit the job, less work motivation, and more emotional exhaustion" (Li, 2018). Additionally, employees who are not favored receive "less coaching, feedback or opportunities, which directly impedes talent development within the organization" (Li, 2018). Managers have also reported needing additional supports to understand "where to start" their anti-racist leadership journey, including training and coaching, which this Action Plan addresses.

Hiring and promotion practices have not yet been sufficiently examined to root out gatekeeping mechanisms resulting in organizational inequities. However, the Central Human Resources department is beginning a process to remove barriers to employment, including updating class specifications to remove artificial barriers related to education and experience, expanding the talent acquisition pipeline, and several other initiatives in alignment with this Racial Equity Action Plan (Sonoma County Human Resources, 2024).

Internal Indicator (Barrier) 2: Staff of color disproportionately report dissatisfaction levels with management practices.

Diversifying the staff is only one piece of the puzzle, however. Satisfaction levels for staff of color are lower than their White counterparts. This is important on a human level, and for purposes of retention. Staff surveys show that staff of color disproportionately report considering leaving their departments and/or the County as a whole due to feeling undervalued, experiencing burnout (especially bilingual staff), having fewer opportunities for advancement, and in some cases experiencing racial microaggressions and overt racism. Survey participants shared that they did not see sufficient response from Departments or the County to these instances.

Hot Root (Why): Management practices do not reflect sufficient capacity, skill sets, and/or interest to contribute to the empowerment of staff, especially staff of color.

There is an overarching sense that the County is not sufficiently equipped to deal with racial equity issues in ways that are effective and promote staff well-being. Staff and leaders report not having the time or capacity to deepen their understanding of racial equity work. Many employees who have gone through trainings report that while their understanding of the issues has deepened, their confidence in their ability to intervene in meaningful ways is lagging.

Robust training, especially for managers and supervisors, coupled with County-wide performance management mechanisms (including evaluation through a growth-mindset lens (Han & Stieha, 2020) and using AR-RBA to identify and address root causes of issues), can move the needle on this.

Hot Root (Why): The County system values productivity over the impact that working conditions have on people, especially staff of color.

The County of Sonoma dedicates resources to service provision and operations, but as demonstrated earlier in this section, when demand for service is so critical, productivity often comes at the expense of staff well-being, particularly for staff of color. Staff, and especially staff of color, report that their workplace experience is a harmful one and that the County has not dedicated sufficient resources to learning about this experience or responding to it.

This matters because as the biggest employer in the County, the impact that we have as an organization in our workforce is both a part and a reflection of the impact we have on the community at large. Valuing productivity over people also impacts the ways in which we make decisions as a County and by extension the way our clients experience our services. Finally, it is costly for the County, both as an employer and a government organization, not to safeguard the wellbeing of its staff. When staff feel insufficiently supported, it can lead to burnout and turnover, which signify losses in investments and knowledge (Bloomberg, n.d.; Hall, 2019; Jeung et al, 2018; Kihlstrom, 2019; McFeely & Wigert, 2019) and challenges around adequate service provision.

Part 4: A Racial Equity Action Plan for the County of Sonoma

The Steering Committee and the Office of Equity looked at the findings presented in Part 3 and identified the following result statement (or goal) for the Racial Equity Action Plan: ***All County staff, especially staff of color, feel a sense of belonging and are supported to achieve their career goals within the County organization.***

With this as the ultimate goal, we continued the AR-RBA process to address the underlying root causes of the issues identified in the findings and move towards better outcomes for County staff. In the table below, we present the framework that responds to the findings

and hot roots listed in Part 3, and that in the end, should move the County towards achieving the goal (result statement) of the Racial Equity Action Plan.

As you read through the Action Plan and implementation tables, consider the following definitions:

Result Statement (Goal): The long-term, end goal of the Racial Equity Action Plan's full implementation.

Internal Indicators (Barriers): The internal County data that can be tracked overtime and disaggregated by race, which helps us see racial disproportionality.

Hot Roots (Whys): The key underlying systemic causes of the internal indicator that are both within the County's power to shift and will create meaningful change.

Recommended Strategies (Headline strategies and sub-strategies): The headline strategies are designed to address the hot roots of inequities. The sub-strategies are the headline strategies broken down into its component parts.

Performance Measures: You will find the measures outlined in the implementation tables only. They will hold the County accountable to the implementation of the sub-strategies intended outcomes by telling how much and how well they are working. If pieces of the Action Plan are less effective than we believe they will be, these measures will support us in understanding where the shift needs to occur.

Headline Better-Off Measures (Accountability): These measurements are directly connected to the internal indicators. They measure the extent to which all strategies and sub-strategies achieved whether people, especially people of color, are truly better off because of them.

COUNTY OF SONOMA RACIAL EQUITY ACTION PLAN

Result Statement (Goal)	All County staff, especially staff of color, feel a sense of belonging and are supported to achieve their career goals within the County organization.		
Internal Indicators (Barriers)	County management is not representative of the racial demographics of Sonoma County.	Staff of color report disproportionate dissatisfaction levels with management practices.	
Hot Roots (Whys)	There are few mechanisms supporting managers in hiring and promoting qualified staff members of color to leadership levels.	Management practices do not reflect sufficient capacity, skill sets, and/or interest to contribute to the empowerment of staff, especially staff of color.	The County system values productivity over the impact that working conditions have on people, especially staff of color.
Strategies & Sub-Strategies	**Strategy 1: County creates capacity for equity work and expands pipelines for hiring and career advancement.** **a.** Department Heads create staff capacity to operationalize equity work by: 1) Designating a Core Team 2.0 Liaison, and 2) Creating equity positions, or 3) Redirecting capacity of existing staff. **b.** OOE creates and convenes Core Team 2.0 to lead the implementation of the Plan across departments. **c.** Department Heads support and include in annual operational budgets resources to support professional and leadership development opportunities to reach all staff, especially staff of color. **d.** Central HR conducts an assessment of County job descriptions and hiring practices, and engages in a codesign process to remove barriers and elevate the value of lived experience.	**Strategy 2: County offers support and creates accountability for management at all levels to develop an understanding of racial equity principles and practices.** **a.** All managers actively participate in learning and training spaces about racial equity principles and practices. **b.** Department Heads, supervisors, and managers are evaluated on their competencies on racial equity principles and practices.	**Strategy 3: County invests in data collection and reporting systems to drive change that is responsive to staff experiences.** **a.** Central HR publishes disaggregated data on recruitment, hiring, promotions, and turnover rates of employees. **b.** Central HR conducts a standard employee survey that consistently collects data on staff experiences, in particular around belonging and career advancement. **c.** All Managers learn how to apply Anti-Racist Results-Based Accountability (AR-RBA) methodology to address racial inequities from survey data. **d.** County institutionalizes spaces for healing, belonging, and connection.
Headline Better-Off Measures (Accountability)	• Percentage of staff hired and promoted into management positions.	• Percentage of Department Heads, supervisors, and managers implementing anti-racist practices. • Percentage of staff who see management taking new kinds of actions in service of equity.	• Percentages of staff retention and turnover. • Percentage of staff who feel like the County is offering a positive space to support their work and well-being.

Part 5: Implementation Plan for the Action Plan

With the overarching picture described above, the following implementation plan serves to illuminate action steps that, if adopted by the Board of Supervisors, and fully implemented by departments in collaboration with the Office of Equity, will move the County of Sonoma further in its organizational anti-racist journey.

In alignment with Goal 3, Objective 2 of the Racial Equity and Social Justice Strategic Plan pillar, this Action Plan establishes yearly and publicly available reporting on the County's implementation of the Action Plan strategies. The implementation tables below provide a recommended timeline, with the understanding that different departments are starting their anti-racist journey in different places and the rate of progress may look different across departments.

Area of Focus 1: Hiring, Retention, and Staff Development and Support Process.

An anti-racist County of Sonoma would have racially diverse leaders at all levels in the organization, supported by hiring practices and promotion mechanisms that recognize and reward a wide variety of experience and skills; by the institutional validation and compensation of equity work; and by the intentional ongoing implementation of a Racial Equity Action Plan.

While demographic shifts are slowly taking place and some communities of color are represented in the workforce close to alignment with the available labor force, the data shows us that the higher up in the organizational hierarchy we look, the higher the representation of White staff (Sonoma County HR, 2023). This is not the case for any other racial or ethnic community. Which begs the question: What is going on? While laws and policies, such as California's Proposition 209, prevent the use of race as a decision-making criterion in public employment, data shows that hiring processes still result in racialized outcomes favoring White people. This requires a thoughtful and intentional strategy to identify what is leading to disparities in hiring, retention, and promotion.

The following are the sub-strategies, action steps, recommended timeline, and performance measures that will aim to create leadership and staff capacity to operationalize equity in the County of Sonoma.

Headline Strategy 1: County creates capacity for equity work and expands pipelines for hiring and career advancement.			
Sub-strategies	**Action Steps**	**Timeline** (Recommended)	**Performance Measures**
1a. Department Heads create staff capacity to operationalize equity work by: 1) Designating a Core Team 2.0 Liaison, and 2) Creating equity positions, or 3) Redirecting capacity of existing staff.	**1a-1:** Dept. heads work with OOE to identify a liaison to Core Team 2.0 based on OOE guidance and parameters	Year 1	% of departments with active Core Team 2.0 participants % of departments with sufficient racial equity FTE allocations % of departments with hired equity staff
	1a-2: Liaison works with OOE to assess current Equity allocations in their departments and create a plan moving forward.	Year 1/2	
	1a-3: Dept. heads implement the plan, including hiring and supporting staff, allocating time and/or resources, etc.	Year 2	
	1a-4: Liaisons and Dept. Heads evaluate and report on the impacts of the plan with OOE support.	Year 3	
1b. OOE creates and convenes Core Team 2.0 to lead the implementation of the Plan across departments	**1b-1:** OOE contracts with a consultant to help facilitate Core Team 2.0	Year 1	% of strategies and actions implemented by CT 2.0 in their departments
	1b-2: Department Heads allocate time and resources for liaisons to actively participate in Core Team 2.0 and implement the Racial Equity Action Plan in their departments.	Year 1	
	1b-3: Core Team 2.0 participates in facilitated meetings and creates	Year 1	

	protocols for progress tracking and reporting, to both track the implementation and impact of the Plan and to ensure transparency.		
1c. Department Heads support and include in annual operational budgets resources to support professional and leadership development opportunities to reach all staff, especially staff of color.	**1c-1:** Liaisons work with the OOE to identify current County-wide and department-specific professional and leadership development opportunities.	Year 1/2	% of staff who participate in existing or new professional development programs % of Department Heads investing and/or improving professional development outlets for staff, especially staff of color
	1c-2: Liaisons, supported by OOE and Central HR, recommend changes to better meet the professional development needs of staff, especially staff of color.	Year 1/2	
	1c-3: Department Heads implement recommendations.	Year 2/3	
	1c-4: Liaisons and Dept. Heads evaluate and report on the impacts of the recommendations with OOE support.	Year 2/3	
1d. Central HR conducts an assessment of County job descriptions and hiring practices, and engages in a codesign process to remove barriers and elevate the value of lived experience.	**1d-1:** OOE, Central HR, Core Team 2.0, and Steering Committee develop a plan for evaluating job classifications and descriptions and through an anti-racist lens.	Year 2	#/% of management and leadership level job descriptions that were evaluated by Central HR #/% of job descriptions with
	1d-2: Core Team 2.0 works in collaboration with	Year 1/2	

	Central HR to identify additional anti-racist hiring practices to pilot within departments.		changes made that are aligned with anti-racist recommendations from (CT 2.0)
	1d-3: Liaisons from departments implement pilots and evaluate progress.	Year 2/3	
Headline Better-Off Measure 1: Percentage of staff hired and promoted into management positions.			

Area of Focus 2: Manager Training, Support, and Accountability

The County's organizational commitment to an anti-racist workplace must be driven by adaptive leaders who can connect data (surveys, focus groups, interviews) to the lived experiences of staff, implement the strategies listed in this Plan, and hold themselves accountable to realizing a vision of an anti-racist workplace for and with their staff (Bernabei, 2017; Gonzalez, 2021; Livingston, 2020).

Currently, the data reveals that County staff of color have disproportionately reported dissatisfaction with management practices compared to their White colleagues. That data tells a human story about the experiences of "othering" that staff of color go through, even when the people in positions responsible for organizing and supporting our best work have good intentions. Good intentions do not create systemic impact, intentional, measurable efforts do. However, data reveals that, in the County, there are few mechanisms in place to support leadership, people in supervisory roles, and staff in learning how to apply anti-racist principles in their jobs.

This Plan resources managers and supervisors with training in racial equity skills to empower County leaders to drive systems transformation and to effectively support the well-being of the people they supervise, who are at the front line of delivering government services. The following sub-strategies, action steps, recommended timeline, and performance measures will support managers at all levels to implement anti-racist principles and practices.

Headline Strategy 2: County offers support and creates accountability for management at all levels to develop an understanding of racial equity principles and practices.			
Sub-strategies	**Action Steps**	**Timeline** (Recommended)	**Performance Measures**
2a. All managers actively participate in learning and training spaces about racial equity principles and practices.	**2a-1:** OOE, Central HR, and Department Heads, identify staff (job classes) for whom training may be required and assign training plans.	Year 1	% of managers participating in learning and training spaces % of staff who see managers taking new kinds of actions in service of equity % of managers implementing anti-racist practices
	2a-2: OOE and Central HR work together to identify the cadence of training and tracking processes.	Year 1	
	2a-3: OOE and Central HR develop an assessment process to evaluate how staff are applying knowledge and skills acquired during training.	Year 2	
2b. Department Heads, supervisors, and managers are evaluated on their competencies on racial equity principles and practices.	**2b-1:** OOE and Central HR work with Core Team 1.0, 2.0, and the Steering Committee to assess existing processes and make recommendations on the evaluation of racial equity core competencies.	Year 2	% of Department Heads, supervisors, and managers who support and create expectations for their staff to implement anti-racist practices % of management whose performance evaluations include racial
	2b-2: Central HR and OOE take steps to begin implementation with relevant stakeholders.	Year 2	
	2b-3: OOE and Central HR work with department HR liaisons to develop a	Year 2	

	communication strategy and implement the new evaluation processes.		equity
	2b-4: OOE, Central HR, and CAO, work to establish a departmental baseline and reporting process for the implementation of the Action Plan.	Year 3	
Headline Better-Off Measures 2: Percentage of Department Heads, supervisors, and managers implementing anti-racist practices; Percentage of staff who see management taking new kinds of actions in service of equity.			

Area of Focus 3: Data Collection, Analysis, and Response

An anti-racist system for data collection and analysis must center the stories that have been left at the margins, making them visible and understood by the people who make decisions that impact our community, so that these decisions can be made with equity at the core (Equity and Results, 2023; Our Identities, Ourselves, 2021).

County systems generate a massive amount of data. Oftentimes, the decisions that have the most impact on County residents are based on data. And other times, data is collected and is simply stored. There are countless stories told by community members and our workforce sitting in spreadsheets still waiting to be told. Some of these stories are simplified into a chart or graph, often removing important context, such as race, gender, age, ability, language, or socioeconomic status, which results in one person's story, generally a person from an underrepresented community, masked by another's.

The following sub-strategies, action steps, recommended timeline, and performance measures will support the County to engage in robust data collection, analysis, and response.

Headline Strategy 3: County invests in data collection and reporting systems to drive change that is responsive to staff experiences.			
Sub-strategies	**Action Steps**	**Timeline** (Recommended)	**Performance Measures**
3a. Central HR publishes disaggregated data on recruitment, hiring, promotions, and turnover rates of employees.	**3a-1:** Central HR, OOE, and CT 2.0 identify an expanded set of data to collect and cadence/strategy for reporting.	Year 1	# of times that the data is updated on the website yearly #/% of times Core Team 2.0 uses this data to bolster the case for a strategy
	3a-2: Data is disaggregated, published, and moved into the action planning stage (See strategy 3c).	Year 1	
	3a-3: Central HR presents a data report on a yearly basis to the Board of Supervisors.	Year 2	
3b. Central HR conducts a standard employee survey that consistently collects data on staff experiences, in particular around belonging and career advancement.	**3b-1:** Central HR in collaboration with the OOE, and Steering Committee (SC) develop County-wide survey questions and implementation cadence.	Year 1	# of times the survey is conducted and data is published # of departments participating in survey % of employees participating in the survey
	3b-2: Central HR, CAO, and OOE develop a communication and implementation strategy to ensure maximum staff participation in the survey.	Year 1	
	3b-3: Survey report is publicly shared.	Year 2	

	3b-4: Board of Supervisors institutionalize periodic staff survey implementation and reporting.	Year 2/3	
3c. All Managers learn how to apply Anti-Racist Results-Based Accountability (AR-RBA) to address racial inequities from survey data.	**3c-1:** Managers go through AR-RBA Training.	Year 1	% of managers trained and using AR-RBA in their work (survey response) % of managers seeking technical assistance to use AR-RBA in their work % of managers who reference survey data when requesting resources to address staff needs % of managers who address survey responses by using AR-RBA
	3c-2: OOE works with departments to establish a Plan to respond to survey findings through the AR-RBA process, including establishing support spaces for Department Heads and managers applying AR-RBA.	Year 2	
3d. County institutionalizes spaces for healing, belonging, and connection.	**3d-1:** The OOE, in partnership with Core Team 1.0, 2.0, and Steering Committee, will outline and communicate the purpose, best practices, and parameters for establishing spaces for belonging, healing, and connection.	Year 1	% of employees who feel they have their experiences validated % employees who feel a sense of belonging and connection

	3d-2: The OOE will work with Central HR to identify and vet a list of pre-approved facilitators/consultants supporting equity work and assess consultant performance based on equity principles set forth with the Steering Committee, and Core Team 1.0 and 2.0.	Year 1/2/3	% of employees who feel safe to express themselves in these spaces % of employees who feel these spaces support their professional development
	3d-3: The Board of Supervisors funds and supports spaces for belonging, healing and connection.	Year 1	
	3d-4: OOE and Central HR engage in ongoing evaluation of the effectiveness of these spaces with the guidance and support of the Steering Committee and Core Team 1.0 and 2.0.	Year 2	
Headline Better-Off Measures 3: Percentage of staff retention and turnover; Percentage of staff who feel like the County is offering a positive space to support their work and well-being.			

Part 6: Setting the Racial Equity Action Plan up for Success

A Racial Equity Action Plan is only as effective as the accountability mechanisms and institutional commitments that support its implementation. Funding, evaluation, reflection, and the dedication to long-term refinement and implementation are all key to success.

Threading Accountability and Sustainability Throughout

Through the adoption of the Strategic Plan Racial Equity and Social Justice pillar, the Board of Supervisors accepted the County's responsibility as local government to "achieve racial equity in County service provision and ensure a workforce reflective of the community we serve." As the largest employer in the region, the County has the opportunity to model what it looks like to take steps to become an anti-racist organization. To begin addressing this commitment, the County must first identify the racial inequities perpetuated within the institution and hold itself accountable for resolving them. Within public administration, research suggests that organizations that take on higher levels of accountability generally yield positive results across different functions of the system (Bovens, Goodin, & Schillemans, 2014).

Braided throughout the Racial Equity Action Plan are accountability measures, which are guided by a design-to-the-margins (DTM) framework and operationalized through the Anti-Racist Results-Based Accountability (AR-RBA) process. These frameworks align with an operational principle of the Office of Equity that recognizes that people closest to the identified issues are also closest to the solutions (Martin, 2017), and that the people who have historically held power have a responsibility to historically marginalized communities when taking on change.

The Office of Equity cannot take on this charge alone. It is imperative that there is County-wide support and that department leaders take ownership over particular pieces of this Action Plan in order to effectively implement these transformative practices.

This Action Plan includes the following accountability mechanisms to hold the County accountable to this work and to the people most impacted by it:

- Data collection and Analysis: Through the use of AR-RBA, the Plan attaches performance measures to strategies and action steps to track progress in the short and longer term.
- Transparency and Public Reporting: In alignment with the County Strategic Plan, this Action Plan sets processes in place to establish regular and publicly available reports on racial equity (County Strategy Plan Racial Equity and Social Justice pillar Goal 3/Objective 2).
- Funding prioritization: The Action Plan identifies three key investment areas, reflected by the proposed strategies, where prioritization of funding and resources will be necessary for successful implementation.

- Stewardship and Oversight: The Action Plan identifies parties responsible for the completion of the actions under any given strategy.

Commitment to an Iterative Process

An important part of the County's commitment towards racial equity is the ongoing review of our disaggregated performance metrics to see where we are meeting our target outcomes and where we are falling short. This commitment to ongoing review will help assess and determine which strategies are successful in driving change and which need to be reevaluated, reconsidered, or changed to meet our goals.

Therefore, the Racial Equity Action Plan is by definition a living document based on the recognition that our strategies may need revision. This level of flexibility and adaptive management is responsive to the evolving needs of the organization and staff, and to the reality that change initiatives like this one may result in unintended consequences that need addressing. When a pivot becomes necessary, this Action Plan should continue to center the wisdom of staff of color.

Commitment to Short- and Long-Term Learning, Growing, and Acting

The ability to choose not to continue learning about race and racism is a privilege that people of color do not always have, and so, in an anti-racist institution, the responsibility to learn and grow and act falls on all of us (Blitz & Kohl, 2012; Carreira, 2018).

In alignment with a commitment to an iterative process, the County's understanding of equity issues needs to be flexible in order to take new developments into account. Shifts, even immediate ones, often take time to demonstrate benefit, so giving strategies time to work and evaluating over the long-term is key.

Some strategies can be implemented quickly, but even for these, the County must remain committed to long-term implementation and evaluation, so we are able to accurately determine their efficacy. Strategies that will take longer to implement require a stronger commitment to the long-term, as they will take more time to see the benefits. For example, we will only see the impacts of hiring shifts over time. This is where the Plan's performance and headline better-off measures keep us focused on the impact of shorter-term actions while not losing sight of the long-term vision and desired impact of the strategies.

Assessing Capacity and Scaffolding Up

This Action Plan is meant to meet departments where they are and build a support structure, like the scaffolding of a construction project, to take their work to the next level towards more equitable versions of themselves.

As we set a new baseline, we can look forward to building new structures within County departments to support change and take steps forward in our anti-racist journeys. The Office of Equity looks forward to deepening collaborative relationships with County departments to ensure that the implementation of this Action Plan is supportive of their needs, specific circumstances, and current efforts.

Part 6: Conclusion

Building a sustainable, anti-racist foundation starts from within. By dedicating our efforts to enhance our internal systems and practices, we create a powerful catalyst to drive change in the community at large. County staff constitute integral members of the County organization and also represent the communities we serve, embodying the diverse composition, needs, and disparities present in the broader community. The way we support County staff and leadership of color can mirror our approach to the wider community.

We have the opportunity to be change makers within the County system. Together, we can work to ensure that the voices of Black, Indigenous, and People of Color are heard and respected and that in response to these voices, we collectively develop and support practices that lead to a working ecosystem where everyone feels a sense of belonging and support for career advancement. By establishing the foundations that advance racial equity work within our organization, and accountability measures to track our progress, we establish a strong backbone for generating transformative change externally.

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